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Morale in General Practice

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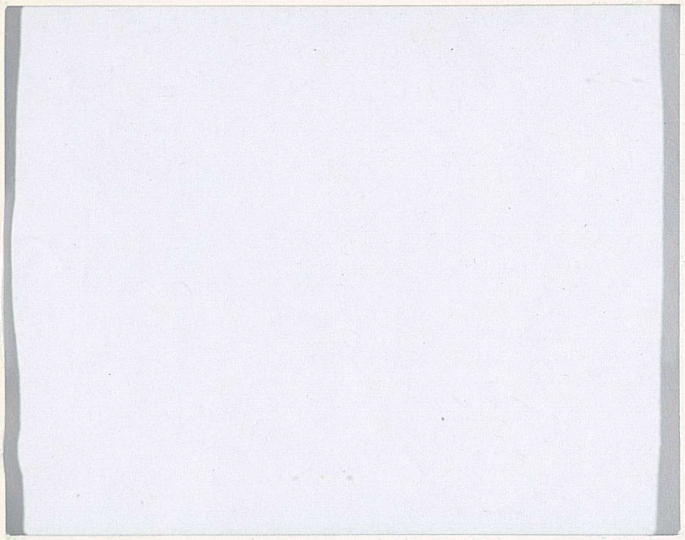
Philippa Hayter, Stephen Peckham
& Ray Robinson

Research Paper

University
of Southampton



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INSTITUTE FOR HEALTH POLICY STUDIES
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EXECUTIVE SUMMARY

1. BACKGROUND

1.1 There is a widespread view that levels of morale amongst general practitioners have fallen in recent years and are presently at a worryingly low point. It was largely in response to this that the Health Commissions of Wiltshire and Bath and Portsmouth and South East Hampshire asked the Institute of Health Policy Studies to undertake this study of GP morale. Whilst there is a good deal of informal and anecdotal evidence which points to a number of factors as causes of low morale, there appears to have been little systematic research which seeks to establish the full range and relative importance of these causal factors. The specific research aims of this study agreed with the two Health Commissions were therefore:

- to identify the experiences, perceptions and organisational factors which combine to produce a GP's sense of job satisfaction, well-being and morale;

- to establish those factors causing low morale which are amenable to different forms of management action at the Health Commission level;

- to make recommendations for appropriate management action to improve morale and increase job satisfaction amongst GPs.

2. THE STUDY

Research methods

2.1 The study involved in-depth semi-structured interviews with a purposive sample of 29 GPs from 19 practices in Wiltshire and 10 practices in Portsmouth City. The majority of interviews were carried out over the period 1st February to 27th March 1995 by a team of three researchers. The sample was selected with the assistance of the two Health Commissions according to criteria determined by the research team to reflect the variations in GPs' age and sex, different sizes and location of practices, and fundholding/non-fundholding status [see paragraphs: 1.2.1 to 1.2.5 in the main text].

2.2 The sample was selected to maximise diversity rather than to yield representativeness. Thus, whilst we would not claim that the results are generalisable to the whole GP population in the two areas studied, we believe that, because of the diversity, the in-depth interviews have enabled us to obtain a deeper understanding of the determinants of morale, and of the range and relative importance of the causes of low morale [para 5.1.1 to 5.1.2].

Defining morale

2.3 The main focus of this study was GP morale, rather than stress. There have been a number of studies examining stress amongst GPs reported in the literature, but an examination of these and other studies which have also looked at morale or job satisfaction, indicate that any focus on stress alone provides an incomplete picture of the situation within general practice. Stress is a response to demands or pressures placed upon individuals.

Stress becomes unacceptable when these demands and pressures pass beyond the control of the individual. These control-thresholds vary considerably between individuals, so for example, what is perceived by one individual as a threat may appear to another as an opportunity. Morale, on the other hand, is a wider concept. It is determined by reference to anticipated future events, which in turn are guided by the individuals experience of past events. The interviews were therefore structured to identify individual responses and perceptions on a range of issues including past experiences and future expectations in order to develop a better understanding of the determinants of GP morale. [para. 2.1.1 to 2.2.6]

3. THE FINDINGS

3.1 The findings are assembled in terms of the following categories:

- Levels of GP morale and stress
- Work with patients
- Management issues: factors external to the practice
- Management issues: factors internal to the practice
- The individual GP: feelings and experiences

Levels of GP morale and stress

3.2 Our diverse sample was, in fact, made up of an even distribution of GPs who reported high, moderate and low levels of morale. [Table 4.7.1] There was also a variation in reported stress levels amongst the sample [Table 4.7.2]. Our findings suggest that GPs with high stress levels do not necessarily have low morale, three GPs reported high levels for both morale and stress, and two more GPs bordered on this [para 4.7.9]. But our sample did also include six GPs with high stress levels and low morale [para 4.7.10]. Whilst there was not always a negative correlation between stress and morale, we did find a close positive correlation between reported levels of job satisfaction and morale [para 4.7.6].

Work with patients

Patient demands

3.3 Increasing and inappropriate patient demands was an area which was consistently cited throughout the interviews by around a third or more of GPs as having a negative impact on morale. These demands were cited in response to various open-ended questions such as what has changed most in the job since you became a GP (Table 4.1.3) or what is least satisfying about the job (Table 4.1.4), as well as what has caused most pressure (Table 4.3.6) and what are the three main causes of low morale amongst GPs.

3.4. The greatest pressure and hence negative impact from patients appears to arise from changes in the nature of patient demands, rather than an increase in the number of demands. Many GPs spoke of the rise in inappropriate demands coupled with increasing expectations of what doctors can provide. Many of the inappropriate demands were described as trivial illnesses and home visits for self-limiting disorders, with more demands relating to social care and social problems. One GP felt, however, that some of this demand was doctor-generated as a result of the palliative approach of GPs. Some GPs talked of the sense of monotony and drudgery which arises from seeing endless patients with such trivial demands. Others felt that patient expectations had become too high or unrealistic for the resources available. The Patients Charter and a more consumer-oriented society, together with demographic changes and developments in medical technology, were also seen as fuelling these changes in demand. (Paras 4.1.14-17)

Patient complaints

3.5 The other pressures related to patient demand were the increase in patient complaints, the complaints handling procedures and the fear of further complaints and litigation. Four GPs consistently expressed strong views about patient complaints and the complaints system at various times in the interview, eight GPs identified "worrying about patient complaints" as causing extreme pressure, and nine GPs (just under a third) cited patient complaints as one of the three main causes of low morale. In fact seven out of the latter emphasised it was the threat or fear of litigation which was the main issue and one GP described this as feeling "as if I'm sitting on a time bomb". This fear also had the effect of forcing GPs into practising more defensive medicine. (Paras. 4.4.47 and 4.7.19)

GP/patient relationship

3.6 But despite these pressures all but two GPs (93%) cited work with patients and their families or clinical work as the most satisfying aspects of their current job (Table 4.1.5). A fifth had cited caring for the whole person and whole families over time as a reason for entering general practice. (Table 4.1.1) Later in the interview, when asked for their vision of the future for general practice, a similar proportion of GPs expressed fears that the patient/GP relationship would become less personalised and there would be a decline in whole person medicine (Table 4.6.1 and para 4.6.6). This was a real concern because these were the factors that had attracted them to general practice in the first place.

Unsocial hours

3.7 Night visits, out-of-hours work and on-call duties are a well known source of pressure and cause of unhappiness amongst GPs. A third of the GPs rated one or more of these areas as a main cause of low morale as well as causing extreme pressure (Table 4.7.9). Generally on-call duties were seen as more of a pressure in larger practices (Table 4.3.3). However, we found that were no differences as a group in reported pressure levels related to on-call between the GPs who used a deputising service and those who did their own on-call or shared this with other practices. (Paras. 4.2.10-12)

Management issues: factors external to the practice

3.8 References to the "bureaucracy", government policy and attitudes, and FHSA/HC actions and attitudes combined with imposed change and the perceived loss of autonomy were jointly cited the most often as having a negative impact on morale. Nearly 60% of GPs cited one or more of these areas as impacting on them in various ways. Dissatisfaction with the government was expressed as arising from more central direction, a sense of feeling powerless and being at the mercy of bureaucrats, not being listened to, undervalued and treated with contempt. (Paras. 4.1.21 and 4.3.3)

1990 GP Contract

3.9 Just under half of all GPs made either direct or indirect reference to the Government's imposition of the 1990 GP contract. The indirect references came from pointing to the main changes in general practice as having arisen in the last five years as a result of the Contract and from other subsequent NHS reforms impacting on general practice. Other GPs, on the other hand, considered the period of change dated back to 1985. A main issue for many were feelings around a loss of control or independence, or the way the changes have impacted on them. With regard to specific issues half the GP sample commented on the new health promotion package with none having a favourable comment to make about this or about the health checks for the over-75s. The requirements to meet targets as a basis of remuneration were also criticised by many. However, when asked about other specific issues arising from the GP Contract and the other reforms some opposing views emerged. For example, comments on medical audit ranged from "we do this because we want to" to "I do as little as possible" and views on the Patients Charter and the removal of the opt-out clause on 24-hour responsibility for patients ranged from the very negative to comments such as the issue has had little impact. (Table 4.3.5 and paras. 4.3.13 to 4.3.27)

Paperwork

3.10 Paperwork is popularly cited in anecdotal reports as a major cause of low GP morale. It is therefore of interest to note that whilst paperwork was cited by more GPs than any other issue as least satisfying about their current job (Table 4.1.4), and ranked sixth in the factors causing pressure, it was identified by only four GPs as one of the areas which has the greatest negative impact and by only two GPs as one of the main causes of low morale. There may be several explanations for this. First, paperwork is an outcome of the changes and increased control the GPs complain about, not a cause. Second, paperwork is not entirely management-generated. Much of it is patient-generated, so that when GPs were asked what paperwork they did out-of-hours, more cited patient-generated than cited management-generated paperwork. Third, "paperwork" appears sometimes to be used as a rather loose term to describe data collection, number-crunching, and writing reports, including annual reports and business plans. The impact of the latter is thus alternatively referred to by the GPs as the "increasing bureaucracy". (Paras. 4.1.18 to 4.1.20)

Unwarranted demands

3.11 One of the main areas of dissatisfaction for GPs appeared to arise from having to do things which are perceived as unwarranted or of little perceived benefit or use. This seemed

to apply to a whole range of areas from the above "paperwork for bureaucrats", to unwarranted demands from patients with trivial conditions, to targets for health promotion and health checks. There was a sense of frustration from time being wasted, both by GPs and by practice nurses, which could otherwise be put to better use. (Paras 4.1.25., 4.3.20 and 4.4.48)

Positive experiences of FHSAs and HCs

3.12 When asked about whether they felt their views and opinions were valued and respected by the FHSA/HC just under half were positive in their response, with comments such as "they seem to appreciate what we say" and "they make me feel I am listened to". (Table 4.4.2 and para. 4.2.27). But some gave a qualified response, for example by inferring that it depended on who they were talking to. Some GPs were clearly appreciative of the support they received, including the directing of resources to their practices. Nine GPs commented favourably on the communication process between themselves and their FHSA/HC (para. 4.4.39 and Table 4.4.4.), and two thirds gave examples of actions by their FHSA/HC to make their work more satisfactory including where GP ideas had been taken up. (Tables 4.4.6., and 4.4.3., and paras. 4.4.36 and 4.4.54)

FHSAs and HCs: management process

3.13 By contrast, a third of GPs identified a range of unsatisfactory experiences of their FHSA/HC as being amongst the factors which have caused the most pressure or have had the greatest negative impact on their morale. Five GPs clearly had quite strong feelings on this and each expressed their negative feelings in response to five or six different questions in the course of the interview. The main thrust of the criticisms seems to be about the <u>way</u> things are done, rather than <u>what</u> is done, since much of the latter is perceived by the GPs not to be within the powers of the FHSAs/HCs to determine. The themes which underpinned many of the criticisms were a sense that the GPs often felt they were not being listened to and a lack of understanding of the work of general practice and "life at the sharp end".

3.14 The main areas of criticism were: communications, regarded by some as inadequate and poorly co-ordinated, "with the left hand not knowing what the right hand is doing"; the decision-making process in many areas, regarded by some as remote, uninformed or just slow; FHSA/HC systems, procedures and processes, particularly the finance functions and the complaints procedures; perceived shortcomings in the calibre of management staff, in the levels of expertise in some areas and in attitudes of staff towards GPs and general practice; the way ideas and proposals by GPs are rejected; and the management of change. (Table 4.4.5 and paras 4.4.42-50). Many of the criticisms the GPs made are picked up in the "GPs' wants list" included in the summary of recommendations below Table 4.5.1 and paras 4.5.12 to 4.5.16).

Accountability

3.15 In response to a question asking if "reduced independence through accountability to the FHSA" had had a negative impact on them, some GPs did not see this as a problem because they accepted the need for accountability as an obligation for the responsibilities

delegated to them through the FHSA/HC. Other GPs, however, saw accountability as an infringement of their self-employed status and their professionalism.

3.16 Just under a third of GPs emphasised the feelings of loss of control and loss of autonomy, generally on two or three occasions in the course of the interview. This applied especially to those GPs who had cited "having control" as a reason for entering general practice. A "progressive feeling of disempowerment and losing control in a more structured and managed environment" and "an increasing intrusion into our working patterns" is how these feelings were expressed by two GPs who saw loss of control as a main cause of low morale. (Paras 4.3.28-30 and 4.7.36)

Change

3.17 Around a third of GPs made a variety of references to the issue of change at some point in the interview. The comments appear to fall into three main categories. First, there is the issue of whether a particular change is actually perceived as appropriate and can be justified. Second, there are criticisms of the process of change, including inadequate consultation, imposed change and a lack of preparation of GPs prior to the introduction of change. Third, there are criticisms of the pace and intensity of change, the latter is reported as causing more pressure when it is imposed by others, and the GPs are unable to have control over the process. (Paras. 4.3.31 to 4.3.35)

Locality managers

3.18 Reference to locality managers or primary care managers were made by just over half of the GPs in response to a variety of questions in the course of the interview. The responses suggest a concept still in early, but varying stages of development. About a third were very positive, another third perceive there may be the potential "to improve things", and the remaining third were sceptical. Two GPs saw the need for locality managers to have power if they were to be of benefit to GPs. (Box 4.4.2 and paras 4.4.52-3)

<u>Management issues: factors internal to the practice</u>

Partnerships and teamworking

3.19 Support within GP partnerships and primary health care teams was a main area where contrasting experiences were reported (Table 4.4.1 and paras 4.4.4-5). The positive factors cited were supportive relationships between partners and a strong focus on developing the primary health care team. Three examples of supportive relationships came from all female two-partner practices, and for two this relationship was an important contributory factor to their high levels of morale (para 4.7.26). A third of GPs reported actions with specific reference to team-building, teamwork or the team in response to questions asking for actions taken by the practice to address or improve morale (Box 4.4.1). Others referred to a culture of informal sharing and support. One GP with a high morale commented that "working together as a team ... is the hallmark of all morale improvement".

3.20 In contrast, twelve GPs reported negative experiences of partners and team-working. Ten reported they had problems, at least sometimes, with sharing workload between partners, due to partners not pulling their weight, a mismatch of ideas about what constitutes work,

or different levels of commitment (para 4.4.12). Whilst 59% of GPs claimed they could comment, as partners, on each others performance, the remainder could not do so all the time. The responses of the latter suggest a culture where complete sharing, trust or support did not come easily (para 4.4.7). Nine of the twelve GPs who reported negative experiences of partners or team working were from the younger half of the sample, with those in their thirties expressing the strongest views. The responses suggest the more junior partners were generally experiencing most pressure from inequitable sharing of workloads or from blocking of their ideas from their more senior partners. (para 4.7.28)

3.21 Ten of the above GPs who reported negative experiences within their practice had low to fairly low morale levels (para 4.7.28). Seven GPs who identified "increasing workload" as a main cause of low morale, in fact worked less hours than the average for the whole GP sample, but they all reported problems in sharing workload with their GP partners (para 4.7.24). No GPs identified problems within the practice as being a cause of low morale, but our data suggests an undercurrent of difficulties in working with partners and suggests there may be a link between partnership problems and low morale for some GPs. This is an area which may merit further study.

Workloads

3.22 Ten GPs cited "increasing workload" as one of the three main causes of low morale. This increasing workload is perceived as coming from many areas including: "work imposed by the bureaucracy", the shift of workload from secondary to primary care and increasing patient expectations and demands. However, the impact on the individual GP would appear to be dependent, at least to some extent, on how well the practice is able to manage these shifts and demands as well as their personal control-threshold (see 2.3 above). Eight of the GPs who cited "increasing workloads" had above average patient contacts, and their mean morale level was well below the average for all GPs. (Paras 4.7.21-22 and 4.7.38 and 4.2.3-4)

3.23 Long working hours appeared to have less of an impact on the morale of our sample than anecdotal evidence would suggest. Eight out of the twelve GPs who worked the most hours had the highest morale levels. The data suggests that those who work longer hours may be more stimulated by their job, than those who work shorter hours. (Para. 4.7.24)

Delegation

3.24 Delegating some work to primary care nurses was clearly seen by some GPs as an important part of providing services and managing the patient workload, both now and in the future. A third of GPs identified problems in such delegation at the present time, four reported lack of nurse resources, one lack of skills, and two patient resistance (para 4.4.15) Six GPs referred to delegation to nurses as a current approach to managing surgery workloads, and seven GPs cited increasing delegation to practice nurses and an enhanced role for nurses as their vision of the future (paras 4.2.7. and 4.4.17). Several GPs, however, expressed concern about the ceding of responsibility to other members of the primary health care team and in particular the development of the nurse practitioner. They saw it as the doctor-patient relationship slipping away. (Paras 4.4.15-18)

The individual GP: feelings and experiences

The concept of "feelings"

3.25 Many of the factors identified above and which determine the levels of morale in individual GPs are to do with GPs' "feelings" about their present position, derived from past and present experiences and from their anticipation of future events. There are four main areas of feelings which impact on GP morale:

being in control	v.	lack of control or loss of control
being valued	v.	undervalued, exploited, loss of esteem
being supported	v.	lack of support, isolation
optimism	v.	pessimism

Individual levels of morale are, in part, determined by the balance between these positive and negative feelings for the individual. (Paras 4.7.34-6)

Control

3.26 Feelings of being in control (4.7.37), or a loss of control and further erosion of autonomy (para 4.6.4) were discussed by many GPs, and such feelings are clearly an important determinant of morale. Feelings of being in control of their work are reported as important in sustaining morale by some GPs, whilst three GPs claimed that what would improve their morale would be "to get some sort of control back". Whilst five GPs cited a general loss of control and autonomy and an increasingly managed environment as a main cause of low morale, it is likely that many of those reporting increasing patient demands and workloads as a cause of low morale (Table 4.7.9) were also experiencing a lack of control over their work. (Para 4.7.38)

Lack of esteem

3.27 Six GPs cited feelings of being undervalued, exploited and the lack of esteem, as one of the three main causes of low morale (Table 4.7.9). The importance of feeling valued emerged in response to a wide range of questions. Feeling undervalued by government and the FHSA/HC was expressed in various ways by a number of GPs. Exploitation by the government, particularly as reflected in the inadequacies of the remuneration system, and not being listened to by government and the FHSA/HC were strongly held views (para 4.3.3 and 4.4.45) Most satisfaction in the job was therefore obtained for a number of GPs through the rewards of working with patients and being valued by them and by the local community. However, some GPs talked of there no longer being complete trust in GPs, and the erosion of the perceived value of GPs to society, as well as the feelings of being exploited by all sectors of the NHS and the community. Not being valued by partners was also experienced by some GPs, and a few referred to the lack of esteem they felt as the result of quality of recruits to general practice falling off (Para 4.7.39)

Support

3.28 Supportive relationships with colleagues (as indicated in 3.19 above) were cited by some GPs as a significant factor in sustaining morale. Many GPs expressed a need for more

support from their FHSAs/HCs, and some from their GP partners. References to personal stress and health were made by several GPs and in particular the lack of available help when a problem arises (para 4.3.6). Around a third of GPs put forward ideas about the help and support needed to prevent and manage stress. There were, however, different and sometimes opposing views about the most appropriate measures, and particular emphasis by some that in developing support systems, there should be recognition that not all stress is an illness, so that an occupational health service may not, for example, be perceived as the solution for all GPs (para 4.5.24). Two GPs referred to the sense of isolation when they first became a GP principal, because of the lack of appropriate support at a vulnerable time in their career. (Para 4.1.9-10)

Balancing GP work with home life

3.29. Over a third of GPs gave having a job which fits in with having a family as a main reason for deciding to become a GP (Table 4.1.1), so the difficulties in balancing GP work with family life might be expected to be a source of pressure for some GPs. Besides the two third of GPs who rated disturbance of home and family life as causing considerable or extreme pressure, seven GPs singled these factors out as having a negative impact (Table 4.3.1). Thus although a source of stress, it is interesting that only one GP cited the impact of general practice on family life as one of the three main causes of low morale. However, an additional two GPs who cited night visits as a cause of low morale gave having a job which fits in with home life as a reason for becoming a GP.

Views on the future of General Practice: optimism v. pessimism

3.30 Some of the most pessimistic views emerged when the GPs were asked what they saw as the future for general practice. "Gloomy", "a sense of foreboding", "unsustainable", "see the whole thing crumbling", and "in terminal decline" were the views expressed amongst the almost two thirds who expressed a pessimistic view of the future. (Table 4.6.1. and para. 4.6.2) Just four GPs were optimistic and for three the optimism came from the prospect of a further shift of services from secondary to primary care (para 4.6.7), providing this is accompanied by an appropriate shift in resources. However, when we asked the GPs in what ways they thought their own practice would change in the next few years, and about their own position, there was a significant shift from pessimism to optimism, so that thirteen GPs appeared optimistic about their own personal future (Tables 4.6.2 to 4.6.6.) Thus when GPs focus on what general practice means to them personally, as a way of life and as a career, their priorities change (Para 4.6.22-23)

4. RECOMMENDATIONS

4.1 Drawing on the foregoing analysis we have identified a number of recommendations. These are set out below.

Health Commission support to GPs

4.2 Our main recommendation is that the Health Commissions need to offer strong support to GPs in the development of a primary care-led NHS. To this end they need to support GPs through the provision of advice, investment and training, and to collaborate with GPs in developing a stronger partnership between the Health Commissions and all GPs as identified in EL(94)79 (NHSE, 1994).

GPs' wants

4.3 We recommend the Health Commissions systematically and sympathetically review the complete list of "GPs' wants" (identified in full in Section 4.5 of the report). We suggest this is done initially as a separate exercise with the relevant staff in each Health Commission, and with the GPs from within each Health Commission, so that both groups have an opportunity to offer their response from their different perspectives.

4.4 An important initial outcome of this process should be:

- clear evidence that:

  a) the Health Commissions have heard what GPs are saying,
  b) the total organisation is involved and listening.

- the listening and hearing is reflected back to each individual GP practice.

- the issues and problems are communicated to the NHSE who are persuaded to discuss them with the GPs locally first hand.

4.5 Many of our more specific recommendations discussed below draw on this list of GPs' wants in combination with our other findings from this study. We should, however, emphasise that diversity among GPs means that not all the recommendations apply to all of them. Policy will need to be developed sensitively on a practice-by-practice basis.

Understanding general practice and the role of the HC

4.6 We suggest that the HCs need to work jointly with GPs to develop shared values in response to the changing role of general practice within primary care. This would include working jointly to determine the purpose of general practice and to work out the changing role of general practitioners in a primary care-led NHS. This may involve a fundamental re-working of roles and relationships within and between the HCs and general practice (Thornton, 1994), linked to our main recommendation in 4.2 above.

4.7 There would appear to be a need for a more explicit understanding of what GPs expect from the FHSAs and HCs and what the HCs expect from GPs. Such an understanding could be promoted through developing joint strategies and for HCs to work individually with GP practices in developing joint action plans to implement the agreed strategies.

4.8 We suggest that a shared understanding is developed between GPs and the managers and staff of the FHSA/HC on what is meant by accountability and responsibility for the NHS resources allocated to GPs. In particular work is needed with those GPs who perceive a conflict between accountability to the FHSA/HC and their self-employed status.

4.9 We believe there is need for the organisational structure of the Health Commissions and the respective roles, activities and functions of their managers and staff and with whom GPs inter-act to be made clear for all GPs. This should take account of the fact that, in the

course of developing a shared understanding with GPs, there may emerge a need for some rethinking on roles or activities for some staff as suggested above.

Support to GP partnerships

4.10 In developing support to GPs as a core function of the Health Commissions (EL(94)79), we suggest some structure is required for both identifying the need for support on a practice-by-practice basis and for the provision of such support.

4.11 We suggest that some specific support may be needed by some practices to help them in responding to the changing expectations of the role of General Practice in a Primary Care-led NHS. This may be needed in particular in practices where all the partners currently do not appear to share the same values and where there are differing views and expectations which have led to existing problems within the partnership. Support may therefore be required in the form of facilitation to review the purpose, values, aims for the practice prior to developing strategies for further development. Practical support may be needed in identifying the causes of any problems and in developing and implementing action plans to solve them.

4.12 We suggest any existing problems within practices are identified and addressed before attempting to develop broader strategies as discussed in 4.6 above and before encouraging or introducing major change.

Managing and coping with change

4.13 We suggest that GPs are given more support and training in the process of change. They need help in understanding, in preparing for and in managing the process better. They should be enabled in anticipating change originating from outside the practice and helped to be proactive rather than reactive in dealing with it.

Managing patient demands and expectations

4.14 We suggest that HCs and GPs need to work jointly on finding solutions to the problem of increasing and inappropriate patient demand and expectation. It may be necessary, as part of this process, to identify more clearly the causes of these changing demands on a local basis. The work on seeking solutions could be linked into the work on sharing values and determining the future role of GPs and general practice as discussed above. This would then bring in a whole range of issues such as delegation of work by GPs, out-of-hours work, on-call and night visits, list size and GP remuneration, targets and so on.

4.15 The work should include identifying action and support required from the Health Commissions, including support for innovative trial schemes aimed at addressing some of the problems. We suggest the HCs may need to be more flexible in their approach to this. Such schemes might include (see also 4.16 and 4.17 below):

- public education programmes
- the role of pharmacists in the management of minor ailments

- triage for work of nurses in large practices
- managing patient expectations of waiting times

Delegating clinical work

4.16 There have now been several studies looking at the feasibility, and in some cases the cost-benefits, of delegating GP work to others, including to nurse practitioners and other members of the primary health care team (for example Fawcett-Henesy, 1995; Marsh et al, 1995; Cragg et al, 1994). We suggest that the Health Commissions review the outcome of these studies jointly with GPs and their PHC teams with a view to identifying what may be appropriate to explore further for local application.

Encouragement of entrepreneurial and innovative GPs

4.17 Linked to some of the above proposals we suggest the Health Commissions could support entrepreneurial and innovative GPs, through encouraging and enabling them to develop well thought out proposals for new schemes aimed at improving efficiency and effectiveness. This would include support for undertaking cost-benefit analyses of such schemes and for trials where appropriate.

Management skills

4.18 We suggest that alternative approaches to management courses and training days for the development of GP management skills are explored for the benefit of those GPs who have a different learning style, and for whom more the conventional course is not appropriate. A preliminary to this should be identification of the precise training needs for individual GPs in management development where this has not been done. Such identification could be linked to the development of personal development plans.

GPs careers and future plans

4.19 We suggest the Health Commissions provide support to GPs to enable them to develop personal goals, to have personal development plans, and to find ways and means of implementing these. Such support could be linked into the South and West initiative for a Career Advisory Service for GPs. The issue of apprehension about accreditation amongst some GPs may need to be addressed in considering this proposal.

Releasing time

4.20 We suggest there is a need for an overview of all the actions that could be taken to release time for GPs. Whilst some actions can be taken at the level of the individual and incorporated into personal development plans, other actions require co-operation from partners and colleagues and from the Health Commissions. Some examples of ways that the Health Commissions could support GPs in a more efficient use of time include:

- review and monitoring of the demands made of GPs by the Health Commission's own staff, including the needs for information and the methods for collecting and submitting these.

- training GPs in time management and in efficient management of their administrative workload.

- enabling GPs and practices to manage and control patient demand as discussed above.

Support for small practices

4.21 We suggest that the existing support by the Health Commissions to small practices be continued, as this is appreciated, and that reassurance is given about the impact of future developments, such as fundholding, on small practices. Such practices need extra support as they do not have the resources to enable the spread of any additional work. The GPs from these small practices want re-assurance that any future co-operative arrangements, for example, will not compromise the freedoms over decision-making which they currently enjoy. The lack of such re-assurance may lower morale.

Isolation of new GP principals

4.22 We suggest the Health Commissions give serious consideration to setting up a support system for new GP principals to be provided on a one-to-one basis, such as a mentor scheme, as the Young Principals Support Groups are not able to meet all the needs of the new GP Principal, particularly in their first few months of appointment. We suggest consulting recently appointed first-time GP principals for their views on what would be most useful and practicable, and then setting something up on a trial basis.

Other areas for action: reviews of FHSA/HC procedures and systems.

4.23 We would like to draw particular attention to the GPs requests to review with them the following procedures and systems:

- patients complaints procedures;

- requests for information: what is being requested and by whom (including duplication of information requested), how often, why, and how;

- systems of communication between practices and the FHSA/HC: use of direct computer links and other technology;

- remuneration systems and methods of payment.

Improving GP morale: the individual GP approach

4.24 Finally, there is the need to recognise that morale is an individual state of mind and therefore problems of low morale also need to be addressed on an individual basis as well as at Health Commission and individual practice level.

4.25 We suggest Health Commissions help individual GPs with low morale to develop a greater sense of optimism about their own future within general practice. Some of the suggestions we make above under each heading, and particularly work in developing joint

values and understanding general practice, and in addressing some of the more negative issues and experiences, could go a long way towards this. Such work, combined with helping these GPs to feel more valued and providing support to them in developing personal development plans and goals (as discussed above under "GPs careers and future plans"), could therefore make a significant impact on GP morale.

4.26 Thus we suggest that some way is found for ensuring that the factors most likely to improve the morale of individual GPs, particularly those with low morale, do not get overlooked when work is done with individual practices. The point being made here is that time has to be found to discuss issues with individual GPs on a one-to-one basis. Group discussions within a practice are not sufficient to address the problems for the individual.

SECTION ONE: INTRODUCTION

1.1 Background and research aims

1.1.1 In recent years, there has been a good deal of attention focused upon levels of stress, job satisfaction and morale among general practitioners (Groenewegen and Hutton 1991, Howie *et al.*, 1992, Handysides 1994a-c). This interest derives from several sources including the impact of the 1990 contract, difficulties in recruiting GP trainees and concerns about increasing workloads and out-of-hours work. (Chudley, 1994; Royston, 1994)

1.1.2 It was in response to these types of concerns that the Health Commissions of Wiltshire & Bath and Portsmouth & South East Hampshire asked the Institute for Health Policy Studies to undertake a study of GP morale. The study was designed to identify those factors which determine GP morale and to establish actions which could be undertaken by Health Commissions in order to improve it.

1.1.3 The specific research aims agreed with the two Health Commissions[1] were:

- to identify the *experiences, perceptions and organisational* factors which combine to produce a GPs sense of job satisfaction, well-being and morale,
- to establish those factors causing low morale which are amenable to different forms of management action at the Health Commission level,
- to make recommendations for appropriate management action.

1.1.4 Particular emphasis was placed upon the identification of levers for change which could be implemented by the Commissions.

1.2 Research methods

1.2.1 The causal links between those factors which determine morale and levels of morale among GPs are complex. Moreover, they can be expected to vary between different GP settings. In view of this complexity and diversity, we decided to undertaken a series of in-depth, semi-structured interviews with a purposive sample of GPs. The sample was selected in order to reflect differences in GPs' age and sex, and also to reflect variations in practice size, location and fundholding/non-fundholding status.

