MANAGEMENT OF CONFLICT
IN
GENERAL PRACTICE

ANNE M LEE
ABSTRACT

The objective of this thesis is to explore developments in general practice in the UK, to draw conclusions and make recommendations from these explorations.

The review is, firstly, historical: the evolution of the medicine man of ancient times to today's fundholding GP. Secondly, it is qualitative, exploring in depth with individual GPs and in small groups how they experience their work, the pressures and the rewards. Thirdly, there is a theoretical review of conflict which illuminates the fact that well-managed conflict can be a positive pressure. The act of reconciling warring opposites can produce new life-enhancing solutions. Individual, intragroup and intergroup (or organisational) conflict are all explored. Fourthly, it is more quantitative, with an analysis of a questionnaire returned by over 350 GPs (60.5%) in Humberside and Surrey.

The survey showed that the most frequently and deeply experienced conflicts were over: time for family life: night and weekend working; patients' expectations and unnecessary paperwork. The lowest level of job satisfaction was recorded by those between forty and sixty years. GPs were also equally divided over whether or not they should have practice leaders.

Taken together, the findings suggest that the issues which need to be addressed are about organisation, education, practice and teamwork development, career structures and individual management.

The main recommendations are: firstly, that practices should review their organisation and leadership structure, so that they can make proactive rather than reactive choices; secondly, that to reconcile some of the tension between business management and medicine some GPs could retrain more for business management. The third recommendation is that selection and teambuilding skills be given much greater priority in order to alleviate individual and practice stress. At a more national level the research establishes that separate reporting structures for the different elements of the primary care team encourage divisiveness. However, unifying the primary care team would require employing acceptable, local, trained managers.
ACKNOWLEDGEMENTS

The labour of work in this case has been not a pain but a great pleasure. This would not have been so without the constant support and encouragement of so many. Drs. Cathy McMullen and Margaret Price both gave invaluable help at every turn. Drs. Ri Hornung, Richard Matthews, John Harding-Price, John Noakes and Anne Orr-Ewing also provided great support and valuable moments of insight.

Those who were the interviewees, who provided the groundwork for Chapter III, and thus for the rest of this document, must remain anonymous, but their time was willingly given. Their responses, analysis and honesty reflect well on a profession which has felt the strain of many changing demands. We are indeed fortunate to have GPs who are so concerned about improving patient care.

Thanks are also due to Professor David Purdie, the Humberside FHSA and to the East Surrey LMC who helped with the distribution of the survey.

Academic support and alternative perspectives have been offered and tested by many members of the Department of Education Studies at the University of Surrey, especially Professor David James, Dr Jackie Tivers, Dr Pam Denicolo, Josie Gregory and Anne Riggs. And to Dr June Huntington of the King's Fund - particular thanks.

For extraordinary patience, persistence and for her vital eye for detail gratitude is due to Sheila Elliott.

For my family's encouragement and tolerance - thank you.

With thanks to you all.

Anne Lee
May 1993

NOTE: In this thesis non-gender specific pronouns have been used wherever possible. Occasionally, in order to clarify the meaning, it has been necessary to use 'his' for his/her or 'he' for he/she.
# MANAGEMENT OF CONFLICT IN GENERAL PRACTICE

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ABBREVIATIONS

(Those in general usage such as GNP, GP, HMSO, IT and NHS have not been included in this list.)

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<td>British Journal of General Practice</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>BMJ</td>
<td>British Medical Journal</td>
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<td>BPMF</td>
<td>British Postgraduate Medical Federation</td>
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<tr>
<td>DHA</td>
<td>District Health Authority</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>FHSA</td>
<td>Family Health Service Authority</td>
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<td>FPC</td>
<td>Family Practitioner Committee</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<td>GMSC</td>
<td>General Medical Services Committee</td>
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<tr>
<td>MAAG</td>
<td>Medical Audit Advisory Group</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MPU</td>
<td>Medical Practitioners Union</td>
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<td>PACT</td>
<td>Prescription Analysis and Cost</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
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CHAPTER I

AN HISTORICAL REVIEW

The Medicine Man

It is understandably difficult to identify the beginning of general practice. Pietroni [1988] claimed that the origins lie in the 'shaman', the member of the tribe who acted as a mediator between mortal man and the supernatural. He argued that the separation of that role into priest and doctor did not occur until the seventeenth century. Certainly, in the Middle Ages medicine was still intertwined with spiritual beliefs. For example, certain days were considered unfavourable for blood-letting [Cule 1980 p 21].

Sigerist [Vol I 1951] disagreed with applying the title 'shaman' outside its particular use describing a psychopathic healer as found amongst the Siberians and the Bantu tribe in West Africa, but agreed that early tribes had a medicine man [p 161] who was probably a healer-herbalist using magic and religious rituals. The medicine man would treat families or whole tribes, rather than just the sick and ailing, so some epidemiologists as well as GPs could argue the roots of their profession came from this source.

Early medicine was pragmatic. Cule [1980] pointed out that it was economically necessary for nomadic tribes to kill those incapable of carrying out their duties [p 6]. Some thought it was considered unethical for the Greek doctor to treat a patient who was in the grip of a deadly disease, "......... for to do so the doctor pitted himself against Nature and ran the risk of that fateful 'hubris' that awaited those mortals who challenged the gods." Pietroni 1988 p 793.

Medicine and Spirituality

Until the nineteenth century, medicine had to rely very much upon the personality and beliefs of the physician or healer. There were herbal remedies (such as opium, coca and digitalis), massage, fumigation, cupping, poultices, simple surgical practices and incantations. But there were no ventilators, blood transfusions, CAT scans, X-rays, in vitro techniques or micro surgery. The two major interventions: pharmacology (especially boosted with the discovery of penicillin) and sophisticated surgical procedures, have altered the role of the doctor, and with it the role of the GP. Developments in genetic engineering may alter it further.
Spirituality, health and medicine were intertwined in primitive and archaic medicine. The sources of information for studying ancient medicine are paleopathology (the study of fossils and mummies); ancient medical texts; medical and surgical instruments; and literature [Sigerist Vol I 1951 p 16].

There were no sharp borderlines between magic, religion and medicine in primitive culture [Sigerist 1951 Vol I p 135]. In Egypt there is evidence that there were priest-magicians who were skilled in the art of surgery and of 'stopping the blood', and there were physicians attached to the royal court. It is not clear when a patient would call one in preference to the other. Diagnosis was largely by observation and palpitation. A Zande witch doctor would conceal pebbles in his mouth and then 'extract' them, with a great deal of sucking and rubbing, from the patient's painful area. The Zande witch doctor was unabashed by exposure, and claimed that the pebbles were a necessary placebo because the patient couldn't understand the "real" nature of his work [Freidson 1970 p 10]. India had an early system of rational medicine and medical schools. Buddhism (originally more of a philosophy than a religion) has clearly laid down abstinences to prolong a healthy life [Sigerist Vol I 1951 p 185].

Typically, ancient medicine is considered to begin with the Greeks. This is not necessarily so, although sources of evidence before then are scarcer. The papyrus Edwin Smith published in 1922 was an ancient Egyptian surgical tract on diagnosis and treatment. It is a scientific treatise not found previously in the ancient world [Sigerist Vol I 1951 p 297].

In the Greek religious texts there are scanty medical observations of accumulated knowledge. In the temples there are tablets recording the history of various chronic conditions such as ulcers and symptoms of hysteria. It is in the Corpus Hippocraticum written in the fourth or fifth century BC that we have what are commonly claimed to be the first scientific medical tracts [Sigerist Vol II 1951 p 84]. Here is the first obvious divide between spirituality and medicine. Symptoms of disease were observed and evaluated appropriately and illnesses were traced through their course. There was highly refined dietic therapy reinforced by pharmacology and very respectable surgery. There were also studies on the nature of Man in health and disease. The Greek doctor would tend to travel from town to town with his assistant and take 'rooms'. There were detailed instructions on how the room should be prepared for consultation including, for instance, instructions on cleanliness, the amount of light and even that the doctor's and patient's chairs should be a similar height.
It has been argued that the Hippocratic doctor refrained from treating the incurably sick or terminally ill, for that would constitute interfering with the gods [Pietroni 1988 p 793]. The contrary claim to this is that half the number of patients reported on in Hippocrates’ ‘Epidemics (14)’ cases died. The author not only "took his chances" but did not hesitate to report on the results [Galdston 1969 p 22].

John Dodds described diagnosis as an "art". He said that a good diagnostician, like an artist:

"......... selects from the broad stream of human experience what seem to him its significant aspects or moments, recombines them and fuses them in the crucible of his imagination into a new synthesis which represents his vision of reality."

Dodds 1969 p 33

He argued that the doctor had to be a humanist in a technological society.

Galdston pointed out that the modern socioeconomic-technological culture brought with it a new order of morbidities - the crowd diseases. He said that in the Western world the crowd diseases, with the aid of developments in public health, vaccines, sera and antibodies, have been largely brought under control. This left us, he said, with the disorders of a "faulty existence" - those disorders that do not kill, but which are chronic, degenerative and make life a trial. The new challenge is: "How are these to be dealt with?" [Galdston 1969 p 25]. It is unclear whether or not Galdston was calling for a return to spirituality in medicine, but there are others who definitely were.

Freidson [1970], Poynter [1969] and Sigerist [1951] all argued that medicine was directly affected by the culture in which it was practised. Religious, Rational and Technological Ages have all called forth different types of treatments. Aldridge [1991] argued that we were moving into an age where the demands for religious renewal had encouraged GPs to entertain the idea of spiritual healing in their practices. He cited Byrd’s study [1988] which showed that in a coronary care unit patients in the prayer group had a better outcome overall, requiring fewer antibiotics and diuretics, and a lower rate of intubation/ventilation, than the control group.

**Medicine: Love and Money**

Jesus personified the great healer and it is argued that, under the influence of the writings of the Apostles and St Paul, the practice of empiric or Hippocratean medicine began to lose its influence. Christian ethics implied an egalitarian relationship between doctor and patient and a moral obligation to care for the dying, the sick and the terminally ill [Pietroni 1988 p 793]. Christianity was the official religion of the Roman Empire. Medicine improved during the time of
Imperial Rome with the building of hospitals and the earliest known medical work in Latin 'De medicina' by Calcus [Cule 1980 p 12].

Paracelsus said in the sixteenth century "Der hochste grund der arnzeis is dei hebe" (Love is the foundation of medicine) [Sigerist Vol II 1951 p 309]. However the image of the doctor has never been totally unblemished. Previously, amongst the Greeks it had been understood that health education was not for the slaves or artisans. Slaves were treated by the doctor's assistant; the poor visited the doctor's surgery and had to return to work as soon as possible [Pietroni 1988 p 792]; and the rich were presumably visited at home. The rich and noble wanted to exercise their fame and wealth for as long as possible. The early physicians were attached to the royal courts. For example, after the Norman Conquest it is said that William Rufus rewarded John of Villula, a churchman and well-tried physician, with the bishopric of Wells [Cule 1980 p 25].

These physicians however are not strictly the antecedents of today's GP. In the Middle Ages the majority of the population were cared for by a group of practitioners who were in the tradition of the Anglo-Saxon leechers.

The Renaissance is seen as heralding a new, rational and scientific attitude to medicine. "The doctor's task is not to obey or love nature, but to penetrate and control it" [Pietroni 1988 p 794]. This attitude of extending the arms of chemistry and technology to the patient has led to evident successes, and has been taken further by the instruction to medical students:

"........ not to get involved or be affected by your patient or by genetic engineering".

op cit p 794

It was through the craft guilds, as they were in the fourteenth century, that the apothecaries developed. It has been argued that the apothecaries were the first GPs [Cule 1980 p 34]. Those who were eligible to go on Henry V's medical register (established in 1421 but not enforced), and those who obtained the first medical degrees conferred by Oxford and Cambridge in the mid-fifteenth century, were the antecedents of modern physicians or specialists.

The apothecaries gradually separated themselves from the grocers. Initially they dispensed for the physicians and then became in great demand, particularly by the merchant classes, for direct diagnoses and treatment.

Regulation

The Royal Charter was granted to the apothecaries in 1671 but there was still conflict between the Royal Colleges of Surgeons and Physicians, the Barber-surgeons and the Apothecaries.
In 1814 Roberts Masler Kerrison stated that the surgeon apothecaries had become the GPs throughout England and Wales. The health of nineteen out of twenty patients was regulated by them [Cule 1980 p 74].

As the apothecaries became less concerned with the preparation and sale of drugs, the chemists and druggists filled the gap.

The first recent attempt at regulation came in 1815 with the establishment of a register under the Apothecaries Act. In 1834 an apothecary was defined as:

".......... one who professes to judge internal diseases by symptoms and applies himself to cure disease by medicine."

Cule 1980 p 82

In 1858 the Medical Act moved towards creating one single portal of entry to the professions. This was the beginning of a rocky road because, whilst general practice was then regarded as a good apprenticeship for specialisation, from 1858 to the current time there has been a difference of opinion about the GP's role in hospital care [Honigsbaum 1979 p 299].

During the Industrial Revolution the care of the poor was poor. Those who were between rich and poor were cared for by GPs for a fee. Patients could choose their doctors and doctors could charge what they wished. However, in poor areas, many doctors had difficulty in extracting even small sums from patients for the care they had received. Employees could be cared for by their friendly societies, but their families and the unemployed still only had the option of the workhouse provided for, under the principle of less eligibility, in the 1834 Poor Law Amendment Act. Under the Poor Law, the destitute sick could be seen at home by the Medical Officers of the Board of Guardians but, owing to the prevailing principles of economy and deterrence, the service was often inadequate and too late [Leathard 1990 p 3].

In 1911 the National Insurance Act was designed to take over from the friendly societies. There was a capitation system of payment for the 'panel doctors'. The middle classes and seriously ill still sought private consultations [Cule 1980 p 115]. Lloyd George had to push the Act through in the face of opposition from the medical profession,

".......... who were ever fearful of state control of their work and of the financial consequences to themselves".

Leathard 1990 p 4

Because of their potential power, particularly strong when people are ill or frightened, there have always been those suspicious of physicians. The plays by Molière highlight a time when that suspicion was particularly prevalent. For example, 'Le Médecin Malgré Lui', 'Monsieur de
Pourceaugnac' and 'La Malade Imaginaire' all highlight reactionary attitudes, selfishness, vanity, pride, ignorance and pomposity.

The image of physicians did gradually improve. King quotes Voltaire as agreeing with Molière that ninety-eight out of a hundred physicians were charlatans but then he asked whether:

"........... anything is more estimable than a physician who, having studied nature in his youth, knows what makes the human body work, the evils that torment it and the remedies that can offer relief."

King 1978 p 5

King thought that, for Voltaire, this was high praise indeed.

**More Regulation and More Conflict**

The 1911 Act gave free GP care to all employed members of the working class. Their wives and children, however, were excluded. By the end of the First World War, fragmented providers and the demand for extended coverage led to the creation of the Ministry of Health (MOH) in 1919. The need for reform had become very evident. For every nine soldiers killed in the trenches, twelve babies died at home. The new MOH included all the functions of the Local Government Boards (who had administered the Poor Law) and the National Health Insurance Commission [Honigsbaum 1979 p 23].

The British Medical Association (BMA) was divided in the first few years of the twentieth century between the 'unionists' (the trade union minded club doctors) and the 'scientists' (or consultants) [op cit p 15], thus they had no coherent plan for health provision. However doctors were clearly against the provision of a salaried service. When the BMA became close to the Royal Commission on National Health Insurance during the Second World War, its members became very suspicious of its ability to represent them. Division between and within the state and the providers continued. In 1918 Sir Bertrand (later, Lord) Dawson thundered: "The practice of putting the skilled under the control of the unskilled must cease." He argued that all places where doctors worked should be under the control of doctors. Dawson also intended GPs to pay for the use of health centres and thus avoid the threat of a salaried service. The Dawson Report of 1918 introduced the idea of primary health centres - a notion which was not implemented for another fifty years. He argued that a salaried service would lead to boring conditions of work and intellectual stagnation [op cit p 64].

During the 1930s the panel system deteriorated. Some GPs had two waiting rooms, one for panel and one for private patients [Leathard 1990 p 23]. GPs had little access to hospitals to enable them to keep abreast of advances in medicine. The result was "a narrowing of GP care
and lowering of medical aspirations” [op cit p 135]. During the negotiations between 1940 and 1945, GPs showed little interest in hospital access; and the Trades Union Congress became concerned to make health a state (not an insurance company) provision and joined forces with the BMA to try and achieve this [op cit p 215].

The National Health Service {NHS} came into being in 1948. The debate over its introduction had been long and stormy. Aneurin Bevan pilloried the BMA leaders:

"......... a small body of spokesmen who have consistently misled the great profession to which they are supposed to belong".

Foot 1973 p 178

The BMA were divided and the press moved for Bevan.

There was a

"......... deeply entrenched belief that almost any system of state control over medicine would destroy the doctors’ freedom".

op cit

They wanted to preserve the sacred relationship between doctor and patient; the intervention of the state, they imagined, would compel service to a new master [Foot 1973 p 103]. He continued to argue that the doctors were not particularly political, but were conservative when it came to change and they magnified any proposals for reform into a “totalitarian nightmare” [op cit].

In 1962 the Medical Defences Review Committee published a report which said:

"When the NHS came into being, fears were expressed about possible effects upon the GP’s clinical independence. At that time much emphasis was laid by the profession on the need to preserve the doctor’s freedom. So far as we can judge, these fears expressed in 1948 have so far proved to be largely unfounded."

Foot 1973 p 217

Honigsbaum argued that the establishment of the NHS concentrated mainly on hospital provision. He quoted Dr A Talbot Rogers speaking in 1971:

"All that seemed to the Ministry essential was to ensure that everyone should have a GP able to provide a service matching that of the club doctor .......... enhanced because of a hospital-based diagnostic service ...... I sometimes wonder whether the progress of General Practice was not set back a whole generation".

Honigsbaum 1979 p 292

Capitation payments for GPs continued. The already cumbersome disciplinary procedure was increased: before a doctor could be dismissed the decision had also to be agreed by the newly formed independent tribunal.

Figure 1 shows the structure of the NHS from its inception until the National Health Reorganisation Act of 1973 became law.
The NHS came into being to improve distribution of services to patients, and to improve the services themselves. However the remuneration of GPs resulted in their widespread dissatisfaction. In the mid-sixties a Review Body recommended major changes which reflected on the individual doctor's services for his patients and "in turn doctors' surgeries and services improved" [Leathard 1990 p 41]. In 1974 the Department of Health and Social Security became responsible for the NHS. The growth of health centres and the attachment of Local Health Authority staff (health visitors, district nurses, midwives and sometimes social workers) to GPs' surgeries were a way forward.
The separation of community and hospital medicine continued. The GP was seen as the "professional of first contact". Bowling ([1981] argued that this was an inadequate role definition and that until there was a less superficial definition it was unlikely that GPs would wish to delegate this part of it. She said that this inadequate role definition belittled the potential role for social workers, health visitors and practice nurses. She also asked whether "...... we can afford a health service based on the private whims of certain doctors" [op cit p 128]. Ten years later GPs were to be confronted with the possibility of a new role as business people.

From the start of the NHS the GP service was popular with patients. Over 95% of the population registered in 1948 (97% according to Leathard [1990 p 31]). The widening split between hospital and general practice has been attributed to the fact that GPs were effectively barred from specialist practice:

"The split in the profession was exacerbated by a disparity in pay in favour of consultants and specialists."

Keele 1981 p 15

In 1952 the Royal College of General Practitioners (RCGP) was established (the Royal College of Physicians had been founded much earlier, in 1518, and the Royal College of Surgeons in 1800 [Leathard 1990 p 10]). Despite opposition from the other colleges, the RCGP quickly established itself. It had 6,200 members by 1962 and was granted a Royal Charter in 1967. In February 1992 membership stood at 15,852 [RCGP 1992].

GPs also began working more in partnerships. In 1948 over 58% of GPs were either single-handed or in two-man practices [Keele 1981 p 17]. By 1974 only one GP in six was single-handed [Leathard 1990 p 42].

In the late 1960s the government sanctioned a programme of health centre building - fifty years after it was first suggested by Lord Dawson.

The 1974 re-organisation attempted to unify the services by bringing them under one authority at Area Health Authority level. Leathard claimed that, far from setting off into a period of consolidation, "the NHS eventually moved ......... towards crisis and chaos [1990 p 57]. During this period the Mental Health Amendment Act [1982] pioneered care in the community.

In 1983 an independent inquiry, led by Sir Roy Griffiths, was established to look into NHS management practices, but the conflict between policy and clinical decision makers continued - particularly on the secondary care issues [Leathard 1990 p 82]. A new vocabulary 'management effectiveness, performance indicators and quality assurance' began to be applied to hospitals. The GPs were untouched directly by the Griffiths' management re-organisation. However the increasing
claims on primary care were unlikely to be assuaged by the 5% funding increase they were then granted.

The 'management' attitudes began to spill over into primary care. In 1988 the Health and Medicines Act led to GPs being given a 'limited list' of drugs which they could prescribe. Prescription Analysis and Cost (PACT) gave participating doctors (and the Family Health Service Authorities (FHSAs) a regular computer print-out identifying the rate and costs of the drugs they were issuing. In another movement towards containing costs, the General Practice Finance Corporation, which provided for doctors' surgeries, was privatised [Leathard 1990 p 106].

The White Paper 'Working for Patients' [HMSO 1989] represented the most far-reaching reform of the National Health Service in its forty year history. According to the Prime Minister's foreword, the NHS would continue to be available for all regardless of income.

Before the White Paper became law, GPs also had imposed upon them a new contract.

"Whereas the 1965 Family Doctor Charter was prepared by general practitioners, supported by the profession and negotiated with the government, the 1990 changes are being imposed on an unwilling profession. While the 1965 charter resulted in improved morale and increased recruitment to general practice, and provided a secure foundation for nearly 25 years of sustained development in primary care, there are already signs that the 1990 contract is producing disillusionment and a reduction in applications for places on GP vocational training schemes".

Chisolm 1990 p ix

The contract introduced target payments for immunisation and cervical cytology, the postgraduate education allowance, fees for night calls and several other terms and conditions of employment were altered. The immediate effect of this contract was that the paperwork for income and expense claims increased enormously - especially amongst those who wanted to meet their targets.

The aims of the White Paper for GPs included:

1. GPs, with larger practices of 11,000 patients, would be able to apply for control of their own budgets, received direct from the relevant Regional Health Authority, in order to buy hospital care for patients, compete with other practices for patients, run their own businesses and plough back savings into their own practice.

2. Patients would be able to change doctors more easily.

3. GP capitation fees, which accounted for 46% of a GP's income, were to be raised to 60%, as an incentive to satisfy patient choice by increasing the income attributable to the number of patients on GP's lists.

4. GP indicative drug budgets, from 1991, would put downward
5. Family Practitioner Committees would be reduced from thirty members to eleven, half lay and half professional, to include a doctor, dentist, nurse and pharmacist. New chief executives would be appointed.

**The GP as a Business Person**

The number of fundholding GP partnerships is slowly increasing, and this revolution is likely to continue. Fundholding GPs have to produce business plans, although in 1991 only two out of five practices produced a budget [Feger 1991]. The plans might set objectives on:

- improving patient care
- premises and resources
- maximising practice income
- time management

Annual reports now have to be compiled, and the figure below shows a recommendation for what should be included in them.

<table>
<thead>
<tr>
<th>What your annual report needs to include</th>
</tr>
</thead>
<tbody>
<tr>
<td>See sections 43A and 51E of the terms of service regulations. By June 30, 1991, you must submit the following information to your FHSA.</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
</tr>
<tr>
<td>• Total staff employed, unnamed.</td>
</tr>
<tr>
<td>• Each staff member's principal duties and hours worked.</td>
</tr>
<tr>
<td>• Their qualifications.</td>
</tr>
<tr>
<td>• Training undertaken by each during preceding five years.</td>
</tr>
<tr>
<td><strong>Premises</strong></td>
</tr>
<tr>
<td>• Any variations in floor space, design or quality since last annual report.</td>
</tr>
<tr>
<td>• Any changes expected for next 12 months.</td>
</tr>
<tr>
<td>• Declaration that premises comply with minimum standards or that steps are being taken to comply.</td>
</tr>
<tr>
<td><strong>Referral information</strong></td>
</tr>
<tr>
<td>• Total referrals of inpatients and outpatients.</td>
</tr>
<tr>
<td>• Referrals by clinical specialty specifying hospital</td>
</tr>
<tr>
<td>- general surgical, general medical</td>
</tr>
<tr>
<td>- orthopaedic, rheumatology</td>
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<tr>
<td>- ENT, gynaecology</td>
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<tr>
<td>- obstetrics, paediatrics</td>
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<tr>
<td>- ophthalmology, psychiatry</td>
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<tr>
<td>- geriatrics, dermatology</td>
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<tr>
<td>- neurology, genito-urinary</td>
</tr>
<tr>
<td>- X-ray, pathology</td>
</tr>
<tr>
<td>- others (including plastic surgery, A&amp;E, endocrinology).</td>
</tr>
<tr>
<td>• Number of direct referrals for hospital treatment.</td>
</tr>
<tr>
<td>• Number of self referrals where these are known.</td>
</tr>
<tr>
<td><strong>GP's other commitments as medical practitioners</strong></td>
</tr>
<tr>
<td>• Any external posts held by GPs in the practice.</td>
</tr>
<tr>
<td>• Description of all work undertaken by the GPs.</td>
</tr>
<tr>
<td>• This must include annual hourly commitment</td>
</tr>
<tr>
<td><strong>Arrangements, if any, whereby GP or staff receive patients' comments on medical services.</strong></td>
</tr>
<tr>
<td><strong>Information about the practice's prescribing</strong></td>
</tr>
<tr>
<td>• Whether the practice has set up its own formulary.</td>
</tr>
<tr>
<td>• Whether each individual doctor uses a separate formulary.</td>
</tr>
<tr>
<td>• The arrangements made for repeat prescribing.</td>
</tr>
</tbody>
</table>

GPs have begun discussions to work out how they can have "competitive advantage" [Hancock 1991] and some practices are adopting an organisation structure which follows a commercial company pattern as far as possible. An example of this is shown in Figure 3.
There were GPs who argued that the emphasis on profits and this 'business ethic' had caused so much concern amongst GPs that there would be a shortage of GPs willing to do the job [Chadda 30.5.1992 p 8].

There were also GPs who argued that being in charge of a budget (and by implication being a fundholder) would empower them to have more control over their patients' treatment [Ross 1991 p 17].

However if GPs are to make this process work efficiently then their graduate and postgraduate training needs will need to change.

**Management Training**

There is little management training available for or applicable to GPs. Doctors who attend external courses have problems over the transfer of learning, and frequently find it difficult to apply apparently cold commercial principles to their practices and patients. Smith [1992] found that if consultants attend external senior programmes designed for experienced senior managers they will not get the basic management and operational skills that they need. Forty consultants (not GPs, but the findings are still worth reviewing), attended programmes from March 1990 to September 1991. Some of the limitations found in the participants included:

"......... a lack of basic management and operational skills, including setting up financial controls, being more interpersonally skilled, handling change at 'the coalface' and practical techniques for application in the NHS."

Smith 1992 p 12
Numbers of Trainee GPs

Whilst the official statistics showed an increase in the number of trainee GPs (2,040 in October 1990 and 2,102 in October 1991) [Chadda 1992], the General Medical Services Committee {GMSC} argued that, overall, there had been a fall in the numbers of principals and trainees since 1989. They also argued that there were going to be far more people retiring in their fifties than there would be new recruits.

A Salaried Service?

As has already been mentioned [p 6], in 1918 Lord Dawson argued that the provision of a salaried service would lead to "boring conditions of work and intellectual stagnation". His worry was also that the skilled would be managed by the unskilled.

The Medical Practitioners Union {MPU} called for "shorter hours, smaller lists and a salaried service" [Pulse 7.12.1992] in their response to the GMSC's 'Building Your Own Future' discussion paper. The MPU suggested a full-time GP should be paid for a thirty-six to forty hour week, with separate contracts for out-of-hours work. With the current (1993) government policy on GPs being responsible for twenty-four hour cover, this is unlikely to happen, but it is interesting to hear larger numbers of doctors stating interest in this approach. The concept of a salaried service appeals particularly: to younger GPs, who are frequently financially disadvantaged when they join a practice; to women; to inner city GPs; to older GPs in rural practices; and to ethnic minorities [Giles 1991 p 35].

Traditionally, GPs have jealously guarded their self-employed, independent status. Now, some of them argue that the new contract blurs the line around their independence, and they would prefer guaranteed hours, guaranteed holidays and sickness pay.

The Future of General Practice - Some Views

In 1972 the future of general practice was seen very much in terms of developing and improving the consultation. Then it was considered avant-garde and controversial to suggest:

".......... that the newer disciplines of the behavioural sciences, no less than the disciplines of the physical and biological sciences, can contribute to the formulation of hypotheses about the patient and his illness which are essential to a realistic practice of medicine".

RCGP 1972 p 46

In educating new GPs, 'The Future General Practitioner' [RCGP 1972] emphasised the need to broaden their "imaginative conjecture" [op cit p 22] in order to be able to produce a complete hypothesis.
"A complete hypothesis is a diagnosis completely realised in physical, psychological and social terms."

op cit p 37

There was also reference to the fact that the GP had to work in a team (and an acknowledgement that the relationship with social workers still had to be clarified). A recent RCGP paper examines how practice nurses, community nurses, practice managers, health visitors, physiotherapists and occupational therapists all form part the primary health care team. In the longer term it also recommends incorporating other health professionals such as general dental practitioners, ambulance service, pharmacists, ophthalmic services, community psychiatric nurses, community based consultants and complementary practitioners [Periera Gray 1992 p 34]. The definition of a GP twenty years ago bears re-examination:

JOB DEFINITION

"The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health."

RCGP 1972 p 1

There was also reference to the need for loyalty in the profession when discovering that a colleague had made a wrong diagnosis:

"If when seeing a patient for a colleague it is realised that an error in diagnosis or treatment has been made, the first duty is to the patient. At the same time his relationship with his own doctor must not be jeopardized ......... if the doctor is accustomed to revising his own plans and explaining this to his patients, it will be easier for him to deal loyally with the problems of a colleague."

op cit p 19

In the objectives listed for the GP (see Appendix A) the only references to finance referred to claiming allowable expenses, loans from the Finance Corporation and Improvement Grants. Contrast this lack of focus on financial issues with how fundholding and the new contract have forced doctors to think; in 1972 there was much less discussion about:

- business plans
- budgets, savings and investment in services
- practice organisation structures
- implementing government screening programmes
- prescribing analyses and cost {PACT}
- information technology/computing.
By 1989 the emphasis had changed and an awareness of costs had grown.

"Among many other responsibilities GPs have the task of acting as the 'gatekeeper' ensuring that the precious resources both in hospitals and the community are used wisely .......... 90% of all problems presenting in the Health Service are now dealt with by GPs. They have taken back the management of many chronic diseases such as hypertension, epilepsy and diabetes. In-patients are discharged more quickly from hospitals .......... a wide range of preventative and managerial skills are required of GPs nowadays".

Berrington et al 1989 p 7

This train of thought was put even more categorically in an editorial in the British Journal of General Practice {BJGP}:

"The balance of services offered in secondary care, should be determined by the primary care team".

Waine 1991 p 442

Richards also saw a tension between:

"......... the traditional role of the doctor and the new pro-active corporate image requiring a different model where the doctor is also manager, leader, influencer of service provision and competitor for budget allocation".

Richards 1991 p 828

Others saw a challenge to the term 'general'.

"The real transformation of general practice has been the move towards all general practitioners developing expertise in specialties."

Jewell 1991 p 512

He continued to argue that this was a positive move which had improved morale enormously because it had provided one means of developing a career without having to leave general practice. He also said that increased expertise in research and epidemiology would create a team of GPs who were well-placed to analyse health trends and make the necessary adjustments to care.

If GPs were to move towards working with an expanded Primary Health Care Team [Noakes 1992 p 355], then it could be argued that "......... working together also implies learning together" [Lawrence 1992]. The teamwork required to bring GPs, district nurses, midwives, community psychiatric nurses and social workers together would be considerable. The potential for co-ordinated care was immense but, as Lawrence warned, there was a "......... major potential for disharmony unless working procedures are defined" [op cit p 401]. GPs might have argued against a move towards greater co-ordination if they had felt that their role in primary health care was being eroded.

The Community Care Act is due to be implemented in April 1993. At the moment it seems likely that social workers would decide how community care will be delivered locally. There were various views on GPs' involvement in Community Care. Some felt that the extra workload involved
in making community care assessments would be too much for GPs [Giles 1992]. Others felt that GPs were well-placed (in terms of knowledge) to be able to do this sort of work [McSweeney 1992]. There was a great concern about what effect on the overall workload of the GP the implementation of the Act would bring, and how differences between social workers and GPs might be minimised and resolved [Chudley 1992].

The Tomlinson Report [1992] said that in London there should be more spending on primary care and a rationalisation of secondary care, education and research. It also argued for extending the powers of the FHSAs so that they were able to commission the full range of primary health care services. Sir Bernard Tomlinson argued that these changes were necessary because of changes in treatment and demography, and because the London hospitals were in financial crisis and the level of primary care in London was already low. Whether London's primary care needed £250 million (as the King's Fund recommended), or £140 million (as Tomlinson recommended), there seemed agreement that there were great needs for improvement in care in the City. The West Lambeth Community Care Centre was cited in a British Medical Journal {BMJ} as a good example of primary care, and the Tomlinson Report recommended four more [BMJ editorial 31.10.1992].

Recent changes have not been universally welcomed by GPs [GMSC 1989]. Huntington [1990] pointed out that any organisation had three functions:

- **Policy** - **Why** the organisation is there
- **Strategy** - **What** it intends to do to enact or express that purpose
- **Operations** - **How** it will implement the 'what'.

She said that as practice sizes grew, so the need for making policy and strategy decisions would grow. This has implications for handling change, and GPs

"........ somewhat later than other people, are learning that the only environmental certainty is uncertainty, that what works now will not necessarily work in five years' time, and that the capacity to track and manage change will be central to survival, certainly to success". Huntington 1990 p 4

**Medical Audit**

From the mid-eighties there had been a growing recognition that a professional group of doctors should be seen to be providing a consistent and high level of service. It was recognised by the RCGP that:

"There is a degree of inconsistency in the services provided by general practice ........ There is comprehensive care of high quality .......... and there is care of such poor quality that patients often seek primary care through hospital accident and emergency departments." RCGP 1985 p 1
This report said that Britain had lagged behind the USA in quality because the professional groups did not regulate themselves and in the USA salaried doctors were regulated by Medicare and Medicaid.

At this time the College called for a major system of continuing professional education for GPs, as well as the vocational training and examinations already in place. The College's main approaches for improving standards were to recognise good practice through the award of the status of a Fellow to improve the role of a General Practice Department in Universities and to encourage more doctors to become GP trainers. The College did not recommend recertification for practising GPs.

Audit: Evaluation or Improvement; Appraisal or Education?

Whilst most of the words surrounding 'audit' inferred that its primary purpose was for improvement or education, there was a latent suspicion amongst two of the research discussion groups that it might be used for evaluation. The whole process of the evaluation of GPs had been kept cloudy.

GPs were reported as voting almost unanimously to support re-assessment of skills and competence at the special conference to discuss the GMSC questionnaire 'Your Choices for the Future' and they urged their leaders to find a popular method to do so. But GPs stressed that the re-accreditation process should put the emphasis on learning [Editorial Doctor 2.7.1992]. The implication of this statement is that GPs would resist assessment.

Monitoring GPs' Performance

There are various bodies involved in assessing GPs' performance, each with a slightly different purpose, lengthy procedures and different sanctions. The FHSAs have a statutory obligation to investigate complaints [NHS 1974 and 1990]. Here the complainant might give reasons why the GP might have been in breach of their contract, and if the complaint were brought within a specified time the FHSA was bound to investigate. The GP would give a written reply which would be shown to the complainant; if this did not resolve the matter a formal hearing might apply a number of sanctions. If the complaint were to be upheld, the most common sanction was the possibility of withholding money from the GP's remuneration [Owen 1991]. Through this mechanism nearly 50% of the complaints brought between 1982 and 1989 were either about failure to visit (24.8%) or failure to diagnose (20.45%). These were in similar proportions to an earlier survey carried out in 1970-71 [op cit p 114]. FHSAs could exercise considerable power by
monitoring employment contracts and in the approval of clinics and protocols for chronic disease management [Chadda 1992].

Medical Advisors are appointed by FHSAs particularly to advise on prescribing policies. The conflict between evaluation and education is felt acutely in this context. Medical Advisors are supposed to be mediators and conciliators between FHSAs and GPs. They are to act as catalysts for change and should make prescribing more effective. In effect, they are not perceived as being independent:

"GPs are suspicious and feel threatened by medical advisors. We are supposed to be independent but our business is being interfered with more and more."

Dr Clayden in Waters 1991 p 36

The General Medical Council (GMC) has historically dealt with matters of gross incompetence or sexual impropriety. The sanctions have been suspension or removal from the register. In future, the proposal is that doctors who display a "pattern of poor performance" would be subject to a screening procedure by a panel of two doctors and an assessor who could recommend retraining and, possibly, suspension or a restriction of their ability to practise while the process is going on [Mackinnon 1992].

The RCGP's formal assessment procedure ends with the vocational training and the RCGP examination. The model produced by the Royal Australian College of General Practitioners, which has served as the basis of many developments in general practice education, is shown below.

![Clinical competencies](image-url)
It is argued that this model cannot be used for re-accreditation:

"Unfortunately experienced principals sometimes do less well than expected in the Membership of the Royal College of General Practitioners examination because they are used to working in the integrated mode and may find it difficult to separate out the different aspects of competence."

Mulholland and Tombleson 1990 p 252

The RCGP and the GMSC have said that they will form a working group to look at the whole issue of re-accreditation [Cresswell 1992 p 30].

Reservations about medical audit or evaluating performance are eloquently expressed by Dr David Haslam.

"We count the things we can count, and list the things we can list. Unfortunately the things we cannot count are probably a great deal more important. PACT figures tell us a great deal about our prescribing costs, but where is the statistic that reports on the quality of our reassurance? Consultation counting tells us how many cases we get through, but where is the figure that reflects the patients who feel supported by our availability in time of need?

"The one aspect of the health service charges that has been supported almost universally is medical audit. Like motherhood, sunshine or apple pie, it is difficult to be against it. After all, it is so very obviously a 'good thing', even if no one has worked out how it should be done. Nevertheless, we must never forget that audit, like the annual report, only reflects the countable and not necessarily the valuable."

Haslam 1991 p 45

In the UK the emphasis has been on a peer review approach to standard setting [O'Dowd and Wilson 1991 p 451]. Even though 'Working for Patients' [HMSO 1989] instituted Medical Audit Advisory Groups {MAAGs} and compulsory audit, it was still unclear quite how 'compulsory' this audit was. Audit was one of the few concepts in 'Working for Patients' which was largely welcomed by the medical profession. Successful audit was likely to increase pressure on costs as previously inadequately treated patients were subjected to the proper treatment, investigation and referral [op cit].

There was strong agreement that standards should continue to be set by groups of practitioners to encourage ownership, understanding and implementation [Baker 1991, O'Dowd and Wilson 1991].

That standards, protocols or competencies could be set, there was no doubt [Marinker 1990, Keele 1981]. Whether they would be welcomed or followed was the next issue. McIntyre and Popper called for a new ethics of medical practice in which error would be valued, cherished even, as a major source of learning [Marinker 1990 p 2]. With the increasing threat of litigation,
open acknowledgement of medical error was a risky path for many doctors to follow. Standards will also change as science continues to advance our understanding of treatments.

**Trends in General Practice**

Bosanquet and Leese [1989] illustrated some interesting trends in the development of general practice. Abstracts from their tables are shown below in Table 1. The trends were toward younger GPs, larger practices and reducing list sizes. They also commented on the increasing proportion of women GPs and the increase in number of GPs born overseas (from 13%-23% between 1968 and 1983). They commented on the ambivalent position of a GP employed as an independent contractor working for a monopoly.

Bosanquet and Leese identified as "innovators" practices which incorporated at least two out of the following three factors: employing a practice nurse, participating in the cost rent scheme, and/or being a training practice. They found that 55% of practices with female partners were more likely to be innovators (compare this figure with that of 37% with male only partners). The 47% of practices identified as "traditionalist" had at least one Asian partner, which suggested Asian doctors were spread more thickly in intermediate and traditionalist practices.

Partnership age, size and the presence of women partners were found to be related to area, and there was a strong correlation between area and type of practice.

Income was shown to be related both to type of practice (in all areas partners in "innovator" practices received more net income than those in intermediate or traditionalist practices), and to the number of partners. The optimum scale of operations appeared to be five or six partners.

This optimum level was also advocated by Pereira Gray [1992] who argued that any larger grouping would make the service lose one of its most important features:

"......., general medical practice is essentially a personal service in which the best results are obtained when patients and doctors get to know and understand each other. This becomes more difficult, although not impossible, in larger organisations."

*op cit p 12*
Overall, 45% of doctors in Bosanquet and Leese's study [1989] felt that they could cope within their normal working hours. This figure concealed a variation of 50% in innovator practices, as 44% in intermediates and 41% in traditionalist practices [p 104]. This survey was done before the imposition of the contract and fundholding, and it suggested that even then over 50% of doctors were not coping with the workload within their normal working hours. Around 13% of doctors considered themselves under great pressure and continually short of time. Pressure was found to be highest in the Thames Valley area.


**Trends from the Historical Review**

This historical review does not let us predict the future, but there are trends and tensions which, given no significant change, are likely to continue.

1. **Medicine and spirituality.** The establishment of The Institute of Religion and Medicine indicates a contemporary revival in this subject by some GPs. Given the historical overlap between the role of the priest and the doctor, perhaps this is not surprising.

2. **Medicine and money.** In an effort to contain costs (which the UK has done more effectively than some of its European partners) [RCGP 1990] the concept of fundholding and the doctors' latest contract do force GPs to become more cost conscious. Historically GPs have resented any state interference or change in the
nature of their relationship with the government, but have accepted it and worked with it in the end.

