

Primary care



The full version of
this paper appears
on bmj.com

Morale among general practitioners: qualitative study exploring relations between partnership arrangements, personal style, and workload

Guro Huby, Marian Gerry, Brian McKinstry, Mike Porter, Johnstone Shaw, Robert Wrate

Working Minds
Research/Department
of Community
Health Sciences,
Primary Care
Research Group,
University of
Edinburgh, 20 West
Richmond Street,
Edinburgh
EH8 9DX
Guro Huby
senior research fellow

Department of
Community Health
Sciences, General
Practice, University
of Edinburgh
Mike Porter
senior lecturer

Family Business
Facilitation,
St Ragnvald's Street,
Kirkwall, Orkney
KW15 1PR
Marian Gerry
*independent
consultant*

Lister Institute,
11 Hill Square,
Edinburgh
EH8 9DR
Brian McKinstry
*director of
postgraduate medical
educational research,
SE Scotland*
Johnstone Shaw
*associate adviser in
general practice,
SE Scotland*

Department of
Psychiatry,
University of
Edinburgh, Royal
People's Unit, Royal
Edinburgh
Hospital, Edinburgh
EH10 5HF
Robert Wrate
*honorary senior
lecturer*

Correspondence to:
G Huby
guro.huby@ed.ac.uk

BMJ 2002;325:140-2

Abstract

Objectives To explore general practitioners' experiences of wellbeing and distress at work, to identify their perceptions of the causes of and solutions to distress, and to draw out implications for improving morale in general practice.

Design Three stage qualitative study consisting of one to one unstructured interviews, one to one guided interviews, and focus groups.

Setting Fife, Lothian, and the Borders, South East Scotland.

Participants 63 general practitioner principals.

Results Morale of general practitioners was explained by the complex interrelations between factors. Three key factors were identified: workload, personal style, and practice arrangements. Workload was commonly identified as a cause of low morale, but partnership arrangements were also a key mediating variable between increasing workload and external changes in general practice on the one hand and individual responses to these changes on the other. Integrated interventions at personal, partnership, and practice levels were seen to make considerable contributions to improving morale. Effective partnerships helped individuals to manage workload, but increasing workload was also seen to take away time and opportunities for practices to manage change and to build supportive and effective working environments.

Conclusions Solutions to the problem of low morale need integrated initiatives at individual, partnership, practice, and policy levels. Improving partnership arrangements is a key intervention, and rigorous action research is needed to evaluate different approaches.

Introduction

Morale among general practitioners is a current concern in the United Kingdom because of difficulties with recruiting and retaining the workforce needed to meet the targets of a primary care led NHS.^{1 2} Work strain for British general practitioners increased after the introduction of the 1990 general practitioner contract,³ but satisfaction subsequently improved and stress from night visits fell.⁴⁻⁶ Recent research into stress and malaise in general practitioners has

examined individual experience of work and how organisational contexts shape this experience.^{7 8} A well functioning team is important for reducing stress and improving performance,⁹ and people respond differently to similar working conditions.¹⁰ More work needs to be done to link the experience of individual general practitioners with the practice context in which they work and with the wider political, economic, and social context of health service reform. We aimed to explore general practitioners' experience of wellbeing and distress at work, to identify their perceptions of the causes of and solutions to distress, and to draw out implications for improving morale in general practice.

Methods

The qualitative study involved 63 general practice principals in South East Scotland (see bmj.com). It consisted of three phases: (1) semistructured, open ended interviews about experience of wellbeing and distress at work, and the relation between work and home; (2) semistructured interviews focusing on issues that emerged as most important in phase 1; and (3) focus groups in which participants discussed a fictitious scenario about a partnership based on issues raised in phases 1 and 2 and considered possible solutions to distress and low morale.

Four key areas were identified: partnership arrangements, increase in workload, personal style, and relation between home and work. The first three areas figured most strongly in accounts of morale and are the subject of this paper.

Results

Phase 1 interviews—partnership arrangements and personal style

Respondents described a range of experiences of general practice, from deep distress to high levels of satisfaction. Contrary to expectations,^{1 2} few accounts told of the pressures coming from increased workload and patient demand, although they varied in emphasis. Rather, in 13 out of 16 interviews, a strikingly similar story emerged of how experience of work was linked to partnership arrangements. This was a factor in accounts of distress and accounts of satisfaction.

How partnerships accommodated differences in working styles and speed of consultation were important, as were procedures for decision making within the partnership, seniority and sex of partners, and part time working. The three accounts that varied from this pattern included partnership arrangements as important, but the respondents described the role of partnerships in their lives differently from the majority. For example, one respondent said that the main problem of morale for him was a lack of career development, which, in turn, he saw as linked to his obligations to his partnership.

