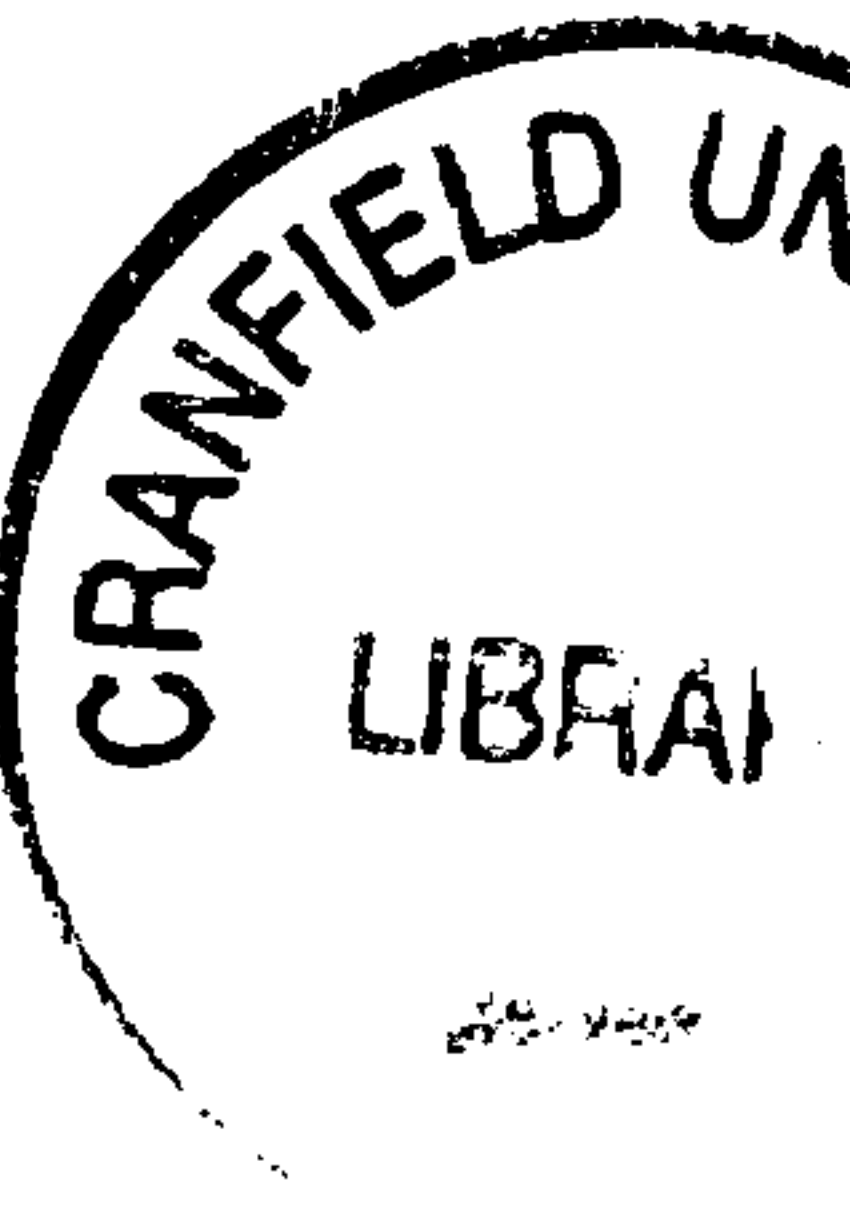




**Cranfield University**

Anne Faricy

**Job Satisfaction and Commitment;  
a Comparison of Medical and Legal Careers**

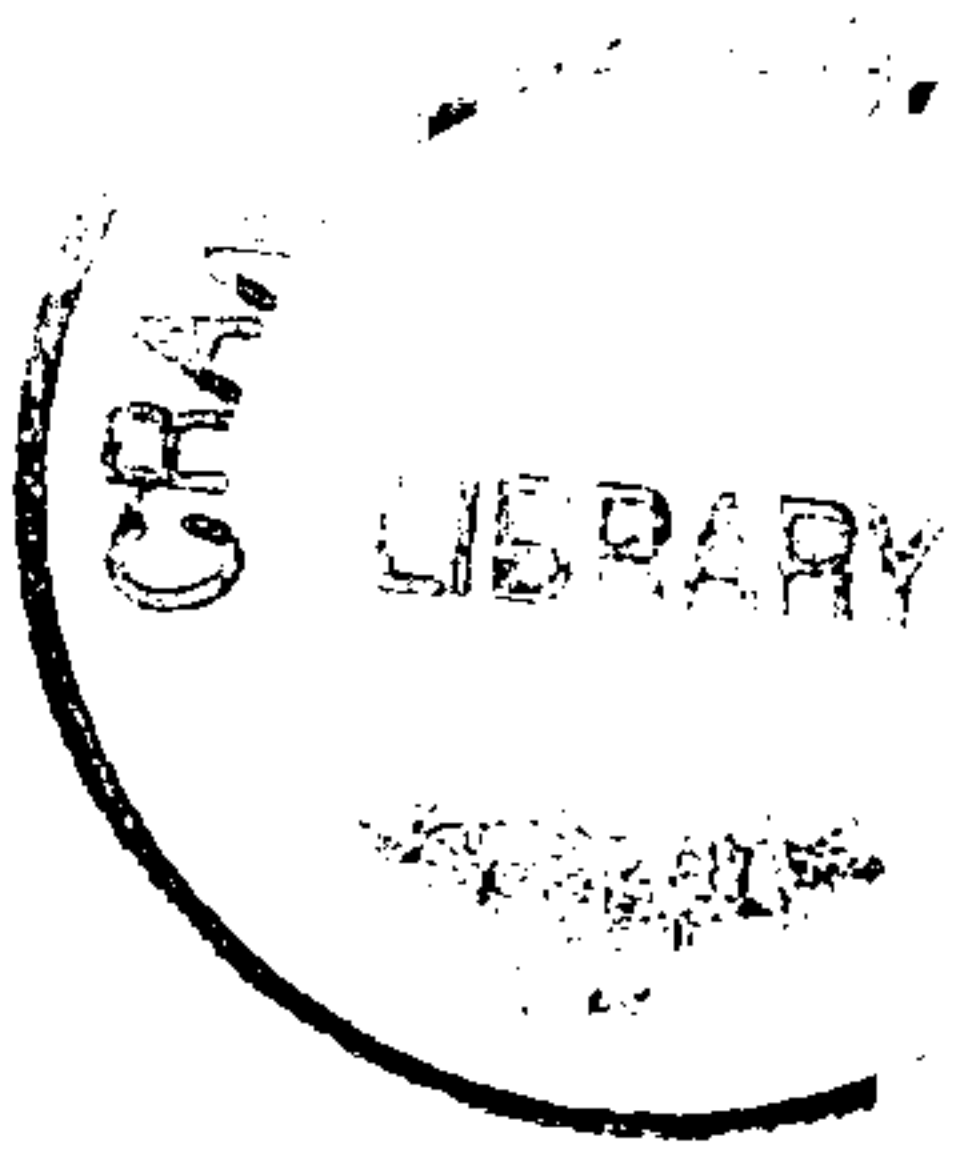
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*What is wrong with General Practice?*

**College of Aeronautics**

**PhD Thesis**





**Cranfield University**

**College of Aeronautics**

**PhD Thesis**

**Academic Year 1998-9**

**Anne Faricy**

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---

*What is wrong with General Practice?*

**Supervisor: R Asch**

**September 1999**



## ABSTRACT

The research presented in this thesis sought to identify the key issues underlying the current recruitment and retention problems in general practice. Previous studies have tended to focus on medical careers in isolation, neglecting the wider context of professional careers in the non-medical workplace. In an attempt to untangle the effects of being in general practice from the effects of being in professional practice *per se*, medical professionals were compared with those in a parallel profession - law. Therefore the present research focused on identifying, and comparing, the career aspirations of doctors and lawyers.

The work comprised two qualitative studies. Study 1 compared the values, beliefs and work perceptions of experienced doctors and lawyers, to establish similarities and differences between the two groups. Study 2 focused on the career expectations of both general and hospital trainees to allow comparisons between trainee groups, and between trainees and experienced practitioners. Participants totalled fifty nine for both studies. Data pertaining to the first study were analysed within the framework of the Job Characteristics Model (JCM). These findings subsequently determined the direction and shape of the second study.

Problems in general practice related to a combination of organisational change, and doctors' reasons for their career choice. Whilst both lawyers and doctors have experienced aggressive government intervention, doctors seemed to have interpreted this as a violation of their relational psychological contract with the State. Moreover, many doctors appear to have chosen general practice for less than positive reasons. Findings according to the JCM showed general practice to be low in motivating potential, with experienced practitioners strongly resenting their diminishing professional autonomy.

Trainee GPs appeared very similar to their predecessors, in terms of reasons for choosing general practice. Furthermore, they were overly optimistic regarding both the job's characteristics, and their ability to cope with potential difficulties. They were also less committed than their experienced counterparts.

The data could offer few assurances of retention problems being eased by this new generation of GPs.



## **ACKNOWLEDGEMENTS**

I would like to thank my supervisor and sparring partner, Dr Rachel Asch, for her pragmatism, innovation and support. As sisters of the '60s we have sparked off each other, crossing swords or chinking glasses over a diverse range of issues. We are surely a formidable pair.

Special thanks must go to the doctors and lawyers who gave so freely of their precious time.

Mr John Chapman also deserves a special mention for his help with the recruitment stage of both studies. I wish him a long and happy retirement.

I would also like to thank my family for their encouragement, especially my mother whose faith in me has never wavered.

Finally, I must acknowledge J S Bach whose baroque 'n' roll genius has sustained me into the wee small hours, long after all sensible folk have gone to bed.



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# Part I

## Chapter 1

### General Introduction

# Part I

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## Chapter 1

### General Introduction

## Chapter 2

### Methodological Considerations



# Part I

## Chapter 1

### General introduction

---

#### 1 Overview of the thesis

*"General practice is facing a recruitment crisis... a report by the General Medical Services Committee (GMSC)... highlights the way in which general practice has been squeezed by fewer entrants coming through from vocational training schemes and more GPs seeking early retirement..."* (British Medical Association, hereafter referred to as the BMA, Parliamentary Brief, February 1996a, p1). Therefore the primary aim of the thesis was to investigate reasons for the current recruitment and retention problems experienced by medical general practice within the NHS.

Further research revealed that hospital practice is also experiencing a retention problem with newly qualified doctors, although there is some controversy surrounding this. For example whilst alarm has been expressed at the loss of a quarter of newly qualified doctors (Beecham, 1996; Boseley in *The Guardian*, July 1996; Richmond, 1993), the Medical Workforce Standing Advisory Committee (cited in Lambert, Goldacre, Parkhouse and Edwards, 1996) estimate the loss from any cohort to be around 20 per cent. 'Loss' is defined as UK qualified doctors who are not working in the NHS or university sector five years after qualification. In fact the absence of any database on the destinations of doctors makes it very difficult to estimate losses from the profession (Baker, Williams and Petchey, 1995; Richards, McManus and Allen, 1997). The Junior Doctors Committee recently endorsed a motion calling for a Government enquiry into the numbers and causes of the loss of newly qualified doctors. They suggested the problem stems from a growing disillusionment with the NHS, inadequate training arrangements and chronic underfunding. Although the new Calman training programme has been designed to address the educational needs of junior doctors, its implementation demands a substantial expansion in the number of consultants. There are concerns that there may be insufficient hospital consultants in the UK to make this practicable (Junior Staffs Conference, Beecham, *BMJ*, Vol 312, 1996). An additional concern is that, because medical school intake is so tightly controlled, any expansion in hospital grades will further exacerbate the shortage of doctors entering general practice (BMA, Parliamentary Brief, February 1996a).

A key question to be addressed by the research was where the main causes for the apparent disenchantment lay. For example, does the problem stem from the nature of general practice or the nature of the medical profession as it has evolved generally, ie within the wider context of (non-medical) professional careers? The decline in popularity of general practice, as a career, is well documented (eg Allen, 1994; Lambert, Goldacre, Edwards and Parkhouse, 1996; Lambert, Goldacre, Parkhouse and



Edwards, 1996; Beedham, 1996; Roland, 1996). However the author is not aware of any previous research that has attempted to compare the working experiences and conditions of doctors, with those of other comparable professions. Hence the focus of the research was the investigation of general practice within the context of both medical *and* non-medical careers. The purpose of this was to identify and compare incumbents' perceptions of their work, and to determine how these lay with their expectations, beliefs and values within the context of organisation change.

Given the apparent paucity of previous work in this area, together with a need to explore the topic in depth, the research question was addressed by two qualitative studies. These are presented both as individual projects and as comparative works. Groups chosen for comparisons included legal professionals, ie solicitors and barristers. Initially the research was conceptualised as being centred round the expectations of doctors but, as the work progressed, the appropriateness of the Job Characteristics Model as a framework for analysis became apparent. Therefore, in accordance with the philosophy of qualitative research, the introduction has been shaped to reflect the evolving nature of this data-driven research.

### ***1.1 Structure of the thesis***

In terms of structure the thesis is divided into four sections. Part I includes a general introduction to the research area and this is followed by Part II, Study 1, which compares the work and experiences of qualified doctors and lawyers. Part III presents the findings of Study 2, which explores the career expectations of trainee doctors in both hospital and general practice. Finally Part IV includes an overview of the thesis, together with conclusions and recommendations.



## 2 General introduction

### 2.1 *The problem*

In addition to the decline in new recruits to general practice, there has been an increase in those taking early retirement, reportedly to escape the pressures of organisational change. Moreover, the number of overseas doctors seeking UK principal posts has also fallen. Reasons offered for discontent include increasing workload, long hours and low morale. The problem has been exacerbated by organisational change resulting in an increasing shift of emphasis from secondary (ie hospitals) to primary care (general practice), which has placed additional demands on general practitioners (BMA 1996a).

The General Medical Services Committee (GMSC) stated that the failure to expand medical school intake has also been partly responsible for the current crisis. The problem has been further compounded by the fact that an increasing number of entrants to general practice are working on a less than full-time basis (CMSC, February 1996). Ironically, the current crisis coincides with the Government's implementation of a primary care-led NHS (NHS Executive, 1994).

So it is apparent that there are many factors believed to be influencing the current problems in general practice. At a very broad level, these include the nature of the job and the impact of major organisational change. Hence the personal values and expectations that encouraged doctors to choose this branch of medicine in the first place, may have been shaken by their experiences of working within a changing NHS.

Factors influencing the recruitment crisis are likely to include the perceived nature of the job, and the personal attributes of potential recruits. It is quite possible that the extensive publicity given to the problems in general practice (eg *'Doctor, doctor, you're not on my wavelength: medical schools must accept lower A-levels in order to avoid creating bored GPs'* Laurence, *The Independent*, 20 August 1997), has contributed to the problem. For example potential recruits are likely to perceive the job as less than attractive and may feel that their values, attitudes and aspirations will not be met by a career in general practice.

Hence the review of the literature will focus on four key areas:

1. The nature of the job
2. Values, beliefs and attitudes (as they relate to professional aspirations and personal values)
3. Career expectations and the role of met/unmet expectations in turnover
4. Organisational change issues (relating to the impact of, and reactions to, change).

Each of these areas will be considered in turn.



## 2.2 *The nature of the job*

### 2.2.1 *Professionalism*

Medicine is usually described as a profession rather than a job. So what is the difference? The Collins English Dictionary (third edition, 1994) defines a *job* as (1) "*an individual piece of work or task*" and (2) "*an occupation; post of employment*". So the notion of a job is vague and broadly applicable to a range of skilled and unskilled occupations. It may also refer to a particular task within a professional capacity.

But what about a *career* - what differentiates a job from a career? According to Arnold (1997), the defining characteristic of a career is that it lays in the eyes of the beholder. In other words, it is subjective and depends on the individual's viewpoint. The example he gives is of two hairdressers, both working in the same place at the same time. Nevertheless, he argues, neither of the two will share the same ideas about their careers. Careers are essentially personal, they relate to an individual's interpretation of a series of work experiences. It is the individual who pieces these experiences together to form their own concept of a career. Indeed, this philosophy is supported by Nicholson and West who "*reserve the term 'career' for the sense people make of them*" (Nicholson and West, 1989, p181). Hence the overall argument appears to be that jobs, or 'work histories' as Nicholson and West would call them, are essentially objective concepts as understood by the world at large. However the term, 'career', refers to the personal interpretation which an individual assigns to those jobs/work histories, ie the 'grand design' or purpose which may underlie them.

So having defined 'jobs' as essentially objective, and 'careers' as subjective, what about professions? What are the defining characteristics of a profession?

According to Armstrong, professions have been described as the "*ideological bulwark of liberal democracy*" (Armstrong, 1990, p691). Traditionally embodying high status and power, professional groups have afforded their members insulation from "*the slings and arrows of the labour market*" (Herriot and Pemberton, 1995, pxiii). In an organisational context, they represent security and exclusivity. Abbott (1991) provides a useful analysis of the sequence of events that lead to professionalisation, defining four key characteristics:

1. the client-professional relationship: specialist education, credentialing, and conduct/ethics codes represent guarantees of a professional client relationship
2. specialist knowledge: the possession of expert knowledge, associated with an intellectual institution, provides the basis for professional monopoly of that knowledge
3. power and exclusivity: the monopoly of specialist knowledge allows the profession to exclude others and thus protect its jurisdiction
4. State recognition and affiliation.



The monopoly of expert knowledge appears to be a central characteristic of professionalism (eg Kanter, 1989; Larson, 1977; Armstrong, 1990). Kanter, like Abbott, attributes this to the power of associations which confers an "*enhanced collective reputation*" in addition to protecting the professional's specialist market (Kanter, 1989, p513). Larson, in her analysis of medicine's success, describes the profession as "*a monopoly of competence legitimised by officially sanctioned expertise and a monopoly of credibility with the public.*" (Larson, 1977, p39). She argues that medicine is distinct from other professions insofar that it seeks to serve the "sacred" value of life within a secularised society, and hence is perceived as having an altruistic service ideal. Finally, a member of the medical profession itself, Donald Irvine (President of the BMA), describes the profession's autonomy as resting on three "pillars": expertise, ethics and service. Expertise is described as knowledge and skills accruing from continuing research, ethical behaviour relates to doctors' values and standards and, finally, service denotes their "*vocational commitment to put patients first.*" (Irvine, 1997, p314).

So returning to the original question of the difference between a job and a profession, the key differences relate to the professional's possession of expert knowledge and skills which bestow membership of a professional association. This, in turn, ensures an exclusive market for those skills. As Rosabeth Moss Kanter points out, it is this monopoly of specialist skills (and the demand for them) that determines the individual's occupational status, as opposed to their position within an organisational hierarchy. How the individual expands and grows in terms of skill and reputation is down to them (Kanter, 1989). Indeed, she makes the interesting observation that some professionals may experience "stuckness"; a situation whereby the individual's opportunity for skills-growth is stifled by structural, rather than personal, reasons. For example they may have skills which are so specialised as to prevent them access to more lucrative growth areas. It is not difficult to apply this notion to medicine. Given the advances in medical technology, some of today's specialist surgical techniques may have to give way to the gene therapies of tomorrow.

So members of a profession have certain advantages over non-professionals. Once individuals have acquired specialist skills and professional affiliation, and provided there is a market for their expertise, their future is assured. Professionals are, in a sense, a 'package deal'; they carry their professional status and the associated guarantees of competence and professional conduct around with them. Hence they have more opportunities to cross organisations or, indeed, nations. Kanter describes this as a case of "*Have reputation, will travel.*" (Kanter, 1989, p512), a fact that will not have escaped the notice of the Department of Health's Medical Workforce Standing Advisory Committee. Medical school intake is tightly regulated, but investing in the training of x number of doctors is no guarantee that they will eventually migrate to where they are most needed nor that, once there, they will stay. Doctors are still, perhaps, amongst the most exalted of professional groups who many would regard as blessed, in terms of earning power and social status. Thus, to outsiders, doctors' dissatisfaction with their work must be something of an enigma. The central issue, in terms of the present research, is to establish the insider's point of view; what is about general practice which is making doctors feel so wretched? As



Arnold (1997) observed, a career is essentially personal - belonging to the individual - as opposed to an occupation which is more generic.

### ***2.2.2 The Job Characteristics Model (JCM)***

Having defined the broad concept of professionalism which provides the backdrop to the working lives of professionals, it is necessary to fill in the finer detail. What about the actual nature of the professional's work? What makes it enjoyable and worthwhile? What is it about a job/post that makes people want to stay? The next task was to find a suitable theoretical framework which would apply to both the professional worker, and the job in question.

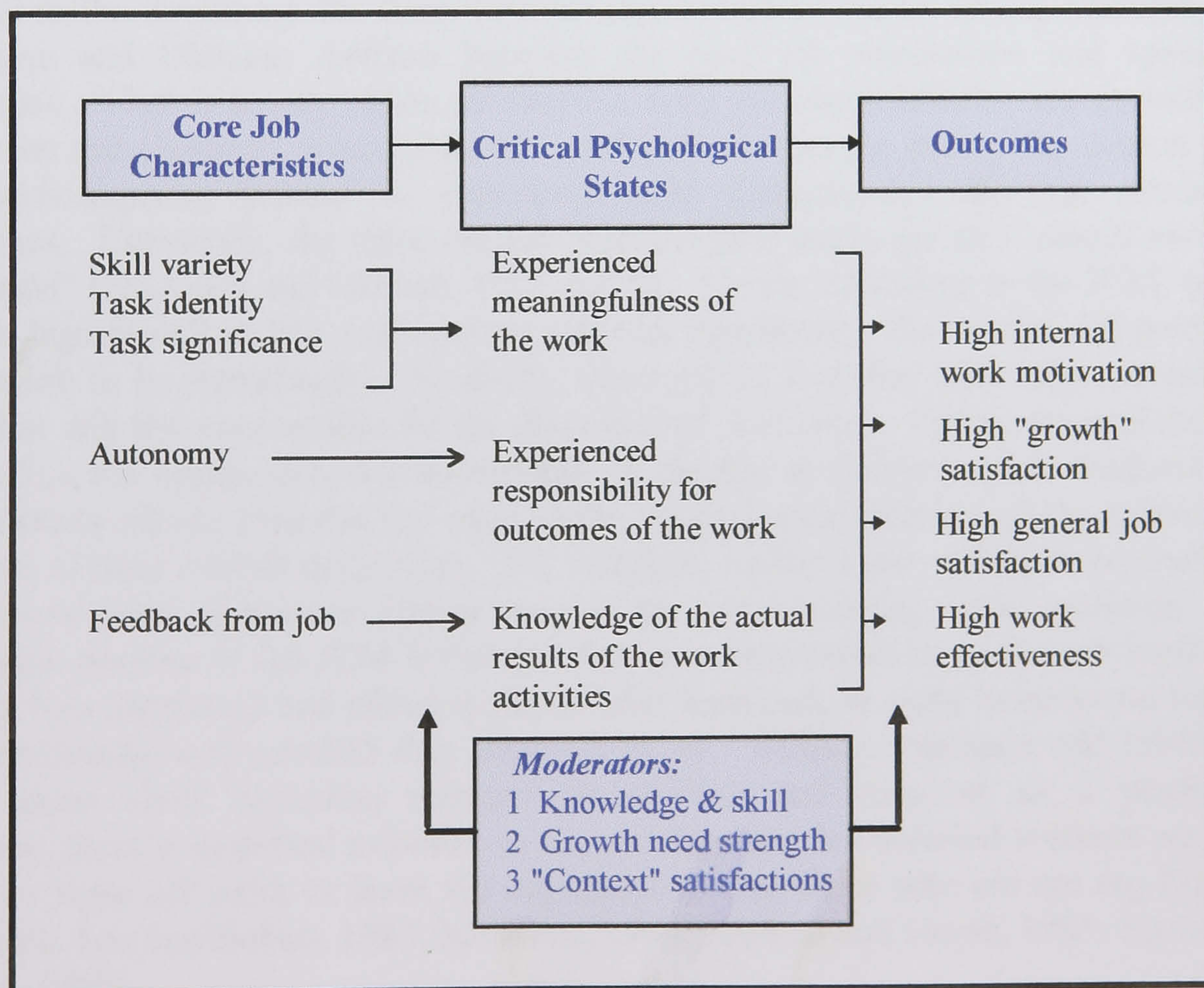
Although Hackman and Oldham's Job Characteristics Model had an immediate intuitive appeal (Hackman and Oldham, 1976, 1980), several alternative theories were considered. For example, Mumford's (1976) adaptation of Alderfer's ERG Theory (Alderfer, 1972) which explains motivation in terms of workers' needs, seemed too abstract and neglected the more tangible aspects of work-content. Similarly, Herzberg's Two Factor Theory of Motivation (Herzberg, Mausner and Snyderman, 1959) whereby the intrinsic aspects of work (eg achievement, responsibility etcetera) are weighed against the extrinsic, situational aspects (eg working conditions) was considered. Although a more holistic model than Mumford's, Herzberg's theory seemed to offer nothing more than the Job Characteristics Model. Moreover, the latter had the distinct advantage of breaking a job down into a number of specific components, which would facilitate the process of analysis. Finally, Salancik and Pfeffer's Social Information Processing Theory (1978) was appraised. Certainly the notion that workers' motivation/job satisfaction can be influenced by the people around them appeared to hold true for doctors. For example the high media attention given to the negative aspects of general practice could go some way to explaining the shortage of new recruits to the profession. However, this addresses only part of the research question; doctors' anguish clearly arises from basic aspects of their job and from the effects of organisational change. Hence the decision to use the Job Characteristics Model was felt to be justified; the theoretical framework it provided would allow doctors' work-related needs to be taken into account, in addition to analyses of the disparate aspects of the work itself.

The Job Characteristics Model (JCM) was developed from Turner and Lawrence's Requisite Task Attributes theory (1965). In exploring the relationship between different types of occupations and job satisfaction and absenteeism, Turner and Lawrence predicted that job satisfaction will increase with more complex and challenging jobs. The six characteristics that defined job complexity were variety, autonomy, responsibility, knowledge and skill, required social interaction and optional social interaction. The basic (ie unmoderated) Hackman and Oldham model omits the social interaction element of the Requisite Task Attributes theory, focusing more on the core aspects of work and how these relate to employee motivation, performance and satisfaction. The diagram overleaf provides an overview of the full model, including moderator effects which will be discussed later in the section.



The JCM provides an index of five **core job characteristics** which, according to Hackman and Oldham (1976), is designed to apply to those jobs which are performed, in most cases, by individuals. These are **skill variety**, **task identity**, **task significance**, **autonomy** and **feedback**. It therefore follows that some jobs will be higher (or lower) than others on the various dimensions. For example an assembly-line worker, whose job is to tighten a particular bolt on a never-ending conveyor-belt of vehicle chassises, is likely to consider his (*viz*) job low in skill variety. He is also likely to rate his work as low on task identity (ie seeing an identifiable task through to completion), task significance (ie feeling his job has an impact on the lives of others), autonomy (ie a sense of having responsibility and independence) and feedback (ie rewards in terms of seeing the outcome of his efforts). On the other hand, a rescue-service mechanic tightening the very same bolt on a vehicle stranded on the hard shoulder, will probably perceive his job to be high on skill variety and several other of the JCM dimensions such as task identity, task significance and, possibly, feedback and autonomy too. In such a case, the worker will have had to diagnose the mechanical problem (skill variety) before he is able to fix it (task identity) and will have the intrinsic reward of a job well done (intrinsic feedback) and a grateful driver (task significance and extrinsic feedback). Patrolling the roads alone, albeit as directed by radio messages, the roadside mechanic would possibly consider his job high in autonomy; eg having a fair amount of responsibility and independence insofar that he has nobody "breathing down his neck".

Table 1



### The Job Characteristics Model

**Source:** J R Hackman, "Work Design" J R Hackman and G R Oldham, 1980, Addison-Wesley Publishing Company Inc. Philippines copyright.



The predicted outcomes of highly motivating work (ie according to the JCM) are similarly broken down into four component parts: **high internal motivation, high "growth" satisfaction, high general job satisfaction and high work effectiveness**. It should be noted that 'reduced absenteeism and turnover' was dropped from earlier publications (eg Hackman and Oldham, 1976) on the grounds that it required further research. For example, the authors argued that highly motivating work may encourage competent workers to decrease their absenteeism, whilst their less competent colleagues might feel more inclined to stay away from work (Hackman and Oldham, 1980). Taking the predicted outcomes each in turn; if a worker's job is enriched, s/he should experience high internal work motivation. That is to say, when a job is well designed (eg rating high on the five core job dimensions), the worker will be spurred on to "*superior effort and performance*" (Hackman and Oldham, 1976, p252). In addition to high internal motivation, the worker should also experience high "growth" satisfaction, which refers to having his/her personal needs for growth and development met by the work. They should also experience a high degree of general, ie global work satisfaction, which is measured by questions such as "*Generally speaking, how satisfied are you with your job?*" and "*How frequently do you think of quitting this job?*" (Hackman and Oldham, 1980, p89). The fourth and final outcome is high work effectiveness. The argument here is that highly motivating work will result in optimal levels of achievement, in terms of both the quality *and* quantity of the goods or services produced.

Central to the model are the three **critical psychological states** which, according to Hackman and Oldham, mediate between the core job dimensions and specified outcomes. That is to say, when all the five core job characteristics are present (ie Hackman and Oldham's prerequisites for enriched, motivating work), the worker will be psychologically 'primed' to experience (and demonstrate) the four predicted outcomes. Essentially, the three critical psychological states are the "*causal core of the model*" (Hackman and Oldham, 1976, p255). Hence, according to the JCM, when a job is high in skill variety, task identity and task significance, the worker will perceive his/her job to be **meaningful**. Similarly, when people feel they have high autonomy, then they will feel **responsible** for the outcomes of their work. Furthermore, if the job also offers the opportunity for **knowledge of results**, ie visible/tangible feedback on the worker's efforts, then this too adds to the psychological 'priming' of the individual, in terms of their overall motivation. For example, seeing a job well-done encourages workers to exert themselves further, and so the self-reinforcing cycle continues. So the whole premise of the JCM is that the five core characteristics of the job itself will predict how motivated and effective the worker feels and, in more behavioural terms, how productive and satisfied they turn out to be. Despite Hackman and Oldham's reservations about including reduced absenteeism and turnover as a predicted outcome, there is empirical evidence to support the idea that satisfied workers are less likely to 'scive off' work or leave the organisation, than those who are not (eg Locke, Frederick, Lee and Bobko, 1984; McShane, 1984; Hackett and Guion, 1985; Scott and Taylor, 1985).

So much for the design of the job - what about the workers? Hackman and Oldham stress that a job, objectively rated as high in motivating potential, cannot *cause* the



jobholder to be internally motivated, to perform well or to feel high job satisfaction. Rather, it creates the ideal situation for those outcomes to occur. Some workers will "*take off*" in highly motivating jobs, while others will "*turn off*" (Hackman and Oldham, 1980 p82). The model therefore includes three 'moderators' which exert their effects in a dual-location process, moderating both the relationship between the core job characteristics and the critical psychological states, and between the states and the outcome variables.

Enlarging on the diagram presented at the beginning of this section (table 1), the moderators are described as follows:

Table 2

| Moderators |                                                                                                                                                                                                                                      | Moderator type           |
|------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| 1          | <b>Knowledge and skill</b> - having sufficient knowledge and skills to perform the work competently                                                                                                                                  | An individual difference |
| 2          | <b>Growth-need strength</b> - referring to the degree to which individuals need to experience personal growth and accomplishment, and for " <i>developing themselves beyond where they are now</i> " (Hackman and Oldham, 1980, p85) | An individual difference |
| 3          | <b>Satisfaction with the work context</b> - considers the degree to which workers are happy with the environmental factors surrounding their work, eg pay, job security, co-worker relations and supervisory practices.              | Situational factors      |

In terms of point 3 above, Hackman and Oldham are careful to point out that a job, re-designed to be high in motivating potential, will usually increase internal work motivation and growth and general satisfaction. However, there is no reason to assume that satisfaction with the contextual aspects of work (eg pay, job security, co-worker relations and supervisory practices) will also increase. Indeed, they suggest that when people are asked to perform more challenging work, their satisfaction with the contextual aspects of the job may even decline. This is especially likely if a jobholder is suddenly given more responsibility and skill variety (therefore perceiving an increase in workload) and yet compensatory factors, such as pay and supervisory practices, are not adjusted accordingly.

So according to Hackman and Oldham, to maximize the outcomes of enriched, motivating work, jobholders must have the necessary **knowledge and skills** to enable them to perform competently. For example selection procedures, which fail to match worker and job, may result in a newcomer being ill-equipped to perform the tasks required. Similarly, technological changes may highlight inadequacies in an organisation's training programme; new developments in a job will require new skills in the worker. Moreover, the job should match the psychological **growth-needs** of the individual. So someone who has high growth-needs should ideally be in a job which challenges and stimulates them, hence encouraging personal growth. However, a person with low growth-needs, who perhaps has a "another day, another dollar" attitude to work, might flounder in a job demanding high levels of initiative and



enterprise. As Hackman and Oldham are keen to point out, their work redesign philosophy is one of fitting the job to the individual, rather than expecting the individual to fit the job, eg *"the view of organisations... can be illustrated... as a child's pegboard... the holes in the pegboard... as [being] jobs, the pegs as people who must fit those jobs... if the peg still won't go in the hole, then we may take a wooden hammer and beat on the peg a bit to force it in (supervisory practices and motivational programmes)." (Hackman and Oldham, 1980, p 42).*

The third moderating variable, **context satisfactions**, is actually a group of variables which relate to contextual factors surrounding work. They include satisfaction with a number of areas such as pay, job security, relationships with co-workers and supervisory practices. These context satisfactions are not unlike Herzberg's hygiene factors (Herzberg, 1966), insofar that they do not constitute the main motivational design of work, rather they are external factors which will facilitate (or impede) the JCM's predicted outcomes.

When all the moderators are taken into account, they sit well with Alderfer's Existence, Relatedness and Growth (ERG) theory of individual motivation (Alderfer, 1972). Knowledge and skill, pay and job security can be seen to equate with existence needs. Similarly, satisfactory relationships with co-workers and good supervisory practices appear to equate to relatedness needs and, finally, growth-need equates with the same growth-need in Alderfer's theory, ie a need for personal development and fulfilment. Just as Alderfer's theory holds that frustration can occur at a single need level forcing regression (ie emphasis) to a lower one, or all three levels of need can operate in tandem, the same would appear to apply to the JCM. For example, a teacher may find her actual work enjoyable and enriching, but if she perceives her pay as lower than that of comparable others', or feels isolated by other staff members, these factors will impact on her overall job satisfaction. Furthermore, if these conditions persist, there is an increasing chance that she will look for alternative work. In terms of the JCM, the beneficial outcomes predicted when there is a good person-job fit, are thwarted by the (in this case, negative) effect of the moderating variables. In terms of the ERG theory, existence and relatedness needs are too pressing to allow for progression to personal growth needs.

With regard to measuring the potential enrichment qualities of a given job, instruments such as Hackman and Oldham's Job Diagnostic Survey (1974) can be used to attribute numerical indices to each of the core job characteristics. The scores can then be combined into a single index, known as the motivating potential score, by applying the following formula:

$$\text{Motivating potential score (MPS)} = \left[ \frac{\text{Skill variety} + \text{Task identity} + \text{Task significance}}{3} \right] \times \text{Autonomy} \times \text{Feedback}$$

Hence an enriched job would be described as one that has a high motivating potential score (MPS).



There is some evidence to support the proposition that the effects of work on individuals is moderated both by their growth-needs and their context satisfaction. For example Oldham, Hackman and Pearce (1976) found that the higher the motivating potential of the job, the stronger the internal motivation and performance of the worker. However, the strongest relationships between the MPS and outcomes occurred for workers who had both high growth-need strength *and* who were satisfied with the work context. What Hackman and Oldham seem to omit, however, is the situation whereby a worker may be performing a routine, low-skilled job, but their general satisfaction with work may nevertheless be high because they enjoy the company of their co-workers. For example, women who are at home all day with young children, may actually look forward to their twilight shift in the local factory if only because it gives them the opportunity to socialise. Certainly there is evidence of a link between camaraderie and work effectiveness (eg Berkowitz, 1954; Greene, 1989). However, Hackman and Oldham would possibly argue that such a situation does not necessarily relate to high work effectiveness; chattering workers may not be concentrating on the quality or quantity of their work (eg Jones, 1984; Albanese and Van Fleet, 1985; Arrow 1974).

Although the JCM represents a pleasingly holistic theory of job design, it has not been without its critics. A search of the literature revealed around 240 studies which roughly fall into two equal categories: evaluative and applied. It would appear that all areas of the model (although not necessarily within one study) have been tested and subsequently supported or criticised. These include the validity of the 5-factor solution (Taber and Taylor, 1990; Dunham, 1976; Fried and Ferris, 1986) the mediating role of the critical psychological states (Arnold and House, 1980; Hackman and Oldham, 1976; Wall, Clegg and Jackson, 1978), whether there should be three (Renn and Vandenberg, 1995) or whether they are superfluous to the model's predicted outcomes (Harris and Schaubroeck, 1990; James, Mulaik and Brett, 1982). The validity of the moderator variables have also been debated (Johns, Xie and Fang, 1992; Tiegs, Tetrick and Fried, 1992; Kulik, Oldham and Hackman, 1987).