3. **The growth in partnerships.** The number of single-handed doctors is falling and the number of doctors in partnerships of six or more has grown from 12% in 1980 to 21% in 1990. The number of receptionists employed in this period has increased by 67% and the number of practice nurses by 16.9% [DOH 1992]. All these figures have implications for the management of General Practice.

4. **Medicine, standards and litigation.** The pressure is increasing to raise standards through the establishment of competencies or standards and audit. In time it is conceivable that there will have to be a system responsible for continuing professional review. Currently it is hoped to achieve this aim through education and consensus. The growth in the number of training practices has led to improved standards in many cases.

5. **Primary and Secondary Care.** Historically there has been a great divide between general practice and hospital doctors. This may change as the concept of fundholding continues and GPs, rather than the District Health Authorities (DHAS), determine the allocation of resources. Already there is evidence of consultants visiting practices [Podmore 1992] and practices offering minor surgery on site [DOH 1992].

6. **Doctors, Salaries and Careers.** From the nineteenth century GPs have fiercely resisted any movement towards becoming salaried employees. It is felt to be an important precondition of being a professional that a GP remains self-employed. However a disadvantage of being self-employed is the limited opportunity for career development. Trends in partnership size and in the type of medicine practised by GPs may ameliorate this, but only if issues involved in partnership structure can be resolved.

7. **Primary Health Care Authority.** Some doctors are calling for a Primary Health Care Authority to replace the FHSAs and the DHAs who employ district nurses and health visitors [Noakes 1992]. The government policy on Care in the Community might push this line of argument towards including social services and voluntary organisations. The roles of GPs in such an authority could vary from being managers, salaried employees or self-employed individuals.

**Summary of the Literature**

The antecedents of the GP can be traced back through the apothecaries and physicians, to the medicine men or shamans of ancient times. The history of medicine is not the main subject of this thesis, but it is useful to review briefly the foundations to try to identify some of the seeds of the current issues. Sigerist [1951] wrote the most comprehensive history of early medicine, covering primitive and archaic, early Greek, Hindu and Persian medicine. His sources were archaeology, paleopathology, ancient medical texts, instruments, extant literature and interviews with some contemporary tribal medicine men.

King [1978] wrote a philosophical history of medicine and identified changes in beliefs as marking changes in medical practice. He argued, for example, that early medicine was about magic, and that Greek medicine was dominated by a division between Plato, whose doctrine was the primacy of the immaterial; and Democritus, who emphasised the primary reality of the material.
The writings of Hippocrates, although evidently compiled by several authors, are an important marker in the move from mysticism to scientific attitudes.

Cule [1980] wrote of 2,000 years of general practice in Britain and Pietroni described the history of medicine in his Royal Society of Arts (RSA) paper on 'Alternative Medicine' [1988]. Aldridge [1991] reviewed over fifty works written mainly in the 1980s in his article 'Spirituality, Healing and Medicine'.

Writers on medicine and general practice in the twentieth century became more political, pragmatic and sometimes pleading.

Honigbsaum [1979] wrote of the separation of general practice from hospital care from 1911-1968. He argued that state intervention and GP indifference led to a widening only of the kind of people GPs served, not the range of services they gave.

Bowling [1981] wrote 'Delegation in General Practice' in an attempt to broaden understanding of what Primary Care could include. She was particularly concerned to contrast the work and responsibilities of practice nurses with those of GPs. Because both are members of the same primary care team, that is perhaps an easier (though possibly less fruitful) line to pursue than that followed by Huntington [1981] in her book 'Social Work and General Medical Practice'. The differences and overlaps, the difficulties and conflicts between GPs and social workers were explored by her. The structure, whereby one group comes under Local Authority supervision and the other under FHSA administration, does not encourage co-operation. Amongst other papers she has written was one prepared for a MSD Foundation Conference highlighting the need for GPs to respond to change and to have a management development strategy [Huntington 1990].

Keele [1981], in his MD thesis, looked at part of the history of general practice, and found that it was possible to identify competencies in general practice.

Health care provision in the twentieth century was described by Leathard [1990], as she reviewed the aims and effects of all the legislation introduced in the last ninety years. 'The Red Book' is the GP's handbook for claiming expenses and income. After the introduction of the new contract the Red Book became sufficiently complex to warrant a guide. Chisolm edited 'Making Sense of the New Contract' [1990] to try to fill that gap.

The RCGP have produced a series of policy documents and books trying to point the way forward as they see it. 'The Future General Practitioner' [1972] dealt with the role, objectives and education of the GP; 'Quality in General Practice' [1985] looked at how the quality and consistency of service could be improved. 'The Interface Study' [1990] was an illuminating study of the different
health care systems in Europe. It compared expenditure (by GNP), with population, life expectancy, health policy and GP profiles across Sweden, France, The Netherlands, Germany, Ireland, Switzerland, Austria, Italy, Finland, Denmark, Norway, Belgium, Great Britain, Spain and Portugal.

Baker [1991] and Marinker [1990] both wrote about medical audit in general practice, encouraging peer review, honesty and attention to clinical detail. O'Dowd and Wilson [1991] identified the conundrum that increased quality in general practice might well increase even further the need for resources.

The BMJ published a series of articles under the heading 'The Future of General Practice' and in one of them, 'General Practice as a Career', Richards [1991] described:

"The paradox for general practitioners is that having rejected the oppressive aspects of a hierarchical career in hospital they have to face the consequences of no career at all. Poor morale is common and not surprisingly many general practitioners are burnt out or bored silly by the age of 40."

Richards 1991 p 827

Regional Advisors (under their Chairman, Dr Berrington) published a report in 1989 on future strategies for Continuing Medical Education. This called for systematic planning and funding to improve continuing education, so that GPs could work towards achieving the obligations of the new role they were facing.

Dr Mike Pringle edited a series, 'Partners in Practice', in the BMJ over the late summer of 1992. This series looked at issues relating to practice management, teamwork and development, and further increased the awareness that the problem of professionals working together needed some consideration.

Many government papers were published in the late 1980s and early 1990s, marking a cascade of change for the GP. HMSO [1989] published the much discussed 'Working for Patients' which outlined the concept of fundholding, and the GMSC [1989] responded with their Supplementary Report, detailing their many criticisms and the few areas that they supported.

'Caring for People, Community Care in the Next Decade and Beyond' [HMSO 1989] marked the movement of long-term care from institutions into the community - with its consequent implications of assessment and health care for GPs.

'Community Care: Managing the Cascade of Change' [HMSO 1992] looked in detail at the options for providing this care, and the support needed in terms of organisational systems, financial systems and training. Costing the proposals was not dealt with. It is in obtaining funding for these apparently praiseworthy initiatives that the system might begin to encounter problems.
Industry in the late twentieth century has experienced many periods when training has been seen to be a "cuttable cost", in the face of conflict over the allocation of - sometimes diminishing - funds. The debate about including ancillary services in general practice has had another injection with the level of independence available under fundholding. Osteopathy was now seriously considered as a medical service [Pringle and Tyreman 1993] and counsellors were available in nearly one-third of the practices in England and Wales [Sibbald et al 1993]. This increase in the need for and provision of counselling has highlighted an inadequacy in the training and registration of counsellors [Pringle and Laverty 1993, Sibbald et al 1993].

Huntington [1993] argued that the increase in responsibility of the FHSAs could lead them towards becoming Primary Health Care Commissions. However, she pointed out that in order to fulfil this responsibility they would need to be willing and able to provide both purchaser (the GP) and provider (the hospitals, etc.) development. In the literature there is still room for more thought to be given to redefining the boundaries between: ill health; social services; health maintenance and education and housing - beyond the contemporary plea that these groups must work co-operatively.
CHAPTER II

PHILOSOPHY, METHODOLOGY AND METHOD

Introduction

This chapter begins with a statement of how the researcher understood her position at the beginning of this study. It weighs the arguments for and against qualitative research in the light of various philosophical stances, and looks at how each possible approach might or might not be applicable in practice.

The object of any research must be firstly to illuminate and to explain, and secondly to enable informed decisions to be made about the future. There is no such thing as the "perfect research design". There are always "trade-offs", for example between depth and breadth [Patton 1990 p 162]. So this leads to two initial questions for the researcher to answer:

1. Why should this topic be researched?
2. How can this topic be best approached and what limitations are acceptable?

The answer to the first question has always to be, at least partially, personal. From a psychological perspective it would be unacceptable to claim that there was no personal motivation in the research, and it is sometimes difficult to know how explicit, or penetrating, to be in order to answer that question satisfactorily. It does lead, however, to the exposure of the most pernicious and difficult bias of all - researcher bias.

One answer to the first question may be to review a personal statement written in October 1989. There are several personal statements which have been included in this chapter, for two reasons:

- they are examples of the introspection required by the Grounded Theory Approach
- they illustrate the development of thought during the research process.
### Personal Statement 1

In October 1989 I wrote:

"I come to the study firstly as a patient, a person who has consulted a wide variety of general practitioners in different parts of the south of England over the last forty years. I start with my own preconceptions of the attitudes, from GPs and their staff. Some attitudes I found helpful and some I found quite disturbing.

Secondly, I come to the study as a friend, a particular friend, of three GPs whose advice and support has helped the study along, and as a friend of the caring professions. My objective is to contribute in a small way to help GPs to enjoy and feel increasingly competent in their work as well as to benefit the end users, in this case - of course - the patients.

As a management consultant I have views about what has worked managerially in other commercial and public sector organisations. I started this work with the belief that a clear mission and unambiguous organisation structure are prerequisites to any successful team. I am aware that a hierarchy brings with it notions of power and control and that this is not always popular with GPs, particularly if they feel themselves being relieved of their power and becoming controlled. A major part of this study will be to look at the options for organising practices and practice teams."

The answer to the second question also comes in layers, in the answers to yet more questions:

1. What is the philosophical approach underpinning the methodology chosen?
2. What research methods does that lead the research design to include?
3. How can the disadvantages of any of the chosen method(s) be overcome?
4. What other approaches might have been explored?
5. What limitations to this piece of research remain?

### Definitions of Terms

'Philosophy' - this word is commonly used to describe quite different things. Firstly, it can refer to the pursuit of wisdom, the search for underlying causes and principles of reality; secondly, it can refer to a science that comprises logic, ethics, aesthetics, metaphysics and epistemology; and thirdly, it can refer to a system of motivating beliefs, concepts and principles [Websters 1981 p 1698 (abridged)].

'Methodology' can be equally confused. It can refer to a body of methods, procedures ...... and postulates employed by a science, art or discipline; it can legitimately be used to describe any group of processes, techniques or approaches employed in the solution of a problem; it can refer to the basic premises, postulates and concepts of a philosophy; and it can be a science or the study of method [op cit p 1423].
A 'method' is a procedure or process for attaining an object, it has connotations of being systematic [op cit p 1422].

Merton stated:

"There is, in short, a clear and decisive difference between knowing how to test a battery of hypotheses and knowing the theory from which to derive hypotheses to be tested."

Merton 1967 p 141

And Denzin continued by saying that different approaches would produce "significantly different conclusions" [1978 p 6]. He argued that it was important for the researcher to develop an individual synthesis of theory, method and specialty.

It has been common for there to be two competing views of research in the social sciences. It is said that:

"Investigators adopting an objectivist (or positivist) approach to the social world ....... and who treat it like the world of natural phenomena as being hard, real and external to the individual will choose from a range of traditional options - surveys, experiments and the like. Others favouring the subjectivist (or anti-positivist) approach and who view the world as being of a much softer, personal and man-created kind will select ......... from accounts, participant observation and personal constructs etc."

Cohen and Manion 1989 p 8

Positivism has been a recurrent theme in the history of Western thought, but it was Auguste Comte who is credited with consciously inventing the 'new science' of society and naming it [op cit p 10]. The central belief was that a statement had meaning only if that meaning could be verified - therefore unverified statements were held to be meaningless. Thus the social scientist became an observer of an external reality.

Mowly [1978] identified five steps in the process of empirical science:

a) experience  
b) classification  
c) quantification  
d) discovery of relationships  
e) approximation to the truth.

The anti-positivists found the scientific approach reductionist and mechanistic. They argued that man was controlled by his 'inner world' and how he construed (or explained) "the sense of the outer world to their satisfaction" [Websters 1981 p 489]. The origins of this philosophy lay in existentialism. It was the work of the Danish philosopher Kierkegaard [1974] which led to this movement. Just as there was a horror in perceiving the world as inhuman and mechanistic, the ultimate horror that existentialists faced was:
"Whatever meaning life may seem to have for us is our construction and that, hence, in an ultimate sense our life is meaningless."

Spinelli 1989 p 113

Although that may strike a gloomy chord, existentialism led to the opening of a whole new branch of humanistic psychology and psychotherapy, which has focused attention on understanding the world as the relevant person perceived it. R D Laing [1961] and Carl Rogers [1961] were exponents of this approach.

**Phenomenology**

**Personal Statement II**

On 1 May 1990 I wrote:

*I have been confounded by arrogance, the inability to listen, to see the wider picture and to try new methods of behaviour by some people.*

Spiegelberg [1976 p 672] wrote:

"Phenomenology begins in silence. Only he who has experienced genuine perplexity and frustration in the face of the phenomena when trying to find the proper description for them knows what phenomenological seeing really means."

Munhall and Oiler 1986 p 76

Buber [1958 p 50] stated that the real knowledge of another person required openness, participation and empathy. The phenomenological approach was challenging for this particular researcher. Buber was considered by Munhall and Oiler to be the most influential Jewish philosopher of the twentieth century. His most notable contribution was his book 'I and Thou'. He talked about the "self" or the "I" of each person and others (or the "I-thou" as phenomenologists preferred to call it, because they argued that it was only possible for individuals to understand and construe others from their own perspective). Buber contended that what had happened was that the proper balance of "I-it" and "I-thou" had been disturbed by the increase of "I-it" relations. The central question of phenomenology was:

"What is the structure and essence of experience of the phenomena for these people?"

and this is a very pertinent question to ask of GPs at a time of great change.
Objectivist and Subjectivist Approaches

Appendices B and C summarise the characteristics of objectivist and subjectivist approaches. Appendix D outlines the variety possible in quantitative inquiry and its theoretical traditions. The question is: Does the researcher have to come down on the side of the objectivist or the subjectivist before the research can be formulated? Research has to recognise:

1. That there are dangers in analysis which assumes that the world is mechanistic, and that the laws of the universe are external and 'concrete' realities waiting to be discovered while a purely scientific approach could be reductionist to the point of being irrelevant.

2. That there are limitations to research which, attempting to understand the world as others see it, could lead to "subjective reports which are sometimes incomplete and could be misleading".

Cohen and Manion 1989 p 37

Initial Hypothesis found Inadequate

The research for this PhD began with a quite clear hypothesis (although it had not been operationalised):

That the role of the senior partner in general practice is no longer relevant.

The interviews revealed so much more urgent information than was strictly relevant to this hypothesis, that the hypothesis was set aside and the interviews were analysed using the techniques originally devised in grounded theory.

The concept of Grounded Theory was devised to deal with exactly the type of material yielded by the interviews - rich, individual, diverse accounts and observations. And the more interviews and discussions that were carried out and analysed, the more focused the process became.

The first discovery at the interviews was that GPs were very concerned about a wide range of issues. The interviews were deliberately held on a semi-structured basis around the questions described in Appendix E.

Grounded theory does not suggest or recommend rigid, structured interviewing. An inflexible set of questions may deny the opportunity to follow a fruitful line of enquiry [Gordon and Langmaid 1988 p 65]. Minimal topic control is exerted during the early interviews with more focusing occurring later, and this indeed is what happened.

The most important art of interviewing is the ability to ask generative questions. Strauss [1987 p 171] suggested this is partly an "instinct for the jugular", partly wisdom and partly skill. The best way of judging whether these "generative questions" have been asked is by reading the material that resulted.
The interviewees had been sent or given the Code of Practice (Appendix F) (see also BPS [1991]) in advance, and were aware that they were going to be recorded. Each interview was fully transcribed and the transcript sent back to the interviewee for checking before it was analysed. There were also telephone conversations and meetings. The telephone conversations were recorded at the time. The meetings were either recorded or transcribed immediately afterwards from notes made at the meetings. There was also a research group of about eight GPs who met three times during the project and gave feedback on the research findings as they emerged.

Grounded Theory

"Grounded theories are guided by the assumption that people do, in fact, order and make sense of their environment although their world may appear disordered or nonsensical to the observer."

Munhall and Oiler 1986 p 113

Grounded theory perhaps emerged as a counter to theorists who preferred to do "desk research". It says that any theory should be grounded in data, and the methodology emphasises the need for developing many concepts and linkages in order to capture the variation of a complex phenomenon [Strauss 1987 p 7].

One of the cores of the phenomenological method, as Munhall and Oiler saw it, was to look for basic sociopsychological processes (BSPs). These are a type of core variable that illustrate social processes as they continue over time, regardless of varying conditions.

One of the differences between grounded theory and the phenomenological method is that the grounded theory requires that the researcher simultaneously collects, codes and analyses the data from the first day in the field. In coding data one can do it at three levels:

- **Level I**: Breaks the data into small pieces.
- **Level II**: Breaks the data into categories, probably condensing the small pieces of level I.
- **Level III**: Theoretical constructs derived from academic and clinical knowledge.

Certain questions are asked of the data and the coding process:

1. What is going on in the data?
2. What are these data a study of?
3. What is the basic social psychological problem with which these people must deal?
4. What BSP would help them cope with the problem?

Phases of the BSP serve as subheadings for the categories. Academic theory "freezes the ongoing for the moment" in a "fixed conceptual description" [Glaser 1978 p 129].
Sample Size in Grounded Theory

Sampling in quantitative research is normally carried out on the basis of representativeness [Patton 1990 p 169]. Qualitative research aims to select information-rich samples and may intentionally select what a quantitative scientist would call a biased sample. In this case the sample of interviewees was based on "typical case sampling" [op cit p 172]. The sample size was then guided by the type of material generated. Simultaneous data collection and analysis are critical elements in grounded theory research. The logic of sampling and the site for data collection are guided by analysis [Chenitz and Swanson 1986 p 9].

Chenitz and Swanson [1986 p 70] suggest twenty interviews may be enough to generate grounded theory. For this research fourteen interviewees were formally contacted, interviews were recorded over time and analysed. Three of the interviewees were interviewed three times and one was interviewed twice.

Thus, in this case, the interviews took place initially with doctors representing various elements of general practice (senior partner/principal/male/female/practice manager/GP trainer/GP examiner). As the focus of the information gathered became clearer it was decided to test the concepts that were arising in discussion groups by some observation and the result of these stages of the research process are described in Chapter III.

Evaluating Grounded Theory

Glaser and Strauss [1968 p 243] suggested the following criteria for evaluation:

1. That it has codes that fit the data.
2. That it must work, i.e. it must explain the major behavioural and interactional variations.
3. It must possess relevance related to the core variable. (Can the subject say: "Wow, that's it"?)
4. Must be modifiable, for example, it will fit a different setting.
5. It must have density (a few theoretical constructs and a substantial number of properties and categories).
6. It must be integrated - the propositions are systematically related to one another in a tight theoretical framework.*

* in Munhall and Oiler 1986 p 127

The Ethnographic Approach

Ethnography literally means 'portrait of a people' and is the methodology which most completely describes the approach used in this research. The main methods that were used to gain this portrait were:
1. Observation
2. Records
3. Written life histories
4. Newspaper reports

Methods used in this research were:
1. Interviews, both longitudinal and latitudinal
2. Observation
3. Group discussion
4. Survey

The ethnographic researcher can collect data as an observer in four different ways:
1. Complete observer - where there is no interaction, perhaps using a one-way mirror.
2. Observer as participant - once credibility is obtained as a researcher this may allow the researcher access to more information than he would gain as a complete observer.
3. Participant as observer - where the researcher gets involved in the solving of issues the group might be working on as well as observing what is happening.
4. The complete participant - where the researcher joins the group and deliberately conceals their identity as a researcher.

During this study the researcher was able to move towards becoming observer as participant, particularly in the longitudinal interviews and group discussions.

Bruyn [1966] said:

"The participant observer must remain a scientist with the insights of a Shakespearean dramatist."

As with all research, ethnographers have to be particularly wary of ethical issues. They have to gain the informed consent of the participants and make absolutely certain that the privacy, anonymity and confidentiality of the subjects are maintained. This includes coding their data in case it should be subject to a sub poena. Ethnographers have to be aware of the potential use of their findings on the power relationship amongst the various levels of the studied population. They also have to be aware of their own objectivity or subjectivity in the selection of phenomena for recording and reporting. In difficult situations researchers following the ethnological path will have to weigh up the issue of intervention versus non-intervention, and these proved to be real dilemmas in the pursuit of this particular research.

**Interviews as a Research Method**

The research interview has been defined as:

"........ a two person conversation initiated for the specific purpose of obtaining research-relevant information."

Cohen and Manion 1989 p 308
The interview can be: structured - rather like a "questionnaire on legs"
semi-structured - where the same core questions are asked, but supplementary questions follow according to the information received
non-directive - a technique which derives from the therapeutic interview which principally includes minimal control from the interviewer
focused - where the interviewer seeks to gain the reaction of the interviewee to a known situation.

In practice, in this research, the forty interviews used different approaches as the research evolved. It began with semi-structured interviews (Appendix E). The use of open and hypothetical questions was maximised, and there were frequent summaries to work towards uncovering important concepts. Sometimes during the longitudinal interviews the interviewees would initiate contact with the researcher, and then it seemed most appropriate to be non-directive. As time progressed, and the concepts became clearer, the interviews became very focused. The final quantitative review was to check the many concepts raised across a wider population via a postal questionnaire.

Problems with the Interview as a Method

The main problems are: researcher bias; researcher incompetence; incompleteness through lack of time or exhaustion; and respondents' intentional evasiveness.

As a method of evaluation of interviews, grounded theory encourages continuous reflection. This helps in minimising researcher bias, which is probably the most intransigent problem encountered by researchers. In the case of this research, non-directive questioning techniques were used; all interviewees were sent complete transcripts of the interview; and the progress of the study was continuously checked back with the research discussion group, to try to minimise bias. There is inevitably bias in the semi-structured interviews and in the analysis. The final test of bias is to ask: Is it appropriate bias and do the participants in this research find it illuminating and helpful?

It is always difficult to answer the question: "Was the data incomplete?" The answer has to be "Probably." The interviews were stopped when the information began to get repetitive, but one is always aware of questions not asked. As the interviews progressed more difficult questions were confronted. Questions about relationships, money and power found the respondents willing to discuss these issues.

Some interviewees were evasive, and on reviewing the transcripts they were heard to be giving some information 'in code'. The interpretation of this information needed further checking.
In practice, these issues either caused a return to the original interviewees, or the topic was addressed with future interviewees. On balance, providing the questions were well-phrased and the interviewer appeared sympathetic, the responses were surprisingly frank. The interviewees said that they found the experience helpful (perhaps cathartic?). At their request, the interviews invariably lasted longer than originally planned (more than two hours in some cases).

Researcher credibility could have been a considerable problem, but because increasing numbers of GPs backed the study, and as the researcher became more informed, it became a non-issue.

The interview was an essential tool in this research. It was necessary to define the parameters and to discover the core concepts. Inexact and weak though it is as a tool, nevertheless it yielded rich material.

Both the ethnographic approach and the grounded theory method require that the researcher keeps a diary after every encounter. The personal statements in boxes throughout this chapter are examples of that record keeping.
Personal Statement III (a)

On 30 October 1990 I wrote:

"I feel hopeless. 'We didn't talk about money' he said as I was leaving. It was significant and uninvestigated. His perception of me as 'groping', whilst obviously kindly, was all too accurate. I don't know what I am doing or whether the reason I started out doing this (to help improve patient care by helping to improve the GP's lot) is attainable even in a small part. There must be millions of people more qualified than I to do this research."

Personal Statement III (b)

On 8 January 1991 I wrote:

"I have carried out fourteen formal interviews, and done hours and hours of analysis. Nearly two years of hard research have passed and there is little to show for it because I asked the wrong questions. I should have asked:

'What does being a senior partner mean to you?' or
'What does the role of senior partner mean to you?'

"That was all I needed to ask, and that was something I signally failed to ask."

Personal Statement III (c)

On 23 January 1991 I wrote:

"My enthusiasm, after compiling the patterns, needed refocusing. X was obviously nonplussed by my apparent lack of reading (I have read masses; I just cannot always call it to mind on demand). She is very right to push me back to look again at the literature, especially including the literature on Grounded Theory. Have I been using this theory correctly?

"Time to take a break for a review before starting on the next round of interviews."

Personal Statement III (d)

On 8 May 1991 I wrote:

"I am still unstructured in my interviewing, although what I do and say feels right. I am exploring (or trying to explore) the things that the interviewees feel most strongly about. Thus I often omit structural/factual details. I am now much less embarrassed about asking difficult questions now. This interviewee seemed genuinely interested and this interview was a key point, I can see some patterns now emerging."

Observation as a Research Method

Ideally the observation of partners' meetings would have been included in this study. The tension surrounding the introduction of an observer to these meetings would have taken some time to abate, and it was not possible to arrange this in the time frame. Observation is essentially initially behaviourist, but it could have been well-used in this context to cross-check information given at interviews.
As a non-participant observer, three meetings of thirty to a hundred GPs were attended. These were held during the time when the new contract had been imposed and fundholding had begun. The advantage of being a non-participant observer was that the researcher affected the subjects very little, and in this case it could be assumed that they would have behaved in a similar way if the researcher had not been present.

The tools used for recording these observations were: a tape-recorder; and written notes covering the physical surroundings and the body language of the participants. For example, the way participants dressed, expressed affection and physically spaced themselves in discussion were non-verbal clues about what was happening [Patton 1990 p 30]. There was minimal affection and support shown between GPs at large meetings but more shown by practice managers at one meeting attended. This could describe some of the isolation GPs felt but it had to be borne in mind that one did not observe everything, so hypotheses drawn from observation had to be tentative.

The information was fed into the material analysed under the grounded theory method. Observations were made during the formal proceedings and during the informal encounters at coffee breaks and lunch (the latter were not taped but were written up immediately afterwards with as many verbatim quotations as possible - these were probably also most open to researcher bias and did not produce much usable material).

At all times, when in direct conversation with people, the researcher explained her role. A little eavesdropping (covert, non-participant observation) was unavoidable but did not yield data that was particularly rich in comparison with other, more ethical, approaches.

The main problem with observation is that of inference. It is still only the question of researcher bias in another form, but it is graphically highlighted in 'Sex, Lies, Margaret Mead and Coming of Age in Samoa' where the original participants in Mead's study claimed to have told her inaccurate stories about free love in Samoa because:

"She seemed always interested in asking questions about sex. And you know in Samoan society we never discuss these things."

Gartenstein 1991 p 20

Discussion Groups as a Research Method

Discussion groups as a research method are not particularly new, but neither have they yet been explicitly widely used. The basic concept is that seven to nine people, who are specially recruited according to a predetermined set of criteria, exchange experiences, attitudes and beliefs [Gordon and Langmaid 1988 p 10].

"As a form of qualitative research, focus groups are basically group interviews, although not in the sense of an alternation between the
researcher’s questions and the research participants’ responses. Instead the reliance is on interaction within the group, based on topics that are supplied by the researcher, who typically takes the role of a moderator. The fundamental data that focus groups produces are transcripts of the group discussions.*

Morgan 1988 p 9

*The hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group.*

op cit p 12

Discussion groups have been widely used as a market research tool and are now being rediscovered by qualitative researchers. The characteristics of a discussion group are:

1. a small number, 6-10 participants
2. participants should share specific characteristics to facilitate broad comparisons
3. the group should be homogenous with respect to characteristics that might influence participants
4. participants should not normally know each other well (because they may have already talked about the topic and reached their views).

Day 1991 p 2

The main purpose of using groups in this thesis was to get participants’ interpretations of results from earlier studies. Other purposes are also possible: generating hypotheses; orienting the researcher; developing interview schedules or questionnaires [Morgan 1988 p 11].

The facilitator may or may not be the researcher. In this study the researcher acted as the facilitator and it was a weakness of this approach. The researcher tended to be drawn into discussion more than was intended.

It is a practical research tool for gaining a lot of information in a short space of time. The disadvantages are that minority viewpoints may be lost and peer group pressure may influence individual opinions. The strength of this method lies in its ability to generate ideas.

In practice, six to ten GPs met three times specifically to contribute to this research. This was a peripatetic group who meet three times a year, mainly to discuss clinical research. The membership was not consistent (although there were four core people who attended each of the sessions dedicated to this research), but all were members of the RCGP, who were the organising faculty.

The value of this group was in its evident interest and support for this research; in its willingness to debate and question tentative findings; and in the individual interactions it initiated. Several members of the group asked for individual interviews where more confidential matters could be discussed.
The meetings were all recorded and transcribed. The first meeting was an open discussion to generate concepts to be tested. The second two meetings focused on a pre-circulated summary of research findings.

A fourth, much larger, meeting was also held, when thirty GPs met to discuss the findings. It was not easy to get feedback from the larger groups in the time available but there was no great dissent either during or after the session. As with the smaller groups, the most valuable feedback came from individuals after the session. In two of the four meetings there were epidemiologists who wanted the study redesigned along purely quantitative lines. This was very much a minority view, and in neither case were these people practising GPs.

Discussion groups in this research were valuable, but more for breadth than depth. The enthusiasm of nearly all of the participating GPs was also important for supporting the sometimes flagging confidence of the researcher.

**The Case Study as a Research Method**

The case study is a part of the phenomenological approach. It requires the self-knowledge discussed earlier because the researcher is a subjective person required to be objective. Cohen and Manion [1989] suggested the following steps:

1. A rough definition of the phenomenon is formulated.
2. A hypothetical explanation of that phenomenon is formulated.
3. One case is studied in the light of the hypothesis with the object of determining whether or not the hypothesis fits the facts in that case.
4. If the hypothesis does not fit the facts either the hypothesis is reformulated or the phenomenon to be explained is redefined so that the case is excluded.
5. Practical certainty may be attained after a small number of cases has been examined, but the discovery of negative cases disproves the explanation and requires a reformulation.
6. This procedure of examining cases, redefining the phenomenon and reformulating the hypothesis is continued until a universal relationship is established, each negative case calling for a redefinition of a reformulation."

Cohen and Manion 1989 p 130

In a case study the techniques available include:

1. Participants' diaries and self monitoring
2. Interviews a) biographical/historical b) to understand the individuals' concepts of reality (including repertory grid analysis if appropriate)
3. Observations a) behavioural grid analysis b) sociograms c) dialogue analysis d) body language
In most cases the findings can be fed back to the participants to gain their view on the researcher’s construct of their reality. This feedback had to be handled sensitively so as not to damage the participants’ ability to live and work productively or the researcher’s reputation.

There is a problem in selecting what evidence should be recorded, and the researcher has to be particularly careful not to record only evidence which supports their hypothesis. Preplanning the structure of the observation can ameliorate this to some extent.

The case study is rooted in reality, and this is its strongest advantage. Its approach recognises complexity and it forms a step into action. It would have been helpful to conduct detailed case studies on one or two practices. The closest this study got to this was interviewing several partners and a practice manager in one practice. This was not a complete case study, but it did provide some rich information.

**Action Research as a Research Method**

It could be argued that action research is a useful tool for this type of enquiry. However, the opportunity (and finance) for working with a group of GPs was not available during this research. It is briefly reviewed here as a concept because it may be an appropriate method for exploring some of the questions for further research highlighted in the final chapter.

The philosophical background to action research is pragmatism. Whitehead, in his foreword to McNiff’s book, said that the question action research is trying to answer is: “How do I improve this process of education here?” [McNiff 1988 p x].

McNiff said that one of the advantages of action research was that it encouraged the teacher to be reflective of his own practice in order to enhance the quality of education for himself and his pupils. It is research with rather than research on. This meant it came closer to the requirement for this study of the chosen methodology not imposing any particular belief or rationale that the researcher might have on the participant. It assumes that what is going on at the moment is not as good as is possible, and that improvement is desirable. Empirical research is geared towards answering the questions of the external researcher. Action research is geared towards the questions of the subject. McNiff isolated the four stages of action research and (based on the work of Lewin) contributed the following three-dimensional spiral:

1. Planning
2. Acting
3. Observing
4. Reflecting

McNiff 1988 p 44
Practically to ascertain whether action research was a suitable model for the type of problem being looked at here, the six critical questions which McNiff quoted as setting the scene for the first stage of action research planning can be reviewed:

1. What is your concern?
2. Why are you concerned?
3. What do you think you could do about it?
4. What kind of ‘evidence’ could you collect to help you make some judgement about what is happening?
5. How would you collect such ‘evidence’?
6. How would you check that your judgement about what has happened is reasonably fair and accurate?

McNiff 1988 p 57

The role of the facilitator in this method of enquiry needs to be explicit.

"Thus the facilitator's role is Socratic: to provide a sounding-board against which practitioners may try out ideas and learn more about the reasons for their own actions."

Cohen and Manion 1989 p 220

The role of the researcher, if this approach were to be adopted, would be to facilitate and record the research of GPs into their own problems.

Cohen and Manion argued that the step by step process could be monitored ideally by diaries, questionnaires, interviews and case studies. Action research relies chiefly on observation and behavioural data; it is empirical, situational and specific; the sample is restricted and unrepresentative; there is little or no control over independent variables; its findings are not generalisable. These were all criteria which should have been met by the research project being envisaged. Even though the findings are not generalisable, it is hoped that others may learn from the analysis.

**Occasions When Action Research is Appropriate**

1. Changing teaching methods
2. Changing learning strategies
3. Evaluative procedures
4. Changing attitudes and values
5. Personal in-service development of teachers
6. Management and control
7. Administration

Cohen and Manion identified the stages of action research as:

1. Identification, evaluation and formulation of the problem
2. Preliminary discussion and negotiation amongst interested parties
3. Review of the literature
4. Modification of original statements and maybe a testable hypothesis
5. Selection of research procedures
6. Choice of evaluation
7. Implementation
8. Interpretation of data*

Cohen and Manion 1989 pp 232-3

Action research might be a useful next concept in testing out some of the recommendations and conclusions of this thesis.

**Quantitative Research and Statistics**

This chapter began with the accusation that quantitative research in the social sciences can be reductionist, mechanistic and even insulting to the human race. It was in his poem 'The Unknown Citizen' (to JS/07/M/378 ...........) that Auden developed his dislike of social science and statisticians (Appendix G).

There was even a suggestion that in the public mind the dislike of statistics could partially have arisen because of a barely conscious awareness of an historical link between eugenics and statistics [Reid and Boore 1987 p 11]. The eugenicists believed that standards of health, social behaviour and intelligence could be raised by selective breeding.

The problem of ethics, however, arises with every type of research tool. The problem of the misuse or misinterpretation of statistics also has its counterparts in other research methods. In this research the survey was used as part of the triangulation process because the researcher agrees that:

"A judicious man ............ looks at statistics, not to get knowledge, but to save himself from having ignorance foisted on him."

Reid and Boore 1987 p 13

The type of tests used are described in Chapter VI on the analysis of the questionnaire.

### Personal Statement IV

On 30 October 1991 I wrote:

"So writing questionnaires is easy is it? All you do is work out what you want to know, write out the questions, pilot it, alter your questions a little to take into account the pilot responses and off you go. So why am I sitting here six months later with the ninth draft still not ready to go?"

### Triangulation

Constantly researcher bias or incompetence has been raised as a potential problem.

"By combining multiple observers, theories, methods and data sources*, researchers can hope to overcome the intrinsic bias that comes from single methods, single observer and single theory studies.*"

Denzin 1970 p 313
The following methods of triangulation were used, as outlined by Denzin and further expanded upon by Patton [1990 p 64].

1. **Methods Triangulation**: Combining research methods would help to check the consistency of findings generated by different data collection methods. This was why interviews, observation, discussion groups and the survey have all been employed. It was important not to try to reconcile irreconcilable data.

2. **Triangulation of Data Sources**: This was important to check out the consistency of findings generated by different data sources within the same method. Attempts at achieving this have included using transcripts of interviews with partners, senior partners and practice managers. In the quantitative paradigm material has been generated from two different regions (Humberside and East Surrey), it can also be compared with other nationwide surveys [Bosanquet and Leese 1989, BMA 1992].

3. **Triangulation through Multiple Analysts**: Throughout this research programme there has been only one researcher, and this is why such strenuous efforts were made to cross-check the interpretation of all data. However, three colleagues (academics) have checked samples of the data.

4. **Theory/perspective triangulation**: This has been attempted by using tools and perspectives drawn from psychologists, sociologists, statisticians and historians.

Overleaf is a summary of the different stages that the research passed through. It lists each stage and refers briefly to triangulation in describing the way each piece of information was checked and cross-checked.
Summary of the Research Process for this Study

Historical Review

Interviews

Interviews transcribed and separated into categories by the researcher. Basic themes (BSP's) identified and cross-checked with the literature

Basic Themes checked with Research Discussion Group (comprising eight G.P's) and three individual academics

Paper disseminated to all interviewees for comment

Theoretical study of conflict

Questionnaire designed
3 pilot studies undertaken circulation of questionnaire

Questionnaire Analysed: Results reviewed by:
a) Research Discussion Group (8 G.P's)
b) GP Trainers study group
c) Results sent to all who completed questionnaire
d) Detailed discussions with 2 of the original interviewees
e) Statistician

Conclusion and Recommendations
Summary

This chapter began with a statement of the researcher's personal position - inasmuch as it was understood at the beginning of this study. The arguments for and against qualitative research were reviewed in the light of various philosophical stances and how each approach might or might not be applicable in practice.

The research process finally used (summarised above) is an amalgam of qualitative and quantitative techniques. The qualitative approach was used to identify and describe the important concepts, and the quantitative approach was adopted to try and establish more broadly how widely these issues might apply.
CHAPTER III

THE INTERVIEWS - PROCEDURE AND ANALYSIS

Background to the Interview Process

This initial attempt at categorisation was based upon interviews with six senior partners, three principals, one assistant, two practice managers, one member of a professional body and one academic.

Represented amongst this group were seven men and seven women. The surgeries were in the south of England and included both large health centres employing chiropodists, psychologists, health visitors, district nurses and physiotherapists, as well as the surgery staff; and the smaller surgeries with partnerships of about six. Doctors were interviewed covering a wide range of practices: inner city, suburban and rural. There were two practices actively pursuing fundholding amongst the sample. There were three doctors who expected to be chairmen of Medical Audit Advisory Groups (MAAG) and four doctors who were GP trainers. Two of the people in the sample have led many short management courses for GPs over the last four years. One of the interviewees was an examiner with the RCGP. The interviewees were identified by using various sources including the British Postgraduate Medical Federation (BPMF), the RCGP and informal sources, to meet the range of objectives outlined above.

Only one GP refused to be interviewed. His reason for refusal was as interesting as many of the interviews themselves: his partnership had been through a crisis and he hoped it was resolved but wanted to let the dust settle before involving his practice in any exercise such as this. Even this GP asked to be kept up to date with progress and said that he might be willing to be involved later.

The interviews lasted on average one and a quarter hours, with the range being from forty-five minutes to three hours.

None of this is an attempt to justify a tiny sample as representative, merely to illustrate some of the variables covered. The sampling strategy is discussed in Chapter II.

The questions which were asked were formulated after the background reading and some initial discussions. They were mainly based around defining competence, audit, attitudes to recent events and the role of the senior partner. Some core questions were asked of all interviewees; follow-up questions were asked or other responses were made as the situation dictated. As time...
went on, some of the original core questions were dropped. In retrospect, the one question that should have been asked was 'What does being a GP mean to you?' (See p 36)

**Stages of Analysis**

1. Background reading.
2. Project outline drafted.
3. Core interview questions drafted (see Appendix E).
4. Interviews arranged, code of conduct circulated (see Appendix F).
5. Interviews carried out, notes made and interviews tape-recorded.
6. Interviews transcribed.
7. Transcripts sent to interviewees for review.
8. Transcripts divided into 'soundbites' (phrases or sentences which seemed to encapsulate an idea or theme).
10. All the soundbites under each heading collected together. Analysis checked by three other academics.
11. 'Conflict' identified as potentially the BSP.
12. Transcripts of the interviews further analysed, referring to the literature available.

After Stage 6. a one page summary was also produced before the detailed analysis was carried out. This was one way of looking at the material, and the researcher was responding intuitively to the overall picture. This analysis was consciously set aside for Stages 8.-12.

In writing this thesis all the interviewees' quotations are anonymous to preclude identification. The exceptions to this are where the role of the interviewee has to be included because it has a bearing on interpreting their statement.

The rest of this chapter is the result of the analysis listed above, combined and compared (see Chapter II) with reference to the appropriate literature. It has been checked by the interviewees and the research discussion groups. Unless otherwise indicated, the quotations are all from the interviewees.

**The Political Scene**

Kaldor [1971] pointed out that post-Keynes' 'Theory of Employment' politicians had accepted responsibility for managing the economy. In economic terms he maintained that their goals were: full employment (3% unemployment accepted in 1950); balance of payments surplus; and a growth target (5% in 1964). This implicitly created a tension between public spending needs and there was an ideological conflict between the main political parties on the control of the money supply and inflation.

Piled on top of the tensions surrounding the issue of how to control inflation was a conflict between the two high expenditure areas of government:
The introduction of the concept of cost limitation into the health service has been a change which many GPs have found difficult. Now GPs are expected to know explicitly how much a service or a prescription costs and, if fundholding, to take the responsibility of deciding whether they will allocate their resources to that item.

<table>
<thead>
<tr>
<th>Doctors should have</th>
<th>Doctors should decide</th>
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<tr>
<td>authority over allocating financial resources</td>
<td>what treatment is appropriate, it is up to the administrators to administrate.</td>
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One senior partner said:

"There are philosophical objections to things going on at the moment. For example, fundholding. There is one partner who feels it is totally wrong and should not be considered. This is very left-wing. The fact that the Russian government has tested it out in Leningrad for about three years doesn't seem to have persuaded him."

An alternative to the 'left-wing' view was explained by a senior practice manager:

"We believe fundholding gives us a voice to speak for our patients."

However too much specific government interference does create difficult uncertainty:

"We are constantly threatened by a new government coming in. Just as you think, 'OK, we'll appoint a business manager for £20k because we have a £32k management budget', that is wiped from under our feet."