1.2.2 The sample practices were selected for us by the Health Commissions on the basis of the above criteria. Ten practices were in Portsmouth City and 20 practices were in Wiltshire. Of the original 30 practices who agreed to take part in the study one later withdrew and another GP was unable to arrange an appropriate interview time due to a holiday. We were able to replace one of these practices in the study providing 29 participants (10 in Portsmouth and 19 in Wiltshire).

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[1] **Editorial Note:** The two Health Commissions and FHSAs are each referred to jointly in this report as the FHSA/HC. References during the interviews to the "Health Commission" or to the "FHSA" by the GP respondents often appeared to be interchangeable, we have therefore generally not attempted to distinguish between the two.

1.2.3 Following a literature search which identified some of the main factors addressed in other surveys of GP job satisfaction, stress and morale (see Section Two). A preliminary interview schedule was drawn up and piloted with three of the sample practices. Thereafter revisions were made to the schedule and a final version was agreed with the Commissions.

1.2.4 The interviews were undertaken by a team of three researchers over the period 1st February to 27th March 1995 (excluding the three pilots), the majority taking place in March. Two preparatory meetings were held before interviewing to ensure consistency between interviewers. The interviewers took notes during the interviews and then taped fuller notes of the interview directly afterwards. These notes were then transcribed for analysis.

1.2.5 In addition data sheets were also completed for each interview with quantitative data from the practices and the GPs. Practice data was double checked with the practices for accuracy. This data was subsequently analysed using SPSS/PC and where relevant is tabulated within this report.

SECTION TWO: GP MORALE

2.1 Introduction

2.1.1 In this section we review briefly some of the literature on GP stress, job satisfaction and morale and offer a working definition of morale which we have used in this study.

2.1.2 There have been a number of studies examining stress among GPs reported in the literature (Meyerson, 1991; Wilson *et al.*, 1991; Howie *et al.*, 1992; Caplan, 1994; Daly, 1995). Moreover, the impact of the 1990 contract has been a particular focus of attention (Sutherland and Cooper, 1992; Chambers and Belcher, 1993a; Rout and Rout, 1994).

2.1.3 These studies identify a wide range of issues relating to stress and job satisfaction. Interestingly, they suggest that stress and GP dissatisfaction are not fully explained by the 1990 contract. In particular Handysides (1994a) identifies a long history of stress and dissatisfaction within general practice, but in particular, focuses on the period from the mid 1980s.

2.1.4 Examining other studies it became clear that there is a link between job satisfaction, morale and stress (Handysides, 1994a-c) and that any focus on stress alone provides an incomplete picture of the situation within general practice. Other studies have shown high degrees of stress in other parts of the NHS (Caplan, 1994; Paxton and Axleby, 1994) and in other professions (Chambers and Belcher, 1993b).

2.1.5 There has also been an emphasis in existing studies on the impact of the changes introduced by the 1990 contract (Howie *et al.*, 1992; Chambers and Belcher, 1993a; Rout and Rout, 1994). However, in a recent study on attitudes to change Petchey (1994) concluded that it is difficult to view general practitioners as a homogenous group not so much as that there are differing sub groups of general practitioners but also because they are undertaking different jobs:

> *"To exaggerate slightly, it could be that general practitioners are not doing the same job differently but are doing different jobs."* (p554)

2.1.6 Howie *et al.*, (1992), however, found that in a particular group of GPs with a mean list size of 1800, time management was a key factor contributing towards acute stress. This would appear to contradict a more individual based perception which has been found in other studies (Norman *et al.*, 1991; Handysides, 1994a-c). These studies suggest though that in truth the determinants of job satisfaction, stress and morale are interdependent and complex relating to both individual perception and constituent elements of general practice.

2.1.7 None of the studies however provides a definition of morale nor identifies the links between job satisfaction, stress and morale. Therefore the key question must be: what are the determinants of morale and how does morale differ from stress and job satisfaction. Undoubtedly, as the results from our study show, high stress can be linked with both high and low morale.

2.1.8 The focus of this study is specifically on GP morale and therefore it is essential to draw out a definition of morale for use within the study.

2.2 Defining morale

2.2.1 Evans (1992) provides a definition of morale in relation to the work of teachers. Comparative studies of teachers and GPs have been undertaken and teachers have been discovered to report higher levels of anxiety and depression, are more likely to smoke and drink more than 22 units of alcohol per week and had more sickness absence (Chambers and Belcher, 1993b). The definition provided is however, appropriate for use in defining morale generally and has been used as the basis in development of this study.

2.2.2 Evans (1992) defines both morale and job satisfaction as states of mind, but views morale as "anticipatory" and "dynamic and forward-looking" unlike job satisfaction which she sees as "a response to a situation" and therefore "static". She therefore sees morale and job satisfaction as distinct concepts, but goes on to say that they "continually interact and so by this process, present the illusion of being one." Robinson *et al.*, (1993) in a study of morale and job satisfaction amongst nurses view morale as "largely attitudinal" whereas "job satisfaction, a closely related construct, is more of an objective, cognitive appraisal of the work domain." This study shows personal morale to be a key predictor of global job satisfaction amongst a group of hospital nurses.

2.2.3 Evans (Op cit: p166) focuses on the individual perception of morale and provides the following interpretation of the concept:

> *"Morale is a state of mind determined by the individual's anticipation of the extent of satisfaction of those needs which s/he perceives as significantly affecting his/her (work) situation."* (Op cit: p169)

2.2.4 Such a definition leads to an examination of anticipatory factors for individuals and thus is essentially about the extent of individuals' goal-orientated needs fulfilment. Thus any examination of morale among GPs needs to focus on individual circumstances. This is implicitly acknowledged in Handysides articles (1994a-c) where case study examples are used to identify issues for those individuals. The individualised nature of general practice has also been recognised in other studies (Petchey, 1994).

2.2.5 Thus this study has used the definition of morale given by Evans (1992) and structured the questionnaire schedule to reflect the fact that:

> *"morale is a state of mind which is determined by reference to anticipated future events; by the anticipated form that they will take and their anticipated effect upon satisfaction. It is dependent upon, and guided by, past events in so far as past experiences provide a basis upon which to anticipate."* (pp168/9)

2.2.6 Key issues arising from the literature were therefore incorporated into a question route which aimed to identify individual responses and perceptions of a range of issues relating to career history and expectation, workload, management, job satisfaction, working with others, and future views and expectations of general practice from general and individualised perspectives. Given the ambiguity of the impact of the 1990 contract more focus was placed on issues of workload, career and job management and satisfaction than in other studies. In addition particular focus was given to perceptions about future changes in general practice ennuied respondents own views about strategies for improving general morale and their own morale.

SECTION THREE: CHARACTERISTICS OF SAMPLE

3.1 Practice characteristics

3.1.1 The practice characteristics reflect the criteria set for drawing the sample detailed in section 1.2. Of the 29 GPs interviewed, eight came from fundholding practices, two of which were from fundholding consortiums. Of the non-fundholding practices, three were in a consortium. Tables 3.1.1 and 3.1.2 show the size of the practice by numbers of partners and list size.

3.1.2 When the sample was drawn the Health Commission for Wiltshire & Bath agreed to provide a range of rural and urban locations whilst Portsmouth requested that all the practices were selected in the Portsmouth City area. Overall, the practices were identified as being located in rural (3), semi-rural (9), suburban (3), city (5) or inner-city (9) locations.

3.1.3 The majority of practice premises are owned (21/29) and of these most are funded through the cost-rent scheme (19/21). Twelve of the practices have branch surgeries, eight with one branch surgery, three with two and one with three, giving a total of 15 branch surgeries. Two of these practices are in Portsmouth, with seven of the remaining ten being in rural Wiltshire. Most branch surgeries (14) are in rented accommodation.

3.1.4 All but five of the practices have female partners, with 12 having one female partner and 12 with two female partners. Three of the practices have female partners only and these are all two handed practices, one in an inner city, one in rural and one in an urban location. In larger practices the female partners are always a minority and in only one of these practices is the female partner the senior partner.

3.1.5 Practices were asked if they employed GP assistants or trainees. Three practices have GP assistants, two fundholding practices having 0.33 and one assistant and the non-fundholding having half an assistant. Ten practices have trainee posts, three fundholding and six non-fundholding have one trainee and one fundholding practice has two trainees.

3.1.6 Practices were also asked to identify the numbers of other staff in the practice such as fund managers, practice managers, and reception staff. Only four of the eight fundholding practices employ a fund manager and one practice has a part-time business manager. Table 3.1.3 gives details of practice managers employed by the number of partners. Table 3.1.4 gives details of the numbers of reception and other clerical staff employed by numbers of partners.

3.1.7 Practices were also asked about the numbers of practice nurses employed and the whole time equivalents this represents. One single-handed practice did not employ any practice nurses. The other practices employed between one and six nurses, although this only related to between one and three full-time equivalent practice nurses. Generally the more partners there are the more practice nurses are employed.

Table 3.1.1 - Number of Partners in Practice

Number of GPs	1	2-3	4-5	6-8	Total
Number of practices	4	9	9	7	29

Table 3.1.2 - List Size of Practices

List size	Up to 3000	3001-6000	6001-9000	9001-12000	12001-15000	15001-18000	Over 18000	Total
Number of practices	4	8	5	6	4	1	1	29

Table 3.1.3 - Whole Time Equivalent* (wte) Practice Managers Employed by Numbers of Partners

Numbers of partners wte equivalents	1	2/3	4 and over	Totals
None	1	2	1	4
Up to 0.24	0	0	0	0
0.25 - 0.49	1	0	0	1
0.50 - 0.74	0	1	1	2
0.75 - 0.99	1	1	2	4
1.00	1	5	11	17
Not known	0	0	1	1
Totals	4	9	15	29

Whole time equivalents were calculated using 37 hours per week as being full-time.

Table 3.1.4 - Whole Time Equivalent Reception and Clerical Staff Employed by Numbers of Partners

Numbers of partners wte reception and clerical staff	1	2/3	4+	Totals
0.00-1.99wte	4	0	0	4
2.00-3.99	0	4	0	4
4.00-5.99	0	4	4	8
6.00-7.99	0	0	6	6
8.00-9.99	0	0	3	3
10.00-11.99	0	0	0	0
12.00-13.99	0	1	1	2
14.00-15.99	0	0	1	1
16.00+	0	0	1	1
Totals	4	9	16	29

3.2 GP characteristics

3.2.1 Of the GPs interviewed 28 are full time and one (female) is part-time. The age and sex distribution of the sample of GPs is shown in Table 3.2.1. Seven of the principals are senior partners, four are single-handed and the remainder are full or part-time partners.

3.2.2 Twenty eight of the GPs were asked about their training. Of these 24 had completed vocational training courses. One GP completed training before 1970, four in the 1970s, 15 in the 1980s and four in the 1990s. Half of the sample (14/29) had undertaken another career within medicine before becoming a General Practitioner.

3.2.3 Two of the GPs entered General Practice in the 1960s, eight in the 1970s, 15 in the 1980s and four in the 1990s. Seven of the respondents have been with their practice for less than five years, eighteen between five and 15 years, three between 15 and 25 years and one over 25 years. Nine of the GPs had been principals in another practice before moving to their existing practice. Seven of these had been a principal in one other practice and two in two other practices.

3.2.4 The list size for each GP varied considerably between under 1000 patients to over 3000. There is no discernable pattern between locations, size or type of practice. The range is shown in Table 3.2.2.

Table 3.2.1 - Age and sex of GPs

Age of GP	Female	Male	Number
29 and under	0	1	1
30 - 39	4	5	9
40 - 49	2	8	10
50 - 59	2	7	9
Total	8	21	29

Table 3.2.2 - Personal and Average list size for all GPs

Size of list	Number of GPs	
	Personal list size	Average list size
1000 or less	1	0
1001 - 1250	1	0
1251 - 1500	3	2
1501 - 1750	5	6
1751 - 2000	5	11
2001 - 2250	4	4
2251 - 2500	7	5
2501 - 2750	1	1
2751 - 3000	1	0
3001 and over	1	0
Total	29	29

SECTION FOUR: THE FINDINGS

4.1 The GPs' careers and job satisfaction

4.1.1 Before addressing morale and specific areas of the work of general practice we wanted to obtain an overall sense of how our sample viewed their careers in general practice, what their first experiences of general practice were, how they thought general practice had changed over the years, and what was their present level of satisfaction with their current job.

The General Practitioners' Careers

4.1.2 In order to assist our understanding of each respondent's present level of satisfaction with their career in general practice we asked what other careers and posts they had had prior to their present job, and what had made them decide to become a general practitioner.

4.1.3 Around a third had worked in another branch of medicine before or after training, the majority in one or more branches of acute hospital medicine. Five had followed another career prior to medical training and becoming a GP, these included careers in the army and as a pharmacist, research biochemist, and osteopath. A few GPs had had experience of locum or assistant posts in general practice prior to becoming a principal.

4.1.4 In identifying what had made them decide to become a general practitioner most respondents gave two or more reasons. These reasons (where cited by more than one GP), together with the total number of times each was cited, are given in Table 4.1.1. Some of the reasons become a recurring theme throughout the study. They are a statement of those GPs expectations of the job and as such they constitute some of the main criteria against which they might judge their own satisfaction with their job. Four of these criteria are: having a job which fits in with having a family; a job which enables caring for the whole person, or whole families over time; a job which provides an enjoyable variety and range of work; a job which provides for control over one's professional life and to be one's own boss. Male and female GPs share the first three, but only male respondents referred to the desire for autonomy as a reason for choosing general practice.

4.1.5 It is also of interest to note that over a third of GPs included negative reasons for choosing general practice. Either they did not want to do hospital medicine or they wanted to escape from it or from another career. These negative reasons varied, but mostly included disliking various aspects of hospital medicine, such as the lifestyle, being too high-tech or academic, constantly changing specialties or being unable to progress beyond hospital registrar. There was a sense that some had almost gone into general practice by default, because it seemed the best option available, having chosen medicine as a career. Five of these respondents gave no real positive reason for going into general practice other than expectations of the lifestyle fitting in with having a family. On the other hand, just over half of the total sample appeared to have a strong commitment to becoming a GP, giving a real sense that general practice was what they wanted to do.

Table 4.1.1. Reasons for becoming a GP

"What made you decide to become a general practitioner?"	No of times cited		
	Total	male	female
The job appealed, thought would enjoy it, or attracted by the variety/range of work,	11	6	5
Fit in with having a family	10	6	4
Not want to do hospital medicine (any more, or as a career)	9	5	4
Always wanted to be a GP and/or influenced by parent/family friend when young	6	6	0
Caring for/ commitment to whole patient/ family including long term continuity of care	6	3	3
To be own boss/ to have control over professional life	5	5	0
Seen as a high profile career at the time trained	4	3	1
Not committed to/ not stimulated by previous (non-medical) career	3	2	1
Contribute to local community	3	2	1
Influenced by senior colleagues/ trainers during medical training	2	1	1
Professionally challenging, provide intellectual breadth rather than specialisation	2	2	0
Want to work with people	2	1	1

4.1.6 Out of the nine GPs who had worked in other practices as a GP principal four had changed practice at least once, because they were dissatisfied with some aspect of the practice they had been working in. Three of the latter were now single-handed practitioners. Two had left because "the practice was not moving forward quickly enough", or "could not persuade the partners the practice needed to be modernised". The third had left because of a fear of violence and pressures of working in a poor inner-city area with insufficient financial recognition of these problems in the 1990 contract. The other changes were mainly situations where practices had split or amalgamated.

Preparedness for general practice and first experiences

4.1.7 Respondents were asked whether there were any differences between their perception of what it would be like to be a GP before they commenced their vocational training - and the reality of becoming one - in the first few years as a GP principal. A summary of responses is given in Table 4.1.2. Just over a third considered general practice was much as they had expected, but a number had been trainees in the same practice and others had previously done GP locums. The majority of these respondents had trained over ten years ago and some made the point that the main changes which they had experienced, and by implication disliked, had come about more recently, following politically-initiated changes in 1985 as well as in 1990.

4.1.8 About one half of the sample felt the reality of becoming a GP was very different from their expectations in one or two respects. Generally this arose from the volume or the nature of the work. Some offered explanations for this. They felt they had been protected during their vocational training, for example they had only seen limited numbers of selected patients, or had been with a practice with a different social class of patient, or had not fully observed the business side of running a practice. "I had ignored the business side of GP work during my training, I did not realise I would have to do this, for example hiring and firing staff", and "I was very sheltered as a trainee and so did not appreciate ... what was involved in running a practice, in dealing with staff, budgets, equipping consulting rooms ... and the sense of responsibility does not hit home until you are a partner and it is your own money". Three out of the four respondents who claimed they had under-estimated the business side of the work entered general practice after 1990.

4.1.9 Two respondents talked about the sense of isolation they experienced in their first months as a GP principal. They claimed there was a marked contrast in the support one gets from trainers when a trainee and the support available once a GP principal.

> *"It was a sense of being rudderless when I first started as a GP principal. I felt all at sea, neglected and isolated. Whilst my partners are very supportive, it was difficult to ask them about specific problems or to solicit support whilst I was in my probationary period. I thought I was reasonably well prepared for GP partnership, so it came as a huge shock when I realised I could not cope. I thought I was really going under."*

4.1.10 Both respondents discussed later in the interview the need for support to be available to GPs, but the point being made here is the critical nature of those first few months as a GP principal: "it can be a very isolating experience". (They both gave positive scores for job satisfaction and morale at the time of the interview.)

Table 4.1.2. Perceptions of the job of general practitioner

"Are there any differences between your perception of what it would be like to be a GP before you commenced your vocational training - and the reality of becoming one - in your first few years as a GP principal?"	**No. times cited**
No differences, matched expectations or much as expected	11
Better than expected, likes being truly independent	2
Busier, harder work, much larger workload, more pressurised	6
Had underestimated/not recognised business side of the work: range, volume, complexity or just time required (includes paperwork/ admin)	4
Nature of patient problems different: more trivial, unnecessary requests, volume of social problems, more diversity than expected	3
Responsibilities greater, for finances or for patients	3
More stressful than had imagined	2
Isolation and lack of support when first become principal	2

Changes in general practice and satisfaction with the job

4.1.11 Respondents were asked what were the differences in the job between now and when they first became a GP principal. The majority of respondents cited between two and five main areas of difference and these are summarised in Table 4.1.3. Most cited changes which impacted on their job and their ability to do it effectively, many of which they viewed in a negative way, only three respondents indicated a positive response to the changes which had occurred.

4.1.12 Respondents were then asked what they found most satisfying and least satisfying about their current job. Many of the responses to the latter tied in with the responses to what had changed in their jobs since first becoming a GP and many of these became recurring themes throughout the interviews. The responses are summarised in Table 4.1.4. and Table 4.1.5.

4.1.13 By far the three most common responses to the questions about changes in the job and what they found least satisfying were references to increases in patient demand or expectations and to increases in paperwork. This was followed by direct or indirect references to Government and FHSA/HC decision-making, policies and attitudes.

Patient demands and expectations

4.1.14 Some saw patient demands and expectations as the biggest area of change in general practice over the last few years. About half the GPs expressed these changes as "increasingly demanding patients", whilst the other half viewed the differences as being more about changes in patient expectations. "It isn't really greater demand in terms of wanting more, but higher expectations of what the doctor can provide, but I don't really offer more services or additional quality of care than I did when I first came into general practice". A number felt such expectations were too high, or unrealistic, and particularly for the resources available.

4.1.15 Several felt that the Patients Charter had fuelled these demands and expectations, and also the media and changes in attitude in an increasingly consumer-orientated society. Some linked the demands to a more complaining public.

4.1.16 Two thirds of the 55% who cited increases in patients demands or expectations in response to differences in the job now were from urban, city or inner city practices. A few identified these increased demands as due to demographic changes in the patient population, that is to say: more social problems in a deprived area, single parent families, child abuse "requiring us to attend case conferences for which we are not trained", an increasing elderly population.

Table 4.1.3. Changes in General Practice

"What are differences between now and when you first became a Principal/ GP partner?"	No. times cited
Increased patient demands and expectations	16
Increased paperwork	10
Specific reference to direct impact on general practice of Government policy/ decision-making and implementation by FHSA	8
Attitudes of Government and FHSAs towards GPs	6
Increase in having to cope with actual or anticipated patient complaints/ litigation	6
More business orientated, more administrative work	5
'Busier' i.e. increased workload, pressures, longer hours	5
Greater emphasis on financial control of medicine	4
Impact of changes in hospital policy/ secondary care	4
More structured approach to care e.g asthma, diabetes, health promotion	2
Can do more for patients	2

n = 27 no response = 2 (GPs who entered general practice in 1994)

Table 4.1.4. **Satisfaction with the job**

"What do you find least satisfying about your current job?"	No of times cited
Paperwork	11
Patient demands and expectations	7
Use of resources/ data collection where no evidence of use or of no perceived benefit	7
Issues of demands on time and managing time*	6
Changes in Government/FHSA policy	5
Loss of autonomy/ control/ independence	5
Business side of general practice	4
Being on-call, out-of-hours work*	4
Patients can't do anything for	4
Meetings	3
Teamwork/ communication problems within practice	2
Lack of funding for resources	2
Rumeneration - inappropriate	2

* Both of these also embrace impact on family life

Table 4.1.5.

"What do you find most satisfying about your current job?"	No of times cited
Patients: dealing with patients and families (15) success with patients (5) appreciated by patients (2)	22
Clinical work (5), including use of skills and specialist work(3)	8
Having autonomy, being in control	4
Working in a small team	3
Being part of the local community	3
Developing new services	3
Out-of-hours work: achieving satisfactory arrangements for	3
Business and management issues	2

4.1.17 In response to what they find least satisfying about the current job one third of respondents also identified the area of patient demand, but here they were more specific. Five talked about the nature of such demands: "dealing with trivial illnesses which people should be treating themselves", "less tolerance of minor, everyday illnesses so people now visit a doctor on the first day", "unwarranted home visits for self-limiting disorders", "a lot of demands around issues relating to social care and social problems such as applications for invalidity benefit or housing transfers, the majority of which have no hope in succeeding". Some respondents conveyed a sense of "monotony" and "drudgery" in the job which arises from seeing patient after patient with the same minor illnesses and from the non-medical demands.

Paperwork and data collection

4.1.18 Half of all respondents referred directly to the term "paperwork" in response to the questions about differences in the job or what they found least satisfying. Most used descriptions such as "the paperwork is colossal", "the enormous amount of paperwork" "immense paperwork" "the paperwork takes up so much time". There was little elaboration on what constitutes the paperwork when describing changes in the job, but a few gave a sense that paperwork numbered amongst the least satisfying aspects of the job because it was not about patient care.

4.1.19 However, at another stage in the interview respondents had been asked to describe the paperwork they did out of hours, if any. This paperwork fell into two broad categories: patient-generated and management-generated. Out of the 80% who claimed they did paperwork out of hours, over two thirds did patient-generated paperwork, whilst just under a half did management-related paperwork. Whilst this question did not ask for a description of all paperwork, or the proportion of time spent on each type, the responses nevertheless suggest that a fair proportion of such work is patient-generated. Eleven respondents had described the latter as reports to insurance companies, employers, for Social Services, benefits and housing agencies and medical reports. In response to the questions about differences in the job or job satisfaction only two GPs referred directly to this patient-generated paperwork, but it may have been implied by others in their references to increasing patient demands and the nature of these demands.

4.1.20 Linked to paperwork was a dislike of collecting data, "number-crunching" and writing reports mentioned by a quarter of GPs, this was because in some cases these were perceived to be of little or no value. Some examples of the reasons given to us for lack of satisfaction in management-generated paperwork and data collection are reproduced below in Box 4.1.1.

Box 4.1.1.

Paper work and bureaucracy
"Paperwork is an immense frustration, the clinical paperwork is OK, I don't mind that, its the functioning bureaucracy I really dislike"
"Its the lack of time for paperwork, this is a real pressure, the increased emphasis on nursing contracts, SQIs, annual reports, business plans. This partly reflects the growth in the practice, but I feel I am being pulled away from patient care and no longer just responding to illness, but instead to other goals set by government and the FHSA."
"Completing useless returns for the Health Commission"
"Having to do an annual report which isn't used"
"Increased amount of administration returned data provided to Health Commission which I feel is not required, for example data on health outcomes"

Government and FHSA/HC policies and attitudes

4.1.21 Nearly a third of respondents made specific reference to the impact on their job of Government decision-making and policies, the implementation of national directives by FHSAs and the attitudes of the Government and FHSAs towards GPs. Many GPs conveyed a sense of things having become more and more beyond their control, for example "the nature of what we do is determined by outside forces", "we are at the mercy of bureaucrats", and of policies they did not like: "we are subject to a cascade of barmy directives which seem to be mostly based on presenting a good image of the NHS to the public". Six respondents referred to the changed attitude towards GPs, for example "the Health Commission and FHSA aren't interested in hearing our views about things, we aren't valued and our status is decreasing".

4.1.22 The sense of loss of control and autonomy and the imposition from above of practices with which they did not agree, such as health promotion and health checks, emerged again in the responses to "what do you find least satisfying?". The issue of decision-making perceived to be beyond the control of GPs and its impact on their autonomy was a recurring theme throughout the interviews.

Other changes in the job

4.1.23 Paperwork, actions by Government and the FHSA/HC, increases in patient complaints and litigation, increases in the administrative workload within the practice and generally being "busier" were each mentioned by five or six respondents as differences in the job since first becoming a GP. These were quite apart from issues of patient demand and expectations.

4.1.24 Out of the three GPs who made positive statements in response to this question, two were positive about being able to do more for patients, and one had been able to move from locum posts to become a GP principal because of GP resignations following the introduction of the 1990 contract.

Dissatisfaction with the job

4.1.25 Permeating many of the responses to "what do you find least satisfying about your current job?" was a sense that a main area of dissatisfaction arises from having to do things which are considered unwarranted or of little perceived benefit or use. This seemed to apply to a whole range of areas, from unwarranted demands from patients with trivial conditions to targets for health promotion and health checks, to annual reports, number crunching and data recording for 'bureaucrats'. There was a sense of frustration from time being wasted which could otherwise be put to better use. Several GPs expressed the view that use was not made of the data and reports demanded by the FHSA/HC or if there was, there was no perceived feedback or benefit to the practices or their patients.

4.1.26 Four respondents reported dissatisfaction with the expanding or increasing emphasis on the business side of general practice or having to attend meetings with the HC/FHSA. Similar statements were made by others later in the interviews. On the face of it this reported dislike of the growing business side to general practice appears to conflict with the

various statements made about loss of control, autonomy and independence. For example, one GP spoke of the frustration which he felt arising from a loss of independence, when it was the idea of autonomy and independence which had attracted him to general practice in the first place. But on closer examination those who complain about loss of autonomy are not the same as those who complain about the business side.

4.1.27 Some claimed that, whilst on the one hand there are demands and edicts from the FHSA/HC about their working practices, when they have ideas about how they want to run things they are "held back by bureaucrats: the Health Commission and Government regulations. I know how I could run this practice properly, but the rules and regulations don't allow it."

4.1.28 It is interesting to note that there is no direct reference to dissatisfaction with the job in terms of interfering with family life, given that one third of GPs gave the latter as a reason for entering general practice. However, six referred to the demands on their time and four to out-of-hours work as being least satisfying aspects about their current job, both of which could be interpreted as impacting on family life. When asked directly in a separate question to rate their level of satisfaction with their hours of work, 81% reported low levels of satisfaction and 72% reported insufficient time to do justice to the job. Only two respondents referred to remuneration in reporting what they find least satisfying, but again when asked directly 58% reported low satisfaction with their "NHS income for the amount of work they do".

Satisfaction with the job

4.1.29 A majority (76%) of GPs talked of work with patients in their response to the question "what do you find most satisfying about your current job". Although many had complained about increasing demands from patients, there was clearly still satisfaction to be had from work with patients and families, work that a number had given as a reason for choosing general practice as a career in the first place. Eight GPs (including three who had mentioned work with patients) also identified clinical work and use of clinical skills and specialist work as satisfying. Thus all but two GPs (93%) found work with patients or clinical work the most satisfying as might be expected.

4.1.30 Beyond clinical work and work with patients many respondents found it difficult to identify other areas of satisfaction. About half did (see Table 4.1.5) and this included satisfaction with working in a team and with colleagues, computerisation and the management side of the practice, teaching "to get away from the constant drudgery of surgeries" and four who claimed satisfaction from still having some control, particularly control of their own work patterns within the practice.

4.1.31 Immediately following this respondents were asked to rate their level of satisfaction with various elements of their job on a scale 1 to 7 where a score of 7 is equivalent to a high level of satisfaction. The mean scores for each of these elements is shown in Table 4.1.6. Satisfaction with their amount of responsibility, variety of work, partners and fellow workers, and physical working conditions is rated higher than recognition for good work, their NHS income and hours of work, the latter being rated the lowest. In addition there are differences in score when the location of the practice is taken into consideration. However,

some care is needed in interpreting the scores for "amount of responsibility" and "freedom to choose methods of working". Some respondents indicated their score applied to clinical work but if it was applied to the business side of the practice it would have been different.

4.1.32 The question concluded with asking the respondents' satisfaction rating "for your job as a whole, taking everything into consideration". This shows a mean score of 4.27, with just over half rating this with a score of 5 or 6, but seven GPs rating their job as a whole with only scores of 1, 2 or 3.

Table 4.1.6 - Mean scores for all GPs indicating level of satisfaction with elements of their job by location.

Satisfaction with	Mean Scores					
	Rural	Semi-rural	Sub-urban	City	Inner city	All
Amount of responsibility	5.50	4.08	6.00	5.00	5.38	4.92
Variety in job	5.00	5.60	6.00	5.50	6.00	5.46
Partners and fellow workers	5.50	5.67	4.50	5.50	5.25	5.38
Physical working conditions	6.50	5.84	4.00	4.25	4.63	5.14
Opportunity to use skills and abilities	6.00	4.20	2.50	5.00	5.38	4.69
Freedom to choose method of working	6.00	4.16	4.00	4.75	3.75	4.35
Recognition for good work	5.50	4.07	2.50	4.00	3.63	3.83
NHS income for the amount of work done	4.50	3.56	2.00	2.25	3.38	3.27
Hours of work	3.50	2.29	2.00	2.25	2.00	2.31
Job as a whole	6.00	4.32	3.00	4.00	4.50	4.27
Number of respondents	2	9	3	4	8	26

4.2 How time is spent

4.2.1 The majority of respondents reported that their workload has been increasing. A range of reasons were given for this, including:

- Increasing demands from patients
- More paperwork
- More business side to the practice
- Early discharge from hospital
- More throughput ie more can be done for patients so there are more referrals to secondary care with which to cope.

These were not uniform comments and some respondents felt that overall their workload has not increased as list sizes have been reduced. However, one respondent commented that over 20 years the list size has remained fairly static but workload in terms of numbers of patients seen and referrals has increased substantially.

4.2.2 In order to ascertain the size of workload and it's impact on morale a series of questions examining overall hours, surgery hours, out of hours work, and activity within work were asked.

Workload

4.2.3 The total working hours, excluding Saturdays and on call duty, reported by the respondents ranged from 28.30 to 57.50 hours. This includes part-time and job share respondents. In addition two thirds of the respondents worked some Saturdays, ranging from 1 every three months to every Saturday. The most frequent work pattern was once each month (1 in 4 or 5 Saturdays). GPs in urban, city or inner city practices reported working longer hours than those in rural practices.

4.2.4 GPs responses about satisfaction with working hours vary considerably between inner city and rural practices (see Table 4.1.6). There would also appear to be differences between number of partners in the practice with GPs from larger practices reporting more pressure from long working hours than single-handed GPs. However, there is no correlation between size of practice or location and total hours worked. This suggests that the perceptions of individual GPs relates to more subtle views about workload, which while individual, do tend to group by location and practice size.

4.2.5 Only five respondents reported that they did not take work home. For those that did, the hours worked ranged from one to 14. This paperwork is both management-generated and patient-generated as discussed in paragraph 4.1.19.

