- 8 Belal A, Glorig A. Dysequilibrium of ageing (presbyastasis). *J Laryngol Otol* 1986;100:1037-41.
- 9 Sloane PD, Baloh RW. Persistent dizziness in geriatric patients. *J Am Geriatr Soc* 1989;37:1031-8.
- 10 Katsarkas A. Dizziness in ageing: a retrospective study of 1194 cases. *Otolaryngol Head Neck Surg* 1994;110:296-301.
- 11 Kroenke K, Lucas CA, Rosenberg ML, Scherokman B, Herbers JE, Wehrle PA, et al. Causes of persistent dizziness: a prospective study of 100 patients in ambulatory care. *Ann Intern Med* 1992;117:898-904.
- 12 Davis LE. Dizziness in elderly men. *J Am Geriatr Soc* 1994;42:1184-8.
- 13 Dix MR, Hallpike CS. The pathology, symptomatology and diagnosis of certain common disorders of the vestibular system. *Annals of Otolology* 1952;61:987-1016.
- 14 Aylard PR, Gooding JH, McKenna PJ, Snaith RP. A validation study of three anxiety and depression self-assessment scales. *J Psychosom Res* 1987;31:261-8.
- 15 Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1:233-8.
- 16 Colledge NR, Cantley P, Peaston I, Brash H, Lewis S, Wilson JA. Ageing and balance: the measurement of spontaneous sway by posturography. *Gerontology* 1994;40:273-8.
- 17 McIntosh S, Da Costa D, Kenny RA. Outcome of an integrated approach to the investigation of dizziness, falls and syncope in elderly patients referred to a "syncope" clinic. *Age Ageing* 1993;22:53-8.
- 18 Hopkins A. *Clinical neurology: A modern approach*. Oxford: Oxford University Press, 1993.
- 19 Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand* 1983;67:361-70.
- 20 Drayer PB. Imaging of the aging brain. II. Pathologic conditions. *Radiology* 1988;166:797-806.
- 21 Day JJ, Freer CE, Dixon AK, Coni N, Hall LD, Sims C, et al. Magnetic resonance imaging of the brain and brain-stem in elderly patients with dizziness. *Age Ageing* 1990;19:144-50.
- 22 Quinn N. Parkinsonism: recognition and differential diagnosis. *BMJ* 1995;310:447-52.
- 23 Brocklehurst JC, Robertson D, James-Groom P. Clinical correlates of sway in old age—sensory modalities. *Age Ageing* 1982;11:1-10.
- 24 Nedzelski JM, Barber HO, McIlmoyl L. Diagnoses in a dizziness unit. *J Otolaryngol* 1986;15:101-4.
- 25 Ensrud KE, Nevitt MC, Yunis C, Hulley SB, Grimm RH, Cummings SR. Postural hypotension and postural dizziness in elderly women. *Arch Intern Med* 1992;152:1058-64.
- 26 Stark RJ, Wodak J. Primary orthostatic cerebral ischaemia. *J Neurol Neurosurg Psychiatry* 1983;46:883-91.
- 27 Ledin T, Kronhed AC, Möller C, Möller M, Ödkvist LM, Olsson B. Effects of balance training in elderly evaluated by clinical tests and dynamic posturography. *J Vestib Res* 1990/91;1:129-38.
- 28 Hu MH, Woollacott MH. Multisensory training of standing balance in older adults. I. Postural stability and one leg stance balance. *J Gerontol* 1994;49:M52-61.

(Accepted 7 August 1996)

Doctors' retainer scheme in Scotland: time for change?

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Abstract

Objectives—To describe the present doctors' retainer scheme in Scotland and ascertain the need for change.

Design—Semistructured postal questionnaires to current and past members of the doctors' retainer scheme and general practitioner employers.

Setting—Scotland, October to December 1994.

Subjects—152/160 current and 104/124 former members responded together with 101/118 general practitioner employers.