And government controls can have unintended results:

"The FHSA had informed us previously that if we were to be allowed any extra reimbursement in future, nursing would be the priority. So we made sure we had enough admin. staff."

"When we compare ourselves with other practices we are overstaffed, someone has to get a grip on that."

Fundholding is a test of our abilities as managers. Fundholding is a subversive activity giving government the information it needs to control us.

"There is a bit of resistance to fundholding practices because it is seen that they are providing information ........ which may well form part of a stick to beat them with."
"Fundholding is not to be sneezed at but we're doing it under a political shadow really. We're fairly outcast by our fellow GPs."

This was a view which was articulated by some GPs, and which could be a fear of many. Others saw fundholding as empowering, a challenge, and the statistics as a time-consuming - but important - tool of measurement:

"We are in a service trade after all, and we have got to attract customers."

In mid-1990 the BMA, the doctors' representative body, was so concerned by the changes being imposed upon them that they published a leaflet (see Appendix H) which was made freely available to patients in many surgeries. These 'scare' tactics were loudly denounced by the government at the time. By November 1990 'Scrutator' was writing in the BMJ:

"I do believe that we shall come to appreciate Kenneth Clarke's (the outgoing Minister of Health) legacy to make the NHS more efficient. Few doctors would deny that management in the NHS is patchy in quality and quantity .......... and that the profession's influence has sometimes been quirkily injected with, and too often dictated by, doctors' individual preferences, and the central concentration of power with the DOH has been more deadening than dynamic."

'Scrutator' 10.11.1990

<table>
<thead>
<tr>
<th>We must serve the community.</th>
<th>We must manage a business.</th>
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<td>from Donald 1990</td>
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There were some who felt that these were two opposing poles, that patients have become commodities, and "We won't want lots of ill people wasting our resources"; the alternative view - that they are not mutually exclusive - was also given. However, combining these two poles was seen as hard work:

"If we don't change we are going to get left behind in the game of being an efficient practice. Certain things have happened in the contract which require very tight and efficient management and we are floundering."

And from another practice an interesting disclaimer:

"We are not in fundholding for the money, we none of us think we are going to get anything out of it."

The doctors' new contract and the first wave of fundholding were both imposed by the government in 1990. While GPs were divided about the advantages and disadvantages of these schemes, the one thing they were united about was that they did not like the way that these decisions had been imposed upon them.
There is a history of inability for the government of the day and the BMA to agree on changes to the NHS. Aneurin Bevan, MP, imposed the NHS on a reluctant BMA in 1948; contract revisions were imposed in the 1960s and again in 1990. Here, however, the conflict seems to lessen with time, and money. In March 1989, when the proposals were first made, there was enormous anger and despair:

*I'm going to feel like a civil servant .......... we are not being treated like professionals, we are being treated like naughty schoolboys who are motivated by our wallets.*

A year later, the feelings had changed:

*We are not necessarily supportive of government changes. Doctors have said that they would stay the same, and they are not, they are going to be budgeted by the DHA, so we had better budget ourselves.*

*We had to choose the best option for our practice and our patients. We chose to hold the budget here.*

A few months after that, in March 1991, the attitude had changed even more:

*At Callverton, Notts., budget holding is seen as the only way of maintaining an environment where new ideas are welcomed, audit is a regular feature, but also liberating the practice from the rigidities of the general practitioner contract.*

The tone had changed from utter resentment to reluctant acceptance.

There was dispute over the ultimate goals and values of the NHS. Black [1980] argued that while the mechanistic model of health holds sway, the most valued posts will be related to surgery: the immunological response to transplanted organs, chemotherapy and the molecular basis of inheritance. He pointed out that medical education and careers will also be influenced by this model.

In 1986 Dr Patrick Pietroni was setting out to prove that the role of the GP could be fulfilled in a much broader manner than hitherto. In the crypt of St Marylebone's Parish Church, his team offered a clinical service including: NHS general practice facilities with all the necessary attached staff such as health visitors and district nurses; a complementary therapy unit, offering a volunteer-based outreach programme; and a joint assessment clinic where patients were examined by four different practitioners (medical, acupuncture, homeopathic and stress counselling) and a joint package was offered [Pietroni 1988].

There are similar experimental schemes operating in Peckham, south London, and in Wales. There are two questions most commonly asked about such schemes. Firstly: Could they be operational without financial support in additional to NHS funding? And, secondly: Is it any better
than conventional therapy? There are moves towards accepting osteopathy as a conventional therapy [Pringle and Tyreman 1993]. There are 1,706 registered osteopaths in England and Wales, more than any other group of complementary therapists [op cit].

<table>
<thead>
<tr>
<th>Mechanistic Model</th>
<th>Holistic Model</th>
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<tr>
<td>GPs are a sorting agency referring to specialists.</td>
<td>GPs are the conductor of an orchestra of orthodox and complementary therapies.</td>
</tr>
<tr>
<td>Stresses the body as a machine.</td>
<td>Stresses participation.</td>
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Historically, doctors have fulfilled their social role most prominently when they have campaigned for clean water, public health and housing. Indeed Illich [1976], a priest and philosopher, claimed that if the same amount of rocketing medical expenditure currently spent on medicine were to be spent on those issues today, there would be a much healthier nation in the UK. Doctors as political campaigners was a concept which came to the fore again in the second half of the twentieth century. There are some who believe they cannot fulfil their role honourably without becoming involved with the decision-makers (politicians), and some who believe that as soon as that happens they become tainted. Underlying this conflict are important questions about: What is Health? What is illness? How much of a doctor’s role should be preventative? and: What level of preventative intervention should be acceptable?

Bowling asked:

“If doctors have a social/psychological role, do they also have a political role?”

1981 p 43

| Doctors should also be political. | Doctors should not be political. |

In May 1991 the BMA announced their intention to campaign about health for the next general election, although they said the campaign should not be party political.

In 1991 the conflicts between the government and the BMA seemed to be nearing a peak. There was a great fear that the NHS would not be able to provide adequate care and that ‘opted out’ hospitals would not be accountable. In looking at Maslow’s higher and lower level needs [Maslow 1970 p 97] one could postulate that this threat was operating at two levels. Firstly, that GPs were genuinely worried about their ability to help their patients and, secondly, that they felt
insecure about their own roles and continued employment. Aside from the political conflicts there were others, as has been mentioned before.

Computers

In 1990 60% of patients attended a practice that had a computer, and computer ownership had almost doubled in the previous year. The estimate was that by 1992 90% of 8,400 practices would have been equipped with computers [BMJ 1.9.1990 editorial]. This was the area where staffing had increased the most.

Computerisation has divided both practice staff and doctors into those who liked the idea and those who did not.

"We took major decisions to computerise and to become fundholders and, over the course of the last two or three years, we have completely lost all our staff."

Patients too had some concerns. In a postal survey to 390 patients, more than 96% stated that contact with their doctor was as easy and personal as before. However, 81 patients thought their privacy was reduced [Rethans et al 21.5.1988].

Computers are essential and welcome in the surgery. Computers will depersonalise the doctor/patient relationship.

The initial feeling of fear was often overcome when needs must, and then competence followed.

"We (doctors) converted somehow. I mean, we were looking at these things for years and thinking 'God, we will never cope with one of those things!' But within a week we had given up pens and written notes."

However some GPs were suspicious about the usage rate. As one GP said:

"You could count the practices which are computerised, yet I can tell you there are some who don't know how to use those computers."

Computerisation became essential for practices to cope with demands for information from the FHSA, and would be essential for fundholding and for audit.

"We don't want to design (more) paper systems for our colleagues, we want to push IT on the grounds that it does give decent audit."

gsaid one senior partner who is heavily involved in a MAAG. It was also recognised by many GPs that statistics were only part of the potential procedures for audit.

Although some GPs remained sceptical about the quality of information that statistics could give, this led into another debate - about audit - which is explored later in this chapter.

The relatively rapid introduction of computer systems also divided both GPs and staff in terms of computer competence. There was frequently one member of staff who led the
computerisation; there might be a connection in people's minds between computer competence and lack of interpersonal skill.

"We were fortunate in having another partner join who was a wizard on computers, he took most of the flak and didn't care."

<table>
<thead>
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<th>Computer incompetence</th>
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<td>is associated with low interpersonal awareness.</td>
<td>is associated with high interpersonal awareness.</td>
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Computerisation had obviously been a hotly debated issue at partnership meetings. The questions of:

1. Whether to computerise?
2. What to purchase? and
3. Who should take responsibility for the system?

had taken up a lot of time and thrown some strain on the decision-making structures.

**Inter-Professional Conflicts**

The GP is a member of a team which typically has authority over practice nurses, receptionists, secretaries and practice managers. Some practices also employ counsellors/therapists and systems experts. The district nurses report to the divisional nursing officers; the social workers to the local authority; and the health visitors ultimately to the DOH.

There are intriguing hints as to how inter-professional co-operation might have unexpectedly positive outcomes. A study by Lyall, of nine practices in north-west London working with a marriage guidance counsellor, found consultations reduced by a third, prescriptions by nearly a half and prescribing of psychotropic drugs by a third [Lyall 1979].

As Bowling said:

"The best method of organising a primary health care team is unknown .......... moreover, the mere presence of other health care staff in a surgery or health centre does not imply teamwork follows."  

Bowling 1981 p 31

It was noticeable that most practice meetings only included other members of the health care team on an occasional, individual, invited basis. Bowling suggested joint training programmes to overcome some of the distance.

It was estimated that the practice nurse was capable of relieving a GP of 19% of their workload [Cartwright and Scott 1981], and receptionists have been shown to be quite competent in carrying out a large proportion of medical audit requirements [Essex and Bale 1991]. Because
doctors are not trained to be managers, delegation is an art with which many of them are not familiar. There are some GPs who think some aspects of it are unnecessary:

"If there wasn't so much bureaucracy and form filling, then we wouldn't need so many practice managers anyway."

| Systems and forms are necessary for an efficient General Practice. | Bureaucracy has got out of hand and is causing more problems than it is solving. |

In May 1991 there was a government funded working party looking at how to reduce GPs' paperwork, however the demands for information were not yet decreasing.

There are many views on the role of nurses in general practice. Friedson [1970] argued that they were included as a subservient group partially because GPs assumed dominance and, historically, the 'serving roles' of nurses, secretaries and receptionists have been filled by women. Huntington also talked about the conscious or unconscious assumptions brought by male doctors to their working relationships with members of predominantly female non-medical occupations [1981 p 18]. This pattern has been reinforced in surgeries and:

"There are thus no barriers to the continuation of that pattern of medical dominance they (GPs) first acquired in the teaching hospital."

'Delegation' was defined by Anne Bowling [1981] as the transfer of a task to a person of lower rank. She pointed out that it was a waste of resources for doctors to perform procedures which others could undertake just as well.

It could also mean a loss of income (or even profit?) for a practice, so, in spite of the BMA's disapproval, one nurse had been appointed as a practice nurse partner to a single-handed East End practice [Jones 14.4.1990].

| Practice nurses could be equal but different contributors with doctors to general practice. | Practice nurses will always be subservient to general practitioners. |

Periodically the issue of nurses not being able to prescribe has been raised. At the time of writing it is still law that they should not be able to do so, although there is a powerful lobby arguing that there are some simple medications and dressings which they ought to be able to prescribe.
The question of whether or not nurses could become the line of first patient contact, and doctors only see patients after a nurse-referral, has also been raised. To implement this would require a big change in attitude about right of access to see a doctor. It could ease the burdens of trivia, of which many general practitioners complain; it could also lose them some jobs. Miller and Backet [16.8.1980] carried out a survey of ninety GPs, of whom 77.3% replied. Two-thirds of those replying were in favour of nurses taking further training and then taking an extended role in history-taking, examination, diagnosis and advice on treatment. The characteristics associated with the acceptance of a new role were: doctors aged less than fifty years; and those from practices where regular, formal practice meetings happened.

However there were still blocks to interdisciplinary co-operation. Owen [1987] was a senior GP trainer who looked at interprofessional education and found that such co-operation was not at all common. He found a lack of interest in training amongst many GPs.

This suggested that, whilst training might be the most effective method of encouraging co-operation, it would be necessary to find a way of overcoming GP resistance to such programmes.

| GPs would not benefit greatly from joint training programmes with other members of the primary health care team. | GPs would benefit from such programmes. |

If collaboration between nurses and GPs has been advocated for a long time, so it has also been between social workers and GPs. Yet little has happened [Huntington 1981]. One practice manager said:

"I'd like to have everything under one umbrella and everyone working towards the patient. There is so much duplication in community care - the DHA, general practice, Social Services - if it could all be integrated we could give a better service."

Yet a health visitor said:

"I couldn't be managed by the GPs, it would be terrible. I couldn't go where the greatest need is."

Yet a doctor said:

"Health visitors flit around seeing babies who do not need their attention too much, when with a bit of 'nous' they could have had the whole business of health promotion."

In her prizewinning essay in 1972, Brooks found many differing views about the roles of those in the primary health care team. Given a list of hypothetical cases used in the investigation
of role expectations (see Appendix I), each group of workers saw themselves concerned with a wider variety of cases than the other team members attributed to them.

In investigating leadership, authority and decision making in seven teams she found that nurses and health visitors tended to regard the doctor as the leader or head of the team, whilst when health visitors felt in disagreement about a course of action they felt their opinion was of equal value with that of the doctor. The social workers would put it more strongly. One said that they would, if necessary, call for the help of a social work supervisor to "...... fight for what I believe in". The social workers were very conscious of their professional skills as complementary to those of the doctor .......... and they did not think that his judgement should prevail in all cases [Brooks 1972 p 246].

Brooks found that regular team meetings aided collaboration, and said that she felt there needed to be a flexible answer to the question of leadership.

<table>
<thead>
<tr>
<th>The Primary Health Care Team needs a leader/co-ordinator.</th>
<th>The Primary Health Care Team does not need a leader or a co-ordinator.</th>
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**To Lead, Manage, Co-ordinate or Chair?**

The semantic differences between the words 'leader', 'manager' and 'co-ordinator' are sometimes difficult to identify. Many books have been written about 'Effective Management', which seem to refer more to leadership and less to management. For the purposes of the rest of this paper these are the proposed definitions.

**Leadership**

"Leadership is about getting things done through people." [A practice manager]. It is about:

"...... a person who has a capacity to lead; it is that ingredient of personality which causes men to follow."

Websters 1981

"The essence of leadership is the successful resolution of problems and the leader successfully moulds individuals into a team."

op cit

Leadership has a quality of inspiration, the effective leader enables others to achieve more than they could have done without him or her.
Management

Whilst leadership may be the inspiration, management is about the 'how'. A manager is:

"someone who conducts business or household affairs with a discreet frugality and care."

Management refers to the 'whole system', it includes the executive functions that Henri Fayol [1964] first identified:

"planning, organising, co-ordinating, directing, controlling and supervising, with responsibility for results. The manager is the employer's representative."

Fayol 1964

In business, management refers to the effective use of specialist personnel, groups and expertise as appropriate as, for example, finance, engineering, marketing and human resources. There is a technical competence implied in a manager.

Co-ordinator

The person who co-ordinates is of "equal rank, authority or importance with another" (not subordinate or superior) and brings items into "common action, movement or condition".

The co-ordinator is:

"one who expedites by recommending, although often not supervising, measures which eliminate confusion."

Websters 1981

Chairman

The presiding officer of a meeting or assembly, the head officer of an organisation or committee who is entitled to preside at meetings and usually to exercise some authority in carrying on its affairs often one who has very little power to determine policy and exercise authority except with the approval of his colleagues.

One can be an effective leader and have others to do much of the managing or co-ordinating. Effective leadership is measured over the longest time span when looking at the success of a vision but individuals will quickly (although sometimes differently) come to a judgement about someone's leadership skills. The leader is expected to add quality in terms of strategic ideas and be able to communicate them persuasively. The co-ordinator is not the employer's representative, but is expected to have sufficient interpersonal skills to enable a group to coalesce. The co-ordinator represents the group's interests. The manager is most definitely an employer's representative, and in these days of 'management by objectives' is measured on more or less quantifiable results. The chairman and co-ordinator roles are linked, but differ in results, prestige
and, perhaps ultimately, in the amount of authority they carry. Both positions can be appointed by the groups themselves and certainly require their approval if not a majority vote.

These terms are, of course, all linked in various ways, but the question of who is whose representative is one which is often 'fudged' or manipulated. Groups are not always clear whether their leader is there to represent their ideas or because the leader is supposed to add value in terms of his or her ideas. In the discussion which follows on the role of the senior partner, the term 'leader' is used to cover all the above possibilities.

**The Role of the Senior Partner**

Historically the senior partner has been appointed through length of service. Over the last fifteen years the privileges attached to the role have been eroded and now there is doubt about the nature of the authority and responsibilities entailed.

This is such a complicated arena that for a while let the interviewees speak for themselves:

"The senior partner is an outdated concept which will always exist. I mean, people will become dominant one over the other, that is the way of life."

"We never use the term 'senior partner' publicly (even though in this practice everyone knows who it is)."

"The senior partner used to trade on 'When I am gone, my boy, you will be here where I am and you can do what I am doing now, which is sit back a bit, because I have worked hard all my life ......... You will do all the 'panel patients' as they were called, the night calls and the weekend work that I used to do. And it will be your turn later on."

"So the senior partner bit is, for nearly everybody, just an extra responsibility."

"I don't look at the senior partner as one who should wield a great deal of influence, I have the same financial share."

"The only way a senior partner can be paid is by saying: 'I need a day off to do the administration.' I should think that is the way most people manage it. To take time off in lieu rather than pay is seen as more egalitarian."

"It is absolutely mad to do it (choose a manager) by length of service. Often in a practice it is not the senior partner who has got the most aptitude for practice managing, and very often that means the whole thing is a complete shambles."

A principal

There is some acceptance that the principle of appointing a principal on length of service is inappropriate.

"The term 'senior partner' is becoming almost out of date. Some practices have an executive partner because the senior partner can't cope with the situation."
"I don't like the term 'senior partner', I really don't. Implying that one rules over everything.

A senior partner

"There are times when the senior partner needs to be more of a figurehead, needs to take a decision and lead in a crisis."

A partner

"My role as senior partner would be to coalesce the whole partnership into a team with ownership of our group objectives."

A partner

"I tend to be the one who innovates. I tend to be the one who tries, tests out new ideas and says to my partners: 'How about this?' My wife says I try too hard."

A senior partner

"If you are a good senior partner then you do not see it as a dying breed."

A senior partner

In these quotations we are hearing ideas about 'natural dominance'; that some form of leadership, explicit or implicit, is inevitable.

However even this is debated, and several people have said something along the following lines:

"I would certainly not claim to be the senior or executive partner - we are a group of four and would deem ourselves equal."

A senior partner

A partner should be equal. Professionals need no leader. A partnership still needs a leader of some sort.

Marshall Marinker has pointed out that the danger of an equal partnership is that it will only move at the pace of the slowest partner [Siddy 1987]. But all leadership, because it has access to power, is open to abuse.

"There are practices where the senior partner takes more money and their holidays are when they want."

"I am a female GP who has just joined her first practice. Another woman partner and I are on a fixed 25% share each and the senior partner is on a 50% share. We all do an equal surgery and out of hours cover. He will not discuss anything with us except surgery times."

Dwyer 1985 p 33

There is additional evidence that if a leader were not appointed, one would emerge. A particularly strong practice manager said:

"I don't like to say I see myself in charge of the GPs. I prefer the OED's definition of leadership - 'Getting things done through people, the ability to influence people.' And that, for a lot of the time, is what practice managers are doing."
"Many doctors are actually run by some elderly lady who sits at the front desk - and they are not unhappy. Their life is reasonably sorted, but the power is actually there."

"There is always the danger that doctors will dominate everything anyway."

Part of the art of effective leadership is allocating resources, including manpower.

Discipline or re-allocating or removing people from their posts is seen to be a doctor's Achilles' heel.

"Most GPs, if you are talking about it (sacking incompetent staff) will run a million miles."

"When confronted with how the disciplinary procedure works, the GPs back down; they don't like the idea of somebody being disciplined."

"In medicine we have a funny type of partnership in that if you feel that a partner is not matching up to the standards it is extremely difficult to get rid of them."

"You can get an authoritarian senior partner who could impose his will if he was strong enough. But he can't fire someone, it has to be the partnership who say 'OK, we will do this."

"The other difficulty is that I like everybody here. We have all lived with one another as trainer/trainee and there is this funny relationship which still continues and it is difficult to be tough."

Underlying the conflict about whether or not a leader is necessary, and whether or not the senior partner is an outdated role, is some confusion about authority, responsibility and management style. Some people confuse the concept of leader with style (often authoritarian); some people want the leader to have responsibility, but are not willing, trusting or sure enough to give that leader the authority to carry out their role successfully.

General practice could be said to be in crisis now - philosophically over fundholding; economically over allocation of scarce resources. It is the researcher's assumption that a partnership of professionals may work well under certain conditions, but it is very difficult for professionals not to represent only their own vested interests when there is a conflict over ideology or scarce resources.

The result of poor or inappropriate leadership was described by one GP as creating "a wasps' nest."

There are moves to reconcile this conflict by appointing executive partners [Journal of RCGP May 1987 editorial], or chairmen, and the GP partners becoming directors of the board [Williams 1986]. These suggestions are gaining popularity slowly, they do encourage GPs to see
management as part of their responsibilities and should increase pressure from them for formal training in order to accept this new part of their role.

Partnership splits, like most divorces, are very painful affairs and take a heavy toll of the partners' emotional energy and time. It may be that some of them happen because of implicit struggles about leadership. The resolution of partnership problems could be easier if this were made explicit. It would be wrong, however, to assume that solving the leadership problem in general practice would solve the dilemma faced by Dr Tobias in 'The patient as piggy-in-the-middle' (Appendix J). It might be a small first step in co-ordinating a response relating to the current problems of the size of some budgets and methods of allocating funds.

**Outside Interests**

There are a great many potential outside interests:

- To do with the development of the profession (e.g. RCGP/BMA)
- To do with the administration of the professions (e.g. FHSAs/MAAGs)
- Specialist clinical experience (e.g. in hospitals)
- Private health services
- Writing
- Research
- Working with lay groups (e.g. St John's, Red Cross)
- Business opportunities (e.g. nursing homes)

These can be major sources of learning for the individual (and, therefore, potentially for the practice) and they can be a major source of envy and dissension.

People who become GPs are expected to stay in one job for longer than those who are on an organisational career ladder. Outside interests provide for some a much needed source of stimulation and, in some cases, useful income. Different practices have different methods of accounting for and allocating that income, but it is often an area where there is an underground layer of mistrust.

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<tr>
<th>Outside interests</th>
<th>Outside interests take the doctor away from patients and cause problems over earning and allocating income.</th>
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<td>bring new perspectives and knowledge which benefit the practice.</td>
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"Dr X was on the Audit Committee but, because of the hours of overtime, I think he has dropped it."

"Our partnership agreement states that external work has to be declared and approved. Everything we do is discussed."

"I took a great deal of stick for being made chairman (of an advisory committee), yet it brings in the practice £3,000 a year."
"We have one of the partners who has unfulfilled ambitions. It is difficult. Dr X has got his buzz by going into the business world."

Bosanquet and Leese [1989] found that doctors from innovator practices were more likely to have outside posts (82%) compared to 75% of traditionalist practices.

**Teams**

Practices all see teamwork as important, but have achieved varying degrees of co-operation and support. Practices claim to work hard at the social side of teambuilding - sometimes this refers just to the Christmas Party, and sometimes to a whole calendar of events.

Some practices go on teambuilding exercises (during practice weekends) and invite consultants in to work with them. One senior partner (who thought he had failed) said that his role was to coalesce the whole partnership into a team with ownership of the group’s objectives.

There is a common understanding that effective teams allow one member to dominate for one facet and another to dominate for something different. The difference is in domination over process or content. In one practice this had become a "cellular structure of responsibilities" with little cross-communication. In another practice the team had quite clearly defined each participant’s skills along Belbin’s model [1981], and drew upon those skills.

"If you are going to deliver effective primary care, it is on a team basis."

"My biggest problem is really making everybody within the organisation feel part of a team."

"We have had practice weekends where we have gone away together. We try to build up our team not only through work but also through social gatherings."

"Some partners pool the parity payments because they say it destroys the parity feeling."

"One of the problems is that we have an almost cellular system at times which is difficult to break down ......... You get reception, nursing, doctoring, finance, health visiting, as separate areas."

"The cellular structure challenges the practice manager’s authority."

"I chose to work for this partnership because they are a happy group. I have seen others and wouldn’t want to work with them."

"I have worked for two other practices, and this is the one which works best."

| Good teamworking is about shoulderering a fair share of the responsibilities of the practice. | Good teamwork is about understanding the strength and weakness of each individual’s contribution, and thus of the team, and working to improve its performance. |
There were also beliefs that good teamworking was about socialising together, about "being happy" and about fair or equal pay.

The literature on effective teamworking is convincing. Belbin's study [1981] identified the useful people to have in teams and showed, through a series of carefully controlled groups, that mixed type teams with at least one person of intelligence are most likely to succeed. Where teams are aware that they are missing a 'type' they can cover that gap between them; if they are not aware of the gaps, or if the group is too unbalanced, the team will fail (see Appendix K).

In 'Superteams', Hastings, Bixby and Chaudry-Lawton [1986] also looked at how successful teams manage their environment, gain their information and have exceptional leaders. The chapter on leadership described the need to create visions, to anticipate events, to create a climate for success and to manage and communicate about team members' performance.

This type of language is foreign to many GPs. They would laugh hollowly at phrases such as 'create a climate for success', yet if they cannot work in an environment where they feel successful, they will become very depressed.

**Decision-Making Procedures**

There were three ways to decision-making in practices revealed in the interviews.

1. **Abdication/Consultation**

   "We are not very good at making decisions. When we do (make them) we are not good at pumping the action through."

2. **Persuasion/Imposition**

   "I think the senior partner is most useful in persuading people to come to a decision."

   "One really has to bypass consultation sometimes, I really do. Because there are some people (not necessarily the argumentative ones) who are waiting for the senior partner to say 'This is the way it is going to be', and they are relieved."

3. **Decision-Making Protocols**

On a major issue - total agreement.

On a less major issue - 5/7 votes.

On a minor issue a simple majority.

The practice manager usually decides the level of the decision and oversees its implementation. The practice manager has an equal vote with the principals.

Mistrust creeps in when people seem not just unequal in decision-making but also unequal in the amount of work involved. There was an example of decision style 1. losing the opportunity to rebuild a badly-needed surgery under the cost rent scheme.
**Change**

Is there an ambivalent attitude towards change? On the one hand, GPs see others who resist change as being negative but, on the other hand, when change comes to them it is an imposition. There is also an attitude that change will always be with us, therefore we design a structure to cope with it.

There was some evidence of what the Prince of Wales called "innovation fatigue" [major policy speech on education 23.4.1991]. The dominant feeling here was that imposed change meant more problems for little gain.

However, there was also evidence of a feeling from those who were becoming fundholders that "It is the old-fashioned who do not like change" and this they applied to other surgeries and to recalcitrant members of their own staff.

Below could be a continuum of attitude towards change:

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<tr>
<th>Your changing me is bad.</th>
<th>Change will always be with us.</th>
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<tbody>
<tr>
<td>My changing you is good.</td>
<td>We will design a way of coping with this.</td>
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Variables for moving along the continuum could include: age, sex, education, training, exterior threats and available information.

**Transitions**

These are some changes which the interviewees commented upon over the last few years:

- from benign professionalism > aggressive management
- from patient orientation > administration
- from being doctors > being clerks
- seeing patients > complying with the new contract
- senior partner earned more and worked less > senior partner earns the same, works the same plus some ill-defined extra responsibility

**Belief Systems and Doctors**

One GP, who is also ordained, was described as "very competent indeed with patients"; another GP, who does a lot of church work, was described as "more interested in church work than medical work".

| Shared beliefs enable the practice to work more smoothly. | Beliefs are irrelevant at best. At worst they divert attention from the main purpose. |
During the life of this study one of the GPs who was interviewed several times left a practice he had worked in because:

"In the end the difference in our beliefs became most important. It was a painful parting because we had all put a lot into the practice, but our differing attitudes over issues such as abortion meant that I had to leave."

**Education**

Education was seen as empowering if it was self-directed. The advance of knowledge and pace of change meant that the need for education was universally accepted. The areas for dispute were mainly about who directed the education and what resources (time and money) were available for it.

"Training came along and people became trainers to stop middle-aged doctors getting complacent."

"We could have filled management courses five times over."

"To be fair to them, the FHSAs would see their activity as being educational."

"Audit is meant to be an education, an academic exercise."

There was a feeling of anarchy around. It was felt that as soon as a group of doctors became 'establishment' they were to be avoided:

"We will probably hold audit meetings away from postgraduate centres, so it is out of their control."

Within practices there was an opportunity for education: doctors might invite primary health care specialists to a practice meeting so they could all learn; pharmaceutical company representatives called; and consultants were reported as becoming keener on liaising with GPs and attending GP meetings since the implications of fundholding might mean that the money would follow the GPs' perception of an effective consultant.

At the time of writing undergraduate education was still focused on people as diseases and was concentrated on the diagnosis/prognosis model. This meant that the undergraduates found going through a simple process, such as 'Describe what is necessary to set up a clinic', was very hard work indeed.

**Educational Opportunities for GPs**

1. GP meetings at postgraduate centres.
2. Literature: BMJ, Lancet, etc.
3. Audit groups.
4. Practice meetings.
5. Short courses.
6. Visits from pharmaceutical representatives.
7. Video tapes.
8. Balint-type groups.

At the time of writing there was little opportunity for GPs to visit other practices and/or to review their own or others' consultations.

| Education is essential. | Education needs time and money. |

**Clinical v. Management Skills**

The clinical work was seen as the cornerstone. It was understood that:

"Good management does not necessarily indicate good patient management."

However the two were interlinked:

"Are you a good doctor if you only see one-third of the patients you are supposed to see?"

There was evidence that GPs wanted and needed more training in management, business and people skills.

"We need a good manager. We can't as clinicians be expected to give the time that is asked of fundholding."

"Doctors are trained in clinical work, not in business skills and little in people skills."

"Fundholding is a test of a doctor's capacity to manage."

"They (the other partners) are a difficult lot to manage."

"It is only when they get to working in a GP practice that they have any concept of seeing people as people and not just diseases."

There was some evidence for this bold assertion by one interviewee:

"The most central important thing to the GP is this feeling of patient dependence."

And one doctor felt that patients would value his services more if they had to pay directly for them - while others felt that money would taint the relationship.

| Clinical work is the cornerstone. | Clinical and management obligations are incompatible. | Clinical and management obligations have to be met for a GP to be competent. |
**Audit**

The interviews revealed that there were very clear differences in perception about medical audit. There was broad agreement that medical audit at its best should be about more than statistics, particularly simple statistics.

"The FHSA has got to thinking about how long people have to wait in a waiting room, and how warm my surgery is, whether my receptionist is welcoming and how long it took to answer the telephone. That can be done by any twerp."

"If we don't do this (audit) someone will step in with a questionnaire about whether the seats are hard. What we are attempting to do is to get doctors to monitor their clinical standards."

McKintyre and Popper [1983] wrote about how we needed to encourage a new environment, where doctors could admit to making mistakes and then not live in fear of professional disdain or legal action, but that those mistakes might be valued as highlighting where improvement might take place. These authors looked forward to a robust independent profession, so open to self-critical analysis that the public would have little need for litigation and the government would have less cause to impose tight contracts.

There was some acceptance that audit was worthwhile:

"Audit is better than just one person's opinion, which is what happens now."

Buckler wrote about the need to audit the organisation as well as clinical standards. He said that it was certainly true that the number of patients seen as well as the quality of care had an effect on competence. Thus he suggested that there was a place for auditing such aspects as: management styles; meetings; workload; access; patient acceptability; practice reports; patient records [1990 pp 145-7].

Most GPs, however, seemed to think of good audit as referring to clinical assessment. This led to groups establishing protocols for the treatment of asthma, for example. The purpose of these protocols was not that they should be mandatory, but that a general practitioner should be able to explain why he had departed from them, if he did.

The irony of medical audit is similar to the irony of education, that is that both education and audit are seen as empowering if they are self-directed. There was a suggestion that there should be a 'group of groups', that audit should be a led activity and that the satellite groups should each produce separate protocols which were then shared. There was another view, that audit was a peer group activity.

"The audit groups will choose their own topics. Doctors like to direct their own education."
"For audit you need a group leader. It is a peer group activity but it must be a led one."

"Audit is best done by people who think it up themselves and decide how to do it themselves. It is not best done by somebody like me going round to practices and saying: 'Right, you should do this.'"

Audit should be a led activity. Audit should be a peer group activity.

There were also differing views about whether audit was compulsory or optional; contractual or educational.

"The reason audit is not written into the contract is that it would have to be resourced."

"The only thing the new contract says about audit is that it is a good thing ....... How it is done is up to each individual."

"GPs would like audit to be primarily educational and voluntary. It is part of the contract; FHSAs are employing GPs as policemen (and calling them Medical Advisors or Medical Directors)."

"(Good) work on audit is setting standards and then finding out where you have met them, finding out where you have not met them, learning why and changing your processes and practices in the process. Contractual audit is largely about providing numbers."

"The DOH has issued quite clear statements saying that audit is an educational exercise."

Audit is for education and voluntary. Audit is for evaluation and is a contractual requirement.

This section highlighted very clearly that one of the major causes of conflict was differences in perception. People would see what they wanted to see - what their experiences, upbringing, language, values, attitudes and beliefs led them to see. (Science offers us only "an aspect of reality" [Polanyi 1967 p 69]. That tacit knowledge affects our perception applies as an inevitable criticism also to this study. Why did this researcher perceive conflict?)

The Role of the GP

Historically the GP evolved from the Society of the Apothecaries. The surgeons and physicians were the elite amongst the early medical profession; the apothecaries were more closely related to the chemists. This 'elitism' has been reflected in the twentieth century by the concentration on hospital medicine in medical school, and the relatively recent emergence (in the
mid 1970s) of vocational training for GPs. There has been a gentlemanly class struggle between the specialisms/the hospital consultants and GPs.

"Hospital consultants are given protected time for audit; this has not been apparent in general practice."

This super- and sub-ordination is even more apparent in the USA, where the wealthy would consider themselves very poor indeed if they had to consult a 'family doctor'. They would ascertain to which specialism their ailment pertained, and decide whether to consult, for example, a dermatologist or a urologist.

The tables are turning in several ways in the UK. Firstly, since the introduction of fundholding, GPs have found themselves for the first time in a position to negotiate with hospitals, rather than being in the position of asking for favours (see Appendix L). Secondly, the movement for holistic and psychodynamic medicine [Balint 1957, Pietroni 1988] puts the specialist at a disadvantage.

| General practitioners are second class because they are generalists. | General practitioners are equal to or more important than specialists. |

There was also evidence that hospital consultants were more willing to get involved in GP postgraduate training programmes, as they realised the potential strength of the purchaser of services.

The question of what is a profession and where does it differ from an occupation is one which has occupied sociologists for many years [Friedson 1970, Parsons 1975, Huntington 1981].

GPs have viewed themselves as professionals, and therefore self-regulating. They object to the implicit belief purveyed in current (1993) legislation that they have abused their freedom and position and require monitoring, or at least educating, to increase their efficiency. Klein [ed. Marinker 1990] wrote that in the 1980s the relationship between the professions and the public shifted from one based on status and trust to one based on contract. Another explanation for the lack of trust did not point the finger of incompetence quite so closely at the medical profession, but did acknowledge that medical science had made so many advances that the role of the doctor today was excessively complicated.

"As therapies become more powerful the public protects itself with more ambitious and punishing litigation."

Marinker 1990 p 2
Whatever the cause of the erosion of trust, it was a potential conflict. The erosion of trust came from the government; from some of the educated population, who wished for autonomy and information about their bodies; and from the public, who would now wonder if they were not getting the best prescription because their GP was cost-limited.

| General practitioners are to be trusted to work in their patients' best interests. | General practitioners cannot be trusted always to work in their patients' best interests. |

That the medical profession would find itself confused about its role was predicted by Sir George Pickering [1977] when he said to the Royal Society that he feared:

"The profession has already chosen the downhill road which will ultimately reduce a learned profession to a technological trades union."

"Is it possible to ensure that doctors are both caring and competent .......... many professionals, especially nurses and social workers, shame doctors by their concern?"

McCormick 1979

Doctors, too, were torn by this conflict, as the definition of 'competence' moved more and more to include complicated technological and medical advances as well as commercial pressures.

| Doctors need to be caring. | Doctors need to be competent. |

One senior partner said that he identified this as an internal conflict in that he was always aware that indulging in sympathy (not empathy) could compromise his judgement.

McCormick went on to propose a solution to part of the problems. He called upon doctors:

"To combine technical competence with a knowledge of its limitations; it is possible to recognise human needs and to allow to Everyman his autonomy and his right to human dignity ......... this requires both wisdom and judgement."

McCormick 1979 p 159

Pay

There was a conflict over a need for a regular income and being paid for the work done.

"Financial management also becomes more difficult as the complexities of GP remuneration produce multiple conflicts with other perceived needs - one has to balance investment in staff and equipment, with maximising the returns to allow further development and still make some profit to support one's family."

Williams 1986 p 160
"I know one practice where they have a regular income, and then anything that is left at the end of the year they will spend on the practice."

"A salaried service would need some medical managers, but I think a lot of people would be happy to opt out."

However, notes of caution were sounded over moving to a salaried service:

"If there was a salaried service would it be like the hospitals - go in and scream because the managers have taken over."

"GPs who actually work as assistants, but who are employed as principals, are not going to give up what they have."

There was at least one practice who would find a salaried service very difficult to implement.

They were very happy with their complicated formula for allocating income:

"We are a very peculiar practice, we have a paid personal list system - some doctors go 'Eughh!' The formula basically rewards the partners for the number of patients they see."

<table>
<thead>
<tr>
<th>GPs should be paid for the work they actually do.</th>
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<tr>
<td>GPs should be paid a regular salary.</td>
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</table>

Bosanquet and Leese [1989] found little opposition to the notion of ‘fee for service’, and innovators were more likely to stress the importance of fee for service income.

Cartwright and Anderson were very against fee for service on the grounds that it would:

"......... encourage inappropriate and possibly harmful patterns of care and increase the cost of health services to the detriment of patients."

Cartwright and Anderson 1981 p 196

Certainly the apparent evidence of experience in the USA suggested that fee for service could lead to overmedication of the rich, undermedication of the poor and an increase in litigation.

Cartwright and Anderson’s suggestion, that doctors who demanded a change to fee for service payment were more likely to be those who regarded a high proportion of their consultancy as trivial, was certainly borne out in this thesis’s small sample.

Isolation

Perhaps because teamwork was so poor, there was a lot of evidence that GPs felt isolated, lonely and out of it.

"There is a fair amount of competition between my partners. I don't know what they are competing about, unless it is money ........ influence?"

"I have given up thinking that the practice is the most important area of my life."
"I am on automatic pilot. I would like to develop fundholding with a new breed of people who are keen to work at teamwork."

GPs like to see themselves as 'nice people' and nice people can not do nasty things. The resulting difficulty in dealing with incompetent staff has already been commented upon. There were others:

"We should get rid of a hunk of the practice which falls under another FHSA. We are unable to do a surgical exercise because the partner there is a rather nice chap. But logically that is the right thing to do."

Some doctors in this practice recognised that this attitude led to an inability to make decisions.

Some have overcome this inhibition:

"Doctors do not like being unpopular. The hardest lesson for a doctor to learn is that not everyone is going to love him. Once you accept that, then life gets a bit easier. When you start out you are under the belief that everyone must think you are wonderful, and if somehow you have failed to impress someone with your goodness and worth, then somehow you have failed."

Of course handling bad news is a stress which affects the doctor/patient relationship as well as the doctor/doctor relationship.

Increasingly through medical training, the students' greatest fear was how to break bad news. Their greatest concern (59% of first year students and 64% of second year students) was how they as individuals would cope emotionally and practically after the news was broken. They also feared harming the patients or relatives by discussing terminal illness. This paper by Sykes [1989] led the GMC to call for improved communication training in schools.

| Doctors must be nice, good, loved and esteemed. | Doctors have to make decisions which hurt people. |

One practice manager saw it very much as her responsibility to deal with these issues. This was someone who was experienced in counselling skills and a practice where the teamwork appeared to be better than normal.

"My role is very much harmonising and facilitating. If anybody isn't happy and I pick it up I will talk to them ......... A fair amount of counselling also goes on to prevent disciplinary problems. That is my responsibility."

"They have never deliberately upset me. We don't like anything festering. We would prefer to have it out in the open."
There was an ambivalence in the role of the practice manager. It could be said that some GPs needed a nurturing or a mother figure to be able to function competently (see p 60). Sometimes the practice manager fulfilled this role. One GP observed:

*It is a strange role - practice manager - it has connotations of chief executive but in other ways it is very much a senior receptionist. It seems to fall ambivalently at different times.*

And a practice manager commented:

*They call me Margaret Thatcher sometimes, but I am very careful never to impose anything on anyone.*

GPs are conditioned by their environment to believe that no feedback is good feedback. The assumption is: *"If a patient doesn't return, they must be better."* In the project organised by June Huntington, social workers - who have been conditioned differently - and GPs were invited to work more closely together [Huntington 1981]. One social worker felt the lack of feedback from the GPs very keenly; on the other hand, when the GP first received feedback he was rather surprised - but quickly came to like it.

| GPs are independent, autonomous beings. | GPs need nurturing and feedback. |

It could be postulated that because of the isolated way and stressful areas in which they worked GPs needed more support than people in most other occupations. For a certain number of GPs the Balint groups [1966] certainly fulfilled this function.

The groups initiated by Michael Balint and continued by his wife, Enid, were concerned with the doctor's role and with understanding the doctor-patient relationship. Michael Balint sought understanding of the consultation as a mutual event. The aim for his groups he stated as a "limited, though considerable, change in personality". He wanted to make doctors feel secure with a more open relationship. He also provided a rare opportunity for doctors to discuss with each other in depth some of their consultations.