GP surgeries

4.2.6 The number of surgeries worked, excluding Saturdays, by the respondents ranged between four and eleven. The majority of GPs undertook eight (8 GPs) or nine (9 GPs) surgeries a week with six undertaking seven, or seven and a part surgery. Total surgery hours varied considerably between 10.5 and 29.3 hours although two GPs reported total surgery times of 41.0 and 47.0 hours. Just over one half of the respondents (15/29) have booking intervals of 10 minutes with the rest ranged between five and eight minutes. The average time respondents allocated to patients is 9.86 minutes, with 15 GPs spending 10 minutes or less with each patient. However, 21 of the respondents reported that their surgeries over run. When asked how often this happens each week only 15 reported this occurring 3 or more times a week. The majority of these stated that the over run is less than one hour.

4.2.7 Most respondents reported that the practices, or they individually have adopted strategies for easing pressure on surgery time. Auditing patient times against booking times is common and generally practices have tried to act on this information. Common strategies include catching up time within surgeries, additional surgeries, open surgery times, using practice nurses where possible, telephone advice sessions and varying individual GP consultation times. Most practices with booked appointments also have emergency appointments. One respondent reported adopting a less personal approach with less open questions to the patient and to ignoring leads to additional issues.

4.2.8 Many of these strategies do not reduce the overall pressure on surgery time. Seven GPs claimed the various strategies tried within their practices had failed. Respondents conceded that emergency appointments, longer booking times and catch up sessions may only serve to add additional pressures on time. Also different GP consultation periods within larger practices can be a source of friction between partners in terms of sharing workloads.

4.2.9 Some practices allow receptionists to allocate differential booking times for different patients based on knowledge of the patient. In other practices the GPs delegate some of the surgery work to practice nurses. Examples given of this include consultations relating to asthma (where the practice nurse is trained) and for minor ailments.

On-call duties

4.2.10 All the respondents undertake some on-call duties ranging from those contracting to do a minimum under a Deputising Service arrangement to those who share the on-call duties within their practice. The former are more likely to be in urban areas and the latter in rural areas. Some practices combined some on-call for their own practice with the employment of a Deputising Service. Five GPs do not work nights on call and seven do not work week-ends on call. Two work less than one night per month with the most worked is one night in two. One third of the respondents worked either one in four or five nights. Weekends on-call reflect the pattern of Saturday working as most GPs do the Saturday morning surgery as part of the week-end on-call duty.

4.2.11 Around two thirds of respondents reported that they see only one person on average when they are on call, with nine reporting between two and five people and one 9 people.

Low call out rates may reflect the fact that urban call outs are dealt with by the Deputising Service and the rural GPs reported low call out rates. When asked what percentage of call outs are unnecessary answers ranged between 0% and 95%. Inner-city and city GPs thought 60% of calls were unnecessary, suburban GPs thought 40% unnecessary and rural and semi-rural GPs thought 24% to be unnecessary. The GPs using a deputising service between them felt 44% of calls to be unnecessary. These figures include the single handed GPs who all, except one, felt that none of their calls were unnecessary. A range of views were expressed as to why the night calls were viewed as necessary or not. For example, many felt calls were unnecessary because they were for trivia, or because patients were not organised or that parents should take more responsibility for their children. On the other hand, other GPs recognised that patients and parents have different criteria from doctors and a psychological need for reassurance is valid and needs to be met.

4.2.12 Generally on-call duty is seen as more of a pressure in larger practices. However, this does not correlate with practice location nor whether the practice undertakes its own on-call whether it is shared, or a Deputising Service is used.

Responsibilities within the Practice

4.2.13 The respondents in practices of three partners or more were also asked whether they had any special responsibility within the practice partnership. Table 4.2.1. lists the responsibilities reported by GPs.

4.2.14 Respondents gave a wide variety of reasons for taking on these roles including coercion, personal interest, delegation, agreement and sharing. Computing and audit were areas of particular interest for some GPs and others found themselves with jobs where they showed a flair for certain activities such as finance. The GPs did not seem to have any training in the business side of the practice and one younger GP felt that this should be part of the training. One GP reported that they had been advised by an external consultant on dividing up the jobs within the practice and that this has worked well.

Services to patients

4.2.15 Respondents were also asked about the range of services to patients provided within the practice and the extent to which they are involved in this provision. The results are given in Table 4.2.2. Where the respondent is not involved in the service the most common pattern of provision involved the Practice Nurse, particularly in relation to asthma, diabetes, hypertension, travel and lipid/diet clinics or services.

4.2.16 It is clear from the responses of the GPs that some of the services offered to patients are motivated by the personal interest of the GPs in the practice. Examples include complementary medicine and sports clinics. The pattern of involvement varies and many practices have lead GPs for certain services rather than equal sharing of the load.

Table 4.2.1 - Responsibilities reported by GPs (n=22)

Responsibilities	Number of GPs
Chair	10
Fundholding budget	2
Practice finance	9
Business planning	12
Contract negotiation/commissioning	2
Staff management	7
Medical audit	5
Computers	7
GP trainees	6
Reception area management	1
Organising complementary medicine	2
Management of buildings	1

Table 4.2.2 Services provided in practices and level of involvement of respondents (n=29)

Service provided	Number of practices offering services	Level of involvement of respondent GP		
		Not involved	Does some	Does all
Minor surgery	26	4	19	3
Maternity services	28	21	6	1
Child health surveillance	27	8	15	4
Contraceptive services	28	0	22	6
Asthma care	27	3	17	7
Diabetic care	28	3	20	5
Osteopathy	1	0	0	1
Homeopathy	3	1	1	1
Counselling	8	6	1	1
Clinical trials	1	0	0	1
acupuncture	4	1	0	3
Complementary medicine	1	0	0	1
Relaxation	1	0	1	0
Hypertension	4	3	1	0
Chiropody	3	3	0	0
Physiotherapy	7	5	2	0
HRT	1	0	0	1
Travel clinic	2	2	0	0
Lipid/diet clinic	3	3	0	0
Wart clinic	1	0	1	0
Child psychiatry	1	1	0	0
Occupational health	1	0	1	0
Sports medicine	1	1	0	0

Table 4.2.3 GP commitments outside the practice

Activity	Number of GPs
Clinical assistant	9
Work in community hospital	5
Other NHS clinical activities	0
GP training	2
GP tutoring	2
Research	1
MAAG membership	1
Membership of LMC	5
Membership of RCGP/BMA etc	6
Medical officer (state school)	1
Occupational health	2
Insurance medicals	1
Voluntary medical duties (for events etc)	1
Medical officer (private school)	2
Special interest committee/responsibility (Maternity, education etc)	6
Purchasing/commissioning committee	6
Police surgeon	2
Army on call/medical officer	2
Public service (JP etc)	1
Teaching	4

GP commitments outside the Practice

4.2.17 Respondents were also asked about commitments outside of the practice. These included other clinical work, committee membership and medical officer appointments. Most respondents have some other responsibilities. The overall pattern of these involvements is given in table 4.2.3.

4.2.18 Again the reasons for taking up additional activities outside of the practice varies between individual practices and individual GPs within the practices. Most respondents have at least one external activity. The motivators for these vary from financial considerations to personal interest.

Managing the workload

4.2.19 Respondents also discussed overall approaches to lowering workload. In particular the delegation of work was a key issue. Those with practice managers delegated some of the business side to them. However, in one practice the manager dealt with all the practice business and administration. Here the key pressure related to patient demands. The need for more delegation to practice nurses and more doctoring time were frequent responses made by the GPs. Three of the practices had also sought to address workload issues by better communication between GPs in the practice. Morning breaks in surgeries and more informal practice meetings were cited as helping to cope with workload. Another surgery had instigated protected surgery time for GPs to be in the practice but have no interruptions.

4.3 The pressures in general practice

4.3.1 Having looked at the levels of job satisfaction amongst our GP sample and how their time is spent, we turned next to identifying where the pressures are and what issues have had a negative impact on GPs. We approached this in two different ways. First, we presented respondents with two lists of issues and factors which have been reported by others as creating pressure or causing stress amongst GPs, and asked them to rate or rank them according to their personal experience (referred to subsequently as the closed questions). Second, we asked two open questions. The purpose of these was to identify what other issues have had a negative impact on our sample and then to identify, out of all the possible factors which might create pressures, which ones have had the greatest negative impact or caused most pressure or frustration.

<u>The main areas of negative impact</u>

4.3.2 When we asked our GP sample to identify what had created most pressure, we asked them to pick the two or three issues which had had the greatest negative impact on them. A total of 65 responses were recorded (a mean of 2.2 for each GP). We have classified these responses into around twenty main areas and have listed them in Table 4.3.1 in rank order according to the number of mentions. Column 'a' shows the number of GPs citing each area. No single area was mentioned by more than a fifth of respondents, but given that each GP was limited to two or three responses, and given that the responses ranged over a number of issues, a high response on a single issue is unlikely to have occurred. However, when the actions by government, actions by the FHSA/HC, the loss of autonomy and references to the process of change are looked at together, because they inter-relate, then over half the respondents claimed that these areas have had the greatest negative impact on them.

4.3.3 Similar views emerged about the "bureaucracy" as had been expressed earlier in response to "what are the differences in the job between now and when you first became a GP", and "what do you find least satisfying about your current job". Phrases such as "the changing of the goal posts", "the lack of recognition of GPs", "not being listened to", "treated with contempt, and feeling undervalued", and "a sense of injustice" were directed by GPs specifically at "the government". Some comments were clearly directed at both the government and the FHSAs/HCs who together constitute "the overwhelming bureaucracy", and "treat GPs like some sort of performing poodle", increase pressures on GPs because of the "constant insistence on change as a management tool" and instil "a deep suspicion over the political motivation" behind the constant flow of new directives. This mass of eloquent missiles directed at the "bureaucracy" who create "a feeling of powerlessness" amongst GPs does appear to arise from what GPs perceive as an ever-increasing impact of the present government's policy-making on the work of general practice. And a reason why current policy-making is cited as being one of the issues having the greatest negative impact for some is voiced by one GP who said: "if change is for the good, I can accept it and re-adapt, but if it is for the worse, all it does is create stress".

Table 4.3.1. GP reflection on the areas which have had the greatest negative impact on them or have created most pressure.

a. ***"What two or three issues have had the greatest negative impact on your morale or created most pressure or frustration?"***

b. ***"Are there are any factors not in the two lists you have just completed, and which you have not mentioned so far which have had a negative impact on you or have created pressures?"***

	Areas cited which have had a negative impact or created pressure - in rank order (by number of respondents to a)	No. of GPs citing each area	
		a only	a and b
1	Government bureaucracy, policy and actions	6	7
	FHSA/HC bureaucracy	6	6
	Loss of control/ autonomy/ independence / more managed environment	5	7
	Process of change	3	6
		16	17
2	Patient demands/ expectations	6	9
3	Impact on family life	5	7
4	Patient complaints & procedures & fear of litigation	4	5
4	Night visits	4	4
6	Out-of-hours work and being on-call	3	4
7	Paperwork	3	4
7	Increasing workload	3	3
7	Financial recognition and remuneration systems	3	3
7	Resources not matching needs or expectations	3	3
11	Insufficient time	2	5
11	Shift from secondary to primary care	2	4
11	24-hour commitment and responsibility	2	2
11	Practice administration and business ethos	2	2
15	Personal stress and physical health	1	6
15	Feeling of isolation	1	1
15	Fundholding - if imposed	1	1
18	Problem patients /difficult patients	0	2
18	GP career structure, recruitment and training	0	2
	Total number of citations for question 'a'	65	-

n = 29.

4.3.4 The areas which next received most mention were patient demands and expectations (6), the impact on family life (5), patient complaints and the fear of litigation (4) and night visits (4). Thus patient demands and expectations, as in the previous section, are identified as one of the most mentioned areas. However, paperwork, which is cited the most in the least satisfying aspects of the job, gets mentioned here only three times. As implied earlier, "paperwork" is an all-embracing term which may carry a different connotation according to the question, and in this case management-generated paperwork may have become absorbed into the perceived negative aspects of government and FHSA/HC bureaucracy.

4.3.5 Just prior to this question, and after completing the two "closed" questions, we asked our sample if there were any factors which had not been mentioned up to that point in the interview and which had had a negative impact or created pressure. A shorter list of issues emerged than in the question which followed. Furthermore, a good many of these items were then identified as one of the two or three issues which had had the greatest negative impact. However, this did not apply to all. If the latter are added to the list of 65 citations already referred to, the number of citations of areas having a negative impact increases to 93 (see Table 4.3.1, column 'a and b').

4.3.6 One of the main areas which was different in this list were the references to personal stress and health. Only one GP had claimed that "the impact of general practice on his home and family life had been the greatest negative experience", and explained this was because "the job was incompatible with a successful marriage". But six more GPs referred to stress or their personal health here in this other question. The responses included : "an expectation that GPs will cope with increasing stress", "the lack of available help in unloading, I went through a bad phase some months ago and would have welcomed help and support, but it was not available". One GP spelled out where the stresses lay:

> *"I experience stress in several ways working in general practice. I don't find dealing with patients stressful, its when general practice interferes with family life and there is a conflict between the two. And I find dealing with the irregularities, dealing with the awkward edges and the sort of sense of uncertainty which is associated with the practice of medicine stressful. I get very stressed at having to return forms to the FHSA and HC regarding the nature of my clinical practice, having to justify what has been done, and without having the time to do this. I feel under pressure to do well all the time."*

4.3.7 Other areas with additional citations include patient demands and expectations (increased to 9 respondents), insufficient time and the shift from primary to secondary care. The responses are an indication that when GPs are asked to identify two or three issues which have had the greatest negative impact or created most pressure, there may be many more areas for each individual where significant pressures are also experienced.

Pressures in the job

4.3.8 The first closed question, which was a thirty-item pressure-rating scale developed for this study, throws some further light as to where GPs experience pressure. The list of items was based on work by others, including a search of the more recent literature on stress and

morale in general practice, and on the anecdotal evidence in the recent popular GP press and from personal communications (see Appendix for more detailed description of the instrument). The GPs were required to rate each item on a scale 1 to 5 according to how much pressure they experienced from each in their job. The list of items are shown in Table 4.3.2 and they are ranked by the mean score for the GP ratings.

4.3.9 The rank order of many of the items correlates quite closely with responses to the questions discussed above and earlier. For example, demands from patients (rank 1), changes imposed by the FHSA/HC (rank order of 3), the disturbance of home life by GP work (rank 4), the paperwork (rank 6), night visits (rank 7). Furthermore the items in the top half of the ranking are all issues identified as having a negative impact in the open questions.

4.3.10 A mean score for all GPs for each item masks, however, the differences between GPs in their rating of each item. There are some issues where several GPs report they experience no pressure because the issue is not relevant to them, whilst others rate these same issues as causing them extreme pressure. For example, three GPs rated night visits and being on call as causing them no pressure, whilst a third rated them as causing extreme pressure. We have therefore identified the range of scores for each item in Table 4.3.3, including the number of GPs who rated each item as causing no pressure and those as causing extreme pressure. This enables us to identify, for example, that the reason for the difference in ranking between inappropriate demands and increasing demands is that 12 GPs rated the former as causing extreme pressure, whilst only six GPs so rated the latter.

4.3.11 The individual scores in this rating list also indicate, as would be expected, there is a variation between GPs in their perceptions of the relative pressures of one issue against another. The range is however greater for some issues than others, for example the spread of scores for increasing workloads, which is ranked second, is narrow compared with those for the pace of change within general practice, and the interruptions of emergency calls during surgery.

4.3.12 We have not done any sophisticated statistical manipulation of the data because we felt the nature and size of the sample did not warrant this, apart from undertaking some cross-tabulations of the data with some of the key characteristics of our GP sample. We found there were some differences in the pattern of responses between practices of different size, suggesting that the more partners there are in a practice, the more likely the GP is to feel pressure (see Table 4.3.4). There are a few exceptions to this, where the order is reversed, for example with finding a locum and the working environment, and some where there is little variation, such as insufficient time to do justice to the job. Overall differences between other sub-groups are very small with few key differences discernible. However, fundholding GPs report that paperwork causes them more pressure than non-fundholding GPs (a mean of 4.41 compared with 3.89).

Table 4.3.2 30-item Pressure Score: mean scores

30 Items rated on a scale 1-5 according to how much pressure respondents experience from each one in their job, where:

1 = causes me no pressure
2 = causes me slight pressure
3 = causes me moderate pressure
4 = causes me considerable pressure
5 = causes me extreme pressure

Rank order	Factors causing pressure	Mean score for all GPs
1	inappropriate demands from patients	4.21
2	increasing workloads*	4.08
3	changes imposed from the FHSA/HC	3.93
4	insufficient time to do justice to the job	3.90
4	disturbance of home/family life by GP work	3.90
6	paperwork	3.89
7	night visits	3.86
8	increased demands from patients	3.83
9	dealing with problem patients	3.76
9	longworking hours	3.76
11	being on call, waiting for calls	3.75
12	worrying about patient complaints	3.66
13	dividing time between work and spouse/family	3.62
14	interruptions by emergency calls during surgery	3.48
15	24-hour responsibility for patients' lives	3.38
16	unrealistically high expectation of role by others	3.24
17	the pace of change within general practice*	3.15
18	dealing with early hospital discharges**	3.03
19	insufficient resources within the practice	2.52
20	worrying about the finances	2.48
21	arranging hospital admissions*	2.46
22	adverse publicity by the media*	2.44
23	finding a locum*	2.42
24	dealing with conflict within the practice	2.41
25	dealing with the terminally ill & their relatives	2.34
26	emphasis on business ethics*	2.24
27	professional isolation*	1.93
28	working environment and surgery set-up	1.79
28	fear of assault during visits	1.79
30	lack of support within the practice*	1.28
	Overall mean score	3.11

N = 29, except for items with asterisk where N = 26* or 28** (i.e pilot GPs not asked)

Table 4.3.3 30-item Pressure Score: range of scores

30 Items rated on a scale 1-5 according to how much pressure respondents experience from each one in their job, where:

1 = causes me no pressure
2 = causes me slight pressure
3 = causes me moderate pressure
4 = causes me considerable pressure
5 = causes me extreme pressure

Rank order	Factors causing pressure	Number of GPs for each score or range of scores			
		1	2/3	4/5	5
1	inappropriate demands from patients	0	8	21	12
2	increasing workloads*	0	4	22	6
3	changes imposed from the FHSA/HC	1	10	18	10
4	insufficient time to do justice to the job	1	7	21	8
4	disturbance of home/family life by GP work	1	8	20	8
6	paperwork	1	9	19	9
7	night visits	3	7	19	11
8	increased demands from patients	0	8	21	6
9	dealing with problem patients	0	9	20	5
9	longworking hours	0	10	19	5
11	being on call, waiting for calls	3	9	17	10
12	worrying about patient complaints	1	10	18	8
13	dividing time between work and spouse/family	1	11	17	7
14	interruptions by emergency calls during surgery	1	12	16	5
15	24-hour responsibility for patients' lives	2	12	15	7
16	unrealistically high expectation of role by others	4	11	14	5
17	the pace of change within general practice*	1	14	11	3
18	dealing with early hospital discharges**	0	19	9	1
19	insufficient resources within the practice	5	21	3	0
20	worrying about the finances	5	21	3	0
21	arranging hospital admissions*	5	19	2	0
22	adverse publicity by the media*	8	12	6	1
23	finding a locum*	10	10	6	0
24	dealing with conflict within the practice	7	15	7	1
25	dealing with the terminally ill & their relatives	7	18	4	0
26	emphasis on business ethics*	7	13	6	2
27	professional isolation*	9	13	4	0
28	working environment and surgery set-up	14	13	2	0
28	fear of assault during visits	16	8	5	0
30	lack of support within the practice*	19	6	1	0

N =29, except for items with an asterisk where N = 26* or 28** (pilot GPs not asked)

Table 4.3.4 30-item Pressure Score: mean scores by number of GPs in practice

30 Items rated on a scale 1-5 according to how much pressure respondents experience from each one in their job, where:

1 = causes me no pressure
5 = causes me extreme pressure

			Number of partners mean scores		
	Factors causing pressure	**all GPs**	1	2/3	4+
1	inappropriate demands from patients	4.21	3.25	3.89	4.60
2	increasing workloads*	4.08	3.67	4.25	4.29
3	changes imposed from the FHSA/HC	3.93	4.00	3.89	3.78
4	insufficient time to do justice to the job	3.90	4.00	4.00	3.80
4	disturbance of home/family life by GP work	3.90	3.25	4.11	3.67
6	paperwork	3.89	2.50	4.10	3.79
7	night visits	3.86	2.50	4.00	4.07
8	increased demands from patients	3.83	3.25	3.89	3.93
9	dealing with problem patients	3.76	3.50	3.44	4.07
9	longworking hours	3.76	3.25	3.78	4.07
11	being on call, waiting for calls	3.75	2.25	3.33	4.00
12	worrying about patient complaints	3.66	3.75	4.00	3.40
13	dividing time between work and home	3.62	3.25	3.67	3.60
14	surgeries interrupted by emergency calls	3.48	2.25	3.33	3.93
15	24-hour responsibility for patients' lives	3.38	2.25	3.22	3.33
16	unrealistically high expectation of role	3.24	1.50	3.40	3.30
17	the pace of change within general practice*	3.15	3.33	2.88	3.28
18	dealing with early hospital discharges**	3.03	2.75	3.22	3.00
19	insufficient resources within the practice	2.52	2.50	2.33	2.60
20	worrying about the finances	2.48	2.25	2.00	2.60
21	arranging hospital admissions*	2.46	2.75	2.50	2.43
22	adverse publicity by the media*	2.44	2.33	2.50	2.38
23	finding a locum*	2.42	4.00	2.75	2.08
24	dealing with conflict within the practice	2.41	1.75	2.44	2.71
25	dealing with the terminally ill & their relatives	2.34	2.00	2.11	2.67
26	emphasis on business ethics*	2.24	2.67	2.13	2.64
27	professional isolation*	1.93	2.33	2.00	2.29
28	working environment and surgery set-up	1.79	2.25	2.00	1.60
28	fear of assault during visits	1.79	2.00	1.56	1.87
30	lack of support within the practice*	1.28	1.00	1.38	1.57
	Overall mean score	3.11	2.89	3.07	3.26

N = 29, except for items with asterisk where N = 26* or 28** (i.e pilot GPs not asked)

The 1990 Contract

4.3.13 Before we asked the wider ranging questions on what creates pressure in the job, we attempted to ask a question which focused largely on the 1990 contract. As indicated in section 2.1 there have been several studies which have looked at stress and job satisfaction or at GP morale, before and after the introduction of the 1990 contract and between them they suggest, that whilst the 1990 contract "does not explain fully the problem of GP morale" (Handysides, 1994c), it has been responsible for some of the dissatisfaction experienced by GPs. However, since most of these studies were completed soon after the introduction of the 1990 contract, and this present study is being conducted some five years after the event, we felt we should attempt to see whether the imposition of the Contract was still having an impact. Our aim therefore was to find out which factors arising out of the contract still have a negative impact on GPs. We felt this was important because the 1990 contract is still referred to anecdotally as a source of stress.

4.3.14 We therefore presented the respondents with a list of some of the issues arising out of the 1990 contract, together with some related issues introduced since 1990. The list comprised twelve issues and the GPs were asked first, to indicate which issues were not relevant to them, and which had had a positive or at least neutral impact on them in order to eliminate these from the ranking. We then asked them to rank the remainder in order, according to how much each issue had had a negative impact on them or their ability to treat patients. The results are given in Table 4.3.5.

4.3.15 Two thirds of respondents completed the ranking satisfactorily, but one third were not able to do so for a variety of reasons. We recognise that having to rank as many as twelve items is not an easy task. However, there were other reasons for the difficulties with this question. First, there were a few GPs who did feel that the 1990 Contract had not in fact had much impact on them. Second, some felt the question to be equivocal, because for several of the issues, the impact on them had both positive and negative aspects. This applied to commissioning hospital care and medical audit for example. Third, around a fifth of GPs felt they had to give equal ranking to several issues, they felt they could not rank one below another, and so four of them ranked four to five issues equal first! Fourth, there were some different interpretations of meaning, a common problem of many closed questions. In this case it applied particularly to the "24-hour responsibility for patients".

4.3.16 Thus we eliminated one third of respondents who either did not complete the ranking or did not rank the items correctly. The quantitative interpretation of the two thirds who did respond needs therefore to be treated with some caution.

4.3.17 The order in which the twelve issues are listed in Table 4.3.5. is therefore the mean of the rank order scores for the eighteen GPs who completed the ranking task correctly (the three pilot GPs were not asked two of the issues). We gave a score of 13 where a GP claimed an issue did not have a negative impact. We excluded respondents where an issue did not apply to them, this applied largely to the commissioning of hospital care.

4.3.18 The most useful outcome of the question was that it yielded some helpful qualitative data. During the process of ranking many of the respondents commented on, or explained the reasons for their difficulties in ranking, and in so doing threw light on how these issues impact on them.

Table 4.3.5 **Issues arising out of the 1990 Contract and other NHS reforms impacting on general practice.**

"Which of the following issues have had had a negative impact on you or your ability to treat patients? Rank in order 1 up to 12 ".

Rank order scoring:

1 = most impact,
12 = least impact,
13 = neutral impact

Rank order	Issues in rank order	mean score	No of GPs
1	Implementing the new health promotion package	4.28	18
2	Reporting to the FHSA/HC on activity including the annual report	5.22	18
3	Requirements to meet targets and to provide specific services as the basis of remuneration	5.27	18
4	24-hour responsibility for patients (removal of the opt-out clause)	5.33	18
5	Reduced independence through accountability to the FHSA/HC	5.93	15*
6	The Patients Charter	6.17	18
7	Health checks for the over-75s and Health checks for new patients	6.18	17
8	The shift of services from secondary to primary care	6.20	15*
9	Commissioning hospital care for patients and/ or negotiating contracts	8.20	10
10	Developments in Care in the Community	8.44	18
11	Managing indicative budgets for prescribing	8.56	18
12	Medical Audit	8.94	18

* issue not asked for three GPs.

4.3.19 The first issue: "implementing the new health promotion contract" is ranked as having the greatest negative impact, whilst the last "medical audit" has the lowest negative impact of the twelve issues. However as with the other closed question, these aggregated findings mask the contrast in opinions between GPs. We therefore discuss each of these issues in turn, where they seem important to the aims of this study.

4.3.20 Fifteen GPs commented on implementation of the new health promotion package and none of these had a favourable comment to make. GPs negative views on this have frequently been reported and our sample reinforced such views. Typical comments were: "this is awful", "irritating, a waste of resources", "band 3 involves a lot of work in known non-productive areas", "this is imposed and I do it mechanistically to get paid, but my heart is not in it", " I rate it as '3' because it is something I am forced to do, when I believe it should be for the GP to identify the need on medical grounds". Although the overall ranking for health checks for the over-75s is seventh, many GPs had similar negative views of this, as for health promotion. The difference in ranking is largely attributable to the five who commented they delegated this work to nurses, but "it still means that nursing time is used up which could be better spent on more important things".

4.3.21 The requirements to meet targets and to provide specific services as the basis of remuneration was ranked second and also drew comments such as "some of these are crazy" and "this is enforcing the responsibility for ensuring uptake onto GPs, whereas there could be more cost-effective ways of dealing with this." However two GPs said this requirement was "not a problem ".

4.3.22 The 24-hour responsibility issue brought out a range of responses. Six ranked it first, whilst four ranked it twelfth. Some viewed it as always having been around and so removal of the opt-out clause made little difference to them, whilst others had very strong views: " I hate it, I view it negatively, because the impact is ballooning", and another claimed the 24-hour responsibility "doesn't go with management targets and goals which I am constantly under pressure to attain."

4.3.23 The Patients Charter, also drew a range of comments here and elsewhere. Many considered the Charter had had a large part to play in altering patient demand and creating unreasonable expectations, it made patients more dependent on their GP and less reliant on self-help, and made people more litigious. One GP claimed that "in principle it is a good idea, but without the resources to support its implementation it is misleading to say that all Patients' Charter standards can be met, and there is not the evidence to support all these standards anyway". Three GPs simply said "pure nonsense", "irrelevant" and "most patients don't know what it is anyway!", and so did not rank the Charter as having an impact on them. When their scores of 13 are excluded, the mean score becomes 4.80.

4.3.24 The shift in services from secondary care to primary care was seen as really quite positive by some, but concerns about the increased workload without additional resources was mentioned by several GPs and also concerns about the manner of discharge particularly by GPs from inner city areas. Nine GPs commented on developments in Care in the community and a common view was that not much is happening, but it was likely to become a problem in the future. One inner-city GP commented, however, that Social Services had become much more efficient since care in the community.

4.3.25 Around a third of GPs commented on medical audit with opposing views ranging from: "we do this because we want to", "we should justify what we do, there should be more of this", to " the HC get paid for this, they should do it", "very irritating, it has to be done to get the money", " I do as little as possible, if I was forced to do it I would make it up".

Thus around eight GPs ranked medical audit between 2 and 7, whilst five claimed it did not have a negative impact.

4.3.26 The comments made by GPs when responding to this question suggest a range of views, with a number of areas not being an issue for some GPs, whilst for others there has been some positive impact. Overall there is an impression that at least some elements of the 1990 Contract have had a negative impact on a majority of the respondents. Taking perceptions of the impact of the 1990 Contract as a whole, twelve GPs made specific reference to this earlier in the interview when asked about what had changed in the job. Some referred to "intense change" or "vast differences", especially over the last two to five years. Others made more specific comments such as "the GP Contract has really spoilt things", "we have had to change radically to accommodate the 1990 Contract but we have learned to adapt", "we have had to survive financially and the 1990 contract has therefore really altered the way that we manage our time" and "the reality has changed since the 1990 contract, our autonomy has been taken away".

4.3.27 This last GP reflects the main concerns of many of those who reported negative views about the 1990 contract or some or all, of its component parts. These concerns are first of all, loss of autonomy, and second, the process of change. We therefore discuss each of these two issues in turn in more detail below.

GP Autonomy v. Accountability

4.3.28 Some GPs considered there was a link between their feelings of loss of control or independence and various aspects of the GP contract. In response to being asked to rank the statement "reduced independence through accountability to the FHSA" one GP claimed "this is happening and it is a major source of aggravation". This GP later cited "a progressive feeling of disempowerment and losing control in a more structured and managed environment" as a main reason for low morale amongst GPs. By contrast three GPs variously observed that "accountability to the FHSA/HC is important", "I do not see it as a problem, we need to be accountable", "it is not true to say that accountability to the FHSA/HC reduces independence". Thus although "reduced independence through accountability to the FHSA" is ranked fifth in Table 4.3.5, this masks the two different point of view, so that nearly half of those responding ranked it between 1 and 3 and the other half between 10 and 12, or as having no effect.

4.3.29 Some GPs therefore accept the need for accountability as an obligation for the responsibilities delegated to them through the FHSA/HC, whereas others see this as an infringement of their self-employed status and their professionalism. At least three GPs claimed they resented the manipulation of the GP contractor status so that they felt they were being treated as employees (but without the benefits), rather as independent contractors.

4.3.30 Feelings of loss of control and loss of autonomy were in fact emphasised by nine GPs in the course of the interview, and generally on two or three occasions. None of these GPs were from fundholding practices. This loss was expressed in several different ways. There were feelings of having less control over their own work, especially for those GPs for whom "having control" had been a reason for entering general practice. These GPs expressed this as "an increasing intrusion into our working patterns by government and the FHSA/HC", and "I feel we don't have control of what goes on in the practice, as so many things are imposed upon us". A feeling of "powerlessness" was expressed by other GPs besides the one quoted above, for example: "we are locked into a contract, which the government seems to be able to vary infinitely and in their favour, we have no powers at all". Many comments were not specific, there was just a general "sense of feeling powerless" or "gradual erosion of autonomy", so that "the one thing likely to improve my morale would be attempts to get some sort of control back" or "to replace accountability with professionalism".

