This is the third in a series of articles examining ways to increase fulfilment from a career in general practice

Enriching Careers in General Practice

Building an efficient and healthy practice

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All happy families are alike but an unhappy family is unhappy after its own fashion.¹

General practitioners' professional status is, or at least has been, lower than that of hospital consultants. The jibe of "perfunctory care by perfunctory men" still cuts, more than 80 years after it was made,² although the context is at least partly sympathetic—what can be expected of inappropriately trained, underpaid, over-worked doctors without effective treatments?³ Lord Moran's surprise that general practitioners (doctors who had fallen off the career ladder) could be thought equal to consultants, expressed in 1960, can still make sensitive general practitioners wonder whether consultants regard them as equals.

This history of being overshadowed by the hospital service may explain the egalitarian philosophy ingrained in general practice. Marshall Marinker, until 12 years ago a general practitioner and now director of medical education at Merck Sharp and Dohme and visiting professor at Guy's and St Thomas's United Medical and Dental School, agrees that "there is an unwritten law that general practitioners must never be hierarchical, an unwillingness to accept that some general practitioners might be better than others, a fear of unfair competition. The BMA used to frown on the display of degrees and diplomas on general practitioners' brass plates."

The need to be equal hinders cross fertilisation between practices and stultifies development. New ideas imply criticism of the status quo and elicit a defensive reaction. Dr Marinker's solution is to "Abolish the rank and file mentality. Give everyone the chance for growth." Perhaps this is what successful practices, like Tolstoy's happy families, have in common. This article is about the development of pride and identity for ourselves, our practices, and our profession.

Recruitment

Appointments are usually made through word of mouth or advertisements in the medical press. In a study of new principals in two London family practitioner committees carried out in the 1980s, applicants' reasons for choosing a practice included compatibility with partners along with location, type, size, and administrative arrangements of the practice.⁴ Senior partners were most influenced by the compatibility of new partners and their acceptance of the conditions offered. A third of the new partners (22/61) felt sufficient tension in their partnerships to contemplate leaving.⁴ The chances of being happy in the practice can be improved by doing a locum in the area where you want to join a practice or joining initially on a short term contract.^{5,6} Trainees should develop realistic

expectations of general practice and learn how to influence and motivate their colleagues.^{6a}

Bryan Hopwood, a general practitioner in Sheffield, said that his practice's policy was to recruit people they knew from the area, using recommendations from training practices. Their particular concerns are whether candidates have "made waves" or got on well with staff. The bias in favour of local candidates may reduce the chances of a geographical move after vocational training.⁷

Some have found psychometric testing valuable both in assessing existing partners to identify roles not currently taken in the practice and in assessing whether particular candidates will fit in.⁸ Mike Pringle's practice in Nottinghamshire employed a personnel officer from a clearing bank to advise on recruitment. At interviews his practice focuses on practical questions about candidates' knowledge, skills, and attitudes.

As new partners work several years before reaching parity of income with their partners, the induction should be gentle. But many begin with a full clinical load.⁹ The "fagging syndrome" of initiation by disadvantage builds up resentment but can be avoided.⁹⁻¹¹ Extra partnership meetings can speed up a new partner's integration, and one partner could act as a mentor in the first three months.

Development

Practical and emotional support can be built into a practice with time, but it requires trust and the ability to both give and take criticism without devaluing colleagues. "Many doctors work more in confederation than in true partnership. Partners may not meet as a group for mutual support, problem solving, or policy making."¹² Denis Pereira Gray, professor of general practice at Exeter university, emphasised the need for feedback. "It's a very giving job. You need to get something back. If you don't, morale goes down—you become cynical and unhappy." Friday lunch at his practice is a time to meet with partners, the trainee, and the practice manager. They also have partnership meetings, held during the day with locum cover, to plan the practice's direction—ideas, vision, response to complaints. Two of his partners are in a group outside the practice, and he has also found support in his work for the university.