There was conflict for some general practitioners about the patient expecting prescriptive advice and certainty:

*In medicine we (doctors) are very arrogant in how we relate to people and some patients want that prescriptiveness.*

And the reality as experienced by some:

*You never know for certain about anything. This sounds falsely modest and trite, but it's the honest truth. Most of the time you are right, and you do appear to know, but every now and then the rules get broken and then you realise how lucky you have been on the
occasions when you think you have known and have been proved correct.*

Berger 1969 p 109

The patient's expectation was put even more forcibly and dauntingly here:

"What is a doctor's job?" I asked a patient, a middle-aged woman who was in hospital with rheumatic heart disease.*

"To keep me alive - and more," she said. "Because, especially now, I don't believe in God any more, really and truly, so the doctor's job is one that never existed before - far beyond any of the others. There were some gods that took care of everything and there was Jesus .......... There was once another world, but since I don't believe in it any more, for me the doctor is now God."* Cassell 1978

Perhaps this is why Dr Clifford found:

"My biggest problem was depressed people and people under stress. This was and is the commonest simple condition I had to deal with. It presented itself in many different ways .......... all I could do was support, listen, advise where it was appropriate and, sometimes, prescribe anti-depressants or tranquillizers .......... All I could offer was my compassion and a transfusion of my own energy. And this was not taught in medical schools."* Clifford 1978 pp 19-20

He also wrote later:

"Dealing with (difficult situations) made me take a long, hard look at myself as a GP. It was too easy with so many people dependent on me to, perhaps unconsciously, develop inflated ideas about myself as a doctor - that I had to solve most people's problems, that I was important." op cit p 112

Byrne [1983] subscribed to a more mechanistic view of health in order to resolve this dilemma when he wrote that a patient might properly expect his doctor: firstly, to help him in preserving or regaining his health; secondly, not to offer authoritative advice about problems (moral, personal or emotional) about which he is not an expert .......... in so far as he does give advice on such matters it is as a friend, not as a physician; thirdly, to offer an adult relationship where he will be listened to and have the nature of their condition and treatment explained; and, finally, to be told the truth (see also Appendix M).

There was a conflict for some between work and family life, particularly for those with younger families.
"A lot of GPs want to have a quiet life. They want to come in, do their surgery, their visits and repeat prescriptions, and then go home."

"When the kids were small I wanted just to do a job and go home. It is almost as if you want to be in a salaried service actually."

| General practitioners want autonomy, authority and responsibility. |
| General practitioners want a quiet life with sufficient time for themselves and their families. |

**Working Single-Handed or in a Group Practice?**

There was a conflict for some GPs about whether to work single-handed or in a group practice. Cartwright and Anderson [1981] found that doctors practising in groups tended to be younger than single-handed GPs. They found that doctors in group practices tended to have a more even distribution of work, more modern and better equipped premises, more ancillary staff, better hospital access and to be more satisfied with general practice.

However another study found that single-handed GPs had found it frustrating when they worked in teams not to see the same patients consistently; to have other doctors "interfering" in their treatment; and to have patients playing doctors off against each other. When operating single-handed they got a great deal more job satisfaction. The author of that study also found that going for a majority decision in the partnership was not sufficient, because the partners who did not agree would not co-operate [Anonymous, Pulse 1977].

"When I asked him whether it was lonely being a single-handed GP, he said 'No', he liked it."

"There are some single-handed GPs who don't feel the need to thrash things out verbally. I expect they survive quite happily."

"Being single-handed, there is no opt out. Patient choice is also restricted, they may want to see someone else."

Of course the conflicts about money presumably did not happen in a single-handed practice.

This was an interesting conflict to look at, because it was largely resolved. Those who wished to work single-handed did, and those who wished to be part of a group practice were. Similarly, in many areas of the country, patients had the choice, too, as to which type of practice they belonged.

**Time**

Time, or lack of it, was a commonly perceived problem. Many of us begin our consultations as patients saying: "I'm sorry to take your time, doctor."
Carney [1987] found that GPs' workload was largely governed by their personality. The greatest usage of patient time was by those doctors who had high recall rates. These doctors tended to be stable extroverts, to have trained locally, to be a trainer, to be male and to be under forty-five. They saw more chronic complaints. Those who had low recall rates saw more acute complaints and were stable introverts.

There were complaints about the nature of the workload:

"We used to see patients; now we hold clinics and process forms."

"That much of this screening is useful is unproven."

"That is another thing with the workload - the things that you have to claim for; remembering to claim for everything; getting the claim in on time."

The most stressful part of the job was commonly felt to be being 'on call'. One trainer felt that was an attitude problem:

"If you put your suit on and go to the surgery, it is a quiet time to get on with work with some, usually easily handled, interruptions. If you are trying to play football with your son, each interruption is unwelcome."

This solution did not cover the problem of night and late evening duties.

Buchan and Richardson (1973) have shown that six minute surgeries regularly overrun by 25%.

"I have increased my appointment time to ten minutes, people are waiting less, I am finishing on what I consider to be on time, and it is much less stressful."

Butler and Calman argued that 10 minutes was the minimum appointment time for a professional consultation, and they estimated that this would require a list of 1,750. In their survey they found that patient bookings ranged from 2.5 to 30 minutes. They concluded by suggesting that, while reducing lists might be a necessary precondition for improving care, it was not a sufficient precondition. Without other incentives to spend time on education and training, doctors might use the time saved for leisure (in itself not a bad thing, but is it sufficient?) rather than on improving care [1987 p 181].

<table>
<thead>
<tr>
<th>GPs can control</th>
<th>GPs cannot control</th>
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<td>their workload and their time.</td>
<td>their workload or their time.</td>
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</table>
SUMMARY OF CONFLICTS

<table>
<thead>
<tr>
<th>Doctors should have authority over allocating financial resources.</th>
<th>Doctors should decide what treatment is appropriate, it is up to the administrators to administrate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundholding is a test of our abilities as managers.</td>
<td>Fundholding is a subversive activity giving government the information it needs to control us.</td>
</tr>
<tr>
<td>We must serve the community.</td>
<td>We must manage a business.</td>
</tr>
<tr>
<td>Mechanistic Model: GPs are a sorting agency referring to specialists.</td>
<td>Holistic Model: GPs are the conductor of an orchestra of orthodox and complementary therapies.</td>
</tr>
<tr>
<td>Stresses the body as a machine.</td>
<td>Stresses participation.</td>
</tr>
<tr>
<td>Doctors should also be political.</td>
<td>Doctors should not be political.</td>
</tr>
<tr>
<td>Computers are essential and welcome in the surgery.</td>
<td>Computers will depersonalise the doctor/patient relationship.</td>
</tr>
<tr>
<td>Computer competence is associated with low interpersonal awareness.</td>
<td>Computer incompetence is associated with high interpersonal awareness.</td>
</tr>
<tr>
<td>Systems and forms are necessary for an efficient general practice.</td>
<td>Bureaucracy has got out of hand and is causing more problems than it is solving.</td>
</tr>
<tr>
<td>Practice nurses could be equal but different contributors with doctors to general practice.</td>
<td>Practice nurses will always be subservient to GPs.</td>
</tr>
<tr>
<td>GPs would not benefit greatly from joint training programmes with other members of the primary health care team.</td>
<td>GPs would benefit from such programmes.</td>
</tr>
<tr>
<td>The Primary Health Care Team needs a leader/co-ordinator.</td>
<td>The Primary Health Care Team does not need a leader or a co-ordinator.</td>
</tr>
<tr>
<td>A partner should be equal. Professionals need no leader.</td>
<td>A partnership still needs a leader of some sort.</td>
</tr>
<tr>
<td>Outside interests bring new perspectives and knowledge which benefit the practice.</td>
<td>Outside interests take the doctor away from patients and cause problems over earning and allocating income.</td>
</tr>
</tbody>
</table>
Good teamwork is about understanding the strength and weakness of each individual's contribution, and thus of the team, and working to improve its performance.

Change will always be with us. We will design a way of coping with this.

Beliefs are irrelevant at best; at worst they divert attention from the main purpose.

Education needs time and money.

Clinical and management obligations have to be met for a GP to be competent.

Audit should be a peer group activity.

Audit is for evaluation and is a contractual requirement.

GPs are equal to or more important than specialists.

GPs cannot be trusted always to work in their patients' best interests.

Doctors need to be competent.

GPs should be paid a regular salary.

Doctors have to make decisions which hurt people.

GPs need nurturing and feedback.

The doctor is human.

Executive responsibility.

GPs want a quiet life with sufficient time for themselves and their families.

GPs cannot control their workload or their time.

Doctors need to be caring.

GPs should be paid for the work they actually do.

Doctors must be nice, good, loved and esteemed.

GPs are independent, autonomous beings.

The doctor is God.

Family life.

GPs want autonomy, authority and responsibility.

GPs can control their workload and their time.
Conclusion

Conflicts that the GP experienced came from:

a) the system
b) the partnership and different working groups
c) their own expectations of self.

There were potential solutions to many of them, and because GPs were so individual it might be that the solutions have also to be individual. Partnerships where rewards were fair, openness was encouraged and a decision-making strategy was agreed seemed to be happier places in which to work than those where these conditions did not apply. The RCGP suggested developing the role of the practice manager and the executive partner [Atkinson 1987]. Those partnerships where they had appointed a chairman and a board of directors [Williams 1986] were enthusiasts for this approach. Some general management training and a teasing out of the options might enable partnerships to work out their own way forward. Chapter IV explores the theory of conflict in more detail.

Deutsch [1980] defined conflict as existing whenever incompatible activities occur. In the reduction of conflicts to two alternatives, it is not intended to suggest that all conflicts were bipolar. The intention is merely to show that these two conflicts were already there. There might well be others.

The question is when is conflict productive and when is it counterproductive? How can it be controlled, or co-operation brought in when necessary?

Summary of 'Crude' Law of Conflict

<table>
<thead>
<tr>
<th>Competition/Conflict is Enhanced by</th>
<th>Co-operation is Enhanced by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of tactics, coercion, threat or deception. Enhancing power differences. Poor communication minimizing awareness of similarities in attitudes and increased sensitivity to opposed interests. Suspicious and hostile attitudes.</td>
<td>Similarity in beliefs and attitudes. Readiness to be helpful. Openness in communication. Trusting and friendly attitudes. Sensitivity to common interests and de-emphasis of opposed interests. Enhancing mutual power.</td>
</tr>
</tbody>
</table>

Work must be done because patients have to be cared for and the profession needs to remain an attractive career choice for the future. The last word goes to one of the interviewees:

*GPs are at a crossroads where they could be at a gateway. The potential is very exciting in terms of service to the community, but they could be backed into a corner and just do the minimal amount.*
CHAPTER IV

CONFLICT IN GENERAL PRACTICE

Introduction

This chapter attempts to review the literature and to explore at a more theoretical level some of the many conflicts currently experienced in general practice. The purpose of this chapter is to explore the philosophical, psychological and sociological nature of conflict.

The survey conducted for this research suggested that conflicts were made worse by inadequate or poor leadership (see Chapter VI: Leadership within the Practice). Leadership could operate at a national, local, professional and/or partnership level. The sources of such conflicts lay in the economic and political system; the groups working towards health care; and in the role of the GP itself.

Conflict is not necessarily negative, it can be a spur for great growth, change and harmony. The preconditions for the positive resolution of conflict will be explored later.

A Philosophical Background

At a time of great national turbulence in the NHS, one aspect of conflict - the political and economic - comes to the fore. The contention is, however, that this is only one of the types of conflict which GPs are struggling to resolve. The purpose of this paper is to begin to look at those conflicts in the hope that ultimately analysis will lead to some enduring and worthwhile solutions.

Conflict comes from the Latin 'conflictus', the act of striking together, or fighting. What is striking what? Webster's [1981 p 476] talked about a:

"clash, competition or mutual interference of opposing or incompatible forces or qualities (as ideas, interests, wills)"

it also referred to:

"an emotional state characterised by indecision, restlessness, uncertainty and tension resulting from incompatible inner needs or drives of comparable intensity".

A conflict is also a prolonged engagement between men at arms and a conflict of laws is a "striking or clashing together of material bodies or substances" [op cit]. Another description of conflict [Fowler 1964 p 254] was as a "collision, clashing". It is a fight and a struggle, both literally and figuratively.

Thus conflict includes a notion of an enduring force and of opposing forces with no obvious or easy point of reconcilement. It is also a struggle of principles, both physical and metaphysical.
The fact of warring opposites not only describes the way things are, but also poses problems for psychologists, moralists, economists and politicians to solve.

Opposition was seen by the philosophers to be at the root of all change and in investigating this, at first sight a depressing concept, the first message of hope appeared.

Plato spoke in Phaedo:

"Are not all things which have opposites, generated out of their opposites? I mean such things as good and evil, just and unjust .......... I mean to say that anything which becomes greater must become greater after being less."

Phaedo 1952 pp 226-227

Aristotle reminded us that in the world of contraries it was not necessary for one to be true and one to be false.

"Health and disease are contraries: neither of them is true or false."

Aristotle I p 18

Spinoza [1952 p 398] was not so optimistic. He proposed that if contrary natures tried to co-exist:

"There would be something in that subject able to destroy it."

Though he did go on to argue that:

"Hatred is increased through the return of hatred, but may be destroyed by love."

op cit p 409

Therefore presumably if contrary natures mutated they might be able to co-exist.

Aristotle seemed to think that all contradictions must be resolved in favour of one of the opposites. Kant (1724-1804) appeared to think that some contradictions could not be resolved at all, and Hegel (1770-1831) proposed the resolution of all contradictions, not by choice between them but by synthesis uniting the opposites and reconciling their differences.

In Hegel's 'Philosophy of History' and in his theory of the development of the state in the 'Philosophy of Right', he argued that the conflict of ultimately interdependent opposites - of opposite classes or forces in society, of opposite political institutions or principles - called for a resolution which should unite rather than exclude the opposites.

Kant argued that change could only happen over time [1952 p 76] and could only be proved to have happened if we experienced it [op cit p 92].

On the conflict between reason and passions, Plato helped us to identify which was in control by looking at outcomes:

"When opinion by the help of reason leads us to the best, the conquering principle is called temperance; but when desire, which
is devoid of reason, rules in us and drags us to pleasure, that power of misrule is called excess.*

Phaedrus 1952 p 120

That desire and reason are a particularly obstinate conflict was illustrated through much (if not most?) romantic literature. Troilus cried:

"Desire and Reason in me ever fight
Desire insists, let force control the day
But Reason counsels quite the other way."

Chaucer 'Troilus and Cressida' p 99

In this case Pandarus counselled mitigating the passion by using reason to help achieve desire.

Archimedes [1952 p 502] reminded us of the importance of the balance of power with his second mathematical proposition on the equilibrium of planes:

"Unequal weights at equal distances will not balance, but will incline towards the greater weight."

The importance of weight or relative power in a conflict is discussed later in this chapter in the section: Conflict and Threats and Promises. Archimedes's mathematical concept was useful if one accepted a conflict as lying between only two parties.

The unpredictability of outcomes in a conflict was illustrated in 'War and Peace' when the author said:

"No battle takes place as those who planned it had anticipated. A countless number of free forces (for nowhere is man freer than during a battle where it is a question of life and death) influence the course taken by the fight, and that course never can be known in advance and never coincides with the direction of any one force. If in descriptions given by historians we find their wars and battles carried out in accordance with previously formed plans, the only conclusion to be drawn is that those descriptions are false.*

Tolstoy 1952 p 571

That conflicts are multi-faceted was highlighted again after Tybalt's death:

"Nurse 'Will you speak well of him that kill'd your cousin?'
"Juliet 'Shall I speak ill of him that is my husband?'"

Shakespeare 'Romeo and Juliet'

Money as a cause of conflict was explored by Marx. It is only touched on here to give it substance as a concept. He argued that money was both power and self-esteem to the capitalist, and the laws of capitalist production:

"...... compel him to keep constantly extending his capital, in order to preserve it"

but extend it he cannot, except by means of progressive accumulation:
"...to accumulate is to conquer the world of social wealth, to increase the mass of human beings exploited by him, and thus to extend both the direct and the indirect sway of the capitalist."

Capital 1952 p 293

Marx discussed at length the inevitable (as he saw it) rebellion arising as the conflict between capitalism and communism/socialism. At the time of writing that rebellion has not really happened, but his comments on class consciousness, money, socialism and power have entered the western ideological debate. In Chapter III: Belief Systems and Doctors, and from the frequency count at the beginning of Chapter VI, it is argued that the debate is also reflected in the differing beliefs of GPs. Burnham [1941] contended that the control of the world was passing into the hands of the managers. His view was that capitalism had virtually lost its power and would be replaced by the rule of the administrators in business and government.

From these discourses some tentative propositions (in the Spinozan sense) can be put forward:

1. Conflict can be verbal or figurative, but the wish to demonstrate it physically increases as the conflict increases. Its potential for violence is what makes it a powerful concept.
2. In any conflict, no matter what the topic, there will be an additional conflict between desire and reason.
3. Some contraries can be analysed by looking at their opposites.
4. Resolving opposites by bringing them together without mutation may mean that they include the seeds of their own destruction.
5. In conflicts neither point of view may necessarily be true or false/right or wrong.
6. Analysis of power is important in analysing conflict.
7. Conflict is not necessarily rational nor its outcomes predictable.
8. Love (desire) and power (money) are two major causes of conflict.

Why Look at Conflict?

The importance of research in this field is highlighted by the proliferation of articles on how GPs should manage their stress levels after the GMSC's report indicating that GPs' mental and physical health was at risk unless their stress levels were reduced [Galloway 1990]. Doctors have a drug addiction rate at least thirty times higher than that of the general population [Lask 1987] and are three times as likely to die from cirrhosis [RCGP 1986] or suicide [HMSO 1983]. Richards put these difficulties largely down to stress, listing as the main problems: heavy workload; on-call commitment; too little time for relaxation; alienation from families and social networks; and difficult professional relationships [Richards 1989]. Anecdotal evidence suggested that these pressures were worsening rather than improving.
Research on occupational stress amongst GPs led to a rash of recommendations in the "popular doctor's magazines" to "take more time off" or "practise relaxation" or even to "cry in the staffroom" [Quilliam 1991]. These were panaceas, differing only from alcohol, drug addiction and suicide in that they were not self-destructive. Panaceas only plaster over conflicts, they do not address or resolve them.

The study by Cooper and Higley of 'Occupational Stress among General Practitioners' [1988] highlighted the high levels of anxiety and alcoholic intake. They argued that these stresses came from the frustrations inherent in the role itself, and that the role of the GP needed to be reanalysed, and probably reconfigured, if it were not to collapse. Burne [1993] argued that the evidence relating day-to-day stress with ill health was inconclusive. However he did accept that there was evidence linking anxiety and depression to ill health. He had a more valid argument when they pointed out that stress management courses might be enjoyable in the short term but had little long term effect. In the conclusion to this thesis it is argued that personal management is only one aspect of reducing stress and conflict. Organisational and educational issues are also important.

During the life of this study the topic of stress related to doctors gained an even higher profile. The BMA [1992 (b)] produced a lengthy document studying stress and the medical profession.

Unresolved conflict causes unproductive stress. Some evidence was found that acute stress produced tumour growth [Eysenck 1983] and Type A coronary-prone behaviour [Cooper and Higley 1988 p 97]. These are dangerous pressures when the role of the GP is becoming increasingly pivotal in providing a national health service [HMSO 1989].

A Review of the Literature on the Social Psychology of Conflict

The seminal work on conflict was written by Deutsch in 1973. He defined a conflict as existing whenever "incompatible activities occur" [1973 p 10]. In the survey used in this thesis, the words 'problem', 'conflict' and 'difficulties' are used somewhat interchangeably. The notion of painful incompatibility is inherent in all three of those words. Conflict may, however, still occur when there is no dispute about the overall goal, therefore 'conflict' and 'competition' are not explaining a similar phenomenon.

Deutsch divided conflict into inter (and intra) personal, inter (and intra) group and inter (and intra) nation. For the purpose of this thesis we shall look at:

1. **Individual conflict** - i.e. psychological conflict, perhaps between what a person does and what they wish to do.
2. **Intragroup conflict** - conflict within a group, for example between partners in a practice.

3. **Intergroup conflict** - conflict between two groups, for example conflict between practices and the FHSA.

Deutsch also divided conflicts according to their type:

- **Veridical Conflict**: This type of conflict exists objectively and is perceived accurately. Deutsch gave the example of two people needing to use the only spare room for incompatible activities. It is difficult to solve amicably unless there is co-operation between the parties or unless they can agree upon a binding, impartial mechanism (e.g. arbitration).

- **Contingent Conflict**: The conflict exists in the eyes of the conflicting parties, but there is another option (e.g. a spare attic) not readily perceived by them.

- **Displaced Conflict**: The manifest conflict (e.g. money) may cover up the underlying conflict (e.g. love). Deutsch suggested that resolving, albeit temporarily, the manifest conflict would make it easier to deal with the underlying conflict, which the protagonists may feel has terrifying implications.

- **Misattributed Conflict**: Faulty attribution may encourage conflict. One of the inevitable concerns of groups interested in producing social change is to reduce misattribution.

- **Latent Conflict**: Consciousness raising groups try to make their members aware of a conflict which they had previously not recognised.

- **False Conflict**: Conflict when there is no objective basis for it. Such conflict implies misperception or misunderstanding [Deutsch 1973 pp 12-14 (abridged)].

Deutsch argued conflict could be divided into five types of issues:

1. Control over resources.
2. Preferences and nuisances.
3. Values (what should be).
4. Beliefs (what is perceived to be).

A common question is: What is the difference between constructive and destructive conflict? Deutsch identified the difference by looking at the outcome. If the parties were more satisfied afterwards, then the conflict had been productive.

The next question is not - How can we eliminate conflict? but - How can we make conflict productive? In managing conflict Deutsch suggested it was useful to know the following:

1. What the respective parties would consider a reward or gain, and a punishment or loss.
2. The prior evaluation of the other party (good, bad, untrustworthy, etc.).
3. The nature of the issue giving rise to the conflict (its scope, rigidity, motivational significance, formulation, periodicity, etc.).
4. The social environment within which the conflict occurred and the facilities (or otherwise) available for resolving such conflict.

5. The interested audiences to the conflict. For instance, if the conflict took place in the public spotlight the course of conflict might be greatly influenced by the participants' conceptions of their audience and how it would react.

6. The strategies and tactics used by the parties. The processes of bargaining, influence and communication include coercion, persuasion, blackmail, ingratiating and seduction.

7. The long and short term effects that the conflict would have on the parties concerned.

Deutsch studied with Lewin. Lewin's work included looking at the nature of groups and their powerful influence on the individual. His main contention was that the totality of events is a "lifespace" determined behaviour at any one time. Thus Deutsch's analysis of conflict was much richer than that put forward by those who operated much more from a behaviourist point of view.

**Individual (Intrapsychic) Conflict**

The consistency theorists (Abelson, Festinger, Heider, McGuire, Osgood and Rosenberg) [e.g. see also p 84 in Worchel, Wood and Simpson 1992] argued that people would seek to eliminate inconsistency if it appeared. Thus they would attempt to act in a way consistent with their beliefs, but also they would attempt to make their beliefs consistent with their actions. This could mean that people who had suffered pain in the course of a chosen path stuck more rigidly to that path in order to justify the earlier pain. The pragmatists, however, were more inclined to write off their losses.

The role theorists [Merton 1967] argued that the occurrence of different types of internal conflict would be influenced by an individual's position or role. A doctor, for example, might experience conflict in prescribing for patients versus keeping costs down for the partnership. Secondly, they said that open defiance of a social norm was likely to be more costly for those in highly paid rather than in lowly paid positions. Thirdly, if individuals suffering role conflict organised themselves into groups the individual would have social support as he sought environmental restructuring and resisted entrapment in the dilemmas of conflicting demands.

The psychoanalytic theorists argued that some internal conflict arose from denial. Anxiety was the result of unconscious conflict and Erikson [1964] provided an interesting list of the characteristics of a strong ego required to enable the individual to handle internal conflict: hope, will, purpose, competence, fidelity, love, care and wisdom. Deutsch stressed that ego strength developed from a moderately high degree of success in coping with a moderately difficult and demanding environment [Deutsch 1973 p 45].
This concept of emotional maturity has been explored by many involved in the psychotherapeutic technique. The behaviourists [e.g. Honey 1980] sought to create emotional maturity by altering or manipulating behaviour. This had been shown to be useful in a therapeutic relationship, but the philosophy "We can only know that which we observe or do" has limitations in exploring a greater understanding. Precisely because of its speculative nature, the search for a greater understanding has to be entered into with caveats.

An example of a review of this search was covered by Lindgren. To him emotional maturity:

"........ means growth and a capacity for self-direction. The mature person is one who is helpful, productive, creative and able to perform these functions effectively and with reasonable efficiency."

Lindgren 1953 p 8

Lindgren also listed some reactions to threat. It is possible to postulate that with the growth of government interference and increasing patients' expectations, some GPs might feel under threat. Lindgren argued that the emotionally mature and immature have very different responses to threat:

<table>
<thead>
<tr>
<th>Reactions to Threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) running away</td>
</tr>
<tr>
<td>b) seeking protection of someone more powerful (dependence)</td>
</tr>
<tr>
<td>c) immobilization</td>
</tr>
<tr>
<td>d) attack the source of threat</td>
</tr>
<tr>
<td>e) displace anger by attacking others or things</td>
</tr>
<tr>
<td>f) defensive tactics - arguing or lying</td>
</tr>
<tr>
<td>g) surrender</td>
</tr>
</tbody>
</table>

**The Mature Reaction to Threat** is to view it as an occasion calling for skill and intelligence, a problem to be solved.

Lindgren 1953 p 67 (abridged)

Lindgren also postulated that some anxiety was caused by inner conflicts [p 71], and listed the common defenses against anxiety: compensation, sublimation, substitute activity, conformity, fantasy, regression, compulsiveness, obsessions, psychosomatic symptoms, accident proneness and suicide. He argued that maladjustment could be produced both by inner conflicts and environment. The lists below are worth re-reading in the light of changes in 1991/92 in the world of general practice.
Factors in Employment that Tend to Produce Frustration

1. Disassociation
2. Loss of identity
3. When progress is seen exclusively as a virtue - you fail if you do not progress
4. Resentment towards 'management' (arising from employee's dependence?)
5. When employee's skill is seen as a tradable commodity

Emotional Climates that Produce Maladjustment

1. Authoritarian
2. Competitive

Factors in Employment that Foster Good Adjustment

1. Where employment helps in giving identity
2. Each employment situation is seen as unique
3. There is opportunity for self-expression

Deutsch made several propositions as a result of his study of intrapsychic conflict. Two that were important to this research were:

**Proposition No. 5:** Unacknowledged or unconscious conflict is more difficult to resolve than conflict that is recognised by the parties involved.

**Proposition No. 6:** Conflict that is resolved by a more powerful tendency suppressing or repressing the weaker one, without the extinction of the weaker tendency's underlying motives, leads to the return of the repressed tendency in disguised form whenever the vigilance or defences of the more powerful tendency are lowered.

If internal conflict did arise from repressing feeling Hochschild [1983] would also argue that the results were serious. Her study of flight attendants suggested that they were more prone to:

".......... sickness .......... situational depression, alcoholism, more drugs, more trouble sleeping and relaxing .......... because of the task of managing an estrangement between self and feeling."

Hochschild 1983 p 131

Doctors frequently referred to "heartsink" patients, but rarely conveyed to the patient in question how they felt when they walked through the door. When the feeling was expressed the result for the individual could be surprising:

"Something finally snapped. I told him that he was a nuisance to my staff, to me and to the ward sister; that he smelt and continuously broke his promises .......... I felt much better."

Anonymous GP, personal communication to researcher 18.6.1992
Conclusions on Individual Conflict

Individual conflict could be avoided or more easily dealt with when the individual had a strong ego and was emotionally mature. Individual conflict was likely to be suffered by some GPs because:

(a) The nature of the patients' dilemmas that they faced daily frequently caused GPs to have to confront (or avoid) their own 'Pandora's box' of anxieties.

(b) The environmental changes had caused role conflicts between being a doctor and becoming a business person.

The Balint [1966] groups played an important role in helping GPs deal with individual conflict. Some of the GP trainers' forums seemed to encourage a similar sharing of problems as well as providing factual input.

As some GPs become convinced that counselling and individual therapy can help some patients, so they may become more open to seeking individual help for themselves. A national counselling scheme was set up in the UK in 1985. Doctors may refer themselves or seek advice about colleagues. There has been no way of monitoring outcome or assessing effectiveness [BMA 1992 (b) p 64].

One leading psychotherapist with several GPs attending for therapy said:

"The major problem that my GPs are facing at the moment is boredom - the same old problems trooping through their door day after day."

Anonymous, personal communication to researcher 26.8.1992

Environmental factors also have a part to play in relieving intraphysic conflict. The stresses caused by night and weekend duties have been well-documented [BMA 1992 (a)] and were substantiated again by the results of the survey in this thesis.

The table below summarises many of the factors to be considered in the prevention and management of individual stress and conflict.
### Stress Management and Prevention

<table>
<thead>
<tr>
<th>ORGANISATIONAL LEVEL PREVENTATIVE MANAGEMENT</th>
<th>INDIVIDUAL LEVEL PREVENTATIVE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task and physical demands</td>
<td>Stressor directed</td>
</tr>
<tr>
<td>Task redesign</td>
<td>Managing perceptions of stress</td>
</tr>
<tr>
<td>Participative management</td>
<td>Managing the work environment</td>
</tr>
<tr>
<td>Flexible work schedules</td>
<td>Lifestyle management</td>
</tr>
<tr>
<td>Career development</td>
<td>Response directed</td>
</tr>
<tr>
<td>Design of physical settings</td>
<td>Relaxation training</td>
</tr>
<tr>
<td>Role and interpersonal demands</td>
<td>Physical outlets</td>
</tr>
<tr>
<td>Role analysis</td>
<td>Symptom directed</td>
</tr>
<tr>
<td>Goal setting</td>
<td>Counselling and psychotherapy</td>
</tr>
<tr>
<td>Social support</td>
<td>Medical care</td>
</tr>
<tr>
<td>Team building</td>
<td></td>
</tr>
</tbody>
</table>

S Palmer 1991 p 57

#### Intragroup Conflict

The definitions of a group seemed to cover slightly different but important aspects of group life. In order for a group to be a group, according to Brodbeck, it must have observable, interpersonal relations; for Newcomb, it must have shared norms; the psychoanalytic view said that it had a common 'object model' (leader) or the same method of relieving conflicts; and Lewin cited concrete, dynamic interrelations and interdependence as essential characteristics [Cartwright and Zander 1968]. A GP partnership is certainly a group by any or all of these definitions.

Social psychologists have studied groups through most of this century to try and understand the power of group behaviour. Much of the seminal work quoted in this section dates from the late 1940s until the early 1960s. Simpson and Wood [Worchel, Wood and Simpson 1992 p 3-7] gave several reasons for the paucity of useful research in the intervening thirty years. They suggested that: the individual was a simpler unit upon which to base social psychological study; quantitative statistics tended to decompose the units studied into smaller units rather than larger social structures; social psychologists began to prefer single factor explanations rather than distal multifactor explanations; an individualistic perspective emerged from the late 1950s and group research was more time consuming and difficult. More recent research has been carried out on intergroup negotiations, principally using versions of the Prisoners' Dilemma Game [Rubin and Brown 1975]. This is referred to later in the chapter in the section: Trust and Co-operation.

Bales [1958] was a behaviourist who produced a categorisation of interaction within groups. His analysis encouraged groups to reduce conflict by giving positive reactions; posing questions and attempting answers; and discouraging negative reactions.
As far back as the late nineteenth century, researchers were trying to establish which performed best: individuals, co-operative groups or competitive groups.

From the psychoanalytical school, Bion [1961] said that conflict in groups often produced banal and tense experiences. He found that this conflict was between the individual and his needs,
the group mentality and the group culture. Group culture he defined as the need the group has for structure and, in particular, for leadership. He also identified three negative group defense mechanisms: fight - flight (maybe in the form of an attack on the leadership); dependency (on structure and rituals); and pairing (an animated discussion between two group members which Bion also saw as a leadership challenge).

Sometimes negative group dynamics have their origins in the task the group has to perform. Main [1956] described tensions in behaviour on surgical and psychiatric wards.

**Group Decision-Making**

Asch [1956] suggested that an "isolated" individual would yield to the opinion of an obviously incorrect majority to avoid appearing different. Those expressing views at variance with the majority would experience considerable pressure to conform.

Research on whether groups took more or less risky decisions than individuals was not entirely conclusive. However, Wallach, Kogan and Bem [1962] argued that groups did take decisions which had more risk attached to them than those taken by individuals because there was a diffusion of responsibility. The "risky shift" phenomenon might also be explained by the processes used to make decisions. In analysing foreign policy, Janis [1968] documented six major defects in decision-making which could lead to failure to solve problems adequately. These defects were the consequences of 'groupthink'.

### Defects which are the Consequences of Groupthink

1. Discussions are limited to the minimum number of alternatives.
2. The group fails to re-examine the course of action initially preferred by the majority from the standpoint of non-obvious risks and alternatives.
3. The group fails to re-examine the course of action initially seen as unsatisfactory.
4. The group fails to use sources of expert opinion.
5. The group uses selective bias in evaluating expert opinions; it shows interest in supportive information and ignores facts and opinions to the contrary.
6. The group spends little time discussing how the initially preferred course of action might be hindered by usual bureaucratic accidents, etc., thus they fail to investigate contingency plans to cope with foreseeable setbacks.

Without confrontation the decision of the group can be literally catastrophic. Whilst personal doubts are suppressed and the illusion of unanimity maintained the value of individual contributions to the collective decision is minimized. Cohesiveness is maintained at a high price.
Some Processes Used to Make Decisions

Rational Decision-Making can occur using combinations of the following:

1. **Consensus**: all members of the group must agree and be committed to a decision.
2. **Majority**: a simple majority would be 51%/49%.
3. **Sliding Scale Majority**: the group decides what level of majority decision (e.g. 60/40 or 80/20) is necessary to implement the decision successfully, and then discusses the issue.
4. **Subjective Expected Utility**: found by multiplying the subjective probability of an outcome occurring by the utility of that outcome. This would form a decision tree analysis.
5. **Criterion Referenced Decision**: the group agrees the criteria that must be met, then examines the alternatives in the light of those criteria.

Hall and Watson [1970] found that groups could produce better quality decisions, achieved greater creativity and performed at a higher level than the most skilled individual member if they followed the following instructions:

1. Avoid arguing for your own rankings: present your position as lucidly and as clearly as possible.
2. Avoid 'win-lose' statements in the discussion of rankings; discard the notion that someone must win and someone must lose.
3. Avoid changing your mind only to avoid conflict and to reach agreement and harmony.
4. Avoid conflict-reducing tendencies such as majority votes, averaging, bargaining and the like.
5. View differences in opinion as both natural and helpful rather than as a hindrance to decision-making.
6. View initial agreement as suspect - explore the reasons underlying apparent agreements.

Leadership and Intragroup Conflict

Weber [1964] distinguished between three kinds of authority: **charismatic** authority based on the outstanding characteristic of the individual; **traditional** authority, based on respect for custom; and **rational legal** authority based on a code of legal rules and regulations. The role of senior partner has been a traditional one, based on length of service for many practices. This is no longer appropriate.

As Bennis and Namus [1985] pointed out:

*Decades of academic analysis have given more than 350 definitions of leadership* and have provided multiple interpretations. None has been complete or unequivocal. Each has reflected on the paradigm of the researcher; on personality, behaviour, environment or relationships.
Most working groups accept the need for a leader without question. They may have conflict over whether the leader or their style is appropriate, but rarely conflict over whether or not there should be a leader. There is, however, a continuing academic debate about whether or not there is a difference between leadership and management.

A few professional groups work outside this hierarchical paradigm; barristers and GPs are notable in this context. Some solicitors and accountants work as partnerships and some university departments claim collegiate leadership. The questions then are:

a) Can partnerships or leaderless groups be sustained in the current climate?
b) If yes, then what conditions will lead to their success?
c) Where partnerships decide upon having a leader, how should that leader behave and be chosen to ensure the most successful working of that partnership?

The purpose of this section is to review briefly the literature on leadership and some answers to the questions are proposed in the final chapter.

The classic study of leadership style was done by the colleagues of Lewin, White and Lippitt [1960], who were interested in the effects of different styles of leadership. They looked at the leadership of young people. Although Figure 11 (overleaf) contains dated information, it has become a seminal work in the study of leadership styles.
**Authoritarian** | **Democratic** | **Laissez-Faire**
---|---|---
All determination of policy by the leader. | All policies a matter of group discussion and decision, encouraged and assisted by the leader. | Complete freedom for group or individual decision, with a minimum of leader participation.

Techniques and activity steps dictated by the authority, one at a time, so that future steps were always uncertain to a large degree. | Activity perspective gained during discussion period. General steps to group goal sketched, and when technical advice was needed the leader suggested two or more alternative procedures from which choice could be made. | Various materials supplied by the leader, who made it clear that he would supply information when asked. He took no other part in work discussion.

The leader usually dictated the particular work task and work companion of each member. | The members were free to work with whomever they chose, and the division of tasks was left up to the group. | Complete nonparticipation of the leader.

The dominator tended to be 'personal' in his praise and criticism of each member; remained aloof from active group participation except when demonstrating. | The leader was 'objective' or 'fact-minded' in his praise and criticism, and tried to be a regular group member in spirit without doing too much of the work. | Infrequent spontaneous comments on member activities unless questioned and no attempt to appraise or regulate the course of events.

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White and Lippitt 1960 p 319

Figure 11 Leader Behaviour and Member Reaction in Three 'Social Climates'

They checked to see whether the leaders did in fact behave differently; they classified all the remarks made by leaders to the group members (some of their results are summarised below) and showed that at least leaders were able to follow the instructions given them. The main question now is whether these different styles had any effect on the groups' behaviour. An abstract from their results is given below.
LEADERSHIP STYLE

<table>
<thead>
<tr>
<th>Percentage of leaders' responses classified as:</th>
<th>Authoritarian</th>
<th>Democratic</th>
<th>Laissez-faire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Giving orders</td>
<td>45%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Giving knowledge or information</td>
<td>15%</td>
<td>27%</td>
<td>49%</td>
</tr>
<tr>
<td>Praise or approval</td>
<td>11%</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

White and Lippitt 1960

Table 2 (a) Leadership Style

LEADERSHIP STYLE

<table>
<thead>
<tr>
<th>Percentage of time spent by group members:</th>
<th>Authoritarian</th>
<th>Democratic</th>
<th>Laissez-faire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working</td>
<td>74%</td>
<td>50%</td>
<td>33%</td>
</tr>
<tr>
<td>'Out and out loafing'</td>
<td>0%</td>
<td>0.2%</td>
<td>5%</td>
</tr>
<tr>
<td>Playing</td>
<td>2%</td>
<td>13%</td>
<td>33%</td>
</tr>
<tr>
<td>Working when adult absent</td>
<td>29%</td>
<td>46%</td>
<td>11%</td>
</tr>
</tbody>
</table>

White and Lippitt 1960

Table 2 (b) Leadership Style

In many ways this research can be seen as a study which stimulates questions rather than provides solutions. These findings have found their way into the common folklore of leadership training. However Maier [1963] carried out an experiment on problem solving which showed that groups with a strong leader (instructed to "lead the discussion, encourage argument and get agreement") achieved considerably better results than the 'laissez-faire' convenor/rapporteur. Maier claimed that the quality of thinking in a democracy was thus dependent on the opportunity it offered for minority opinions to be heard. These propositions rest implicitly on the frustration-aggression-displacement theory of ethnocentricism. This theory assumes that authoritarian leadership is more frustrating than democratic forms. Fiedler [1964], however, suggested that democratic leadership was less frustrating than authoritarian leadership only when the conditions were neither extremely favourable nor extremely unfavourable to obtaining a group consensus.
Personality and Leadership

Mann [1959] concluded, from studying 1,400 different studies of the correlates between personality and leadership, that personality was positively related to leadership.

<table>
<thead>
<tr>
<th>Mann's View of Studies of Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership is positively related to:</td>
</tr>
<tr>
<td>Total No. of Studies</td>
</tr>
<tr>
<td>Intelligence in 50% of studies (182)</td>
</tr>
<tr>
<td>Adjustment in 33% of studies (150)</td>
</tr>
<tr>
<td>Extraversion in 33% of studies (113)</td>
</tr>
<tr>
<td>Dominance in 43% of studies (36)</td>
</tr>
<tr>
<td>Masculinity in 16% of studies (68)</td>
</tr>
<tr>
<td>Radicalism in 29% of studies (59)</td>
</tr>
<tr>
<td>Sensitivity in 15% of studies (98)</td>
</tr>
</tbody>
</table>

White and Lippitt 1960

He did not discriminate between the quality of these different attitudes, and his theory is now dated, but modern leadership academics are returning to the view that personality has a significant impact on leadership success. Adair said:

*The qualities needed to lead are very similar to the qualities needed to be part of a team.*

Adair 1992

He argued that leadership was also a function of the needs of the time, and that the qualities needed might change as the environment changed.

Two points arose immediately: How was personality assessed? and: How was the quality of leadership defined?

Cattell and Stice [1954] tackled the question of leadership in what was then a novel way. They were interested not only in the structure and roles within a group but also in how these interacted with individual variations in the type of group. Comparing the ways in which different groups tackled their problems, they concluded that there were four types of leadership role:

(a) **The problem-solving leader**, that is, the member of the group who was rated by observers as having most influence on the group.

(b) **The salient leader**, the person agreed by raters to have been most important in the group.

(c) **The popular leader**, chosen by the group *after* their activities as having shown leadership.

(d) **The 'elected leader'**, a self-explanatory term.
Intragroup conflict can be a function of:

- inappropriate leadership
- groups feeling threatened
- groups unaware of the strategies available for decision making or interacting
- or of individuals with low ego strength, little motivation or skill being inappropriately imported into the group.

The balance between confrontation/cohesiveness is crucial. Too much confrontation and the group will break up in disagreement; too much cohesion may lead to insufficient exploration of the courses of action.