Orientation to change

4.3.31 Around a third of the respondents made a variety of references to the issue of change at some point in the interview, and many of these did refer as we have seen, either directly or indirectly to the 1990 contract, or to events which have flowed from its introduction. For example one GP spoke of "the intense change of a few years ago, particularly the 1990 contract, when my family became very concerned about my health and welfare, but I have learned to come to terms with it, and to adapt my working behaviour and lifestyle to it". And another GP claimed his main future goal as a GP was "to resist change as much as possible, all things in the past five years since the 1990 contract have been very bad. I would like to see the clock go back to before 1990."

4.3.32 The comments about change appear to fall into three main categories. First, there is the issue of whether the introduction of particular changes is actually appropriate and can be justified, expressed by several GPs as: " I object to change for changes sake", "the constant insistence on change as a management tool" (referred to earlier), "change should only be instigated where the need for change is proven" and "I foresee lots more change in the short term future which is not necessarily for the best". Second, there are the criticisms of the process of change, which includes criticisms of inadequate consultation before introducing change and imposed change and a lack of preparation in the introduction of change:

> *"There is no conception by those who impose changes on general practice, of what impact the changes will have on (a) what we, as GPs want to do, (b) whether we have the skills to do it, and (c) who is going to pay for the changes."*

> *"The issues which have had the greatest negative impact on me are the recent changes which we have not been prepared for such as accountability, audit, prescribing. We have not been trained for these, but we could have been, and if we had, they would have been more manageable."*

4.3.33 Third, there are those GPs who comment on the pace and intensity of change. On the one hand there are those who report: "there is too much change going on", and "there is a need to slow down the pace of change". On the other hand there are the GPs who want and can respond to a faster pace of change. One GP explained that he had split from his previous practice at the time of the introduction of the 1990 contract because he felt the practice was not moving forward sufficiently with the pace of change in general practice and this had caused conflict between the partners. As an innovator he felt held back by the slowness of his partners to respond.

4.3.34 In the 30-item pressure score we asked about the pace of change within general practice. This had a mean score of 3.15 and ranked seventeenth in the list of factors causing pressure. The distribution of individual scores (Table 4.3.3) had a fairly wide spread, but only three rated the pace of change as causing extreme pressure. By contrast changes imposed from the FHSA ranked third with a mean score of 3.93, with ten GPs rating this issue as causing extreme pressure. This suggests the pace of change in general is not a problem for some GPs, perhaps because they feel in control. But where change is imposed by others, such as the FHSA/HC this caused pressure for a greater number.

4.3.35 Finally, later in the interview we administered a psychometric test on orientation to change (Appendix One). All but two of the GPs came into the same category: "whilst change does not rest easily, at least aware that a more positive approach is required". The other two GPs were in another category with a higher score: "realistically accepts change, has some confidence in dealing with it though in a more reactive than pro-active mode. Is cautious with a balanced view." Two other GPs approached this latter score. Five GPs in the first category referred to had low scores approaching the category: "aversion to change, may well have difficulties in dealing with change or encouraging others to change". Four of the latter had overall mean pressure scores and stress scores above the average. This would suggest that an aversion to change may be a source of stress or pressure with these GPs.

<u>The pressures in general practice: overview</u>

4.3.36 In Table 4.3.6 we have taken the list of areas which the GPs identified in the open questions as having a negative impact (Table 4.3.1) and have set alongside these the number of GPs who claimed each issue causes them extreme pressure (from the 30-item pressure score). Where no figure is given, this is because an equivalent issue was not included in the pressure score. We have also included in this table the number of responses to the earlier questions about differences in the job and least satisfying aspects of the job.

4.3.37 We feel that the comparative sets of responses as shown in this table (Table 4.3.6) helps to create a picture of where the pressures are in general practice, what issues have had a negative impact, and where their relative strength of impact lies. There is probably a need to distinguish between issues which have a negative impact and those which create pressures. For example, government bureaucracy probably largely has a negative impact, but the consequences, which are the responsibility of the FHSA/HC to implement, are the issues which create the pressure. These and other management issues are the subject of the next section.

Table 4.3.6 Areas causing pressure or least satisfying to GPs
- comparisons of results to the following questions:

a. ***What two or three issues have had the greatest negative impact on your morale or created most pressure or frustration?***

b. ***Are there are any factors not in the two lists you have just completed, and which you have not mentioned so far which have had a negative impact on you or have created pressures? - see table 4.3.1***

c. ***No. of GPs citing each area "as causing me extreme pressure" = score 5 in 30-item pressure score, - see Table 4.3.2***

d. ***No. of GPs citing each area as "least satisfying about the job" - see Table 4.1.4***

e. ***What are the differences between now and when you first became a GP***

Areas cited (in rank order by number of respondents to 'a')	No. of GPs citing each area			
	a & b	c	d	e
Government bureaucracy, policy and actions	7	-	5	11
FHSA/HC bureaucracy	6	10	7	
Loss of control autonomy independence	7	-	5	
Process of change	6	3	-	-
Patient demands expectations	9	12	7	16
Impact on family life	7	8	*	-
Patient complaints & fear of litigation	5	8	-	6
Night visits	4	11	-	-
Out-of-hours work and being on-call	4	10	4*	-
Paperwork	4	9	11	10
Increasing workload	3	6	-	5
Financial recognition & remuneration systems	3	-	2	-
Resources not matching needs or expectations	3	-	2	-
Insufficient time/ demands on time	5	8	6*	-
Shift from secondary to primary care	4	-	-	4
24-hour commitment and responsibility	2	7	-	-
Practice administration and business ethos	2	2	4	5
Personal stress and physical health	6	-	-	-
Feeling of isolation	1	0	-	-
Fundholding - if imposed	1	-	-	-
Problem patients /difficult patients	2	5	-	-
GP career structure, recruitment and training	2	-	-	-

* impact on family life is included in demands on time and out-of-hours work.

4.4 Management and general practice

4.4.1 Having established the areas which our GP sample identified as creating pressures on them and their work in general practice, we then turned to look in more detail at management issues. This was the next step in trying to obtain a better understanding of the sources of these pressures and how they might be addressed. We wanted to identify which pressures might originate from within or be within the control or influence of, first, general practice and the practitioners themselves, second, the FHSA/HCs, and third the inter-action between general practice and the FHSAs/HCs.

4.4.2 We recognise that many pressures on general practices originate from outside both these groups. Nevertheless, either separately or together, both general practice and FHSAs/HCs should be in a position to anticipate and address the effects of both internal and external pressures.

4.4.3 Thus our aim was to try to find out how far both general practice and FHSAs/HCs were already attempting to address the pressures on general practice, how successful they had been, what worked well, what the stumbling blocks were, and where to look for pointers as to how they might develop this work further.

Management issues within the practice

4.4.4 We decided to focus on three inter-related areas: communications, support and team working within the practice. We asked five direct questions about these areas (see Table 4.4.1) and administered a psychometric test on teamworking (see Appendix). We also asked questions to identify how GPs were addressing the pressures they had identified. We wanted to see what part working relationships between partners and staff within the practice played in determining levels of morale, and also how this related to teamworking and practice management.

Teamworking and support within the practice

4.4.5 Two thirds of the GP sample made references at some point in the interviews to the impact on them or their partners or the primary health care team. For example, two respondents reported problems of team work or communication within the practice as one of the least satisfying aspects of the job. Whilst three respondents gave working in a small team as one of the most satisfying aspects. This contrast in experiences was reflected by other respondents in answers to a number of other questions later in the interview so that a total of seven GPs made positive responses, whilst twelve made negative comments. On the basis of these responses there would appear to be three separate groups of GPs in our sample: those where working relationships were an important factor in sustaining GP morale ("I have three good partners who are friends as well, we keep each other going"), those where relationships with one or more colleagues was not satisfactory and created pressures ("the problems of teamwork in an equal partnership, when one member of the team does not pull their weight"), and a third group who made little reference to working relationships except when asked directly and where responses generally were that there were no problems.

Table 4.4.1. Management issues within the practice

	Yes	Some-times	No	Non-respondents
Do you feel fully involved in the decision-making within the practice?	23	0	1	1
Can you comment on each others' performance?	13	5	4	3
Do you feel your ideas and views are valued and respected within the practice?	22	3	0	0
	No	**Some-times**	**Yes**	non-respondents
Are there any problems in sharing workload between partners?	14	2	8	2
Are there any problems in delegating aspects of patient care to other members of the primary health care team?	15	0	9	1

No of respondents = 25 (single-handed practitioners are excluded)

4.4.6 Support from team members was clearly important to some respondents. As one GP explained: "the problems of GP morale do not originate within the practice. It is the external pressures which affect the cohesiveness of the team. I have a very supportive team environment, but without this, and the appreciation of patients, I would have gone under". Five GPs identified support from fellow workers as a main factor in response to "what has had a positive impact on you?", for example: "having mutual respect with other members of the practice, improved relationships and discussing medical practice in a supportive framework".

4.4.7 In the 30-item pressure score the question "how much pressure do you experience from lack of support within the practice" rated 1.29, the lowest score, with three quarters of respondents claiming that this "causes me no pressure". However, when, much later in the interview, respondents were asked if they could "comment on each others performance?", only 59% claimed they were able to do this all the time. The responses from those who did not varied, but the fact that some could not readily comment on each others performance suggests a culture where complete sharing, trust or support did not come easily. For some this may not matter, but for others there was a hint that it did: "there is difficulty in commenting on each others performance", "we cannot comment easily, we need to find a way to do this", "there are some negative comments by some partners, but there is never any praise or support between partners. This can be very demoralising". Others just responded "rarely" or "one-to-one, but not on a group basis", but one of these said "we have just started *mea culpa* meetings and aim to run them quarterly".

4.4.8 Happily, many respondents recognised the value of mutual support and teamworking. In response to such questions as "have you taken any recent actions to address issues of morale", and "has your practice developed any strategies aimed at improving morale" around a third reported actions with a specific reference to "the team" or "teamwork" or "teambuilding". These responses are set out in Box 4.4.1. A number of respondents described other actions to improve communications, support and indirectly, by implication, to provide for some team-building: three referred to a programme of "away days", four to regular social events for staff, and six to informal arrangements such as weekly working lunches.

4.4.9 Besides the question on commenting on each others performance we asked two other direct questions about communications within the practice. The majority of GPs gave an emphatic "yes" to the question "do you feel fully involved in the decision-making within the practice?", including all the GPs above who had referred to teamworking. However, amongst others, there were one or two qualifications to this "yes", for example one GP who claimed: "as individuals we are autonomous and so most decisions are unilateral". Another claimed to be involved but "I feel I am not listened to all the time, even though my views are respected. The senior partner and older partner often tend to over-rule me, but I feel I am becoming more assertive". And another GP claimed that, "although all partners are involved in the decision-making, it feels unequal". Nearly all claimed their ideas and views were generally valued and respected, but three admitted this did not always happen.

Box 4.4.1 Teamworking: actions reported by respondents

"As a partnership we've tried hard over the last year or two to recognise and emphasise that the more we work together as a team the better we cope. This is the hallmark of all morale improvement."
"team training days"
"The core team within the practice have jointly discussed whether we need team building, but decided we didn't as we were all involved in decision making
"Team meetings have been developed within the last three years"
"Developments entirely within the practice due to our own team building efforts"
"a team building workshop"
"we have discussed this, we need better communication and understanding of the stress which different individuals within the team are under
"we have introduced weekly PHCT meetings to improve teamwork"
"Working on trying to improve communication and working on goals for the practice as a whole and regular PHCT meetings"
"went through a process of team building after a member of staff was dismissed"

4.4.10 It was the single-handed and two-partner practice GPs who threw most light on the difficulties of practice decision-taking. In response to a question on what are the advantages of a small practice the single-handed responded: "decision-taking is much easier because I can actually reach decisions", "can take decisions on my own and live with the mistakes, there is no committee decision-making", "I do not have to defer to or refer to anyone else about making decisions about how I work". One two-partner practice GP responded "it is easier to reach consensus, we have shared ideas and meetings are manageable". But there were perceived disadvantages too: "there are only two of us to solve all the problems". Another two-partner practice GP was apprehensive because they were about to take on a third partner and they anticipated this would make decision-making more difficult.

4.4.11 Six GPs reported they experienced considerable or extreme pressure from "dealing with conflict within the practice" in the 30-item pressure score. Most of these GPs reported elsewhere in the interview that there were problems of communications within the practice. In some cases this problem was being addressed. One GP identified the area of conflict as repeated blocking of ideas by one or two partners, which was very frustrating, particularly as the majority thought the ideas were good. Six claimed they experienced no pressure from conflict within the practice, three of these were single-handed. Most of the remainder rated their experience of dealing with conflict as causing slight pressure. Some conflict is generally inevitable whenever people have to interact regularly over time. The mean pressure score for "dealing with conflict within the practice" for all respondents was 2.41 (Table 4.3.4), but was greater for GPs from larger practices (mean score 2.71), than for small practices (mean score 2.44) and single-handed GPs (mean score 1.75).

Sharing workloads and Teamworking

4.4.12 Ten GPs claimed they had problems, at least sometimes, with sharing workload between partners in response to the question: "are there any problems with sharing workload between partners?"). The range of responses included: "inequitable sharing of night work", "there is a feeling that one of the partners does not really pull their weight, and so I have to contribute substantially more hours", "there are considerable problems, due to our different levels of commitment", "because of differences in attitude, personality and skills it is generally not possible to share out workload equally between partners, and the female partner does not want to do on-call work", "because there is a mismatch of ideas about what constitutes work", "there is a distinct difference and view between the younger and older partners. Younger partners seem to want to share more of the work". And one GP claimed a partner used subterfuge to avoid work, so this made it hard to confront that GP to sort out the problems of sharing workload. This GP said this problem had become one of the least satisfying aspects of the job.

4.4.13 "Partners not pulling their weight" was referred to by several other respondents in answer to other questions. For example a single-handed GP claimed that now that he was single-handed it was a relief "not having to do extras because of partners not pulling their weight". Difficulties in sharing the financial rewards and income was also referred to indirectly by two respondents.

4.4.14 The results of the psychometric test on teamworking (Appendix One) interestingly show that all but three of the GPs fell into the same category: "aware of the necessity of teamwork, but may have difficulty taking the time and making the effort". Out of the other three, the two lower scorers were "loners who see little advantage in working with others. Highly individualistic, confident and happy with own company". The highest scorer was "a good team player, but still able to take individual responsibility. Will see where teamwork is helpful to achieving objectives". Four out of the majority category had scores close to the 'loners', whilst ten had scores closer to the "good team player". Comparing these scores with other interview responses, we felt the results of this test were a fair representation of the majority of the GPs in our sample. It is interesting to note that the mean score for six out of the seven single-handed and two partner GPs was 2.53 points above the mean score for the sample and therefore approaching the "good team player" category. The latter were amongst those who reported obtaining most support and satisfaction from working with colleagues.

Delegating to other members of the PHCT

4.4.15 We asked the direct question "are there any problems in delegating aspects of patient care to other members of the primary health care team?" A third of respondents identified problems. Four identified the problem as lack of nurses or nurse time or not enough members of the primary health care team. One claimed "health promotion and other targets uses up nurses time, which leaves insufficient time for us to use nurses as we would like to do; we would like more nursing hours, and flexibility, which even as fundholders we are not able to achieve". Two gave patient resistance as a reason for difficulties in delegating and one lack of skills: "the two practice nurses are older than the average and so defer to the GP instead of taking on responsibility". Another responded "nurses should be allowed to take on more responsibility, we would welcome being able to employ nurse practitioners". Two acknowledged that they did not delegate enough to members of the PHCT, "there is disagreement as to how much to delegate to GPs, and being taken over by practice nurses would not be very good for me personally".

4.4.16 The latter was an issue referred to by several other GPs in response to questions about the future of general practice: "there will be a ceding of responsibility towards other members of the PHCT, for example the development of nurse practitioners. I am not sure this is the appropriate way forward as I feel that more doctors are needed to maintain family doctor relationships within general practice". Another GP expanded on this: "more of the work, the patient management will be devolved to other people. Thus the GP may become distanced from the patient. "I feel the doctor-patient relationship is slipping away. But I accept that some filtering and processing of patients by other staff is necessary to stop the demands on GPs. So it is keeping the balance between distance and closeness which is the key issue".

4.4.17 Reference to use of nurses and other members of the primary health care team was volunteered by a total of seven GPs in discussions on the future of general practice and by a further six GPs in response to a question about specific actions to manage GP surgery clinical workloads. The latter were all delegating some patients to practice nurses, and in one case a health visitor, to relieve the workload.

4.4.18 A total of two thirds of GPs therefore had specific comments to make about delegation to practice nurses and other members of the primary health care team. It was clearly seen as an important part of managing services and patient demand, both now and as a further development in the future. Some appeared to welcome this development, for others it was an inevitability, but not a particularly welcome one. But a majority gave no clear feelings about their views either way.

Improving practice management and GP management skills

4.4.19 Three respondents referred to the appointment of a practice manager having an impact on morale. One referred to "taking on a new style practice manager who is being requested to address the many management issues and paperwork currently being undertaken by partners". Clearly there ought to be potential for the appointment of non-clinical managers and staff within practices to relieve GPs of some of the bureaucratic work they complain of, but no one else mentioned this. Another GP had appointed a practice manager to help with the 1990 contract, but "it hadn't worked out, so it had backfired in terms of helping morale". A third GP claimed to have been rather critical of the practice manager's work until she attended a management course with her, as a result of which she realised she hadn't been supportive enough of this manager and was now better able to evaluate her work.

4.4.20 We asked all respondents if they had "ever undertaken any management training?". Just half replied that they had. Five had undertaken courses in business management and other management courses organised by or sponsored by the FHSA. One had done an MBA, the remainder had done mainly half day courses. A few referred here, or elsewhere in the interview, to having had training in time management.

4.4.21 We then asked what their personal training plans were for the next twelve months. We wanted to identify first, whether they had a strategy for their own training needs, and second, how far developing management or business skills figured in their plans. There were four non-respondents and five replied "no plans" or "retiring". Of the remaining twenty respondents, only three specifically mentioned doing a management course or training. Two others had considered doing so, but one claimed to have neither the time or the energy, and the other claimed "I would like to undertake management training, but locally the training is not sufficiently well organised for me to be able to attend. It is usually one day a week and it is difficult to find locums."

4.4.22 Five GPs replied they planned to do "just PGA activities", and whilst, in order to obtain the full PGA allowance management options need to be included, two GPs said they only wanted to do the clinical options. One GP claimed: "I don't really want any more management options", yet earlier in the interview had said "I am keen to increase my managerial skills because I feel at the moment I am not a good enough manager to delegate work to other people". It is unclear whether these responses are contradictory or whether this GP had envisaged ways of developing his skills without formal training.

4.4.23 Thus only half of our sample of 29 GPs had ideas of what courses they wanted to do and their responses painted a picture of interest mainly in clinical options, with five wanting to do complementary medicine, or GP trainee courses. The idea of training in business or management skills did not appear to attract much enthusiasm, although a need

for management training amongst GPs had been acknowledged by a few GPs elsewhere in the interviews.

Management relationships between GPs and their FHSA/HC

4.4.24 Views and comments on the management relationship between general practitioners and their FHSA and HC were volunteered in response to the several general questions where the GPs were asked to identify factors which have had an impact on their morale or created pressures.

4.4.25 In order to obtain some specific views from all respondents about working relationships between GPs and their FHSA/HC we asked some direct questions. We wanted to know the GPs' perceptions of how far they felt their ideas and views are valued and respected by their FHSA/HC, and what were their views on the communication process between GPs and their FHSA/HC. We incorporated into each question a means of eliciting from GPs examples of (a) positive and (b) negative experiences in order to further our understanding of their views. We also asked what actions had been undertaken by their FHSA/HC to make their work more satisfactory.

GPs' perception of how their views and ideas are received

4.4.26 The question about whether GPs felt their views and ideas are valued and respected by their FHSA/HC was clearly difficult to answer for some respondents. Some indicated their contact with the FHSA/HC was limited to making returns or reports. It was the GPs who gave examples of having made requests for support, or of ideas they had put forward about a different way of doing things, who were better able to answer the question, thus suggesting they had had more contact with their FHSA/HC.

4.4.27 As Table 4.4.2. shows just under half the sample were positive in their answer to this question, at least to some extent. For example some responded the FHSA/HC "seem to appreciate what we say", "are remarkably supportive", make me feel "that I am listened to".

4.4.28 But five qualified their response in some way and these qualifications fell into two main categories. First there were the GPs who felt that the FHSA/HC were "constrained not to act", for example due to lack of resources or "the Government" impeding them in some way. Second, there were the GPs whose responses indicated that it depended upon who they were talking to or dealing with in the organisation. This point was also picked up on in the responses to the question about communications.

4.4.29 Three GPs said they did not feel their ideas and views were valued, however none provided examples of where their views or ideas had been rejected, although one commented "I feel GPs are no longer valued as the central pillar of the service".

Table 4.4.2: "Do you feel your ideas and views are valued and respected by the FHSA/HC?"

Responses	Number
Yes, positive response	8
Qualified yes, generally positive, but some reservations	5
No	3
Not sure, doubt it	3
No direct response, but negative view expressed	5
Don't know, wouldn't know, no way of knowing	4
Total number of respondents	28
No response	1

4.4.30 Eight GPs indicated they didn't know, or were not sure, whether or not their views were valued or respected by the FHSA or HC, for example:

> *"I have no way of knowing. I really don't know. We receive reasonably warm letters from them, but I often think that they are just gracious statements and the problem is that really the FHSA and HC are serving the bureaucratic system."*

4.4.31 Only one of these GPs reported positive experiences with the FHSA/HC, two gave no examples and five reported just negative experiences (although one did say he had been "hassling the HC/FHSA to set up a research project on GP morale like this one", so must have felt listened to eventually!) It may be that the effect of negative experiences is to raise questions and doubts in the recipients' minds about how their ideas might really be viewed. This interpretation is supported by the fact that the eight GPs who felt their ideas were respected gave examples of very positive experiences, and only one mentioned negative experiences. Furthermore, the latter GP commented that, where ideas were rejected, reasons were given by the FHSA/HC and these reasons seemed reasonable.

4.4.32 Four did not give a direct answer to this question, but instead used it as an opportunity to express a view about some other negative aspect of their relationship with the FHSA or HC. One of these later gave "impotency and being undervalued by the bureaucracy" as a main cause of low morale.

4.4.33 The positive experiences are identified in Table 4.4.3. and 4.4.4 and discussed below in paragraphs 4.4.35 to 4.4.37. The negative experiences are identified in Table 4.4.3 and 4.4.5, and discussed in paragraphs 4.4.52 to 4.4.53.

4.4.34 Seven GPs referred to Locality Managers (or Primary Care Managers) or to Locality Management. Five were positive in their response, one was neutral and one was negative. Locality management was referred to again in other questions by further respondents and so is discussed in more detail later in paragraphs 4.5.2 to 4.5.3.

Ideas taken up and ideas rejected by the FHSA/HC

4.4.35 GPs were asked to give some specific examples of when they felt their ideas and views were (a) taken up by the FHSA/HC and (b) rejected by them. The responses fall into two main categories. Just under half of all the GPs referred to specific proposals or requests they had made for support for services. A smaller group gave examples of specific functions within the FHSA/HC where they felt their views were not being listened to. Aside from these, there was a miscellany of comments including three who referred to locality managers. Again a few GPs made general comments such as: "the FHSA/HC are very helpful in directing resources to the practice, they are making an effort" and "because we are non-fundholders we actually get quite a good deal from the HC in terms of supportive funding and the financial incentives are very good." Some GPs were clearly appreciative of the support they received.

4.4.36 The specific requests and proposals are listed in Table 4.4.3 which shows nine GPs identified proposals or requests that had been taken up and six GPs identified proposals that had been rejected. Where reasons were offered for the rejection it was usually on the grounds of cost. But underlying this some GPs gave a sense they did not always agree with the decision-making process. The three GPs who had made requests for support for complementary medicine or homeopathy services all said that it had been turned down for cost reasons, but one also said they thought this was short-sighted, and another claimed that the decision had been taken on the advice of a GP "who knows nothing about homeopathy". An interest in complementary medicine amongst our sample of GPs was quite striking. A third reported complementary medicine was practised by them or within their practice, five GPs specifically wanted to do training in complementary medicine, mentioned more than any other clinical area, and four mentioned complementary medicine in ideas taken up or rejected, again receiving more mentions than any other topic. They conveyed a sense that this was an area of increasing interest to GPs.

4.4.37 One GP however, did report success in obtaining support for homeopathy, but only after writing several reports. This GP later commented: "we never get a chance to prepare a case properly for the FHSA because there are always other things to do. There is just not enough time to think things through properly". This difficulty in finding thinking time, and opportunity to make a good case for specific requests, may well be a reason why some GPs are less successful in obtaining resources and so experience a sense of frustration as a result.

Communications between GPs and their FHSA/HC

4.4.38 We asked what aspects of the communication process between GPs and the FHSA/HC (a) worked well or were satisfactory and (b) worked least well and in the view of the respondent needed to be improved.

4.4.39 Nine commented favourably on the communication process between themselves and their FHSA/HC, two giving more than one response. These responses are identified in Table 4.4.4. Six GPs referred specifically and positively to their Primary Care or Locality Manager. None of the four GPs who claimed that "individual contact is the best method of communicating with the FHSA/HC, it is best to get to know a particular person" made any reference during the interview, however, to locality managers.

4.4.40 Nineteen GPs made 32 comments about aspects of the communication process with the FHSA/HC which work least well or need improvement. These responses are included in Table 4.4.5. In addition four GPs referred here to Primary Care or Locality Managers. Three GPs were not asked the questions about communications. Two who were very positive about their FHSA/HC had no criticisms to make. Four gave this area as one of the main causes of low morale.

4.4.41 Some of the responses to this question overlap with some of the responses to the question about rejected views and ideas discussed above. In addition many of these issues were also the ones identified by GPs elsewhere in the interview as having had the greatest negative impact on their morale or having created most pressure. These are all therefore included in Table 4.4.5 and are discussed together below.

Table 4.4.3 Specific examples given of when felt ideas were taken up or rejected by the FHSA/HC

Ideas proposed/ facilities requested	Ideas/ requests taken up	Ideas/ requests rejected
Computers/ equipment	1	1
Premises development	2	1
Support for practice development	1	
Funding for feasibility study for GP co-op		1
Support for ideas for dentistry service	1	
Proposals for in-house training and use of nurses	1	2
Complementary medicine/ homoeopathy	1	3
Counselling	1	1
Physiotherapy	2	
Chiropody	1	
Link worker	1	
Ideas for improving complaints procedure		1
Total number of respondents	9	6

Table 4.4.4 "What aspects of the communication process from or to GPs with the FHSA/HC work well or are satisfactory?"

	Number
All pretty good, generally OK	4
Best to deal with individuals, person-to-person	4
Getting better, overall perception of improvement	2
Are approachable and accessible	2
Positive responses in relation to locality management	6
Total number of respondents	14

Table 4.4.5 **GP reports of unsatisfactory experiences with their FHSA/HC in response to:**

A. Provide specific examples of when your ideas or views were rejected by the FHSA/HC
B. What aspects of the communication process with the FHSA/HC work least well?
C. Which issues have had the greatest negative impact on your morale or created most pressure or frustration?

Areas cited	Number of respondents citing each area			
		A	B	C
	TOTAL number of respond-ents	GP ideas/ views/ rejected	Commun-ication process inadequate	Creates pressures /lowers morale
General communication systems/ procedures/ processes criticised	11	3	8	2
Specific FHSA/HC procedures criticised	11	3	9	4
Decision-making process criticised	7	3	4	3
Management of FHSA/HC - perceived shortcomings	4	0	3	2
GP accountability perceived as management/control by FHSA/HC	8	0	2	8
Perceived attitudes towards GPs/ general practice	6	1	3	3
Management of change by FHSA/HC	3	0	0	3
Specific GP proposals/ideas rejected (also in Table 4.5.c.)	6	6	0	0
Other	7	2	4	1
Total number of respondents	24	13	19	10

Unsatisfactory experiences with the FHSA/HC

4.4.42 A third of GPs identified a range of unsatisfactory experiences of their FHSA/HC as being amongst the factors which have caused the most pressure or have had the greatest negative impact on their morale. Five GPs clearly had quite strong feelings on this and each expressed negative feelings towards the FHSA/HC in response to five or six different questions in the course of the interview.

4.4.43 There was an underlying theme amongst many of the varying comments and this was that what was unsatisfactory or the source of pressure was the way things are done. Again a number expressed the view that the FHSAs/HCs were constrained because they are having to act as an agent of Government and "everything else flows from this". The implication was that GPs perceived that much of what the FHSAs/HCs had to do was not within their power to determine, but how they carried out their responsibilities was. When the GPs were asked "what do you think the FHSA/HC could do to make the lot of GPs more satisfactory?", three quarters of GPs were very specific about changing the way things are done.

4.4.44 The main areas into which the GPs criticisms fall are listed in Table 4.4.5. Many of these areas are inter-related.

4.4.45 When we asked the GPs for their views on the communication process between themselves and their FHSA/HC eleven GPs made some general observations. Their feelings were that the process was "poor", "inadequate", "poorly co-ordinated". Some more specific comments were: "conflicting messages on the same topic, the left hand doesn't know what the right hand is doing" and "they use too much jargon which is off-putting". Some felt that communications from the FHSA/HC were only initiated when information was wanted from GPs, and this contributed to their sense of feeling undervalued. Two complained that their responses to GPs was too slow: "I am still waiting for an acknowledgement of a letter I sent four months ago on behalf of a patient" and that telephone calls were not returned. On the other hand when the FHSA want action "it is done too quickly, without adequate notice and deadlines are set which you just can't meet".

4.4.46 Eleven GPs had comments to make on specific functions or procedures within their FHSA/HC. The two areas most criticised were the finance function and the complaints procedures. But other specific areas came in for criticism too, these included patient registration, information technology advice, and public health advisers. One GP, who generally was very supportive of the FHSA/HC, commented "I do worry about the FHSA expertise in some areas". Three GPs were quite vociferous about the finance function and two used the same phrase: "we have constant battles" when referring to disputes about staff remuneration and staff budgets. Their complaints were similar, expressed by one as "we never get anywhere, we go and talk to the finance staff, we think we have resolved the issue, and then a letter comes back totally contradicting what we thought we had agreed".

4.4.47 Unhappiness with the complaints procedure was referred to by at least two GPs and implied by some others. For two this procedure represented one of the three main causes of low morale. One had made proposals to the FHSA/HC on how the procedures could be improved but claimed:

"They have done nothing about this ..... The need for the formal complaint process, which is very distressing, and in many cases unnecessary, could be reduced. There is a sense that the FHSA always take the patient's side when there is a complaint and this is before they have heard the practice's side of the story."

4.4.48 The dislike of data collection procedures came up here as well. There were criticisms about the requests for data not being properly structured, and hence difficulties in fitting the data into the forms supplied or understanding what was actually required. But constantly changing the format created difficulties too. One commented that as a result of these difficulties it was likely that much of the data submitted was inaccurate. Criticisms included inappropriate data being requested, and no feedback being provided on data that had been supplied and again statements about the frustration of collecting data perceived to be of little value..

4.4.49 The decision-making process came in for criticism too, comments ranging from "strategic decisions are often very slow" to not being consulted during the decision-making process, to uninformed decisions being made and when decisions have been made they are not communicated. One GP claimed that one of the three main causes of low morale was "the remote relationship with an organisation (i.e the FHSA/HC) that makes decisions we don't know about" and "despite that organisation having a strategic plan".

4.4.50 Several GPs discussed the issue of elected GP representatives being used in the decision-making process and there were clearly some mixed views here. Six of the respondents were representative of their local BMA or other local GP advisory group. One GP claimed that "when the FHSA/HC wants to make a decision they ask one or two GPs selected by them and not the elected GP representatives in the locality" and so as a result felt that uninformed decisions were made. This GP considered the DMC should be consulted when the FHSA/HC wanted to make a change. However another felt that the local GP advisory committee was not inter-acting with the HC and a third GP referred to "communication by the LMC as a disaster". A fourth claimed that "decision-makers don't listen to us if they don't want to", but admitted that committee work with the HC "can sometimes be quite stimulating".