It is beyond the scope of the present study to produce a comprehensive evaluation of the job characteristics model. Instead, some of the most salient research findings, in terms of the model's strengths and shortcomings, will be briefly covered to provide a fair and realistic perspective to the present study. To facilitate this process, the review and meta-analysis by Fried and Ferris (1987) has been chosen as a main reference point. The researchers evaluated almost 200 studies, 76 of which were meta-analysed using the Hunter-Schmidt meta-analytic procedure. A summary of their key findings, as pertinent to the study, is presented below.

One of the major criticisms of the JCM focused on the subjectivity of self-reported job characteristics (eg Billings, Klimoski and Breaugh, 1977). However Fried and Ferris concluded that, whilst their study cannot completely resolve the issue, there was firm evidence of a positive relationship between objective and perceived job characteristics (Pokorney, Gilmore and Beehr, 1980; Lawler, Hackman and Kaufman 1973; Wall and Clegg, 1981).



Despite the controversy surrounding the five-factor solution, nevertheless, Fried and Ferris reported that, from a study based on 6,930 employees in 876 different jobs, the five-factor solution held true for management and educated workers (Fried and Ferris, 1986).

In terms of the relationship between job characteristics and outcomes, Fried and Ferris concluded that there was evidence of the mediating effect of the psychological states in the job characteristics-states relationship and the states-outcomes relationship. An exception to this was the relationship between job characteristics and <sup>1</sup>work performance. Whilst the reasons for this were not clear to the authors they cited, as one possible cause, organisational 'motivators' which might be operating in some situations. The examples they gave included factors such as organisation pressure for quality work or higher compensational potential. Although not stated by Fried and Ferris, this seems to lend support for contextual satisfactions having a moderating effect on work performance.

Finally, the role of the three moderators was considered. With regard to growth needs strength, the relationship between MPS and performance (Fried and Ferris referred to 'performance' rather than 'work effectiveness') was found to be stronger in people identified as having a strong growth-need, than in those found to be low in growth-need. However, apart from the growth-needs strength moderator, evidence in support of the remaining two (ie skills and knowledge and contextual satisfactions) was lacking. Fried and Ferris stated the reason as being the shortage of available studies and concluded that further research was necessary to clarify the role of moderators in the JCM.

There are two important advantages in the JCM as a theoretical framework. The first is the fact that Hackman and Oldham acknowledge the importance of using workers' subjective ratings of their job. Given that the model purports to provide a measure of a job's overall motivating potential, it makes sense to listen to those who have been selected to perform the work. It is, after all, the incumbent's perceptions of the work which will ultimately affect the outcomes. The second important aspect of the model is the role of moderators. Given that there will be individual differences between workers and in the importance they place on the situational factors of their work, quite apart from differences in their perceptions of these, it is believed that moderators are an essential part of the worker's story. Indeed, the value of employing the full moderated version of the JCM became apparent on reading Pearson's work (1995). Pearson investigated the relationship between met-unmet expectations and voluntary turnover in manual workers (rail track maintenance crews), using Hackman and Oldham's Job Diagnostic Survey (Hackman and Oldham, 1975). The aim was to establish how an intervention of job empowerment impacted turnover. The most interesting aspect of this study was the author's comments on the Job Characteristics Model (Hackman and Oldham, 1976). He criticised Hackman and Oldham's model for not taking into account "*other situational factors*", as opposed to the personal variable of growth-need strength (Pearson, 1995, p417). One of the issues arising from the

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<sup>1</sup> In 1980, Hackman and Oldham dropped the term 'work performance' in favour of 'work effectiveness' to incorporate both the quality and quantity of the goods and services produced.



study was the relationship between the crews themselves (ie co-worker relationships), regarding the new work regimes in terms of communication of set goals. It is argued that had Pearson employed the full model, he might have accrued more meaningful results.

There are clearly advantages in using subjective job-ratings and full moderators in analysing the specialist work of doctors. For example it is quite possible that, to an objective 'outsider', GPs appear to "have it all": Their job has a significant impact on the lives of others, uses doctors' considerable skills and pays very well. Doctors, on the other hand, may argue that they spend most of their time treating the 'worried well' and that the pay is not at all commensurate with their level of responsibility. In other words, doctors' personal expectations of their work may colour their perceptions of general practice in a way that could not be appreciated by the objective observer. Similarly in the case of moderator effects, as just illustrated, doctors' appraisal of their pay (and possibly other contextual factors) may have a bearing on how valued they feel within the health service as a whole. It is therefore argued that the employment of the whole model (ie including moderators) is essential if the complexities of a career in general practice are to be properly investigated and understood.

The JCM clearly provides a good overall perspective of the actual job elements and contexts necessary for high motivation and morale. However, it pays little attention to the personal values which people bring with them to the workplace. It has been shown, for example, that people are drawn to jobs and organisations which (they believe) reflect their own value-orientation, and that such factors have an important role in determining person-organisational fit (Judge and Bretz, 1992).

### **2.3 *Values, beliefs and attitudes***

According to mainstream social psychology values can be described as enduring convictions/judgements about what is right or desirable, which might be at variance with 'reality' (eg Rokeach, 1973; Allport, Vernon and Lindzey, 1951). Beliefs, in contrast, reflect what is perceived to be true, no matter how unjust or undesirable that may be. Attitudes may be understood as an integration of beliefs and values and can be described as affective evaluative reactions, which are triggered by certain classes of stimuli (eg Rosenberg and Hovland, 1960; Petty and Cacioppo, 1981; McGuire, 1985).

So having established that values are enduring, evaluative views about how things *ought* to be as opposed to beliefs, which reflect how things *are*, what are their respective roles in the workplace? One obvious conclusion to be drawn is that an individual's personal values may be at variance with their perceptions - or beliefs - about their work. Take, for example, the case of the fundamentalist school teacher who must teach her class the Darwinian principles of natural selection. Although the curriculum topic may go against her *beliefs* (ie as a creationist), her *values* may hold that education must be a democratic, open process, allowing people the freedom to make up their own minds. Presuming this to be nothing more than an occasional trauma the teacher may find that, in the general run of things, the issue does not cause undue concern. But if this were not the case and every day brought tensions of this



kind into her life, then the rub between personal values and beliefs may become a source of work-related stress.

Allport, Vernon and Lindzey (1951, cited in Robbins, 1993) categorised six types of values:

1. ***Theoretical***: places in high priority the pursuit of truth through a critical and rational approach
2. ***Economic***: interested in what is useful and functional
3. ***Aesthetic***: prizing the beauty of form and harmony
4. ***Social***: emphasising a love of one's fellow beings
5. ***Political***: placing emphasis on the acquisition of power and influence
6. ***Religious***: in pursuit of the unity of experience and spiritual understanding

Based on a study where respondents were asked to rank the six value-types according to preference, Allport *et al* found that responses tended to correlate with different occupational groups. Hence industrial scientists ranked theoretical and political values first and religious and social last. Similarly, church ministers rated religious and social values highest and theoretical and economic last. Such findings have been confirmed by other studies such as Rokeach (1973) with his Rokeach Value Survey and other more recent research (eg Engelbourg, 1980 and Enoch, 1988 cited in Segal, 1992).

So what about doctors; what is known about their value orientations?

### ***2.3.1 BMA's Cohort Study of 1995 qualifiers***

In 1995 the BMA's Health Policy and Economic Research Unit began a ten year longitudinal study of a sample of 609 1995 UK medical graduates. The purpose was to track the doctors' career paths (and intentions), in addition to identifying the professional values which influenced their career decision. The data were collected via a series of questionnaires.

In Part I of the Cohort Study report the sample (544: 86% response rate) were asked to rank 3 statements, from a choice of 18, which most closely reflected their motives for choosing medicine as a career. All reported responses were then ranked according to popularity. The first half of these responses (for both sexes) are represented in the table below (BMA Cohort Study, 1995: First Report - Part I, p13).



### ***Reasons for studying medicine (BMA 1995 Cohort Study, n =544)***

Table 3

| Ranking according to Males |                                                      | Ranking according to Females |                                                      |
|----------------------------|------------------------------------------------------|------------------------------|------------------------------------------------------|
| 1                          | <i>Interesting career</i>                            | 1                            | <i>Interesting career</i>                            |
| 2                          | <i>Good at science</i>                               | 2                            | <i>Wished to work with/help people</i>               |
| 3                          | <i>Wished to work with/help people</i>               | 3                            | <i>Always wanted to be a doctor</i>                  |
| 4                          | <i>Intellectual challenge</i>                        | 4                            | <i>Good at science</i>                               |
| 5                          | <i>Job security</i>                                  | 5                            | <i>Intellectual challenge</i>                        |
| 6                          | <i>Always wanted to be a doctor</i>                  | 6                            | <i>Personal experience of illness/<br/>hospitals</i> |
| 7                          | <i>Influenced by friends &amp; relatives</i>         | 7                            | <i>Job security</i>                                  |
| 8                          | <i>Status</i>                                        | 8                            | <i>Influenced by friends &amp; relatives</i>         |
| 9                          | <i>Personal experience of illness/<br/>hospitals</i> | 9                            | <i>Status</i>                                        |

So for both sexes, medicine was primarily perceived as offering an interesting career. Interestingly, financial reward came 11th and 12th for men and women respectively. In terms of comparing these values with those of Allport *et al* although it is difficult to place "interesting career", the interest in science and wanting to help people would seem to sit squarely with Theoretical and Social Values.

Part II of the cohort report identified the sample's choice of "core values" for medical practitioners. Doctors were, once again, asked to rank in order of importance a series of statements regarding their values (BMA Cohort Study, 1995: First Report - Part II, p5). These are presented, in full, below.

#### ***Attributes required to be a doctor: important core values***

Table 4

| Ranking | Value                                 |
|---------|---------------------------------------|
| 1       | Competence                            |
| 2       | Compassion                            |
| 3       | Caring, commitment and responsibility |
| 4       | Integrity                             |
| 5       | Confidentiality                       |
| 6       | Patient's advocate                    |
| 7       | Spirit of enquiry                     |

The significance of the report was undermined by the fact that there was nothing in the methodology to inform the reader as to how the questionnaire had been developed. For example whether any preliminary qualitative studies had been carried out, or even whether the questionnaire had been piloted. Perhaps unsurprisingly, doctors were reported as finding the completion of the above core values "*a difficult task*" (BMA Cohort Study, 1995: First Report - Part II, p4). Consequently many wrote in their



own values which included (amongst others) stamina, honesty, common sense, a sense of humour, courage, concern for justice, friendliness, *etcetera*. These additional values added a whole new perspective to the rather stiff, formal descriptions in Table 4 above. They allow the reader a glimpse of warmth and vulnerability; to feel there is a real, living person behind the tick-boxes.

Finally, it was interesting to note that only 3 per cent of the sample agreed with the statement that "*medicine is a vocation meant only for those who are prepared to make it their primary commitment*". Eighty seven per cent felt that whilst medicine is a major commitment, the work must be organised in a way that allows doctors to balance their career with family and leisure time. This concern for a balanced, controllable lifestyle is supported by Schwartz, Jarecky, Strodel, Haley, Young and Griffen (1989). They reported a growing trend, amongst the most able students (ie the upper 15% of their classes, across three American medical schools), to choose specialties that featured a controllable lifestyle such anaesthetics, dermatology, pathology *etcetera*.

It is difficult to judge the usefulness of the BMA's study at the present stage, because the present sample are providing the base-line for, hopefully, future cohort studies which may begin to reveal trends over time. As previously stated a real concern is that participants appear to have been led in their responses by their professional association unless, of course, the methodology section simply omitted details of how the research instrument was developed.

Other studies, mostly American, have implied that family practice (the American equivalent of general practice) may have an 'image' problem within the broader context of hospital-based specialties. America too has experienced a decline in family practitioner recruitment, although the trend appears to be reversing now (Kahn, Schmittling and Graham cited in Miller, Fox and Mitchell, 1996), albeit not sufficiently to meet rising public demand. The following sections summarise some of the recent studies which have sought to identify the reasons behind the fall in popularity of family practice as a career.

### ***2.3.2 'Family practice bashing' - perceptions of medical students at San Francisco Medical School:***

Hearst, Shore, Hudes and French (1995) reported that American medical schools were being asked to produce more family practitioners. In response to this, they focused their study on feedback received by medical students (138 respondents) who had previously shown an interest in this specialty. What they found was that, whilst most of the students had previously received positive feedback on family practice (usually from family practitioners), by the time they had reached their fourth year in medical school, 95 per cent reported receiving negative feedback from specialists in other (hospital) fields. Moreover by the end of their fourth year of training only 39 per cent of those, who had previously expressed an interest in family practice, actually chose this as their specialty. The authors claimed that there were many examples of pejorative comments about family practice by both teaching and clinical staff, eg "*But you're too intelligent for family practice!*", "*Why would you want to be a family*



*doctor? They're basically glorified triage nurses."*, *"Many times people [in other specialties] would cut down family physicians, saying they were "family malpractice"... it was very discouraging."* (Hearst, Shore, Hudes and French, 1995, p368)

There are certainly parallels here with the British study by Allen (1994), who reported young doctors being discouraged in a similar fashion, eg *"My whole teaching staff assumed the "clever" students should do a hospital specialty. There was almost no mention of general practice because it did not rate at all with them..."*, *"General practice still has a lowly status with some hospital doctors..."*, *"...some surgeons would say that women... were GP fodder..."* (Allen, 1994 pp 64, 76).

### ***2.3.3 Lay perceptions of the social prestige of various medical specialties:***

Rosoff and Leone (1991) investigated 400 (non-medical) undergraduates' assessment of ten medical specialties in terms of their overall prestige. A stable hierarchy emerged in which certain specialties, such as surgery and cardiology, were consistently ranked at the top and others, such as dermatology, general practice and psychiatry, were consistently ranked at the bottom. In terms of lay perceptions of occupational prestige (ie social standing), general practice was ranked seventh out of the ten specialties, and in terms of income, eighth. Interestingly, when actual reported levels of income were ranked for all ten specialties, general practice came bottom. This is an interesting study because it considers lay perceptions of medical specialties in terms of income and prestige. It will be noticed that the authors used the term 'general practice' and it was not clear whether this pertained to 'family practice' or to a generalist hospital specialty. However, the most likely explanation is that it is the generic term for the primary care *group* of specialties which includes internal medicine, paediatrics and family medicine (eg Fincher and Lewis, 1993).

### ***2.3.4 Preferred specialties of Ibadan interns:***

Another non-British study investigated the preferred specialties of 52 interns (the UK equivalent of house officers, ie junior doctors) in a number of Ibadan hospitals, in terms of their attitudes and values (Ohaeri, Akinyinka and Asuza, 1994). The highly preferred specialties were surgery, paediatrics, obstetrics and gynaecology where there were high expectations of material rewards, public respect and a quick response from patients to treatment. The authors concluded that the problem was linked to a lack of exposure to the less preferred specialties, including family practice. Although the sample size of this study is too small to be of any real significance, the findings suggest that the lack of popularity of family practice as a career choice is not only limited to America and the UK.

So it appears that general practice has a poor image within hospital culture in both Britain and America, and possibly further afield too. Moreover, one study implied that this image may have generalised to the lay population. The BMA's cohort study shows doctors to value compassion and the ideal of helping people but, most importantly, they want an interesting career. There is also evidence that doctors today value a balanced lifestyle where they have time for leisure pursuits. The 1990 GP Contract formalised part-time working in general practice and although it is acknowledged that



this may be associated with a drop in income, the 1995 qualifiers rated financial reward low in their priorities. Therefore the only outstanding values appear to be doctors' desire for an "interesting career" and social prestige.

Is this the nub of the problem - that general practice is not considered to be an interesting enough career? But how do young, newly qualified (hospital-based) doctors *know* that general practice is not for them or, indeed, that hospital medicine would be better?

There is a considerable body of evidence to suggest that met expectations can play an important role in retention, and that realistic job previews can help people make informed decisions about their employment choices.

## **2.4 Career expectations and the role of met/unmet expectations in turnover**

Porter and Steers' classic definition of met expectations reads as follows:

*"The concept of met expectations may be viewed as the discrepancy between what a person encounters on the job, in the way of positive and negative experiences, and what he expected to encounter... we would predict... that when an individual's expectations - whatever they are - are not substantially met, his propensity to withdraw would increase."*

(Porter and Steers, 1973, p152).

Thus met expectation theory centres on the concept that each individual brings their own unique package of job-related needs and expectations with them to the organisation; ideas about pay, co-worker and supervisory relationships, opportunities for advancement and so on. Porter and Steers stress the uniqueness of each individual's set of expectations, which has methodological implications. For example it suggests that between-persons measures (ie as in cross-sectional studies) would be inappropriate because each individual's expectations and perceptions of the organisation are likely to be different. Employees' decisions to remain with, or to withdraw from, the organisation will depend on the degree to which they perceive their overall expectations to be met. The logical argument here, as acknowledged by Porter and Steers, is that low (or realistic) expectations are easier for organisations to meet than those deemed to be idealistically high.

The solution, according to the authors, is to (a) increase the potential rewards of the job (eg pay, recognition and feedback on performance, *etcetera*) in an effort to meet newcomers' expectations or, (b) to enhance newcomers' value-orientation through clear, unambiguous communication about the pros and cons of the job, thus bringing employee-workplace-expectations into closer alignment.

According to Wanous, Poland, Premack and Davis' meta-analysis (1992), the causal sequence of met expectations is job satisfaction and organisational commitment, followed by intent to stay and, finally, job survival (ie retention).



Porter and Steers' implication that employees' pre-entry expectations could be manipulated to realign them with organisational reality, prompted research into a means of achieving this. Based on the premise that most newcomers will have inflated expectations about their jobs and that turnover rates are typically higher for new recruits, Premack and Wanous (1985) investigated the effectiveness of realistic job previews (RJPs). It was found that giving potential/new recruits a preview, clarifying the job and their role within the organisation, lowered expectations and modestly reduced early turnover (Wanous, Poland, Premack and Davis, 1992).

The precise mechanisms by which RJPs work have been variously debated. For example some have argued that they promote employee-organisational compatibility by helping people select a job that best meets their needs, and to reject those which do not (eg Rynes, 1990; Vandenberg and Scarpello, 1990). Others have argued that RJPs exert their effect through met expectations, via a number of mediators. Hom, Griffeth, Palich and Bracker (1998) identified four such mediators in their literature review:

1. ***a 'gratitude-for-being-honest effect':*** RJPs promote organisational commitment by giving newcomers an impression of candour and a caring attitude to employees (Colarelli, 1984; Meglino, DeNisi and Ravlin, 1993),
2. ***a 'forewarned-so-forearmed' mechanism:*** RJPs mobilise coping strategies by forewarning employees about possibly stressful aspects of the work (Breugh, 1983; Wanous and Collela, 1989)
3. ***an 'orientating' effect:*** they help align employees' value orientation by reducing some of the uncertainties surrounding the attributes of new jobs (Meglino and DeNisi, 1987; Meglino, DeNisi, Youngblood and Williams, 1988) and, finally,
4. ***a 'commitment-promoting' mechanism:*** RJPs may assist recipients in their attempts to reduce post-decisional dissonance because they chose to accept the job, despite warnings of its shortcomings (Ilgen and Seely, 1974; Premack and Wanous, 1985).

Initially Hom *et al* (1998) argued for a interdependent-mediating process model, whereby met expectations had both direct and indirect effects on turnover precursors through various mediators (ie as outlined above). However they revised their theory, in 1999, to posit that impressions of employer concern and honesty and employee coping strategies underlie RJPs' efficacy, hence challenging the pivotal role of met expectations. The outcome of the protracted debate on the mechanisms of RJPs would hold that they work by promoting "*accurate pre-employment expectations*", by "*vaccinating*" employees with doses of 'reality' (Hom, Griffeth, Palich and Bracker, 1999, p2).

In terms of applying theories of met expectations and RJPs to doctors, there would seem to be firm grounds for assuming them to have particularly high job expectations. This assumption is based on the highly competitive level of entry to the profession in terms of A-level grades (a minimum of two 'A' grades and a 'B' [Ruston, 1996]), length



of training and external influences such as the glamorous media portrayal of doctors, and medicine's considerable social prestige (eg Coleman and Rainwater, 1978; Hall and Jones, 1950, both cited in Rosoff and Leone, 1991).

A search of the literature provided little insight into the met expectations of professional groups, and even fewer focusing on those of doctors. However, those deemed relevant to the present study are briefly reviewed below:

#### ***2.4.1 The role of met expectations in intent to stay among doctors at US air base:***

Sociologists Kim, Price, Mueller and Watson (1996) investigated the role of met expectations, amongst other variables, in 'intent to stay' amongst doctors at a US Air Force hospital. The authors were careful to explain that the term 'intent to stay' was interpreted in military terms, which equates to intent to remain with the service until retirement. Using a least squares regression, a total of 25 variables were regressed on 'intent to stay'. Met expectations were rated 5th of the 7 significant predictors, explaining 38 per cent of the variance indirectly through organisational commitment which, together, accounted for 88 per cent of the variance in intent to stay.

Data were collected via a single questionnaire which raised methodological concerns. Representing a one-shot measure of participants' reactions, the study relied on post-entry data alone to determine the level of respondents' met-expectations. An example of one of the items was "*My experiences in the Air Force have been better than I originally expected.*". According to Porter and Steers' original concept, met expectations are established via two separate stages; pre and post-entry measures, with the pre-entry stage providing the essential base-line requirement.

Nevertheless, an interesting point raised by Kim et al was their hypothesised link between the degree of education and level of career expectations. For example, they proposed that members of traditional professions will have internalised very high standards from their lengthy training, and will therefore expect their employers to construct work situations which measure up to these. So, for the authors, it followed that "*employers who hire physicians - or lawyers... are hiring employees with expectations very difficult to meet.*" (Kim, Price, Mueller and Watson, 1996, p969).

Dhillon (1990) made a similar point when investigating the relationship between job satisfaction, and educational and organisational level among police personnel. On finding only a moderate positive correlation Dhillon suggested that education may actually reduce job satisfaction in some instances, by raising expectations that cannot be fulfilled by the job.

#### ***2.4.2 A measure of pre-medical students' expectations***

Another American study by Chuck (1996) investigated the career expectations of 84 pre-medical students, comprising 48 women and 36 men. Respondents were asked, via questionnaire, to rate a list of items to indicate (a) which was the most influential in their decision to study medicine and (b) which best matched their career expectations. Results were then compared with responses from a group of experienced practitioners.



Most students (ie 71 per cent) indicated that their decision to study medicine had been through exposure to a role model. In terms of expectations students' responses were only modestly optimistic when compared to experienced practitioners. For example, there were fairly close ratings on items such as *'being able to cure, heal and help people'*, the job being *'intellectually satisfying'* and of high *'social prestige'*. However, students were overly pessimistic on issues relating to lifestyle, eg expecting to have *'control over night-time hours and weekends'* and having *'a meaningful personal and family life'* (descriptive statistical data only). The student group also underestimated the burden of administrative issues which are a necessary part of doctors' lives today. The study concluded by recommending that students should make a more concerted effort to inform themselves of the *"day-to-day realities of medical practice"* and that practising physicians should help provide such information (Chuck, 1996, p230).

Apart from the study being American (and small) and therefore of limited generalisability to the UK, no information was given regarding the experienced sample of doctors, only that they were 'practicing physicians'. Some of the students may have been basing their responses on expectations of a surgical career, where the on-call duties may be generally more onerous than many medical specialities. Nevertheless the concluding plea for would-be-doctors to become better informed regarding their career intentions, supports the argument for pre-entry RJs.

#### ***2.4.3 GPs in principle but not in practice:***

A British study, this time, set out to identify doctors in the Trent region who had been vocationally trained but were not currently practising as principals. The term 'principal' is defined as a qualified general practitioner who would normally be working as an unsupervised doctor under a health authority contract. The authors (Baker, Williams and Petchey, 1995) faced a formidable task in their endeavours to track down these 'missing' doctors. They eventually identified 351 likely candidates, representing 16 per cent of the total number of practising GPs in the Trent region. This was achieved by a system of networking: contacting local vocational training schemes, hospital personnel departments and locum agencies, and 'snowballing' techniques. The authors conceded that their methodology had not been ideal and it was highly unlikely that all the missing doctors had been successfully traced. Of the 351 potential candidates, 251 returned completed questionnaires, yielding a total of 166 deemed suitable for full analysis (66 men and 100 women). Respondents were asked to rate in importance 22 reasons for not currently working as GP principals. When the items were ranked for response frequencies, there was broad overall agreement between men and women. Because of the space constraints of a thesis, only half of the 22 most frequently mentioned problems are presented in the table below.



*Reasons for not working as principals. Factors ranked in order of importance  
(values are numbers; percentages in parenthesis)*

Table 5

| Factor                                               | Men<br>(n = 66) | Women<br>(n = 100) | Total<br>(n = 166) |
|------------------------------------------------------|-----------------|--------------------|--------------------|
| 1) Out of hours commitment                           | 50 (77)         | 96 (96)**          | 146 (88)           |
| 2) Difficulty combining work with family commitments | 31 (48)         | 84 (84)**          | 115 (69)           |
| 3) Requirements of new GP contract                   | 39 (60)         | 65 (65)            | 111 (67)           |
| 4) Increasing demand from patients                   | 40 (62)         | 64 (64)            | 111 (67)           |
| 5) Possibility of complaints                         | 29 (45)         | 50 (50)            | 80 (48)            |
| 6) Exploitation by partners                          | 34 (52)         | 43 (43)            | 76 (46)            |
| 7) Time out before seeking post                      | 30 (47)         | 46 (46)            | 76 (46)            |
| 8) Inadequate remuneration                           | 30 (46)         | 36 (36)            | 73 (44)            |
| 9) Unable to find suitable post                      | 24 (38)         | 37 (37)            | 61 (37)            |
| 10) No need to work                                  | 11 (17)         | 39 (39)**          | 50 (30)            |
| 11) Lack of professional challenge                   | 26 (40)         | 18 (18)*           | 43 (26)            |

\*P<0.05; \*\*P<0.01 for difference between sexes

There were significant differences between the sexes on a total of seven areas (not all shown in the above table). Women were more likely than men to quote reasons of '*out of hours commitment*', '*difficulty in combining work with family commitments*', '*no need to work*' and '*cost of child care*'. Men, on the other hand, were more likely to mention '*lack of professional challenge*', '*acrimonious partnership split*' and '*general practice was not my career intention*'.

The main thrust of the study was to ask doctors whether they would support the idea of re-entry training for general practice (at the time of writing there were no such courses available). However, for the purposes of the present study, it is doctors' actual reasons for dropping out of general practice which is of interest. It is acknowledged that women will inevitably experience problems in combining work and family commitments, despite the fact that they are no more likely than men to be parents. Nevertheless the vital message which the study conveyed, was that many aspects of general practice had taken doctors by surprise.

When the five "female-unfriendly" items were removed, together with just one relating to organisational change (eg the 1990 GP Contract which may not have been possible to anticipate), there were 16 items left. Of these, a further five were judged inapplicable/irrelevant to the present study, eg '*inadequate training*', '*personal illness or disability*', *etcetera*, leaving a total of 11 items. Almost half of these 11 (a total of 5) implied a lack of preparedness for the demands of general practice, ie unmet expectations (total percentages are provided in parenthesis):

- 1. *possibility of complaints* (48%)
- 2. *lack of professional challenge* (26%)
- 3. *unsuited to the work* (24%)



4. *desire to leave medicine* (23%)
5. *general practice was not my career intention* (19%)

Although there were examples of some of the respondents' comments (eg those relating to childcare problems and partnership rifts), the reader was left wondering exactly what doctors were trying to say when they ticked items 2 to 5. For example, why did they feel they were unsuited to the work - specifically which aspects? What was it that drove some to leave medicine altogether? Why did doctors undertake vocational training if general practice was not their career intention? The study raised many more questions than it answered, establishing little more than a base for further enquiry. Nevertheless the overarching message was one of strong support for pre-entry RJs, not just for doctors considering a career in general practice, but in medicine *per se*.

Finally two other British studies are reviewed, both acknowledging that medicine is indeed experiencing some very real problems. The first (eg Carnall and Smith, 1996) makes a fleeting reference to the changing world of work in general, and urges those involved in the recruitment of doctors to take note of these. This was, to the researcher's knowledge, the only paper which made any reference to medical careers within the wider context of the non-medical workplace. However, the paper was a commentary, not a study, written by two editors to mark the launch of a new careers section in the British Medical Journal.

#### ***2.4.4 Doctors' dissatisfaction with their work is due to a mismatch between expectations and reality:***

In their brief article on doctors' careers advice Carnall and Smith (1996) stated, as if accepted fact, that doctors' dissatisfaction with their work was due to a mismatch between expectation and reality. The article then focused on hypothesised reasons for this, suggesting the main contenders were lack of careers advice, unrealistic media portrayals of the profession and the inflexibility of the NHS as an employer. Although Carnall and Smith may be correct in their assumption that doctors' disenchantment is tied into unrealistic expectations, there is insufficient evidence to substantiate such a claim. The authors briefly alluded to the dominance of hospital specialties over undergraduate training which, they suggested, gave doctors the impression that careers outside hospital specialties "*are for failures*" (Carnall and Smith, 1996, p3). Although general practice clearly fits this category, it was not specifically mentioned.

#### ***2.4.5 Doctors and their Careers: implications for policy makers***

Allen's comprehensive study '*Doctors and their Careers*' (1994) makes compelling reading. The entire book is devoted to comparing the views of a sample of doctors, qualifying in 1986, with their counterparts in previous cohorts (1976 and 1981 qualifiers). With copious quotes from both hospital doctors and GPs the study bears rich testimony to doctors' unmet expectations, albeit in the form of post-hoc rationalisations (ie retrospective data). However, whilst Allen does an excellent job in spelling out the misery and disappointments in medicine, eg "*...it's knocked every bit of enthusiasm right out of me. I'm at a massive crisis point...*" (Allen, 1994, p235), the



whole study is centred within the medical arena. If Allen's remit is to inform government policy makers of the state of play in medical careers, it seemed odd that no attempt was made to set the career aspirations of "*the brightest and best of successive generations of young people*" (Allen, 1996, p2) within the context of careers in the wider, non-medical workplace. Surely the medical profession is not so arrogant as to assume it can always attract - and hold on to - this calibre of people, regardless of the outside world and alternative career opportunities?

Having established the central importance of RJP's and met expectations in relation to recruitment and retention, there is yet one other outstanding question to be addressed. At the beginning of the present chapter (see page 3), it was suggested that the very personal values and expectations that encouraged doctors to choose general practice in the first place, may have been shaken by their experiences of working within a changing NHS. The recent increase in retirement rates for existing GPs (eg Beedham, 1996; BMA 1996a) would imply that this may indeed be the case; that for these experienced practitioners, the goal posts have been moved and the job that had once met their needs and aspirations, has now changed beyond recognition.

## 2.5 *Organisational change issues*

### 2.5.1 *Medicine: a decade of change*

In order to understand the tidal wave of change sweeping through the medical profession today, it is necessary to set it in context by considering the recent history of the profession, ie since the inception of the NHS. The first part of the present overview is derived from medical sociologist, David Armstrong's article, '*Medicine as a profession: times of change*' (1990).

After World War II, medicine was seen as the professional ideal and analysed in great detail. The reasons for this were twofold:

- (i) medicine was seen to represent esoteric knowledge; doctors were clearly experts in relation to their clients, and
- (ii) the profession represented a service ideal in which altruistic motives transcended simple greed so doctors were perceived as being devoid of self-interest.

As a consequence of these high ideals, as the welfare state was expanded, the medical profession was given major responsibility for health service resources. As a result, medicine won general acceptance for its self-professed altruism and expertise which, in turn, brought new found wealth, power and influence to the profession.

Freidson's '*Profession of Medicine: A study of the sociology of applied knowledge*' (Freidson, 1970, cited in Armstrong, 1990), marked the turning point in the profession's image. Freidson suggested that medicine's success was not simply due to its possession of the essential "core traits" (ie esoteric knowledge and the service ideal) but rather, it was centred on the complete control the profession had over its own



management. For example, doctors' clinical autonomy was established as an inviolable 'right'. So a more cynical interpretation of medicine's success is that it stems from the skilful exploitation of an ideal marketing opportunity (eg Larson, 1977).

As Larson explained so succinctly, medicine's enormous power derived from its "*cognitive exclusiveness*"; doctors' growing reputation for scientific expertise left the public without any credible or legitimate alternatives (Larson, 1970, p38). However, increasing tension between the might of the medical profession and the power of the State inevitably led to a series of reforms, representing the latter's attempts to recover control over the allocation of health care resources.

In order to understand reactions to the changing role expected of doctors in general practice, it is first necessary to identify the nature of such changes. Therefore, these are briefly listed below as a necessary precursor to the discussion of their effects.

1. ***The 1990 GP Contract:*** formalised arrangements for part-time working and job-sharing and introduced changes to GPs' remuneration system. Reflecting the growing emphasis on disease prevention, doctors were offered financial incentives for reaching set targets, eg compulsory surveillance of children and the elderly, health checks on all new patients and various phased targets for childhood immunisation and cervical cytology screening.
2. ***The internal market:*** the purchaser-provider split was introduced as part of the Government's 1989 NHS reforms. Under this initiative health authorities and fundholding practices became 'purchasers' who placed contracts with 'providers', ie hospitals and NHS trusts. The development of the internal market was part of an overall policy aimed at developing a Primary Care-led NHS, based on the premise that local doctors were best placed to assess local health needs. In addition, many hospital outpatient clinics were transferred to general practices, eg diabetic and asthma clinics, physiotherapy services, well-woman/man clinics, etcetera.

***Fundholding:*** heavily promoted within the vision of a Primary Care-led NHS (and an integral part of the internal market), fundholding allowed practices of a certain size to hold their own budgets for buying secondary care, drugs and practice staff. Non-fundholders continued to rely on health authorities to purchase these on their behalf.

3. ***The Patient's Charter:*** introduced in 1995, informs patients of their rights as consumers in both primary and secondary services, what they can expect in terms of standards of service, and how they can complain if not satisfied.
4. ***Out-of-hours arrangements:*** in response to growing pressure from doctors, changes to GPs' Terms of Service (1995) allowed doctors to share their out-of-hours commitment with other GPs. This has resulted in practices either buying in help through commercial deputising agencies, or sharing the burden with other practices via local co-operative schemes. GPs were also given the responsibility of deciding for themselves whether or not a patient's condition warranted an out-of-hours visit.



5. ***Primary Care Bill:*** introduced in 1998, allows commercial organisations to employ NHS doctors in 'walk-in' surgeries in shopping centres and train stations.

### ***2.5.2 Assessing the damage: doctors' reactions to change***

The 1990 GP Contract was received amidst a storm of protest from doctors, angry at what they perceived as a brutal assault on their independence and working practices (eg Keighley, 1993; Keeley, 1991; Bain, 1991). What particularly incensed practitioners was the lack of consultation; that the Contract was simply imposed on them by bureaucrats who, it was felt, knew little about the grass roots day-to-day work of general practice. Moreover, the move appears to have tarnished the reputation of the Royal College of General Practitioners, as many GPs suspect senior members of working covertly with government in the latter stages of the project (Keighley, 1993). The introduction of the internal market has had a broader impact, affecting the working practices of both hospital doctors and GPs. Indeed, critics of the internal market have claimed that the system has polarised doctors, rather than encouraging cooperation. For example there have been speculations about a 'two tier service' whereby hospital consultants favour referrals from fundholders, over non-fundholders (eg Ross, 1991; Drummond, Crump, Hawkes and Marchment, 1990). This feeling of non-fundholders being perceived as 'second best' has also led to concern about the long-term effects of the scheme on capitation-based funding. Non-fundholders fear, for example, that as fundholding expands there will be less money in 'the pot' for them after health authorities have paid out to the larger fundholding practices (eg Willis, 1991). Similarly, the Patient's Charter has aroused anger amongst many doctors who argue that it has elevated patients' expectations of service-levels, which cannot always be delivered (eg Allen, 1994 and 1997).

Nevertheless, it could be argued that in some ways the medical profession has been instrumental in engineering its own demise, despite protestations to the contrary (eg Allen, 1997; BMA, January 1997). As both Larson in 1977 and, more recently Guardian journalist, Freely (2 March 1996) have observed; doctors have convinced the public that they are the experts and that they alone are competent to discern the difference between, for example, indigestion and a coronary. It now appears that the profession has fallen victim to its own success, with doctors complaining of an uncontrollable rise in patient demand (eg Iliffe and Haug, 1991; Beecham, 1993). As a result of sustained pressure from GPs, the Government introduced new regulations in 1995 (The NHS [General Medical Services] Amendment Regulations, 1995). The effect of these was to relax GPs' responsibilities for out-of-hours care by allowing them to employ deputising agencies, and to decide for themselves whether a patient's condition warrants a home visit.

As a logical consequence of the conflict between increased consumer demand and doctors' apparent reluctance to rise to this, in 1998 the Government introduced the Primary Care Bill. This has allowed commercial organisations to provide general medical services in publically accessible locations such as shopping malls and train stations. Instead of the medical profession welcoming such a move as a means of alleviating the pressure on GPs, the BMA issued a press statement condemning the idea. The statement concluded with the BMA's Chairman (Dr Ian Bogle) declaring



that *"GPs must remain the patient's advocate and any move that threatens GPs' freedom in the surgery is bad for patients..."* (BMA, January 1997, p1).

So it would appear that whilst doctors have been quick to complain about rising patient consumerism, they have been equally quick to reject an attempt to address the problem, presumably because it threatens their clinical autonomy. In other words *"any move that threatens GPs' freedom in the surgery"* is bad for *doctors*, rather than their patients.