**Intergroup Conflict**

The objectives of this section is to review the literature on intergroup conflict as it might apply to conflict between partnerships and other government employed groups. In Chapter 1 of this thesis it was established that there is a history of conflict between GPs and social workers. Interviews also established that there is some conflict between GPs and FHSAs, DHAs and government policy.

Much of the literature on intergroup conflict refers to conflict between nations, class or race. This will only be referred to if it has some bearing on the types of conflict that this thesis is addressing. The other source of literature which will be reviewed is that of conflict in organisations. GPs represent a conundrum in that they are technically (and sometimes emotionally) self-employed, yet they also form part of the workforce of the UK's largest employer - the NHS.

**In-Groups and Out-Groups**

Ethnocentricism is the term used to describe groups who over-evaluate their own work; have an increased liking for their own group members; have greater in-group cohesiveness and who pressure deviates within the group to conform. The conflict arises with other groups because this orientation also leads to a tendency to devalue the out-groups products and increased rejection of and hostility towards the out-group members [Campbell 1965].

The scapegoat theory can be seen as part of the frustration-aggression hypothesis of psychoanalytic theory. It suggests that if a group's goal is blocked it leads to frustration which produces aggression. If the frustrating agent is too powerful to be attacked then the aggression is displaced and redirected towards a non-offending, less powerful, individual or minority group.

The question is: What forces more groups one way or another along the following continuum?

| Positive Intergroup Attitudes | Negative Intergroup Attitudes |
Conflict and Competition

Sherif and his co-authors conducted experiments with youngsters which suggested that competition encouraged conflict and superordinate goals (goals which could only be reached through intergroup co-operation) and increased co-operation. Conflict can lead to ethnocentrism, which can become self-reinforcing and polarising with a greater and greater regard for the in-group, and a less and less realistic view of the out-group.

Deutsch agreed, and said that a competitive process tended to:

1. Produce unreliable and impoverished communication.
2. Stimulate a win-lose scenario.
3. Lead to a suspicious, hostile attitude which increases the perception of differences and minimises the awareness of similarities.

Sherif et al. 1961 p 353

The work of Tajfel [1971] suggested that the mere division of people into groups encouraged discrimination and conflict. This applied when they were in the position to give differential rewards and penalties to their own group and to others. Conflict between groups has frequently been studied using a role playing exercise called 'The Prisoners' Dilemma'.

The implications of this work are far-reaching and suggested that, where groups had interaction, the conditions needed to be carefully managed to prevent conflict and minimise prejudice and discrimination. However, Schuessler [1989] based on a different version of the Prisoners' Dilemma game, found that egotistical co-operation did exist. The orientation of the researcher may be as important here as any research findings. Nevertheless, there was evidence to support the rational idea that intergroup co-operation declined when there was competition for scarce resources [Giles and Evans 1986].

Self-esteem is affected by the position of one's group relative to other groups, and ethnocentrism will tend to occur either when the members of the group feel a need to bolster their image or when groups are in a position where inequitable distribution of reward is possible.

Deutsch had four propositions which are relevant here.

**Proposition I** Co-operation that is elicited by coercion is likely to be minimally productive and less economical as well as less reliable than co-operation that is self-chosen.

**Proposition II** Participants' characteristics are moulded as a function of the importance and duration of any social relationship.

**Proposition III** Interaction tends to develop habits, customs, institutions, attitudes and ideologies .......... There will be a tendency for the interaction to persist in its initial forms, despite objective changes in the situations of the interacting parties.
**Proposition IV** The claim to inherent superiority (whether it be of legitimacy, morality, authority, ability, knowledge or relevance) by one or another side in a conflict makes it less likely that a conflict will be resolved co-operatively.

Deutsch 1973 pp 119-123 (abridged)

**Conflict and Threats and Promises**

Deutsch reviewed research which suggested that while illegitimate threats (based on no apparent need) were viewed with coldness and suspicion, even legitimate (rationalised) threats were not viewed with favour or warmth. Promises were viewed much more positively as a method of inducing co-operation, particularly when the promise related to a group or individual's real need [p 131]. Deutsch also pointed out that when threats or promises which persisted did not have a clear time frame, the constraints or augmentation persisted, often out of inertia or habit. A promise could not then be withdrawn without causing a grievance and a threat lost its power. Mounting threats might not increase their influence; a promise that was honoured reluctantly or begrudgingly because of its costs was less likely to elicit positive attitudes and responses than a reward which was bestowed enthusiastically. This has been seen in action with the government proposing a 'clawback' scheme to take money from GPs because the government felt that GPs had received excessive compensation for fulfilling the new contract. However, excessive promises are also seen as negative because they led to a feeling of being bribed.

**Other forms of Influence**

Refusal to co-operate might arise because:

1. the idea had simply never occurred to the group
2. the group did not know how to implement the idea
3. the group knew what should be done, but feared they were incapable
4. the group believed that the idea would not work, given the current (1993) environmental obstacles.

As Deutsch pointed out, there were clearly effective forms of influence available here: education, discussion, training and removing some of the environmental obstacles.

**Trust and Co-operation**

Deutsch did not regard trust as an altruistic belief. He argued that it arose out of the group's perception of the immediacy and positive or negative nature of the outcome. He said:

"There is a good deal of psychological research to support the proposition that the immediate present is a more potent influence upon behaviour than the distant future."

The Prisoners' Dilemma [Rubin and Brown 1975] is an exercise that has been repeated time and time again to try and identify some of the influences on groups. The groups who were briefed
to be co-operative produced trustworthy behaviour even when there was no communication or additional information.

Froglich and Oppenheimer [1984] found statistical relationships between altruistic decisions and party affiliation. He suggested that problems of socialisation were a major factor in predicting altruistic behaviour.

**Conflict and Communication**

From the Prisoners' Dilemma Deutsch proposed that the following forms of intergroup communication enhanced co-operation:

1. expression of one's co-operative intention
2. expression of one's co-operative expectation
3. expression of one's planned reactions to violations of one's expectations
4. expression of a means of restoring co-operation after a violation of one's expectations has occurred.

Alexander [1979] reinforced the message that problem-solving messages and supportive types of communication were positively associated with conflict reduction.

**Conflict and Mediation**

Outside mediation bodies (e.g. ACAS, United Nations) have been shown to have some success in reconciling conflict. If mediation is to be likely to be successful, and the rules adhered to, the following conditions need to apply:

<table>
<thead>
<tr>
<th>Mediation is likely to be successful, and the rules adhered to when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The rules are known.</td>
</tr>
<tr>
<td>2. The rules are clear, unambiguous and consistent.</td>
</tr>
<tr>
<td>3. The rules are perceived to be fair.</td>
</tr>
<tr>
<td>4. The other adheres to the rules.</td>
</tr>
<tr>
<td>5. Violations are quickly known by significant others.</td>
</tr>
<tr>
<td>6. Adherence to the rules gains significant social approval (and violations gain significant social disapproval).</td>
</tr>
<tr>
<td>7. Adherence to the rules has been rewarding in the past.</td>
</tr>
<tr>
<td>8. The application of the rules in the future is seen as in everyone's best interests.</td>
</tr>
</tbody>
</table>

Deutsch 1973 p 381

Other third party interventions have been studied [Fisher 1983] and include:

- communications group
- laboratory learning
- confrontation design
- action learning
- fact finding and diagnosis
- discussions, videotape and recommendations
- confrontation and problem solving
interpersonal skills training
sensitivity training
lectures, discussions and extra-curricular activities

This list represents thirty-six different case studies or experiments. The only method which reported a problem (termination of consultation) was action learning. All the other studies reported improvements in attitudes, understanding and relationships. Fisher argued that impartiality was obviously an important factor, but that the studies were insufficiently quantitatively substantiated.

Brookmite and Sistrank [1984] found that time pressures produced more contract settlements in the high time pressure situation than in the low time pressure situation. They said intergroup climates could be quickly transformed (either positively or negatively) when one party clearly acted inconsistently with what was characteristic of that climate. In yet another version of the Prisoners’ Dilemma, Lindskold et al [1986] demonstrated that threat, insult or challenge increased competition and that conciliation encouraged co-operation at all times.

**Strategies in Conflict Resolution**

Wendell [1985] provided a useful summary of creative and peaceful approaches possible for dealing with conflict. These are listed below for the reader seeking inspiration and ideas for solving conflicts they are currently facing.

**Unilaterally Take An Initiative Hoping to Influence an Adversary**
1. Graduated Reciprocation in Tension-Reduction
2. Acceptable Fait Accompli
3. Tacit Agreements
4. Influencing Opponent’s Choice of Negotiator by One’s Own Choice

**Call in a Third Party**
1. Sophisticated Mediation
2. Settlement and Arbitration
3. Final Offer Arbitration
4. Control by a Disinterested Third Party
5. Financier Imposed Solution

**Change the Parties Involved**
1. Ignore an Un-cooperative Contender
2. Introduce a Common Adversary
3. Out of Character Positioning (e.g. Prime Minister Thatcher entering the ERM)
4. Changing to Higher Echelons
5. Pinpointing Co-operative Officials
6. Coalition-Building by Scattered, Peaceful Forces

**Seek Common Interests on which to Build**
1. Superordinate Goals
2. Synergy
3. Upgrading of Common Interests
4. Fractionation of Conflict
5. Potential Agreement Discussions
6. Functional Analysis of Disputes (reducing the issue)
7. Maintenance of High Aspirations and a Problem Solving Model
8. Functionalism (e.g. joint space exploration programmes)

Bring in Subject Unrelated to the Object of the Dispute
1. Package Deals
2. Prelude Goals (aim to achieve the lesser more easily attainable goals)

Change the Realm in Question
1. Switching from a Political to a Technical Solution
2. Switching from a Political to an Economic Solution
3. Switching from the Preconditions for Negotiation to their Implications
4. Conversion of Intangible Goals to Tangible Ones

Reveal New Facts or Meanings
1. Discovering the Opponent's Domain of Validity
2. The Trollope Ploy (accepting an offer never clearly made)

Integrate or Assimilate
1. Formation of a Security Community (contenders drop their defenses against each other and defend against outsiders jointly)
2. The 'If You Can't Beat 'Em' Technique (maintain an armed truce)

Disintegrate or Separate
1. Separation of the Unacceptable

Propose a Resolution of a Dispute Early
1. The Insurance Principle (you can draw on a disaster fund if you have contributed to it)
2. Minor Powers' Concerted Appeal to Major Powers' Best Intentions

Postpone the Resolutions of a Dispute while Trying to Build Trust
1. Identification and Ignoring of Intractable Issues
2. Incremental Change (or Muddling Through)
3. The Seizing of Opportunities to Carry Out Secret Policies

Postpone the Resolution of a Dispute while Trying to Build Disgust or a Cooling-Off of Tension
1. Disgust-Building (eventually one side prefers to give in because it is all too much trouble)
2. Holding Action (leave the initiative to the other side)

Untie a Double Bind
1. Simultaneous, Interdependent Actions (e.g. loan, and industrial development)

Change the Institutions
1. Unusual Modification of Existing Institutions
2. Establishment of New Institutions
3. Alteration of the General System

Remove Violence from the Contest, but Continue the Contest
1. Weak-Power Non-violence (non-military protest, non-cooperation or non-intervention)
2. Great-Power Non-violence (e.g. USA urging people in another country to move in a particular direction)

Increase Your Credibility rather than the Amount of Your Offer

1. The Escrow System (e.g. put aside funds to prove willingness to settle)

Vary Procedural and Substantive Approaches

1. Avoidance of Undesired Precedents (ensure this action is seen as unique)
2. The Little Kids’ Cake-Splitting Method (one divides the cake, the other has first choice)
3. Agreement on Procedures
4. Agreement to Violate an Agreement (if a violation occurs there will be a conference)
5. Random Decision
6. The Moot (either achieve a consensus or live with no decision)
7. Single-Text Negotiation (the single text is constantly modified by each side in turn until a compromise is reached)
8. Avoidance of Tactics (do not use any tactics, let the protagonists be creative)

Use an Effective Group Dynamics System

1. A Neutral Person Chairs Meetings of Adversaries (e.g. Dag Hammarskjold)
2. Controlled Communication (e.g. Bales)
3. International Encounter Group (to build trust)
4. The Problem-Solving Workshop (using creative brainstorming techniques)
5. Mutually Acceptable Restatement of Arguments
6. Feeling-Out Procedures (if I will, then would you?)

Make the Request Acceptable

1. The ‘Yesable’ Proposition

Make the Request Fair

1. Principled Negotiation (focus on legitimacy, practicality and lack of pressure)

Provide for Face-Saving

1. Effective Timing to Save Face
2. Unilateral Settlement After Secret Negotiations
3. The Disownable Concession (concessions proposed through an intermediary who can become a scapegoat if the adversary is not interested in the proposal)

Convert the Opponent

1. Persuasion to or Acceptance of New, Integrative Values

Rationalise the Opponent’s Position

1. Rationalisation of a Loss
2. The ‘Donkey Beaten over the Head’ Interpretation (grant public attention to the adversary’s grievance in return for lowering other demands)

Give a New Meaning to the Object of the Dispute

1. Coupling (interpret moves as an increase in détente)
2. Decoupling (find an objective basis)

Accept a Settlement for Reasons Different from the Opponent’s

1. Common Means for Different Ends
2. Acceptance of New Goals

[ Walsh 1985 abridged]
Organisational Development and Conflict

At the turn of the twentieth century the early thinkers on organisation design [Fayol 1949 and Taylor 1947] were attracted to the thought of organisation for efficiency and economies of scale. This task orientation continued until the 1940s and 1950s when, in the post Second World War climate, studies of motivation began to suggest that the peer group, self-actualisation [Maslow 1970] and the nature of the task itself [Herzberg 1966] had an impact on people’s desire to work together.

The 1960s marked the beginning of a long period of the dominance of organisations by the finance director. It became hard to argue for a philosophy that could not be counted. It is this profit orientation which has dominated British business ever since. The introduction of such notions as “management by objectives” [Drucker 1964] asked people to commit themselves to certain levels of performance. If they achieved these levels of performance they were promised monetary (and, sometimes, status) rewards. The GP’s Red Book is a modern method of management by objectives. During the time of writing this thesis, the Red Book fee payable for night visits tripled to £45.00. Many GPs openly admitted increasing their number of night visits.

“We felt that if we were going to be accused of having our hands on our wallets (a reference to a jibe made by K Clarke, the then Secretary of State for Health), we might as well do just that. We now consciously work to maximise our income.”

Anonymous GP 12 August 1992

Fresh doubt has been cast on the efficacy of performance related pay by the Institute of Personnel Management [1992]:

“The trouble with performance related pay is that it motivates 20% of employees at the expense of the other 80%.”

Whitfield 1992

In 1976 Handy put forward his now classic analysis of how organisations evolve as follows:

the power culture (dominated, as it were, by a Zeus)
the role culture (where people are known and function by their titles and roles rather than as individuals)
the task culture (frequently represented as a matrix organisation)
the people culture where the organisation only exists to serve the needs of individuals (e.g. barristers and, perhaps, some GPs).

Handy also described how he saw organisations changing over time.
As far back as 1958 academics studying organisational development were pointing out that an organisation was not an island. Dill said that contemporary theories should take into account four major groupings other than the organisation itself:

- customers
- suppliers (of materials, labour, capital, equipment and work-space)
- competitors (for both markets and resources)
- regulatory groups (including governmental agencies, unions and interfirm associations).

Dill 1958

Organisational Structure and Conflict

Bennis [1966] argued that bureaucracy and hierarchical organisations were out of date. He saw a direct conflict between hierarchies and an individual's need for autonomy. This argument has been strongly stated for groups of professionals who feel their authority and self-regulation being threatened. He said that there were negative and unintended effects of authoritarian rule when, in fact, the nature of the challenges facing organisations and the movement for personal growth have increased the need for interdependence. He argued that leadership was "too complex for one-man rule" [p 221].

Argyris [1967] also believed that traditional pyramidal structures tended to place individuals and departments in interdepartmental warfare. He said that competition polarised stances that tended to get resolved by the superior making decisions, thereby increasing dependence on them. Argyris was more in favour of matrix structures.

The problem is, in terms of organisational design, are we in danger of substituting one form of conflict for another? Pondy [1967] argued that the bureaucratic model encouraged vertical conflict, where the supervisor between clerk and manager was "the man in the middle" who identified with either side at the peril of damaging relationships with the other. But, according to Pondy, the matrix organisation was no panacea, for it resulted in lateral or intergroup conflict. The recent (1993) emphasis on 'downsizing' and flattening hierarchical organisations will reduce, but not

<table>
<thead>
<tr>
<th>Entrepreneurial</th>
<th>(formalisation of centralisation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Growth</td>
<td>(formalisation of decentralisation)</td>
</tr>
<tr>
<td>Decentralised Growth</td>
<td>(formalisation of multistructure)</td>
</tr>
</tbody>
</table>

Figure 13 Organisations Changing over Time and with Increasing Size
eliminate, the opportunity for vertical conflict. Vertical conflict is made much worse if an inappropriate leadership style and atmosphere is present.

Pondy suggested reducing lateral conflict in matrix organisations by:
(a) reducing dependence on common resources;
(b) loosening up schedules or introducing buffers (e.g. contingency funds);
(c) reducing pressures for consensus.

**Organisational Change and Conflict**

"Anyone who has ever planned major organisational change knows:
(a) how difficult it is to foresee accurately all the major problems involved;
(b) the enormous amount of time needed to iron out the kinks and get people to accept the change;
(c) the apparent lack of commitment on the part of many to help make the plans work; manifested partly
(d) by people at all levels resisting making the necessary modifications."

Argyris 1967 p 205

Terreberry [1968] exhorted organisations to become consciously adaptive. His work predated the popular works on organisation change (such as Kanter's 'The Change Masters' [1983] and 'When the Giants Learn to Dance' [1989] and Peters's 'Thriving on Chaos' [1988]), and he planted the seeds well. He said that most organisational change was:

- externally introduced and that adaptability requires a flexible structure;
- advance information of impending externally induced change;
- active searching for more advantageous inputs and outputs;
- a large available memory store.

Overleaf is a diagram showing the five main problems Bennis [1968] identified for contemporary organisations.
## Human Problems Confronting Contemporary Organizations

<table>
<thead>
<tr>
<th>Problem</th>
<th>Bureaucratic solutions</th>
<th>New twentieth-century conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Integration</strong></td>
<td>The problem of how to integrate individual needs and management goals.</td>
<td>No solution because of no problem. Individual vastly over-simplified, regarded as passive instrument or disregarded.</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>The problem of managing and resolving conflicts.</td>
<td>The 'rule of hierarchy' to resolve conflicts between ranks and the 'rule of coordination' to resolve conflict between horizontal groups. 'Loyalty'.</td>
</tr>
<tr>
<td><strong>Adaptation</strong></td>
<td>The problem of responding appropriately to changes induced by the environment of the firm.</td>
<td>Environment stable, simple and predictable; tasks routine. Adapting to change occurs in haphazard and adventitious ways.</td>
</tr>
<tr>
<td><strong>'Revitalization'</strong></td>
<td>The problem of growth and decay.</td>
<td>?</td>
</tr>
</tbody>
</table>

Figure 14 Human Problems Confronting Contemporary Organizations

Probably the best work on managing change is by Beckhard and Harris [1987]. They applied powerfully and with clarity the problem solving model to organisational transitions.

They stressed the importance of identifying resisting forces and of the chief executive acting as a role model. The model for the whole process is shown below.
Professionals Within Organisations

The sociologists debate whether or not professionals are helpful in society. On the one hand is the argument that they are a positive force standing against both individualism and collectivism; on the other hand is the view that they are monopolistic oligarchies which need outside control. Johnson [1972] reviewed twenty-one authors' views on what constituted a professional and identified six main common threads:

1. skill-based theoretical knowledge
2. the provision of training and education
3. the profession tests the competence of its members
4. the profession has an organising body
5. the profession demands adherence to a professional code of conduct
6. there is a notion of altruistic service.
Johnson identified the dilemma for a professional within an organisation between balancing administrative and consumer needs. He argued that outside controls might destroy colleague relationships and neutralise the hitherto self-imposed controls.

On the whole, salaried professionals have neither exclusive nor final responsibility for their work. They have to accept the authority of non-professionals but Wilensky [1972] said that the effects of that authority could be ameliorated if the organisation itself was infused with a large percentage of professionally trained employees and whether the services of the professionals involved were scarce [p 491]. The question is how much might an organisation enfeeble or how might it empower the GP?

The conflict between professionals and organisations is over power. Firstly, the power to work as they wish and have been trained to do; and, secondly, power over their own career development.

Career Development and Organisations

Career success in organisations is measured by the yardsticks of money, power and prestige rather than the spontaneous involvement of work for its own intrinsic and fulfilling nature. In this sense the professional within an organisation can either:

(a) conform, or
(b) seek to professionalise the organisation.

If it is contemplated that GPs should become members of (indeed, create) organisations, then they would be in a better position to affect the nature of those organisations than many.

Handy [1984 and 1989] described some futures for work and introduced the idea of portfolio careers, when people subcontracted their working lives to a variety of employers in a variety of ways. This is an important notion which will be picked up in the conclusion.

Out of the theory of action research came action learning as a method of organisational change. In 'The Learning Organization' Garratt [1987] pointed to the lack of strategic direction and understanding of their responsibilities exhibited by some company directors. He also argued that they needed to act as role models of excellence.

There are several reasons why GPs in their new roles need to develop learning skills. As Argyris pointed out: "Success in the market place increasingly depends on learning." [1991 p 99] Changes in the market place, in technology, in patient expectations, in organisational structure - these all build up to a vast amount of learning. Argyris argued that, because many professionals were almost always successful, they rarely experienced failure. And, because they had rarely
failed, they had never learned how to learn from failure. So, whenever they did fail, they became defensive. In a sense, their very success at education made it harder for them to learn.

Argyris called powerfully for a change in attitude so that both defensiveness and organisational impediments to effectiveness could be uncovered. He suggested doing this by using a case study which highlighted very similar issues to those the organisation and its employees were experiencing. Then, with an experienced consultant, carrying out the transfer of learning for their own situation.

Drucker [1992] asked: "Who will take care of the common good? Who will define it?" He said that today's challenge was to make the pluralism of autonomous knowledge-based organisations rebound both for the benefit of economic performance and for political and social cohesion. Part of that is the challenge for which tomorrow's GPs have to be educated.

**Summary**

This chapter has reviewed the inherent nature of conflict. It has looked at the literature on conflict within an individual, within a group and between groups. It has collected suggestions from the literature on methods of reducing or redirecting conflict and the implications of these suggestions will be explored in Chapter VII.
CHAPTER V

THE SURVEY: DESIGN AND COMPARISONS WITH OTHER STUDIES

Conflict emerged as the BSP from the interviews, the meetings and the literature search. The next question to be addressed was: How widespread is this conflict and in what areas is it most painful? Although conflict is frequently seen as a bipolar concept, it was not the purpose of the survey to reduce conflict to this state. Thus the survey used the terms 'conflict', 'challenge' and 'difficulties' interchangeably. Appendix N shows the complete questionnaire with the final frequencies and the correspondence that circulated with it.

Questionnaire Design

The study was to be cross-sectional, and a major objective was to achieve a response rate of over 70%. The design of the questionnaire was crucial to achieving this response rate, and three pilot surveys were conducted before an acceptable design was established. The study was implemented along the lines suggested by Oppenheim (1966). They suggested ten stages:

1. Deciding the aims of the study.
2. Reviewing the relevant literature; discussions with informants and interested bodies.
3. Designing the study and making the hypothesis specific to a situation.
4. Designing or adapting the necessary research methods and techniques; pilot work and revision of research instruments.
5. Designing the sampling process.
6. Field work.
7. Processing the data.
8. Statistical analysis.
9. Assembling the results; testing the hypothesis.
10. Writing up the results.

Oppenheim 1966 p 2

Figure 16 Stages in Questionnaire Design

The rest of this chapter will proceed according to these headings.

1. Objectives of the Questionnaire
   (1) To identify the major difficulties or conflicts by frequency and by potency.
   (2) To identify whether the following independent variables had any relationship with those conflicts:
       gender of respondent
       status of respondent (senior partner or partner)
       partnership size
practice manager employed
children
age
full time/part-time
location
average list size
training/non-training practice.

(3) To establish whether or not there were different views on the roles of the senior partner.

(4) To establish how satisfied today’s GPs were with their work and to see if there was a relationship with any of the independent variables in (2).

(5) To collect suggestions on overcoming conflict.

2. Reviewing the Literature; Discussions with Interested Bodies

The literature on the evolution of general practice methodology and managing conflict is discussed elsewhere. Apart from Oppenheim, the texts studied were:

Black [1990] looking at using statistics in social science research
Reid and Boore [1987] looking at research methods and statistics in health care
Schuman and Presser [1981], who wrote at length on experiments in question form, wording and context
Berdie and Anderson [1974], who wrote a clear overview of when the whole survey process is appropriate and how to improve response rates.

Wright [1986] was the main textbook used to identify the most appropriate statistical tests to use.

The RCGP provided insights into the range and depth of surveys that they had previously carried out. The BMA sent details of their survey ‘Your Choices for the Future’. This was a major survey which went to all GPs in the UK in January 1992. The Surrey Local Medical Committee {LMC}, the BPMF, and the Humberside and Surrey FHSAs all offered practical help and advice.

Dr Richard Maxwell reviewed the results of this survey in the light of his survey of stress amongst GPs in western England [PhD thesis to be published 1993/4].

3. Designing the Study; Research Questions

Research Questions

1. That there are some areas which cause conflict for GPs in their working lives.
2. That some areas cause more conflict to most GPs than others.
3. That there may be conflict between perceived importance, time taken and enjoyment in the job of a GP.
4. That senior partners feel differently about their perceived role and responsibilities than other partners.
5. That the frequency of practice meetings does not affect the perceived usefulness of them.
6. That job satisfaction can vary by:
   - size of practice
   - gender
   - age
   - age of children
   etc.
4. **Designing or Adapting the Necessary Research Methods**

**Pilot I**

The first pilot identified the main conflict areas and had two scales. This pilot was sent to twenty GPs who had indicated an interest in helping the research. Nineteen were returned (with one doctor on maternity leave), with the comments that the categories were important but the scoring scales were confusing. In fact the two scales were almost three, with degree of conflict, irrelevance and resolution combined into one scale and salience in the second scale. An extract from Pilot I is shown below.

---

**ASSESSMENT OF CONFLICT IN GENERAL PRACTICE**

Please would you complete this assessment. It is only being sent to a tiny selective sample, so if you are unable to complete it, please would you send a nil return. Respondents will be sent a copy of the paper 'Conflict in General Practice', if they would like one (see below). We cannot send the paper out in advance because we do not wish to bias your initial replies.

The purpose of this questionnaire is to try and prioritise conflicts faced by a GP. There may well be others. It would be appreciated if you would note any others which occur to you, or reword or comment on any of these questions if that would make them easier for you to complete.

In the right-hand column you are asked to O if you think the numbered statement is an important concept for GPs as a whole in the UK and X if you think the statement is unimportant.

All individual results will be kept completely confidential in accordance with the British Psychological Society's Conduct Code.

In my practice
- this is an area of:
  - 1 = No conflict because it has been resolved
  - 2 = No conflict because the statement is irrelevant
  - 3 = A little conflict
  - 4 = Some conflict
  - 5 = A lot of conflict
  - O = Important
  - X = Unimportant

**CONFLICT IS REDUCED WHEN:**

**Teamwork and Leadership**

1. Partners hold similar beliefs and values
2. Partners work well as a team
3. Partners have a clear and acceptable leader or co-ordinator
4. Partners have good interpersonal skills
5. The Primary Health Care team has a clear and acceptable leader or co-ordinator

etc.

---

Figure 17  Questionnaire: Pilot I
Pilot II

As a result of discussions after the first pilot a five point scale was introduced with potency reduced to the statement: Please rank in order of importance the question numbers which cause you most problems.

The subheadings grouping the conflicts were eliminated because it was suggested that this would lead to bias.

---

ASSESSMENT OF MANAGING
CONFLICT IN GENERAL PRACTICE

Below is a list of areas where some GPs have experienced conflict. The purpose of this questionnaire is to ascertain how widely spread and how difficult these conflicts are. There may well be other conflicts, if they occur to you would you please note them on page 3.

Respondents will be sent a copy of the paper 'Managing Conflict in General Practice Successfully', if they would like one (see page 3).

Please tick the line which most accurately completes the sentence for you.

<table>
<thead>
<tr>
<th>Never any conflict</th>
<th>Conflict in the past, now resolved</th>
<th>Some conflict reasonably well managed</th>
<th>Some conflict not very well managed</th>
<th>Difficult conflict</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

IN YOUR PRACTICE:

1. Is GPs' control over time and workload a source of ........

| 1 | 2 | 3 | 4 | 5 |

2. Are the resources to give sufficient patient care a source of ........

| 1 | 2 | 3 | 4 | 5 |

---

This was distributed to forty senior partners in southern England (through the BPMF). Only eight replied and interviews with both respondents and non-respondents suggested further revisions were necessary.

Pilot III

Discussions after the second pilot indicated that it was crucial to design the first page so that the questionnaire looked as though it required little effort to complete. At this stage the notion of using Likert (1-5) or Thurstone (semantic differential) scales for the first question was rejected in favour of a simple Yes/No response. It was recognised that the lack of interval data risked degrading the quality of the final analysis. This was countered by asking questions to identify...
salience when respondents were asked to prioritise the most important conflicts (see Nos. 39-40 Appendix N and Chapter VI: Conflicts and Difficulties in General Practice - Salience).

The third pilot was sent to twenty GPs in Humberside, north and south London and achieved a favourable response. Thus the final design (See Appendix N) was achieved.

The covering letters were also tested in a more informal manner. Samples of letters were shown to over forty GPs both individually and at group meetings. Those letters from local GPs with status or academics with credibility in GPs' eyes were found to be most helpful. A letter coming from the researcher herself did not elicit much response unless she was already known by the GPs, and letters offering rewards (such as prize draws) were not considered professional or acceptable. It was crucial to discover how the person signing the letter was perceived by GPs in that area: a GP or an academic with a 'difficult' reputation would adversely affect the response rate.

Reliability

Reliability is usually concerned with stability over time [Berdie and Anderson 1974 p 13]. To aid internal reliability, sets of questions are usually more reliable than single opinion items [Oppenheim 1966 p 73].

In measuring job satisfaction using a scale 1-5 (or more) from Very Satisfied - Very Dissatisfied was considered. In America the scale Very Happy - Pretty Happy - Not Too Happy has been widely used [Campbell, Converse and Rodgers 1976 p 26], and has been measured over time (six different samples from 1957-1972) and by income levels [op cit p 28]. The trends showed a decrease in the size of the groups who selected 'Very Happy' over time, by age and by income level. This decreased ebullience led to many questions: Was it the political scene, increased expectations and, most importantly, what did 'happiness' mean anyway?

Cantril measured life satisfaction on an eleven point scale from 'Best Possible - Worst Possible' and discovered no such downward trend [op cit p 30] and so Campbell et al moved away from single-item measures to a semantic scale.
### Distribution of Responses to the Ten Semantic Differential Scales

<table>
<thead>
<tr>
<th></th>
<th>1%</th>
<th>2%</th>
<th>3%</th>
<th>4%</th>
<th>5%</th>
<th>6%</th>
<th>7%</th>
<th>Total</th>
<th>Mean</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boring</td>
<td>2%</td>
<td>6%</td>
<td>16%</td>
<td>17%</td>
<td>21%</td>
<td>36%</td>
<td>100%</td>
<td>Interesting</td>
<td>5.52</td>
<td>2151</td>
</tr>
<tr>
<td>Miserable</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>13%</td>
<td>16%</td>
<td>27%</td>
<td>38%</td>
<td>100%</td>
<td>Enjoyable</td>
<td>5.74</td>
</tr>
<tr>
<td>Hard</td>
<td>8%</td>
<td>11%</td>
<td>29%</td>
<td>15%</td>
<td>17%</td>
<td>100%</td>
<td>Easy</td>
<td></td>
<td>4.43</td>
<td>2149</td>
</tr>
<tr>
<td>Useless</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>10%</td>
<td>13%</td>
<td>24%</td>
<td>46%</td>
<td>100%</td>
<td>Worthwhile</td>
<td>5.87</td>
</tr>
<tr>
<td>Lonely</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>10%</td>
<td>11%</td>
<td>21%</td>
<td>49%</td>
<td>100%</td>
<td>Friendly</td>
<td>5.85</td>
</tr>
<tr>
<td>Empty</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>12%</td>
<td>15%</td>
<td>22%</td>
<td>44%</td>
<td>100%</td>
<td>Full</td>
<td>5.79</td>
</tr>
<tr>
<td>Discouraging</td>
<td>3%</td>
<td>2%</td>
<td>3%</td>
<td>11%</td>
<td>13%</td>
<td>23%</td>
<td>45%</td>
<td>100%</td>
<td>Hopeful</td>
<td>5.77</td>
</tr>
<tr>
<td>Tied-down</td>
<td>5%</td>
<td>4%</td>
<td>6%</td>
<td>17%</td>
<td>12%</td>
<td>20%</td>
<td>36%</td>
<td>100%</td>
<td>Free</td>
<td>5.31</td>
</tr>
<tr>
<td>Disappointing</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>13%</td>
<td>16%</td>
<td>25%</td>
<td>37%</td>
<td>100%</td>
<td>Rewarding</td>
<td>5.60</td>
</tr>
<tr>
<td>Doesn’t give me</td>
<td>3%</td>
<td>3%</td>
<td>6%</td>
<td>21%</td>
<td>18%</td>
<td>23%</td>
<td>26%</td>
<td>100%</td>
<td>best in me</td>
<td>5.18</td>
</tr>
<tr>
<td>much chance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 4 Distribution of Responses to the Ten Semantic Differential Scales**

The sample was weighted so the results were proportional to the American population as a whole and the survey was conducted in July and August 1971.

This satisfaction scale has become the basis for other studies in the UK [Tivers 1982].

The size of the sample (2,164 persons) enabled the sampling error to be tested [using Kish and Hess 1965 pp 43-46]. When the estimates are concerned with characteristics that vary with individual respondents, then the average sampling errors apply.

**Validity**

The basic questions here are:

Does the question measure what it attempts to measure?

Does it mean the same thing to each person?

Does the respondent answer the question honestly?

Validity is usually sought because a prediction of behaviour is required. Several checks on validity were incorporated into this survey:

a) Face validity could be checked by establishing how involved the respondent became in their answers. An unquantifiable, but substantial, indication of face validity was the range and number of comments written on the questionnaires.

b) Honesty. This was a difficult attribute to check on questionnaires. One respondent wrote: 'I lie on questionnaires', tongue in cheek it was hoped. His responses were similar to those of his colleagues. Every stage of the analysis and interpretation was checked with individual GPs and groups of GPs, and summaries were mailed to the hundreds who requested them.

c) Digging deeper on validity. The best way of establishing validity was to compare it with other surveys, asking similar questions. There were no surveys asking identical questions to this one, but some cross-checks could be carried out with the BMA survey [1992], with Bosanquet and Leese [1989] and with Cooper and Hingley [1988]. The section on job satisfaction was validated and reliable. The survey of conflict was not seeking to establish an attitude scale, thus traditional measures of
validity were not appropriate and these questions were treated as individual items and were not weighted together.

5. **Designing the Sampling Process**

The sample was purposive in that, within budget limitations, samples that were broadly comparable with the country as a whole were achieved. A mix of age ranges, male/female, locations, training/non-training practices and sizes of partnerships were sought. Humberside and East Surrey FHSA both fulfilled these criteria. Other areas were excluded for various reasons. For example, it was decided not to carry out the survey in the West Country as a survey on stress had just been distributed [Maxwell 1991 unpublished] or in East Anglia as it was too rural.

<table>
<thead>
<tr>
<th>Location</th>
<th>Conflict Survey 1992</th>
<th>BMA Survey 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 327</td>
<td>n = 24,478</td>
</tr>
<tr>
<td>Inner city</td>
<td>9.6%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Rural</td>
<td>27.2%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Neither inner city nor rural</td>
<td>63.2%</td>
<td>60.9%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table 5** Sample Comparisons by Location

The BMA survey had a higher response rate from inner city practices. This was only to have been expected given that their survey included large conurbations such as Birmingham, Manchester and London. The responses from suburbs and small towns were comparable.

<table>
<thead>
<tr>
<th>List Size</th>
<th>Conflict Survey 1992</th>
<th>BMA Survey 1992</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 327</td>
<td>n = 24,120</td>
</tr>
<tr>
<td>Under 1,000</td>
<td>1.2%</td>
<td>1.3%</td>
</tr>
<tr>
<td>1,000-1,500</td>
<td>3.1%</td>
<td>10.8%</td>
</tr>
<tr>
<td>1,500-2,000</td>
<td>27.2%</td>
<td>43.4%</td>
</tr>
<tr>
<td>2,000-2,500</td>
<td>43.7%</td>
<td>35.2%</td>
</tr>
<tr>
<td>Over 2,500</td>
<td>24.1%</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

**Table 6** Sample Comparisons by List Size

Both surveys showed that over 70% of practices had list sizes between 1,500 and 2,500.
The age range represented by the respondents to the Conflict survey was broadly comparable with the ages of those from across the country.

The Conflict survey had a slightly higher response rate from men than the BMA survey. The pattern again, though, was broadly comparable.

The BMA survey did not ask whether or not a practice manager was employed. The number of practice managers employed was shown as increasing, but it might also be that those doctors employing practice managers had more time and inclination to complete the Conflict survey.
The Conflict survey had more respondents from smaller practices, and the BMA survey had more respondents from larger practices.

The questionnaire in its final form was sent out between February and April 1992. A reminder with an additional copy of the questionnaire was mailed three weeks later giving the closing date. All respondents were offered a summary copy of the initial results.

The data was processed using Statistical Package for Social Sciences (SPSS) and the next chapter summarises those findings.

**Criticisms of the Survey**

1. **Uncontrolled Variables affecting Response**

   It was suggested that the response rate identifying FHSA paperwork as a problem area may have resulted from the survey timing (immediately after some year-end returns had been sent out). In fact, the third pilot was sent out December 1991/January 1992 and the main survey was sent out Feb/April 1992. The figures remained constant for this problem area.
2. **Non-Responses**

The overall response rate was 60.5% (for further details see the beginning of Chapter VI). It is difficult to know why people did not respond. The non-response rate was not high given comparable surveys, but is always a concern. On the pilots, all the non-respondents were contacted to identify why they had not responded. They said 'time pressures' which, given the fact that they felt under extreme pressure from paperwork, was understandable. Non-respondents to the pilots were given the option of saying that they thought the survey was irrelevant, and none of them ticked that option.

3. **Measuring the Responses**

It would have been preferable to have had a Likert-type scale on the questions, to have established saliency or potency more satisfactorily. But the evidence of the pilots so strongly suggested the need for a simple formula that this had to be rejected. Similarly, it could have been useful to have established definitive reliable and valid concepts of satisfaction with partnerships, external relationships and so on. These were beyond the scope of this study. In checking the interpretation of this study, the research group of GPs suggested that where there were partnership problems they became all consuming. The design of this study precluded checking this hypothesis completely satisfactorily.

4. **Question Order Response**

The primary effect suggested that those items appearing at the top of a list gained votes from position alone [Schuman and Presser 1981 p 72]. This would not appear to have been the case in this survey as the most frequently scoring items were distributed throughout the questionnaire.

5. **Context Effects**

It could have been argued that the questions should not have been put in sub-groups (such as conflict with DHA, etc.). However scattering the questions randomly was tried in the second pilot, and it caused great confusion amongst the participants and lowered the response rate. The effect of social desirability [op cit p 81] should be low because the questionnaire was anonymous. In fact the written responses suggested that social desirability was not a concern at all.

6. **'Don't Know' Responses**

There was evidence that including an option for a 'don't know' response encourages that response [op cit p 161]. Thus, given the need for simplicity, this option was not included.

The conclusion of this chapter should be left to the respondents. Many GPs did respond to the design of the questionnaire and all those responses (both favourable and unfavourable), are listed below.

**COMMENTS ON QUESTIONNAIRE**

**Positive Responses**

1. “Not another form” - was the immediate response, but filling it in has actually made me think about specific factors in the job as they affect my resultant life in general.

2. It made me dedicate a few minutes to analysing or affirming my current situation.

3. I am happy to complete the questionnaire. Basically conflicts are due to over demand by patients and far too much administration. These points have taken the pleasure out of family practice and I fear that the situation is likely to get worse.
I have enjoyed Practice very much until the last two years. **Lack** of time is an important factor.

4. As you say this is very revealing to complete. I feel my response is perhaps not unusual. I might be more optimistic in a year or so's time.

5. Question C is difficult to complete but otherwise questionnaire is easy to complete and appears useful.

6. Helpful to complete. I suspect Section M may be completed in a different way each day. I did it on Monday morning.

7. Sorry, Friday pm, nil else to add.

8. Quite happy to complete questionnaire.

9. I was pleased to complete this questionnaire and hope my relatively optimistic attitude is justified in 1992.

10. Happy to complete questionnaires and share personal experience and great success in practice/employees/team spirit.

11. Fun completing this form.

12. My feelings in answering do vary as to whether I have been busy on call in previous day or two! Apologies for delay. It has been a difficult two years in practice.

13. Enjoyed questionnaire.

14. I felt quite at ease while filling in this questionnaire.

15. Good questions.

16. Questionnaire took less than five mins.

17. **How do I feel about this questionnaire - comfortable!**

18. Excellent survey to start exploring one's anger with the way General Practice is going over the last three years.

19. This questionnaire was quite painless.

20. Question A on Conflict seems to ask for "frustrating conflict" as there will be some conflict in nearly all fields and interactions.

21. Questions benign - no objections to questionnaire.

22. About time something along these lines was investigated.

**Negative Responses**

1. The question on where people qualified was discriminatory.

2. Questionnaires are too time-consuming - and very little positive help comes out of them!!

3. Completing this questionnaire added to my areas of conflict.


5. Questionnaire designed around practice (group) - what about single-handed practices?

6. Two questions need to be framed differently - C & J.
7. This question (C) is ambiguous.

8. Another waste of space/time and money.

9. Are you trying to find out ways of further cutting down on our independence by looking for ways of controlling practice administrators etc??