It was immediately clear from comparing the first interviews that people responded differently to similar issues within their partnerships, with very different outcomes. Partnership dynamics interacted with personal style. Partnership relations also affected the way respondents functioned at a personal level.

Phase 2 interviews—workload, partnership arrangements, and personal style

When we asked explicitly how partnership arrangements affected morale, respondents tended to react by emphasising workload as a significant factor. Five of the 10 respondents were clear that this was more important than partnership arrangements. Workload factors included increased directives and paperwork, patient demand, and transfer of caseloads from secondary to primary care without an increase in resources: "Pressure on us to reduce our ability to make clinical decisions. We are bombarded constantly with guidelines on everything. Restrictions on our prescribing choices. Doing tasks we see as useless, like, one we all wish we could be rid of is the over 75 annual health checks, which we see as totally useless and a waste of time ... What else? Constant change. Higher patient expectations. Pressure to audit absolutely everything, which I agree is a good idea, but it is actually quite difficult to do it with no extra resources in terms of money to spend on staff to help."

Partnership arrangements nevertheless appeared as important, albeit implicitly so, in all accounts. A typical example was one respondent who emphatically criticised the emphasis on partnership arrangements in the interview, but only after giving a 20 minute unsolicited account of how difficulties in a previous partnership had led him to change practice.

It was also clear that personal style interacted with workload factors and partnership relations to create a particular work experience, but again relations were not made explicit. One respondent described his biggest problem as the open ended commitment he had to his patients and then went on to say: "I don't know why I worry so much. If ever I got 20 patients needing a house call one day, the rest of the partners would say, look come on, we will take half of them for you, stop worrying about them. Fear of the unknown to some extent, what is going to come in and see you in the afternoon."

Workload was thus an important factor influencing morale. It related to partnership dynamics and personal styles in intricate ways, which were not always made explicit.

Phase 3—focus groups

Making connections

The focus groups brought out these interrelations more clearly. Before the meetings, we sent participants a fictitious scenario about a practice that was outwardly successful, but which on closer inspection was somewhat dysfunctional in that partners did not communicate with each other and several partners had personal difficulties that had not been dealt with. We asked participants to discuss the problems the practice was facing and to suggest causes and possible solutions at personal, practice, and wider health service levels. Several participants challenged what they saw as an implicit assumption that partnership arrangements were central in creating low morale and tabled workload issues as equally or more important.

We explored with group participants the reasons for the shifting emphasis, throughout the study, between partnership arrangements and workload as the main shaper of morale. Participants saw partnership relations as personal issues, which differed from person to person and had come to the fore in situations in which people had been asked to reflect on personal aspects of the job. Limited opportunities are available to discuss partnership problems publicly, and an interview in confidence with an outsider was seen as an opportunity to offload these issues. When asked, as in phase 1, to reflect in confidence and in an unstructured way about personal experience of general practice work, individual respondents emphasised partnership issues in often intensely personal accounts. When the interviewer suggested a structure—for example, the central importance of partnership arrangements—other aspects of experience (namely, workload) were brought into focus. Workload was also a collective and public issue, which affected everybody equally and tended to be emphasised in "public" accounts such as focus group discussions.

Links between partnership and workload—time and "space"

The focus groups produced links between workload and partnership arrangements and their effect on morale that were absent from individual accounts. Practices that had equitable and inclusive partner and practice relationships managed workload better than practices in which people did not work well together: "I think you are right, having practice meetings; the two common denominators in the two disastrous practices I was in, neither had any form of meeting at all, and I think the forum we have for the meeting on a Tuesday lunchtime, everybody does meet together and every so often we have all the staff in as well, which does allow people to air their gripes and glooms."

Building and maintaining strong and supportive partnerships and practices needed protected time and "space" for partners and practice staff to get together to agree how to run the practice, and some slack in daily work routines that allowed personal or group problems to be noticed and tackled proactively, rather than reactively. Creating this time was becoming more difficult because of the increased pressure of work and the increasing fragmentation of general practice: "Also, I am the only full-timer in the practice, one is associate adviser, one does work for the local healthcare cooperative, two are part-time partners so they are not

What is known about this topic

Morale in general practice is a current concern because of problems with recruiting and retaining sufficient general practitioners

Previous research into stress in general practice has explored and measured sources of stress at the population level

Research into stress and morale in the workforce increasingly focuses on the ways in which organisational contexts shape work experience

What this study adds

Morale in general practice depends on several factors; the dynamics of the relations between the factors is more important than any one factor in isolation

Partnership arrangements are a key factor in mediating between external workload pressures and individual general practitioners' experience of work

Practices need the time, skills, and resources to create supportive working environments to manage workload and change effectively

in all the time, there is one day when one partner is not in, this sort of thing. We don't see them as much as we used to."