Learn to organise

General practitioners need to learn to manage time and people and to develop the skills to organise their work.¹³ They will need to be flexible as the job changes further in response to an aging population and changes in society. The level of support that male doctors

A well organised team is the key to a good practice

receive at home is decreasing as more of their wives or partners go out to work, and practice dynamics are changing as more women enter the profession and are more likely to want to work part time.¹⁴

Problems of practice organisation as well as lack of experience and study leave and poor relationships with other doctors were the causes of pressure in 65% (408/623) of general practitioners surveyed in the west midlands in 1988.¹⁵ Interruptions to work or family life cause the greatest stress.¹⁶ A survey of 917 doctors after the introduction of the 1990 contract found higher levels of stress from night calls, emergencies during surgery hours, and interruption of family life by the telephone.¹⁴

Decisions expose disunity

Practices can run from day to day without much interaction between doctors provided that the doctors turn up to work, are available for on call duties, and cover each other's holidays. It says much for the resilience of their staff that they learn to respond to the different working styles of doctors. But "muddling through" is not good enough.¹⁷ Communication is vital if quality is to be maintained and developed and if a practice is to retain morale in the face of imposed change. Dr Marinker summed up the dark repressive nature of some partnerships: "There is seldom a victim and an aggressor, but there is often a long history, often forgotten, locked into their present unhappiness." In 1984 he observed that change in general practice partnerships is geared to the rate of movement of the slowest, the least imaginative, or the laziest member.¹⁸ Partnerships, like marriages, may be made in heaven or hell. But perhaps they can be saved.

Keep talking

Roger Neighbour, a trainer in Abbots Langley, Hertfordshire, recommended, "Talk, talk, and talk again. Weekly half hour meeting with doctors, the senior nurse, head receptionist, and other section leaders; monthly partners' business meeting; and a two monthly partners' meeting without an agenda." In Mike Pringle's practice, policy decisions are not made by majority voting. "If we cannot agree we retain the status quo. That way there is no opportunity for backsliding. If we can't persuade doubters, perhaps it isn't a good idea. You have to be prepared to back down, and if there are good arguments against a scheme you can incorporate them into the vision." At Darnall Health Centre in Sheffield they too make

decisions by consensus. Janet Power, one of the general practitioners there, said, "Decisions take ages to make, but once they're made they are owned by all."

The risks of making decisions by consensus are stagnation and frustration, as I heard from one general practitioner in a seven doctor partnership. Six voted in favour of sabbaticals, but one was able to veto the plan. Consensus management can mean either that difficult decisions get shelved or, more positively, that they remain stubbornly on the agenda until an agreement is reached.

Management consultancy

Partnerships sometimes reach deadlock, and there may seem to be no solution but dissolution. Arbitration may heal the rift or ease the split. The local medical committee or family health services authority can offer advice, but both might be perceived as too close to be impartial. Sally Irvine, management consultant in general practice at the Royal College of General Practitioners, offers diagnostic management consultancy to troubled practices. She sees it as a pre-crisis activity, however: "Practices have to be sufficiently confident to expose themselves to an external advisor, but most practices have at least one partner who is reluctant. They invariably come round to the idea."

Sally Irvine's consultancy takes about three days. Each member of the team is interviewed, particularly about the ways in which members relate, and hidden agendas are teased out. She writes a report on the practice and then meets the partners together to discuss her findings. The problems the practice presented may not be the ones that the consultancy process identifies as important—for example, perceived problems with members of staff may be a symptom of a partnership problem.¹⁹ Team members need to talk and listen to each other. It is essential to recognise the importance to the speaker of what he or she is saying rather than interpreting it in the context of your own view.

Keith Bolden of the university of Exeter also runs management consultancy for practices, visiting them for a day to focus on developing interpersonal skills and team building. Participants fill in personality inventories before the day so that he can identify potential team problems and possible solutions. He believes that people can learn to resolve their conflicts, "Partnership issues are often subtle, and saying that there is a personality clash does not help to resolve it. You have to clarify the issues and address them. A demoralised practice can find its way by exploring its problems in the safety of a small group."

Videotapes from the Royal College of General Practitioners (available through the BMA library) can introduce a practice to management techniques of making decisions, responding to change, and building quality assurance. The bottom line is to develop a partnership agreement.