4.4.51 The above and the various other areas talked about by the respondents in relation to their FHSA/HC are picked up again in the next section on "GPs' wants".

Locality Management

4.4.52 Half of the GPs referred to locality management in response to a variety of questions in the course of the interview, the majority in response to direct questions about management relationships with the FHSA/HC. All the responses are reproduced in Box 4.4.2 to convey a full sense of the range of views expressed. They suggest a concept still in early, but varying stages of development. About a third are very positive, another third perceive there may potential "to improve things", and the remaining third are sceptical. The latter expressed some uncertainty as to whether the introduction of such managers will make any real difference for GPs. Two (both in the same locality) saw the need for locality managers to have "power" if they were to be of benefit to GPs.

Box 4.4.2 Locality management

Responses from 15 GPs who referred specifically to Locality Management or Locality/ Primary Care Managers in response to one or more questions referring to actions by the FHSA/HC. (The responses are sorted by Locality, the five Localities are labelled A - E. Note: the term locality manager has been used for each respondent for convenience)

A	A good working relationship with the locality manager
A	We have a very good locality manager who works very well and is very supportive. (Cited) the meeting with the primary care manager to discuss practice development.
A	Very good relationship with locality manager
A	There is a new locality manager who we have not yet met. This may help with more contact with the FHSA/HC
A	The locality manager feels a bit closer (than the FHSA), but do not view her as able to do anything. She visits but they do not feel this makes any real difference to the practice.
B	When the locality manager visited us we put forward a lot of ideas, we felt she listened. This was a good example of a satisfactory communication process.
B	Feel very positive about changes towards locality approach, which is certainly developing well and bringing the FHSA nearer to the GP.
B	Communications are improved and locality managers are always responsive, but as yet no real help, although have the potential to improve things. Personal contact is good.
B	The move to localities is just beginning to improve relationships with the FHSA which had been very poor. We see the potential for localities to provide improved support.
B	The locality manager should improve things
B	The locality manager talked at us, but didn't ask our views. We were disappointed.
C	The GPs in the local area agreed to make as much effort as possible to communicate with the FHSA through the locality manager. They have responded, but don't always understand us.
C	See the locality manager from time to time
D	Feels the locality has just added another layer of management and has given no power resources, but changes in the HC may mean locality managers become more powerful.
D	The locality manager is not for GPs, but for the HC benefit. Not sure the locality manager makes any difference, may make things slightly worse, as places an additional layer between the practice and the person they used to deal with. Maybe more beneficial if the locality manager had resources and power.
E	Contact with the FHSA through the locality manager is a bit distant

4.4.53 The locality with only one GP referring to locality management (Locality E) had a significantly greater number of positive responses about working relationships with their FHSA/HC than did any other of the Localities and also had a low mean for negative comments. By contrast one locality (Locality B) out of the two localities where nearly all

the GPs referred to locality management had the lowest number of direct references to the FHSA/HC, either positive or negative.

FHSA/HC actions received well by GPs

4.4.54 We asked GPs what actions their FHSA/HC had taken recently to make their GP work more satisfactory, and to give some examples of where they felt their ideas had been taken up. Eighteen GPs gave one or more positive responses. Most commented on specific issues, but a few made general comments such as:

> *"the FHSA/HC are constantly willing to discuss and support in so far as their funding and strategy will allow any initiatives for the practice."*
>
> *"we have a good FHSA on our side who have recognised the limits of general practice".*

The responses are summarised in Table 4.4.6

Table 4.4.6 FHSA/HC actions to make GP work more satisfactory and GP ideas taken up by FHSA/HC

Area of action by FHSA/HC	Number	Issues*
Provide general support and help	2	For practice initiatives (1) Interpreting GP contract liberally (1)
Provide support in specific areas	8	Set-up GP co-op for out-of-hours work (3) Premises development including funding (4) Practice development (2) Medical audit (2) Ideas for dentistry service (1)
Provide funding/ direct resources	8	Computers/equipment (3) Staff budget (1) Practice Manager (1) Chiropodist, physiotherapist, counsellor (4) Homoepathy (1) District nursing (1)
Interest in stress/ morale	4	Setting up this study (4)
Improvement to systems	2	local practice information gathering (1) pathology item of service link (1)
Other actions	4	
None. No actions	7	
Not asked / no response	4	

* Number in brackets = number of respondents mentioning each issue

4.5 GPs' wants

4.5.1 We considered an important part of this study would be to identify what GPs think needs to be done to make matters more satisfactory for them. We therefore included four questions during the course of the interview inviting the GPs to express their views and to make suggestions:

(i) Can you identify any factors (from the previous questions) which have the potential to increase your morale?

(ii) Do you have any suggestions as to how the issues and problems we have just been discussing could be addressed?

(iii) What do you think the FHSA/HC could do to make the lot of GPs more satisfactory?

(iv) What other ideas do you have about how morale could be improved?

4.5.2 The first two questions were asked in the middle of the interview and the last two towards the end. The 29 GPs gave a total of 171 ideas or suggestions about areas they would like to see improved. We have classified these responses into categories similar to those used earlier, when identifying the issues which respondents claimed to have created most pressure or to have had an impact on morale, together with a few additional categories. We have used this approach to facilitate comparisons between the GPs ideas of areas in need of action with what they say impacts on them and their ability to do their job as a GP. The total number of responses for each category, together with the number of GPs giving one or more suggestions within each category are shown in Table 4.5.1

4.5.3 We decided not to engage in any judgements about which suggestions or ideas should or should not be included in this report. We felt it was important that all should be included in order to convey the full range and variety of views and concerns. The proposals, ideas, suggestions, concerns are therefore set out in full at the end of this section, grouped together in the categories as discussed above. However we have summarised below the key issues and common themes for each category.

4.5.4 The picture that is conveyed by these many responses is predominantly a list of areas in need of action, that is a list of <u>what</u> needs to be addressed, rather than many real suggestions as to <u>how</u> the problems and issues might be dealt with. Whilst it might be said that the interview did not perhaps provide opportunity for respondents to talk at length about their ideas, given that we asked so many questions, it is interesting to note that this experience is not unique to our study. Isobel Allen, in her studies of doctors careers, observed that doctors are very articulate about what is wrong, but have few ideas how to put things right. (). However, having said this, the respondents have come up with what might be viewed as a fairly comprehensive and wide ranging list of areas in need of being addressed if morale amongst GPs is to be improved. And there are some specific and practical proposals

Table 4.5.1 GPs views and ideas on areas in need of action

A. Total number of GPs citing one or more responses in the defined area
B. Total number of responses for the defined area.

Areas cited - in rank order (by number of respondents)	A Total no. GPs	B No. of responses
*Government action required	6 } 19*	9
*FHSA/HC management action/ reduce control	8	8
*FHSA/ HC bureaucracy: paperwork/ information requests and communication systems	12	20
*Communications between FHSA/HC and GPs	11	11
*FHSA/HCs to understand GPs & general practice better	10	11
*FHSA/HCs to improve process of change	5	5
Out-of-hours work and being on-call 24-hour commitment and responsibility Night visits	13	16
Financial recognition and remuneration systems	11	14
Patient demands/ expectations	10	14
Stress management and prevention	9	14
Resources required	7	9
Managing time and workloads	7	8
GP training	6	6
Patient complaints & procedures & fear of litigation	5	5
Quality issues	4	5
Medical profession to promote general practice	4	4
Impact on family life	2	2
Problem patients /difficult patients	2	2
Single-handed practices	2	2
Targets	2	2
GP action within practices	2	2
Fundholding	1	1
Business management	1	1
Total number	29	171

4.5.5 The other feature of this list is that it is made up of actions for others to take, with very few suggestions about actions GPs might take themselves. The majority are proposals addressed to the FHSA/HC. However, given that the aim of this study is to "establish those factors causing low morale which are amenable to different forms of management action at the Health Commission level", this outcome is as might be expected. In fact three fifths of all the responses came from the question towards the end of the interview asking specifically for actions that the FHSA/HC might take (question iii).

4.5.6 Table 4.5.1 shows the areas identified as in need of action have a fair comparability with the range and rank order of areas identified earlier in table 4.3.2 as creating most pressures. There are a few differences, but most can be explained by the fact that respondents put a slightly different emphasis on the issue, causing it to be placed in another category. For example the emphasis on the shifts from secondary to primary care is reclassified here as a resource issue.

4.5.7 A total of two thirds of respondents gave one or more suggestions for actions relating generally to the process of change, management, communications, attitudes and information gathering on the part of government or the FHSA/HC. In many cases the issues overlap between these areas. The next four highest ranking areas (in terms of number of GPs and citations) were: out of hours work and the 24-hour commitment (including being on-call and night visits), financial recognition and remuneration systems, patient demands, and stress management and prevention.

Government action

4.5.8 Six GPs referred to government action, viewing decisions at this level as the major source of the discontent within the profession. Typical comments were: "take general practice out of the political agenda", "stop being confrontational and manipulating", "be more realistic" about what GPs can undertake, and "consult the profession". One GP claimed that all the actions to improve morale had to be undertaken by government, "the Health Commissions are as powerless as we are".

4.5.9 Some of the more constructive suggestions for action at a national level came from four other GPs who suggested their own profession should be more pro-active in influencing government actions "putting forward a case for how general practice should move forward in the future". This was one of the few areas where GPs made proposals about things they could do directly to improve their lot. (As indicated above, nearly all the suggestions are about what others need to do. Only two GPs suggested actions by GPs themselves at general practice level). Only one GP made the suggestion that the FHSA/HC should represent their views to government.

4.5.10 Returning to the medical profession, several GPs made references in the course of the interview to the role in decision-making of their medical colleagues who represent them. Some of these comments, where they referred to more local decision-making, have already been discussed. However, one GP offered a view as to why GP representation at national level may not be as effective as some would like:

"A main frustration comes from things not being decided on a local basis and without consultation.....I recognise the medical profession ought as a body to take more action to address these issues and make suggestions. However, I believe the medical profession does not represent itself very well. The people, the doctors who are the representatives on the various medical committees are a different breed. They do not think the same as GPs on the ground, they are a self selected group."

4.5.11 However, this GP did also acknowledge that this problem of representation was not peculiar to doctors, and that it was inherent in all professional groups that those who represent them are not representative in their views.

Management actions by the FHSA/HC

4.5.12 A range of general actions which GPs felt the FHSAs/HCs could take were proposed. The issue of the conflict between accountability and autonomy came up again. The FHSA/HC should "interfere less", "reduce the policing role", "get rid of big brother management and let GPs be their own bosses". One GP referred directly to increasing the "calibre of management and staff within the Health Commission", which a few others had also inferred elsewhere in the interview.

4.5.13 The two main themes were, however, "talk to us and listen to what we are saying", and develop "a greater understanding of the work of general practice and life at the sharp end". There was a common desire to be consulted before decisions were made, but in some cases GPs wanted more than this, they wanted FHSAs/HCs to work things out jointly with them. Such work ranged from fundamental things like the role of the GP to paperwork: "there needs to be more work in deciding on what the role of the GP is and doing this in partnership", "work with us to redraft the paperwork and simplify claim and payment procedures".

4.5.14 GPs want the two-way process of communication between themselves and their FHSA/HC improved generally. They feel that new ways need to be found for more efficient and effective communications, and which take better account of the constraints and pressures GPs are under. Some made some specific suggestions, such as replacing paperwork with computer communications, and installing video-conferencing. There is a real sense of the need for requests for information to be rationalised. Many GPs conveyed their feelings of frustration in the course of the interview at having to produce information for which they saw little or no evidence of it having been used. The annual report was an example of this.

4.5.15 The management of the process of change was an issue for some. They wanted recognition of how "frequent changes impact on us and our ability to plan and deliver", and some requested a period of stability and a slowing down of the pace of change.

4.5.16 Not surprisingly the respondents wanted more resources. But in some cases what was implied was a redistribution of resources from other areas to primary care and to GPs: "put into practice the promises of resources following patients", "give the social care budget directly to GPs". This need for redistribution of resources linked with other issues, and implied a desire for more flexibility, for example: "change the remuneration package for GPs

to enable nurse practitioners to be appointed so as to create more time for doctors and allow a redistribution of workload".

Remuneration systems and financial recognition

4.5.17 Remuneration systems and financial recognition received a higher ranking in terms of relative numbers of respondents than when GPs were asked to identify what causes pressure. Given that the interviews took place at the time of the "furore over night fees", this finding might not seem surprising. Some of the eleven GPs who expressed views about remuneration were seeking remuneration commensurate with the workload, with the hours worked, with the actual work done, and "a decent pay rise".

4.5.18 However, for others the issues were quite different. There was a desire for fundamental changes in the structure of the remuneration packages so that the latter are better related to quality of care offered, more able to reward innovation and support long term planning, give greater flexibility to GPs in organising protected time as well as releasing time for redistributing the workload. Several GPs wanted the payment by targets system abolished, because it forces them to work in ways which they have little belief in, and so takes away time and resources from the services which they consider to have greater benefit. Here and elsewhere in the interview, some GPs expressed the view that they would prefer to be salaried. The present system is seen as encouraging GPs to increase their workload, and work longer hours, rather than encouraging better quality services.

Out-of-hours work

4.5.19 Almost half the respondents expressed views about changes they wanted in out-of-hours work, night calls and the 24-hour commitment. Five GPs between them wanted to get rid of night visits (two), the 24-hour commitment (two) or on-call (one). But eight wanted some workable solutions. Two suggested specific services using nurses to help with night calls (one reported having already presented this idea, but had been turned down). One wanted GP co-operatives to be encouraged, another wanted the deputising service to be reformed because it is not cost-effective for GPs, and another for patients to be charged for night visits. However some GPs recognised there are no simple solutions. Two suggested what is needed is "a serious appraisal of the cost and value of the current out-of-hours work", and "a workable solution" "that is affordable".

4.5.20 Besides the out-of-hours work there were in fact a range of quite different issues where improvements would imply a different use or redistribution of resources. Some GPs recognised that some suggestions for new ways of doing things on the face of it may appear expensive and so may not get beyond an initial cursory look. But what these more innovative GPs want is a recognition that some radical changes are needed. Instead of ideas being dismissed, they would like to see support for "serious appraisals" of the cost-benefits of new ways of doing things.

Patient demands and complaints

4.5.21 A third of GPs wanted help in reducing patient demands and expectations. Six recommended that the need was to "educate patients to use GP services responsibly ...and so make better use of GPs' time". Two wanted ways to get rid of 'unacceptable patients' and one wanted action on encouraging patients to complain less.

4.5.22 The complaint handling systems and procedures were of serious concern to four GPs as previously indicated. The handling of complaints was sometimes seen as inadequate and unfair, although only one GP went in to some detail with proposals for changes.

Managing time and workloads

4.5.23 Seven GPs expressed views on issues of managing time and workloads, most of which overlap with other areas already discussed. Most were requests for support in various ways to release time for GPs to do other things, or to do what they are doing better. "Help create structures to support the release of time ... because such structures cannot be created from within individual practices". What appears to be implied here is perhaps help from the FHSA/HC in co-ordinating and supporting co-operation between practices, and a re-distribution of resources. There is also a request for recognition from FHSA/HC staff that GPs need thinking time.

Stress prevention and management

4.5.24 Nearly a third of GPs made proposals and comments about the prevention and management of stress. These views are reproduced in full because they illustrate some of the various and sometimes opposing views and opinions that exist on this complex topic. Four GPs proposed that there should be an occupational health service for GPs, with one suggesting this should be pro-active rather than re-active. Others expressed a view that this was not the answer for all types of stress or G.P. They variously suggested stress counsellors, stress management courses, mentors, paid time off and sabbaticals. An important point made by some is that not all stress should be treated as an illness, that stress can arise from a particular professional problem, which is better sorted out by talking it through with a GP mentor or peer from outside the practice.

Training and training needs

4.5.25 Six GPs made suggestions or comments about training in management and coping with change and in the identification of training needs, two more than had claimed an interest in including management training in their personal training plans for the next year. However, two of the latter were the two of the GPs who referred to specific management training courses and had described them as "a good idea" and "very successful".

Fundholding and support to GP partnerships

4.5.26 Finally, one of the interesting features of this long list of suggestions is the almost complete absence of any direct references to support or other actions in relation to fundholding or business or practice management, other than the training discussed above.

Only one GP referred to fundholding, so perhaps GPs feel either that they are well supported or there is a sense of resignation to the inevitable. And one GP suggested the FHSA/HC could help with difficulties in partnership relationships by supporting the appointment of outside consultants and the provision of neutral advice including help in resolving problems of inequitable sharing of financial rewards.

Box 4.5 GPs' wants

Government action

- Take health care out of the political agenda, view GP role as providing health care, not as winning votes [x2]
- Stop being confrontational and manipulating GPs
- Would like to see the DoH acknowledge the difficult work situation of GPs and be more realistic in their assessments of what we can undertake
- The government and NHS bureaucracy should look at the needs of general practice and the way it works, in order to identify the key issues for us, for example patients with high costs.
- All the actions need to be taken by government for morale to be improved, that is government should not take away pay or autonomy, not increase the workload without increasing resources to match, and not encourage complaints
- Proper consultation with the profession, as opposed to telling us what will happen.
- HCs need to be freed up from the red tape which prevents them from being able to respond to local need. They should be enabled to become more autonomous and to work jointly with us to address local issues without having to toe the national line
- Stop Virginia Bottomley quoting statistics!

Medical profession action

- The profession must take control of the agenda and in particular must tackle the political agenda and promote a good view of general practice.
- There should be more support from the top of the medical profession hierarchy in supporting us and actually putting forward a case for how general practice should move forward in the future to counter the governments view.
- The medical profession ought to take more action and make suggestions to address the issues of things not being decided on a local basis and without consultation.
- We should make more noise about our situation.

FHSA/HC management action

- Represent our views to government and make a stand against immoral issues
- Increase the calibre of management and staff within the Commission
- Drastically reduce the staff of the FHSA and Health Commission
- The FHSA/HC need to be better organised
- Reduce the policing role and replace accountability with professionalism
- Need to get rid of big brother management by the FHSA and let GPs be their own bosses
- The HC should interfere less. Imposition of staff budgets and managed budgets are a problem
- Enable greater control over resource decisions by people closer to the community

FHSA/HC communications with GPs

- Better communication is needed. Talk and listen to what we are saying [x3] Be honest with us. All GPs need a real opportunity to be heard and to be listened to.
- HCs should involve us before and not after decisions are made
- There is a need for a big public relations job by the HC. Many staff seem to look for ways of frustrating us, they seem to want to make life as difficult as possible.
- Whoever answers the telephone should be able to find someone with the power to make a decision (response is always write to me)
- Would appreciate better feedback from the FHSA,
- Would like more close links with the HC/FHSA, we need to know of new services , but GPs don't read circulars. They need to think of new ways of putting information across, for example direct information systems.
- There is not a feel good factor in relation to the FHSA. They need to address this.

Understanding GPs and general practice

- There needs to be more work in deciding on what the GP role is and doing this in partnership between the HC/FHSA and ourselves
- The FHSA/HC would help us more if they had a greater understanding of the work of general practice and life at the sharp end. [x3]
- They need to understand us in a much more thorough way, the responsibilities we have and so reduce the demands they make on us. [x2]
- The HC need to do something. They need to see the perceived shift in primary care and how good work is being done here.
- Recognise we are under increasing pressure
- Give us more support
- FHSA /HC see patients only as customers, need to recognise we see them as much more than this
- Feels HC see us as professional managers, and don't recognise that on the whole GPs are amateurs at management. Feels this unhelpful and the HC needs to have a better understanding of how the practice works

Process of change

- Introduce stability for the next couple of years and stop changing things all the time.
- Pace of change need to slow down a bit and only be instigated where scientifically proven.
- Stop changing rules on such a regular basis. It makes it very difficult for us to plan ahead and collect data. The FHSA/HC should sit down with us and agree a set of guidelines which will be kept through out the year.
- The HC need to consult with us and listen to us before making changes
- The HC should undertake research before introducing change, try things out with a sample first. The trial and error approach is wrong and demoralising. They must find other ways, they must think before they act.

FHSA/HC bureaucracy: paperwork/ information requests

- Reduce paperwork [x3]
- Listen to what we are saying about paperwork, recognise the tensions and hence pressure for us to spend more time on paper work at the expense of patients because they feel this is how they are often assessed.
- Work with us to redraft the paperwork and simplify claim and payment procedures
- Rationalise the fundholding business plan and the HC health plan into one document, at present we have to produce both and I am not sure what the difference is anyway.
- The annual report needs to be changed, it is high workload for little value, fear it is not used or read.
- Stop asking us to produce figures which aren't going to improve any body's health
- Generally be more selective about information requests
- Reduce the number and frequency of reports we have to fill in, and stop changing them all the time.
- Much of the data could be obtained more easily from the hospital systems than from GPs
- Address the lack of continuity in asking for data

Computerise communication/ information systems

- Establish direct information systems
- Replace paperwork with computer comunication
- The claim forms on which we communicate with the HC/FHSA would be much more efficient if they were computerised. We need a GP link system here
- It would be much better if we could communicate with the FHSA/HC through a video conferencing system which could be installed in a number of practices. This would enable face to face communication and could show documents at the same time.

Resources required

- Put into practice the promise of resources following patients
- Increase staff budget
- Give us more resources, improvement will not be adequate without adequate funding
- Give us more money to practice, budget next year will be very difficult and will be a constant worry
- Pay higher fees for allocated ? patients as often take up wasted time
- Expand community psychiatric team.
- Improve GP clinic premises to provide better services to patients
- Address pressure for GPs from lack of resources for Care in the Community
- Give the social care budget directly to GPs so that we can have our own social worker in the same way as district nurses. This would enable care in the community to be provided in a much more efficient way.

Financial recognition and remuneration systems

- Abolish the pooled system for payments, allow money to follow the patient so that the GP who treats receives payment for the work done.
- Appropriate financial recognition
- The remuneration is not commensurate with the workload, the long training and the fact we run our own business. Remuneration should be related to the quality of care being offered by GPs. Feels the FHSA should address this with greater emphasis on standards, even though many GPs would hate this.
- Recognise the the service may need to be salaried in inner-city areas to attract GPs
- Remuneration system penalises single-handed GPs who want to employ assistants to have time off.
- Become salaried, would take away many worries, and would reduce number crunching in order to increase targets for pay.
- Change the structure of doctors employment, reward innovative doctors, rather than everything coming from a pool
- Change to remuneration package to enable nurse practitioners to be appointed to create more time for doctors and to allow redistribution of workload within practice. (see also managing workloads)
- The carrot and stick approach interferes with the way general practice works, its not an incentive to develop long term work.
- Stop band 3 remuneration package
- There need to be payment formulas to relate to the actual cost of dealing with patients
- More individual consultation in practices about staff remuneration
- A decent pay rise
- A more consistent FHSA interpretation of the Red Book is needed throughout the UK

Targets
(see also remuneration systems)

- Listen to what GPs are saying about unnecessary target work and assessment of over 75s. Make GP work salaried so GPs don't have to engage in number crunching to increase targets
- Redirect moneys for health promotion to mass advertising on TV, this would get at more people in need. Most goes to the wrong people when carried out by GPs in the way we are required to do it.

Out of hours work/ on-call/ 24-hour commitment

- Get rid of on-call
- An effective on-call system
- Get rid of 24 hr, 365-day obligations. [x3] Doctors should not need to work during the night and then work surgeries during the day. Rebuild GP services from there.
- Do away with night visits [x2] and weekend work or provide additional help
- Problem of night calls could be dealt with by practice employing appropriately qualified nurses to be on 24-hour calls to deal with initial calls from patients. Partners could forego their night fees to help pay for this.
- HC/FHSA to provide alternative centres for patients to go at night, as an alternative to calling doctors out.
- Examine cover for out-of-hours work
- A serious appraisal of the cost and value of the current cover for out-of-hours work. What is needed is a workable solution at a national level.
- Develop out-of-hours service that is both workable and affordable. The costs prohibit this at present.
- Separate out-of-hours service completely from day-time/core service and offer significantly more remuneration for the out-of-hours service
- Encourage the development of GP co-operatives for out of hours services
- Reform the deputising service, this costs a lot and is not an efficient use of resources.
- Charge patients for the out of hours visits (say £10), but this could be at the discretion of the doctor

Patient demands and expectations

- Help to reduce patient demands and expectations
- The HC/FHSA are fuelling public demand, encouraged by the Patients Charter and so should try and look at ways of coping with it
- More work on targeting services
- Sanctions and penalties for inappropriate demands (e.g. as on Guernsey) with an insurance based service available as a safety net.
- Educate patients to use GP services responsibly in order to address problem of inappropriate demands and so make better use of GP time [x7]
- Programmes of patient education could be a government campaign and would, through the media, TV and through schools. The focus should be on use of GP services, and on self-reliance and when to go to a doctor and when to use self help.
- The best way to educate people is through TV (as a practice we have written a booklet for patients on self help, but this did not work as patients did not read it). Most patients in this area have cable TV, so education through this could be supported and funded by the local HC. This proposal has been discussed locally amongst us, but not put formally as proposal to HC/FHSA. The GMSC have demanded the government do something about educating patients on how to use the doctor but no apparent response seems to have been forthcoming

Problem patients

- Get rid of patients who are time wasters
- The FHSA/HC need to find a solution for problem patients, that is the ones who move around surgeries, registering with one, thrown out a few months later, so register with another and so on. Thus asking such patients e.g. violent patients to leave a practice does not solve the problem. The solution may have to be they don't register with a GP at all.

Managing time and workloads

- Give us time to complete tasks properly, for example, give us a chance to prepare a case properly and allow enough time for us to think things through properly
- Reduce list size. [2] Because of the extended role of GPs in primary care there needs to be a change in the formula for the number of GPs per average population. Instead of being 2000, the formula?? for list size should be reduced to 1600 patients per GP.
- Help create structures to support the release of time for us to do other things (e.g. clinical assistantships within practices), because such structures cannot be created from within individual practices.
- Time should be made available for us to develop specialisms, this might need to involve changes in the remuneration package for GPs.
- Support us in enabling introduction of nurse practitioners to deal with minor illness to create more time for us which will involve a change in role and remuneration.
- Get rid of the full-time working clause to enable more flexible working patterns.
- There is need for support for provision of cover for partners when absent, so as not to increase workload on other partners.

Patient complaints and fear of litigation

- Encourage patients to complain less
- Improve the complaint handling system [x2] as procedure is inadequate.
- The FHSA could handle patient complaints differently. Instead of formally writing to the GP when a patient has first lodged a complaint, they could, as a first step, recommend the patient goes to the practice manager to try and get satisfaction to resolve their complaint, before formally registering it with the FHSA. Believes many complaints could be handled in this way, and so reduce the issue of formal letters which is very distressing in the many cases where these are unnecessary.
- Be more even-handed and fair in dealing with complaints

Impact on family life

- Morale could be improved by realising the effect being a GP has on family life.
- The expectation that someone will be at home to take GPs' calls needs to be thought about. This happens particularly in single-handed practices in rural areas.

Single-handed practices

- HC need to recognise and look more sympathetically at there are a variety of ways of delivering general practice and at geographical expediency, small cannot be compared with or treated the same as large practices. If there is no variety, there is no individuality, no competition, no choice for the patient. Economies of scale means monopoly. Need to find other ways of measuring GP work of small practices, because at present based on an accountancy basis small practices are being squeezed.
- Need to address out-of-hours cover for single-handed GPs

Quality issues

- The HC should come and do the quality control themselves, they should have a team of people to do it, so that it can be done more scientifically. We have insufficient resources to do it properly, so in effect we cheat.
- Quality in general practice is driven by the complaints system, but this does not work. This approach should therefore be replaced by more constructive quality monitoring methods. This should include practices being able to produce prospectuses of what they do and how good they are at doing these things.
- Quality and list size re remuneration
- The standard approach to quality has been demoralising and difficult to work with
- The FHSA need to refocus their concern with measuring quality of practice. Measurement tools do not motivate you to do a better job, they divert energy and resources from being a good doctor.

GP action within practices

- Need to create more time to meet as a team
- Need to get more consideration from partners

Business management

The FHSA helps with partnership disputes, but there are times when there are difficulties in partnership relationships when someone neutral from outside could help for example advising on profit sharing, and the FHSA could support provision of such consultancy advice. Linked to this the FHSA should ensure that good advice is available to ensure that partnership agreements are watertight.

Fundholding

- Abolish fundholding

Stress prevention and management

- Find a way to help GPs who are stressed and prevent them from making wrong decisions.
- The FHSA/HC should set up an occupational health service for GPs [x4]
- The occupational health service should be pro-active rather than re-active. The service should be more than just being able to ring up and ask for help. There should be regular occupational health sessions with an occupational health doctor, so that issues within practices can be identified early on. This would be of particular help to small practices.
- Occupational health services for GPs are not well supported because of the fear of records being kept on individual GPs, the service is too formal. [x2] What might be more appropriate would be stress counsellors that GPs could go to anonymously.
- An occupational health service is not the answer to all stresses in general practice, not just because of the fear of records being made of the consultation, but because it is not appropriate to categorise all stress as an illness. In many cases it is a response to a professional problem where the individual needs peer advice not treatment. Mentorship is therefore more appropriate (see training).
- Provide an outside service for GPs to go to when in trouble. Its difficult to go to colleagues in this situation because it is admitting some level of professional incompetence. GPs must be seen to cope.
- I would like to see the LMC and HC collaborate in the development of GP mentors and counselling.
- I believe all GPs throughout their careers should have a professional mentor.
- It is particularly important in the first few months of being a GP to have an experienced principal independent of the practice to go to.
- Educate GPs about stress management much earlier on in their careers about who to go to and when if they have a problem.
- Stress workshops have been offered to GPs. This is a gesture, but in reality they will probably not make much difference. Others have suggested away days, but these on their own are not enough. All GPs should therefore be offered sabbaticals, a few weeks every five years, to allow people to recharge their batteries. Possibly this could be added on to a period of annual leave to allow for maximum benefit. We can't go sick, because it means dumping more work on colleagues, one can't do this to one's partners. Because we are self-employed, when we reach burn-out we cannot go sick, or have time out to recover, a right which is enjoyed by every other member of NHS staff.
- The HC should fund GPs to go on lighter duties, or reduced duties, when they are not well; which is done in many other forms of service.
- Time off for doctors needs to be addressed, for example ten week breaks. If we know we are going to get a break it is easier to cope with the workload in-between times.
- GPs should be able to take paid sabbaticals.

Training and training needs

- The FHSA/HC need to recognise the new role GPs have had to take on, which they are not trained for. More training is needed in IT and management.
- There is a need for training in personnel management and management of one's own time for GP principals, particularly in the first year or so as a GP, and after any major change is introduced.
- More work needs to be done in meeting particular training needs, for example training to meet the changing circumstances imposed by government and the FHSAs/HCs
- The FHSA should carry on running the GP management course because I think it is very successful
- The business management training days are a good idea.
- Funding is needed for GPs to gain management qualifications and management experience.

4.6 The future of general practice and GP morale

4.6.1 In the final part of our interviews with the GPs we focused on issues around their vision of the future for general practice and how they saw their practice and themselves in relation to this. Since the focus of this study is GP morale, and given that we have defined morale largely as "a state of mind which is determined by reference to anticipated future events" (paragraph 2.2.5), an examination of such anticipatory factors seemed to be essential to furthering our understanding of GP morale.

A vision of the future

4.6.2 "Gloomy", "a sense of foreboding", "unsustainable", "see the whole thing crumbling" and "in terminal decline". These and similar words and phrases were used by seven respondents to sum up their vision of the future for general practice. These GPs, together with others who expressed negative views, made up the almost two thirds of our GP sample who expressed a pessimistic view of the future for general practice. Only four GPs had an optimistic view. The remaining seven gave an opinion on how they saw general practice might change in the future.

4.6.3 In Table 4.6.1 we identify a total of eleven GPs who gave a distinct optimistic or pessimistic overview of how they saw the future direction for general practice. The remaining respondents, together with some of these eleven GPs, identified the main changes they expected to see. These views are also identified in Table 4.6.1 where they were mentioned by three or more GPs.