10. I am sorry to see "senior partners" still being referred to. Of course they exist but they should not be seen as acceptable or 'the norm'. This questionnaire should have included more references to equality in practices.

11. This questionnaire - Not another one!!

12. What do you want to sell?

13. Lots of questions are irrelevant.

14. Fed up completing another questionnaire.

15. This form was a trick. It takes much longer than ten minutes to complete!

16. You should have asked more about these fatuous "reforms" in the NHS and about the hospital waiting lists.

Further Comments on the Questionnaire

1. Uneasy feelings about completing this questionnaire, as it is not now anonymous. I trust confidentiality is really assured.

2. These questionnaires are only useful if they change things!!

3. Filling in the questionnaire allowed me to reassess the situation I find myself in although it may be weighted by just having done an on-call weekend.

4. I hope something comes out of this paper.

5. Probing!

6. I tell lies on questionnaires.

7. I completed this questionnaire with the hope that if all GPs could express their concerns about the present state of GPs' working conditions - someone might take note and try to address these concerns sympathetically.
CHAPTER VI

ANALYSIS OF THE RESULTS

This chapter will detail the analysis of the results of the survey. It aims to answer the question:

What are the major sources of conflict for GPs in East Surrey and Humberside, and is there any relationship between areas, type of practice, age and gender and the conflicts suffered?

Five hundred and forty questionnaires were distributed. The overall response rate was 60.5%. In Humberside 262 out of 450 were returned (response rate of 58%); in East Surrey 66 out of 90 were returned (response rate of 72%). The full frequency count is shown in Appendix O.

A summary is shown here.

Conflicts and Difficulties in General Practice

A) Frequency
Respondents were asked to tick boxes where they experienced difficulties or conflicts.

<table>
<thead>
<tr>
<th>Conflict</th>
<th>% of 327 responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict with FHSA over unnecessary paperwork</td>
<td>70.3%</td>
</tr>
<tr>
<td>Conflict with patients over patients’ expectations</td>
<td>68.1%</td>
</tr>
<tr>
<td>Finding sufficient time for family life</td>
<td>65.0%</td>
</tr>
<tr>
<td>Coping with night and weekend duties</td>
<td>65.0%</td>
</tr>
<tr>
<td>Finding sufficient time available for sick patients</td>
<td>56.7%</td>
</tr>
<tr>
<td>Conflict with Government policy over screening procedures</td>
<td>55.7%</td>
</tr>
<tr>
<td>Comparing GP’s remuneration with other possible professions</td>
<td>53.3%</td>
</tr>
<tr>
<td>Conflict with DHA in getting effective physiotherapy services</td>
<td>52.6%</td>
</tr>
<tr>
<td>Conflict with partners re introducing change/planning for practice</td>
<td>40.2%</td>
</tr>
<tr>
<td>Conflict with Government policy over fundholding</td>
<td>40.0%</td>
</tr>
<tr>
<td>Conflict with FHSA over delays in decision-making</td>
<td>38.4%</td>
</tr>
<tr>
<td>Conflict with partners over different styles and speed of work</td>
<td>33.4%</td>
</tr>
<tr>
<td>Conflict with partners over differing beliefs and values</td>
<td>33.1%</td>
</tr>
<tr>
<td>Conflict with social workers</td>
<td>30.3%</td>
</tr>
</tbody>
</table>

B) Salience
Respondents were asked to list the three conflicts which caused them greatest problems.

<table>
<thead>
<tr>
<th>Conflict</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping with night and weekend duties</td>
<td>45.8%</td>
</tr>
<tr>
<td>Time for family life</td>
<td>39.6%</td>
</tr>
<tr>
<td>Conflict with patients over patients’ expectations</td>
<td>24.8%</td>
</tr>
<tr>
<td>Remuneration when compared with other professions</td>
<td>21.3%</td>
</tr>
<tr>
<td>Conflict with FHSA over unnecessary paperwork</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

The importance of these areas was confirmed in a survey of over 300 GPs in the West Country (Personal communication, Dr R Maxwell, 23.9.92).

C) Areas of Little Conflict

<table>
<thead>
<tr>
<th>Area</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining pathology services</td>
<td>3.1%</td>
</tr>
<tr>
<td>Intimate personal relationships between those working around you</td>
<td>4.3%</td>
</tr>
<tr>
<td>Partners’ lack of professional competence</td>
<td>5.3%</td>
</tr>
</tbody>
</table>
Managing Time

The difficulty over managing unsocial hours, unnecessary paperwork, finding sufficient time for sick patients and for family life are problems which all come under the heading of time management.

Problems with time management can be divided into those within the GP's control, those within the partnership's control and those within the control of the system in which GPs operate.

The severity of the problem for some respondents can be more fully illustrated by some of the written comments made in response to the open question at the end of the survey. Some 176 statements were added in the 'comments' section. Over one-third of the respondents amplified their responses in this way.

*Humberside FHSA sent out at least 219 circulars in 1991.*

*The need to do screening clinics to maintain income has restricted the time available to see really ill people.*

*My main problem is lack of time for the family.*

*I am experiencing increasing difficulties in my personal life due mainly to the stresses of the job and a young family and the fact that I am often near exhaustion. Something has to give, and at this rate it is going to be me.*

*Without my wife and family I would not be able to manage the amount of stress. Missed diagnosis is a big threat, especially felt when fatigued.*

*Too much bloody crappy paperwork for the idiotic 'contract'. No wonder the forests are vanishing!*

*Minor and trivial illness takes up most of my time.*

Patients' Expectations

This was the second highest response in terms of frequency, and the third highest in terms of salience or potency. The question could have been worded more competently, because the next question is "What is difficult about patients' expectations?" Again, the written responses help:

*99.9% of patients do not appreciate that when covering emergencies at night we do a full day's work both before and after.*

*Dealing with the worried well, the 'antibiotic addicts', etc, i.e. those who really do not need to see a doctor, is a major problem.*

*Remuneration for me as a junior partner (most months £1,000 before tax) is very poor - how can I live? Most patients think I am on £40-60,000 p.a. as the newspapers quote.*

*There is a problem over patients' perceptions of GPs as money oriented, but this is our own fault.*

*I am very distressed by the unreasonable expectations of some patients who seem totally unable to think for themselves nowadays.*
And a verbal comment from one of the interviewees:

"I would charge for people visiting the doctor, and it must be an amount that is relevant. I don't wish people to come to me for half an hour and pay £1. That would denigrate what they are getting. When I call out a plumber it costs £40 for 10 minutes. There would be an ethical difficulty for patients who don't have the cash, but it is a real problem for doctors who put in a lot of hours for them to be rung up off duty."

There were two written comments suggesting that the doctor/patient relationship should be seen as one of mutual problem-solving, and one doctor said he saw his patients as friends.

**COMPARISONS BY AREA**

The two areas represented very different parts of the country. All the inner city responses came from Humberside; just over 30% of each area classed themselves as urban or suburban.

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>East Surrey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inner City</strong></td>
<td>n = 257</td>
<td>n = 66</td>
</tr>
<tr>
<td></td>
<td>31 (12.1%)</td>
<td>-----</td>
</tr>
<tr>
<td><strong>Urban/Suburban</strong></td>
<td>92 (36%)</td>
<td>22 (33%)</td>
</tr>
<tr>
<td><strong>Small Town</strong></td>
<td>40 (15.6%)</td>
<td>27 (40.9%)</td>
</tr>
<tr>
<td><strong>Rural</strong></td>
<td>75 (29.2%)</td>
<td>13 (19.7%)</td>
</tr>
</tbody>
</table>

Table 12  Area Comparison - Practice Location

The age distribution between the two areas was roughly comparable. About two-thirds of the doctors in both areas were between 30 and 49 yrs. There were proportionately slightly more doctors in the 50-59 years range in East Surrey (n = 20), and proportionately slightly more doctors in the 60+ years bracket in Humberside (n = 18). The numbers working full-time were about 95% in each area. There were proportionately more female doctors (30%) in East Surrey than in Humberside (17%).

In Humberside there were three times as many practices employing partners who qualified outside the UK as there were in East Surrey.

Doctors' remuneration by area was calculated in similar ways, with well over 80% in each area describing their remuneration policy as being equal after time to parity.

**Training and Non-Training Practices**

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>East Surrey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training Practices</strong></td>
<td>29.2%</td>
<td>36.4%</td>
</tr>
<tr>
<td><strong>Non-Training Practices</strong></td>
<td>70.4%</td>
<td>63.6%</td>
</tr>
</tbody>
</table>

Table 13  Area Comparison - Training Practices
Fundholding

In Humberside 14.4% said they were already fundholding; in East Surrey 4.5% said they were already fundholding (respectively slightly higher and lower than the national average). About one-third in each area said they might fundhold in the future (this survey was carried out just before the 1992 General Election).

Conflict with Partners

The survey revealed that there was no significant difference in the frequency or types of conflict between partners in these two areas. The main areas of conflict between partners were:

<table>
<thead>
<tr>
<th>Type of Conflict</th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over introducing change and future planning for the practice</td>
<td>130 40.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over partners' different styles and speed in dealing with patients</td>
<td>108 33.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over partners' differing beliefs or values</td>
<td>107 33.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over equal sharing of responsibilities and working as a team</td>
<td>82 25.4%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conflict with District Health Authority

Physiotherapy: No significant difference in the difficulties or conflicts associated with getting the required physiotherapy service between these areas was found. In both areas over 50% of the doctors surveyed said that this was a problem.

Hospital Admissions: In East Surrey there appeared to be more of a problem in gaining the hospital admissions that doctors wanted for their patients. 50% of doctors who worked in East Surrey and overall about one-third of doctors had problems in this area.

Do you experience conflict over gaining the hospital admissions you want for patients?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>82 (31.9%)</td>
<td>34 (51.5%)</td>
<td>116 (35.9%)</td>
</tr>
<tr>
<td>No</td>
<td>175 (68.1%)</td>
<td>32 (48.5%)</td>
<td>207 (64.1%)</td>
</tr>
</tbody>
</table>

Total 257 (100%) 66 (100%)

Chi square = 7.94  p = .005  Missing cases = 0

Table 14 Area Comparison - Conflict in Gaining Hospital Admissions

(All chi squares and p values are quoted after Yates correction)

Radiology: Over 40% of doctors in East Surrey but just one-quarter of all the doctors surveyed experienced conflict over gaining effective radiology services for their patients.
Do you experience conflict over gaining the radiology services you want for patients

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46 (17.9%)</td>
<td>28 (42.4%)</td>
<td>74 (22.9%)</td>
</tr>
<tr>
<td>No</td>
<td>211 (82.1%)</td>
<td>38 (57.6%)</td>
<td>249 (77.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>257 (100%)</td>
<td>66 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 16.53  p = .001  Missing cases = 0

Table 15 Area Comparison - Conflict in Gaining Radiology Services

Pathology: Few people in either area had problems over gaining the pathology services they required, and those who did were equally spread between the areas.

Conflict with the FHSA

Over Unnecessary Paperwork: Overall 70% of respondents experienced this problem; a greater percentage of East Surrey doctors experienced problems.

Do you experience conflict with the FHSA over unnecessary paperwork?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>172 (66.9%)</td>
<td>55 (83.3%)</td>
<td>227 (70.3%)</td>
</tr>
<tr>
<td>No</td>
<td>85 (33.1%)</td>
<td>11 (16.7%)</td>
<td>96 (29.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>257 (100%)</td>
<td>66 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 6.0  p = .01  Missing cases = 0

Table 16 Area Comparison - Conflict with FHSA (a)

Over Investigations of Complaints: About one-fifth of the respondents had problems with investigations of complaints, and those were evenly spread in each area.

Do you experience conflict with FHSA over delays in claims?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57 (22.2%)</td>
<td>47 (71.2%)</td>
<td>104 (32.2%)</td>
</tr>
<tr>
<td>No</td>
<td>200 (77.8%)</td>
<td>19 (28.8%)</td>
<td>219 (67.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>257 (100%)</td>
<td>66 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 55.6  p = .0001  Missing cases = 0

Table 17 Area Comparison - Conflict with FHSA (b)

Nearly 40% reported problems with delays in decision making. 56% of doctors in East Surrey, but only 34% of doctors in Humberside defined this as a problem.
Do you experience conflict with FHSA over delays in decision-making?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>87 (33.9%)</td>
<td>37 (56.1%)</td>
<td>124 (38.4%)</td>
</tr>
<tr>
<td>No</td>
<td>170 (66.1%)</td>
<td>29 (43.9%)</td>
<td>199 (61.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>257 (100%)</td>
<td>66 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 10.03  p = .001  Missing cases = 0

Table 18  Area Comparison - Conflict with FHSA (c)

GPs' Level of Remuneration

GPs in East Surrey were more concerned about their level of remuneration when compared with other professions. 53% reported concern in this area; of that number, 68% of East Surrey doctors and 49% of Humberside doctors expressed discontent.

Do you experience conflict over GPs' level of remuneration when compared with other professions you might have entered?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>E. Surrey</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>127 (49.4%)</td>
<td>45 (68.2%)</td>
<td>172 (53.3%)</td>
</tr>
<tr>
<td>No</td>
<td>130 (50.6%)</td>
<td>21 (31.8%)</td>
<td>151 (46.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>257 (100%)</td>
<td>66 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 6.7  p = .001  Missing cases = 0

Table 19  Area Comparison - Conflict over Levels of Remuneration

Other Differences of Less Significance

Much smaller numbers reported problems with the practice manager (n = 34) but, of that 10%, there were 23% of East Surrey doctors and 7% of Humberside doctors who expressed concern.

Similar smaller numbers reported problems with whether or not to use complementary therapies (n = 53). Of that 15%, 18% of Humberside doctors and 9% of East Surrey doctors identified difficulties.

Again, similar small numbers reported problems with the work carried out by community nurses (n = 57). Of those 27% of doctors in East Surrey and 15% of doctors in Humberside had problems. This trend was not repeated with other attached staff (social workers and health visitors).

Care and Support

Overall, the patterns of those to whom GPs would turn for care and support as they worked remained broadly comparable. Over 80% in each area turned to their spouses and families. The
differences were that, whilst only 10% overall turned to their senior partners, 20% of doctors in East Surrey and 9% of doctors in Humberside experienced care and support from their senior partners. Overall, more would turn to the practice manager (n = 114 or 35%), and 40% of Humberside GPs and 17% of Surrey GPs experienced care and support from the practice manager.

The pattern for those who claimed not to experience care and support at all was 1 in East Surrey and 18 in Humberside, an overall figure of 5.9%.

What are the main sources of care and support you experience at work?

<table>
<thead>
<tr>
<th></th>
<th>Humberside</th>
<th>East Surrey</th>
<th>Total No. of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Family</td>
<td>83.7%</td>
<td>81.8%</td>
<td>269</td>
</tr>
<tr>
<td>Senior Partner</td>
<td>8.9%</td>
<td>19.7%</td>
<td>36</td>
</tr>
<tr>
<td>Partners</td>
<td>51.4%</td>
<td>59.1%</td>
<td>171</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>40.1%</td>
<td>16.7%</td>
<td>114</td>
</tr>
<tr>
<td>Other Doctors</td>
<td>24.1%</td>
<td>34.8%</td>
<td>85</td>
</tr>
<tr>
<td>Friends</td>
<td>40.9%</td>
<td>47.0%</td>
<td>136</td>
</tr>
<tr>
<td>Patients</td>
<td>28.8%</td>
<td>22.7%</td>
<td>89</td>
</tr>
<tr>
<td>Don’t experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care and Support</td>
<td>7.0%</td>
<td>1.5%</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 20 Area Comparison - Main Sources of Care and Support

These figures seem to be summed up by a couple of the handwritten comments:

"Without my wife and family I would not be able to manage the amount of stress."

"It might be worth investigating the effect of the job on the marriage."

This table also brought to mind a wife who interrupted one of the early interviews, as she sailed out of the room she said over her shoulder:

"....... and don't forget to mention the wives, dear, they are very important."

Areas of No Significant Difference between the Two Regions

Conflicts reported over government policy and procedures, within the practice, with partners, with attached staff (except community nurses), over patients' expectations, communication with consultants and over finding time for sick patients and family life were comparable across the two areas.
The main differences in the number of times difficulties were reported were mostly found in the area specific variables. There was a difference in the way doctors in the two areas perceived the services of the FHSA and the DHA, and in how they perceived the level of their remuneration.

**COMPARISONS BY ROLE**

The role of the senior partner is not a clear concept. Historically it has referred to the seniority bestowed on the partner who has served with that practice for the longest time. The role confers with it no pecuniary advantages (although it used to), little or no intrinsic authority and varying perceptions of degrees of responsibility.

It is a phrase which arouses much passion amongst many GPs:

"I am sorry to see 'senior partners' still being referred to. Of course, they exist but they should not be seen as acceptable or 'the norm'."*

"I, as a new senior partner, felt very undermined by X who came to fill a vacancy. He has now left and I have just about re-established my position a year later."*

"Most senior partners are crooks and exploiters."*

"A good senior partner can make all the difference to a practice; many people look for a clear and fair leadership."*

"As a senior partner I feel I 'carry' the rest of the practice. They expect me to be the innovator."*

"There is no mechanism for providing young doctors going into practice with support or confidence."*

"Many replies to my letters are addressed to the senior partner."*

"We do not believe in the senior partner concept in the 1990s. It dates back to times of abuse of younger partners by their elders."*

However 31.9% replied in the affirmative to the question: "Are You a Senior Partner?" This may include some single-handed practitioners, but few of those (less than ten) responded. Four of the single-handed practitioners who responded said they would have liked a survey concentrating on their needs as much as on the needs of GPs working in a partnership.

There were 103 respondents who identified themselves as senior partners: ninety were male, twelve were female. There was no significant difference in the list sizes between the senior partners and others. Senior partners tended to be older, with more of them falling into the 50+ years age range, and commensurately more of their children are aged eighteen years or over.

In the survey 40% said their partnership had a clear leader, 50% said it did not have a clear leader and 10% did not reply. Just over 40% said they wanted their partnership to have a clear leader. 45% said they did not want a clear leader, which presumably left 15% undecided about
whether or not they wanted a leader. There was no significant difference in the types of conflicts experienced by those who had or did not have a clear and acceptable leader, or between those who wanted or did not want a clear leader. However these figures did tell us that this was a disputed territory with the 'pro' and 'anti' leader factions almost equally divided.

In the tables the category 'other' refers to principals, assistants and some part-timers. The fact that people assigned themselves senior partner status for the purpose of this survey does not mean that that status is necessarily undisputed. It was a useful question to ask because it has identified some significant differences in how conflicts are experienced.

Conflicts with the District Health Authority

Hospital Admissions: Senior partners had fewer difficulties in arranging the hospital admissions they needed for their patients. Whether this was due to experience and knowing how to work the system, or whether this was due to a hospital's perception of the senior partner's role is unclear.

Do you experience conflict with the DHA over gaining the hospital admissions you want for patients?

<table>
<thead>
<tr>
<th></th>
<th>Senior Partners</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31 (30.1%)</td>
<td>63 (45.0%)</td>
<td>94 (38.7%)</td>
</tr>
<tr>
<td>No</td>
<td>72 (69.9%)</td>
<td>77 (55.0%)</td>
<td>149 (61.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>103 (100%)</td>
<td>140 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 4.94  p = .03  Missing cases = 90

Table 21 Senior Partner/Other - Conflict over Gaining Hospital Admissions

There was, however, no significant difference in the problems faced by senior partners when trying to arrange physiotherapy or radiology for their patients.

Conflict with the Family Health Authority

There was no significant difference between senior partners and others over the frequency with which they had problems over paperwork, dealing with complaints and delays in decision-making.

Only one-third of the total number of respondents had a problem with delays in claims, but 70% of these delays were not experienced by senior partners. Three-quarters of senior partners experienced no delays. The likelihood of experiencing a delay in a claim was greater if a doctor was not a senior partner.
Conflict with Partners over Change

There was no significant difference in conflict over differing beliefs, partners' different speeds and styles of working, outside interests, equal sharing of responsibilities and working as a team.

There was a significant difference in the level of conflict experienced over introducing change. Senior partners experienced much less conflict in this area than others in their practices.

Do you experience conflict with partners over introducing change and future planning for the practice?

<table>
<thead>
<tr>
<th></th>
<th>Senior Partners</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31 (30.1%)</td>
<td>67 (47.9%)</td>
<td>94 (38.7%)</td>
</tr>
<tr>
<td>No</td>
<td>72 (69.9%)</td>
<td>73 (52.1%)</td>
<td>149 (61.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>103 (100%)</td>
<td>140 (100%)</td>
<td></td>
</tr>
<tr>
<td>Chi square</td>
<td>7.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing cases</td>
<td>90</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22 Senior Partner/Other - Conflict over Introducing Change

About 15% of respondents experienced some conflict over who should lead the practice and nearly 8% of those were senior partners while 20% were principals.

Conflict within the Practice

There was no significant difference in the survey results in conflict experience between senior partners and others over the use of computers, over the employment of counsellors, over the competence of practice nurses, over the lack of time available for the sick and over whether or not to use a deputising service. However, there was a difference in that senior partners experienced less conflict with their practice managers and administrative staff than others did. Only 10% of respondents reported conflict over the competence of the practice manager, but the vast majority of them (80%) were 'others', not senior partners. Similarly, 22% reported conflict over the competence of the administrative staff, and 75% of them were 'others' not senior partners.

Leadership within the Practice

Practices with a Clear Leader

Some GPs argued strongly that the age of the senior partner as a leader was dead. In this survey:

41.8% of the respondents said that they wanted a clear and acceptable leader
45.5% did not
40% of respondents (n = 130) said that their practices had a clear (but not necessarily acceptable) leader
50% of respondents (n = 164) said that their practice had no clear leader - presumably these were either single partners, practices
which worked as equal partners or practices where there was a dispute over leadership.

There was a statistically significant difference between these two groups for those who experienced conflict over screening procedures, over the use of computers, with the practice manager, over time available for sick patients, over introducing change and future planning, and over practice leadership.

**Do you experience conflict with government policy over screening procedures?**

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>64 (49.2%)</td>
<td>105 (64%)</td>
<td>169 (57.5%)</td>
</tr>
<tr>
<td>No</td>
<td>66 (50.8%)</td>
<td>59 (36%)</td>
<td>125 (42.5%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130 (100%)</strong></td>
<td><strong>164 (100%)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 6.5, p = .01, Missing cases = 29

Table 23: Clear Leadership and Conflict over Screening Procedures

Those practices with a clear leader appeared to experience less conflict over screening procedures.

**Do you experience conflict with the FHSA over delays in decision making?**

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>43 (33.1%)</td>
<td>72 (43.9%)</td>
<td>115 (39.1%)</td>
</tr>
<tr>
<td>No</td>
<td>87 (66.9%)</td>
<td>92 (56.1%)</td>
<td>179 (60.9%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>130 (100%)</strong></td>
<td><strong>164 (100%)</strong></td>
<td></td>
</tr>
</tbody>
</table>

Chi square = 3.4, p = .06, Missing cases = 29

Table 24: Clear Leadership and Conflict with FHSA (d)

This table indicated that where a practice had a clear leader, the partners had slightly less conflict with the FHSA over delays in decision-making. Whether this was because their internal systems coped better with such delays, the delays were in fact less or the FHSA had fewer decisions to make for such a partnership is unclear.
Do you experience conflict within the practice over the use of computers?

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>28 (21.5%)</td>
<td>53 (32.3%)</td>
<td>81 (27.6%)</td>
</tr>
<tr>
<td>No</td>
<td>102 (78.5%)</td>
<td>111 (67.7%)</td>
<td>213 (72.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>130 (100%)</td>
<td>164 (100%)</td>
<td></td>
</tr>
<tr>
<td>Chi square</td>
<td>4.2</td>
<td>p = .04</td>
<td></td>
</tr>
<tr>
<td>Missing cases</td>
<td></td>
<td></td>
<td>29</td>
</tr>
</tbody>
</table>

Table 25 Clear Leadership and Conflict over Use of Computers

Those practices with a clear leader appeared to experience less conflict within the practice over the use of computers. The trend in computing in general practice has been dramatic. In 1987 10% of practices were computerised; in 1991 this had reached 63%. Even so:

"Many general practices now have systems installed which provide power equivalent to those used by national institutions only 20 years ago."

Pereira Gray 1992 p 13

Do you experience conflict within the practice over the competence of the practice manager?

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9 (6.9%)</td>
<td>24 (14.6%)</td>
<td>33 (11.2%)</td>
</tr>
<tr>
<td>No</td>
<td>121 (93.1%)</td>
<td>140 (85.4%)</td>
<td>261 (88.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>130 (100%)</td>
<td>164 (100%)</td>
<td></td>
</tr>
<tr>
<td>Chi square</td>
<td>4.3</td>
<td>p = .04</td>
<td></td>
</tr>
<tr>
<td>Missing cases</td>
<td></td>
<td></td>
<td>29</td>
</tr>
</tbody>
</table>

Table 26 Clear Leadership and Conflict over Competence of Practice Manager

These were only small numbers but they indicated that where there was a problem with the competence of the practice manager it was more likely to happen in a practice without a clear leader.
Do you experience conflict over finding sufficient time for family life?

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>75 (57.7%)</td>
<td>114 (69.5%)</td>
<td>189 (64.3%)</td>
</tr>
<tr>
<td>No</td>
<td>55 (42.3%)</td>
<td>50 (30.5%)</td>
<td>105 (35.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>130 (100%)</td>
<td>164 (100%)</td>
<td>Missing cases = 29</td>
</tr>
<tr>
<td>Chi square = 4.4</td>
<td></td>
<td>p = .04</td>
<td></td>
</tr>
</tbody>
</table>

Table 27 Clear Leadership and Conflict over Finding Sufficient Time for Family Life

This indicated that where a practice had a clear leader, the partners experienced slightly less pressure on finding time for family life. This was an important finding because time pressure was one of the greatest causes of conflict for GPs.

Do you experience conflict with partners over who leads the practice?

<table>
<thead>
<tr>
<th></th>
<th>Practices with a clear leader</th>
<th>Practices without a clear leader</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12 (9.2%)</td>
<td>33 (20.1%)</td>
<td>45 (15.3%)</td>
</tr>
<tr>
<td>No</td>
<td>118 (90.8%)</td>
<td>131 (79.9%)</td>
<td>249 (84.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>130 (100%)</td>
<td>164 (100%)</td>
<td>Missing cases = 29</td>
</tr>
<tr>
<td>Chi square = 6.6</td>
<td></td>
<td>p = .01</td>
<td></td>
</tr>
</tbody>
</table>

Table 28 Clear Leadership and Conflict over Leadership

Again, overall there was a low level of conflict over leadership but where there was conflict it was more likely to arise in a practice without a clear leader. The level of rebellion against existing leaders was not insignificant but it was small.

There were also indications that GPs in practices without a clear leader might have more problems over patients’ expectations, over finding sufficient time for family life and over partners’ different styles and speed in dealing with patients, but none of these tendencies was statistically significant.

Gender

Of the respondents, approximately 20% were female. There were no significant differences in the experience of conflict between the groups. There was a tendency for female GPs to find problems with FHSA paperwork and with computers more frequently than male GPs did, but this was not statistically significant. Equally, there was a tendency for male GPs to have more problems with
partners' differing beliefs and values than the female GPs had. A more significant difference between male and female GPs was their differing levels of job satisfaction.

**JOB SATISFACTION**

The bipolar adjectival scales used in the semantic differential test for 'satisfaction with life' are shown below.

![Figure 19 Quality of Working Life - Questionnaire](Image)

In using this type of scale it was assumed that the perception of well-being held by the individual was an accurate representation of actual well-being. This particular scale had been used both in American and British quality of life studies [see Campbell, Converse and Rogers 1976 and Tivers 1985].

Work on a major scale in Britain was also carried out by Hall [1976], but funding was withdrawn from the SSRC survey unit. Tivers [1985] compared her work on the quality of life for mothers with small children with some previously unpublished tables by Hall.

This type of scale was originally developed by Osgood, Suci and Tannenbaum [1957]. The semantic differential items give us a more differentiated picture of the meaning underlying our global responses. Campbell et al found eight of the semantic differential scales were correlated at a
high level, and concluded that they lost little or no information by going from eight separate items to a single summary index [p 45]. The two items they found that fitted less clearly with the other eight were easy/hard and free/tied down scales.

Campbell et al [1976] tested reliability with a small subsample (n = 285) of their respondents, over an eight month time span. They found that positive and negative life changes were reflected in the scale [p 47]. They quoted a stability index of .56. The study was also positively correlated with the Index of Well-Being and the Index of General Affect [p 50].

As has become the custom with this scale, the bi-polar constructs were alternately reversed to avoid any bias from question order affect. In total 1 = Low Satisfaction, 7 = High Satisfaction. This question was also placed towards the end of the survey when respondents had had a chance to identify their main conflicts, support mechanisms and the parts of the job they found most enjoyable.

Comparisons with Other Studies

Comparisons with other studies using this scale might not be particularly illuminating since they measured such different populations. Campbell, Hall and Tivers all used the study to measure the quality of life in general. The 1992 Conflict survey asked respondents to measure the quality of their working life. The overall mean was 4.3. The higher the mean score, the greater the level of satisfaction. The confounding variables of context, time, gender and country meant that direct comparison was dangerous, but it would appear that GPs' satisfaction with their working life was low. However it would be worth carrying out further studies on similar occupational groups to establish whether or not GPs did have a significantly lower level of satisfaction with working life.

Relationships with Other Variables

The separate variance estimate was used to establish significance because the F value was generally small [SPSS p 156]. The hypothesis was that job satisfaction would vary by:-

(1) gender because most female GPs also had family responsibilities;
(2) whether or not there was a practice manager to take some administrative workload;
(3) working in a training practice where GPs would be more highly skilled and motivated;
(4) GPs in Surrey or Humberside might have different levels of job satisfaction;
(5) a senior partner might have a different level of job satisfaction;
(6) job satisfaction might be affected by having young children.
Important Dimensions of Job Satisfaction

The factor analysis of this scale identified three important subsets of meaning in identifying job satisfaction for GPs.

<table>
<thead>
<tr>
<th>Rotated Factor Matrix</th>
<th>FACTOR 1</th>
<th>FACTOR 2</th>
<th>FACTOR 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyable/Miserable</td>
<td>.78696</td>
<td>.27284</td>
<td>.23353</td>
</tr>
<tr>
<td>Free/Tied Down</td>
<td>.03396</td>
<td>.67279</td>
<td>.37992</td>
</tr>
<tr>
<td>Rewarding/Disappointing</td>
<td>.76988</td>
<td>.19520</td>
<td>.09508</td>
</tr>
<tr>
<td>Easy/Hard</td>
<td>.10794</td>
<td>.02720</td>
<td>.92651</td>
</tr>
<tr>
<td>Fulfilling/Frustrating</td>
<td>.17594</td>
<td>.74149</td>
<td>-.22590</td>
</tr>
<tr>
<td>Fully/Empty</td>
<td>.72890</td>
<td>-.19644</td>
<td>-.09295</td>
</tr>
<tr>
<td>Under my control/Controlled by others</td>
<td>.32443</td>
<td>.55879</td>
<td>-.09079</td>
</tr>
<tr>
<td>Full of possibilities/In a rut</td>
<td>.54944</td>
<td>.26476</td>
<td>.02622</td>
</tr>
<tr>
<td>Happy/Unhappy</td>
<td>.58713</td>
<td>.52618</td>
<td>.06710</td>
</tr>
<tr>
<td>Brings out the best/Don't get much chance</td>
<td>.73391</td>
<td>.25862</td>
<td>.01286</td>
</tr>
</tbody>
</table>

These results showed three factors. There were several highly correlated variables loading on two of these factors; the third factor appeared to represent one variable only. To try to find a unifying term we shall look at the negative aspects of each factor. The means of each group of factors were quite different.

<table>
<thead>
<tr>
<th>Group I</th>
<th>Miserable</th>
<th>Mean</th>
<th>4.8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disappointing</td>
<td>SD</td>
<td>.97</td>
</tr>
<tr>
<td></td>
<td>Empty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a rut</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unhappy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Doesn't give me much chance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 29 Quality of Working Life (a)

These factors were all highly correlated and related to a feeling of nothingness, a depression and sense of purposelessness.

<table>
<thead>
<tr>
<th>Group II</th>
<th>Tied-down</th>
<th>Mean</th>
<th>3.6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frustrating</td>
<td>SD</td>
<td>1.07</td>
</tr>
<tr>
<td></td>
<td>Controlled by others</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 30 Quality of Working Life (b)

These factors all related to external impediments, ties or frustrations to progress.
<table>
<thead>
<tr>
<th>Group III</th>
<th>Easy-Hard</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2.9</td>
<td>1.36</td>
</tr>
</tbody>
</table>

Easy-Hard is an orthogonal factor which stands alone.

Table 31: Quality of Working Life (c)

This suggested that overall in terms of job satisfaction the respondents found that the job itself gave them a sense of purpose. They found the job more enjoyable, rewarding, full of possibilities, happy and bringing out the best in them, than the reverse.

Considerably less satisfying were the parts of the job which related to external impediments, ties or frustrations to progress. The job left them feeling more tied down, frustrated and controlled by others, than free.

The final element of job satisfaction is the area defined in the orthogonal factor: Easy-Hard. With a (comparatively) very low mean of 2.9, most GPs were saying that they find the job hard. The whole of this thesis is about trying to identify the parts of a GP's life which contribute to that 'hardness'.

Job Satisfaction and Gender

<table>
<thead>
<tr>
<th>No. of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>Separate Variance Estimate 2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>63</td>
<td>4.5</td>
<td>.69</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>}</td>
</tr>
<tr>
<td>Male</td>
<td>257</td>
<td>4.2</td>
<td>.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>} .03</td>
</tr>
</tbody>
</table>

Table 32: Job Satisfaction and Gender

The hypothesis was disproved. Female GPs might have a slightly higher level of job satisfaction and if they had extra family responsibilities this did not detract from the quality of their working life. In the 1973 and 1975 national surveys Hall also found that, in general, women tended to experience greater satisfaction with life than men (Tivers 1985 p 223). The factor analysis of this variable supports the observation that it was the sense of purpose within the job itself (Factor I: p = .05) which women found particularly satisfying.
Job Satisfaction and Employing a Practice Manager

<table>
<thead>
<tr>
<th>No. of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Manager Employed</td>
<td>266</td>
<td>4.3</td>
<td>.81</td>
</tr>
<tr>
<td>No Practice Manager Employed</td>
<td>51</td>
<td>4.0</td>
<td>.81</td>
</tr>
</tbody>
</table>

Table 33 Job Satisfaction and Employing a Practice Manager

The hypothesis that there was a relationship between employing a practice manager and job satisfaction for GPs in the two areas studied was supported. The factor analysis of this variable suggested that employing a practice manager enhanced the sense of purpose and reduced the feeling of being tied down and frustrated (Factor I: p = .01 and Factor II: p = .06).

Job Satisfaction and having Pre-School Age Children

<table>
<thead>
<tr>
<th>No. of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs with pre-school age children</td>
<td>110</td>
<td>4.3</td>
<td>.75</td>
</tr>
<tr>
<td>GPs without pre-school age children</td>
<td>19</td>
<td>4.6</td>
<td>.74</td>
</tr>
</tbody>
</table>

Table 34 Job Satisfaction and Having Pre-School Age Children

The hypothesis that there was a relationship between having pre-school age children and job satisfaction for GPs was not conclusively supported, although there did appear to be a tendency for GPs with pre-school age children to have a lower level of job satisfaction.

Job Satisfaction and having Post-School Age Children

<table>
<thead>
<tr>
<th>No. of Cases</th>
<th>Mean</th>
<th>SD</th>
<th>2-Tail Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs having post-school age children</td>
<td>118</td>
<td>4.3</td>
<td>.73</td>
</tr>
<tr>
<td>GPs not having post-school age children</td>
<td>20</td>
<td>4.6</td>
<td>.84</td>
</tr>
</tbody>
</table>

Table 35 Job Satisfaction and Having Post-School Age Children

There was no significant difference in job satisfaction between those GPs who had school age children and those who had not. There was a difference between those who had post-school age children and those who had not, although this was not statistically significant. This did not appear to be explained by looking at age. There is a debate about whether satisfaction increases or decreases with age (see Campbell et al pp 138 and 466).
Job Satisfaction and Age

<table>
<thead>
<tr>
<th></th>
<th>Under 30 yrs</th>
<th>30-39 yrs</th>
<th>40-49 yrs</th>
<th>50-59 yrs</th>
<th>60+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>4.4</td>
<td>4.4</td>
<td>4.1</td>
<td>4.2</td>
<td>4.7</td>
</tr>
<tr>
<td>No. of cases</td>
<td>13</td>
<td>117</td>
<td>100</td>
<td>69</td>
<td>21</td>
</tr>
<tr>
<td>Mean of total sample (n = 230) = 3.3</td>
<td>p = .04</td>
<td>Missing cases = 3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In this sample job satisfaction appeared to drop for GPs between 40 and 60 years, and increased to its highest level after 60 years. This is the age at which many GPs take 24 hr retirement and then return to work only with patients, leaving the administration of the practice to their partners. The significant factor which caused the decline in job satisfaction was Factor 2: (p = .014). This suggested that GPs between 40 and 60 yrs found the feeling of being tied down, frustrated and controlled by others particularly irksome.

Variables with No Significant Effect on Job Satisfaction

No statistical evidence was found to support the hypotheses that job satisfaction would vary according to: whether or not the GP was in a training practice; which area the GP worked in; list size, type of community the GP served (e.g. inner city, suburban, small town or rural); whether or not the GP was a senior partner; whether or not the GP had school age children; and whether or not the GP’s practice held funds, or intended to do so.

It would be possible to carry out further research on the effect of various aspects of the job on these factors. For the moment it is interesting to note that these results reinforce the results of the interviews and of the first part of the questionnaire. Conflicts arise from an inner sense of nothingness, a purposelessness, and from frustrations and regulations imposed upon them. This will be commented on in the concluding chapter.

Aspects of the Job which are: Most Important, Enjoyable and Timeconsuming

Respondents were asked to identify the parts of their job which they felt were most important, most enjoyable and which took most time. The full table is shown below.
Table 37 Aspects of the Job: Important; Enjoyable; Time-Consuming

<table>
<thead>
<tr>
<th></th>
<th>Most important</th>
<th>Most enjoyable</th>
<th>Takes most time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with the sick?</td>
<td>92.6%</td>
<td>63.2%</td>
<td>53.9%</td>
</tr>
<tr>
<td>Preventative medicine?</td>
<td>30.3%</td>
<td>16.7%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Contributing to the administration of the practice?</td>
<td>28.2%</td>
<td>9.0%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Supporting colleagues?</td>
<td>29.1%</td>
<td>13.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Keeping up to date?</td>
<td>49.8%</td>
<td>21.1%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Practice meetings?</td>
<td>27.6%</td>
<td>7.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Partnership meetings?</td>
<td>30.7%</td>
<td>6.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Self/career development?</td>
<td>20.4%</td>
<td>0.3%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

n = 323

It was interesting to note from this table that GPs would like to spend more time with the sick than time allowed. They recognised that contributing to the administration of the practice was important, but resented the amount of time it took, and few enjoyed it. Very little time was spent on supporting colleagues, nearly one-third of respondents regarded it as important and only 14% regarded it as enjoyable. This was another indication of a lack of partnership support in some practices.

The conflict over preventative medicine was that, while nearly one-third regarded it as important and a similar number regarded it as taking a lot of time, only half of that number regarded preventative medicine as enjoyable.

Keeping up to date was rightly regarded as important. It would appear that the amount of time taken and the enjoyment gained were in harmony.

Practice and partnership meetings were also recognised as important. The amount of time they took and the enjoyment they provided were also in harmony. The lowest rating for enjoyment was given to self/career development. Just one person marked this as enjoyable. This might relate to the fact that some saw it as politicking or self-aggrandisement, or it might relate to the fact that there are very limited opportunities for career development for GPs. The question might have been more illuminating had it been just 'self-development'. The introduction of the notion of 'career development' might have confused the issue.

The Role of Senior Partner

Over 70% of senior partners felt that they were inadequately remunerated for their responsibilities. All respondents were asked to identify:
Should a senior partner or leader, after consultation, have the power to: (Tick all those boxes which apply)

<table>
<thead>
<tr>
<th>Power</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate patients' complaints</td>
<td>51.1%</td>
</tr>
<tr>
<td>Control practice costs</td>
<td>30.0%</td>
</tr>
<tr>
<td>Recruit partners and practice staff</td>
<td>17.6%</td>
</tr>
<tr>
<td>Terminate others' employment</td>
<td>19.8%</td>
</tr>
<tr>
<td>Represent the partnership to official bodies</td>
<td>65.6%</td>
</tr>
<tr>
<td>Appraise and train partners</td>
<td>17.6%</td>
</tr>
<tr>
<td>Determine remuneration</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Table 38 Role of Senior Partner

This is a list of responsibilities which would normally reside with a senior manager for his/her team in a commercial business. When a focus group were shown this result their reaction was:

"How amazing that over 17% of respondents should think that a senior partner or leader should be able to recruit, terminate, appraise and train."

The power to control practice costs is effectively the power to allocate resources, and it was interesting to see that of this sample 30% would be willing for that power to reside in one person.

Over 40% said that their partnership did have a clear leader, and a similar number (though not necessarily the same people) said that they wanted their partnership to have a clear and acceptable leader.

Practice and Partnership Meetings

Most practices (60%) held meetings for all staff only occasionally, but over 60% of practices held partners' meetings either weekly or monthly. Partners' meetings were seen as a little more useful. The usefulness of these meetings frequently depended on the skills of the chairperson, as well as the skills of the participants and the issues on the agenda.