Doctors' indignation at others 'meddling' in their affairs is aptly summed by Drummond, Crump, Hawkes and Marchment (1990, p1289): *"Everyone, including the government, should realise that the inappropriate application of managerial innovations can do as much, if not more, harm to patients as an untested drug, device, or surgical procedure."*

Armstrong has also argued that, with increasing government intervention, British medicine may be in danger of being 'de-professionalised'. For example, in America doctors are losing much of their clinical autonomy, becoming agents or employees of corporate providers of health care. Some of these strategies are already becoming apparent in the UK, with the adoption of a free-market policy whereby medical decisions are increasingly governed by managers responding to market forces. Moreover, patients have become consumers and the overall lesson for doctors appears to be *"that a satisfied patient is an important as a medically improved one."* (Armstrong, 1990, p693).

However, whilst it is acknowledged that the medical profession is undergoing dramatic (and continuing) change, doctors are by no means unique. Organisational change has been transforming the wider world of work throughout the 1980s with devastating results for many employees, particularly middle managers. Moreover, the medical profession appears to represent one of the last bastions of job security. Medical unemployment is rare and is usually limited to doctors not seeking work because of domestic reasons (Lambert, Goldacre, Parkhouse and Edwards, 1996). The following section therefore considers doctors' plight within the context of the global workplace.

### ***2.5.3 Change within the global context of work***

The buzzwords used to describe the 1980s/early 1990s' theme of corporate restructuring, or 'business process engineering', provide a flavour of the times, eg

*"downsizing", "rightsizing", "focus without fat", "lean and mean",  
"vision and mission",*

and so the euphemisms continue. The message is clear; the business environment has changed, is still changing, and major players have had to adapt to the new pace or face oblivion. The influence of computer technology, micro-electronics and Japanese penetration of Western markets have all been named as possible culprits in the game of 'corporate Olympics' (Kanter, 1989; Pettigrew and Whipp, 1991). The results have manifested themselves in a bewildering cycle of 'booms' and recessions, with many organisations unable to compete, or indeed, to survive. Global trading is now a reality



and the old certainties of the Western post-war era have been replaced by a fast-moving and unpredictable future, demanding both agility and ingenuity to stay ahead. Large corporations, responding to a perceived need to cut costs and improve productivity, have worked at becoming less bureaucratic and more entrepreneurial (eg Pettigrew and Whipp, 1991; Kanter, 1989). Hence the corporate restructuring jargons listed at the beginning of the section; hierarchical management structures have been slimmed down and flattened, which Kanter likens to a physical fitness regime aimed at producing swift-footed, more agile organisations: "*Corporate giants, in short, must learn how to dance.*" (Kanter, 1989, p20). So in true Darwinian style organisations who chose to stay with 'the game' have had to evolve and adapt to a new type of environment. This has inevitably impacted the working lives of their employees, particularly those in middle management.

Whilst in the past (ie 1970s) it was not at all unusual to hear of unskilled workers or clerical staff being 'laid off', stories of executive management redundancies are a relatively new phenomenon. Take-overs, mergers and business process reengineering have all taken their toll on this once 'untouchable' population of career professionals. These were people who had grown up in a culture of a job-for-life, a culture which has now "*Gone, all gone, and for ever*" (Herriot and Pemberton, 1995, pxiv). Attempts to quantify such effects report losses ranging from 7 per cent in the UK for 1992 (Herriot and Pemberton, 1995), to over 12.2 million in America for the period between 1989 and 1991 (Hiltrop, 1996). Kanter brings this down to a personal level by graphically describing the effects that corporate restructuring can have on individuals, eg "*Some people come to work in an almost catatonic state, starting no new programs; others who have been let go continue to come in to the office.*" (Kanter, 1989, p63). Herriot and Pemberton similarly talk of sacked executives continuing "*to catch the 7.45 to the City and sitting on a park bench all day.*" (1995, p xiv). These are stories of people in shock unable to 'take in', let alone comprehend, what has happened to them.

There is also evidence that over-zealous downsizing, or 'corporate anorexia', has left some organisations with the same workload, but too few people to deal with it (Kanter, 1989). For example Mumford (1995) claimed that American employees are working, on average, 320 more hours per year and concedes that the same is happening in Britain. Similarly Herriot and Pemberton quoted a survey in which 89 per cent of managers reported an increase in workload, with 58 per cent complaining of working more than 50 hours per week (Coe, 1993 cited in Herriot and Pemberton, 1995).

However, it would be wrong to assume that all organisations are proactive and enthusiastic in their approach to change. Like some of the individuals described above, some companies will use denial tactics too. Pugh (1978), for example, wryly observed that those organisations which most need to change, are often those who resist it most strongly. The examples he gives have uncanny parallels with the NHS of the 1990s: Given that organisations are "*resource-allocating mechanisms*", the promise of increased effectiveness and productivity through improved methods of working should "*be easily discussed and adopted*" (Pugh, 1978, p108). So what goes wrong? According to Pugh, it is often the way in which organisations *manage*, or mismanage,



change that causes the problems. For example 'top-down' decisions risk being perceived by workers as imposed from 'on high'. Unsurprisingly, the resulting rigidity, resentment and reduced motivation can skew results, sometimes leading to less cost-effective outcomes than previous methods. This was illustrated by doctors' reactions to the 1990 GP Contract, whereby government targets for disease prevention were passed down to doctors in a ready-to-go format, eg a case of "x number of cervical smears = £x reward: get on with it". As previous studies would indicate, having workers participate in plans for productivity improvements is more likely to win co-operation - and results (eg Morris and Steers, 1980 cited in Hiltrop, 1996; Kanter, 1989; Pugh, 1978). This philosophy also underpins the Job Characteristic Model: The degree to which a job motivates people will depend on (amongst other factors) workers feeling that they are responsible for the outcomes of their work (Hackman and Oldham, 1980).

To summarise, changes in the global (ie non-medical) context of work have radically changed both the way organisations are structured and the way in which they operate. Middle management, in particular, has been squeezed by the new flattened structures. Moreover, a harsher trading environment has meant harsher working conditions for those still 'lucky' enough to have a job. Traditional expectations of a job-for-life have disappeared and the new ethos of "doing more with less" can be translated to "less people doing more of the work". So what are the rewards for working longer and harder?

The section which follows will consider the impact of change on the psychological contract.

#### ***2.5.4 Assessing the damage: the new psychological contract***

Rousseau defined the psychological contract as follows:

*"the understandings people have, whether written or unwritten, regarding the commitments made between themselves and their organisation."*

(Rousseau 1994 cited in Hiltrop, 1996, p1).

It will be noted that this definition is vague and subjective and, indeed, as Hiltrop concedes people will "*fill in the blanks*" as they go along (Hiltrop, 1996 p1). Nevertheless the literature suggests that there has been a consensus about what constituted the contract in the past, and that this has recently changed in accordance with the changing workplace (eg De Meuse and Tornow, 1990 cited in Hiltrop 1996; Herriot and Pemberton, 1995, Mumford, 1995).

Herriot and Pemberton, for example, spell out both the old ('relational') contract and the new ('transactional') version. In the former, the organisation 'promised' job security (ie a job-for-life), opportunity for training and promotion and "*care when in trouble*" (Herriot and Pemberton, 1995, p17). In return, the employee offered loyalty, compliance, commitment and trust in the organisation. More importantly, according to Herriot and Pemberton, employees were willing to go the 'extra mile', ie to give that little bit extra when necessary, without counting the cost. In contrast the new



'transactional' contract comprises the following: The organisation offers high (performance-related) pay - and a job. In return, the employee offers long hours, more responsibility, a wider range of skills, greater flexibility and tolerance of ambiguity. What is missing, the authors argue, is loyalty, affection, trust - and the willingness to go the 'extra mile'. In other words, the new psychological contract is purely transactional, based on tangible returns for both parties.

In addition, however, the new contract conveys overly simplistic inferences about the nature of employees. It assumes, for example, that (a) that people have a sycophantic desire to do anything to keep a job, and (b) that money is a universal motivator, the latter of which is known to be a flawed assumption (eg Hackman and Oldham, 1980; McClelland, 1961; Herzberg, Mausner and Snyderman, 1959). Herriot and Pemberton suggest a major difference between the 'old' and the 'new' contract is the fact that the latter has been imposed, rather than negotiated with employees.

Hiltrop's argument runs along similar lines: The new contract, with its emphasis on flexibility, self-reliance and achieving immediate results, suggests that employees are now responsible for their own "*employability and career*" (Hiltrop, 1996, p4). The problem, she argues, is that organisations have only bought one half of the contract; whilst they still want employee commitment and loyalty, they are unable to deliver their part of the deal, ie security and promotional opportunities. Hiltrop quotes Kolb, Rubin and McIntyre's (1991) warning: "*a company staffed by 'cheated' individuals who expect far more than they get is headed for trouble*" (cited in Hiltrop, 1996, p1).

So having outlined the stark differences between the old and the new psychological contract, what have been the effects of the latter in terms of employees' reactions?

### ***2.5.5 Violation of the psychological contract***

The answer, according to Morrison and Robinson (1997), is anger, resentment and feelings of betrayal. Morrison and Robinson distinguish between 'perceived breach' of contract and 'violation'. Perceived breach, so the argument goes, is based on an essentially cognitive process of appraisal. This involves the employee weighing up the difference between what s/he understands the organisation to have promised in the way of contributions, and what is believed to have been received. A perceived discrepancy between the two would imply that the organisation had reneged on their part of the deal hence the term, breach of contract. Violation, on the other hand, involves an emotional interpretation of the appraisal. This has been described as incorporating "*feelings of betrayal and deeper psychological distress [whereby]... the victim experiences anger, resentment, a sense of injustice and wrongful harm*" (Rousseau, 1989, p129 cited in Morrison and Robinson, 1997).

Indeed, the medical profession can bear testimony to the psychologically damaging effects of the 'emotional interpretation' of change. The fact that the profession suffers problems with stress is no longer news. High rates of depression, suicide and drug abuse amongst doctors have been known for some time (eg Brandon and Oxley, 1997; Sutherland, 1995). The Royal Medical Benevolent Fund, which cares for the welfare of doctors and their dependents, collected data which suggested "*an alarming trend*"



in the mental health of doctors. They reported that doctors who had sought help over the past decade had been younger (under 40 years) than in previous years and had problems with anxiety, depression and family breakdown which were secondary to their addiction problems. Demand is apparently outstripping resources, and they have appealed for donations (BMJ, Vol 302, p1230, 1991).

Although perceived breach of contract is a prerequisite for feelings of violation to develop, the two are not interdependent. For example, several factors will determine whether or not the individual will go on to experience the anger and frustration associated with *violation*. These may include the perceived degree of magnitude of the discrepancy, and the power asymmetry within the organisation-employee relationship. So people who place a high value on the nature of the breach, and who feel powerless to act (eg difficulty in finding alternative employment) are likely to interpret the unmet promise as a violation. According to Robinson and Morrison, violation of the psychological contract can negatively affect employees' trust in the organisation, commitment, job satisfaction and intent to remain (Robinson In press; Robinson and Morrison, 1995; Robinson and Rousseau, 1994).

The logical sequence of this argument is that people who lack marketable skills are more likely to experience violation of the psychological contract, than those who can find employment elsewhere. This indeed is the argument offered by Morrison and Robinson, who refer to 'critical skills' or 'expertise' as a key factor in the power balance between employer and employee.

Doctors, however, represent an exception to the rule. Although they possess valuable skills which, in theory, they can take away with them if the contract fails to meet their criteria, where do they take them *to*? The NHS is a monopoly employer (Ferriman, 1999; Litwinenko and Cooper, 1995) so short of setting up exclusively in private practice (rare) or emigrating to greener pastures, doctors have no real alternatives. The 1990 GP contract was previously quoted to illustrate GPs' wrath at the Government's imposition of changes to their terms and conditions (which can also be seen as representing a violation of their psychological contract). Below, is a very recent account of junior (hospital) doctors' renewed attempts to win better working conditions from a new government:

*"The government wants to modernise the NHS but perpetuates Victorian working conditions for the most vulnerable junior doctors... poor accommodation, no hot food on call, long hours, no rest, relentless intensity - and all for half pay. ...we have asked. We have pleaded... and we have got nowhere... we will ballot for industrial action..."*

(Andrew Hobart, Chairman of the Junior Doctors Committee,  
cited in Ferriman, 1999).

Dr Hobart's standing ovation from committee members reflected the strength of feeling on the matter. It would seem reasonable to conclude that these valuably skilled professionals have moved on from perceptions of a breach of contract, to those of



overt violation. Could it be that the NHS is approaching a stage where it is "*staffed by 'cheated' individuals who expect far more than they get*"?

Having drawn some analogies between changes in the broader context of work and those impacting doctors, certain differences will have become apparent. For example middle managers' problems primarily stem from changes within their employing organisation, as it strives to adjust to the external dictates of the market. It is argued that employees will be aware of this and may even (reluctantly) recognise the necessity or inevitability of some of the decisions affecting them. Doctors, on the other hand, are denied this 'insider' view. As clinicians working at a 'grass-roots' level within a vast organisation (the largest employer in Europe according to Litwinenko and Cooper, 1995), they have no means of knowing the rationale behind the decisions affecting their working practices, apart from the 'rhetoric' of politicians. Therefore doctors may be more likely to perceive such decisions as imposed from above, eg by government officials who, they might argue, have no conception of what life is like for those down at the coalface.

General practitioners' changing role within the NHS has resulted in an increasing emphasis on their developing managerial/business skills. Hence the traditional divide between professional and manager may have blurred.

Hence it is clear that change is not unique to the NHS or to doctors. Nor indeed is it unique to managers. But what about other professional groups such as lawyers?

#### ***2.5.6 Comparing like with like: doctors and lawyers***

Like doctors and middle managers, lawyers have also experienced a decade of change through increasing government intervention. Indeed there are many parallels in the kind of changes experienced by both the medical and legal professions. For example, the Courts and Legal Services Act of 1990 has led to solicitors being given extended rights of audience in the higher courts. This has been associated with a downturn in an important source of work for young barristers. Changes in legal aid payments have meant that for many lawyers, particularly specialists in criminal law, the work is no longer commercially viable. Moreover, lawyers' monopoly on certain legal services has now been removed and this has opened the way for competition from non-legal 'outsiders', such as accountants, surveyors and licensed fee-earners. So for lawyers, recent changes have introduced competition from within the profession, eg between solicitors and barristers, and from without, eg competition from non-legal professionals. The implications of such changes would suggest that for lawyers too there has been a breach, or indeed a violation, of their psychological contract with the State.

#### ***2.5.7 De-professionalisation issues***

Taking an overall perspective on what is happening in the two professions, there can be little doubt that both medicine and law have been affected by the last government's anti-monopoly stance which underpinned their free-market strategy. While professional associations may strive to maintain power and exclusivity in terms of the



monopoly they hold on expert knowledge and control of membership (eg Abbott, 1991; Dearlove and Saunders, 1991), in recent years the Government has sought to erode some of those privileges. Hence barristers' exclusive rights as advocates in the higher courts has been overturned and solicitors have lost their monopoly over areas such as domestic conveyancing. Meanwhile the health service has seen the introduction of the internal market which has led to hospitals (ie 'providers') competing for contracts with GPs and health authorities (ie 'purchasers'). The controversial 1990 GP Contract has introduced 'commission'-style payments to entice doctors to perform to given targets and, indeed, to punish those who underperform. The last straw, for many doctors, has been the 1995 Patient's Charter. Aimed at empowering patients by informing them of their rights and how to make a complaint if they perceive any shortfall in service standards, doctors believe that the Charter simply raises expectations without the resources to meet them.

Table 6, overleaf, summarises some of the most significant changes which have impacted the medical and legal professions over the last decade.



Table 6 *A decade of change: the medical and legal professions*

| Changes in Working Practice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                          | Changes in Training                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Medicine</b></p> <p>1989 NHS reforms introduced the Internal Market: health authorities &amp; fundholding GPs became 'purchasers' who placed contracts with 'providers', eg hospitals &amp; NHS trusts.</p> <p>In line with new Primary Care Led NHS, fundholding was heavily promoted, with an increasing shift of secondary services (ie hospital) to primary care (GPs), eg diabetic clinics, physiotherapy, early discharge of patients from hospitals, care in the community, etc leading to an increased workload for GPs.</p> | <p>1990 GP Contract formalised part-time working &amp; changes in doctors' remuneration system: compulsory surveillance of young &amp; elderly, plus phased targets for specific healthchecks, eg childhood immunisation, cervical cytology, etc.</p> <p>The Patient's Charter (1995) informed patients of their rights, as consumers, in terms of what they can expect from service providers and how to complain if not satisfied.</p> | <p>Calman Training introduced in 1995, in response to EEC directives. This formalised doctors' training, in line with Europe: training not to exceed 7 yrs after registration, with formal teaching, assessment &amp; feedback. Successful implementation depends on substantial expansion of consultants - to provide posts for (more quickly) trained doctors and to allow for consultants' additional teaching responsibilities.</p> <p>Changes in both content and final assessments of GP Vocational Training were introduced in 1993. This was to help equip GPs with the broader range of skills needed for a primary care led NHS.</p> |
| <p><b>Law</b></p> <p>The Courts and Legal Services Act (1990) led to changes such as the Law Society gaining extended rights of audience, allowing experienced solicitors (ie senior partners) to appear as advocates in the higher courts.</p>                                                                                                                                                                                                                                                                                            | <p>Advocacy units are being set up with some solicitors' firms which reflects growing number of solicitor-advocates who now compete for work with barristers</p> <p>Young barristers have been impacted by a downturn in their work.</p>                                                                                                                                                                                                 | <p>The Law Society's Final Examination Course was replaced by the Legal Practice Course (LPC), and articles are now 'training contracts'.</p> <p>The Inns of Court School of Law lost its monopoly on training barristers (Bar Vocational Course). Increases in Bar school graduates, has led to increased competition for tenancies.</p>                                                                                                                                                                                                                                                                                                      |



### 2.5.8 *Differences in reactions to change*

Nevertheless, despite the number of similarities between doctors and lawyers in terms of the structure of their work and the impact of increased government intervention, there was one puzzling anomaly. There has been a marked difference between doctors and lawyers in their reported reactions to change. For example doctors' disenchantment has been emblazoned in the national press for years, and the following examples of recent articles provide a flavour of these:

- **'Trust me, I'm a doctor: is our faith in the family GP at an all-time low?'** Porter, *The Observer Review*, 16 June 1996;
- **'Peak practice which has had its fundholding withdrawn because it spent too much on patients'** Self and Fraser, *The Mail on Sunday*, 9 February 1997;
- **'Doctors' dilemma... we don't have enough GPs to fill surgeries or anaesthetists for hospitals'** Boseley, *The Guardian*, 9 July, 1996.

The BMA has also issued a steady flow of press releases, registering a mix of dismay and alarm:

- ***Patient care threatened by exodus of university doctors, says BMA***  
(16 September 1996)
- ***GPs set their face against privatisation of primary health care***  
(9 January 1997)
- ***BMA warns against commercialisation of family doctor service***  
(26 January 1997)
- ***Too little too late, say GP leaders*** (27 May 1999)

Lawyers, in contrast, seemed to have grumbled quietly through their journals. For example:

- **'Accountants add to uncertainty: who's afraid of multi-disciplinary partnerships?'** Holland, *The Lawyer*, 19 March 1996;
- **'Survey reveals a demoralised profession'** Sweet, *The Lawyer*, 7 May 1996;
- **'Families feel law is "hostile and threatening" says report',** *The Lawyer*, 15 October 1996;
- **'Job's Worth: solicitors' pay'** Sidaway and Cole, *Law Society's Gazette*, 30 October 1996.

Of course, the difference in media cover may simply reflect the public's interests; perhaps people are more interested in doctors and healthcare matters than in issues concerning the legal profession. Another possibility is that the difference reflects the strength of doctors' feelings. However, if they perceive a violation in their psychological contract, why are lawyers not responding similarly? Do doctors, perhaps, perceive government intervention as more of a threat to their autonomy than lawyers? Both professions have had to adapt to a relentless schedule of change, so what is it about doctors' work that causes them to object so much more vehemently?



One plausible explanation, although there is no evidence to support it, is that doctors may perceive a greater *need* to protect their autonomy than lawyers. As previously stated, the NHS is a monopoly employer and if doctors object to their work-package, they are fairly impotent to effect a remedy. Solicitors, on the other hand, are more favourably placed to utilize the advantages of their professional skills-package. This is because legal firms operate as separate, commercial companies and the disgruntled lawyer can, in effect, take his/her skills elsewhere.

## 2.6 *Summary*

In pursuit of an answer to '*what is wrong with General Practice?*', the chapter began with an overview of the nature of doctors' work.

It has been established that medicine is a profession, as opposed to a job. As such it confers status and a protected market for doctors' specialist skills (ie through association). Moreover, the professionals' 'portable' skills and expertise provide the potential for greater trans-organisation mobility. However, there is a moral dimension that is unique to the medical profession. Doctors have traditionally considered themselves the rightful guardians of the sanctity of human life. Moreover there is evidence (eg Larson, 1989; Armstrong, 1990) that the public have also 'bought' this view of the medical profession, which has served to strengthen doctors' power and social standing.

In terms of values, beliefs and attitudes, it was suggested that people tend to be drawn to occupations which reflect their own, personal value-orientations. However, whilst it appears that one of the main attractions of medicine is that it represents an 'interesting career', general practice was held in low esteem by many doctors. In terms of identifying the possible role of unrealistic expectations in this phenomenon, previous studies indicate that doctors tend to be ill-prepared for the challenges that lay ahead of them in a medical career, *per se*, quite apart from general practice. Moreover, whilst the literature suggests that unrealistic expectations may indeed lie at the heart of the problem, there is a lack of empirical evidence to support such a claim.

Finally, the role of organisation change was considered. It was established that whilst doctors in general practice had experienced major change within the last decade, they are by no means unique. Middle management has been particularly hard hit by corporate restructuring and changes in the global market resulting in many involuntary redundancies. This contrasts with the increasing number of experienced doctors who are voluntarily leaving general practice (eg through early retirement), reportedly in response to organisational change (eg BMA, 1996a). Previous studies would indicate that in the current climate employers are hard task-masters *per se*, and that the NHS is no exception. Nevertheless there were differences relating to the psychological contract insofar that any advantage that doctors may have, in terms of (portable) specialist skills, is levelled by the NHS being a monopoly employer. It was suggested that this might explain their apparent interpretation of government intervention as a violation of their psychological contract.



In recognition of the fact that doctors, as members of a very specialist profession, might differ in a number of ways from more generalist professionals (eg middle management) it was decided to compare 'like with like'. When doctors were compared with lawyers it became apparent that there were many parallels both in terms of how they derive their work, and in their experiences of increasing government intervention. There was also an important difference relating to the fact that doctors appeared to be much more incensed about government intervention than lawyers, as evidenced by the extensive press coverage given to the former. Whilst it was hypothesised that this may be due to doctors feeling 'trapped' by a monopoly employer, to the author's knowledge, there is no evidence to substantiate this.

Therefore, it was deduced that doctors' anger and disenchantment is possibly related to three broad areas:

1. unrealistic expectations, not only of general practice, but of a career in medicine *per se*
2. the fact that doctors differ from other professionals insofar that they may feel 'trapped' by a monopoly employer, and therefore threats to their autonomy will have a particular significance for them
3. doctors' anger and disenchantment may reflect a moral outrage at a government's apparent cynicism towards their role as guardians of the sanctity of human life (ie offending the professions' altruistic service ideal).

A review of the literature appears to confirm the negative undertones associated with a career in general practice, which is currently experiencing problems with recruitment and retention.

As stated at the beginning of the chapter identifying doctors' values, beliefs and career expectations, within a broader work-context, should help to establish some of the key underlying issues. For example does the problem stem from the nature of general practice, or the nature of the medical profession as it has evolved generally, ie within the wider context of professional careers? In other words, has the medical profession failed to keep abreast of professional careers within the broader, changing world of work?

Whilst previous studies have sought to identify doctors' values and beliefs, they have been limited to within-group comparisons. Therefore they have failed to provide a contextual background for establishing what might separate doctors from other professionals.

The literature pertaining to doctors' career expectations is patchy and inconclusive. Previous studies would indicate that unrealistic expectations may have a vital role in explaining doctors' current disenchantment, but there is a paucity of research that seeks



to identify doctors' met/unmet expectations. Furthermore, to the author's knowledge, there have been no previous attempts to compare doctors' career aspirations with those of other professions.

## **2.7 *Aims and objectives***

The present study therefore seeks to address this gap in the literature by identifying, and comparing, doctors' career aspirations with those of lawyers. In so doing it is hoped to provide answers to the following questions:

- what do general practitioners enjoy/dislike about their work?
- how does this compare with hospital doctors?
- to what extent is doctors' apparent dissatisfaction linked to unrealistic job expectations - and how do GPs compare with hospital doctors?
- how do doctors compare with lawyers on the above issues? eg, is it possible that the medical profession is unique in some way? How?

The overall aims and objectives of the study were as follows:

- (i) to identify the values, beliefs and career expectations of GPs and hospital doctors, and to establish the extent of any differences (and similarities) between the two groups
- (ii) to identify, and compare, the values, beliefs and career aspirations of solicitors and barristers
- (iii) to draw between-groups comparisons based on findings; comparing solicitors and GPs, and barristers and hospital consultants (eg are doctors, *generally*, more idealistic about their careers than others in a comparable profession?).



# Chapter 2

## Methodological Considerations

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### 1 Introduction

Having established the overall aims and objectives of the study, the next step was to decide on the best methodological design with which to address these issues.

As previously stated, the concept of met-expectations is based on the discrepancy between a person's expectations and their (later) perceptions of their work (eg Porter and Steers, 1973). Such a definition implies a study of two phases or, indeed, two separate studies: one to assess an individual's career expectations, and a second to assess their perceptions of that career.

It must be stressed, from the outset, that the study evolved as it progressed and was essentially data-driven. Hence the remainder of the present chapter will not only outline the initial plans for the research, but will also show how these changed and developed with experience and time. Staff at Cranfield University often speak of "*the dirty world of applied research*" which seems a fitting description of the compromises that must sometimes be made, especially when the focus of the research is people. The ideal research design will not always be logistically viable. In the case of qualitative work, particularly, it is necessary to take account of various constraining factors such as the researcher's available time, location, transport arrangements, *etcetera*. Just as important are the concerns and constraints of the potential sample. For example, asking people sensitive questions about their work will clearly raise very real concerns about the confidentiality of findings. In the case of doctors and lawyers, it was also important to recognise the inherent constraints on their time. For lawyers, certainly, time will equate to potential earnings.

### 2 *The research design*

Given that the aim of the study was to assess the values, beliefs and expectations of doctors, and how these may change over time, the ideal methodological design would be a longitudinal one. This would perhaps begin with medical school where newcomers' pre-entry career expectations could be identified, and then followed up at specific points in their careers. The advantages of such a study would be its compliance with Porter and Steers' original concept of met expectations as focusing on changes occurring within the individual. Following the same individual through, from the beginning, would yield robust data in terms of reliability and validity.

The disadvantage of longitudinal studies is the time factor, making them incompatible with the constraints of a PhD. It was therefore decided to employ the only viable alternative, a cross sectional design. This, of course, changes the fundamental nature of the study: Instead of investigating the expectations and values of the same



individuals over time, a cross sectional design substitutes two (or more) cohorts, separated by experience/age, in their place. So rather than measuring the subtle changes in one person's values, beliefs and expectations over time, the researcher substitutes these repeated measures with a series of 'single shots' of different people at specific stages of their careers. The main disadvantage of cross sectional studies is the question of comparability. There is no sure-fire way of knowing that cohort groups are genuinely comparable, in the same way that a within-person, longitudinal design would ensure. Nevertheless, because the present study centred on people's opinions of their work within the same professions (eg medicine and law), it was felt that, in terms of work experiences, the groups would be fairly homogeneous.

## 2.1 *Sampling considerations*

In order to identify early career aspirations and to monitor how these change over time and with experience, as established, it is necessary to take a minimum of two separate measures. Moreover, using a cross sectional design would mean selecting two separate and representative samples. In addition to these considerations, there was also the between-groups comparisons to be accommodated, eg comparing lawyers and doctors. Because of these multiple aims and objectives, it was decided to break the research down into two separate studies. Study 1 would therefore focus on experienced professionals, whereby establishing each group's career *perceptions* would enable both within and between group comparisons to be made. So in effect, the research design was to incorporate comparison of doctor with doctor, lawyer with lawyer, in addition to GP with solicitor and hospital doctor with barrister. Study 2 therefore would centre on the values, beliefs and *expectations* of trainees.

The reason for starting with the experienced sample was to provide the researcher with a firm grasp of the key issues, ie what was going on within each professional group, as perceived by the experts. Hence the findings of the first study were a prerequisite for the second, in terms of providing a framework for interviews with trainees. In essence, it was a case of asking the expert sample "*how do you see your job?*" (ie their *perceptions*), before turning to trainees and asking "*what are you expecting in your job?*" (ie their *expectations*).

Given that the aim of the study was to compare two different professions, in terms of their common ground (eg GPs and solicitors, hospital specialists and barristers), it was important to select the samples so as to achieve as close a 'match' as possible. For example, solicitors are often employed as 'in-house' legal executives within large commercial organisations. Alternatively, so called 'high fliers' may opt for employment with large City firms where the emphasis of the work is often on advising corporate clients in commercial legal matters. For these reasons, the solicitors selected for the study typically represented provincial high street practices. These practices offer a range of specialist services, eg matrimonial, conveyancing, commercial law, *etcetera*, and members of the public consult the appropriate solicitor in much the same way they would their GP. Similarly, barristers can be employed by the State, as in the case of the Crown Prosecution Services, or they can be sole practitioners working as tenants in chambers. The latter receive solicitors' referrals in the form of 'briefs', which are the



equivalent of GPs' referral letters to hospital specialists. Hence the barristers recruited for the study were members of the independent Bar.

Having decided to split the research into 2 separate studies to accommodate experienced professionals in the first instance, and trainees in the second, the next question was how to define '*experienced*' and '*trainee*'.

### 2.1.1 Definitions of '*experienced*'

To avoid a cohort effect between the experienced and trainee samples, it was decided to limit the 'gap' of experience between the 2 groups to around 8 years. A second reason was to take account of the particularly long post-registration training of doctors. Taking a second tenure point of 8 to 9 years further experience should therefore ensure that the hospital practitioners, selected to represent the experienced sample, will actually have progressed to a consultant's post in that time. Hence it was stipulated that all experienced participants should have worked within their chosen profession (as qualified practitioners) for a period of 7 to 10 years. In practice, however, even the 10-year proviso proved to be insufficient for many of the consultant sample. Many recently appointed specialists (ie a mean of 4 years in-post experience) had a mean of 11 years post-qualification experience, ranging from 6 to 14 years. Hence an extra margin had to be allowed for hospital consultants, changing the criterion from having approximately 10 years post-qualification experience to one of having been appointed, to a consultant's post, within the last 5 years.

Because of differences in the way doctors and lawyers train, there were marked differences between the medical and legal samples' length of in-post experience. To clarify this point, when solicitors and barristers qualify/register, it marks the *completion* of their training and they are licensed practitioners. For solicitors, this point is the successful completion of a trainee contract, and for barristers it is associated with obtaining a tenancy (ie in chambers). For doctors, however, registration merely marks the beginning of *further* training which, prior to the introduction of Calman training in 1995, could last for as long as 14 years. All experienced doctors recruited for the study trained in the pre-Calman days, hence a newly appointed consultant may have 13 years' post-qualification experience, as was indeed the case for one member of the sample (eg the paediatric consultant). Although the aim was to recruit a total of 5 to 6 individuals per group, the researcher encountered a better response than expected. This resulted in 10 experienced professionals per group, rendering a total of 40 participants for Study 1.

**Gender issues:** To reflect the fact that 50 per cent of medical school entrants are now women (eg Allen, 1994; GMSC, 1996), and 56 per cent of new GP trainees are female (General Medical Services Statistics, 1 April 1997) there was a concerted effort to reflect this within the medical groups. Moreover, because surgery is perceived as extremely competitive - and male (eg Allen, 1994; Dillner, 1993) - efforts were made to ensure that surgical specialties were represented within the hospital samples of both studies, and to include women surgeons wherever possible. Similarly the Bar appears to be a predominantly male arena, and, although the number of female barristers has doubled over the past decade, women still only constitute around a fifth of practising



barristers (eg Cox and Sadler, 1995). Therefore attempts were made to recruit female barristers to the experienced sample wherever possible. A summary of the sample recruited for Study 1 is presented below.

**Table 7**      ***Study 1: the Sample*** (experienced practitioners)

| <b>GPs</b>                                           | <b>Solicitors</b>                                    | <b>Hosp Consultants</b>                                  | <b>Barristers</b>                                     |
|------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------|
| <i>Total:</i> 10<br>7 men, 3 women                   | <i>Total:</i> 10<br>6 men, 4 women                   | <i>Total:</i> 10<br>6 men, 4 women                       | <i>Total:</i> 10<br>6 men, 4 women                    |
| <i>In-post mean:</i> 7 years<br>(range: 4 - 7 years) | <i>In-post mean:</i> 7 years<br>(range: 7 - 9 years) | <i>In-post mean:</i> 4 years<br>(range: 9 wks - 8 years) | <i>In-post mean:</i> 8 years<br>(range: 7 - 10 years) |
| <i>PQE mean:</i> 10 years<br>(range: 9 - 12 years)   | <i>PQE mean:</i> as above                            | <i>PQE mean:</i> 11 years<br>(range: 6 - 14 years)       | <i>PQE mean:</i> as above                             |

Note: *PQE* refers to post-qualification experience

### **2.1.2 Definitions of 'trainee'**

Met expectation theory suggests that the first measure should comprise pre-entry expectations, ie the expectations that an individual brings with them to the organisation (eg Porter and Steers, 1973). So ideally the first sample (eg trainees) should be university/medical school students. However there is evidence that doctors, in particular, can change their minds about their chosen specialty many times before reaching a final decision (eg Allen, 1996; Edwards, Lambert, Goldacre and Parkhouse, 1997). The researcher's personal experiences (ie as a nurse in a teaching hospital) also suggested that obtaining sensible, considered responses from medical students might be something of an up-hill struggle. It was therefore decided that there were definite advantages in having a sample who had given serious consideration to their intended careers. Hence trainees were defined as qualified doctors who had recently embarked on specialist/GP vocational training. A total of 19 doctors participated in Study 2.

The original intention was to include trainees from the legal profession as well as medicine as an extension of the first study, and indeed the data were collected from trainee solicitors and pupil barristers. However on completion of Study 1, it was felt that the fundamental differences between legal and medical professionals were already clear. Moreover in view of the focus of the study (ie "**What is *wrong* with general practice?**"), honing the second study to trainee doctors alone, represented a more promising course of action.

So who were the trainee doctors?

- **Hospital trainees:** (total: 11) in hospital medicine, trainees are known as specialist registrars. These are qualified doctors who, after completing their pre-registration year as house officers and possibly a further 2 or 3 years as senior house officers, are now embarked on a specialist training programme. This represents the final run up to the coveted consultant post.

**Tenure point:** within the first 12 months of specialist training.



- **GP trainees:** (total: 8) known as GP registrars, these doctors can opt for GP Vocational Training immediately after completing their post-registration year. This comprises 2 years as senior house officer in 'approved posts' and 1 year working in a general practice (not necessarily in that order).

**Tenure point:** within the general practice year of the GP Vocational Training Scheme.

**Tenure point:** with regard to selecting a tenure point in doctors' training, all GP registrars were interviewed during their general practice year, which represents one third of their total training programme. The main reasons for this were a) it ensured that trainee GPs had experience of working in a general practice environment and b) it was easier to access them in a general practice centre, rather than trying to track them down in a large hospital. In terms of their post-registration experience, the sample's mean (and mode) was 2½ years and this included their GP vocational training.

Turning to specialist registrars, all were in the first year of their specialist training programme (range: 2 to 6 months). However, there was a broad variation in terms of their general post-registration experience, which ranged from 3 to 8 years. There were equally wide ranging reasons for this discrepancy. For example, a female paediatrician had almost completed her specialist training in Nigeria, but after a substantial career break, had had to repeat her higher training in Britain. The respiratory medical registrar had changed specialties, so was having to repeat certain aspects of his specialist training. Other anomalies included a qualified GP who had managed to return to hospital medicine, and a biochemistry graduate who entered medicine as a mature student.

The diagram below summarises the sample in Study 2, whilst a general overview of lawyers' and doctors' career routes is provided in the chart overleaf.