4.6.4 Six GPs spoke of "being controlled more and more by bureaucracies", "an increasing management of general practice, accompanied by disempowerment of GPs", "an erosion of autonomy" and a "a bleak, downhill diminution of responsibility and status". Three GPs did not relish the prospect of relinquishing some patient management to nurses. Together these GPs made up the group of seven pessimistic GPs who all gave a strong sense of a feeling of "disempowerment and losing control".

4.6.5 A further six GPs, from practices of varying size, but all except one from rural or semi-rural locations, saw the main future for general practice as "privatisation". Some elaborated on this saying they saw the development of a two-tier system, similar to the development in general dental practices with only core services remaining within the NHS. Two GPs referred to the polarisation of general practices into two main types, with inner city practices changing the most, and the GP services which remain within the NHS becoming salaried. Associated with this were concerns about the vulnerability of small practices both in rural and inner city areas. One non-fundholding GP however claimed that "fundholding was a last great hope to halt the decline into a run-down NHS sector".

4.6.6 Many of the comments were around perceptions of shifts in direction in the delivery of patient care and the ways this will come about. Some GPs expressed concern about the increase in defensive medicine as a response to increasing patient complaints and the fear of litigation. A total of seven GPs referred to the delegation to nurse practitioners. The opposing views of some GPs towards this has already been discussed earlier (paragraphs

Table 4.6.1 "What do you see as the future for general practice?"

	No of times cited
Optimistic overview	4
Very pessimistic overview	7
Delegation to nurse practitioners and to others in expanding PHCT, - viewed positively by 4 GPs - viewed negatively by 3 GPs	7
Increasingly managed by the HC accompanied by loss of autonomy/ control/ status	6
Privatisation or a combination of privatisation/ insurance-based services and core NHS services	6
Workload continuing to increase	5
Continuing shift from secondary to primary care: - threatened if no increase in resources, but viewed positively if concurrent expansion in PHCT	5
The patient/GP relationship will become less personalised with increasing specialisation and decline in whole person medicine	5
Defensive medicine increasing and at the expense of preventive medicine	3
Vulnerability of small practices and inner city practices	3
Problems arising out of inability to recruit GPs	3

4.4.16 to 4.4.18). Associated with these negative views was a concern that the patient/GP relationship would become less personalised with increasing specialisation and there would be a decline in whole person medicine. However, those who had a positive view of such delegation, perceived it in terms of supporting the shift of services from secondary to primary care. The latter was clearly a main reason for the optimism about the future of general practice for three out of the four GPs who had an optimistic overview of the future.

4.6.7 Thus we have a group of twenty nine GPs who fall into three main categories with regard to their view of the future. Just under two thirds (62%) appear pessimistic, of which seven GPs appear really very pessimistic. This pessimism is either because of anticipation of an increasing loss of control (24% of all GPs) or largely because of a general sense of decline or disintegration in general practice as they have known it. Just four GPs (14%) are optimistic and this optimism is largely centred around the shift of secondary to primary care and hence general practice becoming "much more important". The remaining group (24%) see change as inevitable and whilst they may not particularly like some of the developments such as privatisation, they appear accepting of them (without any show of enthusiasm.)

4.6.8 There are few discernible differences between the pessimists and those whose views appear neutral, except that the more extreme pessimists exclude all but one of the 40-year olds, but given the size of the sample this may not be of any significance. The four optimists are city or inner-city GPs and are also GPs in their 30s or 50s. Four of the eight fundholding GPs were pessimists and four were neutrals but none were optimists.

<u>How the GPs see the future for their own practice</u>

4.6.9 Our next two questions asked in what ways the GPs thought their own general practice would change in the next few years and what factors would bring about this change. Around two thirds of GPs cited changes which would primarily be initiated by the practice, rather than changes that would be imposed upon them. However, a majority of these changes would largely be initiated as a response to external factors.

4.6.10 The larger number of responses related to changes in staff, in staff responsibilities and to an accompanying increase in the number and range of services offered "in-house", and developments in premises to cope with this. Seven GPs again cited delegation to practice nurses and an enhanced role for them. Four GPs thought they would take on extra GP partners, whilst another four referred to changes in GP partnerships. The latter included reference to more female GPs, a change in the partnership structure because of more GPs going part-time, and the problem of recruiting GPs because of the negative image of general practice.

4.6.11 Five GPs referred to the shift from secondary to primary care with three expressing concern about money not following patients. Around seven saw changes as being largely finance driven, they would need to take action within the practice to maintain their income, such as increasing non-NHS activity. A few GPs referred to a changing local population which would impact on them in various ways.

4.6.12 Again increasing patient demands and expectations and the role of government were cited by around a third of GPs as being the main external factors.

4.6.13 Six GPs referred variously to the potential of changes being brought about by fundholding, of which three were from fundholding practices. Two of the latter referred to total fundholding, one of whom "dreaded being placed in the moral dilemma of having to make profits out of some areas of spending on patients". Two of the three non-fundholders were positive about going fundholding even though their partners were not in favour, but a third was uncertain other than that fundholding "would have an immense negative impact on the practice". This was the only point in the interview where more than one or two GPs referred to fundholding, other than when a direct question was asked about fundholding early in the interview. During the latter four other non-fundholders (with a population of over 7000) claimed a main reason for not having gone fundholding was the extra workload and the stress this would create. Two of the fundholders seemed to feel that , on balance, it was a right decision to have become fundholders, a third was more positive and claimed it had helped "the feel good factor".

4.6.14 A variety of other changes were referred to, but only two mentioned changes directed at improving quality, and two mentioned the failures of community care resulting in more work for them. One GP thought there would be no change, and two others had no idea how their practice might change. Just one GP referred to the shift of emphasis from a caring to a business ethos, but two wondered whether their practice would survive at all, one because all the partners had plans to resign, sooner or later.

<u>How GPs see their own future</u>

4.6.15 Having obtained a picture of how the respondents thought their practice might change in the future we then asked them how they thought these changes would affect them. As with the first question about the future of general practice, we were able to divide the respondents into three categories according to whether their views were mainly optimistic, pessimistic or neutral. On this occasion seven GPs gave a positive response, but five of these were qualified in some way. Ten gave a negative response. Six GPs gave a response which we have classified as neutral. Five GPs were not asked this question. Each response was different and so a selection have been reproduced in Box 4.6.1 to convey a sense of the range of views expressed.

4.6.16 These examples convey a sense of the variation in responses by GPs to the pressures of external factors.

4.6.17 Having discussed how the changes which they anticipated would take place within their own practice we next asked each GP what impact these changes were likely to have on their morale. Six out of the seven GPs who had given a positive response said the changes would improve their morale. The ten who had given negative responses all said the changes would lower their morale. The responses to these two questions are summarised in Table 4.6.2.

Table 4.6.2 GPs views of anticipated changes in their general practice in the next few years

(i) anticipated changes classified as positive, neutral or negative

(ii) impact of changes on respondents morale

How will these changes affect you?	Positive effect	Neutral effect	Negative effect	No response to (i)	Totals
Improve my morale	6	2	0	1	9
Have no effect on my morale	1	4	0	0	5
Lower my morale	0	0	10	2	12
Totals	7	6	10	3	n = 26

Table 4.6.3 (a) "Do you still see yourself in general practice in 5 years time?"

	Yes	No	Don't know	Retiring
Number of GPs n = 29	24	3	1	1

Table 4.6.4 (b) "If yes, are you happy about this?"

	Yes	No
Number of GPs n = 24 i.e. yes to (a)	17	7

Table 4.6.5 (c) "If you had your time over, would you become a GP again?"

	Yes	No
Number of GPs n = 29	18	11

Table 4.6.6 Total number and age ranges of respondents answering "Yes" to all three questions i.e. (a) + (b) + (c)

Age range	Number of GPs answering "yes" to (a) + (b) + (c)	Total number of GPs *
27 to 42	10	14 (50%)
43 to 54	3	14* (50%)
total	13	28*

* excludes the GP about to retire

Table 4.6.7 "What are your goals or ambitions in the next five years?"

	No of times cited
Become a trainer	5
Survival	4
Develop/consolidate PHCT	3
Do a good/ better job	3
Develop specialism	3
Keep on top of or resist changes	3
Reduce working hours/ become part-time/ discontinue out of hours work	3
Sort things out	2
Other: find a mentor, become FRCGP, move into new premises	3
Total number of respondents	19

Box: 4.6.1 "How will the anticipated future changes in your practice affect you?"

Examples of positive responses:

- if we can develop the site I will get personal satisfaction from being able to offer patients a better service, and from earning more money,
- if all the planned changes for the practice go well there will be a sense of achievement, if they don't go well there will be disappointment, particularly of we suffer financially,
- if specialisms develop and more work can be relocated to nurses, everything will be wonderful - if this doesn't happen, the potential increase in stress and reduction in job satisfaction could cause major problems in the future,
- I feel very positive about the policy shifts in regard to primary care, so of the changes are put across properly they will stimulate me
- as long as fundholding is adequately resourced I will enjoy the challenge of implementing it and keeping it going,

Examples of negative responses:

- Very badly (because of loss of jobs to other professions and the unwillingness of government to do anything about patient demands).
- I feel increasingly uneasy as a result of government policy and further changes will make me feel less at ease with my partners and are likely to cause problems within the practice.
- I plan to leave general practice by the end of the century. GPs in inner city and urban areas are all disenchanted, I don't know anyone who does not want to leave general practice.
- There are problems in recruiting new GPs, so if a partner leaves this practice it could create a real dilemma for us
- Personally, I am just treading water, I am dissociated, I have stopped fighting...(because I can only see the situation getting worse because of the shift from secondary to primary care without any shift in resources and because of inappropriate discharges resulting in a continuing increase in workload)
- I could be out of a job and my health is likely to suffer (because of money problems within the practice), but if the FHSA start listening there may be an opportunity to move the health service forward and out of this deadlock.

4.6.18 Following this we asked the respondents (a) if they saw themselves in general practice in five years time, and (b) and if they did were they happy about this. We then asked (c) if they had their time over again, would they become a GP again. The results are shown in Table 4.6.3 to 4.6.5.

4.6.19 These tables show that seventeen GPs (around two thirds) reported they were happy at the idea of still being in general practice in around five years time. However when we look at the responses of these GPs to the question "if you had your time over, would you become a GP again?" , four of these said they would not. Two said that with hindsight, they would have chosen a different career and one would never want to go through medical school or being a junior doctor again. The fourth felt general practice was "too intrusive and takes up too much of personal time and resources". All four of these GPs appeared to have ambivalent views towards general practice, with both strong positive and strong negative views about different aspects, which could explain why their responses to question (b) and (c) were different.

4.6.20 Thus a total of thirteen GPs, just under half of the sample, were both happy to see themselves in general practice in five years time, and would become a GP again. It is interesting to note that ten of them come from the younger half of the sample (Table 4.6.6) and this includes all the female GPs in this age group. The three other GPs were all in their 50s, two were single-handed and one was from a three partner practice. These findings therefore suggest that, amongst other things, disillusion is more likely to set in with GPs who have been in practice for some time, particularly those who are in their mid- to late 40's whilst the younger GPs still retain some sense of optimism.

4.6.21 We asked all the GPs who answered "yes" to (a) above to tell us what their goals or ambitions were for the next five years. The responses from the nineteen GPs who answered this are summarised in Table 4.6.7. The positive responses, with one exception, all come from the thirteen GPs identified in Table 4.6.6.

Optimism for the future and GP morale

4.6.22 The responses to the various questions about the future of general practice and how the GPs saw their practice and themselves in relation to this, show a significant shift in the ratio from pessimism to optimism amongst the GPs in these three main areas. Thus whilst only four GPs appeared optimistic about the future of general practice as a whole, seven were positive about the future within their own practice, and thirteen were positive about having become a GP and the prospect of still being a GP in five years time. We consider this shift in view to be an important finding within this study, because our analysis of the reasons underlying this shift we believe help to further our understanding of GP morale and provide some pointers as to how low morale might be addressed.

4.6.23 A likely explanation of this shift in view would appear to be that when GPs focus on what general practice means to them personally, as a way of life and as a career, their priorities change. Support for this interpretation is revealed when the individual's interview responses are examined together in turn for each GP. What becomes apparent is that, despite the fact a respondent may have strong or numerous negative views and negative experiences, there can be just one, or perhaps two very positive factors, which are so

important to that individual, that they over-ride all the negative factors. This interpretation is illustrated by the three GPs out of the thirteen GPs who were positive about being in general practice, and yet at the same time were quite pessimistic in their views with regard to the future of general practice. A close examination of all the responses to their interview shows that these GPs each have a clear reason for being positive about being a GP.

4.6.24 The first of the three GPs had cited many negative aspects concerning the future of general practice, such as "interference by the government....increasing management by the HC, ...gradual erosion of autonomy, ... increasing pressures from fundholding and the financial aspects of drug budgets", but despite this was positive about his own position because he felt in control of his own work pattern and what goes on in the practice, and there was the prospect of continuing improvements in staff relationships and work practices within the practice. This GP acknowledged, when pressed during the interview, that the practice of family medicine was more important than issues around autonomy and independence from the HC.

4.6.25 The second GP also talked of "being increasingly managed by the HC and a substantial increase in the workload resulting in more burn-out for GPs", she also felt the "practice would be hard pushed to maintain its income" because of various changes, and that she no longer enjoyed her job as much as she did when she first entered general practice. However, despite this her main reason for wanting to stay in general practice was because she was able to do part-time work and so combine a career with having a family, and in the future she hoped that job share opportunities might further enhance this situation for her.

4.6.26 The third GP was largely concerned with the predominance of minor illness work which he believed "would grind GPs down and reduce morale" if this didn't change, and this was one of the key issues relating to lack of recruitment of new GPs. The remuneration system also meant a high workload pressure for him because other partners in the practice wanted to remain high earners. But this GP was the one quoted in Box 4.6.1 who indicated that if he could offload minor illness work onto nurses and pursue his specialist interests "everything will be wonderful".

4.6.27 Thus whilst each of these GPs had some strong negative views, there were aspects of their current job situation which they enjoyed and in particular there were prospects of improvements to their enjoyment of their job in the future. It is the latter which would seem to be the key to improving GP morale. But as we can see from just these three cases there is no one single issue which would have equal impact on all GPs. The issues are quite different for each one.

4.7 The determinants of GP morale

4.7.1 In this last section of the findings we look at the morale levels of our GP sample and how these relate to the other findings. We discuss what the GPs consider to be the causes of low morale in general practice and finally propose a framework for developing an understanding of the determinants of morale in individual GPs.

Morale, stress and job satisfaction

4.7.2 Whilst our examination of the literature shows others to have identified a link between morale , stress and job satisfaction amongst GPs, what is less clear is how and to what extent the three inter-relate. We therefore set out to find out from our sample of GPs what they considered to be their own levels for each of these three factors, so that we could then look at what relationships might exist between them.

4.7.3 In the course of the interview we asked each GP to rate their levels of job satisfaction, stress and morale in relation to their job at the present time. However, we asked for each of these ratings at quite different stages in the interview. We asked them to rate their level of job satisfaction early on in the interview, immediately after the series of open questions about their satisfaction with their current job (see also paragraphs 4.1.31 to 4.1.32). We asked for the stress level rating in the middle of the interview following discussions on pressures in the job, and we asked about morale during the discussions about the future, towards the end of the interview. By structuring the questions in this way, we were able to obtain considered responses to the ratings and to lessen any influences which might have arisen had we asked for the ratings sequentially without a break in-between.

4.7.4 The GPs were asked to rate their current levels for morale, job satisfaction and stress on a scale 1 to 7. In the tables below we define the scales and first of all set out the range of scores for each of these three factors, together with the mean score for all the respondents (Tables 4.7.1 to 4.7.3). These ratings were not asked of the first three GPs and so the total number of GPs is twenty six.

4.7.5 We then plotted the morale scores in turn with the job satisfaction and stress scores and also the overall pressure scores from Section 4.3. These are shown in Charts 4.7.1 to 4.7.3.

4.7.6 Chart 4.7.1 shows that there is a relationship between morale and job satisfaction. Chart 4.7.3 shows that there is an inverse relationship between morale and the pressure scores, with the GPs having the highest pressure scores reporting the lowest morale scores. Chart 4.7.2 however, shows that there is not an inverse relationship between morale and stress for all GPs. This is important to note and is further discussed in paragraphs 4.7.8 to 4.7.10.

4.7.7 We also looked at the distribution of morale scores in relation to age, sex, number of partners and location (Tables 4.7.4 to 4.7.7). These tables show that the GPs in our sample who were in their thirties and fifties had higher morale levels than those in their forties. It was the group of GPs in their forties who were the most pessimistic about their own future.

The GPs from the practices with four to five partners had the lowest mean morale level. The city and suburban GPs had a lower mean morale level than the inner city GPs. It is interesting to note that there is a correlation between location of the practice and reported stress levels (Spearman correlation co-efficient of 0.505, significance of 0.008), (Table 4.7.8 and Chart 4.7.4). These mean figures for morale and stress however are solely to inform us about the characteristics of our GP sample. They cannot be read as representative of GPs within the two FHSA/HC areas studied.

The determinants of morale

4.7.8 An important finding for this study has been to discover that the small sample of GPs we selected have reported stress and morale levels which range from very high to very low, rather than having a sample where the majority report high stress or low morale. Since one of the aims of this research has been to develop our understanding of the determinants of GP morale, this variation in levels of morale and stress has provided us with the opportunity to study this in ways which would not have been possible had we only selected GPs with low morale or high stress. The final stage in the research therefore has been to examine the differences between those respondents who have high morale levels and those with low morale levels, and for varying levels of stress.

4.7.9 There is a common assumption that GPs who have high levels of stress have low levels of morale. An analysis of the reported levels for stress and morale by our GP sample suggest this may not always be the case. Chart 4.7.2 shows the relationship between morale levels and stress levels in our GP sample. This shows that three GPs have both a high stress and a high morale level (scores of 6 or 7 for both) and two more GPs have scores which border on this (scores of 5 and 6).

4.7.10 Our sample does, of course, include a group of GPs who have a high stress score (6 or 7) with a very low morale score (morale scores between 1 and 3, which fall well below the mean). There are six GPs who fall in this category. There are two further main groups: five GPs whose morale is high (score of 6), and stress is below the mean (scores of 2 to 4), and five GPs whose morale scores are around the mean and stress scores at or just below the mean (4 for morale, 4 to 5 for stress).

4.7.11 We have therefore examined the case studies for the GPs in each of these four groups in order to seek explanations for their differences in morale level, and the way in which these levels relate to their stress levels. And we have found differences, some are distinct differences, others are more subtle. We discuss these differences and the possible explanations below, along with what our sample of GPs consider to be the main causes of low morale amongst general practitioners. We examine three areas in more detail in order to illustrate some of the issues under discussion.

Morale, job satisfaction and stress levels

Table 4.7.1. Morale levels

"How would you rate your level of morale in your current job at the present time?"

where 1 = extremely low morale and 7 = very high morale

	Low morale						High morale
Morale score	1	2	3	4	5	6	7
No of GPs	1	4	3	7	2	8	1

Mean score for morale = 4.27 n = 26

Table 4.7.2 Job satisfaction levels

"How would you rate your level of satisfaction with your job as a whole, at the present time, taking everything into consideration?"

Rate on a scale 1 to 7, where 7 = high satisfaction

	Low satisfaction						High satisfaction
Morale score	1	2	3	4	5	6	7
No of GPs	2	2	3	5	8	6	0

Mean score for job satisfaction = 4.27 n = 26

Table 4.7.3. Stress levels

"How stressful do you regard your job at present?"

where 1 = not stressful and 7 = highly stressful

	Not stressful						Highly stressful
Morale score	1	2	3	4	5	6	7
No of GPs	0	1	3	5	5	7	5

Mean score for stress = 5.12 n = 26

Mean scores for morale: distribution of scores

overall mean score for morale = 4.27 (n = 26).
Standard deviation = 1.66.

Table 4.7.4 Morale scores: distribution by sex

	Mean Morale Score	SD	No. of GPs
Female	4.43	1.99	7
Male	4.21	1.58	19

Table 4.7.5 Morale scores: distribution by age

	Mean Morale Score	SD	No. of GPs
39 and under	4.50	1.43	10
40 - 49	3.50	1.69	8
50 and over	4.75	1.83	8

Table 4.7.6 Morale scores: distribution by number of partners

No. of partners	Mean morale score	SD	No. of GPs
One	5.66	0.58	3
2 - 3	4.57	1.81	7
4 - 5	3.56	1.88	9
6 - 8	4.28	1.25	7

Mean Scores for morale and stress: distribution by location

Table 4.7.7 Morale score: distribution by location

Location	Mean Morale Score	SD	No. of GPs
Rural	6.00	0	2
Inner city	4.75	1.98	8
Semi-rural	4.11	1.45	9
City	3.75	1.71	4
Suburban	3.00	1.00	3

Table 4.7.8 Stress scores: distribution by location

Location	Mean stress score	SD	No. of GPs
Rural	3.50	0.71	2
Inner city	5.63	1.77	8
Semi-rural	4.33	1.12	9
City	5.75	0.50	4
Suburban	6.33	0.58	3

Spearman Correlation Coefficient for stress and location = 0.506
(Significance = 0.008)

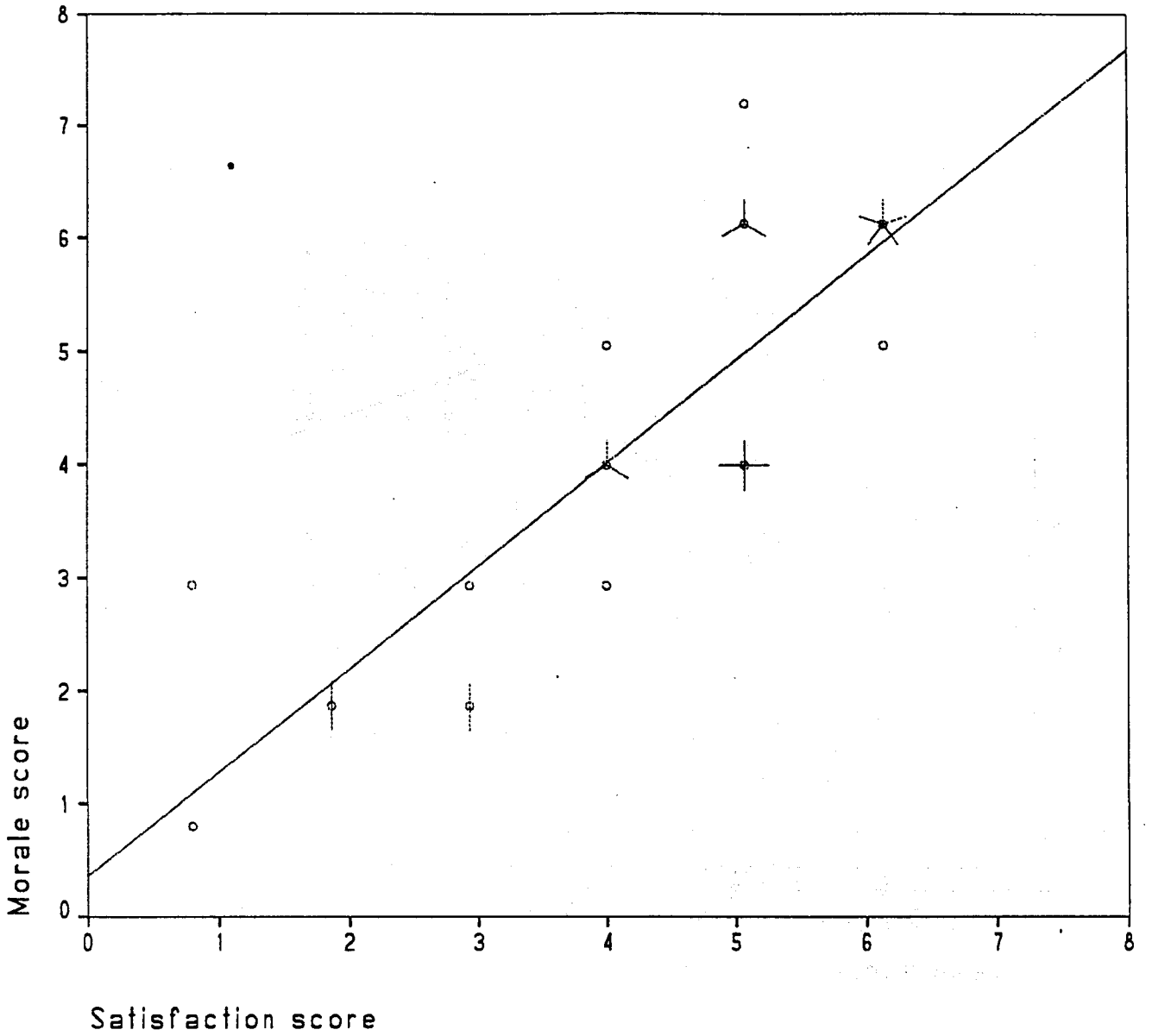
Morale Score by Satisfaction Score
Morale score
Satisfaction score
0
1
2
3
4
5
6
7
8

CHART 4.7.1

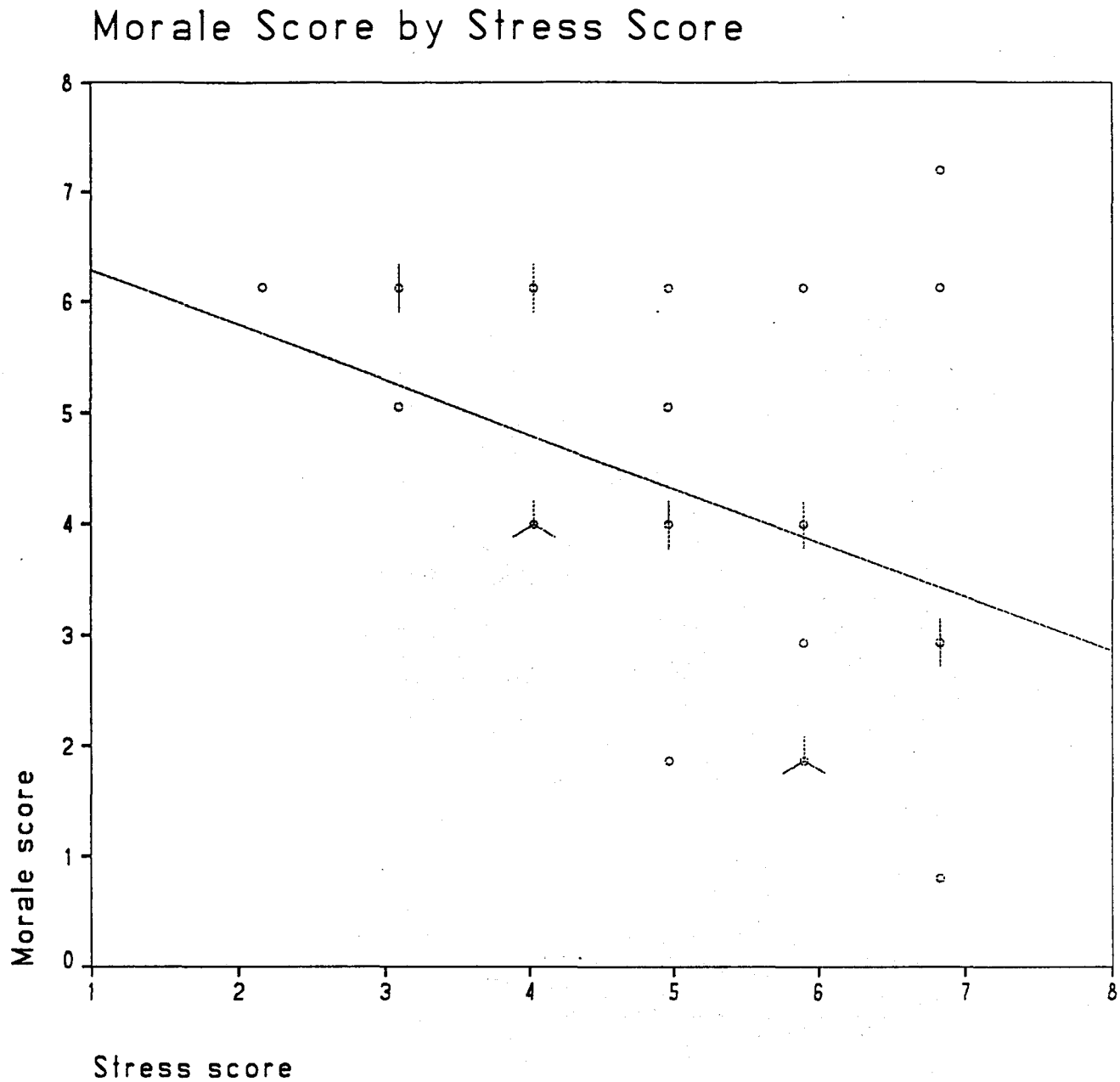
Morale Score by Stress Score
Morale score
Stress score
0
1
2
3
4
5
6
7
8
1
2
3
4
5
6
7
8

CHART 4.7.2

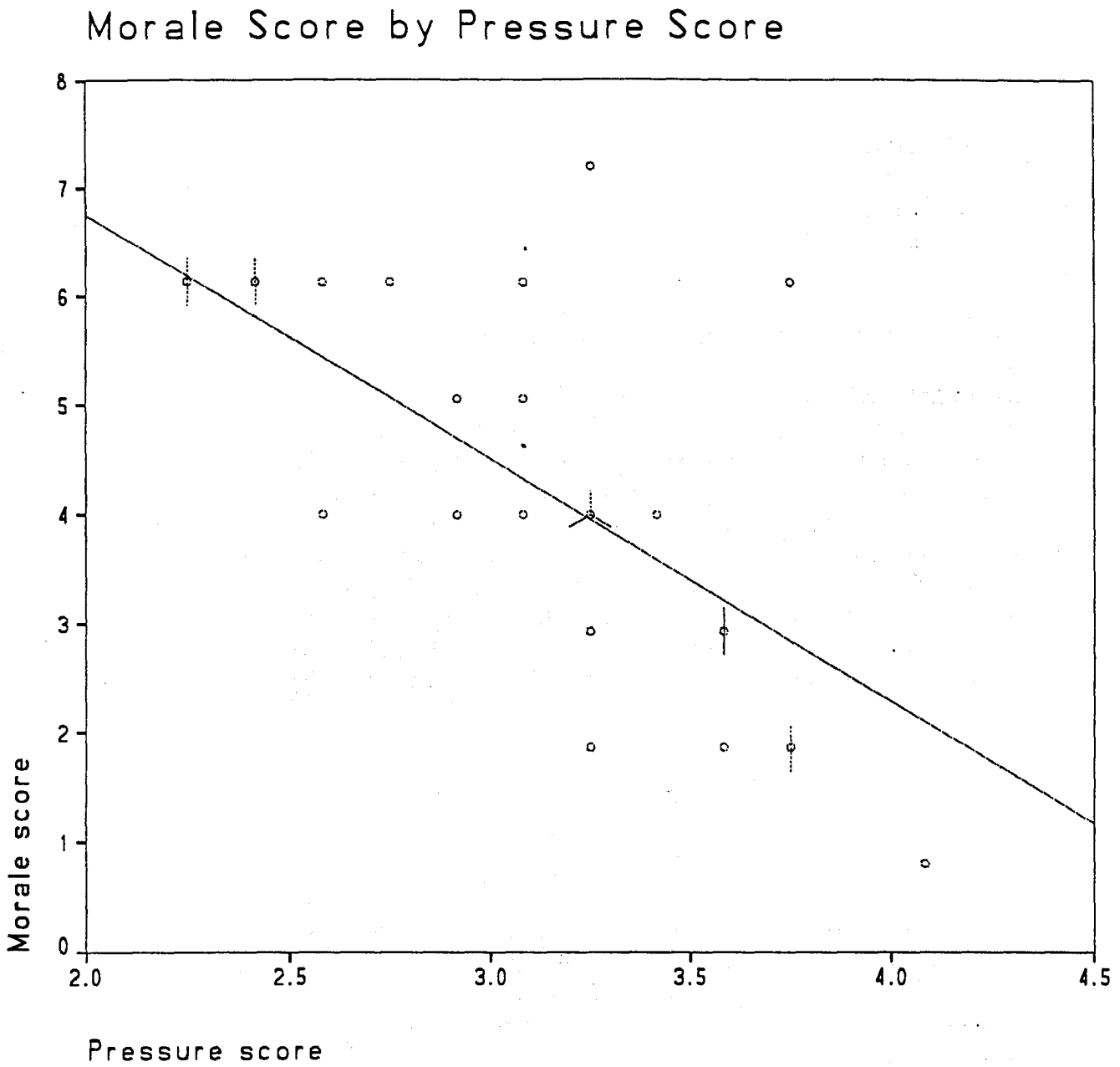
Morale Score by Pressure Score
Morale score
Pressure score
0
1
2
3
4
5
6
7
8
2.0
2.5
3.0
3.5
4.0
4.5