Just 12% of respondents saw practice meetings as not very effective and helpful, and only 8% of respondents saw partners' meetings as not very effective and helpful. There was no statistical significance in the level of job satisfaction and the number of times either type of meeting was held. However, in the case of both all staff and partners only meetings, job satisfaction did appear to be higher when meetings were held more frequently.
### Practice Meetings Involving All Staff

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>1.9%</td>
</tr>
<tr>
<td>Monthly</td>
<td>20.1%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>59.1%</td>
</tr>
<tr>
<td>Never</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

### Practice Meetings Just for Partners

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>26.9%</td>
</tr>
<tr>
<td>Monthly</td>
<td>37.5%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>21.1%</td>
</tr>
<tr>
<td>Never</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

### Table 39 Practice Meetings: Frequency and Effectiveness

### Summary of Detailed Analysis

There was evidence to support the view that the major problem areas for GPs in East Surrey and Humberside were: time management; role conflict between running a business and dealing with patients; and that some GPs suffered significantly from a lack of support from within their partnerships. Most GPs relied on their families for care and support to enable them to cope with the work environment.

In Humberside the relationship with the FHSA seemed easier than in East Surrey and, as some might expect given the relative affluence of the two areas, GPs in East Surrey were more dissatisfied with their pay levels than their counterparts in Humberside.

GPs in these two areas were fairly evenly divided between those who wanted a clear leader and those who wished to work as equal members of the team. Over 15% said that they thought partnerships should have a leader with ultimate executive authority over finance and all staffing matters (this does not rule out the need for consultation before such decisions are taken). Some
senior partners found it easier than the other principals to gain the hospital admissions they wanted and to get claims dealt with by the FHSA. Whether this was because of their greater experience or because of the apparent power inherent in the role of senior partner was unclear. Senior partners also found change less problematical than other members of the practice.

There were also differences between practices with and without a clear leader in that those practices with a clear leader coped better with some government policies (e.g. screening), and experienced less conflict with the FHSA over delays in claims. Those practices with a clear leader also experienced less conflict over the use of computers, had fewer problems with the practice manager, had less conflict over the time available for family life and had fewer problems over who leads the practice.

A higher level of job satisfaction was recorded by female GPs and by those practices employing a practice manager. A lower level of job satisfaction was recorded by those with pre- or post-school age children. There was no difference in levels of satisfaction between those who did and did not have school age children. However age did affect the reported level of job satisfaction with the highest level of satisfaction recorded by those of 60+ years, and the lowest level of satisfaction recorded by those between 40 and 60 years.

The survey results showed that GPs experienced greater job satisfaction when they had a sense of purpose; did not feel that they were impeded in achieving that purpose; and when the work was not perceived to be too difficult. Further research could be carried out into the implications of these groupings.

The GPs in this survey derived most satisfaction from dealing with the sick and tended to find other tasks (such as administration and attending meetings) irrelevant and annoying. This reinforced the image of the GP as someone who preferred to be working with patients rather than someone who liked running a business, planning strategy and administration.
CHAPTER VII

CONCLUSIONS

The conclusions from this study were drawn from the interviews and meetings with GPs, from the results of the survey and from the literature searches. A common criticism of any conclusion is that it is dependent on the methodology and upon researcher bias.

The methodological approach has been deliberately catholic, with the objective of validating the conclusions drawn from a more humanistic approach, by a more quantitative study. There are many further questions to be answered, and for those questions different methods (such as action research) may be appropriate.

Main Conclusions

The historical review - Chapter I - suggested that there are trends which are likely to continue. There are pressures over: medicine and spirituality (see also Chapter III p 49); medicine and money; growing partnerships; litigation; primary and secondary care; a salaried or independent service; and the role of the primary health care authority. All of these concerns are reflected in later chapters in various ways.

The GPs who were interviewed indicated that they faced a range of conflicting pressures (see Chapter 3: Summary of Conflicts). Those conflicts seemed to be rooted in three different places, although in practice the effects are intertwined. The conflicts identified came, firstly, from the system (e.g. FHSA paperwork; difficulty in gaining adequate physiotherapy), secondly, from the partnership and other working groups (e.g. over introducing change; different working speeds and styles; and conflict with social workers) and, thirdly, from their own expectations of self (e.g. their level of remuneration compared with that of other professions; patients’ expectations; and time management).

The theoretical review of conflict (Chapter IV) reviewed the philosophical background and suggested that conflict can arise from many sources. It can erupt over values (see also Chapter III: Belief Systems and Doctors, and Chapter I: The GP as a Business Person); because of the conflict between desire and reason (illustrated by many of the conflicts in the Summary in Chapter III, for example GPs want autonomy, authority and responsibility versus GPs want a quiet life with sufficient time for themselves and their families). Conflict can also arise over power (see
the sections on leadership in Chapters III, IV and VI). It suggested that there is a link between conflict and ill health (see Chapter IV: Why Look at Conflict?).

Chapter IV continued by looking at individual, intergroup and intragroup conflict, in order to try and illuminate the three types of conflict identified through the interviews in Chapter III. It is also intended that Chapter IV should provide a source of information for those in general practice seeking ideas for resolving their own conflicts (see particularly Chapter IV: Strategies in Conflict Resolution).

Individual conflict can arise from many sources and can be helped by training, by counselling/therapy, by effective teamwork and, this author suggests, also by effective leadership (see Chapter IV: Individual Conflict).

Intragroup conflict can be helped by the practice team consciously agreeing its structure, its decision-making procedures and by increasing its ego strength (see Chapter IV: Intragroup Conflict and Leadership).

Intergroup conflict is enhanced by poor communication and increased feelings of ethnocentrism. This has certainly been the case between GPs and social workers (see Chapter I p 24 and Chapter VI: Conflicts and Difficulties in General Practice).

The structure of organisations and the changes they can face can also cause conflict (see Chapter IV: Organisational Structure and Conflict and Chapter I p 8).

The survey was intended to describe the level of conflict experienced in a more quantitative manner. The research questions were (see Chapter V: Designing the Study: Research Questions):

1. That there are some areas which cause conflict for GPs in their working lives.
2. That some areas cause more conflict to most GPs than others.
3. That there may be conflict between perceived importance, time taken and enjoyment in the job of a GP.
4. That senior partners feel differently about their perceived role and responsibilities than other partners.
5. That the frequency of practice meetings does not affect the perceived usefulness of them.
6. That job satisfaction can vary by:
   - size of practice
   - gender
   - age
   - age of children
   - etc.

Chapter VI listed the areas where GPs felt the most conflict. Particularly important was finding time for the family versus the business demands of the practice; the exhaustion of night and weekend working; and conflict with patients over patients' expectations.
The conflict between the perceived importance of, the time taken by and the enjoyment in the job of being a GP arose particularly over preventative medicine (only 16% regarded it as enjoyable, whilst 30% regarded it as important and time-consuming) and over practice administration (only 9% regarded administration as enjoyable, whilst nearly 30% regarded it as important and over 40% regarded it as time-consuming). (See Chapter VI: Aspects of the Job which are Most Important, Enjoyable and Time-Consuming.)

70% of senior partners felt they were inadequately remunerated. Senior partners experienced less conflict than others over introducing change to the practice and over gaining hospital admissions (see Chapter VI: Hospital Admissions and Conflict with Partners over Change).

Practice meetings for partners were held more often than practice meetings for all staff. Practice meetings for partners were also considered more helpful (see Chapter VI: Practice and Partnership Meetings).

Job satisfaction was found to vary by age, by age of children, by gender and by whether or not the practice employed a practice manager (see Chapter VI: Job Satisfaction).

In addition, conflict was seen to increase in several cases where there was no clear leader (see Chapter VI: Leadership within the Practice).

The major themes of this thesis are interlinked. In order to move forward, and to reconcile conflict, the issues in the diagram overleaf have all to be considered:
Figure 20: Issues to be Considered in Reconciling Conflict
If GPs want to be pivotal in patient care, then this diagram shows a way of looking at the issues which lie behind the service they could provide. At this moment GPs are at the gateway; they have the option. They can broaden their perspective, their responsibilities and their influence, or they can effectively be marginalised into providing just part of a service. Individual GPs will make individual choices, but the profession, the Department of Health and the Social Services Inspectorate also have choices to make.

These conclusions, it must be remembered, are offered on the basis of:

- the replies to a survey of about two-thirds of GPs in East Surrey and Humberside
- in-depth interviews and meetings with GPs in the south of England
- observation and extensive literature search.

It cannot be claimed that these conclusions represent the experience of every GP in the UK.

**ISSUES TO BE ADDRESSED**

In a little more detail, the main problems which arose in this thesis were:

**Organisational Issues**

1. The Primary Health Care Team is growing in terms of resources, staffing, obligations and management challenge.

   The management challenge includes strategic planning, staff management, co-ordination of care, negotiation for the best use of secondary care resources, and representing the case for primary care to government. There is still a strong feeling that the government unnecessarily keeps 'moving the goalposts'. Small isolated practices may not be either interested in or able to respond to all of that challenge.

   Nurse practitioners and practice managers are, in some cases, becoming partners in some primary health care teams. GPs may feel the need to protect their autonomy by becoming both 'Directors' of the Primary Health Care Team and, as doctors, by being part of a specialist department within the team (similar to the chart shown on figure 3 shown earlier).

2. The role of the senior partner is currently fraught with controversy. 17% of those surveyed thought that even as the role exists (promotion by length of service, unclear job definition and obligations, no obvious additional remuneration for additional responsibility), that senior partners ought to have executive authority over managing the practice.

3. There is an increasing call for greater accountability of GPs through various mechanisms. These include the FHSA's control through the 'new' contract, Medical Advisors and PACT, medical audit, re-accreditation, litigation and continuing education.

4. The relationship between the FHSA and GPs is not always harmonious and supportive. The role of 'paymaster' means that the FHSA's powers and competence are regarded with some suspicion.

5. In areas where GPs cannot respond to the challenges, social workers and hospital accident and emergency units may shoulder increasing responsibility. There is a tension between the two methods of operating:
taking primary care and consultants to the health centres; or

inviting GPs to work in the casualty units of hospitals because it is claimed that local GP service is poor.

Practice Organisation and Teamwork

1. GPs do not easily give support to other GPs at work (for example, in the survey only 6% found partnership meetings "most enjoyable"). Many surveys are pointing to an unacceptable level of stress being experienced by GPs at this time. The danger is that this will eventually have an effect on recruitment.

2. In the survey, practices with a clear leader were found to suffer less conflict over screening procedures, with FHSAs over decision-making, within the practice over the use of computers and over the competence of the practice manager and, perhaps most importantly, over finding sufficient time for family life. The value of screening itself is still a contentious issue for many doctors.

Career Development

1. Male GPs between 40 and 60 years have the lowest level of job satisfaction amongst GPs as a whole in the two areas surveyed. A lack of career development opportunities within a practice may account for some of this low trend. Female GPs have a higher level of job satisfaction and their numbers within the profession are increasing.

2. There are currently many additional opportunities for GPs: to offer complementary medicine, to move into management, to move into education and training. In addition there are the opportunities which have always existed - for example in prison, police and hospital work, research, private work or sports medicine [Hancock 1992 p 45]. However, these need to be entered into carefully because they can be the cause of partnership problems. A robust partnership will discuss and anticipate any likely problems and deal with them quickly; a less robust partnership may let such problems fester.

Personal Organisation and Patient Care

1. Time was a major problem with GPs. They found night and weekend working increasingly difficult; they felt that they had insufficient time for really sick patients and for their families. They felt they were spending too much time on bureaucratic form filling. The fear was that the new reforms would eventually undermine the human element of care.

"The doctors are beginning to creak .......... the sensitive ones crumble .......... it is the macho ones who are surviving."
Anonymous, an interviewee, two years after the interview

2. Dealing with unrealistic patient expectations was a major problem for one-quarter of GPs, and was cited as a problem by nearly 70% of those who completed the survey.

Manpower Development and Training

1. There may be a decline in the numbers of GP trainees applying for posts relative to the numbers retiring. GP spokesmen put this move away from general practice down to the increasing business ethic. If this business ethic is an enduring principle then it needs to be
addressed during selection; undergraduate training; by partnership organisation and structure; and by exploring alternative career paths.

2. There is little management training available for those in primary care. Those interviewees who had had some management or teamwork development said they found it useful. There is no training ethic similar, to that recognised by many commercial organisations, which says that before a GP (or anyone within the practice) takes on a management responsibility they should be trained for it. The current vocational training scheme is training GPs for the service that they have historically provided, not for the service they are now expected to provide. One GP, on reviewing this chapter, observed that they have become "population accountable" for personal care and this is fragmenting the continuity of personal care.

**Different Types of Organisational Structure in General Practice**

The practices studied displayed different methods of working. These methods could be grouped into the following four categories:

<table>
<thead>
<tr>
<th>SENIOR PARTNER</th>
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<tbody>
<tr>
<td>- Seniority achieved by length of service in that practice</td>
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<tr>
<td>- Gives stability and security</td>
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<tr>
<td>- Perceptions of whether or not this is an outdated role differ</td>
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<tr>
<td>- Senior partner may or may not be willing and able to be the senior manager</td>
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<tr>
<td>- Frequently little additional financial reward (depends on partnership agreement) but there may be flexibility over time and duty rotas</td>
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<tr>
<td>- Authority depends on personality</td>
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<tr>
<td>- There is some status (at least in the eyes of the patients and administrative staff) and some responsibilities (e.g. sometimes representing the practice to external bodies and FHSA)</td>
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<tr>
<td>- Administrative staff tend to turn to the senior partner as the senior manager</td>
</tr>
<tr>
<td>- The role mixes clinical and management responsibility</td>
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</table>

Figure 21 Organisational Structure (a) - Senior Partner

This could be diagrammatically represented thus:
The lack of lines between the senior partner and the other principals is intended to illustrate the lack of formal authority inherent in this role.

Where the senior partner's skills were respected and valued, this model could give some stability. Where there was conflict and lack of trust, this model could lead to a rebellion and partnerships sometimes wanted to move completely away from the notion of any partner having authority over the others. In this case they would choose either the 'Rotating Chairman' or 'Equal Partners'. Even if the senior partnership model were working well the future can hold problems. It is not always acceptable to partners these days that the senior partner should be chosen due to length of service.

**ROTATING CHAIRMAN**

- May rotate over time (e.g. each year) or by meeting place (e.g. each host takes the chair)
- Chairman has co-ordinating role, but no authority to impose decisions
- No financial reward; time spent on administration generally not compensated
- Can be a useful way of testing and developing different partners' skills of leadership
- Difficult decisions may be postponed until someone else has the 'chair'

*Figure 22 Organisational Structure (b)*

This could be diagrammatically represented thus:

**EQUAL PARTNERS**

- May have different leaders for different areas of responsibility
- Has the potential for gaining excellent team commitment and motivation
- Requires highly developed interpersonal skills from all partners - otherwise open to subversive attempts to exercise leadership (e.g. in representing the partnership articulately to outside bodies the 'spokesman' may eventually become the leader)
- Can be appropriate for professional partners all at a similar stage of development
- Can respond slowly to change because of the time needed to obtain full agreement
- Meets many GPs' desire to be autonomous

*Figure 23 Organisational Structure (c)*
This could be diagrammatically represented thus:

![Diagram](image)

**MANAGING OR EXECUTIVE PARTNER**

- Person appointed because they are seen to have the necessary skills
- A permanent appointment can give stability; appointee not necessarily a GP
- Difficult decisions may be confronted
- Remuneration and time for administration can be calculated separately from remuneration for clinical skills; clinical and managerial responsibilities can be separated
- Does not preclude partners having special administrative responsibilities (see Figure 3 p 12)

Figure 24 Organisational Structure (d)

This could be simply represented thus:

![Diagram](image)

The Board of Directors would appoint from amongst them a managing or executive partner.

For a further illustration of Organisational Structure (d) see Figure 3, p 12

**Continuing Professional Education and Training - Some Current Sources**

'Continuing professional education' frequently refers to clinical education, and 'training' could be taken to refer to management or administrative skills training. However these definitions are not clearly agreed widely in the medical world, and so the two phrases here will be taken to refer to both types of educational need.

The BPMF provides short courses on a wide range of educational topics for GPs. The RCGP also provides short courses, including some distance learning packages, on management skills. These courses have been frequently oversubscribed and the College can only provide a
limited number of places per year. The King's Fund Institute provides a range of longer and short
courses, some looking at medical management and health administration. The Open University has
recently provided a distance learning course 'Managing Health Services'. The Association of Health
Centre and Practice Administrators and Association of Medical Secretaries, Practice Administrators
and Receptionists courses for practice managers now have a larger management component. The
Marylebone Centre provides a few multi-professional courses from a holistic perspective. Some
local universities and department of general practice provide other training opportunities. The BMA
and LMCs also offer conferences and courses as they see appropriate. Medical Audit also offers
educational opportunities, and pharmaceutical companies support clinical education which is relevant
to them.

The number of education and training providers is diverse, and not co-ordinated. Well-
intentioned they may be, but because of their various funding backgrounds they have different
emphases; they cannot be counted upon to support multi-professional teamwork; and their
philosophy and knowledge of management education is sometimes patchy. Many of these training
providers rely on popularity to sell their programmes. In the long run, this is probably the only way
to continue; but in the short run, organising only popular training programmes will not necessarily
support the new developments (e.g. interprofessional teamwork) in the system. Training should
be regarded as a necessary investment (i.e. creating an initial financial loss) to ensure the success
of a new initiative. There is some evidence that GPs belonging to a subscription scheme have a
more balanced postgraduate education than those who pay individually for each course.

Murray et al [1993] believed that the postgraduate education allowance could and had led
to two problems. Firstly, doctors' postgraduate education tended to be 'all or nothing' and,
secondly, where doctors were concerned to protect income, the low cost or free courses might be
attractive. Free courses are generally provided by the pharmaceutical industry.

It could be argued that this approach smells of propaganda and manipulation - not to say
of wasting yet more time. Training cannot be carried out in isolation, in its design and its
implementation it needs practitioners as well as experienced adult educators. Equally important
is the need to have the obligation to feed back into the system the suggestions for change made
by the participants as a result of the programme.

Further Training Issues

Teasdale wrote in a BMJ series on 'Partners in Practice' about the growing role of the
practice manager and clearly identified a training need for GPs:
"Who can be expected to appraise the practice managers and motivate them to improve their performance? ... staff appraisal is not something which general practitioners can expect to do with no training?"

Teasdale 1992 p 454

The concept of appraisal frequently suggests the need for a hierarchical organisational structure. Peer appraisal and review is possible, but it is neither common nor easy to manage. Universities have been trying to implement appraisal of professionals into a largely collegiate system and have found that it takes an inordinate amount of management time. However the prospect of no review or assessment is not, at an organisational level, a useful one.

Teasdale also pointed out that fundholding practices might come under an additional pressure - patients may transfer to them in order to obtain preferential hospital referral [op cit p 456].

GPs are not likely to be trained in staff or business management. Many existing practice managers, secretaries and receptionists have also had little training [Jones 1992 p 506]. There is a great backlog of training needs building up. Jones argued that the responsibility for education within the practice "rests squarely with the general practitioner". This would indicate that GPs needed skills to identify staff training needs, and to have some ideas (including developing their own coaching skills) about how these needs should be met. In the larger practices the practice manager could be delegated the task for administrative training, but the GP had to take responsibility for managing clinical training. Jones concluded that audit could be a good mechanism for developing teamwork. Some audit will include multi-professional teams but, as has been stated earlier, such audit is not compulsory and the bringing together of multi-professional teams can, indeed, be easily avoided.

If it is true that:

"In the end what makes a successful team is not merely the quality of the individual members but how they work together."

Hasler 1992 p 234

then GPs must be encouraged to be less isolationists about their training, and be prepared to work with other groups; to acknowledge and learn about the way other professionals work; and to educate others in their priorities. Given the response to the 1992 Conflict survey it would be surprising if most GPs did not report "We'd love to, but we don't have the time". The principles of community care do suggest that time will have to be found from somewhere for multi-professional team training if suspicion and ignorance are not to threaten the concept.
Training is also a consultative concept, and can be used to modify the system to make it more practicable.

Undergraduate education is also a major cause for concern [Jewell 1991 and Weatherall 1991] and is being studied in a separate thesis [Maxwell unpublished].

**Collaboration between Primary Health Care Providers**

The diagram below shows how divisive the former method of working could become. The outcome of the care a patient received would depend upon the referring agency with which the patient first came into contact.

---

As Dr Wilson said:

> "Health is not just about medical things - it is about housing, peace, warmth, sewers .......... a combination of physical, emotional and environmental factors."

Mowbray 1992

Noakes [1992] has made the clearest call yet from a practising GP for a "Primary Health Care Authority" which co-ordinated the many aspects of health care, including those already covered by the FHSA. Pereira Gray [1992] listed this as one (and the most desirable) of three options. He added that an evolutionary approach was the most likely because of the likely need for legislation if Primary Health Care Authorities were to be created immediately.
There are two good examples of moves towards this ideal. 'Training for Community Care: A Joint Approach' was a report produced by the Department of Health and the Social Services Inspectorate. Primary recommendations included:

- collaboration between the Health Authorities, Local Authorities and the voluntary, private and 'not for profit' sectors;
- local and systematic development and training strategies;
- the clarification of the responsibilities of local agencies, central government and training institutions and the involvement of the carers.

An interesting example of the collaboration between GPs and social workers is happening in Upton-upon-Severn, in Hereford and Worcester where a social worker has been attached to a small local surgery for nearly a year. The GP said:

"Having a social worker here has meant that we have had a fresh look at these patients, which has been invaluable and has helped us to give a better service."

The social worker said:

"Because I am being introduced to people by a family practitioner who has been their trusted advisor for up to thirty years - any reserve they might have about social workers is broken down. I can also work more efficiently because I can see patients within three days of referrals coming into the surgery."

Mowbray 1992

This experiment appears, so far, to be a success. If the pattern were to be replicated and not to depend utterly upon the personality and goodwill of the professionals involved, then the system would need to change to work for it, to break down the barriers of ethnocentrism and to ensure that the system itself was not divisive. Ultimately, separate hierarchical reporting structures (e.g. FHSA, DHA, Social Services Inspectorate) create divisions.

Clear organisational structures; areas of accountability; divisions of professional responsibility; funding which unites rather than divides; supportive teamwork; and joint training and educational initiatives all have a part to play.

From the theoretical review of conflict it was clear that there were many skills and strategies which could be learned to reduce conflict. These should be incorporated both into the NHS and into the education of the carers who worked in the system.

**Personal Organisation**

The greatest worry would appear, for the Conflict survey sample, to be finding sufficient time for family life. Given that 84% of these GPs got their main support for their working lives from their
spouses and/or families, it was not surprising that they were concerned at the potential mismatch here.

How much time is sufficient time for family life? There can be no general answer, but the fact that the respondents' children ranged evenly from babyhood to adulthood suggested that the problem did not get significantly easier as children grew up. It was not just time that was necessary either; it was time where the parent, spouse or partner felt alive, healthy and free enough to get involved in non-work activities.

What can education and training do to arm the trainee against the onslaught of unnecessary paperwork, the strains of being on-call and difficult patient expectations? How can the course educator devise a training programme which encourages trainees to be efficient and to keep their lives in balance? Encouraging trainees to "open a book occasionally" and read great works of fiction is a necessary, but not substantial, part of this quest [Salinsky 1990]. Caring for people is seductive. It can take time away from the carer before they know it. Without realising it, it can quickly become easier to spend time solving patients' problems than confronting the anger that can arise from having over-postponed solving one's own.

Some Mechanisms for Managing Time

Managing Repressed Emotion

The literature on time management surveyed the topic either from the position of self-analysis [Pedler and Boydell 1985] or from the behaviourist's position [Welsh 1983].

Managing time from the position of self-analysis often suggested using an analytical framework based on Jung. The rationale being that if GPs were not self-aware they would misuse time trying to compensate for an unexpressed or repressed emotion. For example, a GP might spend longer than strictly necessary with a particular age group of patient because they felt they had let their father/daughter (or whomever) down in the past. There were some appropriate examples of this in the in-depth interviews carried out. A certain amount of exploration can be done through reading, but more help may come from a well-qualified psychotherapist. The Balint groups also met some of these needs [Balint 1966]. A clear example of how repressed emotion affected performance was described in a study of prescribing behaviours [Bradley 1992]. The GPs interviewed admitted that their prescribing behaviour was affected by the behaviour of patients they saw as "Aggressive", "Demanding" or "Manipulative". The author claimed that the study revealed a great deal of "suppressed dislike" [op cit p 455].
Behavioural Time Management

Aside from the debate about whether consultations should be spaced at seven, ten or twenty minute intervals, there are a host of useful behavioural activities which can be employed to assess and improve effectiveness in the use of time. Defining long, medium and short term goals and priorities can be an effective beginning. Keeping a 'time log' is initially time-consuming and often resisted, but it can give some unpleasant and useful answers [Adair 1987].

Difficulties with Delegation

There are useful techniques which can be employed in managing paperwork too. This is not to deny that the paperwork may have become excessive and needs vigilant pruning. But procrastination over paperwork can make matters very much worse. "Deal with each piece of paper only once" may not always be advice which can be followed, but it can be a useful goal.

Below are some examples of the more practical advice available:

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<tbody>
<tr>
<td>1.</td>
<td>If you have several items of similar urgency and importance, do the hardest one first.</td>
</tr>
<tr>
<td>2.</td>
<td>Do the most important items during that part of the day when you perform best.</td>
</tr>
<tr>
<td>3.</td>
<td>Never do a task that someone else can do. Do not let guilt, pride or fear keep you from delegating.</td>
</tr>
<tr>
<td>4.</td>
<td>Skim all documents before reading them. Do not read documents with low return on investment.</td>
</tr>
<tr>
<td>5.</td>
<td>Whenever a subordinate presents a problem, require that person to suggest one or more solutions.</td>
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Adapted from Quinn et al 1990

"Could **someone else** be doing this?" Or: "What would happen if this activity was not done by me?" [Welsh 1983] are useful questions to ask over some routine matters which it might be possible for the practice nurse, manager or secretary to carry out. There is an art in delegation however and, as for other leadership skills, many people delegate more effectively and acceptably when they have been taught how to do so.

The difficulty with delegation is that there are frequently very good reasons for not having done it:

- "They won't do it as well as I could."
- "Everyone expects **me** to attend."
- "They haven't enough experience, they might make a mistake."
- "They might ask for an increased salary."
- "I might do myself out of a job eventually."
The other big difficulty with delegation is that it takes time to do it properly. In this sense it does 'take time to make time'. By the time a training plan has been worked out and the delegates have been briefed, trained, monitored and coached, the GP might be justified in thinking "it would have been quicker to have done it myself". However, if GPs are at a gateway of opportunity, in terms of the responsibilities they could handle, only if they learn to delegate (and to motivate the delegatee to want to perform the task) are they going to free themselves for their real work. Enabling others to learn is a key managerial competency [Quinn et al 1990].

Techniques including daily planning, managing meetings and the effective use of practice staff's time can be taught or discussed.

**Doctor-Initiated Consultations**

The doctor is the biggest factor in initiating return consultations and there was some evidence that patient/doctor communication on this point was not always clear [Armstrong et al 1990].

Whatever the causes, once life is out of balance it usually takes superhuman effort, a tragedy or an illness to refocus it. Prevention is always better than cure. "Physician, prevent thine own illness" is not going to be an easy dictum to teach to GPs or for them to learn.

On the other hand, the desire to manage time can, taken to its extreme, turn a person into an effective automaton.

"Over-preoccupation with one's own time is not an attractive quality. Moreover the management of time can never be seen in isolation. It is only one of the elements of effective performance."

Adair 1987 p 1
Summary

Competence and job satisfaction come from many sources. For the GP the ultimate purpose of seeking competence and job satisfaction must be to improve patient care, and that care can come from a number of sources. During their working lives GPs should be able to choose whether to concentrate on patient care or to move in or out of management or other specialities. In either case, their education and postgraduate training must be relevant to the problems they are facing. In their careers and in their profession GPs face the choice of being organised by others, or of getting the training necessary to become organisers themselves.

The idea of collaboration in care is now clearly expressed in the literature, but the reality is far from that. Further change will have to occur, and during times of change there are always a great many fears. If the change is to be effective at each stage many people will need reassurance, education and to be listened to - their ideas on effective implementation must be sought and examples of practices following these principles working well must be widely disseminated.

Effective leadership within practices (whichever organisational structure is chosen) will be key to maintaining competence as the services that the GP can offer broaden. An effective leadership style does not imply dominance or authoritarianism; it does imply consultation and caring. In some practices that leadership may be shared, but as practices grow the pressure and need for a figurehead may increase.

The final word should be left to a member of the profession, a GP who had not participated in the interviews or in the survey asked to read the thesis as it was nearing completion. His conclusions were typical of many GPs' views:

"I return your outline thesis which I read with interest. One of the main sources of conflict in a practice is between partners, and I think this requires more exploration. I agree that our lack of management expertise can be very frustrating, particularly as more of the responsibilities of management are coming our way without any diminution in our role as physicians.

"I always think of partnerships generally as having all the frustrations of marriage with none of the fun!"

Anonymous 1993
SUMMARY OF RECOMMENDATIONS

1. No one element of primary care can be examined in isolation. The solutions to managing conflict productively are, inevitably, intertwined.

2. At an organisational level the Commission for Primary Care is an important step forward into examining more closely how multi-professional teams might collaborate. Funding for collaborative research and education will need to be provided if multi-professional teams are to be effective.

3. Also at an organisational level, the various authorities to which the various members of these teams report need to work together under one umbrella. Separately funded and housed authorities will create conflict and division.

4. At a health centre or partnership level, the appropriate organisational structures need to be chosen for each practice.

5. Management and leadership training for all those involved in managing people will aid competence. As practices grow, training in the art of effective delegation will be especially important.

6. The vocational training, continuing education and professional development of GPs should reflect the changes in their role and responsibilities.

7. The career structure for GPs should allow those who wish to concentrate only on patient care to do so and those who wish to combine, or even replace, this element of their job with management or other professional interests should also be able to do so. Both types of GPs will be needed in the future.

8. The support network for GPs needs to improve. Increased opportunities for mentoring, counselling, nurturing, teamwork and self-development will improve GPs’ ability to manage change and to cope with difficult patient expectations.

9. The basic concept of the patient having the automatic right to see a GP may need to be further examined. Triage is currently working in many A and E units (where a nurse assesses the patient’s level of need). If multi-professional teams are to work well, a nurse-practitioner (or similar) might assess which member(s) of the team the patient needs to see. This would be a difficult concept for some GPs to accept and has many implications.
QUESTIONS FOR FURTHER RESEARCH

Arising from any thesis there are often more questions than answers. The questions below are the issues which the thesis suggests are most important. They relate both to long and short term potential changes. Not all of these changes would affect every GP. The research suggests clearly that whilst some GPs are frustrated and want new and different ways of working, other GPs wish to concentrate almost exclusively on patient care. Appropriate research methods for many of these enquiries could include action research as outlined in Chapter II (p 39).

1. How closely does the current education and vocational training of GPs reflect the business/administrative content of their job?

2. How could career paths for GPs be developed which would reflect the differing needs and skills which they have. For example: business management; direct patient care; and co-ordination of care?

3. What approaches might GPs find useful to help them with time management and with developing a supportive climate within general practice?

4. How could the co-ordination of all primary care be best achieved?

5. What further needs to be done to develop and make practical the alternative objectives and organisational structures from which general practice can currently choose?
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The trainee should be able:

**CLINICAL PRACTICE: HEALTH AND DISEASES**

**Health Examination**

1. To list and criticize 3 definitions of health;
2. To list 3 characteristics of healthy people.

**Health Education**

1. To demonstrate that he is aware of the possibility of changing the behaviour of individual patients towards healthier habits;
2. To discuss the aspects of health education which are proven or generally accepted.

**DISEASES**

**Selecting Diseases to be considered**

1. To recognize early, treat and/or manage acute diseases threatening life, e.g. acute appendicitis;
2. To detect the early signs of disease which may be aborted or of which the complications may be reduced, e.g. pulmonary TB, depression and other emotional disorders, glaucoma, pernicious anaemia, myxoedema;
3. To recognize early the dangerous complications of conditions not otherwise dangerous, e.g. toxaemia in pregnancy, broncho-pneumonia in measles;
4. To recognize and treat a wide range of common conditions which will not require referral or hospitalization;
5. To recognize in conditions of a chronic nature the important factors requiring continuing care.

**Natural History**

1. To describe the natural history of 3 serious disorders for which no effective prevention or treatment is known;
2. To describe the natural history of 3 serious disorders for which intervention may be effective.

**Prevention**

1. To name 10 diseases which can be prevented, taking them from at least 3 different sections of the International Classification;
2. To identify at least four vulnerable groups in the practice population which can benefit by the application of personal preventive methods.
Patterns of Early Stages of Disease

To name 12 diseases which are seen at least once a year by a GP and for which early diagnosis is of great importance.

Management

1. To list and demonstrate the simpler forms of psychotherapy used in general practice.

2. To contrast the management of serious illness at home and in hospital.

3. To identify instances where co-operation with the several members of the domiciliary health team is most effective.

EXAMPLES FROM THE INTERNATIONAL CLASSIFICATION OF DISEASE

Infective and Parasitic Diseases

1. To recognize the rashes and other clinical features of the common infectious diseases.

2. To carry out all the common immunizations and to know their dangers.

Neoplasms

1. To list the early symptoms and signs of cancer in the 8 sites where it occurs most commonly.

2. To carry out the techniques of examination listed above (skills in diagnosis).

3. To discuss from experience the problems of home care in terminal cancer.

Mental Disorders

1. To describe the natural history of 3 major psychiatric illnesses.

2. To recognize and list 10 symptoms of psychiatric disorders in children and adults.

3. To describe how he would assess the risk of suicide in a depressed patient.

4. To describe and recognize 6 common causes of emotional conflict and distress in everyday life.

5. To demonstrate that he understands the importance of the doctor-patient relationship.

6. To list and discuss 6 simple methods of psychotherapy useful in general practice.

7. To describe the proper indications, use and dangers of 4 sedatives (including tranquillizers) and 3 stimulants (including anti-depressives).

8. To describe 3 ways in which a social worker might be of value in dealing with a patient with a psychiatric problem.

9. To discuss the indications for and technique of referral to a psychiatrist.

10. To discuss and demonstrate that he knows how to influence:

   a) the attitudes of relatives to a depressed patient
   b) the difficulties of relatives in the face of this disturbance.
Diseases of the Respiratory System

1. To list the preventive measures applicable to the disorders of the upper and lower respiratory tract.
2. To describe the diagnostic methods which distinguish between the transient and the life-threatening disorders of the respiratory tract.
3. To show that he is able to treat all common disorders of the tract, except pulmonary tuberculosis and those requiring surgery.

Diseases of the Genito-Urinary System

1. To list 10 conditions which depend for diagnosis on vaginal examination with fingers or speculum, and to describe the diagnostic features of each.
2. To describe the diagnostic features of urinary tract infection in children, in adult females and adult males.
3. To list the abnormalities which may underlie a urinary infection in:
   a) an adult male
   b) a child of either sex.

Symptoms and Ill-Defined Conditions

To list the methods of investigation and the differential diagnosis of the symptoms and objective findings on such conditions.

HUMAN DEVELOPMENT

The First Year of Life

1. To describe a satisfactory feeding regime for an infant of 9 weeks.
2. To decide correctly whether a given feeding regime is satisfactory for a particular infant of 9 weeks.
3. To recall a given list of those conditions which may cause a mother to state that her 10-week-old child has vomited repeatedly (knowledge).
4. To perform successfully the abdominal examination of a crying 10-week-old child (skills).
5. To reach correctly the diagnosis of regurgitation in a 10-week-old child (use of knowledge and skills).
6. a) to advise a mother properly on ways of dealing with the family problems of having a regurgitating child (social skills);
   b) to help her establish and maintain a rewarding relationship with a regurgitating child (interpersonal skills).
7. To demonstrate an understanding of the minor frustrations experienced by a doctor treating a regurgitating child (self-understanding).

The Pre-School Period

To consider the developmental causes of the difficulties which arise when school starts, the pre-school child having seen himself as the key figure in the world in which he lives.
Pre-Puberty

To understand how the child at school entry should have intellectual development to be capable of school work, sufficient self-control to live with his peers and to take direction from other people and sufficient emotional development to tolerate separation from his mother.

Puberty and Adolescence

To learn the different roles he needs to adopt in different situations - an adolescent gives to his doctor only that authority which stems from what he sees as the doctor's expert knowledge in certain defined fields, not from social status, and he must be absolutely honest with an adolescent patient and become aware that any consultation with him will contain an element of testing, the results of which will be borne in mind by him when consulting a doctor in the future.

Young Adults - Young Parents

1. To identify and write down his opinion of each of the methods of contraception available to his patients.

2. To distinguish between his professional opinion and his personal opinion when fulfilling objective 1.

3. To demonstrate the non-directive counselling of a patient who asks for advice on contraception and be able to list the patient's needs and fears, about sexuality as well as about contraception.

4. To identify his reaction to the information, given at a consultation by a patient, that advice on contraception has been sought from qualified outside sources.

Mature Adulthood

To understand problems due to diminished capacity to adapt to work situations in the male and perhaps to family situations in the female, developmental happenings.

Pre-Retirement and Retirement

To be able to distinguish those symptoms which are due to expected changes in tissues, those due to accelerated changes, those due to genetic constitution, those due to a consistently adverse environment, and those due to the added effects of pathological change, and to make hypotheses about the feelings of patients in this age-group in terms of:

1. the preparations being made, or already made, for retirement;

2. the attitudes of society towards them;

3. the attitudes of their family towards them;

4. the loss of self-esteem and the boredom which result from ceasing to be employed;

5. the sense of inadequacy and of physical unattractiveness implicit in some of the changes we have listed.

Old Age

To grasp how, since the NHS and the advent of the affluent society, the discipline of geriatrics has been asked to provide medical answers to a social and demographic problem and to be encouraged in his contacts with patients in this age-group because the elderly can only benefit from the air of enthusiasm and optimism which he can bring to their care.
HUMAN BEHAVIOUR

Stigma

1. From detailed case-histories of 2 children with otitis media that he has examined, to show how contrasting psychological and social factors in each case have affected the presentation and management, and will affect the prognosis in the patients.

2. From detailed case-histories of 2 adults with insulin-dependent diabetes that he has examined, to show how the contrasting psychological and social factors in each case have affected the management, and will affect the prognosis in the patients.

3. To describe the factors which have caused some patients to reject his advice that they should be admitted to hospital.

4. To describe, from his own experience, why some healthy children are presented by their mothers to the GP for frequent consultations.

5. To describe and analyze the history, management and prognosis of one patient who has been extensively investigated for several years without positive findings.

Behaviour in Inter-Personal Groups

1. To describe an occasion, from his own experience, when some verbal cue from a patient has led him to explore an unsuspected, but relevant, aspect of the patient’s problem.

2. To describe an occasion, from his own experience, when some non-verbal cue from a patient has led him to explore an unsuspected, but relevant, aspect of the patient’s problem.

3. To describe an occasion, from his own experience, when he has made diagnostic use of his own reactions to a patient’s behaviour.

4. To describe a case, from his own experience, where a patient’s concept of himself has led to unreasonable demands on the doctor.

5. To describe his management of a patient he has seen, where symptoms have been caused by injury to the self-esteem.

Behaviour in the Family

1. To describe or invent a situation where a ‘family myth’ of illness has been presented in the GP’s consulting-room.

2. To analyze the difficulties he has experienced in deciding who is the patient when one member of a family has complained for another.

3. To describe a case-history where a marital relationship disturbed by conflicting needs and roles in the partners has presented as illness in one partner.

4. To describe a case-history where the behaviour of the spouse has hindered the management of a patient with some organic illness.

5. To describe a situation where the GP has been unable to function as a family doctor.

Behaviour between Doctor and Patient

1. To recall a consultation which became difficult owing to different basic assumptions between himself and a patient, and to recount what happened as a result.

2. To describe any particular kind of situation he finds difficult to handle, and what action he takes as a result of such difficulty.
3. To offer 3 recent examples of times when he has manipulated a patient, with outcome.

4. To offer 3 recent examples of times he has been manipulated by a patient, with outcome.

MEDICINE AND SOCIETY

Culture, Class, Health and Illness

1. To compare the cultural attitude of our own society with that of a contrasting society in respect of the following conditions: chronic alcoholism, adult male homosexuality, schizophrenia.

2. To list 2 culturally determined factors which affect the experience of pain.

3. To list 5 culturally determined factors which promote the chances of survival in infancy.

4. To list culturally determined factors in each of the following conditions: carcinoma of the cervix, carcinoma of the breast, pulmonary tuberculosis, chronic bronchitis, coronary thrombosis.

5. To recall the classifications of social class most widely used in this country, and be able to give an estimate of the percentage of the population under the different headings.

6. To list 3 specific problems encountered in the allocation of social class to individuals in the practice.

7. Given the names of a number of conditions, to differentiate between those where the prevalence rises, falls, or is randomly distributed between social classes I to V and should be able to state the theoretical reasons for these findings.

8. For a number of infants under the age of 1 year who are on the practice list, to list those class-related factors which may affect morbidity and life expectancy.

9. To list 5 class-related factors which may affect the health expectation of an infant born into: a social class I family; a social class V family.

10. To name one class-related factor which may operate in requests for: tonsillectomy, circumcision of an infant, oral contraception, meals-on-wheels.

11. To contrast middle-and working-class factors which modify the patient's use of the sick-role and social support in the sick-role.

12. To list 3 class-related factors which may reduce the effectiveness of the doctor/patient communication.

Diseases of Civilisation

1. To list 2 factors in the built environment which: inhibit social interaction, and which encourage social interaction.

2. To list 6 examples of environmental pollution and describe their sequels.

3. To list 3 types of malnutrition which may be met in practice in the UK, and describe their causes and effects.

4. To discuss and contrast the uses of tobacco, marijuana and alcohol in our society, and examine the attitudes of our society to each of them.
5. To list the potential health hazards to patients working in 6 stated occupations, and to list the steps the GP can take to minimize or detect early the effects of each of these hazards.

6. To list 3 modes of social movement and describe how these may give rise to stress.

7. To observe the following factors described by sociologists:
   a) Reproductive efficiency in women - the recruitment to higher social status of women with higher reproductive potential (as expressed in stature, health, attractiveness, etc).
   b) Intelligence - the distribution of intelligence quotients is very much class-determined in our society (there is an excess of subnormal IQs in the lower classes and in the upper classes the subnormal IQs are usually found among individuals who are clinically not normal because of deafness, brain damage, etc, seeming to suggest that there is an inertia in class mobility; nonetheless, there have been changes in the proportions of the social classes between 1921 and the 1951 census with classes I, II and III having increased and classes IV and V having decreased.