**Table 8**                    ***Study 2: the Sample*** (trainee doctors only)

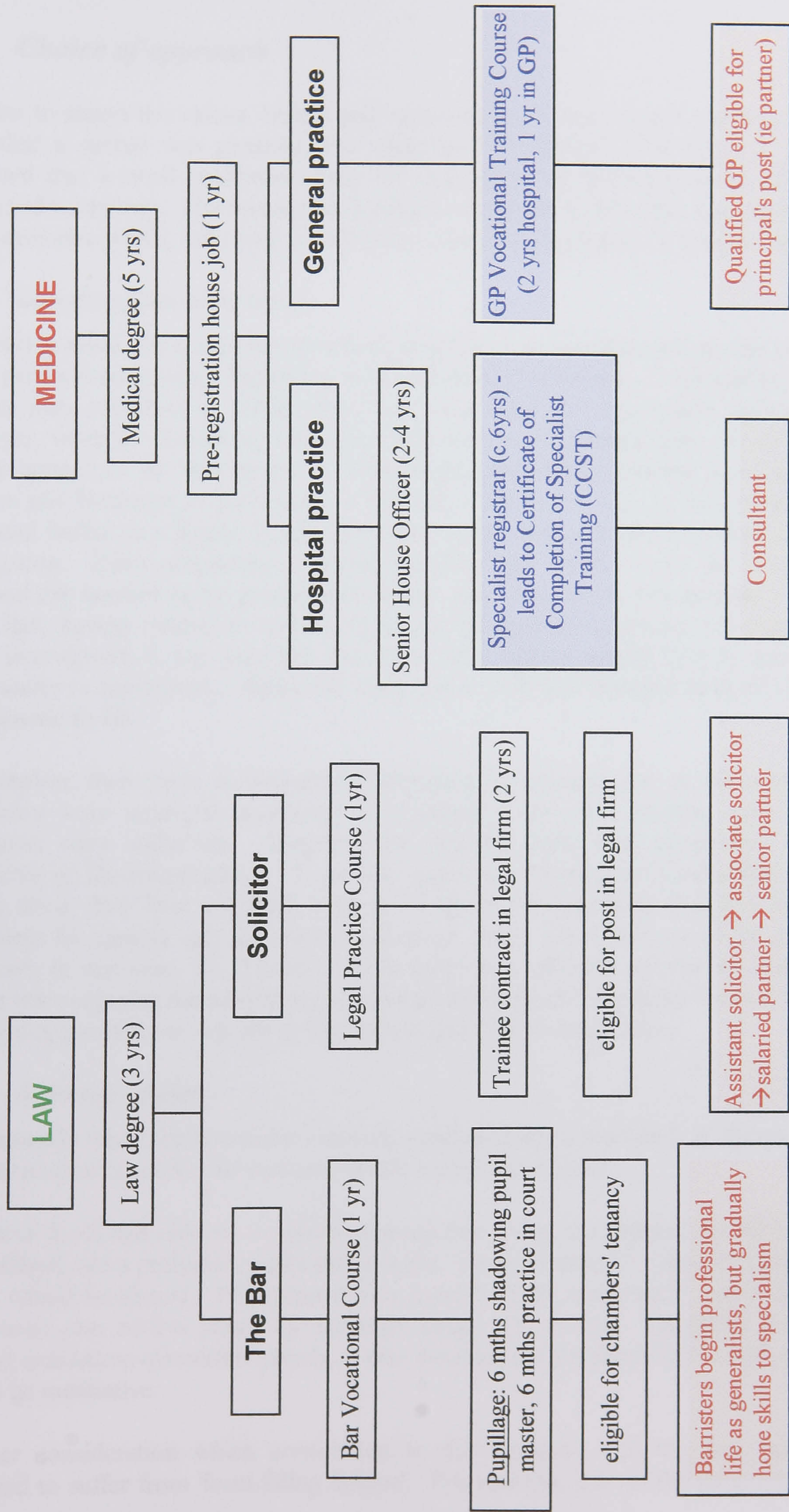
| GP Registrars                                                                                                              | Specialist Registrars                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>Total:</i> 8<br>5 men, 3 women                                                                                          | <i>Total:</i> 11<br>6 men, 5 women                                                                                                                   |
| <i>Mean time in GP training:</i> 2½ years<br>(range: 0 - 2¾ years)<br><br><i>PQE mean:</i> 3 years<br>(range: 1 - 4 years) | <i>Mean time in specialist training:</i> *3 months<br>(range: 2 - 6 months)<br><br><i>PQE mean:</i> 7 years (mode: 8 years)<br>(range: 3 - 14 years) |

\* excludes a respiratory medicine registrar who changed specialty and was unclear on start date for new training



Table 9

Law and Medicine: Two professions - four career routes



KEY: Blue = trainee sample (doctors only)    Red = experienced sample (lawyers and doctors)



## 2.2 *Choice of approach*

In order to assess the values, beliefs and expectations of doctors and lawyers, it was clear that a survey was required, but what kind of survey? For Study 1 it was proposed that a small qualitative study be undertaken, comprising a series of semi-structured interviews. The subsequent findings would then assist in the construction of a questionnaire which, following a small pilot, would be distributed to a larger sample.

### 2.2.1 *Learning from experience*

With this in mind, the researcher set about recruiting 5 or 6 representatives for each of the 4 professional groups, beginning with experienced solicitors. Anticipating a low success rate, introductory letters were sent to a total of 19 potential participants. However, when the follow up telephone calls were made a week later, 10 solicitors readily agreed to be interviewed. Anticipating particular problems in persuading doctors and barristers to participate in the study (the latter was, in fact, justified as discussed further in Chapter 2), the researcher continued to target 20 individuals for each group. After procuring a further 10 GPs with relative ease, the researcher accepted this number as the prerequisite sample size. Underlying this decision was the belief that, having written to individuals asking for their co-operation with regard to being interviewed, it was only fair that those who agreed should then be given the opportunity to participate. Hence the study grew from the intended total of 20 - 25 participants, to 40.

Nevertheless, there were no thoughts of changing the original plan at this point, and interviews were arranged according to schedule. The next surprise came when interviews were underway. Despite GPs stressing their time constraints to the researcher on the telephone (eg "*I can only spare you 20 minutes!*"), once they began talking about their lives and their work, with all the accompanying joys and stresses, their plans for sparing only 20 minutes fell away. Most interviews ran on for over an hour and, in one case, for 2 hours. So it came as a pleasant surprise to learn that people were enjoying the interviews as much as the researcher, perhaps because it gave them the opportunity to talk about themselves and their working lives.

### 2.2.2 *A change of plan*

Consequently when the interviews were all completed and transcribed, it became clear that the original plans for the research would need to be revised.

The sheer depth and richness of data suggested that trying to condense the information they offered into a preliminary qualitative study, ie a forerunner to a larger quantitative study, would be absurd. Following advice from both the researcher's supervisor and the second year review panel, the research design was revised. Departing from the original qualitative-quantitative study, it was decided that the approach to both studies should be qualitative.

Another consideration which contributed to this decision, was the fact that GPs appeared to suffer from 'form-filling fatigue'. For example, one of the sample greeted



the researcher with "*It's not another questionnaire, is it?*". There was a definite impression that these doctors were so overwhelmed with paperwork, that any extraneous sheets of paper arriving on their desk that were not strictly pertinent to work, would be destined for the bin. Being interviewed was perhaps a novelty. Extra form-filling clearly was not. Certainly, there was the feeling that a large questionnaire-based survey would be poorly received by the sample and if these people were willing to be interviewed, then the study should be interview-based. Again, it was a case of logistics; researchers should surely be flexible enough to accommodate the needs and wishes of those whom they seek to study.

For the researcher, the change to a qualitative-only approach marked a personal milestone. Having only a quantitative background, there was an instinctive distrust of anything qualitative in nature; a feeling that it was nothing more than 'quality journalism', lacking in substance and objectivity. In the initial, preparatory stages of the study there was a sense of 'going through the motions' (eg this is what must be done in order to proceed to the 'real' bit of the research - the questionnaire), but as interviews got underway, this feeling gave way to a sense of wonder. Wonder that people could be so trusting and frank, and wonder at the opportunity the face-to-face encounter gave for clarification of certain points, further probing of interesting asides - or avoidance tactics. Another joy was witnessing the rich flow of non-verbal data pouring in: facial expressions, eye-contact then no eye-contact (why? - what was going on here?) physical signs of discomfort (a shift in the chair) or of enthusiasm (leaning forward, towards the researcher).

Thus the qualitative research did more than inform the study, it enlightened the researcher. The true purpose (and significance) of qualitative work became clearer: it was not simply a forerunner to the (more important) quantitative stage/s of research. Rather it shares equal status, with each style of approach complementing the other (eg Firestone, 1987). Hence the qualitative approach asks the question '*what is going on here?*', whilst a further quantitative study might ask '*do these findings generalise to a wider population?*'.

So by changing the methodology to a purely qualitative approach, the present study addresses what is, arguably, the most important part of the research question, eg "*what is going on here?*". Answers to the second part of the question must await another day, and another study.

### **2.3 *Choice of qualitative approach***

The history of the research programme was a story that had to be told. However, the order in which it is presented may have given the impression that little thought went into the planning of the qualitative aspects of the study, ie that it was merely *ad hoc*. This was not the case and the present section will therefore outline the original rationale behind the qualitative study, eg the decisions that were made and the reasons behind them.



### **2.3.1 *Design considerations***

As previously stated the corporate aims of the research (ie across both studies) were to identify doctors' values, beliefs and career aspirations and (a) to compare similarities and differences between doctors and their counterparts in the legal profession, and (b) to assess the extent of doctors' unmet/met expectations.

### **2.3.2 *Interviewee considerations***

It was also stated in section 1 that asking people sensitive questions about their work is likely to raise concerns about the confidentiality of findings. It was therefore considered important to create a situation in which individuals felt sufficiently 'safe' to express their thoughts freely and in confidence. Equally important to the research was to have people describe their hopes and aspirations, concerns and disappointments in their own words.

Individual depth interviews therefore represented the ideal method of data collection. Focus groups or group interviews were rejected on the grounds of their inherent problems: the dynamics of group interaction were thought to present a possible deterrent to individuals expressing opinions on sensitive and highly personal issues. Individual unstructured interviews, on the other hand, have the advantage of giving participants the freedom to define their own ideas in an individual way, in private and without the imposition of the researcher's biases and preconceptions. The drawbacks of this method are mainly the associated difficulties of analysing data in the absence of any structured format, data-overload and the time-consuming nature of 'free-running' interviews. The researcher had to bear in mind that solicitors bill clients on an hourly basis, which means that time spent helping the researcher may equate to lost earnings. Given the fairly large sample size and participants' likely concerns regarding their time, semi-structured depth interviews were deemed the most appropriate format for data collection.

### **2.3.3 *Semi-structured depth interviews***

Having a semi-structured framework of areas to cover, within each interview, has several advantages. The most obvious benefit is the assurance of consistent data sets across all sample groups, greatly facilitating analysis. Bearing in mind the purpose of the study was to identify and compare various aspects of participants' work, semi-structured interviews would also ensure that areas pertinent to the research were in fact covered (eg internal validity and generalisability). A happy balance was needed between the researcher's agenda and the participants' freedom to express themselves. Despite the potential problem of researcher-bias, having a list of topics to hand can serve as an efficient "ice-breaker". Not all interviewees are easy conversationalists and providing a starting point can help to orientate people, and so encourage them to explore and expand their thoughts on a given topic. Although still time-consuming (but possibly less so than unstructured), semi-structured interviews were believed to represent an efficient use of the researcher's and interviewees' time. Interviews follow a defined course and, providing the questions are sufficiently open-ended and the interviewer is sensitive to cues for further exploration or a change of emphasis,



*etcetera*, a semi-structured format can provide a wealth of rich qualitative data (eg Walker, 1985; Miles and Huberman, 1994).

Expanding a little on the latter point it behoves the researcher, when using an agenda driven format - however 'open' this might be - to be particularly diligent in *listening* and attending to the respondent. There is always the danger of being so preoccupied with the format of the interview-structure that a crucial message, either verbal or non-verbal, is totally missed (see Jones, 1985).

## 2.4 *Gender issues*

Initially, the gender issue was carefully skirted by the researcher. It was felt that the topic was too vast to address within the limitations of a PhD, and that the results might represent a disproportionately large part of the overall thesis. However, it would be less than honest not to acknowledge the impact that the topic had on the researcher. The following paragraph encapsulates this effect, for the benefit of the reader.

***Personal biases - the researcher's background:*** becoming a parent at the age of 22 and now in her mid 40s, the researcher has been a full-time working mother for most of her adult life. Hence she has first-hand experience of trying to juggle the competing commitments of work and family. This background had a definite bearing on the way the researcher responded to working mothers within the samples. For example, there was an acute awareness of just how quickly a rapport was struck with these women. Gestures such as the odd grimace, a nod, or the odd murmured word or two, quickly conveyed a sense of shared experience. The divided loyalties that working mothers experience too often bring feelings of guilt and inadequacy; a sense that the most carefully planned childcare arrangements are somehow not quite good enough. In the interviews with such women, it was very apparent that their children were never far from their minds, and they frequently cropped up in their conversation. It was hoped that by establishing a sense of sympathetic support and understanding, interviewees were freed of any perceived need for further explanations or justifications. On the researcher's part, there was only admiration for their having the stamina and courage that is commensurate with trying to "have it all". In contrast, there was a (suppressed) sense of exasperation and surprise when a female pupil barrister declared that mothers should stay at home with their children, because otherwise there was no point in having them. The surprise came from hearing such a response from a woman in her early 30s.

Conversely, although there were many fathers in the study, the researcher only learned of their status when collecting demographic data at the close of the interview. For these men, home and family seemed to be much more deftly separated from their world of work.

## 2.5 *Methodological concerns: ensuring rigour in qualitative research*

One of the major concerns of qualitative researchers has to be one of reliability and validity. For example, how can the researcher be sure that the research question has indeed been addressed (ie internal validity)? A constant agony for the researcher has



been the dilemma of "Am I scratching where it isn't itching?" (eg Wolcott, 1990, p61). One of the recommended solutions is to check the reported findings with participants (eg Miles and Huberman, 1994). Another means is 'triangulation'; a process whereby other disinterested parties are given the data to see whether or not they agree with the categories and conclusions of the researcher. This method was adopted by the author. Both the PhD supervisor and another doctoral student were shown a selection of uncoded scripts presented in the format of a wall chart, along with a number of pre-assigned categories shown on separate cards. The latter comprised the pre-coded questions (ie in accordance with the requirements of the Nud.IST qualitative research software), reflecting the interviewer's agenda (see table 11 on page 62, and table 23 on page 174). For example participants were asked to name the 'highs' and 'lows' of their work, to which the question was allocated the code, Q4 in interview scripts. Similarly, problems and regrets were allocated the code, Q8. The question posed to both parties, was where they would place participants' responses in relation to the designated cards. The underlying logic of such a procedure is that the research findings of the potentially biased researcher, are given added weight by an 'outsider's' opinion. Both supervisor and 'outsider' endorsed the researcher's findings. However, it has to be said that the structured nature of interviews greatly facilitated the process. Having a 'draft' agenda for interviews ensured fairly consistent data sets across groups and the pre-coding of data meant that transcripts were uniformly organised and therefore easily comparable. As stated in Chapter 14, a hospital consultant was given the researcher's findings pertaining to hospital trainees. Apart from his criticism that it had been unfair to catch doctors 'off-guard' with the 'why not general practice?' question, his overall comment was that the researcher had "*captured the essence of the junior doctor's experience*".

In terms of reliability, the question posed is whether another researcher would reach the same conclusions. To which the answer has to be: possibly not. The objective reader will always be denied the personal experience of the live interview. Reading an interview script brings the whole encounter to back to life for the researcher; the energy, the nuances, the postures - the rapport. It is impossible to convey the mood of every interview in a write-up. What invariably happens, is that certain participants tend to become 'favourites' insofar that they have the gift of clear articulation. Hence for every four or more respondents, there will be one individual who appears to 'say it all'. How impartial is this? The interpretation of the qualitative researcher will inevitably be open to debate. For example, there is always the danger of 'spoon-feeding' the reader, in terms of deciding what s/he needs to know (eg Wolcott, 1990). The author has attempted to overcome this by including those participants' views which run counter to the majority. The whole process must depend on the integrity of the researcher. Nevertheless, as a recent convert to qualitative research, it must be said that people express themselves in words, not numbers. There can be no guarantee, for example, that the tick-box is any less prone to the mood of the moment on the part of the participant, or to the preconceptions of the researcher who assigned it. Hence the honesty of the researcher, in addressing fellow research colleagues is at least fairly and squarely open to trust - and interrogation. As stated at the end of the present chapter, copies of interview transcripts will be made available to the reader on request from the author.



## 2.6 *The overall research aims and objectives*

The primary aim of the research was to establish what is so wrong with general practice as to cause the current crisis in recruitment and retention. To achieve this objective, 2 studies were undertaken. The first was an investigation of the values, beliefs and work perceptions of experienced doctors and lawyers, with the intention of establishing the extent of similarities and differences between the two professions. For example, is it possible that doctors are more idealistic in their job aspirations than others in a comparable profession?

The second study focused on trainees in general practice (GP registrars) and hospital medicine (specialist registrars) to establish their values, beliefs and career expectations. The purpose of this was to assess not only between group differences, but to compare trainees' *expectations* of their careers with the *perceptions* of the experienced group (ie the findings of Study 1). This should go some way to revealing how realistic newcomers' job expectations are, and the extent of any differences between those who choose a career in general practice and those who choose a hospital specialty.

Hence the specific aims of the research were as follows:

1. to establish the values, beliefs and career perceptions of experienced doctors (GPs and hospital specialists), and their equivalents in the legal profession (solicitors and barristers)
2. to draw both within and between group comparisons of the above, in order to establish similarities and differences between the two professional groups
3. to establish the values, beliefs and career expectations of GP registrars and specialist registrars
4. to draw between group comparisons of the above, in order to establish the extent of any similarities and differences between the two groups of trainee doctors
5. to compare the ideals of GP registrars and specialist registrars with their experienced counterparts (ie GPs and hospital specialists), in order to assess the extent of their unmet/met expectations.

Copies of original transcripts, whilst too bulky to submit with the thesis, are available on request from the author. Copies of interview 'agendas' can be found in Table 11 (Chapter 4) for Study 1, and Table 23 (Chapter 11) for Study 2.



## Part II

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### **Chapter 3**

Introduction to Study 1

### **Chapter 4**

Method

### **Chapter 5**

Results & Discussion: General practitioners

### **Chapter 6**

Results & Discussion: Solicitors

### **Chapter 7**

Results & Discussion: Hospital Consultants

### **Chapter 8**

Results & Discussion: Barristers

### **Chapter 9**

An Overview of the Four Groups



# Part II

## Chapter 3

### Introduction to Study 1

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As stated in Chapter 1 (section 1), general practice is experiencing a recruitment and retention problem with not only a fall in the number of new entrants, but an increase in those seeking early retirement. According to the BMA's Parliamentary Brief (BMA, February, 1996a), reasons include an increasing workload, long hours and low morale. This comes at a time when healthcare services are undergoing major reforms to effect a new, primary care led NHS.

Initial plans to simply compare GPs with hospital doctors, in order to identify some of the key work-related issues, had to be reconsidered in the light of a growing unrest among (junior) hospital doctors (eg Beecham, 1996).

It has been suggested that doctors' disenchantment is due to unmet expectations (eg Carnall and Smith, 1996) and, certainly, this would seem a logical deduction: whatever it was that initially attracted these people to a career in medicine, appears to be falling short of their expectations at this point in time. However, there appears to be a paucity of research to substantiate this hypothesis, despite its common sense appeal. More importantly, there is nothing in the current literature that seeks to identify doctors' expectations and perceptions and to compare these, whatever they might be, with others in a parallel profession.

The present study therefore seeks to identify what is important to doctors *per se*, in terms of their work-related values, beliefs and aspirations, and to compare these with others in a comparable profession such as law. This may reveal important differences between groups. For example, do doctors have particularly high ideals which are 'out of sync' with other professionals? Are their working conditions particularly stressful or are doctors, perhaps, too segregated from the rest of the world (eg 'blinkered') to notice changes in the general workplace? As previously stated (Chapter 1, section 2.5.3), a 1993 survey reported that 89 per cent of managers were complaining of increased workloads and 58 per cent were working in excess of fifty hours a week.

It was also stated in Chapter 1 (section 2.5.6) that there are many parallels between the legal profession and medicine. Solicitors, like GPs, represent the first port of call for the public and operate a similar referral system for specialist cases, ie to barristers. Both professions are included in the Registrar General's Classification Scheme under the same social class and major grouping. Moreover, both medicine and law require a specialist first degree which then opens the way to two main career routes, eg solicitor or barrister in law and GP or hospital specialist in medicine.



There are other parallels. Both professions have experienced a decade of change, the most noticeable difference being the reactions of the two groups. Whilst solicitors also appear to be suffering from low morale, long hours and increasing competition from 'outsiders' such as accountants, surveyors and licensed fee-earner, this is only apparent from their professional newsletters and journals (eg Sweet, 1996). In contrast, the medical profession's outrage is regularly given a high-priority airing by the media. Whilst it is acknowledged that these differences may simply reflect public interest, eg people may be more interested in doctors and healthcare matters than in lawyers, it may also reflect the extent of doctors' wrath.

Having stressed the similarities between the two professions, it is perhaps important to point out differences between doctors and lawyers in terms of how they derive their work and remuneration.

One fundamental and inescapable difference between GPs and solicitors is the latter's tendency to specialise. Fifteen or so years ago, solicitors were generalists but these days most work within specialist areas of the law. This is reflected in the larger size of some of the legal practices represented in the study (eg ranging from 2 - 51), as firms strive to provide a broad range of services to the public. Solicitors must work at acquiring their clients in an increasingly competitive environment. Since changes in the law allowing them to advertise their services to the public, there is considerable pressure on individuals to bring new business into the firm. Moreover, non-partners are given specific billing targets to reach, which relate to the number of chargeable hours they are expected to bill clients.

GPs, on the other hand, remain generalists within smaller partnerships, for example the present sample were drawn from practices ranging from 3 - 9 partners. In terms of acquiring their lists, general practices are assigned to a specific community which is demographically and geographically defined. Contrary to what is implied in the Patient's Charter (Department of Health, January, 1995) there is little choice, either on the part of patients selecting their practice or *vice versa*. With regard to remuneration, 50 per cent of GPs' salaries derives from their list size. In theory a GP can be paid for looking after patients they never see. The remainder of their salary comprises special payments for banded targets in specific healthchecks and childhood immunisation, plus any extra amenities offered by the practice, eg diabetic clinics, physiotherapy services, well woman/man clinics, *etcetera*.

In terms of differences in hospital consultants' and barristers' work and remuneration, the former are normally salaried employees of an NHS Trust, eg a hospital. Some, but not all, can earn considerably more through a system of merit awards which are graded according to the type of contribution the Trust consider the doctor to have made. A top merit award can double a doctor's salary. In addition to these, some - but again - not all, can acquire an independent practice which runs parallel to their NHS duties, eg a 'private' list. These tend to be limited to surgical specialties, although some physicians do manage this, eg enterologists, valued for their laparoscopy skills.



Barristers, on the other hand, are paid on a job-lot basis, eg for each brief they receive from solicitors. They have no salaries as such, and must make their own arrangements for sickness cover, holidays, pensions, tax, *etcetera*. Barristers, like hospital consultants, are normally specialists. Although they usually begin their careers as generalists, there is a tendency to hone their skills to one or two specific areas, according to their interest and expertise, as is the case for doctors.

As explained in Chapter 2 (2.1 sampling considerations), to ensure as close a 'match' as possible, the solicitors' sample was drawn from provincial high street practices. Similarly, barristers represented members of the independent Bar, ie sole practitioners working in a set of chambers with other independent barristers.

Because the aim of the study was to explore the perceptions of experienced professionals, participants across all four groups were chosen to represent approximately ten years' post-qualification experience (eg between 7 and 10 years). This was mainly to take account of the especially long apprenticeship of hospital specialists and to ensure that they were, by that time, consultants and not still 'junior' doctors. In terms of sample size, although the initial intention had been to recruit around 5 or 6 individuals per group, the final sample size was 10, resulting in an overall total of 40 participants. Attempts were made to ensure women were represented in each group, although an even gender balance was never quite achieved.

Again, as discussed in Chapter 2 (section 2.3.3), individual semi-structured depth interviews were the preferred method of data collection (see Table 11 in Chapter 4 for a copy of the interview format). These conferred the advantages of privacy and confidentiality for participants, consistent data-sets across groups and represented the most efficient use of limited time. Doctors and lawyers work within various time constraints and GPs, in particular, were keen to point this out to the researcher prior to interview. Having a semi-structured 'agenda' to hand also provided a useful starting point for both interviewer and interviewee, without the latter having to guess the purpose of the meeting. These benefits were believed to outweigh the potential problems of interviewer-bias. In recognition of this, the researcher endeavoured to keep the agenda as 'loose' as possible, with interviewees being encouraged to expand on, or to add to, topics as they so wished.

Participants were recruited individually by letter. This was followed by a telephone call one week later to gauge response and, where appropriate, to arrange a mutually convenient time and venue for interview. The possibility of gaining support for the study from professional associations, in term of facilitating access to individuals, was briefly considered. This was rejected however on the basis that it might hinder rather than assist the process. Confidentiality and anonymity were believed to be of paramount importance in eliciting frank and open responses to interviews. If the researcher was perceived to be liaising with interviewees' professional associations, it was feared it could convey conspiratory overtones. This, in turn, could inhibit the establishment of trust which was considered central to the success of the study.



The telephone follow-up call to the introductory letter represented the first point of contact with potential participants. This offered the researcher the following opportunities:

1. to reiterate the aims of the study and to answer any relevant questions/clarify points
2. to offer further assurances of confidentiality and anonymity, of both participant and their workplace
3. to establish a rapport on the telephone, prior to interview, whilst making the necessary arrangements to meet.

All but 3 interviews took place in a work setting. The remaining 3, at participants' own requests, were conducted in their homes.

The main aims of the study were:

1. to establish the values, beliefs and career perceptions of experienced doctors (GPs and hospital specialists)
2. to establish the values, beliefs and career perceptions of experienced lawyers (solicitors and barristers)
3. to draw both within and between group comparisons of the above, in order to establish the extent of similarities and differences between them. So, in effect, GPs would be compared with solicitors, and hospital doctors would be compared with barristers. Finally, GPs would be compared with hospital doctors, and solicitors with barristers.

Reflecting the primary aim of the research, ie to identify the problems in general practice, the study begins with the analysis and discussion of GPs in Chapter 5. This then leads into their equivalent legal group, solicitors, in Chapter 6.

Similarly Chapter 7 considers the hospital sample, which then leads into the analysis of barristers in Chapter 8. A final overview of all four groups is provided in Chapter 9.



# Chapter 4

## Method

### 1 Semi-structured depth interviews: rationale

As previously stated, individual semi-structured depth interviews represented the preferred format for data collection. Although time-consuming, they follow a definable course, ensure fairly consistent data sets across samples and help provide a useful starting point for interviewees. They were also believed to represent the most efficient use of limited time. These advantages were considered to outweigh any potential problem of interviewer bias. Although it has been argued that having a list of topics to cover in an interview is incompatible with the term ‘depth’ (Jones, 1985), this description was felt to be justified. Topics for the interview schedule (see table 11, page 63) were derived from the literature review and preliminary informal discussions with three medical practitioners. Participants were interviewed individually, and were given free reign to expand on topics as they wished or, indeed, to deviate from them in some cases. Because of this approach not all interviews covered the researcher’s ‘agenda’; some participants clearly had their own.

### 2 Participants

Forty people (25 men and 15 women) participated in individual, semi-structured depth interviews. Four professional groups were represented: GPs, solicitors, hospital specialists and barristers. The sample were selected to represent approximately 7 to 10 years post-qualification experience and this is summarised, together with their demographic details, in the table below.

Table 10                      *The Sample* (experienced practitioners)

| GPs                                                                                                        | Solicitors                                                                          | Hosp Consultants                                                                                               | Barristers                                                                          |
|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <i>Total:</i> 10<br>7 men, 3 women<br><i>Mean age:</i> 36 years<br>(range: 35 - 40)                        | <i>Total:</i> 10<br>6 men, 4 women<br><i>Mean age:</i> 33 years<br>(range: 31 - 36) | <i>Total:</i> 10<br>6 men, 4 women<br><i>Mean age:</i> 40 years<br>(range: 33 - 44)                            | <i>Total:</i> 10<br>6 men, 4 women<br><i>Mean age:</i> 36 years<br>(range: 31 - 45) |
| <i>In-post mean:</i> 7 years<br>(range: 4 - 7 years)<br><i>PQE mean:</i> 10 years<br>(range: 9 - 12 years) | <i>In-post mean:</i> 7 years<br>(range: 7 - 9 years)<br><i>PQE mean:</i> as above   | <i>In-post mean:</i> 4 years<br>(range: 9 wks - 8 years)<br><i>PQE mean:</i> 11 years<br>(range: 6 - 14 years) | <i>In-post mean:</i> 8 years<br>(range: 7 - 10 years)<br><i>PQE mean:</i> as above  |

In terms of mean ages, barristers and GPs were the same (36 years) with similar ranges. Solicitors were the youngest with a mean age of 33 years, and consultants



were the oldest group (40 years), reflecting the long apprenticeship associated with hospital medicine.

For the legal sample, solicitors were selected from the Solicitors' and Barristers' Directory (1996) for the Northamptonshire area. Similarly barristers were selected from lists of chambers provided in the same directory for Cambridgeshire, Northamptonshire and London, the majority being in London.

For the medical sample, the names of GPs were obtained through liaison with Northamptonshire Health Authority and South Northamptonshire Community Health Council. Consultants' names were selected partly from the lists provided in the Medical Directories (1996) in a local library, and partly through a system of networking. These specialist doctors were working in two district general hospitals in Northamptonshire and Buckinghamshire, and a larger regional teaching hospital in Oxfordshire. There were 4 selection criteria:

1. ensuring that all participants had approximately 7 to 10 years post-qualification experience
2. attempting to achieve representatives of both surgery and medicine in the hospital sample
3. achieving, wherever possible, a gender balance across all four groups
4. ensuring all potential participants were located within reasonable travelling distance of the researcher.

As outlined in Chapter 1 (section 4.3.1) the size of samples was, to a certain extent, self-determining. Expecting a low success rate, the researcher had approached around 20 individuals in each group in the hope of recruiting around 5 or 6 participants (ie a total of 20 to 25). With the exception of barristers, the researcher's pessimism was unfounded and 10 participants per group were eventually recruited, rendering a total of 40 (20 doctors and 20 lawyers). Difficulties in recruiting barristers will be explained under Participant Recruitment. Consequently the overall sample size was considerably larger than planned.

### **3 The interviewer**

It is argued that if a questionnaire represents the instrument in quantitative surveys, so the interviewer is the equivalent in qualitative studies. Acknowledging the individual interview as a dynamic interaction between participant and researcher, eg an *interview*, depicting an exchange of views (Jones, 1985; Walker, 1985), the following details are considered pertinent to the study.

The researcher describes herself as a woman in her mid-40s with 3 children aged between 15 and 24 years. In terms of physical appearance she is 5' 7" tall and, for interviews, wore makeup, smart casual clothes and minimal jewellery. She describes her conversational style as informal and direct. She is an intent listener, maintaining steady eye-contact with a tendency to interrupt. With a growing awareness of the 2



latter traits, a conscious effort was made to sit adjacent to, rather than directly opposite, interviewees and to keep interruptions to a minimum.

With regard to interviewer bias and preconceptions, the researcher describes herself as having a healthy scepticism of the medical and legal professions. Training as a nurse in a London teaching hospital at the end of the 1960s/early 1970s, she has memories of consultants as awe-inspiring figures of authority and would like to think that times may have changed. Although she had never met any members of the Bar before the study, she has acquaintances who are solicitors and has experience of working in legal firms. In terms of relating to differing age groups, the researcher often prefers the company of people younger than herself, valuing their openness and optimism.

### *3.1 The interviewer's style*

Whilst it must surely be the intention of most interviewers to establish a 'rapport' with participants (eg Walker, 1985; Jones, 1985), what exactly does this mean? There is obviously a need to strike a balance between establishing an atmosphere of mutual trust on the one hand, and avoiding a situation whereby the need to be 'good buddies' obscures the purpose of the meeting, on the other. For the present researcher, establishing a rapport is defined as being sensitive to the mood of the moment and 'tuning in' to the individual. The human experience can be intense, fascinating, sad and sometimes just very funny. It is difficult to spend an hour or more, actively listening to a person talking intimately about their working life, without experiencing some kind of emotion. Who grinned first? Such moments are lost to an audio-recording, and yet they can change the whole mood of the interview. The researcher can recall sharing many humorous moments with participants, which were probably triggered by a quick grin. For example one young doctor with an interest in palmistry, offered to 'read' the interviewer's hand which seemed totally bizarre and irrelevant to the interview. It is argued that such momentary digressions are rarely a waste of time and do not slow down the process of data collection. Rather, they 'oil the wheels' of the whole process by loosening inhibitions and facilitating a more frank interaction, hence misunderstandings become far less likely.

Retrospectively, it was felt that there may be a personal price for establishing a good rapport with interviewees. For example, in some of the sadder cases where the interviewees were clearly under great strain in their jobs, the researcher had difficulty in maintaining neutrality. Although the interviewees' rights of confidentiality and anonymity were firmly adhered to throughout the study, there were times when the researcher could gain little pride in this. Indeed, there can be a great sense of unease when an interviewee spells out their misery and distress. Inevitably, this is followed by a sense of personal responsibility which can be hard to ignore. The following example (there were others) illustrates one such dilemma.

During the course of the study, the researcher interviewed a GP principal who was also a trained counsellor. Furthermore, he specialised in counselling his peers; troubled general practitioners. Later during the study, the researcher encountered a 36 year old male GP who was a partner in a busy, town-centre (non-fundholding) practice. The



interview took place in his tiny surgery, which barely accommodated his desk and examination couch. During the course of the interview, it became clear to the researcher that the doctor was under considerable strain. Overall, his behaviour gave the impression of an anxious individual at the end of his tether. Hence the researcher's dilemma was whether or not she should try to put the two different GPs in touch with each other; the 'counsellor' and the 'client'. After careful consideration the urge to intervene was resisted, on the ground that any such move would inevitably constitute a violation of interviewees' rights to confidentiality and anonymity. It is, however, difficult to feel happy about such a decision, even after a considerable time lapse.

## 4 Participant recruitment

All potential participants received a letter outlining the purposes of the research and requesting their co-operation with regard to being interviewed. It was explained that the interview would take between 40 minutes and an hour, at the maximum. In addition, it was stressed that all information would be totally confidential and that both interviewees and their workplaces would remain anonymous. The letter concluded by stating that the researcher would telephone them in a week's time to hear their views on taking part in the study.

Of the 40 participants, 4 replied to the introductory letter. Of these, 1 consultant and a solicitor (both male) confirmed that they would be happy to assist in the research, and a GP (male) and another solicitor (female) wrote to decline the invitation. The GP gave no reason and the solicitor explained that she was unable to spare the time.

All letters were sent direct to potential participants. However, in the case of GPs, practice managers also received a letter outlining the aims of the study and explaining that the researcher would be contacting the surgery in the near future. This small act of courtesy proved to be well worthwhile; most practice managers were extremely helpful when the time came for telephoning GPs.

In retrospect, having (since) grasped a better understanding of the role of chambers' clerks, it would have been prudent to have adopted the same approach with the barrister sample. Clerks may have been a little more helpful had they been included in the initial stages of participant recruitment. The term 'clerk' is an unfortunate misnomer for what is, essentially, a chambers' manager. From the researcher's experience clerks tend to have an uncomplicated approach to their work, and appeals or arguments regarding the significance of academic research were mostly futile. For example if the telephone call did not equate to potential business (eg a solicitor's brief), the conversation was often swiftly terminated. They can also be fairly direct and to-the-point, as evidenced by the manner in which the researcher was told to go away on a couple of occasions.

### 4.1 *Legal samples*

Solicitors were the first group to be contacted. Of a total of 19, 10 agreed to be interviewed. Most of these returned the researcher's first telephone call when



messages were left with secretaries. Of the 9 who were not included in the study 4 (3 men and 1 woman) failed to return the researcher's 2 telephone calls, 2 women were on leave, 1 female wrote to say that she was too busy and another 2 (a man and a woman) left messages with secretaries. The first was to say that the solicitor concerned believed that he fell outside the selection criteria (regarding years of experience) and the second reported that she was still considering the proposal. Interviews with solicitors took place between October and November 1996. The final sample comprised 10 solicitors, representing the following levels in order of seniority: 2 full equity partners, 2 salaried partners, 3 associates and, finally, 3 assistants. The structural hierarchy of solicitors' firms is based on a partnership whereby full equity/senior partners are co-owners of the firm. The next 'rung' down the hierarchical ladder are salaried partners who, as the name suggests, are senior employees. Beneath this level are associates and then, finally, assistant solicitors who are at the very bottom of the promotional 'ladder'.

Barristers were the second group to be interviewed and were, by far, the most difficult sample to recruit. Of the 21 barristers who were approached, only 8 were successfully contacted by telephone. Of these, one explained that his diary was elsewhere and promised to telephone the researcher at another date (and failed to do so), and the second politely refused to participate. The 6 (males) who agreed to take part were most sympathetic and had guessed the problems that were being encountered, without the researcher saying a word. The interviews took place between December 1996 and January 1997.

A lack of female participants necessitated a second attempt to find interviewees. Again, names were selected from the Solicitors' and Barristers' Directory. Five female barristers and 2 female silks (ie Queen's Counsel/QC) were subsequently approached. Again, the same sort of problems were experienced in trying to contact them by telephone. Eventually, however, 3 agreed to be interviewed. These included 2 barristers and 1 silk. These later interviews took place in early April 1997. During the course of interviewing, one of the woman 'recruited' a female colleague who was both willing to be interviewed and satisfied the experienced sample criterion, providing a total of 4 women barristers. The silks were approached in view of the acute shortage of women in the upper echelons of the Bar. It was felt that their experiences might be particularly enlightening regarding the problems women encounter at the Bar. The silk who finally agreed to be interviewed (the other was away on a lengthy case) has a fairly high media-profile, which made the opportunity to hear her views particularly gratifying. At the time of interview, however, she was unexpectedly called upon and had to curtail the interview to just 15 minutes.