Partnership agreements

Like other contracts partnership agreements define what their signatories are prepared to do for each other and what they expect in return. The BMA and other sources offer detailed guidance about drawing them up,²⁰ but it has been estimated that about a half of partnerships work without a written agreement or have one which is inadequate (Norman Ellis, personal communication). This impression is supported by a recent survey of 653 women in general practice.²¹ A solicitor should be consulted about the wording and nature of the conditions to make sure that the agreement means what the partners think it means, and that it is enforceable if necessary. By thrashing out the

Box 1—Principled negotiation

The aim is to achieve a wise outcome rather than victory or agreement at any cost²⁴

- Separate people from problems and recognise their stake in developing solutions
- Focus on the interests of each party rather than on how far you or they are prepared to be pushed
- Think of a variety of possible outcomes, and the benefits of each, and allow time to consider them
- Make sure the arguments are based on objective standards

issues for such an agreement partners may uncover their needs and expectations and be less likely to need recourse to the law.

Share leadership and develop skills

At the James Wigg practice in Kentish Town, a partnership of eight principals, they have adopted a democratic system of leadership. Marek Koperski, one of the general practitioners there, told me how "each partner rotates through the position of executive partner. This is a coordinating, visionary role without specific tasks. The other partners each take on a particular task—for example, finance, computers, nurses—and form a task group to develop policies in that area. It requires trust and protected time to work but has the advantage over a natural hierarchy of allowing fresh ideas to be pushed."

Forming task groups within the practice may save time as the participants have a specific remit and small group meetings tend to be more effective than big ones,²² but the practice needs to give the group a mandate for its task.²³

Significant event audit

What do people do at meetings? Mike Pringle's practice has 12 primary health care team meetings and 12 business meetings each year as well as six conventional audit and six significant event audit meetings, four staff meetings, two formulary meetings, and an accounts meeting. Significant event auditing (sometimes known as critical incident analysis²⁴) is a method of assessing whether practice events have been managed well or could have been managed better. Significant events are logged as they occur—for example, attending a patient with a myocardial infarction, a patient leaving the practice, or a member of staff being upset. The person concerned tells the story to the meeting and the team discusses it. Praise as well as criticism is doled out. The idea is to learn from events. The whole team can benefit from hearing about good technique as well as learn from others' mistakes.²⁵

Goals for ambitious practices

Some practices seem to be models of good organisation. Others are still muddling along. A practice that has organised itself well may now apply for accreditation by the British Standards Institute. BS 5750 is an industry standard of management which has been applied to two practices in Britain. Other awards have followed—the prime minister's charter mark for excellence in delivering public service and the general practice quality assurance award from the Medical Protection Society.²⁶

Abdollah and Jacqueline Tavabie, whose practice in Orpington, Kent, was the second to be awarded the certificate, took it as confirmation that they were on the

right track. "It took a lot of work," said Jacqueline Tavabie, "but the audit involved was interesting and rewarding and revealed enormous potential in the team. It helped to define boundaries between jobs, which makes work much easier. You know who to hand things on to and know your job is finite. Maintaining the standard requires a six monthly reappraisal, and we also have a three hour monthly meeting with all the staff." The practice has its own patient's charter. This spells out the practice's responsibilities to its patients, and in almost as much detail, the patients' responsibilities to the surgery. Abdollah Tavabie said, "We have been careful to promise only what we can deliver." I asked how they managed to keep to their promise that patients will usually be seen within 20 minutes of their appointment time. "The receptionists reorganised the appointments system," said Jacqueline Tavabie. "We see patients in 10 minute slots, and the receptionists book a gap every fourth slot, which allows us to catch up or see an extra patient. They keep an eye on what happens and can alter the system."

Managing change

Keeping an eye on what happens and altering the system is part of managing change. Change has occurred rapidly in the past four years, with little time to think about what the changes mean and whether they may have some benefits. Stephen Head, a general practitioner in Nottinghamshire, said: "Two basic rules to bear in mind are to introduce ideas gradually and to share ownership of ideas with others."²⁷ If the initiator of change is to identify "stakeholders" and "validate each person who speaks by appreciating their contribution" in meetings he or she must be in a position of power.²⁸ But initiators may not feel so empowered and the techniques of negotiation and finding out what people think may be helpful if applied sensitively.

If change is a solution to the morale problem in general practice then improving management of change is essential. Principled negotiation may be a useful alternative to bargaining (box 1).²⁹

Is business culture applicable to general practice?