CHART 4.7.3

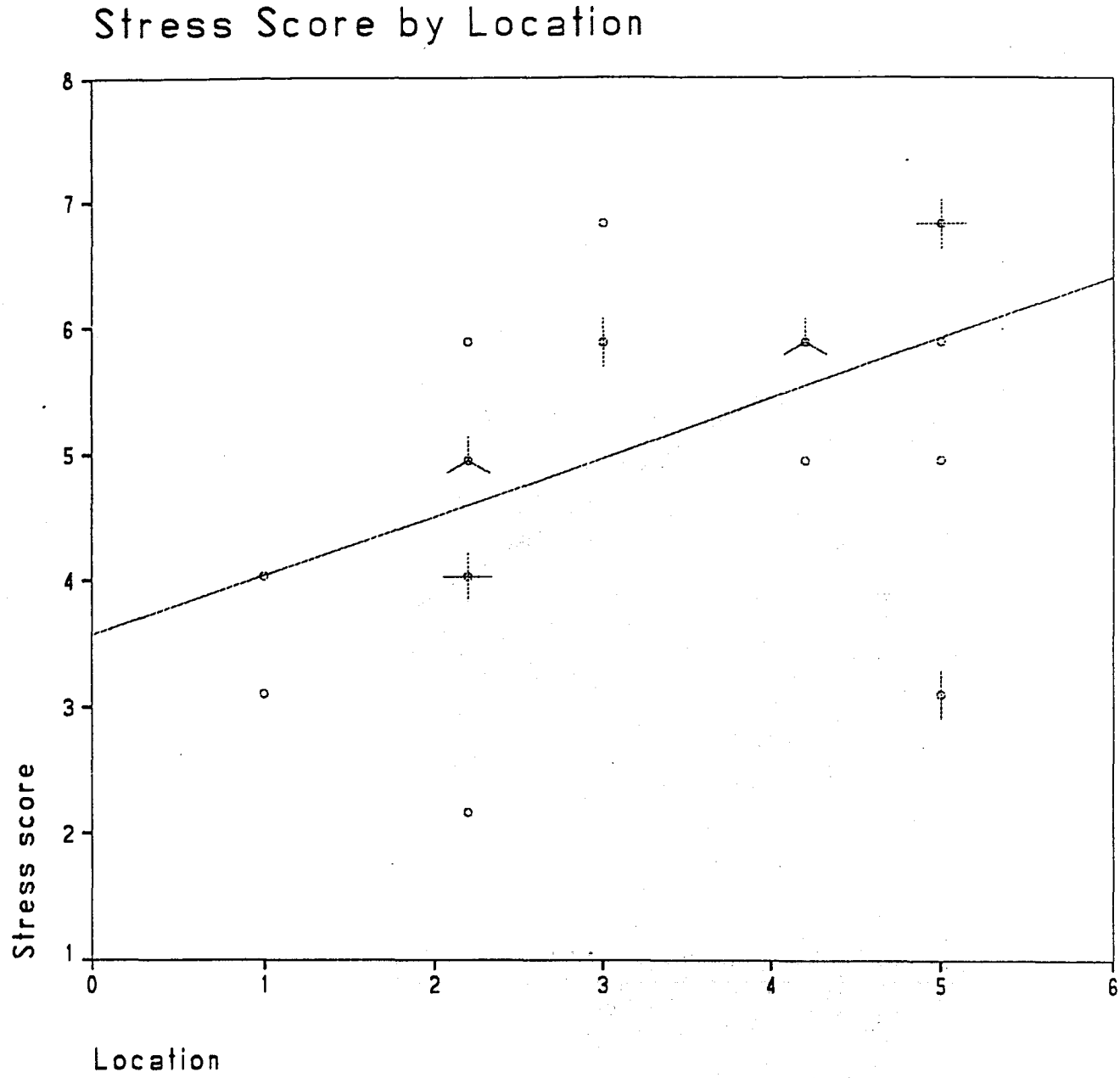
Stress Score by Location
Stress score
Location
8
7
6
5
4
3
2
1
0
1
2
3
4
5
6

CHART 4.7.4

The causes of low morale

4.7.12 Towards the end of the interview we asked the respondents to reflect back on our discussion and to identify what they considered to be the three main causes of low morale in general practice today [question (i)]. We then asked them if their answer reflected their personal position [question (ii)]. Clearly it seemed important to ask about the causes of low morale in this way, as otherwise we could have been assuming all our respondents had a low morale, and as we have seen this was clearly not the case. However there was also a danger in this approach in that we were assuming a commonality of experience amongst GPs.

4.7.13 The areas cited by the respondents were very similar to the areas identified earlier in the interview when they were asked what issues had had the greatest negative impact on their morale or created most pressure. There were, however, three additional areas. These were the problems of dealing with difficult patients, references to deficiencies in the quality and expectations of potential recruits to general practice, and feelings of lack of esteem, being undervalued and exploited. Apart from these three additional areas, the main differences between the two sets of aggregated responses were differences in the numbers of GPs who cited each of the areas in the two questions. One explanation for the change in numbers is that most GPs only cited two issues in the earlier question, whereas the GPs were asked to give three main causes for low morale in the later question. Thus there are an additional twenty five citations for this latter question.

4.7.14 In Table 4.7.9 we list the areas cited and against each we have entered in the first column, the number of GPs who cited the area as a main cause of low morale (question i). In the second (right hand) column we show the number of citations from the earlier question referred to above, for comparison. This Table therefore shows that there are eight main areas where the numbers of citations increase, these are patient demands and expectations (increased to 11), increasing workload and long hours (to 11), patient complaints, and complaint procedures and fear of litigation (to 9), out-of-hours work and being on-call (to 6), financial recognition and remuneration (to 6), feelings of being undervalued, exploited and lack of esteem (6), and difficult patients (4). Impact on family life, and the process of change are the two areas where the number of citations falls by more than one mention.

4.7.15 Whilst the main reason for the increase in the aggregated responses can be explained by the increase in the total number of citations for each GP, there are also some shifts in responses by individual GPs. Just under half gave one or two different responses to the two questions. The reason for this is that the first question asked about what has a negative impact on morale or causes pressure, whereas the later question asked for the causes of low morale. A comparison of the responses for each individual supports this explanation. Thus the differences within individuals are largely explained by a shift from identifying the issue to identifying the cause or the outcome. For example, the issue of "the impact of secondary care on primary care" identified as creating a pressure in the first question becomes "increasing workload" as a cause of low morale in the later question. Similarly "increasing patient demands" becomes "increasing workload" or "difficult patients and the fear of complaints and litigation", "the impact on family life" becomes "night work and out-of hours work", and "loss of autonomy" becomes "a feeling of being exploited by the NHS".

Table 4.7. 9 GP reflection on the causes of low morale (n = 29)

(i) What are the three main causes of low morale in general practice today?
(ii) Does this reflect your personal position? if not where does it differ? (shown by the figures in brackets)
(iii) What two or three issues have had the greatest negative impact on your morale or created most pressure or frustration? (from Table 4.3.a)

	Areas cited - in rank order by main causes of low morale	No. of GPs citing each area (i) & (ii) 3 main causes of low morale	 (iii) creates pressure - from Table 4.3a
1	Government bureaucracy, policy and actions	6(5)	6
1	FHSA/HC bureaucracy	5	6
1	Loss of control autonomy independence / more managed environment	5	5
1	Process of change	1	3
1		15(14)	16
2	Increasing patient demands expectations	11	6
3	Increasing workload (and long hours)	11 (9)	3
4	Out-of-hours work and being on-call	6	3
4	Night visits	3	4
4	24-hour commitment and responsibility	3	2
4		10	8
5	Patient complaints & procedures & fear of litigation	9 (5)	4
6	Feelings of lack of esteem, being undervalued	6	0
6	Financial recognition and remuneration systems	6	3
7	Problem patients difficult patients	4	0
8	Resources not matching needs or expectations	3	3
9	Paperwork	2	3
9	Insufficient time	2	2
9	Shift from secondary to primary care	2	2
9	GP career structure, recruitment and training	2 (1)	0
13	Impact on family life	1	5
13	Practice administration and business ethos	1	2
13	Personal stress and physical health	1	1
	Feeling of isolation	- (1)	1
	Fundholding - if imposed	-	1
	Total number of citations	84 (76)	65

4.7.16 Four GPs indicated where and how their responses to question (i) did not match their personal position, and so the revised figures, where this applies are shown in brackets in the first column to reflect these differences. Three of these GPs had a high morale level (score 6) and so these issues either did not apply to them or else did not constitute sufficient pressure to impact on their morale. The fourth GP (morale score of 4) identified the feeling of not coping and the sense of isolation, as a main factor impacting on his own morale, whereas he saw the increasing workload and the fear of complaints and litigation as the more general reasons for low morale amongst GPs.

4.7.17 This list therefore tells us that half the respondents, as in the earlier question, see government attitudes and policies, the FHSA/HC bureaucracy, together with the more managed environment and the loss of control as being a cause of low morale amongst GPs. This is followed by over a third of GPs who see patient demands and expectations as a cause, most referring to increases in unrealistic or inappropriate demands or expectations. Just under a third cited patient complaints or the complaints procedure as a cause of low morale, and in particular the fear of "getting it wrong" and the fear of litigation. And over a third referred to the workload , the majority expressing this as the "increasing workload", although some used phrases such as "too much work", "having to work much harder", "work saturation".

4.7.18 There is a common theme between the main areas cited above as causing low morale. The references to increases in unrealistic patient demands, complaints, fear of litigation and workload are all references to anticipated future events as well as to current experiences. Anticipation of a more managed environment and a further loss of control has already been identified in the earlier discussion of GPs views for the future of general practice. Thus as suggested earlier the GPs' stated views about morale are in accord with our definition of morale as "a state of mind determined by reference to anticipated future events", but also "dependent upon and guided by past events" (see paragraph 2.2.5).

Anticipating the future: the fear of litigation

4.7.19 The increased number of GPs who cite a fear of litigation as a cause of low morale reinforces the point about anticipation of the future. Four GPs consistently expressed strong views about patient complaints and the complaints system at various times in the interview, eight GPs identified "worrying about patient complaints" as causing extreme pressure in the 30-item pressure score, and now seven out of nine GPs referring to patient complaints as a cause of low morale emphasise that it is "the threat" or "the fear of litigation" which is the issue. This sense of fear and anticipation was talked about at length by one GP, but some of his views seem to represent those of several GPs we interviewed:

> *"I feel very strongly that government should stop encouraging people to complain. Recently government has made a statement 'doctors welcome complaints'. I wonder whether they recognise the major cost implications of this. First, we are getting more and more unwarranted complaints, which take up both time and energy to resolve. Second, encouraging complaints is forcing GPs to practice defensive medicine. It is right that we should be held to account, and in fact if a GP does make a mistake they feel awful about it. And it is more likely to happen when we are*

tired and overworked. Even though we are practising at a higher standard now than at any previous time, there is more litigation. Government needs to recognise these things and do something about them."

"The result is I feel as if I'm sitting on a time bomb. There is probably something that I and others are now doing in good faith, that a complaint will make, retrospectively, gross professional misconduct. I have a real fear of what might happen or what I might do wrong. My first thoughts each time I see a patient used to be: "how can I help this patient?", now they are "how can I protect myself from this patient?."

4.7.20 This was an inner-city GP with the lowest morale level of 1. One other inner -city GP with a low morale also had strong fears of litigation. Four of the other GPs fearing litigation were from semi-rural or rural locations, their morale levels were higher at 4 and 6.

The relationship between stress and morale: the example of increasing workloads

4.7.21 Reports of increasing workload expresses both current experience as well as anticipation of the future. It might be expected that there would be a correlation between GPs identifying workload as a cause of low morale, GP morale and stress levels, hours of work and numbers of patients seen per day. We therefore did some cross tabulations between these factors.

4.7.22 The mean morale level of the GPs who reported higher than average patient contacts in a normal working day was 3.85, and thus was lower than the mean morale level of 4.45 which applied to the GPs reporting lower than average patient contacts. The mean stress score was higher for the first group. In addition eight out of the ten GPs who cited workload as a cause of low morale (and for whom all the relevant data exists) reported patient contact levels at or above the average. Their mean morale level is 3.5. Thus it would seem that there is a relationship between above average patient contacts, and perceptions of increasing workload and low morale.

4.7.23 When we look at total hours of work, morale and stress levels and workload a different picture emerges. The mean stress level for the GPs whose hours worked per week are above the average was 5.36 and thus slightly higher than the mean stress level of 4.83 which applied to the GPs reporting total working hours below average. However, the mean morale level for the GPs whose weekly hours were above the average was 4.64 and therefore also higher than the mean morale level of 3.75 for the GPs with working hours below average. In fact eight of the twelve GPs who worked between 53 and 67 hours per week (including work taken home, but excluding weekends and out-of-hours work) had morale levels of 6 or 7. Three out of the remaining four GPs in this group had morale levels at the other extreme of 1, 2 and 3 respectively. Job satisfaction scores corresponded with the morale scores.

4.7.24 The above suggests that many of those GPs who work longer hours may be more stimulated by their job, than those who work shorter hours. Furthermore those GPs who identify "workload" as a cause of low morale, and yet whose hours of work are less than

the average, are all the GPs who report problems in sharing workloads with their GP partners. This applies to seven GPs. This may well be one of the less obvious, yet important causes of low morale revealed in this study. As we have seen no GPs have referred directly to problems within the practice as being a cause of low morale. The nearest to this has been the one GP who spoke of feelings of isolation as a main factor lowering his morale. But an examination together of all the responses from each GP in turn reveals an undercurrent of difficulties in working with partners. Thus although not identified in response to what are the main causes of low morale, such difficulties may have a significant impact on morale for some individual GPs.

GP partners, PHC teams and levels of morale

4.7.25 We have already discussed at some length the two thirds of the GP sample who made references at some point in the interview to the impact on them of their GP partners or the primary health care team. Seven GPs made positive references and twelve were negative in this respect. Below we discuss how these positive and negative reports are related to morale levels and to characteristics such as age and size of partnership.

4.7.26 The positive factors cited were supportive relationships between partners, and a strong focus on developing the primary health care team. Three examples of supportive relationships come from the three all female two-partner practices. All three GPs had a high stress score of 7 or 6. Two had a high morale score of 7 and 6 respectively, whilst the third had a morale score of 2. For the GP with scores of 7 "the close relationship with her GP partner" was the main factor responsible for her high morale, for the GP with scores of 6 one of the most satisfying aspects of her job was "the multidisciplinary small team, which I find very supportive, and for the third GP with very low morale: "we have an exemplary and supportive team working environment, the problems concerned with morale are all the external pressures". The male GPs have supportive partners too: one GP with a very low morale was the one who claimed: "I have three good partners who are friends as well, we keep each other going", and the senior partner of another four-partner practice who claimed: "as a partnership we've tried hard over the last year or two to recognise and emphasise that the more we work together as a team, the better we cope. This is the hallmark of all morale improvement", this GP had a morale level of 6.

4.7.27 Whether a GP has a high or low morale in each of these cases is determined by the extent and strength of the negative factors which impacted on them. Where the latter were strong and extensive the positive partner relationship was not enough to overcome these and so these two GPs had a very low morale.

4.7.28 All but two of the twelve GPs reporting negative experiences of partners or of team working had low morale levels between 2 and 4. The most common problems were about sharing workload, partners "not pulling their weight" and a "mismatch of ideas about what constitutes work". Three of these GPs came from three-partner practices, one from a four-partner practice, and the rest from five to eight partner practices. Nine out of the twelve were GPs from the younger half of the study sample, with the GPs expressing the strongest views in their thirties. The responses suggest the more junior partners were generally experiencing the most pressure from an inequitable sharing of workloads. The two GPs with high morale expressing negative views were also both in their thirties. One claimed "there

is a distinct difference and view between the younger and older partners, the younger ones seem to want to share more of the work and take on more of the practice issues. But there are some negative comments by some partners, there is never any praise or support, this can be very demoralising". But this GP also had a sense of optimism about the situation within the practice, as she hoped the new practice manager would improve many internal management arrangements.

4.7.29 The above discussion would appear to give support to the theory that relationships between partners and their PHC teams play an important part in determining morale levels for some GPs.

Individual levels of morale

4.7.30 We have looked at what GPs report as the causes of low morale in general practice and have looked for patterns in levels of morale in relation to some of these stated causes to further our understanding of GP morale. So what are the factors which determine the level of morale, whether high or low, in each individual GP?

4.7.31 At this point it is worth reminding ourselves again of our discussions about morale in Section 2.2 and Evans' (1992) definition of morale:

> *"Morale is a state of mind which is determined by reference to anticipated future events, by the anticipated form that they will take and their anticipated effect upon satisfaction. It is dependent upon, and guided by, past events in so far as past experiences provide a basis upon which to anticipate."*

4.7.32 Throughout this report we have been aggregating and ranking in order of mentions, all the various issues which our GP sample have reported impact on them in some way. And in asking the respondents to identify the main causes of low morale amongst GPs in general this could be interpreted as implying that we view morale as a group phenomenon. However in our discussions of our findings in the various parts of this report we have made clear there is often quite a variation in responses and sometimes opposing views between GPs on different issues. These finding support the theory that morale is a state of mind which is based on individual experiences, personality traits, values, attitudes, goals and priorities. Thus morale is first of all an individual rather than a group phenomenon.

4.7.33 In order to be in a position to make recommendations for actions to address issues of morale amongst GPs it is essential, therefore, to be able to recognise and understand the individual nature of morale.

4.7.34 To develop this understanding we turned to examining the interview data of each GP as individual case studies, in order to identify the key factors which appeared to determine their reported individual levels of morale. We found that the morale status of each GP appeared to be a function of two main concepts. The first concept is centred on feelings. Many of the factors which determine individual morale are to do with GPs' feelings about their present position, derived from their past and present experiences, and also their anticipation of future events. These feelings can be subdivided into four main categories: control, value, support and optimism v. pessimism. These feelings in fact occur for each

individual at some point along a continuum ranging from the very positive to the very negative.

4.7.35 Second, there was the concept of the level at which these feelings occurred. These levels ranged from the level of the individual, to practice level, to patients, the FHSA/HC and government. As we have seen when we asked the GPs about issues that have impacted on them, or where they wanted to see improvements, the majority of the responses were directed at the FHSA/HC or government. However, if we examine the factors which sustain morale in those GPs reporting a high level of morale we find that most are at the individual, practice or professional level.

4.7.36 We have summarised these two main concepts below and in fact believe this can be used as a general framework for understanding the determinants of morale for individual GPs.

<u>The concept of "feelings":</u>

Feelings of:

a)	being in control	v.	lack of control or loss of control
b)	being valued	v.	undervalued, exploited or loss of esteem
c)	being supported	v.	lack of support, isolation
d)	optimism	v.	pessimism

<u>The concept of "level":</u>

Feelings which determine morale can operate at several different levels. In the case of GPs they operate at the level of:

a) the individual (i) the professional self and
(ii) the private self and family and friends
b) the professional community: GP partners and colleagues, practice staff
c) patients and the wider community
d) other providers: e.g. NHS Trusts and Social Services
e) NHS managerial/ administrative bodies: the FHSA/HC and NHSE
f) the government.

Before applying this framework to the individual GPs in our sample we discuss below some examples of the concepts we have outlined above.

4.7.37 When we look at what the GPs report as sustaining their morale some GPs, particularly those with a high morale level, report feelings of being in control of their own work. They have achieved this in various ways. For some it has been by through a sense of satisfaction at having become more efficient through better time management techniques, for others it has been through becoming single-handed, and for others, particularly from larger practices, taking on an outside commitment or a specialist area in order to have an area of work over which they feel they have some personal control.

4.7.38 A lack of control or loss of control, as we have seen, is mentioned by many GPs. There are those GPs who feel strongly about a loss of autonomy, and three GPs identified that what would improve their morale would be "to get some sort of control back". But there are a larger group of GPs who feel a frustration at not being able to control or influence the "workload". Workload is an example of a factor which arises from several different levels. The loss of control over workload is perceived as coming from "work imposed by government and the HC/FHSA bureaucracy", from "being pushed by secondary care", from increasing and unrealistic patient expectations, and from inequitable sharing of workloads between GP partners. These may all be perceived as factors which have a potential to decrease morale.

4.7.39 Being valued perhaps receives less overt recognition than other factors in discussions about morale. But it emerged as an important determinant of morale with our GP sample at a number of different levels. A number of GPs reported that the rewards of working with patients and being valued by them and by the local community gave them most satisfaction in their job. Conversely some GPs talked about the there "no longer being complete trust in GPs", "the erosion of their perceived value to society", , "being exploited by all sectors of the community". Some referred to "the lack of esteem" as a result of the quality of recruits to general practice falling off. Being valued by GP partners and the rest of the team is clearly important too as indicated by the GP who reported "there is never any praise between partners; this can be very demoralising". Perceptions of being valued or undervalued by the FHSA/HC has been discussed at length. Lack of appreciation or recognition of the value of GPs by government is also expressed through negative feelings about the inadequacies of financial remuneration of GPs as well as not being listened to.

4.7.40 Support within practices and PHC teams has also been discussed at length, but the desire for more support from GP partners and the FHSA/HC suggests that more GPs feel isolated than the one or two GPs who talked about this openly.

4.7.41 The sense of optimism or pessimism emerged in our discussions about GPs views of the future for themselves and general practice. For some there were hopes of the future, others were less optimistic

4.7.42 How do all these various factors inter-act and so result in a state of mind which reflects the level of morale of the individual? Evans (Op cit: p.168) states that:

> *"an individual's morale level may be determined by a kind of unconscious summing up process whereby, at any one point in time, the anticipated dissatisfying constituents are balanced by the satisfying ones."*

4.7.43 Thus an individual is likely to balance their personal negative feelings against their positive feelings. Evans also believes there is an intuitive, unconscious ranking of these feelings and the process is influenced by the personal goals of the individual. These goals in turn are influenced by the personal values of the individual, and so some take priority over others. The result is that these goals are also subject to some form of ordering into a hierarchy.

4.7.44 We have already seen in paragraphs 4.6.22 to 4.6.27 when we were discussing 'how GPs see their own future' that this process appears to have come into play with our GP sample. We saw how, when the respondents were asked to change their focus from their vision of the future for general practice to their vision of their own personal future, the ordering of their priorities changed. By examining the case studies for all the individual GPs and comparing and contrasting those with high morale levels, and those with low morale levels, (together with the varying reported stress levels), we can see how the balancing of dissatisfying feelings against the satisfying feelings operates in relation to the goals of the individual.

4.7.45 The eleven GPs with a high morale level of between 5 and 7 could each be characterised as expressing some positive factor about their current situation or a positive anticipation of the future through the realisation of one or more of their goals. Two talked of the satisfaction at being in control of their own work, three emphasised the importance to them of a supportive team, and anticipation that this would continue to develop, three spoke of the balance between work they did within and outside the practice and the importance of these things to them. Five anticipated the prospect of new developments within the practice about which they felt very optimistic (this includes the third GP discussed earlier in paragraph 4.6.26). For example hopes for a new practice manager for improving the practice organisation, "lots of plans for improvements to the practice such as new premises, increasing in-house services, so there will be a sense of achievement if things go well". On balance the four GPs with the highest stress scores, as well as highest morale scores, were the most positive in their outlook.

4.7.46 Six of the seven GPs reporting a morale level of 4 also expressed some positive factor about their current situation or goal for the future. The positive factor for four was an expression of satisfaction about their work with patients. Five identified their goal for the future, but for three their main goal was just "survival". Additionally for two there was the anticipation of being able to become part-time to "overcome the stress and the workload factor". However two GPs in this group did have the more positive goal of becoming a trainer. There was however a sense that the positive factors with this group were less imaginative and creative than with the higher morale group.

4.7.47 The eight GPs with a lower morale level ranging from 1 to 3 were all characterised by having either a long list of negative feelings or some very strong negative feelings. These therefore appeared to outweigh any positive feelings they had. Four were positive about their PHC team. One felt fulfilled by work with patients and still having some independence. But four out of the five with morale levels of 1 or 2 were extremely pessimistic or fearful of the future and this appeared to outweigh all the positive factors.

4.7.48 The review of these individual GPs' responses confirms the view that morale is an anticipatory rather than a responsive state of mind and that those with high morale appear more motivated and energised than those with lower levels of morale. These findings suggest that the key to improving morale amongst general practitioners is to recognise that:

(a) morale is an individual phenomenon

(b) morale is a state of mind strongly influenced by factors which anticipate future events. Thus, GPs with positive and creative goals for their future work, are more likely to have higher levels of morale.

(c) morale is a balance between positive and negative factors, so that reducing some of the negative factors and increasing the positive factors could change the balance in a positive direction significantly, but these factors would have to be the ones relevant to each individual if they were to have any benefit for that individual.

(d) a single positive factor, if it coincides with the goals of the individual could have a significant impact on raising morale for that individual.

4.7.49 Finally, in seeking to alleviate low morale, it is important to recognise that, in aggregating individual views on the determinants of morale, this may appear to give a group perception of morale, whereas such an aggregated view is in fact the outcome of a consensus of individual perceptions. Group morale is thus not the main influence on the morale of individual GPs.

SECTION FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Our study has aimed to identify the range and diversity of experiences, perceptions and organisational factors which combine to produce a GP's sense of job satisfaction, well-being and morale. Our sample of GPs was necessarily small and was selected to reflect their diversity rather than to yield representativeness. Thus in drawing conclusions about the determinants of morale from the data we have gathered, it is important to recognise that these have been based as much on this diversity, as on the aggregation of similar responses. In fact a recurring theme throughout this study has been the differential impact of particular factors on individual GPs, together with the sometimes opposing views expressed by them. These findings confirm the well known existence of heterogeneity among GPs and support the use of a case study approach.

5.2 This conclusion, combined with our interpretation of GP morale as an individual, rather than a group, phenomenon is fundamental to our response to the second and third aims of this study; that is "to establish those factors causing low morale which are amenable to different forms of management action at the Health Commission level", and "to make appropriate recommendations for such action". Thus while the aggregation of our data has been important in helping us to understand where the common areas of concern lie, it is important to recognise that there are substantial variations among GPs in their responses to these common areas. For example, the experience of increasing patient demands and the impact of this in relation to other issues will be different for each individual GP. These differences need to be taken into account when it comes to making recommendations and to identifying solutions to problems.

5.3 In looking at the possible management actions to address the causes of low morale, we can start with the range of issues which are common to many GPs. However, when it comes to working on the solutions, these will need to be addressed on a practice by practice basis. This will obviously have resource consequences for the Health Commissions.

5.4 Bearing these points in mind, what does a broad overview of the aggregate data suggest are the least satisfying aspects of the GPs' job? Which factors have had the greatest negative impact on them? And what are the main causes of low morale? Our findings suggest that there are two main areas; namely the demands and impositions upon GPs arising from (a) the bureaucracy, and (b) patients and patients' needs.

5.5 Many of the other areas cited by GPs as having a negative impact are, in fact, consequences of these demands. Thus references to increasing workloads, longer working hours, insufficient time, increasing paperwork can all be related to these areas. In addition some of the demands in both these areas were perceived as having a negative impact because they were variously viewed as unwarranted, unjustifiable, inappropriate, or unrealistic. In fact a common theme was the frustration from having to divert time and energy into doing things for both patients and the bureaucracy which were considered to be an ineffective and inefficient use of GPs' time and skills. The effect of this, as expressed by some GPs was first, they had less time to give to patients who really were in need of their services and second, an increased sense of drudgery and monotony in the job.

5.6 Another important dimension of the increasing and changing demands and expectations of patients are the effects this has on out-of-hours work, night calls and visits. Where these are reported as having a negative impact, and this does not apply to all GPs, the impact is from increases in both the number of calls and the proportion of unwarranted calls and visits. This in turn has an impact on the GP who has to stay awake the next day in surgery, and disrupts family life. There is also the high cost and the unsatisfactory alternative of using a deputising service - where this is available - if a GP wishes to minimise the impact of night work on his health and his family life.

5.7 Changing expectations of patients can also lead to more complaints and fears of litigation by some GPs. Yet another source of increased patient demand arises from the changing nature of the care required as a result of earlier (and sometimes inappropriate or inadequately managed) discharges from secondary care, particularly in relation to increased rates of day surgery.

5.8 Thus many of the issues identified by GPs as having a negative impact or increasing pressures are in fact inter-related and stem from the two main areas of a GPs work; that is, providing services to patients and inter-acting with the "bureaucracy". But what actually lowers morale or job satisfaction for each individual GP are the "feelings" which GPs experience in relation to these issues.

5.9 When we asked the respondents what they thought could be done to make the lot of GPs more satisfactory or what would improve morale many of the responses were to do with feelings of being recognised, valued and supported and having or regaining some control. These feelings therefore need to be taken into account when considering the management actions to address the causes of low morale. We set out below our main recommendations for addressing those factors which this study suggests cause low morale amongst GPs.

Recommendations to the Health Commissions

5.10 Drawing on the analysis and conclusions from this study we have identified a number of recommendations. These are set out below.

Health Commission support to GPs

- **Our main recommendation is that the Health Commissions need to offer strong support to GPs in the development of a primary care-led NHS. To this end they need to support GPs through the provision of advice, investment and training, and to collaborate with GPs in developing a stronger partnership between the Health Commissions and all GPs as identified in EL(94)79 (NHSE, 1994).**

GPs' wants

- **We recommend the Health Commissions systematically and sympathetically review the complete list of "GPs' wants" (identified in full in Section 4.5 of the report). We suggest this is done initially as a separate exercise with the relevant staff in each Health Commission, and with the GPs from within each Health Commission, so that both groups have an opportunity to offer their response from their different**

perspectives. Once all sides have had an opportunity to review this list of GPs' wants, a more detailed plan would be needed to take these issues forward.

5.11 Some of the GPs "wants" are directed at the government. Thus one of the outcomes of reviewing the GPs' "wants list" with the GPs may be to draw up some joint proposals for change, where action is needed at a national level. This might include recommendations for changes in the GP contract, particularly with regard to the way the remuneration structure forces working practices which are contrary to GPs values and beliefs, including delivering on quantity rather than quality, combined with the perverse incentives to working longer hours. There appears to be a need to relate GP remuneration more closely to quality, intensity of work and skills required.

- **An important initial outcome of this process should be:**
  - **clear evidence that:**

    (a) the Health Commissions have heard what GPs are saying,
    (b) the total organisation is involved and listening.

- **the listening and hearing is reflected back to each individual GP practice.**

- **the issues and problems are communicated to the NHSE who are persuaded to discuss them with the GPs locally first hand.**

5.12 Many of our more specific recommendations discussed below draw on this list of GPs' wants, in combination with our other findings from this study. We should, however, emphasise that diversity among GPs means that not all the recommendations apply to all of them. Policy will need to be developed sensitively on a practice-by-practice basis.