## 4.2 *Medical samples*

Twenty <sup>1</sup>unrestricted GP principals were the next group to be approached for inclusion in the study. A total of 10 agreed to be interviewed. One GP (the 'counsellor'

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<sup>1</sup> *unrestricted* refers to GPs who are not restricted to a specific group of patients such as an institution, eg student or factory doctor.



referred to earlier) telephoned the researcher personally to make arrangements for the interview. Of the 10 doctors who were lost to the study, 7 (5 men and 2 women) said that they were too busy, another (male) wrote refusing to participate without giving a reason, one doctor (male) was on holiday and 1 other (also male) was working at another practice. Interviews took place during February and March 1997.

Hospital consultants were very straightforward with regard to arranging interviews. Most had already briefed their secretaries when the researcher made the follow-up telephone calls, and it was simply a matter of arranging a mutually convenient appointment. Ten agreed to participate in the study. Of the 13 who were approached only 1 refused to participate, a second was away on maternity leave and a third was on annual leave. All 3 were women. The women who were interviewed were particularly keen to help the researcher in her efforts to find more women for the study and were happy to be quoted as the source. During the course of interviews 2 surgeons were unexpectedly called away, without warning, and interviews had to be re-scheduled.

Although no attempt was made to represent a range of specialisms in the legal samples, indeed it would have been almost impossible to achieve, the hospital samples were an exception. As stated in the introduction to the study, surgical specialties are often perceived as exceptionally competitive, elitist and male. This, in addition to the fact that women are particularly underrepresented in surgery, led to a conscious decision to try to include both male and female surgeons in the study. Overall there were 6 medical and 4 surgical specialties represented in the experienced group. Surgical specialties included colo-rectal surgery, general surgery with a special interest in breast disease (2) and general surgery with a special interest in vascular disease. Two of the surgeons were women. Medical specialties included radiology, gastro-enterology, clinical genetics, haematology, pathology and paediatrics.

Interviews with the hospital sample took place from the beginning of May until the end of July 1997.

## **5 Participants' choice of venue**

Of the 40 participants, 37 were interviewed at their workplaces and 3, at their request, were interviewed at their homes. Of the latter, 2 were GPs (1 male, 1 female) and one was a solicitor (female). The reason the women gave for preferring their home as a venue, was needing to be there with small children (both worked part-time). The male GP, however, explained that he could not allow the interview to impinge on patients' time.

### **5.1 Interviews in people's homes**

For the interviewer, the main disadvantages of holding interviews in participants' homes were the presence of very young children who can be noisy and distracting, and not seeing the interviewee within a work context. For example interviewing a GP in a small surgery, where the desk is set opposite the door through which patients normally enter, can give the interview an added dimension. Similarly, interviewing a barrister in



a large airy sitting room, resplendent with antiques and leather-bound books, can convey something of the majestic pomp of a high court. Being received by participants as guests in their home was also a little disquieting for the researcher, as it represented a subtle shift in the relational dynamics. In a workplace context, for example, both the interviewer and participant are in ‘work mode’. It was easy for the researcher to politely decline the offer of refreshment in the interests of maximising contact with the interviewee within a limited time span. Accepting the offer can often lead to the participant disappearing to make tea or having interruptions from staff members as they deliver refreshments. Offers of refreshment were, however, accepted in interviewees’ homes. In the presence of small children, this inevitably resulted in the researcher trying to guard a mug of hot tea with one hand whilst protecting the recording apparatus with the other.

## 5.2 *Interviews in the workplace*

Fortunately most interviews were held in the workplace and, in the case of GPs, solicitors and consultants, were conducted in their own personal offices. These were fairly uniform in terms of size, layout and general ambience. Most barristers, in contrast, appeared to work in conditions which can only be described as that of elegant splendour. This was found to be the case in both provincial and City chambers. Interestingly, the only exception was the chambers and office of the female QC, who was the only silk interviewed for the study. Her London office was small, cluttered and humble by comparison. On one occasion, after expressing surprise at the luxurious ambience of a particular set, the researcher was told that chambers are now expected to treat visiting solicitors in much the same way that businesses treat clients. It is, apparently, no longer acceptable to “*push people into the broom cupboard*” to await conference (barrister in one of the larger City chambers).

## 6 Interview procedures

In terms of the interview procedure, following formal introductions, all interviews began with the researcher restating the aims of the study and the purpose of the interview. Participants were asked if they had any questions in this regard. Permission was then sought to tape-record the interview, with the researcher outlining the reasons for this. For example, the type of analysis was explained in terms of requiring accurate transcripts of the interview. In addition, interviewees were assured that any quotations used in the study would always be unattributed. The assurances of confidentiality, which had been given in the introductory letter, were reiterated. Finally, all participants were informed that they had the right to refrain from answering any question they did not wish to, and the right to terminate the interview at any time. While many members of the legal sample found this entertaining (eliciting a broad grin), most interviewees seemed to appreciate these final words of reassurance. Following permission to tape record the interview (all agreed) and assurances of confidentiality, the format of the interview was discussed with participants. It was explained that although the researcher would be asking a number of questions, these should be regarded as open-ended. Interviewees should therefore feel quite free to



expand on each topic as they so wished. Reasons were also given for following an agenda, eg to ensure consistency across all 4 groups.

The legal samples gave more freely of their time (or possibly had more time to give) than the medical samples. Interviews frequently exceeded an hour. Hospital doctors were particularly concerned about their time and, consequently, not all topics were successfully covered with all participants. Because of some apparent gender differences, which were alluded to in the introduction to the study, women interviewees were asked specific questions relating to their perceptions of their work. For example, women surgeons and barristers were asked what the perceived barriers were for women in their field of work and why they thought they had succeeded.

At the end of the interview, participants were asked whether they would mind answering a number of questions relating to demographic variables. All agreed to these, which included date of birth, marital status and number of children (where relevant), date of registration and date of appointment to their current post. GPs were also asked whether or not they were fundholders. Interviews concluded with the researcher expressing gratitude for their time, and a formal handshake. Some participants expressed an interest in the results of the study and these were duly noted after the interview.

The researcher's list of interview topics is presented at the end of the present chapter.

## 7 Treatment of data

Transcripts of interviews were made with topics individually coded on entry. Participants' names were also coded and were entered together with demographic details. In addition, a log was kept of each interview which recorded the researcher's impressions of the participant, the quality of the interview and the perceived degree of rapport between the researcher and participant.

The data were initially analysed using QSR Nud.IST® 3.0, a software package designed to assist qualitative analysis. The most useful aspect of the package was that learning about the system, prior to data collection, prompted the researcher to work within an organised framework from the beginning. For example an index system was designed, in addition to codes being allocated to each separate topic, which helped the overall process of analysis considerably. However once all the preparatory stages had been completed, and the real process of analysis was underway, the 'micro' approach of Nud.IST was not found to be particularly helpful. After some frustration Miles and Huberman came to the rescue with some timely advice: "*Work with all of the data on a single page, even if that page covers a wall...*" (Miles and Huberman, 1994, p131). Consequently, huge wall-sized charts were erected, allowing the data to be viewed as a whole, at any one time. As a constant reminder of the focal point of the study, the centre of the wall charts bore the research question in dayglow capitals:

**"WHAT IS WRONG WITH GENERAL PRACTICE?"**



This allowed the researcher to 'live' with the data and to play with ideas, patterns and concepts. The only disadvantage of such a system was the vague prospect of a GP's home-visit (though all GPs' names were coded), eg "Okay, tell me - what *is* the problem with general practice?". However, when the researcher's supervisor (Dr Asch) saw the chart display of GP data, she immediately suggested using Hackman and Oldham's Job Characteristic Model as a framework for analysis. Hence the decision to display the data, in its entirety, led to an important turning point in the research. Analysis was then simply a matter of 'plugging' the data into a structured format. The software package was consequently abandoned, with few regrets.

## 8 The researcher's 'agenda'

An outline of the researcher's agenda is provided below. Although this may look very structured and rather daunting when presented as a list, it must be stressed that once participants started talking many topics were covered quite naturally, without the researcher having to laboriously read off each question. It was simply a matter of the researcher keeping alert and giving the appropriate prompt now and then.

**Table 11**

### ***List of topics covered with each group:***

1. reasons for choosing their career - the main attractions
2. careers advice - whether it was sought and how useful it was
3. what sort of personal attributes were perceived necessary for success
4. a brief outline of current job in terms of the highpoints and downsides
5. usual hours of work
6. perceived level of control over working life, in terms of autonomy
7. awareness of the extent of competition at the outset of career/training
8. perceived relevance and quality of training
9. reactions to recent changes
10. perception of threat to professional autonomy
11. views on long-term job security
12. current rating of job satisfaction on a scale of 1-10 (where 10 is high)
13. current rating of stress levels on the same scale.



## Chapter 5

### Results and Discussion: General Practitioners

With the exception of two GPs who were interviewed in their homes, interviews with the remaining eight doctors took place in their surgeries. As explained in Chapter 4, talking to people in their workplaces provided a valuable contextual dimension to the study. The interviewer sat in the patient's chair; sometimes beside the doctor, sometimes across a desk. Once doctors had adjusted to the mood of the encounter, initial reservations quickly slipped away and they relaxed. In general terms, the sample struck the interviewer as intense, serious individuals, with little signs of humour. Many spoke with anger and passion about the downsides of their work. There was also an impression of catharsis, a feeling that these were people who rarely had the opportunity to talk about themselves or their concerns. Indeed the degree of trust and intimacy demonstrated by informants was a constant surprise to the researcher, as was the length of interviews which frequently ran on for an hour and sometimes longer.

Analysis within the JCM framework immediately revealed flaws in the basic job design of general practice. As the table below illustrates, all three critical psychological states appeared to be compromised. Examination of moderator effects showed that while doctors were well equipped for the job (ie ample knowledge and skill), their work often lacked the intellectual challenge required to meet their growth-needs.

#### *Overview of GPs' work within the JCM*

Table 12

| Critical Psychological States |   | Moderator Effects           |          |
|-------------------------------|---|-----------------------------|----------|
| Meaningful work               | × | Adequate knowledge & skills | ✓        |
| Experienced responsibility    | × | Work-met growth-needs       | ×        |
| Knowledge of results          | × | Context satisfactions:      |          |
|                               |   | pay                         | ✓        |
|                               |   | job security                | ✓        |
|                               |   | co-worker relationships     | ?        |
|                               |   | supervisory practices       | State: × |

? = some problems

### Analysis of data

#### Job satisfaction and turnover as outcome variables

#### 1 Outcome variables

Working within the JCM's framework, the predicted outcomes of an enriched job are high internal motivation, high quality work performance, high job satisfaction and low



absenteeism and turnover. The problems in general practice have been identified as low job satisfaction and high attrition (Allen, 1994; Baker, Williams and Petchey, 1995; Carnall and Smith, 1996). Although the focus of the present study relates to the retention problem, rather than the lack of new recruits, identifying the issues in the former may help inform the latter.

The first section of the analysis will focus on the outcomes of general practice in terms of global job satisfaction.

GPs were asked to give a self-rating of their current job satisfaction on a scale of one to ten, where ten is high. In retrospect the framing of this question is regretted. Asking people to summarise their thoughts on their current levels of job satisfaction, may have produced more useful data. The folly of this type of question was demonstrated by the meaningless of replies. For example, a woman who gave one of the lowest satisfaction ratings of 4.5 was cheerful and vociferous, whereas a male who was clearly under considerable strain gave a rating of 6.5. For this reason it was decided to omit these data and to use instead, answers given to two probe items asking doctors (i) *"Given the chance again, would you still choose general practice?"* and (ii) *"If you won the lottery tomorrow, would you stay in this job?"*

Whilst it is not suggested that answers to hypothetical situations, such as a lottery win, should be taken at face value they do, nevertheless, provide valuable insight into the affective state of the jobholder. Moreover, as these questions were presented at the end of interviews, they gave participants the opportunity to reflect on and to summarise the views they had given earlier.

In view of the purported relationship between stress and job-related dissatisfaction (Hackman and Oldham, 1975; Beehr and Newman, 1978), doctors were also asked to give ratings of their current stress levels. Although this question was also asked in a quantitative style, this time responses were more expansive and have been included in the analysis.

For ease of reference and in order to convey the sense that the following quotations belong to 'real' people (whilst still protecting individual identities), fictitious initials have been assigned to each speaker. In addition, because a number of gender issues arise in the study, it is believed that analysis will be aided by identifying the sex of speakers. The biological symbols for male (♂) and female (♀) have been used for convenience. Most of the quotations are displayed within text boxes and any explanatory asides, including the researcher's questions, are provided in parentheses and italics. In accordance with the constraints of a thesis, it has been necessary to edit quotations to keep them sharp and focused. Edited text is denoted by ellipses. Similarly it has been necessary to select a maximum of two or three quotes to illustrate any particular point.

It is important to state that the results of the present study relate to the sample base alone, and therefore cannot be extrapolated to the wider population.



### 1.1 Job satisfaction - 'If you had the chance again'

*"If you had the chance again, would you still choose general practice?"*

The sample was divided: Six of the ten doctors said that, given the chance again, they would still choose general practice, although Dr TM (below) appeared unconvinced:

Dr TM ♂ "Um, inevitably there are times when you think... 'Oh I wish I'd done such-and-such' but overall, looking at it realistically, then I would say I'm fairly happy with the choice I made..."

Dr BR ♂ "Yes, I find it a fulfilling career which, despite all the pressures, has still got a lot going for it."

Of the four who would not choose the same career again, two women spoke wistfully of their regret in not staying with hospital practice, one man spoke of only being interested in the business side of general practice and another male wished he had become an accountant:

Dr AP ♀ "I think I might have gone a little further, I think - given my first choice more of a whirl... had I known that, at the end of the day, I could do a lot of my work on autopilot, I perhaps wouldn't have done it."

Dr JH ♂ "That's a difficult question... I think it's good fun running your own business really. I wouldn't say the actual practice of medicine inspires me greatly anymore, running a business does..."

Dr WA ♂ "No." [*what would he do instead?*] "Accountancy."

When considering responses to the 'chance again' question, it is useful to look at some of the reasons doctors gave for choosing general practice, at the beginning of the interviews. Five of the sample cited disenchantment with hospital medicine as a primary reason for choosing general practice, eg

Dr RC ♂ "... hospital medicine... just wasn't attractive really. I mean the career path, there weren't enough consultant posts... it was years of slaving away on heavy rotas, not much money - general practice appealed."

Dr WB ♂ "Hospital medicine just seemed such a bad option at the time... I didn't envisage myself working as a registrar on a one-in-three on-call basis at the age of 35, 36, 37, 38 - 40, you know?"



Dr LA ♀ "I think probably the first thing that made me go into general practice... was that I couldn't stand the hours I was working in hospital... I knew I couldn't cope with it... general practice was the only way I was going to survive..."

In addition to these, another two males spoke of barriers to success in hospital practice. For one, it was not being "clever enough" to be a consultant and for another it was being four years older than his peers. An eighth GP, a male, appeared to have chosen general practice because it was a popular option at the time, and because none of the hospital specialties particularly appealed to him. In summary, only two GPs appeared to have wholly positive reasons for choosing general practice:

Dr SD ♂ "General practice I think came from... the interest in the whole person... from a spiritual side of my upbringing... my knowledge of specialties was that they limit that, ...they look at an organ... they look at cases, they don't look at people... I'm interested in the art of medicine..."

Dr WA ♂ "... I was always going to be a GP rather than hospital medicine."

In examining reasons for choosing general practice, is there a relationship between not wanting a career in hospital practice and answers to the 'chance again' question? The table below shows that six of the doctors who 'actively' rejected hospital careers said that, given the chance again, they would still opt for general practice.

***Doctors reasons for not choosing hospital medicine  
and replies to 'chance again' question***

**Table 13**

| <b>'Not hospital medicine'</b>         | <b>'Chance again?'</b>                     |
|----------------------------------------|--------------------------------------------|
| 1) Dr AP ♀ - too many sacrifices       | No, she would not choose GP again          |
| 2) Dr LA ♀ - couldn't stand the hours  | Yes, she would choose the same again       |
| 3) Dr RJ ♀ - too threatening/difficult | Yes, she would choose the same again       |
| 4) Dr CR ♂ - consultant posts too rare | Yes, he would choose the same again        |
| 5) Dr WB ♂ - consultant posts too rare | Yes, he would choose the same again        |
| 6) Dr BR ♂ - 'too old' to compete      | Yes, he would choose the same again        |
| 7) Dr SD ♂ - 'not holistic enough'     | Yes, he would choose the same again        |
| 8) Dr WA ♂ - 'not clever enough'       | No, he would not choose GP again           |
| 9) Dr TM ♂ - 'hours are too long'      | Not sure (expressed vague regrets)         |
| 10) Dr HJ - 'no specialties appealed'  | Not sure (attracted to idea of a business) |



It would appear that general practice, despite all its pressures, still represents a more attractive option than hospital medicine. A lack of viable alternatives, however, is a worrying motive for choosing general practice as a career, from the viewpoint of both patients and doctors. Disillusionment with hospital practice, however, can also be a source of inspiration; Dr SD was clearly very happy and fulfilled in his work.

## 1.2 *Job satisfaction - perceptions of stress*

*"Where would you place your current stress level on a scale of one to ten, where ten is high?"*

Because participants gave fuller answers to the question on stress, their answers were categorised according to their comments and not their actual scores. The majority of doctors spoke of the fluctuating nature of stress:

Dr RJ ♀ "Oh my stress levels vary violently from day to day - it's very difficult to generalise!"

Dr TM ♂ "... life goes through phases... you have a few weeks where life seems insufferable... and some where things are okay..."

The scores people attributed to their current stress levels were on a par with those relating to job satisfaction. For example, one doctor who described his stress level as 'reasonable' gave a rating of 6-7, compared to another who thought he was over-stressed and yet estimated his score to be the same. Two doctors pointed out that a certain degree of stress was functionally necessary, eg

Dr SD ♂ "... I imagine you have to have some stress... to be able to function..."

Taking account of comments, as opposed to scores, it appeared that over half of the sample perceived their stress levels as being too high, whilst the remainder implied that their stress levels were acceptable. Those who described their stress as being too high included the following:

Dr AP ♀ "... you [ie the patient] can get what you want from me and walk out of the door, but I've got to deal with the other ten people who are behind you... and when I've finished with all these people, I'm going to go home to two demanding children and a husband that I'd like to... stay married to..."



Dr RC ♂ "... our practice manager's resigned and we've had a flood. We opened a branch surgery on the 1st January so it's been a hefty winter. I mean if you'd asked me that the week before last I'd have said 'nine!' But I had a week off last week, so... I'd say seven or eight."

Ironically one GP felt particularly stressed because of his work in stress management with GPs:

Dr SD ♂ "... I'm involved in an outside project... the management of depression in general practice... We're also involved in stress conferences so there's a lot of... conferences to speak at... I am too stressed, I'm doing too much."

Four of the doctors, however, thought their stress levels were acceptable, eg

Dr TM ♂ "... I'm reasonably stressed without being over-stressed, so probably about six or seven."

Dr LA ♀ "... I'm happy with the way things are going at the moment, I actually look forward to coming to work..."

When compared to the men in the sample, there was a noticeable difference in the way women spoke about their work lives, including the stresses. Unlike the men, family responsibilities were mentioned throughout the interviews and two of the women (including Dr AP who was quoted earlier) spoke about their children when considering their stress levels:

Dr RJ ♀ "... I'd say I probably average out at about five, four or five... every so often it'll peak right up to ten and I'll be stressed out, shout at the kids and all that, and then other days I'll be feeling quite relaxed. But I'd say an average of four or five."

One explanation for the anomaly could be the women's perceptions of the researcher as a fellow working mother, who was therefore likely to empathise with family versus work issues. On the other hand, men may have an ability to separate work and home more completely than women. There seems to be no evidence, however, to suggest that professional women with children are any less work-centred than men (Kaufman and Feters, 1980; Mannheim and Schiffrin, 1984.).



### 1.3 *Job satisfaction - thoughts on winning the lottery*

*"If you won the lottery tomorrow, would you stay?"*

One doctor was not asked this question due to an interrupted interview. Of the remaining nine, four doctors declared that they would give up general practice if they won the lottery, two said they would still stay, another two thought they would stay but on reduced hours and one GP was unsure. However, amongst the four doctors who said they would resign from general practice there was one exceptional case, a male GP with an unusual proviso:

Dr HJ ♂ "I'd still stay, part-time, but try and get into management possibly, something like that. [*what sort of management, the NHS?*] No, no - management within this practice, so I could quite happily forget seeing the patients, but would be very happy to be running things in terms of finances."

According to the BMA's guidelines for general practice (BMA, 1996b), there appears to be no provision for GPs who do not wish to involve themselves directly in patient care. GPs are self-employed and they, in turn, employ practice managers. In relinquishing his clinician's role, the individual could not be described as a practising GP. For this reason he has been included in the group of GPs who said that they would leave general practice, given the opportunity.

The remaining three were, however, unambiguous in their replies to the question of a lottery win:

Dr RC ♂ "If I won the lottery I'd give up being a GP." [*what would he do instead?*] "Don't know. I'd worry about that afterwards. I wouldn't carry on doing general practice."

Dr WA ♂ "I'd stop tomorrow." [*Really?*] "Yep."

Dr AP ♀ "If I won the lottery tomorrow? I would resign."

Of the two who said that they would remain in general practice one woman, whose husband was Australian, thought that she would leave the UK:

Dr LA ♀ "... Yeah, I think I would actually. We'd probably go and live in Australia."



One of the doctors who thought that she would stay in general practice, but on reduced hours, was already working part-time. However, this is more easily understood when three young children are taken into account.

The doctor who was unsure of his reaction to a lottery win, spoke of the loss of identity, or rather the feeling of belonging, that he thought he would suffer if he left general practice:

Dr TM ♂ "My immediate reaction would be to assume something quite different, but you would lose some of the sort of social ties... the fact that one is a doctor amongst others and you go to a meeting and you know people... you know you can talk to them [*it's an identity?*] Yes, I think it is... I would like to... say yes, I would pack it all in, but in reality... I would... half pack it in first and then see."

#### **1.4 Pattern of responses**

These data begged the question: Was there a discernible pattern in doctors' responses? When the sample was divided according to perceived stress levels, as shown in the table below, responses fell into two distinct categories: those who believed their stress levels were too high, and those who felt they were reasonable. A pattern then began to emerge (see table overleaf).

As expected, on the question relating to a lottery win, the 'high-stress' group had the highest proportion (four out of six) of '*I would resign from general practice*' responses. Similarly, the majority of '*I would stay in general practice*' responses occurred in the 'reasonable-stress' group (three out of four).



*Pattern of responses to 'chance again' and 'lottery win' questions,  
when categorised according to self-rated stress levels*

Table 14

| 'HIGH-STRESS' GROUP                                                                        |                                                                     |
|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 'Chance again'                                                                             | 'Lottery win'                                                       |
| Dr SD ♂ - Yes, he would still choose GP                                                    | Yes, he would stay, but on reduced hours                            |
| Dr HJ ♂ - He would still choose GP but <i>only the business aspects</i> (not the patients) | He would stay, <i>but only in management</i> and on reduced hours   |
| Dr RC ♂ - Yes, he would still choose GP                                                    | No, he would resign                                                 |
| Dr WA ♂ - No, he would prefer accountancy                                                  | No, he would resign                                                 |
| Dr AP ♀ - No, she would stay in hospital                                                   | No, she would resign                                                |
| Dr WB ♂ - Yes, he would still choose GP                                                    | Not asked (interview interrupted)                                   |
| 'REASONABLE-STRESS' GROUP                                                                  |                                                                     |
| Dr RJ ♀ - Yes, she would still choose GP                                                   | Yes, she would stay, but on reduced hours                           |
| Dr BR ♂ - Yes, he would still choose GP                                                    | Yes, he would stay                                                  |
| Dr LA ♀ - No, she would stay in hospital                                                   | Yes, she would stay in general practice but would move to Australia |
| Dr TM ♂ - Yes, he would still choose GP (but unconvincing)                                 | Not sure.                                                           |

### 1.5 Outcome Variables: Summary

Over half of the sample believed their stress levels to be high and, of these, the majority declared that they would leave if finances allowed. Hence, unsurprisingly, perception of stress was related to intent to stay.

More worrying was the fact that eight doctors reported choosing general practice because of disenchantment with, or perceived barriers to, a career in hospital medicine. Moreover, as discussed later in section 7 (growth-need strength), entry to general practice is considered to be a one-way ticket. Four of the sample spoke of the difficulties of moving practice, whilst another described the stigma that follows those who try to re-enter hospital practice. So choosing general practice appeared to be an irrevocable decision which means it is even more essential for individuals to choose wisely and carefully. It is possible, for example, that the widely reported exodus of experienced doctors from general practice, may reflect those doctors who were reluctant recruits in the first place. The recent de-stabilising effect of major organisational change may have represented the final straw for such individuals.



Having explored those outcome variables which were available to the researcher, the next stage marks the beginning of analysis within the framework of the JCM.

The basic tenet of the JCM is that when the five core characteristics of a job are such that they promote the prerequisite psychological states in the incumbent, internal motivation is enhanced. The extent to which the jobholder will grasp the opportunity to experience internal motivation to perform well, thereby achieving job satisfaction, will depend on individual differences expressed in the model as moderators. Hence the best possible scenario will be one where an individual with high growth-need strength has a complex and challenging job, whose knowledge and skills are commensurate with work demands and who is happy with the contextual factors surrounding the job (ie pay, job security, relationships with co-workers and supervisory practices).

The following section therefore begins with the analysis of doctors' critical psychological states, before moving on to explore the impact of moderator effects.

## **Analysis of data**

### **The Critical Psychological States**

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## **2 Toward an experienced meaningfulness of work**

### **2.1 *Skill variety***

This is defined as the degree to which a job offers the incumbent the opportunity to use a wide variety of skills and talents.

GPs are generalists who serve the health needs of their community. Being the first port of call for patients GPs must, by the very nature of their job, see a wide variety of ailments and types of patient (different ages, socioeconomic status and gender) and are called upon to use a variety of skills. Indeed, three GPs felt that they were sometimes asked to advise on matters outside their domain:

Dr AP ♀ "... I'm also their counsellor, their confessor, their social worker and they try and get all those things out of you..."

Dr HJ ♂ "... patients come along and want you to do the most bizarre things that you wouldn't dream a doctor would have anything to do with... all sorts of housing problems and problems with neighbours..."

Dr LA ♀ "I had a woman 'phone me at half-past nine with 'My children have got paint on their hands!' - and what should she do about it..."

In addition to seeing patients, GPs also have administrative responsibilities in terms of the general running of the practice. Four doctors raised the issue of excessive



paperwork and/or bureaucracy, although one thought it represented an improvement on the previous system, eg

Dr RC ♂ "... but then I prefer it - I think we get a lot more control... I mean I know the cost of what I prescribe and I don't think that's a bad thing."

Dr WB ♂ "... and then the administrative paperwork in terms of staff management and the finances, just holding a building together and making it work - there's plenty to do there." [*and later*] "Lows? Never-ending bureaucracy, mountains of paperwork..."

Dr AP ♀ "... there is much more paperwork, much more bureaucracy."

Women doctors, in particular, appeared to enjoy less job variety than men. It appears that general practice *"...often ghettoised women as being the one who deals with women's complaints..."* (Dr AP). All three women in the sample mentioned this problem, and even one of the men alluded to it, eg

Dr RC ♂ "Dr P will have more than fifty per cent... women on her list because she'll attract ladies... she's one of two lady doctors in the practice... and there's lots of... issues lying calm below: 'Because I'm a female partner, I get all the gynae, I get all the family planning' - they're desperate to see a male patient... just for variety!"

Dr AP ♀ "...when I was first here it was 'Ahh - bloody women! You do them on Mondays' and I said, 'well I'll end up with 60 per cent women and I shall see the same thing over and over again' ...I want to see everything."

It would appear that GPs do have skill variety, although women may have less than men, in terms of the type of patients (and complaints) they treat.

## 2.2 Task identity

This refers to the degree to which an individual's work allows the completion of a task in its entirety.

Except in cases of referral GPs do experience task completion. For example, they will monitor a patient's progress from initial diagnosis to completion of treatment. Indeed, three GPs spoke of the satisfaction they derive from continuity of care, as this GP described so succinctly:

Dr AP ♀ "... getting a sense of seeing the film as opposed to the snapshot. Putting people into their context, seeing them as a whole... part of a family."



However, the problem for GPs related to their not feeling free to complete a task in the manner they would like, being constrained by both time (5 doctors) and resources (7 doctors), eg

Dr AP ♀ "... there's a rising demand which impacts against limited resources, and the GP is supposed to be the gate-keeper and safety valve and that's quite a difficult place to be..."

Dr SD ♂ "...when you get too busy, there's just too much going on and you end consultations abruptly, because you don't have time..."

Dr WB ♂ "... if I could get someone a hip replacement by a week on Friday then I would, but the reality is it takes two years and it's going to be a difficult two years for them, and therefore a difficult two years for me, jollyng them along..."

So although GPs have the satisfaction of continuity of patient-care, it would appear that not being free to complete a task in the manner they would like, because of time constraints and a lack of resources, posed a problem.

### 2.3 *Task significance:*

This pertains to the impact the job has on the lives of others.

For the sample, task significance appeared to have little in common with the popular image of doctors making 'life or death' decisions about their patients. The problem for many GPs related to a perceived *lack* of significance in their work, ie that much of their work has little to do with treating real illness. As will be discussed in autonomy, eight of the sample complained of an uncontrollable rise in patient-demand, ie consumerism. It would seem that, related to this, doctors were also exasperated at the number of patients who abuse the system with 'trivial' or 'inappropriate' demands. Six GPs spoke of this during interviews, eg

Dr LA ♀ "...people call you up for stupid things like, for example... a fourteen year old who couldn't get out of bed because he'd got tonsillitis!..."

Dr WA ♂ "I don't think any doctor minds spending time with people who are poorly, but I increasingly find that... I'm wasting my time with... inappropriate patient demands."

Dr RJ ♀ "... they can ring up and say 'can I take one paracetamol with my antibiotic?' and... 'what time does the surgery open tomorrow?'..."



Of the two doctors who did not complain of the rise in patient-demand or the 'trivia', one was specifically asked why he had not mentioned it. Dr SD's answer was illuminating but atypical; he was also a trained counsellor who specialised in treating depression in GPs:

Dr SD ♂ "... it's always a difficult argument... when something is on somebody's mind, then it's an illness to them and I think of the idea of disease as being... literally dis-ease... I think there's a danger in trivialising what people bring... and sometimes you can find... there is maybe another agenda which has been completely missed..."

Nevertheless, five doctors spoke of the clinical satisfaction they derived from their work, including two who also complained of the 'trivia' aspects, eg

Dr RC ♂ "I mean the best side of it is clinical satisfaction, in looking after somebody successfully..."

Dr SD ♂ "The highs, I think, are when people come in and say they're feeling a bit better... or seeing a newborn babe or when somebody... has a good death and you think you've helped the family through it. You feel you've done your job..."

Dr TM ♂ "...the good things are, I suppose, doing something for somebody and doing it well and actually feeling you've done something."

Doctors' work can undoubtedly have a great significance on the lives of others. However, judging from the sample base, GPs' task significance is compromised by a perceived rise in medical consumerism and inappropriate patient-demands.

## 2.4 *Toward an experienced meaningfulness of work: Summary*

With the possible exception of some women doctors, GPs appear to have considerable breadth of skill variety. In terms of task identity, although doctors enjoy the continuity of patient-care in general practice, this was marred by constraints on the way they carried out their work. With task significance, again there were problems. Although half of the sample spoke of the clinical satisfaction of seeing patients recover, almost all complained of the inexorable rise in patient-demand, with over half objecting to the increasing number of patients who abuse their time with trivial complaints. It is possible that part of the problem may stem from doctors' fundamental values. For example as stated in the General Introduction, Allport, Vernon and Lindzey (1951) categorised six types of values which, reportedly, corresponded with occupation preference. Of the six, it would seem that '**theoretical** - *placing a high priority on the pursuit of truth through a critical and rational approach*' most closely applies to doctors. If this is so, it is perhaps easier to understand doctors' reactions to apparently



healthy people coming to them for medical 'healing'. From a purely rational, scientific approach, sick people do not have need of a doctor. Similarly, the rising amount of bureaucracy/paperwork which doctors talked about in section 2.1, might also challenge these same values. If basic administrative duties equate to the occupational '**economic value** - *interested in what is useful and functional*' and doctors are indeed more 'theoretically' inclined, then again, it is perhaps understandable that they should feel frustrated at this growing emphasis in their work as GPs.

Judging from the sample base, there appeared to be serious obstacles to doctors perceiving their work as meaningful and worthwhile.

In terms of evaluating the impact of the above findings to the JCM, there were signs that (lack of) autonomy may be related to task identity and task significance in the present study. Interestingly, other researchers have suggested a dimensional overlap between autonomy, skill variety and task significance, hence excluding task identity (Fried and Ferris, 1986; Dunham, Aldag and Brief, 1977).

### **3 Toward an experienced responsibility for work**

This refers to the extent to which a job allows independence and personal responsibility for both the scheduling and execution of tasks. The core job characteristic associated with promoting this psychological state, is autonomy.

In the summary and discussion which conclude the section, it will be argued that autonomy is fundamental to professionalism. For general practice it is also a complex issue. The following section has therefore been divided into two main subsections:

1. Personal autonomy
2. Perceived threats to professional autonomy.

#### **3.1 *Personal autonomy***

GPs' independent contractor status was evidently part of the attraction for many. Six doctors specifically mentioned the appeal of working for themselves, eg

Dr WB ♂ "... having certain independence - so-called independent contractors - it still appeals to me - I enjoy that status..."

Dr AP ♀ "... there is still an indefinable independence among GPs because I do feel that we work for ourselves..."

Dr RJ ♀ "...I think I was expecting a career... where you could be your own boss... you'd have full responsibility and you'd be in control..."



However, eight doctors expressed exasperation at a perceived escalation in patient-demand, over which they felt they had no control, eg

Dr AP ♀ "...GPs have to be more responsible... you have to think about the cost of what you're doing - reasonable - but how do you reconcile that with rising expectation, rising consumerism?"

Dr RJ ♀ "... the out-of-hours is the classic example [*of patient-demand*]... you get the most amazing amount of abuse done and there's nothing you can do about it..."

Dr HJ ♂ "... it can be constant hassle... people wanting to sort things out, often wanting it sorted out yesterday... I think consultants are finding exactly the same thing - that patients are, more and more, finding a way through to them themselves... I mean at one time a patient wouldn't dream of pestering a consultant..."

Whilst GPs obviously value the autonomy that self-employment offers, this can be a double-edged sword. The individual responsibility of patient-care brings with it an element of uncertainty and, in some cases, fears of litigation. Four doctors spoke of "living with uncertainty" which, for a further two, translated into litigation concerns, eg

Dr RJ ♀ "...we have to live with a certain degree of uncertainty... you see so much you have to let go and say I've made my decision, that's what I'm going to live with."

Dr TM ♂ "You have to... sometimes be prepared to make decisions without feeling very comfortable about them... there's quite a lot of uncertainty... you have to somehow do a skimming sort of job... which inevitably means that you're not going to get it right, first time, every time..."

Dr WA ♂ "...your knowledge that for every one in 1,400 that you refuse to go and visit because they've got earache and they refuse to come to the surgery, they might get nasty and you end up in court. Therefore you go out and visit these kind of people."

So whilst Armstrong may exhort doctors to appreciate that "*a satisfied patient is as important as a medically improved one*" (eg Chapter 1, section 2.5.2), doctors may argue that such ideals cannot be accommodated within current time constraints.

### 3.2 *Perceived threats to professional autonomy*

There were examples of doctors feeling that their professional autonomy was under threat from a variety of sources. Four areas were identified, which included the following:



1. Nurse practitioners - increasing empowerment of practice nurses
2. Patient empowerment - increasing use of information technology
3. The commercialisation of general practice
4. The Government's attitude to GPs

### 3.2.1 *Nurse practitioners*

Two doctors perceived the increasing empowerment of practice nurses as something of a threat to their autonomy:

Dr HJ ♂ "...there seems to be a move towards getting nurse practitioners involved and that may work out quite well... but I think I would probably perceive that as a threat actually..."

Dr SD ♂ "...I can see nursing encroaching... into areas which we have previously done... I can see other forces acting to take us away from the central theme of being responsible for patients..."

Two others apparently disagreed, eg

Dr RC ♂ "...if nurse practitioners or whatever, can take some of the pressure off, then so much the better."

### 3.2.2 *Patient empowerment*

One GP spoke of the problems he foresaw in patients being able to access medical journals on the Internet:

Dr SD ♂ "...I think now people can access the research journals [*via the Internet*] as much as we can - probably more so - and they will be up with all the research, and they can come in and say 'there's been this double-blind control trial with evidence of this kind of work, and I want it.'..."

### 3.2.3 *The commercialisation of general practice*

At the time of the interviews, a government White Paper was in progress considering the merits of the privatisation of GP services. If approved, this would allow commercial organisations such as supermarkets and rail companies to employ medical practitioners. Despite the BMA's objections, the Primary Care Bill has since (ie post-interviews) been passed and private GP services are now available in several train stations and supermarkets.