Results—93% of members currently working in general practice were either vocationally trained or had previously worked as principals. 84% of current members held postgraduate qualifications. 73% of former members had left the scheme within 4 years and 72% of current members had been with the scheme for 4 years or less. 66% of current members said that the scheme prevented them from leaving medicine. Both members and employers were dissatisfied with the current limit of two working sessions per week, 77% of employers wanting it increased. 61% of current members would not have joined the scheme if suitable part time work had been available and 46% of those would have preferred to work flexibly, up to 5 sessions per week. 52% of members do not receive BMA rates of pay and, of those, 46% work more than 3.5 hours per session.

Conclusion—The scheme appears to be appreciated and would be more so if inconsistencies in pay and conditions were addressed. An increase in the permitted number of weekly sessions would enable these highly qualified doctors to maintain their skills and confidence.

Introduction

Half of medical graduates are now women and there is an increasing demand for part time training and work from both men and women.^{1 2} Opportunities are still limited, however, and this study aimed to explore the existing and potential usefulness of the doctors' retainer scheme, which has been in existence in Scotland since 1972 (and also in the rest of the UK).

The scheme was established to "encourage doctors who were temporarily unable to practise because of domestic commitments to remain in touch with medical

activity and continue their training in order eventually to return to substantial practice." The conditions of membership have remained unchanged^{3 4} and are:

Work up to a maximum of 2 paid sessions per week.

Receive in addition to salary an annual retainer fee (currently £290) paid by the health board.

Keep up registration with General Medical Council and belong to a defence organisation.

Subscribe to a professional journal.

Attend at least 7 educational sessions a year.

Work at least 12 paid service sessions per year.

In general practice one session a week is reimbursed to practices by health boards. The present level of reimbursement is £40.50 per session.

Recently, the scheme has been felt to be in need of modernisation,^{5 6} and in 1992 the Advisory Committee on Medical Establishment recommended that doctors in the scheme should be allowed to work up to four sessions per week and do controlled short term locum work; that the retainer fee should be updated annually to cover expenses; and that time spent in the scheme should be limited to five years.⁷ There is no indication that these recommendations will be implemented, and there has been no large study to help shape policy. We therefore carried out a structured inquiry of both present and past members of the scheme in Scotland and of employers.

Methods

Our aims were to: (a) describe the characteristics of the current membership, to assess training needs; (b) acquire data on length of membership and subsequent career development of former members; (c) gather information on pay and conditions and other factors affecting satisfaction with the scheme; and (d) seek suggestions for improving the scheme.

Names and addresses of current members were easily obtained from the five Scottish postgraduate centres. It was harder to identify former members because the length of time that records are kept varies between the five centres, and our data are therefore incomplete. Current addresses of former members were found using the *Medical Directory*, telephone directories, and information from staff in postgraduate centres.

Semistructured postal questionnaires were sent to current members and those former members who could

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BMJ 1996;313:792-4

Table 1—Profile of 152 current members of doctors' retainer scheme in Scotland

	No
Age (years)	
23-28	6
29-34	66
35-40	57
41-46	19
47-52	3
≥53	1
Place of work	
General practice	114
Hospital	8
Community	3
General practice and other	17
Other	4
Not working	1
Unknown	5
Main postgraduate qualification	
MRCGP	78
DRCOG	73
Family planning certificate	26
None	25

Table 2—Length of membership of scheme among current and former members

Years of membership	Current members*	Former members
1-2	66	57
-4	44	18
-6	15	14
-8	11	5
-10	10	5
-12	1	1
-14	2	1
-16	1	1
-18	2	0
Unknown		2

*Time spent on the scheme at the time of the survey.

be traced. Questionnaires were also sent to the general practitioner employers of current members. A few retainees worked exclusively in hospital but because of difficulties in tracing employers and variability between posts, a questionnaire was not sent to hospital employers. Reminders were sent to non-respondents after three weeks. Replies were coded and entered on to computer and the data analysed using SPSS for Windows.

Results

One hundred and sixty questionnaires were sent to current members of the scheme, 124 to former

members, and 118 to employers. Of these 152 (95%), 104 (84%), and 101 (86%) were completed respectively.

Of the 152 current members 150 were women, 123 were aged 29-40, and 149 had children, 117 of them a preschool child. Of the 131 working in general practice 120 were vocationally trained and 21 had previously worked as principals, and 127 held postgraduate qualifications (table 1).