8. To list 3 major factors which influence class mobility, and to describe the effects of these factors.

9. To list the morbid processes which may be initiated by the use of the following 5 pharmacological substances: tetracycline, phenylbutazone, MAO inhibitors, steroid eye-drops and trifluoperazine.

**The Uses of Epidemiology**

1. Given a short list of conditions, to indicate the way in which the clinical features, incidence, prevalence and death rate have changed in the UK over the past 30 years.

2. To list the major difficulties in undertaking a practice morbidity survey, and to discuss the uses to which such a survey may be put.

3. To describe the setting up of a card-index age/sex register and explain how this can be used in a screening programme for carcinoma of the cervix, and in the running of a paediatric development/immunization programme.

4. Given the following 5 clinical situations, to specify what data from group experience may be used in estimating the individual risk to: an obese woman aged 40 who asks for oral contraceptives; a primigravida aged 40, social class V; a pregnant woman who has contracted rubella at 6 weeks; a 30-year-old doctor who has recovered from a coronary thrombosis; a 40-year-old man who smokes 30 cigarettes a day, presenting with a persistent cough following a cold.

5. To describe the profile (i.e. prevalence and outcome) of duodenal and of gastric ulceration.

6. To produce an example illustrating Morris's 4-step model for searching for the causes of chronic disease.
The Organization of Medical Care in the UK and Comparisons with Other Countries

1. To describe the major functions of the following medical advisory bodies in the NHS:
   - Medical Practices Committee
   - Regional Hospital Board
   - Central Health Services Council
   - Hospital Management Committee.

2. To list the major functions of the following major medical professional bodies in relation to the DHSS:
   - General Medical Services Committee
   - British Medical Association Guild
   - Conference of Local Medical Committees
   - Joint Consultants Committee.

3. To list the major functions of the following bodies involved in lines of communication between the DHSS and GPs:
   - Executive Council
   - Local Medical Committee
   - General Medical Services Committee
   - Medical Practices Committee
   - Central Health Services Council

4. To discuss the conflict between the bureaucratic and professional ethos when the GP asks for the immediate admission to a long-stay geriatric ward of an 80-year-old with hemiplegia, when she is left alone as the result of a family crisis.

5. To list the major medical services outside the NHS available through the following bodies:
   - Nuffield Provincial Hospitals Trust
   - BUPA
   - IOD
   - TUC

6. To list, in each of the following situations, instances of help which may be available from a voluntary social service for:
   - an epileptic patient well-controlled on anti-convulsants who asks for information concerning life assurance
   - an elderly arthritic widower who lives alone
   - an alcoholic housewife.

7. To contrast the major functions of:
   - the GP in the UK
   - the 'uchastok' physician in the USSR
   - the non-specialist internist in the USA.

The Relationship of Medical Services to Other Institutions of Society

1. To list 6 circumstances in which he would report a death to the coroner.

2. To name the schools available in the practice area for severely asthmatic, mentally handicapped or spastic children.
3. To list 5 items of help that he may wish to request from the local authority for a new family which has moved into the district with a father who has not worked for years because of a paranoid psychosis, includes 5 children, is living in a dilapidated and overcrowded tenement flat, and the fifth child has been brought to the surgery by his mother because of persistent school absence on account of asthma.

4. To list the 3 most important industrial hazards in 3 specified contrasting occupations in the area of teaching practice.

5. To discuss the significance of:
   - the Apothecaries Act of 1815
   - the Medical Act of 1858
   - the National Health Insurance Act of 1911

6. To describe the historical background of general practice which led to the formation of the BMA, and the effects on general practice of the foundation of the College of General Practitioners.

7. To state, in the following conditions, the approximate date when they were first described, and the background of medical science which they reflect:
   - rheumatic chorea
   - Grave's disease
   - decompensated heart failure
   - phenylketonuria.

THE PRACTICE

Practice Management

1. To examine communications within the practice and identify blockages and the underlying reasons for them.

2. To report on methods by which effective working relationships within the team can be fostered.

3. To describe the main features of his practice's policy, and know how they were arrived at.

4. To gain experience of problem-solving by, for example, considering how a new immunization programme should be implemented, or by indicating how his practice might cope with planned early discharge of 'cold' surgical cases.

Re: Finance

5. To list the main allowances and other sources of fees under the NHS.

6. To list the main groups of allowable expenses.

7. To describe the role of the Finance Corporation and the conditions under which doctors may borrow from it.

8. To draft a letter to the Executive Council outlining a request for an Improvement Grant, total £850, and to describe the steps which will be taken by the health service authorities upon its receipt.

Premises and Equipment

9. To outline the main provisions of an agreement relating to a Section 21 health centre.
10. To indicate what information will be required by an architect for a new treatment room, and which members of the practice should contribute to the brief.

Re: Records

11. To discuss the doctor’s statutory obligations in relation to medical records, incorporated in his Terms of Service.

12. To describe the principal features of medical record envelopes at present on trial.

Re: Medico-Legal

13. To list the principal functions of the GMC.

14. To describe the practitioner’s obligations under the Dangerous Drugs Acts and Regulations.

15. To describe the steps which will be taken by the Executive Council under the Services Committee and Tribunal Regulations following a complaint against a family doctor, and suggest the measures the practitioner might take in his own defence.
# APPENDIX B

## ALTERNATIVE BASES FOR INTERPRETING SOCIAL REALITY

<table>
<thead>
<tr>
<th>Dimensions of comparison</th>
<th>Conceptions of Social Reality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Philosophical basis</strong></td>
<td><strong>Objectivist</strong></td>
<td><strong>Subjectivist</strong></td>
</tr>
<tr>
<td></td>
<td>Realism: the world exists and is knowable as it really is. Organisations are real entities with a life of their own.</td>
<td>Idealism: the world exists but different people construe it in very different ways. Organisations are invented social reality.</td>
</tr>
<tr>
<td><strong>The role of science</strong></td>
<td>Discovering the universal laws of society and human conduct within it.</td>
<td>Discovering how different people interpret the world in which they live.</td>
</tr>
<tr>
<td><strong>Basic units of social reality</strong></td>
<td>The collectivity: society or organisations.</td>
<td>Individuals acting singly or together.</td>
</tr>
<tr>
<td><strong>Methods of understanding</strong></td>
<td>Identifying conditions or relationships which permit the collectivity to exist. Conceiving what these conditions and relationships are.</td>
<td>Interpretation of the subjective meanings which individuals place upon their action. Discovering the subjective rules for such action.</td>
</tr>
<tr>
<td><strong>Theory</strong></td>
<td>A rational edifice built by scientists to explain human behaviour.</td>
<td>Sets of meanings which people use to make sense of their world and behaviour within it.</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>Experimental or quasi-experimental validation of theory.</td>
<td>The search for meaningful relationships and the discovery of their consequences for action.</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Abstraction of reality, especially through mathematical models and quantitative analysis.</td>
<td>The representation of reality for purposes of comparison. Analysis of language and meaning.</td>
</tr>
<tr>
<td><strong>Society</strong></td>
<td>Ordered. Governed by a uniform set of values and made possible only by those values.</td>
<td>Conflicted. Governed by the values of people with access to power.</td>
</tr>
<tr>
<td><strong>Organisations</strong></td>
<td>Goal oriented. Independent of people. Instruments of order in society serving both society and the individual.</td>
<td>Dependent upon people and their goals. Instruments of power which some people control and can use to attain ends which seem good to them.</td>
</tr>
<tr>
<td><strong>Organisational pathologies</strong></td>
<td>Organisations get out of kilter with social values and individual needs.</td>
<td>Given diverse human ends, there is always conflict among people acting to pursue them.</td>
</tr>
<tr>
<td><strong>Prescription for change</strong></td>
<td>Change the structure of the organisation to meet social values and individual needs.</td>
<td>Find out what values are embodied in organisational action and whose they are. Change the people or change their values if you can.</td>
</tr>
</tbody>
</table>

Adapted from Barr Greenfield 1975
**APPENDIX C**

**DIFFERING APPROACHES TO THE STUDY OF BEHAVIOUR**

<table>
<thead>
<tr>
<th><strong>Normative</strong></th>
<th><strong>Interpretive</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Society and the social system</td>
<td>The individual</td>
</tr>
<tr>
<td>Medium/large-scale research</td>
<td>Small-scale research</td>
</tr>
<tr>
<td>Impersonal, anonymous forces regulating behaviour</td>
<td>Human actions continuously recreating social life</td>
</tr>
<tr>
<td>Model of natural sciences</td>
<td>Non-statistical</td>
</tr>
<tr>
<td>'Objectivity'</td>
<td>'Subjectivity'</td>
</tr>
<tr>
<td>Research conducted 'from the outside'</td>
<td>Personal involvement of the researcher</td>
</tr>
<tr>
<td>Generalising from the specific</td>
<td>Interpreting the specific</td>
</tr>
<tr>
<td>Explaining behaviour/seeking causes</td>
<td>Understanding actions/meanings rather than causes</td>
</tr>
<tr>
<td>Assuming the taken-for-granted</td>
<td>Investigating the taken-for-granted</td>
</tr>
<tr>
<td>Macro-concepts: society, institutions, norms, positions, roles, expectations</td>
<td>Micro-concepts: individual perspective, personal constructs, negotiated meanings, definitions of situations</td>
</tr>
<tr>
<td>Structuralists</td>
<td>Phenomenologists, symbolic interactionists, ethnomethodologists</td>
</tr>
</tbody>
</table>

Cohen and Manion 1989 p 40
## APPENDIX D

### VARIETY IN QUALITATIVE INQUIRY: THEORETICAL TRADITIONS

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Disciplinary Roots</th>
<th>Central Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ethnography</td>
<td>Anthropology</td>
<td>What is the culture of this group of people?</td>
</tr>
<tr>
<td>2. Phenomenology</td>
<td>Philosophy</td>
<td>What is the structure and essence of experience of this phenomenon for these people?</td>
</tr>
<tr>
<td>3. Heuristics</td>
<td>Humanistic psychology</td>
<td>What is my experience of this phenomenon and the essential experience of others who also experience this phenomenon intensely?</td>
</tr>
<tr>
<td>4. Ethnomethodology</td>
<td>Sociology</td>
<td>How do people make sense of their everyday activities so as to behave in socially acceptable ways?</td>
</tr>
<tr>
<td>5. Symbolic interactionism</td>
<td>Social psychology</td>
<td>What common set of symbols and understandings have emerged to give meaning to people's interactions?</td>
</tr>
<tr>
<td>6. Ecological psychology</td>
<td>Ecology, psychology</td>
<td>How do individuals attempt to accomplish their goals through specific behaviours in specific environments?</td>
</tr>
<tr>
<td>7. Systems theory</td>
<td>Interdisciplinary</td>
<td>How and why does this system function as a whole?</td>
</tr>
<tr>
<td>8. Chaos theory: nonlinear dynamics</td>
<td>Theoretical physics, natural sciences</td>
<td>What is the underlying order, if any, of disorderly phenomenon?</td>
</tr>
<tr>
<td>9. Hermeneutics</td>
<td>Theology, philosophy, literary criticism</td>
<td>What are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meanings?</td>
</tr>
<tr>
<td>10. Orientational, qualitative</td>
<td>Ideologies, political economy</td>
<td>How is x ideological perspective manifest in this phenomenon.</td>
</tr>
</tbody>
</table>

Patton 1990 p 88
OBJECTIVES/ROLE OF SENIOR PARTNER

Objectives of the Interview

1. To gain an organisational picture.
2. To identify the different roles and expectations which may be fulfilled by the senior partner.
3. To identify: strengths, weaknesses, opportunities and threats facing General Practice and the senior partner today.
4. To gain an understanding of the managerial task facing the senior partner; how that task might evolve; and the learning they might need to tackle it.

Techniques to be used

1. Open questions with supplementary questions as necessary, probing for core constructs if relevant.
2. Interviews to be recorded and notes taken.
3. Positive reinforcement to be given to interviewees to encourage them to contribute.

Outline Interview Questions

1. Can you briefly describe your practice here? Number of patients, principals and staff, those directly employed by you, and those employed by others but under your day-to-day control? (Aim to draw an organisation chart from the response?) (Staff turnover and training?)
2. How is the practice organised? For example, what meetings take place and who attends them?
3. How long have you and your principals been here?
4. What are your objectives in managing this practice? Personal Business - prioritise them.
5. What skills do achieving those objectives require?
6. What do you see as the strengths of this practice?
7. What do you see as its weaknesses?
8. Are these weaknesses also your greatest problems or are there others?
9. What do you see as the opportunities for your practice in future? What additional skills will achieving those opportunities require?
10. What do you see as the threats facing your practice?
11. Can you take me through a typical day for you? Say, yesterday.
12. What are the greatest problems or pressures your GPs face at the moment?
13. What one thing would help you the most? If you could have that, is there anything else ....... (and so on)?
15. How many different ‘hats’ do you need to wear to run this practice successfully? Which do you regard as your priority(ies)?
16. How would you identify or describe an effective general practice? What do you think the patients want/need from your practice?
APPENDIX F

CODE OF PRACTICE
FOR
RESEARCH PROGRAMME: MANAGEMENT IN GENERAL PRACTICE

Interviews and Discussions

1. All interviews will be taped. All interview notes and tapes will be transcribed either by the researcher, Anne Lee, or her personal secretary, Sheila Elliott. Both people are bound by this Code of Practice.

2. After transcription the tapes will be numbered and stored in a locked strong box. The original tapes will be sent to the participants as soon as the statutory regulations for the submission of a thesis allow. The interviews will be transcribed anonymously (Dr A, etc) and the code will be kept in a safe box in a locked cabinet away from the other research papers. All tapes and papers will be kept under lock and key at all times.

3. Each interviewee will be sent a transcript of the interview and invited to identify any inaccuracies or omissions. At this stage they may also request deletion of any items which they feel may identify them personally.

4. If the interviews include meeting more than one person within a practice then the researcher will not repeat others' opinions. Some practices may wish for a synopsis of all the interviews and research findings. The protocol for doing this would be worked out in consultation with each interviewee.

Presentation of Findings

The work will need to be presented so that it is useful but so that it does not lead to identification of participants or practices. A discussion about what categorization would be acceptable in terms of urban/rural, size of practice (eg 0-10,000, 10,000-15,000, etc), number of male and female principals and distinguishing services should be held at or after each interview.

In addition to these principles, the researcher is bound by the code of conduct issued by The British Psychological Society (1985).

Further information

Mrs Anne M Lee, The Post House, West Clandon, Guildford, Surrey, GU4 7ST
He was as found by the Bureau of Statistics to be
One against whom there was no official complaint,
And all the reports on his conduct agree
That, in the modern sense of an old-fashioned word, he was a saint,
For in everything he did he served the Greater Community.
Except for the War till the day he retired
He worked in a factory and never got fired,
But satisfied his employers, Fudge Motors Inc.
Yet he wasn't a scab or odd in his views,
For his Union reports that he paid his dues,
(Our Report on his Union shows it was sound)
And our Social Psychology workers found
That he was popular with his mates and liked a drink.
The Press are convinced that he bought a paper every day
And that his reactions to advertisements were normal in every way.
Policies taken out in his name prove that he was fully insured,
And his Health-card shows he was once in hospital but left it cured.
Both Producers Research and High-Grade Living declare
He was fully sensible to the advantages of the Instalment Plan
And had everything necessary to the Modern Man,
A phonograph, a radio, a car and a frigidaire.
Our researchers into Public Opinion are content
That he held the proper opinions for the time of year;
When there was peace, he was for peace; when there was war, he went.
He was married and added five children to the population,
Which our Eugenist says was the right number for a parent of his generation,
And our teachers report that he never interfered with their education.
Was he free? Was he happy? The question is absurd;
Had anything been wrong, we should certainly have heard.
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
APPENDIX I

TABLE 1

HYPOTHETICAL CASES USED IN THE INVESTIGATION OF ROLE EXPECTATIONS

1. Young mother of a baby of six months refusing to go on solid food.

2. Mother of a girl of ten years who wets her bed nearly every night.

3. Boy of 15 with a boil on the neck.

4. Woman of 50 with a heavy cold, temperature and running nose.

5. Mother of a boy of 12 who refused to go to school when there seems to be nothing wrong with him.

7.?? Parents of a boy of 13 who persists in stealing small things.

8. A mother whose only child of 18 months has just been found to be mentally subnormal.

9. A married woman of 35 who has just returned home from a mental hospital and needs help to try to adjust to family and social life.

10. A married couple who quarrel so much they are beginning to think seriously of divorce.

11. Woman patient of 75 with long standing osteoarthritis, living alone, and becoming unable to manage housework.

12. Couple of 25 who want advice on family planning.

13. Man of 45 just returned from hospital after losing a leg in a road accident and needs help to re-adjust himself to life.

14. Wife of married man of 70 whose deafness, in spite of his hearing aid, has made him withdraw from his normal social activities.

15. Parents of a teenager who have just found out he is taking drugs.

16. Wife of a man who appears to be habitually drinking too much.

17. Mother of a young family who is living in a rented house, the roof of which is leaking.

18. The parents of a girl of 16 who has just left school and started work in a factory. She hardly talks at all and has no friends and never goes out.

Mary Boothroyd Brooks, Management of the Team in General Practice from Journal of Royal College of General Practitioners 1973 Vol 23 p 243
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
## Useful People to Have in Teams

<table>
<thead>
<tr>
<th>Type</th>
<th>Symbol</th>
<th>Typical Features</th>
<th>Positive Qualities</th>
<th>Allowable Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Worker</td>
<td>CW</td>
<td>Conservative, dutiful, predictable.</td>
<td>Organizing ability, practical common sense, hard-working, self-discipline.</td>
<td>Lack of flexibility, unresponsiveness to unproven ideas.</td>
</tr>
<tr>
<td>Chairman</td>
<td>CH</td>
<td>Calm, self-confident controlled.</td>
<td>A capacity for treating and welcoming all potential contributors on their merits and without prejudice. A strong sense of objectives.</td>
<td>No more than ordinary in terms of intellect or creative ability.</td>
</tr>
<tr>
<td>Shaper</td>
<td>SH</td>
<td>Highly strung, outgoing, dynamic.</td>
<td>Drive and a readiness to challenge inertia, ineffectiveness, complacency or self-deception.</td>
<td>Proneness to provocation, irritation and impatience.</td>
</tr>
<tr>
<td>Plant</td>
<td>PL</td>
<td>Individualistic, serious-minded, unorthodox.</td>
<td>Genius, imagination, intellect, knowledge.</td>
<td>Up in the clouds, inclined to disregard practical details or protocol.</td>
</tr>
<tr>
<td>Resource Investigator</td>
<td>RI</td>
<td>Extroverted, enthusiastic, curious, communicative.</td>
<td>A capacity for contacting people and exploring anything new. An ability to respond to challenge.</td>
<td>Liable to lose interest once the initial fascination has passed.</td>
</tr>
<tr>
<td>Monitor-Evaluator</td>
<td>ME</td>
<td>Sober, unemotional, prudent.</td>
<td>Judgement, discretion, hard-headedness.</td>
<td>Lacks inspiration or the ability to motivate others.</td>
</tr>
<tr>
<td>Team Worker</td>
<td>TW</td>
<td>Socially orientated, rather mild, sensitive.</td>
<td>An ability to respond to people and to situations, and to promote team spirit.</td>
<td>Indecisiveness at moments of crisis.</td>
</tr>
<tr>
<td>Completer-Finisher</td>
<td>CF</td>
<td>Painstaking, orderly, conscientious, anxious.</td>
<td>A capacity for follow-through. Perfectionism.</td>
<td>A tendency to worry about small things. A reluctance to &quot;let go&quot;.</td>
</tr>
</tbody>
</table>

From: Management Teams Why They Succeed or Fail
R. Meredith Belbin
Oxford Heinemann Professional Publishing 1981
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
... the ideas that patients have about their symptoms are often quite different from those of the doctor.

Livesey 1986 p 49
Dear Dr

Challenges to General Practice

GPs who have completed this questionnaire have found that it focused their thinking in a helpful way and enabled them to make changes. It differs from the BMA questionnaire in two ways. Firstly, it takes only 10 minutes to complete, secondly it looks in more depth at what is satisfying and collects ideas for ways of overcoming the problem areas.

The results will be analysed looking at satisfaction with the job, practice administration, partnerships and relationships with external bodies. Please complete the form below if you would like to be sent a copy of the results and the paper. The form can be sent in a separate envelope if you prefer.

Confidentiality is assured. The study is an independent thesis, but has been approved by the Surrey LMC and the RCGP.

Please complete the form over the next 2-3 weeks and send it to Anne Lee, Visiting Fellow, Department of Educational Studies, University of Surrey, Guildford, Surrey, GU2 5XH. A freepost envelope is enclosed. This important piece of research has serious implications for how we might manage the future of general practice. If every GP who receives this completes it, the results can be used.

Yours sincerely

[Signatures]

Dr Ri Hornung
Associate Advisor in General Practice
South West Thames Region

Dr Brian Mathews
GP Tutor
East Surrey Health District

To: Anne Lee, Visiting Fellow, FREEPOST, Department of Educational Studies, University of Surrey, Guildford, Surrey, GU2 5XH

Please send me a copy of the result of the survey and the paper 'Managing Challenges in General Practice.'
Challenges to General Practice

This survey differs from the BMA questionnaire in that it takes only 10 minutes to complete and it looks at satisfaction in the following areas:

- with external bodies
- within the partnership
- with practice administration
- with the job

It is intended to collect examples of good practice and to identify the frequency and severity of problems.

The initial results show areas where a great deal of work needs to be done. Such work can only be pursued if the replies represent the total community of GPs. Please could you either complete the questionnaire in the next 2 weeks, or put one tick on the slip below. We do need to know how many of you are finding your current working life acceptable.

You may have already received and completed the survey, in which case thank you and the results will be sent to you in a couple of months.

The research is for an independent thesis. It is approved by the Surrey LMC and the Royal College of GPs.

With thanks

Yours sincerely

Professor David W Purdie MD FRCOG
Director

Dr C P Aber, Mr M D Barber, Prof E A Dawes, Dr P J Muller, Mr R Parish, Prof G A Smith, Dr N C Varey

---

I have completed the questionnaire and would like a copy of the results sent to:

[ ] me

[ ] Address:

I have not completed the questionnaire because:

1. The questions seemed irrelevant
   [ ]

2. I am too busy
   [ ]

3. Other (please specify):
   [ ]

Please return to: Anne Lee, Visiting Fellow, FREEPOST, Department of Educational Studies, University of Surrey, Guildford, Surrey, GU2 5XH (sae enclosed)
### A: DO YOU EXPERIENCE CONFLICT

**With the DHA**

1. Over gaining the hospital admissions you want for patients? [ ] 1
2. Over gaining effective Physiotherapy services for your patients? [ ] 2
3. Over gaining effective Radiology services for your patients? [ ] 3
4. Over gaining effective Pathology services for your patients? [ ] 4

**With the FHSA**

5. Over unnecessary paperwork? [ ] 5
6. Over investigations of complaints against GPs? [ ] 6
7. Over delays in claims? [ ] 7
8. Over delays in decision making? [ ] 8

**With Government policy and procedures**

9. Between fundholding and non-fundholding practices. [ ] 9
10. Over screening procedures? [ ] 10
11. Over medical audit? [ ] 11

**Within the practice**

12. Over the use of computers? [ ] 12
13. Over the employment of counsellors for patients? [ ] 13
14. Over the competence of practice nurses? [ ] 14
15. Over the competence of the practice manager? [ ] 15
16. Over the competence of administrative staff (receptionists and secretaries)? [ ] 16
17. Over time available for sick patients? [ ] 17
18. Over whether or not to offer complementary therapies? [ ] 18
19. Over the decision to use or not to use a deputising service? [ ] 19
A: DO YOU EXPERIENCE CONFLICT

With partners?

(Please tick all the boxes where difficulties are experienced)

20. Over introducing change and future planning for the practice?  □ 20
21. Over allocation of money, pay and profits?  □ 21
22. Over who leads the practice?  □ 22
23. Over partners’ differing beliefs or values?  □ 23
24. Over partners’ personal problems?  □ 24
25. Over partners’ different styles and speed in dealing with patients?  □ 25
26. Over dealing with outside interests (e.g. private work, research, etc.)?  □ 26
27. Over equal sharing of responsibilities and working as a team?  □ 27
28. Over partners’ lack of professional competence?  □ 28

With attached Staff

29. Over the work carried out by health visitors?  □ 29
30. Over the work carried out by social workers?  □ 30
31. Over the work carried out by community nurses?  □ 31

In General

32. Over communication with consultants?  □ 32
33. Over patients’ expectations?  □ 33
34. Over patients’ perceptions of GPs as money oriented?  □ 34
35. Over coping with night and weekend duties?  □ 35
36. Over intimate personal relationships between those working around you?  □ 36
37. Over finding sufficient time for your own family life?  □ 37
38. Over GP’s level of remuneration when compared with other professions you might have entered?  □ 38

Please list the 3 conflicts which cause you the most problems:
(e.g. 3, 15, 29)

1.  □ 39/40
2.  □ 41/42
3.  □ 43/44

B: WHAT ARE THE MAIN SOURCES OF CARE AND SUPPORT YOU EXPERIENCE AS YOU WORK?

(Tick all those that apply)

a. Your spouse/family  □ 45  e. Other doctors  □ 49
b. Your senior partner  □ 46  f. Friends  □ 50
c. Partners  □ 47  g. Patients  □ 51
d. The practice manager  □ 48  h. Don’t experience care and support  □ 52

Others (please specify)  □ 53
C: Which parts of your job do you feel are most important, most enjoyable and make most demands on your time:

(Please tick all those which apply)

<table>
<thead>
<tr>
<th>Most important</th>
<th>Most enjoyable</th>
<th>Takes most time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with the sick?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Preventative medicine?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Contributing to the administration of the practice?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Supporting colleagues?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Keeping up to date?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Practice meetings?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Partnership meetings?</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Self/Career Development</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>□ □ □</td>
<td>□ □ □</td>
</tr>
</tbody>
</table>

D: Are you a senior partner? □ Yes (Please continue with next question) □ No (Please continue with question F)

E: If you are a senior partner
(Please tick one box per question)

<table>
<thead>
<tr>
<th>Too Much</th>
<th>About Right</th>
<th>Too Little</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ □</td>
<td>□ □ □ □ □ □</td>
<td>□ □ □ □</td>
</tr>
</tbody>
</table>

Do you feel that the amount of responsibility you have is:

Do you feel the amount of authority you have over your partners is:

Do you feel that in comparison with your partners your remuneration is:

ALL RESPONDENTS PLEASE CONTINUE HERE:

F: Does your partnership have a clear leader? □ Yes □ No

G: Do you want your partnership to have a clear and acceptable leader? □ Yes □ No

H: Practice Meetings Involving All Staff

Are these meetings held?

<table>
<thead>
<tr>
<th>Weekly</th>
<th>Monthly</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ □</td>
<td>□ □ □ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
</tr>
</tbody>
</table>

Are these meetings effective and helpful?

I: □ Yes □ No

J: Practice Meetings Just for Partners

Are these meetings held?

<table>
<thead>
<tr>
<th>Weekly</th>
<th>Monthly</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ □ □</td>
<td>□ □ □ □ □ □</td>
<td>□ □ □ □</td>
<td>□ □ □</td>
</tr>
</tbody>
</table>

Are these meetings effective and helpful?

K: □ Yes □ No
L: Should a senior partner or leader, after consultation, have the power to:

<table>
<thead>
<tr>
<th>Power</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate patients' complaints</td>
<td>□</td>
</tr>
<tr>
<td>Control practice costs</td>
<td>□</td>
</tr>
<tr>
<td>Recruit partners and practice staff</td>
<td>□</td>
</tr>
<tr>
<td>Terminate others' employment</td>
<td>□</td>
</tr>
<tr>
<td>Represent the partnership to official bodies</td>
<td>□</td>
</tr>
<tr>
<td>Appraise and train partners</td>
<td>□</td>
</tr>
<tr>
<td>Determine remuneration</td>
<td>□</td>
</tr>
</tbody>
</table>

(Tick all those boxes which apply)

M: My Current Working Life

Here are some words or phrases we would like you to use to describe how you feel about your current working life. For example: If you feel your current working life is more enjoyable than miserable, but not quite as enjoyable as it could be, you might complete that line as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyable</td>
<td>□</td>
</tr>
<tr>
<td>Miserable</td>
<td>□</td>
</tr>
</tbody>
</table>

Now continue:

I would describe my current working life as:-

<table>
<thead>
<tr>
<th>Description</th>
<th>Box</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyable</td>
<td>□</td>
</tr>
<tr>
<td>Miserable</td>
<td>□</td>
</tr>
<tr>
<td>Tied down</td>
<td>□</td>
</tr>
<tr>
<td>Free</td>
<td>□</td>
</tr>
<tr>
<td>Rewarding</td>
<td>□</td>
</tr>
<tr>
<td>Disappointing</td>
<td>□</td>
</tr>
<tr>
<td>Easy</td>
<td>□</td>
</tr>
<tr>
<td>Hard</td>
<td>□</td>
</tr>
<tr>
<td>Frustrating</td>
<td>□</td>
</tr>
<tr>
<td>Fulfilling</td>
<td>□</td>
</tr>
<tr>
<td>Full</td>
<td>□</td>
</tr>
<tr>
<td>Empty</td>
<td>□</td>
</tr>
<tr>
<td>Controlled by others</td>
<td>□</td>
</tr>
<tr>
<td>Under my control</td>
<td>□</td>
</tr>
<tr>
<td>Full of possibilities</td>
<td>□</td>
</tr>
<tr>
<td>In a rut</td>
<td>□</td>
</tr>
<tr>
<td>Unhappy</td>
<td>□</td>
</tr>
<tr>
<td>Happy</td>
<td>□</td>
</tr>
<tr>
<td>Brings out the best in me</td>
<td>□</td>
</tr>
<tr>
<td>Doesn't give me much chance</td>
<td>□</td>
</tr>
</tbody>
</table>
**Practice Details** (please tick or put appropriate number)

1. No. of male partners in your practice | | No. of female partners in your practice | 29/30

2. Average list size of your practice
   - Under 1,000
   - 1,000-1,500
   - 1,500-2,000
   - 2,000-2,500
   - Over 2,500

   □ | □ | □ | □ | □

3. Do you have a practice manager
   - Yes
   - No

4. Is your practice:
   - Inner City
   - Urban/Suburban
   - Town pop. under 100,000
   - Rural

   □ | □ | □ | □

5. Are you:
   - Full-time
   - Part-time

   □ | □

6. Are you:
   - Male
   - Female

   □ | □

7. Are you:
   - Under 30
   - 30-39 yrs
   - 40-49 yrs
   - 50-59 yrs
   - 60+ yrs

   □ | □ | □ | □ | □

8. Is your practice:
   - Training
   - Non-Training

   □ | □

9. Is doctors' remuneration:
   - By experience
   - Equal after time to parity
   - According to workload
   - Other

   □ | □ | □ | □

10. Does your practice:
    - Fundhold
    - Think it may fundhold in future
    - Have no current intention of fundholding

    □ | □ | □

11. No. of partners in your practice who qualified in
    - The UK
    - Other

    □ | □

12. How many children do you have
    - Under 5
    - 5-18
    - 18 and over

    □ | □ | □

**Comments** (Additional conflicts or techniques you have employed for overcoming conflicts and how you felt about completing this questionnaire - please continue overleaf if necessary.)

__________________________________________________________

__________________________________________________________

__________________________________________________________

Please return to: Anne Lee, Visiting Fellow, FREEPOST, Department of Educational Studies, University of Surrey, Guildford, Surrey, GU2 5XH (sae enclosed)
# APPENDIX O

## CONFLICT SURVEY RESULTS

### DO YOU EXPERIENCE CONFLICT

<table>
<thead>
<tr>
<th>With the DHA</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Over gaining the hospital admissions you want for patients</td>
<td>116</td>
<td>35.9%</td>
</tr>
<tr>
<td>2. Over gaining effective Physiotherapy services for your patients</td>
<td>170</td>
<td>52.6%</td>
</tr>
<tr>
<td>3. Over gaining effective Radiology services for your patients</td>
<td>74</td>
<td>22.9%</td>
</tr>
<tr>
<td>4. Over gaining effective Pathology services for your patients</td>
<td>10</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>With the FHSA</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Over unnecessary paperwork</td>
<td>227</td>
<td>70.3%</td>
</tr>
<tr>
<td>6. Over investigations of complaints against GPs</td>
<td>68</td>
<td>21.1%</td>
</tr>
<tr>
<td>7. Over delays in claims</td>
<td>104</td>
<td>32.2%</td>
</tr>
<tr>
<td>8. Over delays in decision-making</td>
<td>124</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>With Government policy and procedures</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Between fundholding and non-fundholding practices</td>
<td>130</td>
<td>40.2%</td>
</tr>
<tr>
<td>10. Over screening procedures</td>
<td>180</td>
<td>55.7%</td>
</tr>
<tr>
<td>11. Over medical audit</td>
<td>108</td>
<td>33.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Within the practice</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Over the use of computers</td>
<td>85</td>
<td>26.3%</td>
</tr>
<tr>
<td>13. Over the employment of counsellors for patients</td>
<td>46</td>
<td>14.2%</td>
</tr>
<tr>
<td>14. Over the competence of practice nurses</td>
<td>33</td>
<td>10.2%</td>
</tr>
<tr>
<td>15. Over the competence of the practice manager</td>
<td>34</td>
<td>10.5%</td>
</tr>
<tr>
<td>16. Over the competence of administrative staff</td>
<td>78</td>
<td>24.1%</td>
</tr>
<tr>
<td>17. Over time available for sick patients</td>
<td>183</td>
<td>56.7%</td>
</tr>
<tr>
<td>18. Over whether or not to offer complementary therapies</td>
<td>53</td>
<td>16.4%</td>
</tr>
<tr>
<td>19. Over the decision to use or not use a deputising service</td>
<td>64</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>With partners</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Over introducing change &amp; future planning for the practice</td>
<td>130</td>
<td>40.2%</td>
</tr>
<tr>
<td>21. Over allocation of money, pay and profits</td>
<td>39</td>
<td>12.1%</td>
</tr>
<tr>
<td>22. Over who leads the practice</td>
<td>45</td>
<td>13.9%</td>
</tr>
<tr>
<td>Appendix O - cont</td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>23. Over partners' differing beliefs or values</td>
<td>107 33.1%</td>
<td></td>
</tr>
<tr>
<td>24. Over partners' personal problems</td>
<td>36 11.1%</td>
<td></td>
</tr>
<tr>
<td>25. Over partners' different styles &amp; speed in dealing with patients</td>
<td>108 33.4%</td>
<td></td>
</tr>
<tr>
<td>26. Over dealing with outside interests (e.g. private work, research)</td>
<td>45 13.9%</td>
<td></td>
</tr>
<tr>
<td>27. Over equal sharing of responsibilities and working as a team</td>
<td>82 25.4%</td>
<td></td>
</tr>
<tr>
<td>28. Over partners' lack of professional competence</td>
<td>17 5.3%</td>
<td></td>
</tr>
</tbody>
</table>

With attached staff

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Over the work carried out by health visitors</td>
</tr>
<tr>
<td>30. Over the work carried out by social workers</td>
</tr>
<tr>
<td>31. Over the work carried out by community nurses</td>
</tr>
</tbody>
</table>

In General

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. Over communication with consultants</td>
</tr>
<tr>
<td>33. Over patients' expectations</td>
</tr>
<tr>
<td>34. Over patients' perceptions of GPs as money oriented</td>
</tr>
<tr>
<td>35. Over coping with night and weekend duties</td>
</tr>
<tr>
<td>36. Over intimate personal relationships between those working around you</td>
</tr>
<tr>
<td>37. Over finding sufficient time for your own family life?</td>
</tr>
<tr>
<td>38. Over GPs' level of remuneration when compared with other professions you might have entered</td>
</tr>
</tbody>
</table>

The three conflicts which cause the most problems:

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. 35 45.8%</td>
</tr>
<tr>
<td>No. 37 39.6%</td>
</tr>
<tr>
<td>No. 33 24.8%</td>
</tr>
</tbody>
</table>

What are the main sources of care and support you experience as you work?

<table>
<thead>
<tr>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Your spouse/family</td>
</tr>
<tr>
<td>b. Your senior partner</td>
</tr>
<tr>
<td>c. Partners</td>
</tr>
<tr>
<td>d. The practice manager</td>
</tr>
<tr>
<td>e. Other doctors</td>
</tr>
<tr>
<td>f. Friends</td>
</tr>
<tr>
<td>g. Patients</td>
</tr>
<tr>
<td>h. Don't experience care and support</td>
</tr>
</tbody>
</table>
Appendix O - cont

What parts of your job do you feel are the most important, most enjoyable and make most demands on your time?

<table>
<thead>
<tr>
<th>Area</th>
<th>Most Important</th>
<th>Most Enjoyable</th>
<th>Takes Most Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with the sick</td>
<td>92.3%</td>
<td>63.2%</td>
<td>53.9%</td>
</tr>
<tr>
<td>Preventative medicine</td>
<td>30.3%</td>
<td>16.7%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Contributing to the administration of the practice</td>
<td>28.2%</td>
<td>9.0%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Supporting colleagues</td>
<td>29.1%</td>
<td>13.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Keeping up to date</td>
<td>49.8%</td>
<td>21.1%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Practice meetings</td>
<td>27.6%</td>
<td>7.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Partnership meetings</td>
<td>30.7%</td>
<td>6.2%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Self/career development</td>
<td>20.4%</td>
<td>0.3%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Are you a senior partner?</td>
<td>31.9% - Yes</td>
<td>15.5% - No</td>
<td></td>
</tr>
</tbody>
</table>

For senior partners only:

<table>
<thead>
<tr>
<th>Question</th>
<th>Too much</th>
<th>About right</th>
<th>Too little</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel the amount of responsibility you have is</td>
<td>4.6%</td>
<td>24.8%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Do you feel the amount of authority you have over your partners is</td>
<td>0.3%</td>
<td>25.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Do you feel that in comparison with your partners your remuneration is</td>
<td>27.6%</td>
<td>1.9%</td>
<td>70.6%</td>
</tr>
</tbody>
</table>

For all respondents:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your partnership have a clear leader</td>
<td>40.2%</td>
<td>50.8%</td>
</tr>
<tr>
<td>Do you want your partnership to have a clear and acceptable leader</td>
<td>41.8%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>

Practice meetings involving all staff

<table>
<thead>
<tr>
<th>Are these meetings held:</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.9%</td>
<td>20.1%</td>
<td>59.1%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are these meetings effective:</th>
<th>Never</th>
<th>Not often</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.2%</td>
<td>10.5%</td>
<td>47.7%</td>
<td>22.9%</td>
</tr>
</tbody>
</table>

Practice meetings just for partners

<table>
<thead>
<tr>
<th>Are these meetings held:</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26.9%</td>
<td>37.5%</td>
<td>21.1%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are these meetings effective:</th>
<th>Never</th>
<th>Not often</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.5%</td>
<td>5.6%</td>
<td>35.3%</td>
<td>45.5%</td>
</tr>
</tbody>
</table>
Appendix O - cont

Should the senior partner or leader, after consultation have the power to:

YES

Investigate patients' complaints 51.1%
Control practice costs 30.0%
Recruit partners and practice staff 17.6%
Terminate others' employment 19.8%
Represent the partnership to official bodies 65.6%
Appraise and train partners 17.6%
Determine remuneration 8.0%

My current working life

(see analysis from page 135)

PRACTICE DETAILS

<table>
<thead>
<tr>
<th>No of Male Partners</th>
<th>Percent</th>
<th>No of Female Partners</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.9%</td>
<td>0</td>
<td>21.1%</td>
</tr>
<tr>
<td>1</td>
<td>10.8%</td>
<td>1</td>
<td>49.5%</td>
</tr>
<tr>
<td>2</td>
<td>14.9%</td>
<td>2</td>
<td>11.5%</td>
</tr>
<tr>
<td>3</td>
<td>24.8%</td>
<td>3</td>
<td>0.6%</td>
</tr>
<tr>
<td>4</td>
<td>18.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>19.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average List Size:  
- Under 1,000: 1.2%  
- 1,000-1,500: 3.1%  
- 1,500 - 2,000: 27.2%  
- 2,000-2,500: 43.7%  
- Over 2,500: 24.1%

Do you have a practice manager
- Yes - 83%  
- No - 15.8%

Is your practice:
- Inner city - 9.6%  
- Town pop under 100,000 - 20.7%  
- Urban/Suburban - 35.3%  
- Rural - 27.2%

Are you:
- Full time - 93.8%  
- Part-time - 5.9%

Are you:
- Male - 79.9%  
- Female - 19.2%

Are you:
- Under 30 - 4.0%  
- 30-39 yrs - 36.5%  
- 40-49 - 31.0%  
- 50-59 yrs - 21.7%  
- 60+ yrs - 6.5%
Appendix O cont

Is your practice: Training - 30.7% Non-training - 69.0%

Is doctors remuneration: By experience: 1.2%
Equal after time to parity: 83.6%
According to workload: 5.0%
Other: 2.8%

Does your practice: Fundhold: 12.4%
Think it may fundhold: 31.9%
Have no intention of fundholding: 54.2%

No of partners who qualified overseas: No of partners

<table>
<thead>
<tr>
<th>No of partners</th>
<th>1</th>
<th>16.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

No of children: Under 5 5-18 18 and over

<table>
<thead>
<tr>
<th>No of children</th>
<th>Under 5</th>
<th>5-18</th>
<th>18 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>19.2%</td>
<td>17.3%</td>
<td>8.4%</td>
</tr>
<tr>
<td>2</td>
<td>13.9%</td>
<td>12.7%</td>
<td>13.6%</td>
</tr>
<tr>
<td>3</td>
<td>0.6%</td>
<td>6.5%</td>
<td>9.6%</td>
</tr>
<tr>
<td>4</td>
<td>0.3%</td>
<td>3.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>0.6%</td>
<td>5 and over 1.5%</td>
</tr>
</tbody>
</table>