It was not until the third interview, when one of the GPs raised the matter, that the researcher became aware of the debate. Following this, those doctors who did not



mention it, were asked for their opinions on the Paper. Inevitably, the five GPs who spontaneously spoke of it, already had strong opinions on the matter. The two who did not, had been unaware of the debate prior to the researcher's questions, and it was they who thought that the change posed no threat. It is quite possible that these doctors were put on 'the spot' by the researcher, and had little time to consider the full implications of the proposal.

Five GPs spoke of the threat they perceived in the commercialisation of general practice, eg

Dr TM ♂ "...in terms of threats that are looming... there's a government White Paper now talking about general practice where... basically anyone can set up a service in... supermarkets... there would be commercial organisations running it, paying the doctors... it would demean I think, everything involved in general practice..."

Dr WA ♂ "...there's some talk that healthcare is going to be completely deregulated, so that anyone can go to a doctor anywhere. Quite where responsibility starts and ends, I don't suppose anyone's ever thought of it..."

Dr HJ ♂ "I think the biggest impact [*re change*]... is going to be... if general practice is sort of sold off to various organisations... [*did he mean 'supermarket doctors'?*] Yeah, it worries GPs... the worry for us... is that it's going to take money away from us... at the end of the day..."

Dr WB was one of two doctors who disagreed:

Dr WB ♂ "Well I don't know. Would you consider a consultant to be de-professionalised because he's employed by a trust? ...no, I don't see that as a huge problem..."

### 3.2.4 *The Government's attitude to GPs*

Almost half of the sample were disappointed with the Government's attitude towards general practice. In Supervisory Practices (section 7.4) it will be argued that dissatisfaction with the procedural elements of government 'supervision' may represent a violation of GPs' psychological contract with the State. Most of the criticisms centred on the mishandling of the changes recently introduced to general practice, but



three also related to a perceived undervaluing of GPs, eg

Dr SD ♂ "...I mean I went into general practice because of its autonomy... you can be a bit of a free spirit, and this [*the GP Contract*] was just recognising that we're not free spirits, you know? It completely...dismissed it, it brushed it aside and it just showed that you weren't respected for your views... I think we are political puppets in the NHS..."

and later this same doctor spoke of the erosion of GPs' clinical autonomy through government interference:

Dr SD ♂ "... it was the lack of consultation... I mean elderly surveillance and compulsory health checks have been proven to be an utter and complete waste of time..."

Dr RJ ♀ "...there's no government interest - they don't give a monkey's because they're getting this wonderful service for such a cheap price... the lack of respect for what the GP can offer... is all very depressing."

Three doctors (all non-fundholders) spoke out against the increasing shift of patients from secondary (ie hospital) to primary care, as hospitals strive to improve their productivity and efficiency figures. There was a sense of doctors becoming mere pawns in an internal market that had taken on a momentum all of its own, eg

Dr RJ ♀ "...I think the shift from secondary to primary care is... having its effects... it's very easy for them to shift it all back here and we have the abilities and the facilities now to handle it - what we don't have is enough time or the resource... we can't do everything..."

Dr HJ ♂ "...hospitals wanting us to do... extra things, it's difficult to know where we're going to fit those things in... unless there's some flow-system so that we can off-load certain things... at the other end..."

[*and later*]:

"... we don't feel greatly valued, we try to object but it doesn't make a lot of difference really."

Dr WB ♂ "...the steady flow of work from secondary to primary care has had... a major impact really... I had a patient... discharged within five or six days following coronary-artery bypass surgery... the purchaser-provider split... is impacting me because... they [*the hospital*] were shunting the patients through as quickly as they could to get more... cash into Oxford..."



Two fundholding GPs, however, spoke of experiencing more autonomy and control as a result of the purchaser-provider split. Both comments related to fundholders (as purchasers) having the ability to withdraw contracts from hospitals that fall short of GPs' expectations, in terms of providing secondary care for their patients:

Dr SD ♂ "...when you actually have... some ability to withdraw a contract, then I think that does allow you to have teeth."

Dr RC ♂ "...I think we get more control [*since becoming fundholders*]... we moved our contract to XXX ...so I think it has dropped the power of the consultants which... is a good thing... it's broken a few little kingdoms..."

It is possible that the GP fundholding scheme, which enables practices of a certain size to hold their own budgets, may confer a greater sense of control and autonomy. In terms of the sample base, the ratio of fundholders to non-fundholders was 6:4. When all the doctors' comments about change were taken into account, fundholders totalled 10 positive comments to 6 negative. This was inversed for non-fundholders with a total of 7 positive to 11 negative comments.

### 3.3 *Toward an experienced responsibility for work: Summary*

At the beginning of the present section it was stated that autonomy is fundamental to professionalism. The most appropriate perspective for understanding the phenomenon is a sociological one. It is argued that any move that threatens a profession's autonomy, must strike at its most centrally defining characteristic. Historically, medicine was believed to be the most powerful of all professions (eg Armstrong, 1990) and this is aptly illustrated by G B Shaw. When asked, "*Have we lost faith?*" he replied, "*Certainly not; but we have transferred it from God to the General Medical Council.*" (Shaw, 1932). Theorists, such as Friedman (1970) and Larson (1977), have argued that it is the exclusionary power of professions that separates them from the rest of the labour market. Hence membership of professional groups is understood to confer status, and an ability to exclude 'outsiders' from their jurisdiction through the monopoly of expert knowledge. So practitioner-nurses, informed patients and commercial competition may all represent, not only a threat to doctors' autonomy, but a gradual chipping away of their traditional power and status by unwelcome and possibly, in their eyes, unqualified 'outsiders'.

General practice is changing and doctors' autonomy is being squeezed by rising medical consumerism on one side, and increasing government intervention on the other. It would appear that the medical profession can no longer rely on its historical power and status to protect its members from the commercial pressures that have already pervaded most other occupations (eg Armstrong, 1990; Kanter, 1989).



## 4 Toward knowledge of the results of work

The core job characteristic relating to knowledge of results is feedback. This refers to the degree to which an individual receives information on the effectiveness of their work performance, directly from the job itself (Hackman and Oldham, 1980).

Nine of the sample mentioned various aspects of feedback. Although half of the sample mentioned the intrinsic satisfaction of patient-care, what appeared to be so important to doctors was verbal feedback from patients, ie patients expressing (or not) their appreciation of the doctor's efforts.

### 4.1 *Intrinsic feedback from the job*

As stated under task significance, half of the sample spoke of the clinical satisfaction in their work, eg

Dr RC ♂ "... the best side of it is clinical satisfaction, in looking after somebody successfully..."

### 4.2 *Patient appreciation*

Six of the doctors stressed the importance of patients expressing gratitude, with four of them mentioning it first when asked about the highpoints of their job, eg

Dr LA ♀ "The highpoints are when patients show their appreciation for what you've done for them, I mean say 'thank you'..."

Dr SD ♂ "The highs... are when people come in and... say 'thank you for listening'..."

Dr RC ♂ "... the best side of it is clinical satisfaction in looking after somebody successfully and occasionally getting a thank you for a job well done!"

Five of the six GPs implied that getting thanked by patients was not a common occurrence, and this lack of appreciation was clearly upsetting for two of the doctors:

Dr WA ♂ "... I thought people might appreciate what you've done more often than... they do, but they just assume that what we've done is to be expected..."



Dr AP ♀ "... they're not even grateful even when you really put yourself out because they just think, well that's your job... you don't expect people to kiss your feet, but 'thank you' is reasonable... when you get consumerism, what people forget to do is, they forget to say 'thank you'..."

Moreover, it was not only lack of appreciation that upset doctors. Half of the sample talked, often with passion, about difficult patients who seemed to epitomise negative feedback, eg

Dr AP ♀ "...the problem is... when people come in and are very hostile, aggressive, confrontational from the moment their bottom hits the seat. ...and you will meet people that I call the 'vampires', who suck every bit out of you... women [*ie doctors*] are particularly prone to that because of the nurturing role..."

Dr RC ♂ "I think the downside is the stropky, the obnoxious, objectionable patients really, that we've all got and are difficult to get rid of sometimes - the heartsink ones....."

Dr WB ♂ "But the stresses...more impact on me are the negative pressures, you know - 'I'm not satisfied with this', 'This isn't good enough' 'It's about time something was done Doctor!' and when you look at the notes, you realise that everything possible has been done... those sort of stresses where the blood starts to boil with indignation..."

Two doctors also spoke of threats of physical violence from patients:

Dr SD ♂ "... you have somebody who's threatened you - six foot four from Broadmoor - murdered somebody and wants some drugs, you know?..."

Dr WA ♂ "We can say 'right, you can come to the surgery at half-past three and I'll see you' ...but if you've got someone screaming down the 'phone 'I'll come and put a brick through your window unless you come and visit' ...you've got to be quite brave to stand your ground... it's quite upsetting really."

There is evidence that violence against GPs may be increasing. According to a recent survey of 251 GPs in the UK, 80 per cent felt that patients had become more aggressive in the last decade and 15 per cent reported having been attacked in their surgeries (Pulse, 1997). In 1999, the BMA News Review (March 10) reported that 41 per cent of doctors in their poll had been assaulted in their surgeries or while on-call.



The sample's need for patient-gratitude is consistent with Allen's recent report in which both GPs and hospital doctors "*felt a strong need for appreciation by patients*" (Allen, 1997, p6), eg

"It makes such a difference when somebody writes in and says I really appreciate what you did for us. And I've kept letters for months... they're so few and far between..."

### 4.3 *Toward knowledge of the results of work: Summary*

In terms of overall impressions, the researcher was left with an overwhelming sense that these men and women had, or believed they had, entered medicine with an altruistic service ideal. Listen again to the way so many of the doctors (half of the sample) spoke about the clinical satisfactions of their work:

Dr TM ♂ "...the good things are, I suppose, doing something for somebody and doing it well and actually feeling you've done something."

Dr BR ♂ "The highs... are the feeling that you can do something for people, something to help their lives..."

Dr SD ♂ "The highs... are when people come in and say they're feeling a bit better... or seeing a newborn babe or when somebody... has a good death and you think you've helped the family through it. You feel you've done your job..."

This sense of vocation is also supported by a small study carried out by an American professor of medicine (O'Brien, 1995) who was interested in identifying the real motives for choosing medicine, as opposed to the socially desirable responses given at medical school interviews. His rationale was that asking people these questions, much later in their training, was more likely to elicit honest replies. As 'insiders' the doctors would have nothing to lose in stating the truth. Responses from residents (the US equivalent of the pre-registration year) and senior medical students included the following:

"Because it allows me to exercise my compassion while healing"

"This sounds corny, but I really enjoy helping people who are suffering and in pain."

"If you gave me food and shelter, I would do it for nothing".



While it may not be easy to imagine British doctors expressing themselves in the same manner, the underlying ethos may still apply. In fact two of the sample spoke overtly of medicine as a 'calling', eg

Dr SD ♂ "My fundamental thing would be vocation. I mean that's what has kept me going... the idea that... you're in the right place and doing a valuable job and you're doing it right."

Once again, Allen's report for the BMA also lends credence to this view. She spoke of there being little doubt that the majority of participants were "driven" by a sense of vocation (Allen, 1997, p4), eg

"I don't think you can compare ourselves with any other body of professionals. It's the whole thing - you cannot just walk into a hospital, do a job and leave. It's a physical thing, a mental thing - the empathy, the compassion.... you give yourself every time virtually..."

People may choose medical careers for other reasons too, and medical sociologists will certainly talk of the power and prestige that is associated with medicine (Armstrong, 1990; Freidson, 1970). However, the JCM is based upon the perceptions of the jobholders themselves and not those of objective outsiders (Hackman and Oldham, 1980).

So, to address the question of whether GPs have knowledge of the results of their work, in terms of the sort of direct feedback that doctors *want* or value, ie patients' appreciation, then the answer is possibly no. Although the clinical satisfaction of seeing someone get better is obviously an important source of feedback for doctors, patients' appreciation was a central issue for the sample.

Equity theory may provide the key to understanding the situation from a general practice viewpoint. For example, the investment model of distributive justice purports that people will strive to maximise their rewards in their interactions with others. Satisfaction with outcomes will depend, therefore, on the perceived balance between the amount of time, effort and sense of giving of oneself that is invested in the relationship, and the subjective returns (Thibaut and Kelley, 1959). If, when assessing the patient-doctor relationship, doctors feel that their gains are relatively small in comparison to their perceived investments, then they will feel dissatisfied with the outcomes. Several studies have found that organisational commitment and exit behaviours are associated with such investment evaluations (Rusbult, Farrell, Rogers and Mainous, 1988; Rusbult and Lowery, 1985; Farrell and Rusbult, 1981).

It has been suggested that feedback may impact all three psychological states (eg Fried and Ferris, 1987). Certainly, a deficit in one of the core job dimensions could be



expected to lower the overall motivating potential of work (Hackman and Oldham, 1980).

## **5 The Critical Psychological States: Summary**

So general practice has fallen at the first hurdle in the analysis; the problems were immediately apparent at the unmoderated stage of the model. According to the sample, general practice lacks motivating potential.

In terms of meaningfulness of work, although doctors enjoy good skill variety, there were problems relating to task identity and task significance. Doctors reported time and resource constraints which impacted their clinical freedom in treating patients as they saw fit. There were also obstacles to their receiving the sort of feedback which was so important to them; patient-appreciation. Moreover, half of the sample complained of aggressive or hostile patients, with two reporting threats of physical violence. Finally, it appears that doctors' autonomy is under attack from rising medical consumerism on one side, and increasing government intervention on the other.

Moderator effects were then explored to establish their impact on the problem. The next stage of the analysis will begin with the first of the personal-characteristics moderators; knowledge and skill.

## **The Moderator Effects**

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### **6 Knowledge and skill**

According to the JCM, in order for people to enjoy the benefits of an enriched job, they must have sufficient knowledge and skills to enable them to perform well. An inability to meet the demands of a complex and challenging job, through insufficient knowledge and skills, will result in incompetence. This, in turn, causes the jobholder to experience frustration which will then have implications for absenteeism and turnover.

Doctors were asked "*Was your training appropriate for the job you are doing now?*"

Although the researcher had expected doctors to refer only to the general practice Vocational Training Scheme (VTS), four doctors were critical of their basic medical training. Bearing in mind that doctors must decide on specialty choices whilst working in a hospital setting, sufficient exposure to general practice during that time has important implications for future recruitment. Three criticisms related to a lack of



exposure to general practice during basic training, eg

Dr RJ ♀ "... you have to go for the basic medical training to be able to deal with what we do, but I think it could have been better in that it could have had more general practice training, because general practice is so different from hospital medicine, and you spend - what - a month of your whole five years of medical school in general practice?"

Dr BR ♂ "... the training in most medical schools, when I was at medical school, had very little specific bearing on general practice... One had a few very basic lectures on the general practice consultation, and then exposure of three to four weeks in a general practice..."

Interestingly, sociology and psychology were highlighted, by three of the sample, as highly relevant to general practice, with two of the doctors criticising its low profile in the medical school curriculum, eg

Dr HJ ♂ "... where I was at medical school... a whole day a week... was dedicated to things that essentially were quite useful in general practice... epidemiology, psychology and that sort of thing... that's been a lot more useful than I gave it credit for at the time..."

Dr SD ♂ "... the trouble is it didn't have a very high profile, and wasn't reviewed by the other lecturers as having a high profile, so I think that was probably the most useful aspect of my training and it's one we skipped the most... [*What - psychology and sociology?*] Yes... that's what medicine's about... there's a lot which is non-medicine which we're not trained for."

Dr BR ♂ "... one had a few... lectures on sociology and psychology... but there was much greater emphasis put on other aspects of medicine..."

The relevance of GPs having a basic understanding of sociology and psychology was illustrated in Skill Variety (Section 2.1), when doctors described the broad ranging nature of their work.

There were also hints, from two of the sample, that general practice was held in low esteem by those working in hospital medicine. The second doctor, however, thought that vocational training had now addressed the problem:

Dr BR ♂ "... the first lecture I ever had from our statistics lecturer at medical school, he had a running joke that he always gave to all his students which he said, 'statistically, 50 per cent of you will leave medicine altogether and go into general practice.'..."



Dr PA ♀ "... when I decided to become a GP, it was - you know - you kind of sat pitying people who went off to be a GP... it was not regarded at all ...vocational training has changed that... GPs can run clinics and monitoring for every chronic disease and we weren't thought capable of doing it a few years back..."

Five doctors, including two who had criticised aspects of their basic training, were fairly satisfied with the postgraduate vocational training for GPs, eg

Dr HJ ♂ "... I suppose the general practice training was quite relevant... quite good, and I think I picked up most of the important things which would get you through the average working week, as it were, safely..."

Dr RJ ♀ "VTS was better, but still it was largely hospital-based. You do need that, in a way, because you need to get the basic experience... it's not bad..."

Dr RB ♂ "...the training... when I was at medical school had very little specific bearing on general practice... but after medical school, one does the three years post-graduate training to become a GP... so that makes up for it."

The remaining four doctors made no specific mention of the VTS, speaking only of the general training aspects. There were two final comments. One GP, who had struck the researcher as showing signs of strain, gave a short retort to the question of adequacy of GP training, eg

Dr WA ♂ "No. I don't see how it can be when the Government keep changing what they want GPs to do anyway."

and finally, one doctor spoke of being over-skilled for his work in general practice:

Dr TM ♂ "... I feel often that my potential skills are not being used to their full, but that's very much because everything is diluted by all the trivialities that we see..."



## 6.1 *Personal Attributes*

GPs were asked what personal attributes were necessary for their work. Unsurprisingly, over half of the sample (six doctors) stressed the need for good communication skills. When all responses were collated, the story unfolded as follows:

### A good GP should be:

- "...**quite an organised person**..." (Dr RC) "...*fairly conscientious*..." (Dr AL) "...*fairly obsessional because your chickens always come home to roost... if you muck up*..." (Dr HJ)
- able to "...**live with a certain degree of uncertainty**..." (Dr RJ) "...*you have to learn to live with uncertainty... to live with risk*." (Dr RC) "...*be prepared to make decisions without feeling very comfortable with them*..." (Dr TM)
- have "...**endless patience**..." (Dr BW) "...*you need a lot of patience... because a lot of your work is repetitive and humdrum*..." (Dr RJ)
- It also helps "...**to be sort of laid-back**... not to get too stressed out..." (Dr RJ) "...*be relatively laid-back... don't fly off the handle... it nearly always makes the situation worse*..." (Dr RC).
- "...**to be able to listen... to empathise with all types**..." (Dr RB) "...*able to communicate with people and be willing to give them your time*..." (Dr AL) "...*patients... like someone who's prepared to listen to them*..." (Dr HJ) "...*you have to like people - you have to have skills of talking to people... it's people all day long*..." (Dr RJ) "...*be their counsellor, their confessor, their social worker*..." (Dr AP) "...*if you can't communicate with the patients, then you're on a bit of a loser, aren't you?*" (Dr SD)
- "...**be reasonably independent and just get on with things**..." (Dr TM) "...*do the job without getting involved to some degree*..." (Dr AP) be "...*hard-skinned... not to let them grind you down*..." (Dr HJ)

Interestingly, there was no sign here of any of the BMA's reported "core values" for doctors (eg BMA Cohort Study, 1995, First Report - Part 11, p5). As stated in Chapter 1 these comprised (in order of importance) '*competence*', '*compassion, caring, commitment and responsibility*', '*integrity*', '*confidentiality*', '*patient's advocate*' and, finally, '*spirit of enquiry*'. Indeed, when these core values are compared with the pragmatism reflected in the sample's list, they have a stilted, academic feel about them, as if far removed from the realities of everyday practice.

## 6.2 *Adequacy of Knowledge and skills: Summary*

Doctors' retrospective comments about their basic training, implied that medical schools could do more to encourage students to consider general practice as a career by increasing their exposure to the specialty. Moreover, future doctors might benefit from a broader curriculum which gives weight to non-medical subjects too, such as sociology and psychology, which the sample considered highly relevant to clinical



practice. Those who mentioned GP vocational training seemed fairly satisfied with its relevance, although one doctor thought that it was still too hospital-centred.

When considering the adequacy of the present sample's knowledge and skills, it is highly unlikely that even new GPs are anything less than very well equipped for the job. These people will have completed a minimum of five years undergraduate training, plus one year as pre-registration house officers usually followed by at least one year as senior house officers, before then going on to complete a further three years GP vocational training. It is surprising that only one doctor mentioned the problem of being over-skilled, especially in view of the six who complained of the trivia of patients' complaints (Section 2.3 Task Significance).

In terms of personal attributes, good communication skills and ability to empathise, patience, a high tolerance of ambiguity, independence and an ability to remain emotionally detached were the main qualities that emerged.

In summary, GPs' knowledge and skills were considered to be commensurate with their present work.

Knowledge and skills alone, however, do not guarantee successful outcomes in terms of the job characteristics model. People who have sufficient knowledge and skills to meet the demands of complex and challenging work, may not necessarily feel motivated to rise to that challenge. What makes the vital difference? The answer, according to Hackman and Oldham, is growth-need strength. This is described as a psychological need for personal growth and development. Such individuals, it is argued, will seek challenge and personal accomplishment in their work. Hence, knowledge and skills combined with high growth-need, represent a critical component of the individual differences-enriched job outcomes equation.

## **7 Growth-need strength**

GPs were not asked specific questions relating to growth-needs. Hence the findings reported in this section accrue from comments made spontaneously by doctors during the course of interviews. Comments were divided into two categories:

1. Growth-needs and lack of career structure
2. Are growth-needs always work-centred?

### **7.1 *Growth-needs and lack of career structure***

Three of the sample implied a lack of intellectual challenge in their work:

Dr AP ♀ "... general practice can be intellectually quite deadening in that... the challenges that you face are not intellectual challenges, and I miss that..."



Dr LA ♀ "I think now, if I went into medicine, I might stay in hospital medicine because I was quite academic, I won a prize at university... general practice... it's not that special in terms of an amazing career."

Dr TM ♂ "... I think it's important to do other medical things that are separate and stimulating..."

One doctor however spoke of the excitement he sometimes experienced in this work. The interviewer had put it to him that barristers expressed a great distaste of the type of work that GPs and solicitors do, in terms of dealing with people 'fresh off the street':

Dr SD ♂ "Well it can be a threat, it can also be the excitement, you can be living on the edge, it can be the idea of 'what next?' - that can be the fun of it! ... if you had total control it would be boring, that's the fun of it... you look at.. how am I going to improve? and it's a movement towards... growth... improving your professional ability..."

Nevertheless, this GP was among five others in the sample who pursued interests outside general practice. This was clearly very important for two of the doctors:

Dr AP ♀ "... I work one day a week at the health authority, because I work part-time here and... I didn't think it was enough and thought I'd try for a bit more to do... and it's intellectually more satisfying..."

Dr TM ♂ "I work for solicitors - I do medical-legal reports, and things like that, for people who've been injured at work... it's important to make sure that you have some other interests... because I think without those, I probably would go mad."

One tangible measure of personal growth and development may lie in a sense of career progression. Suspecting that this might present a problem for GPs (Richards, 1991), the researcher asked doctors *"How do you feel about the apparent lack of career structure in general practice; the fact that the job you enter at thirty is the same one you will retire from at sixty?"*. Although no one denied the fact that general practice was lacking in career structure, the sample was divided in terms of whether or not it presented a problem.



Half of the sample perceived the lack of career structure as a distinct disadvantage, eg

Dr AP ♀ "I hate it, hate it! ...you want to grow... to branch out a little bit and sitting here at this desk, this is a very worthwhile job - but - and that's a big 'but', not necessarily what I would want to do... for another thirty years... There is no career structure... and I have to just sit here now, and say, right, this is it..."

Dr RJ ♀ "I think it's a shame, I think it could offer more... I mean I was thirty when I got into the practice I was going to be in for the rest of my life, and that's a very odd feeling... quite demotivating... the thought of being here 'till I'm sixty is - God - awful!"

Two doctors suggested changing practice as a solution to the problem of career stagnation, eg

Dr WA ♂ "... if you wanted to change, you could... change practices completely to broaden your horizons."

Dr RJ ♀ "... the prospect of a different working environment might be quite a challenge..."

However, four of the sample spoke of the difficulties in changing practices. The main problem appeared to be the stigma of 'damaged goods' that follows experienced candidates in their search for a new post, eg

Dr LA ♀ "...there is a lot of resistance, among my partners especially, to people changing practices... we had trouble getting another partner in: 'Oh he's had three jobs already!' and I said, 'What's wrong with that?' What's wrong with moving around different jobs - it keeps you fresh!..."

Dr AP ♀ "...it's a bit like a marriage, you've got financial and legal bonds... and if you want to cut and run, people look at you and say, 'Why, what is *wrong* with you? ... are you damaged goods?'..."

This stigma also followed people who wanted to re-enter hospital medicine, as explained by Dr AP who had obviously considered it:

Dr AP ♀ "It's difficult. ...you have to be 100 per cent down the line for everything, going back into general medicine - or whatever - I think people would be quite suspicious... 'You've been a GP for six and a half years so... what's wrong with it, what's wrong with *you*?' ...if you've made the wrong choice, then your judgement is suspect..."



Of those who could not see a problem with a lack of career structure, four suggested outside interests could compensate, eg

Dr RC ♂ "I don't think you go into general practice unless you accept that and there are ways of getting around that, either sabbaticals or... trying to get out and go and do something for a while... I've only been a GP for five years so perhaps in another five, I'll start thinking about spending a year out doing something."

Dr TM ♂ "... I suppose the answer to that is that... it's important to make sure that you have some other interests... and that's one of the reasons that I... do occupational health and things like that..."

## 7.2 *Are growth-needs always work-centred?*

There was one particular individual who brought into question the JCM's assumption that growth-needs are necessarily work-centred. Dr RC had given the impression of being in control of and enjoying his work. He had also been very positive in his reply to the 'chance again' question:

Dr RC ♂ "...I have what I wanted... a semi-rural practice in a part of England I like... and a practice that is a good practice, with partners I like..."

Yet in answer to the 'lottery win' question, Dr RC declared "*If I won the lottery, I would give up being a GP*". Why?

Dr RC ♂ "...I've a friend... a doctor, who's just sailed round the world, he was my best man... and decided he didn't want to settle down, so he bought a boat...and then set off, ...spent a few months in Australia and then...came back round the other way... I think there's an awfully big place out there and... you could spend an awfully long time just having a look around!"

As Dr RC has demonstrated it is possible that, for some individuals, work may be considered a means to an end rather than the central value of their life (eg Paullay, Alliger and Stone-Romero, 1994).

Moreover, there was evidence that even when growth-needs are work-centred, this may not remain stable over time. Dr LA was clearly surprised at the shift in her



personal values since the birth of her baby daughter:

Dr LA ♀ "...for me, the time of life I'm at... my family is more important than my career - I mean actually, for the first time. I suddenly realised this year - that yes, maybe I... could easily take a salaried job at the moment...I'd have just hated to hear myself say this ten years ago... "

### 7.3 *Growth-need strength: Summary*

It is possible that individuals with high growth-needs may, with increasing tenure, 'adapt out' of the challenges of an enriched job, ie perceiving any challenges to have been met and conquered (Johns, Xie and Fang, 1992). On the other hand, Kanter (1989) referred to a process of professional 'stuckness' whereby people's skills-growth can be capped by their limited range. However, in general practice it appears more likely that the problem relates to doctors' lack of opportunity to fully utilize their existing skills, rather than these being outstripped by the demands of the job.

These experienced GPs had spent an average (mode) of seven years in the job, and were mostly aged between mid to late thirties (mean: thirty six years). In terms of Super's career stage model (Super, 1978) other researchers have operationalised the 'establishment stage' as between two and ten years in the job (Mount, 1984; Stumpf and Rabinowitz, 1981; Gould and Hawkins, 1978). This stage refers to the time when people experience an increased commitment to their career, career advancement and personal growth. According to Levinson's model of life development (Levinson, Darrow, Klein, Levinson and McKee, 1978), the 'settling down' life stage, occurring in the mid to late thirties, also coincides with both Super's notion of the establishment stage and the actual ages of the sample. However, as Ornstein *et al* (Ornstein, Cron and Slocum, 1989) observed, some individuals may need more time to adjust to differing life/career stages, and not everyone will experience a smooth transition. Hence it may simply be too early for some doctors to be reflecting on their long-term career prospects, as illustrated by some of their responses to the 'lack of career structure' question, eg "...I've only been a GP for five years so, perhaps in another five I'll start thinking about ... doing something." (Dr RC) and "It hasn't so [worried him] at this stage. Ask me again in fifteen years' time." (Dr WB).

As indicated by the sample, it is also possible that work may not always represent the focus for high growth-needs. Some individuals may consider their job a means to an end. Such people may seek challenges outside work, perhaps like Dr SD who 'doubles' as a stress counsellor or Dr RC who envied his friend for sailing round the world. A high work-centrality may also change over time, possibly triggered by a major life-event as demonstrated by Dr LA.

Overall, in terms of general practice meeting doctors' growth-needs, three GPs implied a lack of intellectual challenge in their work. Moreover, half of the sample reported pursuing outside interests, two of whom believed this represented an essential source



of work-related satisfaction which general practice could not provide. These findings are even more poignant in view of the findings reported later in section 8.5 (Volume of Work). Four of the sample spoke of work spilling over into non-work time and, of these, three pursued work outside their normal working hours. So despite working long hours, almost half of the sample still felt the need for extra activities. The present study must therefore cast serious doubts on whether a career in general practice can satisfy high (work-centred) growth-needs.

Having considered individual differences in the jobholders themselves, in terms of knowledge and skills and growth-need strength, the working conditions of general practice were explored, ie context satisfactions.

## **8 Context Satisfactions:**

GPs were not asked specific questions relating to their working conditions. Hence the quotations which follow refer to comments made spontaneously by doctors during the course of interviews.

Each of the context satisfactions will be considered in turn and the section begins with doctors' pay.

### **8.1 Pay**

Six doctors mentioned three aspects of pay during interviews. Topics raised were as follows:

1. General practice pays more early on
2. Comparisons with other professions
3. Out-of-hours' pay

#### **8.1.1 General practice pays more early on**

One doctor described the attraction of earning more, earlier on, than hospital doctors:

Dr WB ♂ "The highs? ...more income earlier on in your career. Although over a lifetime, it's clear that people staying in hospital medicine can earn more than a general practitioner does... for a GP, more of it comes earlier on - probably when you're needing it with a young family and setting up a home..."

#### **8.1.2 Comparisons with other professions**

Three doctors thought that their pay compared badly with other professions, with two emphasising the stresses of general practice. Accountants and solicitors were the two referent groups specifically mentioned, although the latter may have been prompted by



knowledge of the researcher's interests, eg

Dr RJ ♀ "...out-of-hours are cheap, very cheap compared with other professions. I mean I don't know how much a solicitor charges for doing a letter but I'm sure it's a substantial amount and if we do a private report... we get something between £12 and £15... which is a pittance really!..."

Dr SD ♂ "... I think I have enough money, I mean I think GPs can get greedy, but when you compare yourself to other professions... certainly I think we fall well below what I could have achieved if I'd done other jobs, and probably had less hours and less stress..."

Dr WA ♂ [*having announced he would prefer accountancy, given the 'chance again', he was asked why*] "I think the pressure of work really... I'd happily settle for the salary I've got but with less hassle."

### 8.1.3 *Out-of-hours' pay*

Increased demand for out-of-hours' visits has long been a contentious issue for GPs. Recently, sustained pressure from the profession brought about a number of changes such as the introduction of co-operative schemes, and emergency centres for out-of-hours' consultations. This means that local practices can work together to share the burden of out-of-hours' care with a system of shifts or sessions.

Despite Dr RJ's comment above, the work appeared to pay well. Both of the women quoted below (including Dr RJ) implied that there were financial incentives to work extra shifts for the out-of-hours' cooperatives:

Dr RJ ♀ "... and out-of-hours, I do two or three shifts a month [*"Two or three shifts? That sounds a bit heavy."*] Well we have an expensive lifestyle! Lots of holidays and they're asleep [*her children*] so I think, well, they won't miss me, so I'll work the evening shift..."

Dr LA ♀ "The thing with co-operatives... it's good in the fact that if I don't want to do a session, or I can't do a session, then there's always somebody else who'll do it for you.... because it pays - it pays quite well..."

### 8.1.4 *Pay: summary*

In terms of doctors' satisfaction with their general levels of pay, it is difficult to gain a good overall impression from the few comments above. There were, however, hints that GPs felt somewhat exploited when compared with other professions who they perceived as having higher remuneration and less stress. Interestingly, none of the sample compared their pay with that of hospital doctors, despite Dr WB (point 8.1.1) implying an awareness of this 'others-inside' group (Goodman, 1974; Adams, 1965)



earning more in the long term. One possible explanation for this could be that hospital doctors are also known to work long hours with similar stresses, which would rather defeat their argument. Another reason for GPs not considering hospital doctors an appropriate referent group, could be due to a notion that general practice is somehow 'second best' to hospital medicine. For example, Dr WA had believed himself not "...*clever enough to be a consultant*...", while Dr LA spoke defensively of being quite capable of doing hospital medicine "...*because I was quite academic, I won a prize at university...*". This sentiment was also supported by Dr RB (section 6), when he referred to his university lecturer stating that "...*50 per cent of you will leave medicine altogether and go into general practice...*". Moreover, there are echoes here of the American study into 'Family practice bashing' (Hearst, Shore, Hudes and French, 1995) where medical students reported similar derogatory comments from teachers and clinicians.

Dr SD's assertion that other jobs have "less hours" is not supported by the evidence. For example, according to the sample, full-time GPs are working a mean of 43 hours per week (range: 36-46), excluding out-of-hours' work which can vary. According to a recent Law Society survey (Cole, 1997), solicitors are working an average of 46 hours per week, with a quarter claiming to work 53 or more per week. Moreover, many business personnel are working over 50 hours a week (Herriot and Pemberton, 1995). Doctors are not alone in working long hours.

Judging from the quotations above, there is no firm evidence to suggest that doctors are dissatisfied with their pay, *per se*.

## 8.2 Job security

In terms of the second context satisfaction, job security, it was clear that general practice is perceived as undeniably secure. A total of six doctors spoke of job security, although for three of these it was simply implied when they spoke about their lives:

Dr HJ ♂ "...I think it's nice to actually... buy your home, settle down and think you're going to live there for thirty years or so..."

Dr RJ ♀ "...it's quite an odd feeling to get into your practice, I mean I was thirty when I got into the practice I was going to be in for the rest of my life..."

Dr AP ♀ "...the expectation is that here I am, I've been here for a few years, got parity, got settled... and I'll just stay here 'till I'm sixty and I don't think that is going to be the case...I could do it for another thirty years, but I don't want to..."

Three other doctors showed a keen awareness of the value of job security, within



today's wider job-market:

Dr LA ♀ "...it's nice to have the job security, because nobody else has job security like we do..."

Dr SD ♂ "...I think we're secure and I think that's something that a lot of professions aren't."

Dr TM ♂ "...I suppose the best thing in this current day and age is that my job is pretty secure, so from that point of view, I think we're quite fortunate..."

In section 3.1 (Personal autonomy), four GPs described the uncertainties in their daily work. It was not clear whether these reflected concerns for the welfare of patients (ie the results of misdiagnosis) or risks to their job security, eg via the threat of litigation. However, litigation concerns were more apparent for two doctors:

Dr LA ♀ "I think the general atmosphere is that everyone expects things to be done legally. These days, if you have a car accident, you don't just sort out... the insurance, you sue somebody because you've got whiplash!"

Dr WA ♂ "...your knowledge that for every one in 1,400 that you refuse to go and visit because they've got earache and they refuse to come to the surgery, they might get nasty and you end up in court. Therefore you go out and visit these kind of people."

### 8.2.1 *Job security: summary*

The issue of job security must represent one of the few occasions when GPs have considered themselves to be better off than other professionals. In a changing world of work where job security is so elusive, general practice must be considered something of a haven. Most of the sample seemed to appreciate the significance of this. However, it was apparent that litigation fears are beginning to filter through to general practice, and this may erode doctors' sense of job security in the future.

For the purpose of the present study, however, work in general practice was considered secure.

## 8.3 *Co-worker relationships*

Seven doctors spontaneously spoke of co-worker relationships. Five of the sample spoke of the advantages of having good relationships with colleagues, who were mostly other doctors within the practice, eg



Dr RC ♂ "... I think it makes or breaks the job. If you have an environment in which you get on well with your partners, there's no in-fighting and you can have a laugh and a joke."

Dr RJ ♀ "Highpoints generally, are relationships in the practice, because I get on well with all the staff - with the doctors and they're good friends - most of the time... there are exceptions, but on the whole that helps, it's supportive."

One of the sample who felt he had "*good supportive partners*", nevertheless hinted at some of the tensions that can arise in general practice:

Dr SD ♂ "For equity's sake, you're expected to see the same number of patients. There are two things you argue about in general practice; one's money, the other's workload."

For two of the women, whose partners were either predominantly male (Dr LA) or all-male (Dr AP), there was bitterness at a perceived lack of support at a time when they had clearly needed it:

Dr LA ♀ "...because I was the first married woman-partner in the practice, nobody really understood about me wanting to go part-time. They were very, very resistant to it... it took five months for them to come round and that was hard when I was pregnant... I mean when I left work... there was hardly a word said about me having the baby."