LENGTH OF MEMBERSHIP

Length of membership varied from 1 to 17 years. However, 76 of the 104 former members had left the scheme within four years, and at the time of the study 110 of the 152 current members had been with the scheme for four years or less (table 2). Of the 35 current members who had been in the scheme for more than five years eight still had one preschool child and four had experienced serious illness either themselves or in family members. When asked about future career plans 49 were unsure when they would leave the scheme but 30 had definite plans to leave within the next year. Twenty four said they would leave when their children were older and 47 said they would leave if a suitable job opportunity arose. Thirty one former members were principals with most of the remainder working in a wide variety of general practice and hospital posts. Only seven were not working, and, of those, one was retired and one was on maternity leave.

PAY

The pay received by members varied widely, although this is difficult to interpret because of differences in hours worked. However, over half of current members did not receive the rate recommended by the BMA for the work they were doing and, of those, 46% worked more than 3.5 hours per session. Members receiving lower rates were less likely to be satisfied with their pay and were more likely to feel undervalued in the practice (table 3). When asked to give an overall rating for the scheme in terms of their career development, 84% of respondents receiving BMA rates and 65% receiving non-BMA rates gave a positive rating (table 3). Eighty eight of the 101 employers thought that health board reimbursement should be nearer BMA rates.

LIMIT ON SESSIONS

Eighty of the employers thought the current limit of two sessions per week should be increased, 15 favouring three, 37 four, 25 five, 1 seven, and 2 "unlimited." Their reasons were mostly to increase continuity and flexibility and to give more involvement with the practice. Members of the scheme also wanted an increase in the permitted number of weekly sessions: 129 thought that working more sessions would increase their confidence before leaving the scheme. Ninety one (61%) current members and 73 (78%) former members would not have joined the scheme if a suitable part time job had been available. Among this group, 33 current members and 26 former members would have preferred to work flexibly, up to five sessions a week; 25 current and 17 former members would have preferred to work less than five sessions; and for 14 and six respectively job sharing was the preferred option. Nineteen current and 24 former members did not specify a preference.

FULFILMENT OF SCHEME'S AIMS

An important aspect of the study was to find out if the scheme's original aims were still being fulfilled, and these results are summarised in table 4. Forty six per cent of current members said that the scheme prevented them from leaving medicine, 82% that it enabled them to practise regularly, and 90% that it enabled them to be with their children.

Table 3—Satisfaction with schemes and length of sessions according to whether members were paid in accordance with BMA recommended rates

	Current members		Former members	
	Paid at BMA rates (n = 71)	Not paid at BMA rates (n = 81)	Paid at BMA rates (n = 54)	Not paid at BMA rates (n = 50)
Satisfied with pay				
Yes	66	39	51	17
No	5	42	3	33
Length of session				
≤3.5 hours	63	44		
>3.5 hours	8	37		
Feel undervalued				
Yes	21	35	17	28
No	38	30	27	15
Overall rating of scheme				
Positive	60	52	37	37
Neutral	7	11	10	2
Negative	4	18	7	11

Table 4—Benefits of scheme. Results are numbers of current and former members of scheme

	Agree strongly	Agree slightly	Neither agree nor disagree	Disagree slightly	Disagree strongly	Missing replies
Keep in contact with colleagues						
Current	67	59	10	11	3	2
Former	46	34	8	11	3	2
Able to practise regularly						
Current	125	23	2	0	0	2
Former	60	31	10	2	0	1
Be with children regularly						
Current	137	7	4	0	0	4
Former	76	16	6	1	1	4
Keep aware of medical developments						
Current	46	71	20	10	3	2
Former	36	43	9	13	2	1
Prevent from leaving medicine						
Current	69	31	27	14	9	2
Former	33	26	14	10	21	0

Discussion

This was a pragmatic study to discover the views and experiences of as many doctors as possible who had been involved with the doctors' retainer scheme in Scotland. Because of difficulties in identifying former members, the findings relating to this group can be criticised. In particular, our data relating to length of time spent on the scheme may be inaccurate and, for this reason, we presented detailed information on current members' future career plans. Nevertheless, because of the high response rate from both groups and the similarities in experiences and opinions of current and former members we think that our group was not unrepresentative.