As independent contractors, general practitioners have run small businesses for many years, but whether they have been businesslike has varied with their own aptitude. Four types of business culture have been identified (box 2).³⁰ It often helps to identify how your practice operates (by recalling how major decisions about policy have been made) and to discuss whether this is the best way to practise or whether change could improve it. Such changes often take several years to enact even with full commitment.³¹ The practice can

Box 2—Four types of business culture in general practice³⁰

- Power culture depends on the charisma and wisdom of a senior partner whose colleagues are compliant, or leave
- In a task culture the job is central and people work to achieve a shared vision according to their aptitudes. The culture promotes innovation
- Role cultures define responsibilities, but these may rotate from time to time. Decisions are made by consensus
- A person culture allows unbridled individuality: teams receive conflicting messages from partners

then develop a business strategy by listing the ways in which the business deviates from the way it should run; identifying the strengths and weaknesses of the partnership and the opportunities and threats that face it; and setting out strategies to achieve its goals. The difference between a good and an average practice often depends more on effective organisation than on clinical ability.³¹

Building a healthy team

The division between doctors and staff is narrowing, with some practice managers becoming partners and talk of practice nurses going the same way. This idea is taken to its logical extreme in cooperative practices such as Darnall Health Centre in Sheffield, set up in the late 1970s. The idea behind Darnall was to see if patient care would improve in a setting in which workers felt more valued. Doctors and other staff get paid the same hourly rate. Everyone attends a weekly practice meeting that lasts 90 minutes, and decisions are made by consensus. Despite this philosophy, Janet Power said that hierarchy still exists there and that it is sometimes hard to delegate jobs. Many would not wish to go this far, but practice teams have grown since funds were made available by the 1966 charter.

It is important, however, that team members are given responsibility rather than simply having work off loaded on them. The views of each team member need to be sought in meetings, and doctors must be prepared to act on suggestions made by team members who are not doctors. Some practices are already good at this; others have not developed it, but it is central to quality management.³²

Members of teams that work accept and understand their common objectives—each member understands his or her own role and responsibilities, each member understands the roles of others, and team members treat each others with mutual respect. While many doctors would agree with these ideas, it can be difficult to reconcile the individualism that attracts people to general practice with the teamwork that is also needed. Members of the team who work from different premises—for example, district nurses and health visitors and reception staff at branch surgeries—can find it more difficult to feel a part of the team. Commitment from them and from in house staff will depend on your own commitment both to the job and to them. Bryan Hopwood spoke of the loyalty of his staff: "We've always been on first name terms, tried to be approachable; there's a lot of laughing, a lot of cursing. We try and support the staff and they take very little time off. We have two big parties a year, and practice meetings tend to be quite social events."

Geoffrey Marsh, a general practitioner in Teesside, has been team building for over 30 years. "The more that patients perceive practices working as a team the more they will come to equate care by one team member with care by them all."³³ He finds no conflict between this idea and the concept of personal doctoring, but tasks that can be done by non-medical staff are not done by doctors, thus freeing doctors to treat patients with serious conditions. "There is a vast amount of trivia which is only trivia and that needs only reassurance or simple treatment." The minor illness nurse at his practice treats people with minor illness, referring on those patients who need a doctor. People meet daily at coffee time, and there is a house committee meeting once a month to discuss clinical and operational matters. Receptionists have meetings themselves—a working lunch once a fortnight. He thinks it is better for general practitioners to see themselves as coordinators rather than leaders of the team. "Doctors can be taught by nurses, and they

can learn together. Multidisciplinary learning in this practice includes the receptionists—even they need a certain amount of diagnostic training."

Limitations of practice and team development

The main limitation is the partnership. If the partners respect and trust each other they will pull together and support, or at least negotiate with, each other when decisions have to be made. They will be able to share responsibilities according to abilities. If partners agree, they can give consistent messages to their staff and patients. If partners lack trust in each other there will be conflict every time a decision has to be made, and staff will have to make allowances for the doctors' idiosyncrasies.

The 1990 contract has made organisation and co-operation imperative. In the consultation room things go on much as they did before, but the organisation that has now to underpin work in general practice makes timekeeping more difficult, and poor time-keeping is a major stressor.³⁴ Tightly organised practices will have found the demands of the new contract less traumatic than more loosely organised ones.

There seems to be some hope. Whatever your partnership and team relationships are now, it is vital to maintain them if they are good and work on them if they are bad. These are ongoing tasks; they cannot be done once and forgotten. A healthy practice has an essential role in keeping up general practitioners' morale.

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