Dr AP ♀ "... you come into a partnership and you find, as a woman, that your partners don't support you as much as you'd like... things like maternity leave - there was a lot of lip service paid to it, but when it came to it, it was awful! ...You would think that if you worked with someone for five years and that person goes off... sick, you might ring up and find out how they are... but I had my first baby and my partners - it was as though it never actually happened..."

It may be that pregnancy and maternity-leave represent the 'acid test' for good working relations. It may only be then that women learn of the real attitudes behind interview platitudes.

### 8.3.1 *Co-worker relationships: Summary*

Several studies have shown that support from coworkers and supervisors is strongly related to reduced job-stress (Cottingham and House, 1987; Constable and Russell, 1986; LaRocco, House and French, 1980). However, when comparing doctors'



reports of social support from colleagues with their stress categories, as defined in section 1.4, there appears to be no discernible pattern. Four of the six doctors categorised as having 'high stress' reported good relations with partners. Of the four doctors assigned to the 'reasonable stress' group, only three mentioned relationships with colleagues and of these, two reported them as good. These findings, however, do not necessarily contradict the theory that good relations with coworkers can ameliorate the effects of stress. It may well be that individuals, who feel particularly stressed, may also value relationships with coworkers more highly than those reporting lower stress levels.

The fact that two of the women reported such similar problems with co-workers was surprising, given the increasing number of women entering general practice (eg almost fifty per cent were women in 1996). So although more flexible part-time and job-sharing arrangements were formalised within the GP Contract seven years ago, clearly, there are areas that still need to be addressed.

Indeed, there were signs that practice partners may have violated the psychological contract (Herriot and Pemberton, 1995) in their treatment of Dr AP and LA, respectively, eg

Dr LA ♀ "...It was a shame really because it ruined, in a way, the way I thought about the practice... there was so much bad feeling..."

Violation of psychological contracts are negatively associated with trust, job satisfaction and intent to stay with an organisation, and positively related to turnover (Robinson and Rousseau, 1994).

In summary, it appeared that good co-worker relations were enjoyed by five of the seven doctors who mentioned it, and that these were valued for the support they offered. However, there are clearly problems for women partners who wish to start a family, despite part-time arrangements having been formalised by the 1990 GP Contract. This view is endorsed by Allen who quoted a male GP explaining "*...male GPs hate young women trainees without children. They're worried about maternity leave...*" (Allen, 1994, p74).

The fourth and final contextual moderator is satisfaction with supervisory practices. As stated earlier in the chapter, doctors who work in general practice are independent contractors which means that, although they contract their services to the NHS via local health authorities, they are essentially self-employed.

Although Hackman and Oldham (1976) tested the application of their model in a variety of jobs, which included professions, they only investigated the moderator effects of growth-need strength. Because of an apparent paucity of research relating to applications of the *full* model, it is difficult to establish how other researchers would overcome the problem of supervisory practices, as a moderator, when investigating the



jobs of autonomous professionals. If, in broad terms, the primary function of a supervisor or leader is to direct and motivate subordinates (eg Robbins, 1993; Hackman and Oldham, 1980) then, for GPs, there are no supervisors. However, general practice is part of a larger organisational structure, in the sense that the Governmental Department of Health sits at the apex of the hierarchy. Given the new concept of a primary care-led NHS, the Department of Health would undoubtedly claim the direction and motivation of GPs to be one of its prime objectives. So whilst family doctors may value their independent contractor status, they must ultimately conform to the directives of the State. GPs were forcibly reminded of this fact in 1990, when the GP Contract introduced major changes to their terms and conditions and remuneration system. Moreover, despite the medical profession's objections, the Department implemented the changes as planned. The GP Contract has been blamed, by some, for the current recruitment crisis in general practice and for the early retirement of many mature doctors, eager to escape its introduction (Allen, 1994; Richards, 1991).

Therefore the following section focuses on doctors' comments relating to the Government's supervisory role of general practice.

## **8.4 *Supervisory practices***

Five GPs expressed dissatisfaction with various aspects of the Government's handling of change in general practice. Comments ranged from objections to the lack of consultation with doctors, to specific objections regarding policy.

### **8.4.1 *Lack of consultation***

In section 3.2.4 (autonomy) two doctors talked about the perceived undervaluing of GPs (Drs SD and RJ). Of these, Dr SD had angrily spoken out on the Government's mishandling of the GP Contract, namely the lack of consultation.

### **8.4.2 *Government policy***

A third doctor complained of the Patient's Charter which he felt was encouraging unrealistic expectations of the health service and what it can deliver:

Dr WB ♂ "You can't tell patients that they have... all these rights... without them making those demands on the system... It's far more unsatisfying saying that you can expect this, this and this to a patient, without giving them any idea how they're going to achieve it... dashing false expectations is the biggest bone of contention at the moment..."

A further two doctors objected to the ethos of the internal market on the basis that a competitive open-market policy was inappropriate for the provision of healthcare:



Dr WA ♂ "... the internal market... I wonder if it's the Government's way of deliberately fragmenting the medical profession... it's drifted now into hospital doctors versus GPs and very soon it'll be one practice against another..."

Dr BR ♂ "... fundholding versus non-fundholding, I find ideologically unpleasant... encouraging hospitals to compete with each other than co-operate and, although I can see that in many walks of life competition improves efficiency, I'm not sure that in a service-related profession like medicine that works..."

#### 8.4.3 *Supervisory practices: Summary*

So half of the sample expressed resentment at the Government's handling of change in general practice. Dissatisfaction with the procedural elements of management is well documented, and has been shown to be related to attitudes of supervisory trust and organisational commitment (eg Lowe and Vodanovich, 1995; McFarlin and Sweeney, 1992; Folger and Konovsky, 1989). Certainly, there was evidence of a deep distrust of government in Dr WA's comment above.

In section 8.3, relating to satisfaction with coworker relationships, the psychological contract between individual GPs and their partners was discussed. Two cases of women practitioners experiencing barriers to their rights to maternity leave and part-time arrangements were reported. It was considered that such instances constituted a violation of the psychological contract. It is argued that, for GPs, there may be two separate kinds of psychological contract: a 'micro' contract between the individual and their practice partners, and a 'macro' contract between the individual and the larger organisation, the NHS (ie the State).

Judging from the sample base, there was evidence that doctors were adhering to the 'old-style' relational psychological contract with the State (eg Herriot and Pemberton, 1995). Angry statements like "...*we are political puppets in the NHS.*" (Dr SD) and "...*there's no government interest - they don't give a monkey's...*" (Dr RJ) implied that doctors felt that they were indeed 'going the extra mile', but without recognition or appreciation from the Government.

In summary, it appeared that dissatisfaction with the procedural element of government supervision represented a violation of doctors' psychological contract with the State.

In the present study, analysis of supervisory practice served to underscore the findings reported in section 3 (autonomy). The message was clear; general practice is changing and doctors can no longer expect to be insulated from the 'slings and arrows' of the broader workplace.



## 8.5 *Volume of work - a potential moderator?*

Whilst GPs have been shown to enjoy variety in their work, there was a problem relating to work-overload. Hackman and Oldham (1980) briefly concede that excessive *quantity* of work may impact the *quality* of workmanship and the motivation of the jobholder may suffer as a result. However, there appears to be no designated 'slot' for such a concept within the model.

Four doctors spoke of work spilling over into non-work time, eg

Dr RC ♂ "...I don't get home 'till 6.30 and then I probably do an hour at home, most evenings."

Dr SD was also quoted earlier (section 1.2) talking about his workload, eg "*...I am too stressed, I'm doing too much.*"

It is suggested that, in the long-term, sustained overwork will have a detrimental effect on motivation. There certainly seems to be a case for incorporating "volume of work" in the model, as an additional moderator, ie as one of the contextual satisfactions.

## 9 **Conclusions**

Even before moderator effects were taken into account, analysis of general practice immediately revealed fundamental flaws in the design of doctors' work. Judging from the sample base there were serious obstacles to doctors feeling autonomous in, and responsible for, work that was meaningful and worthwhile. Moreover, doctors felt they were denied the sort of feedback they felt was important; patient-appreciation.

In terms of the doctors themselves, there was evidence that many may have chosen general practice for the wrong reasons, eg because of perceived difficulties in pursuing a career in hospital medicine. Although amply qualified for the job, there were signs that general practice lacked the necessary intellectual challenge and opportunities for personal growth and development.

Examination of doctors' satisfaction with contextual factors showed the main problems to be centred around co-worker relationships and supervisory practices. In the case of the former, women can experience problems in negotiating maternity leave and part-time work arrangements with male colleagues. In terms of the latter, doctors appeared to have a relational psychological contract with the State, which was interpreted as having been violated by the Government's handling of recent changes in general practice.

The use of the complete JCM (including moderators) was considered to have been well worth the extra time and analysis. It has facilitated a deeper understanding of the problems surrounding general practice, not only of the job itself, but of the people who



have chosen it as a career. Without the inclusion of moderators it would not have been possible to identify lack of career structure as a problem relating to growth-need strength. Nor would it have been possible to establish the reason for doctors' anger at government-intervention, ie a perceived violation of their psychological contract with the State.

Having examined general practice in accordance with the Job Characteristics Model, the next chapter focuses on solicitors' work within the same theoretical framework.



# Chapter 6

## Results and Discussion: Solicitors

The sample, comprising ten solicitors, represented the following positions in order of seniority: Two senior partners, two salaried partners, three associates and three assistants. Except for one woman who was interviewed in her home, all solicitors were interviewed at their workplace. This was usually their own office, although two interviews were conducted in tiny client-meeting rooms and one took place in a large boardroom. In all of the workplace settings the researcher and informant were seated formally, separated by a desk or table. In terms of overall impressions, solicitors appeared to be more heterogeneous than the GP sample, and it was therefore more difficult to generalise. For example, one male associate presented as very relaxed with a quick wit, whilst two of the women appeared generally dispirited in their work. Two men, on the other hand, seemed to have experienced a 'divine calling'. Like the GP sample, everyone gave of their time freely.

As the table below illustrates, analysis showed solicitors' work to be basically enriched and motivating, with all three psychological states potentially 'activated'. Investigation of moderator effects, however, revealed problems relating to knowledge and skill, job security and supervisory practices.

Table 15      *Overview of solicitors' work within the JCM*

| Critical Psychological States |   | Moderator Effects           |   |
|-------------------------------|---|-----------------------------|---|
| Meaningful work               | ✓ | Adequate knowledge & skills | × |
| Experienced responsibility    | ✓ | Work-met growth-needs       | ✓ |
| Knowledge of results          | ✓ | Context satisfactions:      |   |
|                               |   | pay                         | ? |
|                               |   | job security                | × |
|                               |   | co-worker relationships     | ✓ |
|                               |   | supervisory practices       | × |

? = some problems

### Analysis of data

#### The Critical Psychological States

#### 1      Toward an experienced meaningfulness of work

Although the sample comprised both generalists (4) and specialists (6), there were no apparent differences in the way the sample perceived the meaningfulness of their work.



There was evidence of skill variety for all but one of the sample, eg

DJ (♀ generalist) "... I can do two types of work independently... contentious and non-contentious... it's varied... no two days are really the same... the variety of the work is important."

AE (♀ specialist) "... I'm involved in buying, selling companies and businesses, setting up new businesses, partnerships... anything that's in the commercial field. It's very varied which is what I like about it. No two things are the same all over..."

HD (♂ specialist) "I'm a litigation partner. I do... resolution of disputes between companies, businesses, partnerships... I also have emphases which... include competition law, insolvency... challenging planning decisions in the high court... I find... the complex issues of law... very interesting..."

Only one solicitor lacked skill variety; a male personal injury specialist who seemed to have fallen victim to his firm's success. The emphasis of his work was on throughput at the expense of variety:

ED (♂ specialist) "... we do something like... 5,000 PI [personal injury] claims for road traffic cases from anybody in Penzance to Newcastle [*did he ever find it tedious?*] Yes. Exactly, I get bored."

Mr ED has since left the firm he was with at the time of interview, and now works for a new organisation where he has a broader, advisory role, dealing direct with insurance companies rather than clients. However, it was clear that he still had task identity, task significance, feedback and autonomy, which implied that lack of skill variety alone may have a direct effect on turnover.

All ten solicitors appeared to enjoy task identity, eg

AE (♀ assistant) "...if we're doing a big deal... selling a company or buying a company, we've got to deal with the whole sphere of everything, the commercial property people will deal with the leases, but that's just one finite little bit... then they go home and leave us to sort out the terms of the commercial deal."

HD (♂ salaried partner) "...I actually enjoy the resolution process... once you've spotted the problem, actually working out how to resolve it... you have to find out what makes the client tick... that's all very interesting..."



There were shades of autonomy in some of their responses, eg Ms AE "...selling... or buying a company, we've got to deal with the whole sphere of everything..." and Mr HD "... once you've spotted a problem, actually working out how to resolve it..."

There was also ample evidence of task significance. Indeed, half of the sample spoke of being able to help people or doing their best by their clients, eg

DJ (♀ salaried partner) "...I generally like the work... I like to be able to help people, be it small people or companies. I enjoy dealing with people really..."

ED (♂ associate) "...I wouldn't say it's a vocation, but I mean, certainly... getting compensation for somebody who's seriously injured... you can recover £2,000 for somebody and that is more money than they've ever dreamed of in their life, or getting a £100,000 plus - you get a kick out of that..."

HJ (♀ assistant) "It [*wills and probate*] is differentiated, it is difficult work... a lot of the clients are elderly and you're really having to hold their hands and guide them and they can become very dependent on you... I actually quite like that, because you can really feel as if you're doing some good..."

That solicitors should show the milk of human kindness challenges the public view of lawyers, as illustrated by an article in *The Lawyer* (May, 1996, p12): "*Despite all the profession's attempts to counter it, the public image of lawyers is slipping. As the joke goes, how can you tell the difference between a dead snake and a dead lawyer lying in the road? There are skidmarks in front of the snake.*"

Moreover, two solicitors spoke of their Christian values in relation to their sense of vocation:

BM (♂ partner) "... I started my own practice here with J. ... it was regarded as something of a divine call, we felt we were meant to be in partnership together... if I felt that God was calling me away from this business then I... must, if necessary, appoint a successor..."

HD (♂ salaried partner) "... I'm a committed Christian... my faith is a fundamental part of my life and I believe every time I wake up in the morning, I have to decide whether I want to change jobs... if I feel a click in here [*pointing to his chest*] that says, 'you're in the wrong place' then I'll get out."

The fact that both men specialised in commercial litigation, surprised the researcher, although Mr BM had become more of a generalist because of his two-partner business.



The researcher pursued this apparent conflict of values with Mr BM:

*["Something that intrigues me is how do you reconcile... commercial litigation with your Christian beliefs? ... I see that field as very cut and thrust, dog-eat-dog... how does that rest with your Christian values?"]*

BM (♂ partner) "The resolution of disputes is at the core of Christian beliefs. Christianity is all about how God resolved the dispute between himself and his creation... I mean I can't see any conflict at all... If a client comes to me and says 'I want to take this man to the cleaners' then I'm his lawyer, not his priest..."

Judging from the sample base, it would appear that *job* satisfaction is intrinsically linked to *client* satisfaction, ie winning the case is good for both parties; the client is happy and the success reflects on both the lawyer and firm.

### ***1.1 Toward an experienced meaningfulness of work: Summary***

According to the sample solicitors appeared to experience their work as meaningful and worthwhile. There was just one exception relating to Mr ED, the personal injury specialist, whose work had become repetitious and lacking in breadth because of the sheer volume of through-put. This is perhaps a good illustration of Kanter's theory of professional "stuckness" which was mentioned in the Introduction. Mr ED's opportunities for skills-growth were being stifled by the way his work was structured, rather than any shortcomings on his part. As previously stated Mr ED has since left the firm he was with, at the time of interview, in a quest to find more variety and scope in his work.

## **2 Toward an experienced responsibility for work**

As with the last chapter, solicitors' views on their autonomy is divided into two categories, *personal* autonomy and perceived threats to their *professional* autonomy.

### ***2.1 Personal autonomy***

Not surprisingly, the more junior solicitors (eg assistants) in the sample appeared to have less autonomy and responsibility than those higher up in the firm's structure. As explained in the Method (Chapter 4), assistants are on the lowest 'rung' of the hierarchical career ladder and have usually recently qualified. Associates are the next step up and will be working towards becoming a salaried partner. Depending on the size of firm and their contract of employment, salaried partners, as the name suggests are partners who are paid salaries rather than owning a share of the partnership's profits. Equity partners (also known as senior partners) have a financial stake in the firm, formalised within a partnership agreement, and will be liable for the firm's debts as well as a share of the profits.



The following quotations illustrate the way in which solicitors' personal autonomy is linked to their 'rank' within the organisation. The first two quotes come from the most junior 'ranks', an assistant and an associate, eg

AE (♀ assistant) "Being an assistant, rather than a partner, you're always at someone else's beck and call, and they have a tendency to book a meeting and say 'We want you to come to a meeting' without so much as a by-your-leave..."

SD (♂ associate) "... I have sufficient control. I think you put extra hours in here and there, but if I want to take an afternoon off or leave early, I can just do it now without having to go and ask somebody..."

The growth in confidence and autonomy is very evident in the next two quotes from a salaried and full-equity partner, eg

HD (♂ salaried partner) "...I hate bills, I hate dealing with the administrative accounts and that sort of mundane thing... wherever possible, I end up delegating it! ...at a senior level in this practice, you're given responsibility - you choose when you want to work, I can work at home if I want to... I have complete control..."

BM (♂ partner) "... on the conveyancing side of it... we've had a very, very busy past couple of months... I haven't got much litigation on at the moment, so I've actually been retraining myself to deal with some of the straightforward conveyancing, which has been a challenge..."

### 2.1.1 *Women's progress*

Unfortunately all three assistants in the sample were women, which makes it impossible to assess gender differences at that level. Nevertheless, there was a noticeable difference in the way the two *salaried* partners (from different firms) spoke of their autonomy. For example, compare salaried partner, Mr HD quoted above, with Ms DJ below:

DJ (♀ salaried partner) "...every month you're supposed to fill in a certain figure - you get targets, you know, if you don't meet your targets... you get a little note from whoever - the financial partner... [*telling you what - to pull your finger out?*] Yes... but you see, you can't do this if the clients are there!..."

The reason for the apparent difference might be due to firms' individual policies, ie possibly a gender bias or, perhaps, different ideas on how much autonomy should be



due salaried partners. It is also possible that Mr HD was merely enhancing his image for the researcher.

Interestingly, although all members of the legal sample qualified within two years of one another (ie between 1987 and 1989), all three assistant solicitors were women. After seven years' experience, none of the men were still assistants and two were actually senior partners. Only one of the four women in the sample ranked higher than assistant. Closer inspection of the data revealed that one of the three assistants had just returned to work after a four-year gap (due to starting a family), which may explain her junior position. Nevertheless, the fact that the remaining two were still on the lowest rung of the promotional ladder after seven years, implies that there may be a problem for some women lawyers.

It is also important to note that part-time work in private legal practice is fairly rare. According to the Law Society's Omnibus Survey 2 (1997) only 15 per cent of women are working part-time, compared to 36 per cent of female GPs (General Medical Services Statistics for England and Wales, 1997).

## ***2.2 Perceived threats to professional autonomy***

As with the GP sample, solicitors' perceptions of threats to their professional autonomy were classified according to four very similar categories:

1. Competition from 'outsiders'
2. Consumer-power
3. The commercialisation of legal practice
4. The government's attitude

### ***2.2.1 Competition from 'outsiders'***

Competition between high-street practices has intensified in recent years and, with the property crash of the late '80s/early '90s depriving many law firms of a major source of income, survival has been tough.

Four solicitors spoke of the situation being exacerbated by other, non-professional executives who were now encroaching on their domain, eg

ED (♂ associate) "... if you look at this firm, ...at any time we've got 5,000 road traffic cases on... and although we've got... thirty six what I would call 'lawyers' doing the work, only about eight of those are actually solicitors, the remainder are fee-earners... most... are ex-insurance staff... Those individuals who don't have the training [*ie not qualified solicitors*] are cheaper... and I think that is to the detriment of the rest of us."



HJ (♀ assistant) "... the question of will-making companies taking over, so there is more pressure from that point of view, and probate's being extended so that banks are going to be able to deal with deceased people's estates, so it's all pressure all the time and quite how it's going to evolve, we don't know..."

So, compared to the GP sample, it would seem that solicitors face competition from considerably more 'outsiders', eg accountants, banks, will-making organisations and licensed practitioners (eg conveyancers and personal injury fee earners).

### 2.2.2 *Consumer-power*

As illustrated later in section 3.2 (feedback from clients), half of the legal sample spoke of rising consumer demand in terms of clients wanting more value for money. it would therefore appear that the public are becoming less intimidated, and possibly more strident, in their dealings with doctors and lawyers. Indeed, two solicitors spoke of the way their profession had lost some of its traditional "kudos" with the public:

SD (♂ associate) "... the kudos... it's definitely been worn down, I think, over the years. I mean no one is sort of frightened by... a solicitor - nervous in his company, thinks... that's an amazing thing..."

BM (♂ partner) "... people... have become far more consumer-conscious, far less willing to just genuflect at somebody's who's got a professional qualification..."

### 2.2.3 *The commercialisation of legal practice*

All but two of the sample described the increasing pressure to advertise their services to the public. As the solicitor below explained, this is not only costly but can sometimes detract from the job itself:

HD (♂ salaried partner) "... it's [*marketing*] actually... become a little bit ridiculous because it's got to the point where you are expected to do things which mean that you... spend less time doing the work which would enable you to deliver the real service... effectively... I don't think it really helps the clients. There's a merry-go-round... solicitors just get on and market, and spend money doing it."

In high street firms, where competition can be fierce, solicitors need to compete against one another in order to survive, commercially. Four of the legal sample spoke of how the commercialisation of legal practice had changed the fundamental nature of



the profession, and not all comments were negative, eg

HA (♂ associate) [*Do you feel you've been de-professionalised then?*]  
 "De-professionalised? Yeah, I think because of the business aspect and the competition..."

KA (♂ partner) "... the overriding difference between law now and what it was when I was just starting out, is consumer power..."

BM (♂ partner) "...I think the whole change from a profession to a business has been healthy... the lawyer is now... just... a supplier of services... It's far more transparent and open..."

#### 2.2.4 *The government's attitude*

Only one solicitor criticised the government, and this related to cut backs in legal aid:

HA (♂ associate) "... expectations is one of the problems, certainly with the legal aid schemes, because if costs are being cut back - and fixed fees - is the Lord Chancellor, the government, the powers that be, - expecting us to provide a Rolls Royce service for the cost of a Mini?"

Except for this one case, solicitors did not 'connect' with the government in the same way as the GP sample, despite having equal cause for complaint. For example, since the Courts and Legal Services Act of 1990, lawyers have been forced to share their litigation rights with accountants, surveyors and licensed practitioners. The future of legal aid is also under intense debate. Yet the surprising lack of animosity toward government would suggest that solicitors do not have a psychological contract with the State. The impression that the sample gave was one of grim acceptance; very much a 'heads down' approach when compared to the overt indignation of the GP sample.

### 3 **Toward knowledge of the results of work**

Eight out of the ten solicitors spoke of elements of feedback in their daily work. The remaining two made no reference to it during interviews. Comments were categorised according to two main areas:

1. Intrinsic feedback as a part of the job, eg successful completion of tasks,
2. Direct feedback from clients.



### 3.1 *Intrinsic feedback from the job*

Feedback is fairly straightforward for solicitors, insofar that they will always know whether or not they have won their client's case. Indeed, three solicitors spoke of the satisfaction of winning, eg

HD (♂ salaried partner) "... I have days when I come out and I think to myself... I've done a really good job for a client, and I come out and you know - job satisfaction - 100 per cent!..."

HJ (♀ assistant) "... the highs are... when you really can develop a rapport with the client... and, if all goes well, they pay your bill at the end of the day, without complaining!..."

### 3.2 *Feedback from clients*

Half of the sample spoke of rising consumer-demand in terms of clients wanting more value for their money, whilst a further three talked about clients chasing them up on the telephone, eg

HA (♂ associate) "... all the while, with litigation, the pressure is to drive down the fees... it's a challenging time... everyone else is facing the same problem, so it's a question of getting out in the market place... in a much more business way than had been done before."

KA (♂ partner) "I mean you find now, with increased market pressures forcing you to work more for less, ... well if that's all the client is prepared to pay, then he can jolly well expect to have less for his money... they can't have it both ways!"

HA (♂ associate) "... barristers... don't have any problems with clients ringing them up. Clients are not for ever on the 'phone saying 'Why haven't I heard from you over this?' 'Why haven't you done this?' ...

Only one solicitor mentioned the 'high' of having a client express their gratitude, compared with five of the GP sample. She too implied that this was not a common experience:

DJ (♀ salaried partner) "... the highs, I suppose, are when you've done a good job for a client and they write back to you and say 'Thank you very much', so those go on the wall or get passed around..."



Referring to a less direct form of feedback, one solicitor spoke of how lawyers' reputations can be made by serving their clients well:

HD (♂ salaried partner) "... if clients will say to each other 'That guy knows what he's doing and he really wants to do it for me...' then that's good enough for me and, if I have a reputation amongst clients like that, then I don't care what the outside world thinks."

So solicitors certainly receive feedback on their work, whether it be news on the outcome of a case, or telephone conversations with clients bartering on price or chasing up delays. There were echoes of patient-consumerism from Chapter 5 in some of the above quotations, which lends support to Mr BM's observation that people have become far more consumer-conscious and less willing to "genuflect" at professional qualifications (section 2.2.2).

#### 4 The Critical Psychological States: Summary

With the exception of one personal injury specialist who was clearly bored, the sample demonstrated good skill variety, task identity and significance when talking about their work. Solicitors' autonomy was particularly interesting; whilst solicitors have lost much of their *professional* autonomy with the removal of many (formerly) restricted practices, their *personal* autonomy remains strong. High street practices are highly autonomous units where survival depends on identifying, and responding to, local demand within an increasingly competitive market. Moreover individual levels of autonomy are commensurate with rank within an organisational hierarchy, with assistant solicitors having the least autonomy and senior partners the most. There was evidence, however, that women's career progress may be slower than men's. With regard to the government's role as instigators of change, there was nothing to suggest that solicitors have a psychological contract with the State. Finally, solicitors' knowledge of work outcomes was considered. Although only three of the sample spoke of the satisfaction of winning a case and, indeed, half of the sample mentioned the problem of rising consumerism among clients, there can be little doubt that solicitors do have feedback on the outcomes of their work. Monitoring the status of ongoing cases is, after all, a major part of their work.

So solicitors appeared to have knowledge of the outcomes of work perceived as meaningful, and for which they felt directly responsible. Once again, the inclusion of moderator effects provided the opportunity for deeper probing which looks beyond the basic design of a given job.



## 5 Moderator effects

### 5.1 Problem areas

Analysis of moderator effects revealed the main problems to be centred round knowledge and skills, job security and supervisory practice. However, there was an additional problem which is not addressed by the JCM; volume of work, and this is briefly discussed at the end of the present section.

There was also evidence of some disappointments over *pay*. Whilst four were satisfied (or pay was not an issue for them), three solicitors clearly had unmet expectations, eg

DJ (♀ salaried partner) "...I mean that's why I chose law, I suppose. I had hoped that it would pay better, but it doesn't really pay that well at all. I mean my brother is a management consultant and he gets phenomenally more money than I do..."

HJ (♀ assistant) "I thought I would... be able to lead a comfortable life, that my salary would be sufficient... I don't think either I, or many of my colleagues, are earning the sort of figures we thought we would..."

Moreover just as hospital doctors were not a referent group for GPs, so none of the solicitors compared their pay with that of barristers. Indeed, there were signs that the Bar may be held in higher esteem, intellectually, than solicitors' work. Like Dr WA, in the last chapter, who spoke of not being "*clever enough*" for hospital medicine, one of the salaried partners spoke of not being 'bright enough' for the Bar:

HD (♂ salaried partner) "Why not the bar? I don't have such a high opinion of myself. I don't think I'm competent to be a barrister. You have to be very bright... and I'm not that bright... I've seen them in operation in the field where I operate... you see them and you are gobsmacked...."

Most of the sample believed their *job security* to be generally poor, with three solicitors recounting previous experiences of redundancy. It appeared that tenure can often depend on the number of cases acquired, and yet no training is provided in the marketing and public relations *knowledge and skills* necessary to achieve these goals. However, despite the sample's awareness of the growing emphasis on marketing and public relations in law firms today, some seemed to miss the point when discussing future career strategies. For example, three solicitors who opined they could improve their chances of promotion with further training, fastened on the idea of a higher law degree despite the apparent lack of supporting evidence. As one of the salaried partners pointed out, firms were looking for "*somebody who can actually bring something value-added, who's got a science degree or a French degree... some additional skills to add a dynamic which is not really there in the staid - whatever -*



*straightforward law.*" (Mr HD). In other words, firms were looking for much broader-based skills than the traditional law degree, so taking further academic qualifications seemed unlikely to confer any promotional advantage. Nevertheless, it was interesting to note that two of the sample were aware of the value of their knowledge and skills within the wider job market, eg

AE (♀ assistant) "I may try and move... more towards... company secretariat work... in a private company... which would be using quite a lot of the same skills, but outside the legal profession."

In terms of the *personal attributes* listed by the sample, only four solicitors mentioned the need for interpersonal skills such as an ability "*to get on well with people*" and "*good communication skills*", eg

**A good lawyer should:**

"...*like working in an office...*" (Mr ED), "...*be supremely confident...*" (Ms AE), "...*flexible...*" (Ms HJ), "...*like what they're doing and be committed...*" (Mr HD), "...*be organised and thorough...*" (Mr BM and Mr SD), "...*get on well with people...*" (Mr SD and Ms DJ), "...*possess intellectual/academic ability...*" (Mr BM and Mr KA) and "...*good communication skills...*" (Mr BM and Ms DJ).

In contrast to GPs' list of qualities which were more people-orientated, eg "*endless patience*", "*able to listen*" and "*empathesise*", solicitors' descriptions could apply to any number of office-based managerial jobs.

Comments relating to *supervisory practices* focused on the methods employed by some firms to maximise their profits (eg billing targets), and/or to minimise labour costs by employing non-qualified legal staff. Three solicitors spoke disparagingly of billing targets, and the significance of these is explained by the two women quoted below:

HJ (♀ assistant) "...there's so much... emphasis on justifying how your days are spent, your time-recording is vital. There's a minimum amount of chargeable hours which you must record every day and it's just pressure from all angles... it's long hours and it's just fees and time-sheets really."

DJ (♀ salaried partner) "...job security's been eroded... if you don't make a target, that means... perhaps you're surplus to requirements..."

There were also complaints about the lack of flexibility regarding work schedules, with three of the four women expressing frustration.



Whilst there was nothing to suggest that solicitors have a psychological contract with the State, junior solicitors appeared to have a transactional-style contract with their employers, ie senior partners. Certainly, there was little evidence of good will or trust on the part of employing partners or their staff. Women appear to be particularly disadvantaged by the 'new' style of psychological contract. For example, in the harsh competitive world of high-street practice, there may be little room for niceties like concessionary hours for female employees. It is argued that most firms will be interested in optimising their availability to the client, especially in the aftermath of the hard-hitting property recession. As company and commercial law specialist (Ms AE) explained, in some specialisms solicitors can be "*working on a deal for ten million pounds*". At such times, it is not unusual to begin a meeting "*...at eleven o'clock in the morning and, if the clients are keen to complete the deal that day, you might be there 'till five o'clock the next morning...*". In these circumstances, it is easy to see how concerns about getting home to the children might be misinterpreted, ie as a lack of commitment to both the organisation and one's career.

Such an attitude lends further support to the assertion that the old relational psychological contract is dead (eg Hiltrop, 1996; Herriot and Pemberton, 1995). In these times of financial uncertainty, legal firms must protect their own immediate interests. Hence the prevailing attitude towards employees' gripes about hours, is likely to be somewhere along the lines of: 'if you have problems at home - resolve them or go.' So whilst employees might not willingly offer the 'extra mile' it appears that organisations expect it of them anyway, as part of the job.

### 5.1.1 *Volume of work*

Like one of the GP sample, there was also one case of work overload among solicitors. In the last chapter, Dr SD spoke of being "*too stressed, I'm doing too much.*" Although he enjoyed all aspects of his work and was more positive about it than most of the sample, his problem related to work volume. A female specialist in wills and probate spoke in a similar vein:

HJ (♀ assistant) "Since I've been here, I have never, ever caught up with my workload... [it] has been excessive for six years. I work long hours, by the time I get home I'm completely exhausted... it could be fine... liking the place, liking the people, liking essentially the content of the work - if the volume could be pitched right, you know?"

The fact that Ms HJ feels that she is fighting a losing battle, in terms of workload, implies that she is denied the intrinsic feedback that comes with the satisfaction of task completion. In Chapter 5 it was argued that, in the long-term, sustained overwork will have a detrimental effect on motivation. It was also stated in the General Introduction that job satisfaction is associated with reduced absenteeism and turnover. Therefore it seems reasonable to suggest that work overload may have adverse effects on absenteeism (eg through stress-related illness) or even turnover. Indeed, the researcher made the following field note on completion of the interview. "*I feel that this woman is heading for a crisis [a breakdown?].... she knows what she ought to be*



*doing to shorten her day - more self-discipline and better time-management, but I feel she is demotivated by the sheer volume of work."*

## 5.2 Positive effects

Eight solicitors spontaneously raised issues relating to **growth-needs** (ie they were not specifically asked), and for most there was ample evidence of this being met by work. For some it was the challenge of running their own business, whilst for others it was realising their personal potential or achieving professional status, respectively. The three exceptions included one male associate whose growth-needs were hobby, rather than work, centred and two female assistants who had young children, eg

AE (♀ assistant) "I could happily retire tomorrow! ... I've been amazed... I had a baby in March and... took some maternity leave... and I wasn't a bit bored... I didn't miss work - not one little bit... I always thought... I'd crawl the walls if I was at home all the time."

For the latter, the story may be more complex. As revealed in the previous chapter, one of the female GPs appeared to have experienced a shift in work-related values, following the birth of her baby daughter. Therefore it is argued that some women may experience a temporary 'glitch' in a previously high work-centrality, when they first become mothers. However, there is no reason why this effect should not level out over time, as children become less dependent. There is evidence, for example, that women GPs have a tendency to seek part-time contracts in the first instance, moving on to full time work later in their careers (BMA, 1996b).

Of the five solicitors who raised the topic, all appeared to value and enjoy **co-worker relationships**. There was evidence that two of the more senior solicitors (eg a senior partner and a salaried partner) shared a relational-style psychological contract with their respective colleagues, eg

BM (♂ partner) "... every person here has the same ideology which helps a great deal... we're all in it together."

However, for the remaining three relationships were of a more social nature, eg

MG (♀ assistant) "...I was off work for four years... and I became - not so much bored - but lonely... [*and talking about why she took her part-time job*] ...just to get out and meet other adults... I enjoy... talking about claims... talking about the law..."



SD (♂ associate) "...it's sort of a happy environment here - friendly people. I think they've made a point here of taking on people who get on well with other people... it's quite a friendly atmosphere... they're a... nice bunch..."

## 6 Conclusions

Judging from the sample base, a solicitor's job is potentially enriched and motivating. They perceive their work as meaningful and they are increasingly responsible - not only for work outcomes - but for generating new business too. Moreover, because of the nature of their work, they will have knowledge of the results of their efforts, ie winning or losing their case. Solicitors' personal autonomy increases with status (rather than tenure), with assistant solicitors having the least and senior partners the most. However, there were signs that progress for women may be slower than for their male counterparts.

In terms of moderator effects, apart from some disappointments over pay, the main problems related to knowledge and skills, job security and supervisory practices. Based on solicitors' perceptions of their success (and possibly their job) depending on attracting new business to the firm, there were firm grounds for including marketing skills in their training. With regard to supervisory practices, although solicitors may work long hours there seemed to be little flexibility offered in return. Opportunities for part-time work are rare which, together with rigid work schedules, means women may be particularly disadvantaged. Finally, it appeared that 'junior' solicitors (ie non-partners) and their employers have a transactional psychological contract where long hours and flexible skills are offered in return for good pay and a job (eg Herriot and Pemberton, 1995).

As noted in Chapter 5 there would seem to be a case for including 'volume of work' as an additional moderator in the JCM, because of its likely (adverse) effects on absenteeism and turnover. The findings of the present chapter served to strengthen this argument.

The following chapter will examine the work of hospital doctors in relation to the model.



# Chapter 7

## Results and Discussion: Hospital Consultants

Interviews with the ten hospital consultants took place in their NHS consulting rooms with the exception of one, who was interviewed in his private rooms. The seating arrangement was always formal, ie interviewee and researcher separated by a desk. In terms of overall impressions, the sample can be summarised with three P's: poised, patient and pragmatic. Articulating carefully considered opinions, their composure never wavered, even when the conversation turned to issues which clearly incensed them.

Hospital medicine appeared to be highly motivating and challenging, even after eleven years (mean post-registration experience) in the profession. Problems tended to be restricted to worries about junior doctors' training (impacting co-worker relationships), and context satisfactions such as pay and, surprisingly, job security.