Discussion

A qualitative study with a small sample presents challenges of bias and also particular opportunities to check this. We controlled for bias in three ways. Firstly, we examined participants' reasons for taking part in the study, particularly in the focus groups as they were self selected. Most had personal experience of distress at work, but many had successfully dealt with or were actively dealing with this, and their experience provided appropriate data. Secondly, the 26 individual interviewees were purposely sampled, from 403 practitioners interested in taking part, to ensure variety by age, sex, marital status, size and location of practice, and morale. Thirdly, the analysis included a careful examination of the relation between the interview context and the findings, and this provided one of its main insights. Respondents included only general practice principals; further research should include study of practice teams and non-principals.¹⁰

This paper has identified partnership dynamics, personal style, and workload related to changes in the NHS in Scotland as key factors in general practitioners' morale. The substantive findings from this qualitative study are similar to findings of quantitative studies on larger populations.^{3 4 10} However, findings from large scale cross sectional studies do not directly map on to those of qualitative studies with smaller samples, and the two types of study can complement each other in interesting ways. In this study, rigorous attention to the way three different research contexts subtly, but appreciably, shaped the research outcomes indicates

that the experience of morale in general practice is multifaceted, and people draw on different types of account to express this.

This has implications for further research. As different research methods are applied in changing political and private contexts, other key factors will be identified. The crucial findings from this study are the complex interrelations between factors identified, the way these relations vary between individuals and contexts, and the way they are understood and managed.

We thank all study participants for their time and contribution. This study is a development of the work of the late Pamela Baldwin of Working Minds Research.

Contributors: See bmj.com

Funding: The work was made possible by a bequest from the family of a local general practitioner.

Competing interests: None declared.

- 1 Kmiotowicz K. Quarter of GPs want to quit, BMA survey shows. *BMJ* 2001;323:887.
- 2 Scottish General Practitioners Committee. *The reality behind the rhetoric: a survey of the views of GPs in Scotland on morale, service provision and priorities for improving primary care*. Edinburgh: BMA, 2001.
- 3 Sutherland VJ, Cooper CL. Job stress, satisfaction, and mental health among general practitioners before and after introduction of new contract. *BMJ* 1992;304:1545-8.
- 4 Sibbald B, Enzer I, Cooper C, Rout U, Sutherland V. GP job satisfaction in 1987, 1990 and 1998: lessons for the future? *Fam Pract* 2000;17:364-71.
- 5 Heaney D, Gorman D, Porter M. Self recorded stress levels for general practitioners before and after forming an out-of-hours care centre. *Br J Gen Pract* 1998;48:1077-8.
- 6 Fletcher J, Pickard D, Rose J, Stewart-Brown S, Wilkinson E, Brogan C, et al. Do out-of hours co-operatives improve general practitioners' health? *Br J Gen Pract* 2000;50:815-6.
- 7 Firth-Cozens J. Individual and organisational predictors of depression. *Br J Gen Pract* 1998;48:1647-51.
- 8 Howie JGR, Porter AMD. Stress and general practitioners. In: Firth-Cozens J, Payne RL eds, *Stress in health professionals*, 2nd ed. Chichester: John Wiley, 1999.
- 9 Firth-Cozens J. Hours, sleep, teamwork, and stress. *BMJ* 1998;317:1335-6.
- 10 Calnan M, Wainwright D, Forsythe M, Wall B, Almond S. Mental health and stress in the workplace: the case of general practice in the UK. *Soc Sci Med* 2001;52:499-507.

(Accepted 13 March 2002)

Corrections and clarifications

Private finance and "value for money" in NHS hospitals: a policy in search of a rationale?

The authors of this article, Allyson Pollock and colleagues (18 May, pp 1205-9), would like to correct some of the statements that they made. In the first sentence of the results (and again in the discussion, under "The higher costs of PFT") the costs of raising the finance should be 29%, not 39%. In the second paragraph of the results the second sentence should start: "In all [not both] cases the annual cost of capital rises steeply ..."; and the third sentence should start: "In the case of North Durham the PFI costs are almost double ...". In the discussion, in the second paragraph of the section "The higher costs of PFT" the second sentence should read: "The cost of private capital as a percentage of trusts' annual revenue expenditure rises from an average of 8% to up to 32.7% [not 27%] in the case of Dartford."

This Week in the BMJ

Our editing process unfortunately led to an error into the labelling of the graph at the start of our summary paragraphs ("Cell salvage during surgery reduces need for blood") in the issue of 1 June. The x axis on the graph (number of units of allogenic blood transfused) should be labelled 0 to 4 [not 1-5]. The labelling of the related graph in the main paper, by Neil McGill and colleagues (pp 1299-303), is correct.