We found a well qualified, motivated group of doctors who, in the main, were committed to a career in general practice but who had decided to opt for extremely limited, often very poorly paid, work. The main reason for this appears to be the regularity of work on the scheme, which is valuable for the planning of child care. There are few other options for regular part time work in general practice without the commitment of partnership. We have shown that the doctors' retainer scheme continues to be a valued option for those with young

children, and over 46% of members would have left medicine if this scheme had not existed.

This study has shown that 53% of members do not receive rates of pay recommended by the BMA and that this accounts for much dissatisfaction with the scheme. These doctors have completed their training and should be able to give a full service commitment, with appropriate remuneration. At present, there are no national guidelines on pay and conditions, which makes it difficult for individuals to negotiate an appropriate salary with their employers.

Although appreciated, the scheme is flawed in its present form. The current upper limit of two sessions a week is insufficient to maintain skills and confidence and both members and employers would welcome an increased limit. There is no clear consensus, but four sessions a week, as suggested by the 1992 report,⁷ would seem to be acceptable to most respondents. The same report proposed a time limitation of five years and this should also be acceptable, particularly if allowance is given for maternity leave and exceptional circumstances such as illness.

At present the members of the doctors' retainer scheme are a very small proportion of doctors working as non-principals in general practice.⁸ This would probably change if the conditions of membership were relaxed, as the scheme might prove extremely attractive. The potential financial implications of this are considerable, but we submit that investment in such a career break scheme is likely to reap considerable dividends. While they are members of this scheme these doctors will be able to give a substantial service commitment to the National Health Service which will go some way to help ease increasing levels of workload and stress in general practice.^{9 10} It is a relatively small step from four sessions per week to part time partnership, and when they leave the scheme these doctors will probably be much more ready to commit to partnership. We believe that changes to the doctors' retainer scheme could help the present recruitment and retention problems in general practice. To be effective, however, these changes must include the introduction of guidelines on pay and conditions.

We thank the Scottish postgraduate medical departments for their time and cooperation; Professor R A Wood, dean of postgraduate medicine in Aberdeen for his support and encouragement; Mrs Pauline Browell-Hook for her administration of the project; and Mrs Katherine Deans for secretarial help.

Funding: Scottish Council for Postgraduate Medical and Dental Education.

Conflict of interest: None.

Key messages

Changes to the doctors' retainer scheme have been suggested but, so far, there has been no large study to inform policy.

At present there are no national guidelines on pay and conditions and 53% of members do not receive BMA rates.

This study shows that most members are vocationally trained with appropriate postgraduate qualifications for a career in general practice.

The opportunity to have a career break remains valuable and 46% of members would have left medicine if the scheme had not existed.

According to both members and employers, an increase in the permitted number of weekly sessions is necessary to increase confidence and to give more involvement in the practice.

- 1 Allen I. *Any room at the top?* London: Policy Studies Institute, 1988.
- 2 Allen I. *Part time working in general practice.* London: Policy Studies Institute, 1992.
- 3 Scottish Home and Health Department. *Circular SHM 51/1972.* Edinburgh: SHHD, 1972.
- 4 Scottish Office Home and Health Department. *SHHD/DGM (1991) 19.* Edinburgh: SHHD, 1991.
- 5 Bahrami J. Survey of doctors on the retainer scheme. *Education for General Practice* 1994;5:26-33.
- 6 Oswald J, Ray R. Looking to the future. *Scottish Medicine* 1994;13:6-7.
- 7 Advisory Committee on Medical Establishment. *Part-time training and working for doctors in Scotland.* Edinburgh: SHHD, 1992.
- 8 Baker M, Petchey P, Williams J. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995;310:1301-4.
- 9 Howie J. Attitudes to medical care: the organisation of work and stress among GPs. *Br J Gen Pract* 1992;42:181-5.
- 10 Sutherland VJ, Cooper CL. Job stress, satisfaction and mental health among GPs before and after the new contract. *BMJ* 1992;304:1545-8.

(Accepted 7 August 1996)