Understanding general practice and the role of the Health Commission

5.13 One of the main requests of the GPs is for the FHSA/HC to understand general practice and GPs better.

- **We suggest that the HCs need to work <u>jointly</u> with GPs to develop <u>shared values</u> in response to the changing role of general practice within primary care. This would include working jointly to determine the purpose of general practice and to work out the changing role of general practitioners in a primary care-led NHS.**

- **There would also appear to be a need for a more explicit understanding of what GPs expect from the FHSAs and HCs and what the HCs expect from GPs. Such an understanding could be promoted through developing joint strategies and for HCs to work individually with GP practices in developing joint action plans to implement the agreed strategies.**

5.14 One important aspect of HC/GP interaction which requires clarification is the process of accountability. At the moment there are confused views about accountability among some GPs. While acknowledging the need to understand their FHSA/HC better, one GP commented: "it should be a two-way educational process", whilst another remarked: "I don't know where the Health Commission ends and the Elephant and Castle begins". As

suggested by Thornton (1994) there may be a case for "a fundamental reworking of the roles and relationships between the new HAs and general practice."

- **We suggest that a shared understanding is developed between GPs and the managers and staff of the FHSA/HC on what is meant by accountability and responsibility for the NHS resources allocated to GPs. In particular work is needed with those GPs who perceive a conflict between accountability to the FHSA/HC and their self-employed status.**

- **We believe there is a need for the organisational structure of the Health Commissions and the respective roles, activities and functions of their managers and staff and with whom GPs inter-act is made clear to all GPs. This should take account of the fact that, in the course of developing a shared understanding of accountability with GPs, there may emerge a need for some rethinking on roles or activities for some staff.**

Support to GP partnerships

5.15 The "GPs' wants" list discussed above is largely made up of proposals addressed to the FHSA/HC. This list, together with the common areas of concern we have discussed above, convey a sense that most of GPs' woes come from what is imposed or demanded of general practice by others, and thus implying that perhaps only a minority of problems are generated from within general practice itself. But, as we have indicated in the findings, whilst internal problems were not identified directly in response to what causes low morale, there was a lot of evidence for pressures or conflict arising within practices and between partners.

5.16 Such conflict included inequitable sharing of workload, inequitable sharing of profit, conflicts on how to deal with patient demand, pressures on some partners by those who want to maintain a high income, blocking of ideas, conflicts about delegating work to other members of the PHCT, senior partners views outweighing junior partners, and a lack of support between partners. Thus there was a sense that more GPs were professionally isolated than the one who admitted this directly or those who indicated this in the pressure scores. A number of GPs talked of team-building, but it would seem that continuing support is needed in this area. One GP spoke of the need for help in advising on profit sharing and wanted outside consultancy help for this.

5.17 Some general practices will presumably have worked on defining the purpose and values associated with the services they provide as part of developing their business plans. However, the data we refer to above suggests that, for some practices, there may not be shared values with which all partners are in agreement.

- **We suggest that some specific support may be needed by some practices to help them in responding to the changing expectations of the role of General Practice in a Primary Care-led NHS. This may be needed in particular in practices where all the partners currently do not appear to share the same values and where there are differing views and expectations which have led to existing problems within the partnership. Support may therefore be required in the form of facilitation to review the purpose, values, aims for the practice prior to developing strategies for**

further development. Practical support may be needed in identifying the causes of any problems and in developing and implementing action plans to solve them.

- **In developing support to GPs as a core function of the Health Commissions (EL(94)79), we suggest some structure is required for both identifying the need for support on a practice-by-practice basis and for the provision of such support.**

- **We suggest any existing problems within practices are identified and addressed before attempting to develop broader strategies as discussed in 5.13 above and before encouraging or introducing major change.**

Managing and coping with change

5.18 Our findings revealed many reservations on the part of GPs about changes taking place in general practice. Some of these were based on the belief that changes were not based on scientific evidence and were undertaken for the wrong reasons. On other occasions there were criticisms of the pace and intensity of change. However, given that change is an increasingly inevitable feature of professional life - and that the development of a primary care-led NHS is likely to lead to more rather than less change:

- **We suggest that GPs are given more support and training in the process of change. They need help in understanding, in preparing for and in managing the process better. This will involve the development of a better understanding of strategic issues and organisational development within general practice. It should also encourage a proactive rather than a reactive stance.**

Managing patient demands and expectations

5.19 Because patient demands exceed the ability of GPs to meet these demands a tension exists between the ideal response to the needs of individuals and the reality of providing a service. Generally, because GPs have not wanted to ration services to patients, they have looked for strategies to cope with this demand. A range of strategies were described to us including practising "reductionist" medicine, and delegating to other members of the primary health care team. In this way GPs have been able to exert some control (and thus also in their turn becoming what Hudson describes as "street level bureaucrats" (Hudson, 1988)), but this has been counter-balanced by patients taking back some of the control through invoking their rights under the Patients Charter and so provoking GPs into a wider application of defensive medicine.

5.20 Clearly increasing and inappropriate patient demands or expectations are a major source of pressure or stress for many GPs. Whilst many GPs talked of strategies directed at managing this increase, a number admitted to having tried and failed. A wide range of reasons for this increase were cited, such as demographic changes, the Patient's Charter, and technological developments in medicine. But whilst most GPs cited causes originating from outside the practice, one GP did admit that many patient demands were doctor-generated as a result of the palliative approach of GPs. Managing the problem is complex and not helped in some cases, as we have discussed above, by the difficulties that exist within some partnerships. A few suggestions were made by GPs in the "wants list" towards alleviating the problem, and it is interesting to note the main suggestion was directed at educating patients and parents to use GP services more responsibly.

- **We suggest that HCs and GPs need to work jointly on finding solutions to the problem of increasing and inappropriate patient demand and expectation. It may be necessary, as part of this process, to identify more clearly the causes of these changing demands on a local basis. The work on seeking solutions could be linked into the work on sharing values and determining the future role of GPs and general practice as discussed above. This would then bring in a whole range of issues such as delegation of work by GPs, out-of-hours work, on-call and night visits, list size and GP remuneration, targets and so on.**

- **The work should include identifying action and support required from the Health Commissions, including support for innovative trial schemes aimed at addressing some of the problems. We suggest the HCs may need to be more flexible in their approach to this. Such schemes might include (see also 5.21 and 5.22 below):**

  - **public education programmes**
  - **the role of pharmacists in the management of minor ailments**
  - **triage for work of nurses in large practices**
  - **managing patient expectations of waiting times**

Delegating clinical work

5.21 There are clearly issues for GPs around delegation of clinical work to others whilst retaining clinical responsibility for a patient. This arose in the interviews over the use of locums and in delegating work to nurses and nurse practitioners and to other members of the primary health care team. It is probably also an issue in the use of deputising services for night visits, although this was not made explicit. The issue of clinical responsibility is a professional matter, but as the art of delegation is an issue of efficient and effective use of resources, the FHSA/HC needs to provide both appropriate support in terms of reviewing allocation of resources relevant to this area, whilst at the same time understanding the GPs' values and professionalism.

- **Work on the development of primary health care teams has made considerable progress in parts of Wessex. But we believe more can be done. There have now been several studies looking at the feasibility, and in some cases the cost-benefits, of delegating GP work to others, including to nurse practitioners and other members of the primary health care team (for example Fawcett-Henesy, 1995; Marsh et al, 1995; Cragg et al, 1994). We suggest that the Health Commissions review the outcome of these studies jointly with GPs and their PHC teams with a view to identifying what may be appropriate to explore further for local application.**

5.22 In undertaking any reviews of the role of the GP there is a need to recognise that 93% of our sample of GPs reported they obtained most job satisfaction from dealing with patients and their families and with clinical work. They value their generalist role and their unique NHS role in offering whole person medicine. Thus any proposals for actions to relieve GPs of their patient-generated workload needs to take account of this, ensuring that any proposals for reduction in time spent with patients does not undermine GPs' personal values and professionalism.

Encouragement of entrepreneurial and innovative GPs

- **Linked to some of the above proposals we suggest the Health Commissions could support entrepreneurial and innovative GPs, through encouraging and enabling them to develop well thought out proposals for new schemes aimed at improving efficiency and effectiveness. This would include support for undertaking cost-benefit analyses of such schemes and for trials where appropriate.**

Management skills

5.23 A few GPs indicated in the course of the interviews, either directly or indirectly, that they needed to improve their management skills. However, only three were definite in wanting to undertake management training in response to the question on their personal training plans. Clearly there are training needs in this area, such as managing change, managing their own time, problem-solving, staff management and so on. Several GPs expressed appreciation of the management courses for GPs organised by one HC/FHSA. However, attendance at management courses may not suit the learning styles of some GPs.

- **We suggest that alternative approaches for the development of GP management skills, which may be more appropriate for some GPs, be explored. A preliminary to this should be identification of the precise training needs for individual GPs in management development where this has not been done. Such identification could be linked to the development of personal development plans.**

GPs careers and future plans

5.24 The low number of GPs who were able to give a considered and positive response to the questions asking for their personal training plans for the next twelve months and their personal goals and ambitions as a GP for the next five years was quite striking. The responses suggest that the majority of GPs in the sample do not have a personal development plan, or if they do, such a plan is not very effective in its impact.

5.25 The issue of GPs careers and the lack of opportunity to change partnerships is clearly relevant to GP morale. There are other fundamental issues associated with GPs' careers which were raised by some GPs during the interviews, including the opportunity to become salaried. Many of these issues need addressing at a national level and by the GP profession, but the Health Commissions may be able to work with local GPs in contributing to the national debate.

- **We suggest the Health Commissions provide support to GPs to enable them to develop personal goals, to have personal development plans, and to find ways and means of implementing these. Such support could be linked into the South and West initiative for a Career Advisory Service for GPs. The issue of apprehension about accreditation among some GPs may need to be addressed in considering this proposal.**

Releasing time

5.26 Many GPs identified a personal need for more time to think, plan and do other things, or to work less hours and to work more social hours so as to reduce the conflict between

time given to work and time for their families and home life. Several of the issues we have discussed above should result in less pressure on a GP's time.

- **We suggest there is a need for an overview of all the actions that could be taken to release time for GPs. Whilst some actions can be taken at the level of the individual and incorporated into personal development plans, other actions require co-operation from partners and colleagues and from the Health Commissions. Some examples of ways that the Health Commissions could support GPs in a more efficient use of time include:**

    - **training GPs in time management and in efficient management of their administrative workload**

    - **review and monitoring of the demands made of GPs by the HCs' own staff, including the needs for information and the methods for collecting and submitting these.**

    - **enabling GPs and practices to manage and control patient demand as discussed above.**

Support for small practices

5.27 GPs in single-handed and two-partner practices promote the existence and retention of small practices as essential to patient choice. There is also the issue of the individual personality of GPs who choose to work in small practices because they cannot or do not want to have to cope with the partnership issues of larger practices. The latter is also therefore a significant factor in their fear of the demise of the small practice. The support currently given to small practices by one of the Health Commissions was praised by one of the single-handed GPs.

- **We suggest the existing support given to small practices be continued and reassurance is given about the impact of future developments, such as fundholding, on small practices. Such practices need extra support as they do not have the resources to enable the spread of any additional work. The GPs from these small practices want re-assurance that any future co-operative arrangements, for example, will not compromise the freedoms over decision-making which they currently enjoy. The lack of such re-assurance may lower morale.**

Isolation of new GP principals

5.28 The reference by two GPs to the sense of isolation when they first became a GP principal was quite striking. We consider that the need to implement some appropriate form of support system for new GP principals is very real. The Young GP Principals' groups obviously offer some general support, but may not offer specific support at a time of need or crisis. The idea of having an experienced GP principal from another practice as a GP mentor for the first critical months as a GP principal was proposed by one of these GPs.

- **We suggest the Health Commissions give serious consideration to setting up a support system for new GP principals to be provided on a one-to-one basis, such as a mentor scheme, particularly in the first few months of appointment. We suggest consulting recently appointed first-time GP principals for their views on what would be most useful and practicable, and then setting something up on a trial basis.**

Other areas for action: reviews of FHSA/HC procedures and systems

5.29 Apart from the areas discussed above, there were a range of other specific areas identified as being a cause of low morale, and which were included in the list of "GPs wants". We would hope that these would be looked at as part of the process of reviewing this list with Health Commission staff and the GPs themselves, or under our suggestions above for support to GP practices, understanding general practice and managing patient demands.

- **We would like to draw particular attention to the GPs requests to review with them the following procedures and systems:**
  - **patients complaints procedures;**
  - **requests for information: what is being requested and by whom (including duplication of information requested), how often, why, and how;**
  - **systems of communication between practices and the FHSA/HC: use of direct computer links and other technology;**
  - **remuneration systems and methods of payment.**

Improving GP morale: the individual approach

5.30 Finally, there is the need to recognise that morale is an individual state of mind and therefore problems of low morale also need to be addressed on an individual basis as well as at Health Commission and individual practice level.

- **We suggest Health Commissions help individual GPs with low morale to develop a greater sense of optimism about their own future within general practice. Some of the suggestions we make above under each heading, and particularly work in developing joint values and understanding general practice, and in addressing some of the more negative issues and experiences, could go a long way towards this. Such work, combined with helping these GPs to feel more valued and providing support to them in developing personal development plans and goals (as discussed above under "GPs careers and future plans"), could therefore make a significant impact on GP morale.**

- **Thus we suggest that some way is found for ensuring that the factors most likely to improve the morale of individual GPs, particularly those with low morale, do not get overlooked when work is done with individual practices.**

5.31 The point being made here is that time has to be found to discuss issues with individual GPs on a one-to-one basis. Group discussions within a practice are not sufficient to address the problems for the individual.

5.32 There is also the need for preventing and managing stress among GPs. Around a third of GPs put forward ideas for this, which are set out in the GPs' wants list.

5.33 We recommend that, when the GPs' suggestions for the prevention and management of stress are reviewed, emphasis is given to the important point made by some that provision of an occupational health service and stress counselling service for GPs is not the complete solution, as such provision implies that stress is an illness. As we have seen there are some GPs who report high stress levels and yet also have a high morale level. The response to stress is therefore very much an individual matter.

5.34 Some GPs have also suggested there is a need for some system to be set up for identifying problems amongst GPs at regular intervals before such problems do degenerate into a continuing state of high stress and low morale and physical ill health.

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APPENDIX ONE CHANGE ORIENTATION AND TEAM WORKING: SCORING AND INTERPRETATION

CHANGE

Up to 20	Aversion to change, may well have difficulties in dealing with change or encouraging others to change.
21 - 30	Whilst change does not rest easily, at least aware that a more positive approach is required.
31 - 40	Realistically accepts change, has some confidence in dealing with it though in a more reactive than pro-active mode. Cautious with a balanced view.
41 - 50	Pro-active and positive about change. May occasionally cause blind spots when unable to emphasise with others who lack similar vision and open-mindedness.

TEAMWORK

Up to 20	A loner who sees little advantage in working with others. Highly individualistic, confident and happy with own company.
21 - 30	Aware of the necessity of teamwork but may have difficulty taking the time and making the effort.
31 - 40	A good team player but still able to take individual responsibility. Will see where teamwork is helpful to achieving the objectives.
41 - 50	Extremely gregarious and in need of support and encouragement of others. Strongest when working in a team rather than alone.

INSTITUTE FOR HEALTH POLICY STUDIES
UNIVERSITY OF SOUTHAMPTON

MORALE IN GENERAL PRACTICE

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1. Subject No:
2. Interviewer
3. Date of interview

CONTENTS

MORALE IN GENERAL PRACTICE

1. PRACTICE DETAILS - DETAILS SUPPLIED BY HEALTH COMMISSION

		Data from HC - enter or circle		
1.1	Fundholding practice?	Yes		
		No		
1.2	If Yes, which year became fundholder?			
1.3	Is the practice part of a Consortium?	Yes		
		No		
1.4	If Yes, what type of Consortium?	FH		
		Non-FH		
1.5	Training practice?	Yes		
		No		
1.6	Total number of partners			
1.7	W.T.E. of all partners			
1.8	How many partners are part-time?			
1.9	How many partners job share, if any?			
1.10	Number of female partners?			
1.11	GP assistants W.T.E.?			
1.12	GP trainees - establishment?			
1.13	Practice Manager W.T.E.?			
1.14	Fundholding Manager W.T.E.?			
1.15	Business Manager W.T.E.?			
1.16	Practice Administrator W.T.E.?			
1.17	All other admin & clerical staff W.T.E.?			
1.18	Total number of Practice Nurses			
1.19	Total W.T.E. for all Practice Nurses			
1.20	Practice location:	rural		
		semi-rural		
		suburban		
		city		
		inner city		

MORALE IN GENERAL PRACTICE

1. PRACTICE DETAILS - DETAILS SUPPLIED BY HEALTH COMMISSION

			Data from HC - enter or circle		
1.21	In what year was the main surgery built or converted?		1990s		
			1980s		
			1970s		
			1960s or earlier		
1.22	Do the partners own the premises?		Yes		
			No		
1.23a	If yes, under what scheme?		Cost-rent		
			Notional rent		
			Other scheme		
1.23b	If no, what is the arrangement for occupation?		Rent from local Trust		
			Other		
1.24	Are there any Branch Surgeries?		Yes		
			No		
1.25	If yes, how many Branch Surgeries?				
1.26	What is their location?	a. b.			
1.27	Under what scheme are they occupied?	a. b.			
1.28	What is the Jarman Index allocated to the Practice?				
1.29	Total Practice list size				
1.30	Average list size per GP				

2 PERSONAL DETAILS AND CAREER

		Data from HC - enter or circle		
2.1	What is your position in the Practice?	Senior partner		
		Oldest partner		
		Chair/team leader		
		Partner		
		Other		

2.2	Are you full-time?	Yes		
		No		
	If part-time, W.T.E.?	0.75		
		0.5		
		Job share?		
2.3	What is your personal list size?			
2.4	What is your age?			
2.5	Sex?	Male		
		Female		

2.6	Did you undertake vocational training in general practice prior to becoming a GP?	Yes	
		No	
2.7	If yes, in what year did you complete your vocational training?		
2.8	In what year did you enter general practice?		

2.9 If there is a gap in time between completing your vocational training and entering general practice why was this?

2.10	How long have you been in this practice?		
2.11	Have you worked in other practices as a principal	Yes	
		No	
2.12	If yes, how many other practices?		
2.13	If yes, when did you last change practice?		

2.14 Why did you change practices?

2.15	Have you worked in other branches of medicine or another career?	Yes	
		No	

2.16 If yes, what?

2.17 What made you decide to become a general practitioner?

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3. PRESENT POST: JOB SATISFACTION

3.1 Are there any differences between your perception of what it would be like to be a GP, before you commenced your GP vocational training
- and the reality of becoming one - in the first few years as a GP principal?

3.2 What are the differences in the job between now and when you first became a principal/GP partner?

What has caused these differences?

3.3 What do you find <u>least satisfying</u> about your current job?

3.4 How about <u>most satisfying</u>?

3.5 In your job at present, how would you rate your level of satisfaction with each of the following?

Circle the appropriate number for each item on a scale 1 to 7

A high score = high satisfaction

The amount of responsibility you have	1	2	3	4	5	6	7	
The amount of variety in your job	1	2	3	4	5	6	7	
Your partners and other fellow workers	1	2	3	4	5	6	7	
The physical working conditions	1	2	3	4	5	6	7	
Your opportunity to use your skills and abilities	1	2	3	4	5	6	7	
The freedom to choose your own method of working	1	2	3	4	5	6	7	
The recognition you get for good work	1	2	3	4	5	6	7	
Your NHS income for the amount of work you do	1	2	3	4	5	6	7	
Your hours of work	1	2	3	4	5	6	7	
Your job as a whole, taking everything into consideration	1	2	3	4	5	6	7	

4. THE JOB: HOW TIME IS SPENT

4.1 Which of the following specialist services are undertaken:
(a) within the practice by one or more partners (b) by you

	(a) done within practice?: yes/no	(b) by you: none/ some/all	
minor surgery			1
maternity services			2
child health surveillance			3
contraceptive services			4
asthma care			5
diabetic care			6
other (1):			7
other (2):			8
other (3):			9

4.2 Would you like to personally undertake more or less work in one or more of these and other specialist areas?

(i) content with present level

(ii) more

(iii) less

4.3 If you would like a change, what is preventing this?

4.4 <u>For practices with population over 7,000 only</u>

I believe you are a fundholding/non-fundholding practice:
What is the main reason your practice decide to go/ not to go fundholding?

4.5 Do you think this was the right decision?
Yes/ No...

Because ...

4.6 (a) For practices with 3 or more partners:

Do you have a particular area of responsibility within the practice?

	Tick	Comments	
Chair of partners/ team leader			
Fundholding budget			
Practice financial management			
Business/strategic planning			
Contract negotiation/ commissioning care			
Staff management			
Medical audit			
Computers			
GP trainees			
Other, please describe:			

Why did you take these on?

(b) For single-handed and two-partner practices

Practices with several partners are able to share out the tasks of decision-making with regard to running the practice with other partners. What are:

(a) the advantages and

(b) the disadvantages

for you in running the practice single-handed or with just two partners?

4.7 Do you have any regular commitments outside the practice?

	Now	In the past	Comments (including why given up)	
Clinical Assistant to DGH				1
Work in local community hospital				2
Other NHS clinical activities				3
GP training				4
GP tutoring				5
Research				6
Membership of local MAAG				7
Membership of LMC				8
Membership of other committee:				9
Medical officer in education sector:				10
Other outside job:				11
Other activities:				12

4.8 If yes to any of these, what factors motivated you to take these on?

4.9 If time given to these activities has changed over the last three years, why?

4.10 Could you please indicate in the table below your timetable for an average/typical working week, excluding out of hours work?

To include: surgeries, specialist clinics (e.g diabetes), minor surgery, child health surveillance, home visits, staff meetings, half days etc

	Monday	Tuesday	Wednesday	Thursday	Friday
Time start GP work					
A.M.Surgery start/finish* times					
Other A.M. activities					
Lunch-time activities					
Other P.M. activities					
P.M. Surgery start/finish* times					
Time finish GP work					

* Note if this the booked finish time or the usual finish time (if surgeries over-run)

No of weekday surgeries per week		Average no working hours per week	
Total surgery hours per week		(Monday to Friday)	

4.11	What is the average number of patient contacts in a normal working day?		

4.12 How many hours per month do you spend on the following activities?

		Within normal working week	In own time/ out of hours	Hrs/ wk	
☐	Furthering own education and training e.g attending sessions qualifying for PGEA				
☐	Keeping up-to-date with clinical/ NHS developments *e.g by reading*				
☐	GP trainees and/or GP tutoring				
☐	Membership of Medical/ Professional Committees *e.g MAAG, LMC, BMA, RCGP*				
☐	Other Activities: *describe e.g Clinical Assistant sessions in local hospital*				

4.13 Does your practice use a GP deputising service for out of hours on-call work?

Yes	
No	

4.14 How often do you do GMS work out of hours/ on call?

Nights..... None ___ in ____ = _____*weekday nights/ month*
Weekends ..... None ___ in ____ = _____*weekends/month*
Saturday mornings .. None ___ in ____ =_____ *Saturdays/month*

4.15 Is the above out of hours/on-call work undertaken for:

	Yes	No	
☐your Practice only			
☐on-call rota shared with other practices			
☐GP Deputising service (for your practice and/or others)			
☐other: please describe (e.g as police surgeon) and identify %			

4.16	On average how many times are you called out by patients out of hours per night when on call?		

4.17	What percentage of these are unnecessary calls?	%	

4.18 Why are they unnecessary?

		Minutes	
4.19	What is the usual booking interval for patients attending your surgery?		
4.20	On average how much time do you give to each patient who comes into your consulting room?		

4.21	Do your surgeries over-run the planned time?	No, generally not		
		Yes		

4.22	If your surgeries over-run , how many times per week?		
	and generally by how much time?		

4.23 Have you taken or considered taking any specific actions to manage your time and clinical workload and to avoid feeling pressurised during surgery times?

Prompts (if not volunteered)

1. *Delegate to nurses/ paramedics*
2. *Alter booking times*
3. *Alter number or length of surgeries*
4. *Make a series of F.U appointments*
5. *Negotiate new systems with partners*
6. *Reduce list size*
7. *Reduce other activities*

4.24	How many hours per week, on average do you spend out of hours on paperwork, if any, in the evenings or at weekends?		

4.25 What is this paperwork?
Prompt: private clinical work, data, reports for HC, fundholding work etc

5. JOB STRESS AND MORALE

5.1 In priority order which of the following issues arising out of or introduced since the 1990 contract have had the greatest negative impact on your ability to treat patients?

Rank in order **1 = greatest negative impact** **up to 12= least impact**

P = has a neutral/positive impact X = not relevant to me

	Rank in order 1 up to 12	***Comments/ Reasons***	
Commissioning hospital care for patients and/or negotiating contracts			
Requirements to meet targets an provide specific services as the basis of remuneration			
Managing indicative budgets for prescribing			
Implementing the new health promotion package			
Health checks for the over-75s and new patients			
Medical Audit			
24-hour responsibility for patients			
The Patients Charter			
Reduced independence through accountability to FHSA/HC			
Reporting to FHSA/HC on activity including the Annual Report			
The shift of services from secondary to primary care			
Developments in Care in the Community			

5.2 Can you please rate each of the following factors according to how much pressure you experience from each one in your job?

1 Causes me no pressure	2 Causes me slight pressure	3 Causes me moderate pressure	4 Causes me considerable pressure	5 Causes me extreme pressure

Circle the appropriate number for each item

01	increased demands from patients	1	2	3	4	5	
02	inappropriate demands from patients	1	2	3	4	5	
03	dealing with problem patients	1	2	3	4	5	
04	dealing with the terminally ill & their relatives	1	2	3	4	5	
05	dealing with earlier discharges from hospital	1	2	3	4	5	
06	worrying about patient complaints/litigation	1	2	3	4	5	
07	24-hour responsibility for patients' lives	1	2	3	4	5	
08	working environment and surgery set-up	1	2	3	4	5	
09	insufficient time to do justice to the job	1	2	3	4	5	
10	fear of assault during visits	1	2	3	4	5	
11	interruptions by emergency calls during surgery	1	2	3	4	5	
12	disturbance of home/family life by GP work	1	2	3	4	5	
13	dividing time between work and spouse/family	1	2	3	4	5	
14	night visits	1	2	3	4	5	
15	unrealistically high expectation of role by others	1	2	3	4	5	
16	worrying about the finances	1	2	3	4	5	
17	being on call, waiting for calls	1	2	3	4	5	
18	insufficient resources within the practice	1	2	3	4	5	
19	dealing with conflict within the practice	1	2	3	4	5	
20	longworking hours	1	2	3	4	5	
21	paperwork	1	2	3	4	5	
22	changes imposed from the FHSA/HC	1	2	3	4	5	
23	arranging hospital admissions	1	2	3	4	5	
24	finding a locum	1	2	3	4	5	
25	adverse publicity by the media	1	2	3	4	5	
26	lack of support within the practice	1	2	3	4	5	
27	emphasis on business ethics	1	2	3	4	5	
28	the pace of change within general practice	1	2	3	4	5	
29	professional isolation	1	2	3	4	5	
30	increasing workloads	1	2	3	4	5	

5.3 Can you tell me, using a scale 1 to 7, how stressful you regard your job at present?

where 1 = not stressful, and 7 = highly stressful

5.4 Are there any factors not in the two lists you have just completed, and which you have not mentioned so far, which:

- have a negative impact on your ability to treat patients, and/or
- are stressful or create pressures, and/or
- have lowered your morale?

5.5 Can you identify any factors from these lists (questions 5.1, 5.2 and 5.4) which have the **potential** to increase your morale?

5.6 Reflecting back on the two lists, and what you have said so far, can you pick out **2 or 3 issues**, or a combination of issues, which **have had the greatest negative impact** on your morale, or which have created most pressure or frustration?

Can you also explain why?

5.7 Can you give me some specific examples, from your experience, of what happens?
e.g if response to 5.6 is "Patients Charter increases patient expectations and hence demands" ask for some specific examples of these increased demands and how they impacted on the respondent.

5.8 Can you tell me about the issues or factors which **have had a positive impact** on your ability to treat patients and/or on your morale?

5.9 Have you, or others, taken any recent actions to address the issues which:
(a) cause most stress or frustration or which have lowered morale? and
(b) have the scope for increasing morale?

What were the outcomes?

5.10 Has your practice developed any strategies aimed at improving morale within the practice?

5.11 Do you have any suggestions as to how the issues and problems we have been discussing could be addressed?

Prompt: Include actions that could be taken by:
(a) you and your family/friends
(b) the practice and individual partners
(b) the Health Commission (FHSA)
(c) others.

6. MANAGEMENT

6.1 How far do you feel involved in the decision-making process within the practice?

6.2 Are there any problems in sharing workload between partners?

6.3 Are there any problems in delegating aspects of patient care to other members of the primary health care team?

6.4 Can you comment on each others performance?

6.5 Do you feel your ideas and views are valued and respected within the practice?

6.6 Can you give some specific examples of when you felt your ideas or views were:

(a) taken up by your colleagues within the practice?
(b) rejected by them?

6.7 Do you feel your ideas and views are valued and respected by the FHSA/ Health Commission?

6.8 Can you give some specific examples of when you felt your ideas or views were:

(a) taken up by the FHSA/ Health Commission?
(b) rejected by them?

6.9 What aspects of the communication process **from** the FHSA/Health Commission **to** GPs:

(a) work well or are satisfactory?
(b) work least well and in your view need to be improved?

6.10 What aspects of the communication process **to** the FHSA/Health Commission **from** GPs, and which you have not already just mentioned (i.e in 6.5):

(a) work well or are satisfactory
(b) work least well and in your view need to be improved?

6.11 Have you ever undertaken any management training?

Yes		
No		

If yes, please describe when and what?

6.12 What are your personal training plans for the next twelve months?

6.13 Change orientation and teamworking: please tick the most appropriate box for each statement.

		Strongly disagree	disagree	un-certain	agree	strongly agree
1	I find major change rather unsettling.					
2	I am more radical than conservative in my approach					
3	People would say that I am good at coping with change					
4	I regret the passing of many old traditions					
5	I see change mostly as an opportunity					
6	I enjoy finding solutions to problems					
7	I prefer to know what I am doing before it happens					
8	I am constantly looking for options to produce better results					
9	I like to preserve well proven methods					
10	I prefer structure to variety in my work					

		Strongly disagree	disagree	un-certain	agree	strongly agree
1	I like to get consensus before acting					
2	I prefer my own company to that of others					
3	I am rather sensitive to criticism					
4	I gain lots of pleasure from other people's company					
5	I never feel envious of other people					
6	I think conflict at work is healthy					
7	I don't mind if my beliefs are at odds with others					
8	I frequently find myself thinking through how others will react to situations					
9	I think teamwork is essential to getting the job done					
10	Companionship at work is important to me					

7. THE FUTURE

7.1 What do you see as the future for general practice?

7.2 How do you think the general practice you work in will change in the next few years?

7.3 What do you think are the main factors which will bring about this change?

7.4 How do you think these changes will affect you?

7.5 In what way are these changes likely to impact on <u>your</u> morale?

	select one	
lower my morale		
have no effect on my morale		
improve my morale		

7.6 How would you rate your level of morale in your current job at the present time, on a scale 1 to 7?

where 1 = extremely low morale and 7 = very high morale

7.7 Do you still see yourself in general practice in 5 year's time?

Yes	
No	

7.8 If yes,
(a) are you happy about this?

Yes	
No	

(b) what are your goals or ambitions as a general practitioner for the next five years?

7.9 If no (to 7.7), what are the reasons likely to be for leaving general practice?

7.10 Reflecting back on our discussion what would you say are the three main causes of low morale in general practice today?

7.11 Does this reflect your personal position?

7.12 What actions have the FHSA/Health Commission taken recently to make your GP work more satisfactory?

7.13 What else do you think the FHSA/Health Commission could do to make the lot of GPs more satisfactory?

7.14 What other ideas do you have about how morale could be improved?

7.15 If you had your time over would you become a G.P again?

Yes		
No		

7.16 Your reasons?

7.17 Thank you very much for your help.
Could you tell me your main reason for agreeing /or volunteering, to take part in this study?

7.18 Is there anything else you think we should know about?

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