Table 16      *Overview of hospital doctors' work within the JCM*

| Critical Psychological States |   | Moderator Effects           |                  |
|-------------------------------|---|-----------------------------|------------------|
| Meaningful work               | ✓ | Adequate knowledge & skills | Selves✓ Juniors✕ |
| Experienced responsibility    | ✓ | Work-met growth-needs       | ✓                |
| Knowledge of results          | ✓ | Context satisfactions:      |                  |
|                               |   | pay                         | ✕                |
|                               |   | job security                | ?                |
|                               |   | co-worker relationships     | ?                |
|                               |   | supervisory practices       | N/A              |

? = some problems  
N/A = not applicable

### Analysis of data

#### The Critical Psychological States

### 1      Toward an experienced meaningfulness of work

It was clear that all of the sample enjoyed considerable skill variety, eg

CJ (♀ breast surgeon): "...the clinical work is a mixture of outpatient work, operating, in-patient work and teaching... I teach undergraduates on the trauma service... and I also teach communication skills which is something I feel is particularly important..."



FN (♂ radiologist): "...it's a sort of varied programme through the week with lots of imaging modalities... it's very, very variable... the people that you... work with tend to stay the same, but the kit changes get better all the time..."

and task identity, eg

HD (♂ general surgeon): "...you don't know what's wrong with someone - you do an operation - you know what's wrong with him and that's it - over... I mean in medicine, you're never really quite sure what's wrong, you fiddle, and you're not quite sure..."

WC (♀ community paediatrician): "...sometimes we're asked to see... a diabetic child who's causing problems and everybody wonders if it's his diabetes... and practically always it isn't... and then all the children who are... statemented... have to have a medical opinion for the first statement and for every annual review..."

There was, however, one classic example of lack of task identity which also overlaps knowledge of results. Dr FN, radiologist, explained how he only ever sees one part of the patient's story:

FN (♂ radiologist): "...one of the frustrating things about it, you sometimes get left half-way through a process and you never find out exactly what happens in the end. It's like the opening chapters of the story - you don't get to read the last page... that's just intrinsic to the job really, there's not much you can do about it..."

In more general terms, four doctors complained of time pressures which sometimes constrained the manner in which they carried out their work, eg

DJ (♂ colorectal surgeon): "...the hard thing... is not actually the cash restraints, it's actually trying to see patients... in the time available and give them the time that I want... you can't sit down like this and talk - you haven't got time..."

MA (♂ pathologist): "...there's a lot of pressure just to bang the reports out. A quick diagnosis - bang, bang, bang. Of course, there's an increasing risk of missing things or misdiagnosis."



So it was beginning to look as if work-overload might also be a problem for hospital doctors, in addition to GPs and solicitors. The de-motivating aspects of this sort of pressure are also apparent, particularly in the pathologist's account above.

No one had a problem with task significance, and surgeons were particularly adept at describing this aspect of their work, eg

HL (♀ vascular surgeon): "...the other thing that's wonderful in my job... is taking somebody with an ischaemic leg - a cold, white, painful leg, and re-vascularising them and having a warm, pink foot at the end of the procedure."

DJ (♂ colorectal surgeon): "...the main focus of the week... is... operating... the bit you enjoy, it's the bit no one else can do. I mean I enjoy all of it, but you know... there's this adrenaline rush that you get when the patient's about to bleed to death and you manage to put your finger over the hole... it's good!..."

MA (♂ pathologist) [*talking about the high points of his work*]: "...the diverse contact with most branches of medicine, seeing a wide spectrum of disease passing underneath your microscope... being the person who really communicates the diagnosis that matters to the clinicians..."

### 1.1 *Toward an experienced meaningfulness of work: Summary*

There can be little doubt that hospital consultants experienced their work as both meaningful and worthwhile. Nevertheless, time constraints were clearly a source of irritation for many. Indeed, in the case of Dr MA (the pathologist), there were echoes of the personal injury solicitor from the last chapter with another illustration of professional "stuckness", ie where repetitious work denies individuals a sense of personal growth and development. There were no echoes, however, from the GPs' in Chapter 5 insofar that none of the consultants complained of either rising demand, or patients complaining of trivial complaints. This will be partly due to the 'filtering' aspects of GPs' work, whereby only those deemed genuinely ill are referred on to a hospital specialist. Hence hospital doctors' task significance is, in a way, enhanced by the efficiency of GPs.

## 2 **Toward experienced responsibility for work**

Within an ever-changing NHS, it was clear that hospital consultants still wield considerable power. Indeed, they can lay claim to four of French and Raven's (1959) five bases of power, as detailed below:

1. **Reward power:** the capacity to bestow favours on a chosen few. The system of 'patronage' works by a consultant providing advice and



'backing' (good oral as well as written references) to assist their protegees' careers, eg *"They give people jobs. They get people jobs. They teach them more when they're actually in a job... they introduce them socially to people who could help them..."* (a psychiatric registrar quoted by Allen, 1994, p121)

2. **Expert power:** the influence that accrues from specialist knowledge and skills. As argued in Chapter 3, it is the monopoly of expert knowledge that distinguishes the professions from other occupations
3. **Legitimate power:** the formal rights bestowed on those who hold a high ranking position within the organisation, eg separate dining facilities, consulting rooms, personal secretary, carpark reservation, *etcetera*
4. **Referent power:** derives from others' admiration for that person who may become something of a role model, eg Question: "Are you aware of being one [role model] now, yourself?" *"I don't know... I think it's quite possible yes, yes. Quite a few of the female students are thinking of surgery, at least."* (Ms HL, vascular surgeon).

Judging from the sample base, consultants bear ultimate responsibility for patient-care, eg

DJ (♂ colorectal surgeon): "...in terms of conditions, well - its just my life. I mean I accept that this is what I want to do, I regard myself to be on-call twenty-four hours a day for my patients, and that's it..."

MA (♂ pathologist): "...in theory... we're supposed to provide a... 365 days a year, twenty-four hour service but, in practice, we don't get called out-of-hours very often..."

WC (♀ community paediatrician): "...I do do some work at home, but it's when I choose to... and I do sometimes accept calls on my day off, at home, but its... my choice..."

in addition to responsibility for staff management, eg

WC (♀ community paediatrician): "...some of the staff management problems... there's been a lot of undercurrents brewing for a long time, that haven't been addressed, so people - I assume - think I'm going to change things and they thought 'she'll do it my way' and I've thought 'I don't know about this!'..."



and junior doctors' training, eg

HS (♀ clinical geneticist): "...I'm organising our training scheme in time I don't really have..."

This extensive range of responsibility appears to confer ultimate control and status, eg

SU (♂ enterologist): "...once you get to be a consultant, you are in control... there's nobody on my back telling me that I've got to do it [*gesturing to a pile of papers*]. There's nobody who can tell me off really and, if I've done something wrong, people will go to great lengths to be tactful about it!"

GP (♂ haematologist): "...what I like about it is the complete independence... I have nobody interfering in my ...life... we're just left to get on with things... we're big fish in a small pond and I like that... this is actually the largest haemophilia centre in the UK, so... we're looked up to..."

Doctors' twenty-four hour responsibility for their patients often means the boundaries between work and non-work are blurred, and yet there were no signs of resentment. The sample's pragmatism is demonstrated by the flamboyant Mr DJ:

DJ (♂ colorectal surgeon): "...supposing I'm at home, having my kid's birthday party, and somebody says... 'Jo Bloggins you operated on has fallen to bits, what shall we do?' You've got an option: you either say '...I'm dealing with little Timmy's birthday party, carry on - if he dies - tough shit' or 'I'll come and fix it' ...you have to make a judgement..."

However, the above quote reveals a fundamental *control* over events, ie a choice. This appears to be quite different from the relentless grind of work-overload, as described by the same Mr DJ when talking about his out-patient clinics, and Dr MA (pathologist) earlier in section 1.

## 2.5 *Toward experienced responsibility for work: Summary*

Consultants' immense responsibility is matched by the almost total control they enjoy in the day-to-day management of their work. The power of these senior doctors was illustrated using French and Raven's five power bases, whereby consultants appeared to lack only one of the bases; coercive power, ie achieving dominance through fear. However, with reference to her experience of working in a London teaching hospital,



the researcher can testify to instances where consultants have struck fear in the hearts of patients, nursing staff and junior doctors alike at various times.

Consultants' responsibility for the training of junior doctors will be briefly revisited in the analysis and discussion of moderator effects.

### 3 Toward knowledge of the results of work

Most of the sample experienced feedback in their work. There were two exceptions; the radiologist and pathologist and they will be discussed at the end of the section.

Surgeons relished the immediacy of feedback in their work, even though things can go wrong, eg

DJ (♂ colorectal surgeon): "...surgeons tend to be more Type A... more into immediacy... immediate satisfaction."

HL (♀ vascular surgeon): "...when I'm in theatre, in the middle of the night, working on one of those legs and just nothing will go right... you just think, 'I want to stop playing now, I want to go home...' and you just can't... see a way out of it... that's really miserable."

HD (♂ general surgeon): "...you always get a very quick return... if all goes smoothly, that is rewarding..."

On the other hand, physicians spoke of both the intrinsic and extrinsic aspects of feedback of their work. For example, the intrinsic related to successful outcomes of treatment (referred to by the enterologist and the haematologist), and the extrinsic related to communicating with patients about their concerns (eg the geneticist and paediatrician), eg

SU (♂ enterologist): "...sometimes I walk out of there, and I feel absolutely shattered... but... sometimes I walk out of there, and I feel really, really high because I've restored somebody's swallowing and eating is so terribly important..."

WC (♀ community paediatrician): "...you don't enjoy telling somebody that their child has got autism, but... actually listening to their concerns and coming out of a feedback over something fairly traumatic and... feeling that I've done it reasonably well, I enjoy..."

The two exceptions were Dr FN the radiologist, and Dr MA the pathologist. As explained in task identity (section 1), the radiologist felt that he saw patients only very briefly and was therefore denied knowledge of patient-outcomes. In fact he later



described his job as "*more a sort of channel-hopping on the TV than watching the fifteen hours of Wagner Ring Cycle on video.*" The pathologist spoke again about the pressures of his workload and the consequences of making a mistake, adding emphasis to his earlier comments in section 1:

MA (♂ pathologist): "...when the work piles up, the stress goes up and you're more likely to feel... increasing worries about the sort of diagnosis that you're making..."

### **3.3 *Toward knowledge of the results of work: Summary***

Apart from the two doctors quoted directly above, the sample appeared to experience good levels of feedback from their work. Surgeons, in particular, enjoyed the quick returns intrinsic to their job. There was a problem relating to work over-load and this will be discussed, more fully, in section 5 below (moderator effects).

## **4 The Critical Psychological States: Summary**

So, notwithstanding some complaints about time constraints (ie task identity), and two relating to feedback, hospital consultants appeared to experience enriched and challenging work. All three Critical Psychological States are potentially 'activated': the sample felt that they were carrying out meaningful and important work, in which they had immense responsibility and knowledge of outcomes.

So far, so good. The moderator effects were then examined to establish how they interact with the basic job design.

## **5 Moderator effects**

### **5.1 *Problem areas***

As stated at the beginning of the chapter, analysis of moderator effects showed problems were restricted to concerns about the junior doctors' new training programme and context satisfactions. The latter included issues relating to pay and job security. However, once again the issue of 'volume of work' raised its head, and this will be addressed at the end of the present section.

Consultants are responsible for training the next generation of specialists (ie *knowledge and skills*). The new Calman training programme has formalised this responsibility, which two doctors were unhappy about because of its impact on their



workload; eg

CJ (♀ breast surgeon): "...training has to take very much precedent over what we call, the service commitment. ...that's going to have a tremendous knock-on effect on us - it already is, because... the onus of the service work goes onto the consultant..."

Four doctors thought the new Calman training programme was a good thing, eg

HL (♀ vascular surgeon): "I think it's a good thing to have clarified and stipulated training... to put it down in writing..."

CJ (♀ breast surgeon): "...I think Calman will have a particular benefit to women, because one of the great disincentives to women going into surgery, was the length of training..."

However, all four surgeons expressed concerns about the combined effects of the new shortened training and the reduction in junior doctors hours (ie The New Deal, NHS Management Executive, 1991), eg

DJ (♂ colorectal surgeon): "...Calmanisation... it's a massive retrograde step... the new guys are going to have about five years' experience... so... they're not going to be capable of doing what I was trained to do... you can't read it in a book! ...you've got to just do it..."

CJ (♀ breast surgeon): "...with the dramatic reduction in hours in combination with the reduction in years, there's no doubt... that the finished product is going to be different... it's all very well people saying... there won't be a two-tier of consultants - there will be..."

In other words consultants or, more specifically, *surgical* consultants feared that the lack of experience in newly appointed specialists would lead to a two-tier system. This, in turn, would result in the new 'junior' consultants calling on their more experienced colleagues for assistance. Hence the sample's worries about future consultants' knowledge and skills spilled over into concerns about *co-worker relationships*. There was little doubt that the present sample of consultants had undergone a rigorous, if prolonged, training which had prepared them very well for the challenges ahead. Nevertheless, the present section would be incomplete without acknowledging the very real sacrifices which some of the women made, particularly



surgeons, in order to succeed in their specialty. This is summarised by Ms CJ and Ms HL quoted below:

CJ (♀ breast surgeon): "...I think when I embarked on my career, I never... envisaged having a family... and... I then realised that the years were going by and it was something that I might not be able to put off indefinitely, so I had my first child... eighteen months after I'd been appointed... a consultant..."

HL (♀ vascular surgeon): "...during my training I had no commitments and I enjoyed it so much, that it would have had to be a very strong commitment to make me think... I'm going to give this up or modify this in any way, in order to get married..."

*[and later, talking about her recent marriage]:*  
having lived on my own for twenty years... I think... I've missed out a bit..."

Hospital doctors were also asked to comment on the sort of personal attributes necessary to succeed, and these will be covered later in section 5.2.

With regard to *pay*, five of the sample spontaneously raised the issue during interviews and all were men; none of the women mentioned money. Of the five, only one was satisfied with his pay:

SU (♂ enterologist) [*Do you have a private list?*]: "That's another joy. I mean I never expected to make so much money! I didn't realise that gastro-enterology was a gold-mine. For endoscopies, you get paid enormous amounts of money. Enormous amounts!..."

Dissatisfactions included:

1. fears that pay levels were on a downward spiral and therefore destined to become eroded over time (radiologist),
2. a belief that they could earn more in the private sector (surgeon),
3. a belief that they could earn more in another profession such as law (haematologist),
4. a belief that they could earn more abroad (pathologist).

There was also overt resentment, expressed by a physician (haematologist), towards surgeons' greater earning potential through private patients:



GP (♂ haematologist): "I... think money motivates quite a few people and... in particular, the surgeons... I couldn't get a lot of private work in this field, even if I wanted to..."

Hence referent groups for pay comparisons included both 'others-outside' the profession (eg the legal profession) and 'others-inside' (eg colleagues in the private sector or abroad). With the new Calman training programme, combined with the reduction in junior doctors' hours, there is little doubt that hospital specialists' workload will increase. Unless consultants feel that they are being adequately compensated for these additional responsibilities, there is a real danger that their overall level of motivation and satisfaction may suffer as a result (Hackman and Oldham, 1980).

In terms of *job security* six doctors thought that their future was indeed secure, whilst a further four were not so sure. Reasons for the latter included overlaps, as some doctors were concerned about more than one issue regarding their security. Briefly, fears for the future included having one's skills outstripped by changing technology (2 doctors), organisational change resulting in short-term contracts for consultants (2 doctors) and, finally, litigation concerns (4 doctors). Litigation concerns were not merely hypothetical, one of the physicians described an ongoing case in which he was currently involved. However, the growing awareness of litigation risk is best described by a surgeon, eg

CJ (♀ breast surgeon): "...that's a huge aspect of the job that is unattractive... breast disease is now the second biggest litigation field... whenever I get a letter from a GP that says 'You saw this lady last year and said she was fine, and now I think she's got another problem' ...you think, oh *please* may... I not have missed a cancer!... one of my juniors is being sued at the moment and it's very stressful..."

Consultants' responses to the question of job security came as a big surprise. Listening to the sample, it would appear that the changes which rocked the wider job market almost twenty years ago, are at last creeping into the upper echelons of the medical profession.

### 5.1.1 *Volume of work*

Once again there was evidence that work-overload may be detrimental to work motivation and satisfaction (eg Dr MA, the pathologist, and surgeons worrying about the impact of less-experienced colleagues). It is also possible that increasing consultants' existing workload may serve to highlight any underlying dissatisfaction with pay.



## 5.2 Positive effects

As with GPs and solicitors, consultants were asked to name those *personal attributes* which they felt were necessary to succeed in their work. Overall, the picture was as follows:

### *Hospital doctors should be:*

- **determined** (HL, surgeon: "...people say I'm the most determined person they know..." and HS, geneticist: "...you've got to be very determined...")
- **academically able** (GP, haematologist: "...up to, and including senior registrar, the emphasis is always on academic work.")
- **conscientious** (MA, pathologist: "...conscientiousness, attention to detail...")
- **able to talk to people** (CJ, surgeon: "...I teach communication skills which... I feel is particularly important - that doctors... learn how to actually talk to people properly... how to break bad news...")
- **able to listen** (HL, surgeon: "...I'm... happy to... sit back and just listen to the patient...". SU, enterologist: "...if you encourage them to talk... at the end of that, they feel somebody's actually listened to them, maybe for the first time...")
- **with an ability to communicate with colleagues** (MA, pathologist: "...ability to communicate with colleagues...", FN, radiologist: "...able to get on with colleagues..." and GP, haematologist: "...at consultant status... people have to fit in - personality becomes very important...").

### *Surgeons, in particular, felt that they needed to be:*

- **self-disciplined and exacting** (DJ: "...you can't survive in surgery without being self-disciplined and extremely exacting - or at least your patients cannot survive!...")
- **adept at decision-making** (DJ: "...surgery is renowned for being confrontational... about decision-making...")
- **and obsessional** (HD: "...surgeons have to be obsessional... if you're... laissez faire, you'll be in hell..." HL: "...obsession... in the management of patients and in the operation itself...").

Once again, there was little support for the BMA's "core values", as reported in section 5.1 in Chapter 5. Although, perhaps, being '*academically able*', '*conscientious*' and '*obsessional*' might equate to the BMA's core values of '*competence*' and '*commitment and responsibility*'. Certainly there is no equivalent, in the sample, to the qualities of '*compassion*', '*integrity*' '*caring*', '*confidentiality*', '*patient's advocate*', or '*spirit of enquiry*' reported by the BMA's cohort study. However, it is possible that doctors simply considered many of these qualities too obvious to mention.



There appeared to be tentative support for situationalism (eg Mischel, 1968); two of the surgeons described how the job had affected their personality:

DJ (♂ colorectal surgeon): "...it's surprised me that my character has been shaped as much as it has by my specialty... I would have thought that I would bring my personality and character to the job and shape the job to suit that, but actually, it doesn't work like that..."

HL (♀ vascular surgeon) [*Do you think you're a sort of Type A?*]: "To a certain extent, yes. I mean I can be quite laid-back about things, I think I sort of 'switch on' in surgery - I become that sort of personality..."

The list of attributes provided few clues to the nature of the sample's work and could equally belong to the business world. Take, for example, Bennis' "Competencies of Leadership" (Bennis, 1984):

- **a compelling vision or sense of purpose** (HL: "...*the other thing that's wonderful in my job... is taking somebody with an ischaemic leg - a cold, white, painful leg and re-vascularising them and having a warm, pink foot at the end of the procedure...*")
- **ability to communicate this vision to others** (DJ: "...*an anaesthetist will say '...he's too sick - if I give him an anaesthetic - he'll die' and you say 'well if I don't operate... he'll die... so damn well put the patient to sleep and... let's just get on with it!'*...")
- **consistency and focus in pursuing their vision** (CJ: "...*I was a junior doctor for thirteen years, and... was actually appointed relatively young... at thirty six...*" DJ: "...*it's just my life... this is what I want to do...*")
- **a knowledge of own strengths and how to capitalise on them** (DJ: "...*I think I am... well suited to what I do and basically.. I'm mechanically... orientated.*" HD: "...*It goes with being obsessional... I like to have everything absolutely... right. I'm a perfectionist.*").

The four main competencies, listed above, were derived from studying ninety of America's most successful leaders. The sample's quotations (within parenthesis) were all from surgeons. Despite searching through all ten transcripts for the most fitting quotations, it was surgeons who best illustrated each point. So, it would appear that surgeons, in particular, demonstrated qualities of leadership.

In the case of work-met **growth-needs**, like the two previous samples, hospital consultants were not asked direct questions in this regard. Hence the following summary derives from general comments made by doctors during interviews. Doctors were, however, asked the 'lottery win' question (eg '*if you won the lottery, would you stay?*') and their answers are included in the quotations selected below. As previously stated under 'autonomy' (section 2), consultants maintain twenty-four hour responsibility for the patients in their care. It is therefore argued that work will have a



high centrality in their lives, regardless of their personal value system. It is also unlikely that individuals who have spent a number of years working in excess of 100 hours a week, would have remained in their careers *without* a high work centrality. Seven of the doctors clearly found their work challenging and enjoyable: it must be said that when some people spoke about their actual work, their whole countenance changed and they 'came alive'. So it was for the exuberant surgeon and the quietly-spoken physician, quoted below:

DJ (♂ colorectal surgeon): "...operating is an obvious highpoint because it's just good fun- it's a party! It's like driving a sports car - operating... it's just fantastic... there are unlimited challenges and that's what you live for..."

*Lottery win:* considered unlikely to be sufficient to make a difference.

SU (♂ enterologist): "...I do have hobbies - I play the clarinet sometimes... and I play with computers in the same way that men used to play with cars, but there's no doubt where the centre of my being is, and that's with the job... I love it!..."

*Lottery win:* would stay.

It would be hard to find two more perfect examples of high-work centrality and work-met growth-needs. Nevertheless, three consultants were less enamoured with their work for a variety of reasons. For example the pathologist claimed to prefer a more academically-orientated environment (*lottery win:* would stay under different circumstances), whilst the haematologist believed his hobbies to be just as important as his work (*lottery win:* would leave if a big enough win). However, the third doctor provided further evidence of work-related growth-needs changing with the advent of motherhood. Dr WC, quoted below, worked part-time and had three very young children:

WC (♀ community paediatrician): "...I started looking for more paediatric jobs, with the idea of going back into general practice with a special interest in paediatrics... I did a year in Chester... and that was a brilliant job and I just... fell in love with it and then I thought... I'd better do some exams and I got... membership, and then I went to... Manchester to do more neonates and... just got stuck into paediatrics then..."

Having invested so much in her burgeoning career, her later comment came as a surprise:

...when the children are older... I don't think I'd increase my hours here - no... we've got a bit of land now, and I'd rather have some sheep and a smallholding than... coming back to being full-time... definitely!"

*Lottery win:* would leave.



However, it was clear that most of the sample enjoyed the sense of expansiveness and challenge that is so central to Hackman and Oldham's concept of high growth-needs.

In terms of *supervisory practices* hospital doctors' complaints tended to be directed more toward their immediate 'supervisors', ie hospital trusts, than toward central government, eg

HL (♀ vascular surgeon): "...it is a game, it doesn't make any sense... it used to be the bottom line that if we said 'oh - the patients will suffer' then we couldn't do it. But that's no longer the bottom line - cost is..."

Hence there was no evidence to support the notion of consultants having a psychological contract with the State. However, even when trusts were considered as possible 'supervisors', the situation was not entirely clear. The impression these senior doctors gave was one of enormous autonomy, and one in which 'bad' hospital management (ie the trust) was more of a nuisance factor, than something to be taken too seriously. It was clear that the doctors knew where their responsibilities lay and this was with their commitment to patients and to their teaching responsibilities. Trusts facilitated these commitments or hindered them but either way, to borrow Ms HL's analogy, there was little doubt that 'the game' would go on regardless. Consultants gave the impression of being very much in control.

## 6 Conclusions

Notwithstanding the problem of time constraints (ie task identity) which is arguably endemic throughout the NHS, in terms of job characteristics the hospital sample appeared to enjoy work which is both enriched and challenging. Despite an ever-changing NHS hospital consultants are still powerful figures, as evidenced by the comparison of their work-perceptions with French and Raven's five power-bases. Their ultimate responsibility for patient-care is matched by an equally impressive degree of both personal and professional autonomy. For example there was no evidence to suggest that supervisory practices (eg government intervention or hospital trust management) represented any perceived threat to doctors' professional autonomy, even though it was sometimes annoying. Similarly consultants' personal autonomy was apparent in the degree of control and status which the sample appeared to exercise over their work (eg section 2).

When moderators were taken into account, the most notable dips in satisfaction related to concerns about the competence of new consultant colleagues (eg in terms of both their knowledge and skill and as co-workers), pay and, most surprisingly, job security. The strengths of consultants' work, however, lay in their work-met growth-needs and the obvious confidence they had in their personal expertise (ie knowledge and skill).

Of the five doctors who talked about remuneration, only one, the enterologist, appeared to be unreservedly satisfied with his pay. Therefore there are concerns that



increasing doctors' workloads (eg the combined effects of additional teaching responsibilities and assisting more junior colleagues) may exacerbate dissatisfaction with pay. Analysis of personal attributes identified surgeons as leaders. However, it is not possible to say whether a career in surgery attracts 'leaders' or, as Mr DJ suggested, creates them. With regard to job security, almost half the sample were worried about keeping apace with technological or organisational changes. A further four were concerned about the perceived rise in litigation risks. It is argued that a combination of these factors may, in the long term, constitute a threat to the considerable autonomy enjoyed by this elite group of professionals. In other words, the proverbial writing may already be on the wall for this last bastion of job security.

Work over-load appears to be a common theme, running through the analysis of all groups so far, and hospital consultants have been no exception.

The next chapter returns to the legal profession, with an analysis of barristers' work within the framework of the JCM.



# Chapter 8

## Results and Discussion: Barristers

Without exception, all ten barristers made the interviewer feel not only welcome, but the focus of attention, establishing an almost instant rapport. The author began to congratulate herself on her interview technique until the realisation dawned that the skill lay with the sample, rather than the interviewer. Once seated, a forward-leaning posture, congruent body positioning (ie mirroring the interviewer) and high eye contact were the hallmarks of these adept self-monitors. Such skills are not so surprising given the nature of their job, eg *"...when you're addressing the jury... you identify - you try to - who's going to be the foreman... who's nodding and who's... looking away, ...who's a convictor and who's an acquitter."* (Mr UR, criminal barrister).

Analysis within the framework of the JCM revealed a good job design, insofar that all three critical states were present for the sample. Consideration of moderator effects, however, identified many potential obstacles which, in the normal course of events, would be expected to lower the motivating potential of barristers' work. Surprisingly, this was not the case with the present sample. Barristers appeared to thrive on the uncertainty of life at the Bar, and were identified as being simultaneously professionals and entrepreneurs.

Table 17      *Overview of barristers' work within the JCM*

| Critical Psychological States |   | Moderator Effects           |     |
|-------------------------------|---|-----------------------------|-----|
| Meaningful work               | ✓ | Adequate knowledge & skills | ✓   |
| Experienced responsibility    | ✓ | Work-met growth-needs       | ?   |
| Knowledge of results          | ✓ | Context satisfactions:      |     |
|                               |   | pay                         | ✗   |
|                               |   | job security                | ✗   |
|                               |   | co-worker relationships     | ?   |
|                               |   | supervisory practices       | N/A |

? = some problems  
N/A = not applicable

### Analysis of data

#### The Critical Psychological States

#### 1      Toward an experienced meaningfulness of work

The sample, comprising nine barristers and a QC, clearly found their work meaningful.



There was ample evidence of skill variety, eg

BF (♀ police advocacy & prosecution): "I defend police forces when they are sued, and I prosecute police officers in discipline proceedings, they're two very different things... it's very interesting."

DJ (♂ family): "...the law is so complicated, one cannot hope to... be an expert in everything, it's not possible, so within narrow fields, it's still possible to get variety and stimulation."

task identity, eg

MR (♂ crime & civil): "...there's nothing more exciting than addressing the jury... you've got the evidence, ...you've heard what the witnesses have said, ...you've cross-examined them, ...so you've got the starting point but, after that, it's entirely up to you what spin you put on the case..."

HA (♂ crime): "...crime generally boils down to the simple issue: the charge is ABH. Did he hit him or not?..."

and task significance, eg

CM (♀ family): "...there are... cases where you find yourself passionately believing... for example, this child should be with this parent, and the worst is to lose a case which you think you ought to win, in the sense that... your client should win..."

UR (♂ crime): "...there's quite a serious murder took place in X-shire... I've been involved in a very early stage - meeting the police officers, advising them on what evidence to get, what questions to go back and ask this chap... so you're meeting... those involved in the preparation of the case..."

### ***1.1 Toward an experienced meaningfulness of work: Summary***

According to the sample barristers enjoy fulfilling and meaningful work, rich in variety and task identity, which has a significant impact on the lives of others.

## **2 Toward experienced responsibility for work**

The sample were unanimous when speaking of their remarkable autonomy. For example, "*I like the buck to stop with me*" (BF ♀ police), "*I've got complete control*" (CM ♂ banking) and "*it comes down to not being answerable*" (CS ♀ family) were



typical of barristers describing the highpoints of their work. Most of the sample also described the drawbacks of high autonomy, such as accepting responsibility for defeat as well as victory. Additional factors included the <sup>2</sup> Cab-rank rule which, in theory, means barristers have little control over the amount of work coming in and their sole practitioner status which makes them sole decision-makers as well, eg

CS (♀ family): "...if I get something wrong, I may not sleep at night but... better that than have somebody on my back... that's the joy of being self-employed..."

HA (♂ crime): "...one of the great attractions of the job... is... it's all down to you with no one to report to... it's also one of its biggest drawbacks. There is no one that you can just pass things on to... if things get creaky, then you're stuck with it..."

CM (♀ banking): "...what I haven't got any control over is the amount of work coming in... a barrister can't refuse to take on any work as long as it's offered... at a proper, professional fee... it's called the Cab-rank principle..."

The Silk spoke of the onerous responsibility that is commensurate with her rank as "leader of the profession":

Silk (♀ crime) *when asked to differentiate between a barrister and a QC:*

"...you need guts, with a capital G, when you're in silk. Big decisions to be taken. ...and be capable of a really heavy workload - at the criminal Bar."

Barristers, like surgeons, also exhibited French and Raven's (1959 cited in Robbins, 1993) Bases of Power but, in this case, barristers seemed to have all five (ie including *coercive power*):

1. **Reward power:** the capacity to bestow favours on a chosen few. The Cab-rank principle, theoretically, prevents a barrister from choosing who s/he will represent in court. However, as a member of chambers, barristers will decide who they will accept as a pupil and, ultimately, who will be offered the much coveted tenancy.
2. **Expert power:** the influence that accrues from specialist knowledge and skills. There can be little question that barristers hold expert power, eg "...if I bog up a case... it's down to me and that again, is where the satisfaction comes into the job... it renowns to you." (Mr MR).

<sup>2</sup> The 'Cab-rank' rule is the principle whereby barristers are professionally obliged to accept a brief, current workload permitting.



3. **Legitimate power:** the formal rights bestowed on those who hold a high ranking position within the organisation. The prestige of tenancy, the traditional wig and robes, the pomp and ceremony of the court, all serve to reflect the legitimate power of the Bar.
4. **Referent power:** derives from others' admiration for that person who may become something of a role model. There is certainly the opportunity for a barrister to become a renowned role model, and the sample frequently mentioned famous barristers who had inspired them, eg "*...one in particular, he's a star barrister; he's very, very, very clever... he destroys people... he will take the world over.*" (Ms CS) "*...I'd spent some time with a female barrister who's now a QC... and through her I realised there was definitely nothing else to do but to be a barrister...*" (Mr MR).
5. **Coercive power:** achieving dominance through fear. There was little evidence in the sample's transcripts of individuals demonstrating this kind of power. However, it might be argued that part of a barristers role in a court of law may very well, at times, be to exhibit coercive power, eg "*...I think it [the wig] adds to the gravitas... suddenly you're brought up from the well of the court... the jury's up there, and there's paraphernalia - and all those bewigged people, you must think, 'Oh Christ, this is serious!'*" (Mr UR).

### 2.1.1 Gender issues

There were four female lawyers in the sample: one QC and three barristers, two of whom were mothers; the QC and one barrister. Although the Silk was asked how she managed to juggle her career as a mother of three children, the extreme time constraints of the interview (fifteen minutes) prevented useful probing. Hence the following comments relate to only one of the sample, a female common law specialist. Asked how she felt, in retrospect, about her decision to become a barrister, Ms KG replied as follows:

KG (♀ common law) "*...I'm glad I made the decision [re the Bar] because I think with the situation I have now, where I have a young baby, the fact the Bar is, in some ways, a more forgiving profession because I can take time out, I don't feel compelled to do this nine to five... five or six days a week.*"

*and later:*

*"...as long as you're performing your responsibilities of the cases that you've got... if I wanted to leave this afternoon, I could..."*

So according to Ms KG, the Bar was amenable to working mothers who wanted to return to work. However, it appeared that women barristers must make their own



financial arrangements regarding maternity leave, eg

KG (♀ common law): "...we're not paid a salary... you don't have maternity pay - when you're not working, you're not earning..."

It later transpired that Ms KG was married to a successful commercial specialist. Nevertheless, Ms KG felt comfortable in managing her dual roles as professional barrister, alongside that of new mother. The situation also reflects the high level of autonomy that barristers have, insofar that they have complete control over the work they undertake. The prime motivators here are, presumably, the need to build/maintain a reputation and the desire to earn a good standard of living.

## 2.2 *Toward experienced responsibility of work: Summary*

Barristers resembled hospital consultants in terms of their power and autonomy. For example their perceptions also appeared to correlate with all five of French and Raven's power bases. Moreover, they bear sole responsibility for the briefs they accept, without anyone *"to pass things on to... if things get creaky"* (Mr HA). Because of barristers' self-employed status, women do not have paid maternity leave. Nevertheless, there were indications that the Bar may be *"a more forgiving profession"* than some, because of the high degree of personal autonomy it offers in terms of how people choose to organise and execute their work.

## 3 **Toward knowledge of the results of work**

Feedback, for barristers, was unambiguous; it was simply winning or losing the case. Criminal barrister, Mr HA, epitomised the sample's stance:

HA (♂ crime): "...winning is the highpoint and, if... you've got a good result, then you feel really quite elated at the end of it... the downside is when you make a mistake, because you can't cover it up... it's very public and there's no one else there to make a mistake, other than you, and that's when you walk out thinking, I can't do this job - why do I bother?..."

However, there were two interestingly different views on feedback. One of the sample mentioned the importance of client-appreciation, whilst the QC took a more detached



view when describing the sort of feedback that she enjoyed:

KG (♀ common law): "...when you win a case... that is a real highpoint. At other times... you can try very hard and not succeed in proving anything at all, or have clients who are completely ungrateful..."

Silk (♀ crime): "...I'd choose this or being a consultant. I wouldn't mind as long as I had people to listen to, and people together to watch the way they operate... twelve of them there - I don't know anything about, I can entertain myself... watching the facial expressions, all I know is the voice I hear when they take the jury oath - it's fascinating."

### ***3.1 Toward knowledge of the results of work: Summary***

Like one of the solicitor sample in Chapter 6, one of the barristers enjoyed the extrinsic feedback of client-gratitude. Another similarity related to the way in which barristers, like solicitors (and possibly surgeons), are assured of intrinsic feedback by winning or losing the case.

## **4 The Critical Psychological States: Summary**

With the exception of one male barrister (Mr CM who will be discussed more fully in moderator effects), the remainder gave the impression of being high self-monitors who thrived on a diet of challenge, uncertainty and almost total autonomy. According to Kanter, such qualities define the entrepreneurial career and, certainly, barristers 'grow' their own territory below them, rather than moving up an organisational structure (Kanter, 1989). Moreover, the high degree of uncertainty associated with entry to the Bar, in addition to an ability to make rapid decisions under pressure, possibly marks these people as high risk-takers from the outset. Thus far, it seems logical to assume a good match between job-design and individual needs. According to the unmoderated JCM, barristers enjoy work that is enriched and high in motivating potential. Indeed, the QC spoke of the rewards enjoyed by those at the top of the profession: "...you've got the kudos, you've got the label, you're a Queen's Counsel. That's what it's all about."

Moderator effects were then explored to determine the full extent of this potential.

## **5 Moderator Effects**

### ***5.1 Problem areas***

Analysis of moderator effects revealed problems relating to barristers' work-met growth-needs, and context satisfactions.



In terms of ***growth-needs*** most of the sample clearly enjoyed their work, with four still excited by the challenge. This is best illustrated by criminal barrister, Mr UR: "*...if I were not a barrister by profession, I would choose to do this job at weekends, as a hobby, because it provides me with so much stimulation...*". There were, however, three exceptions: two individuals who appeared to have 'adapted out' of the job's initial challenge, and Mr CM (to whom the theory may also apply) who described himself as a frustrated academic, eg

CM (♂ banking): "...I regarded it as the next best thing to academia... I... would have liked to have gone on to do a PhD, but... didn't feel I had a good enough degree to justify it. [*Do you still feel the Bar is second best?*] Oh yes."

CS (♀ family): "Five years ago I would have said I'll stay in the profession because I love it... but I now... think - do I want to be doing this in ten years' time? And the answer is no, really..."

PC (♂ civil & family): "sometimes it is quite nerve-racking... it's almost like preparing for an exam every day... (*and later*) "...It's really quite boring... you do get the odd... little gem... they are odd incidences... they keep me ticking over..."

Four of the sample described the terror/thrill of the courtroom, eg "*unless you're frightened... you don't do a good job...*" (Mr MR), "*...you never know what's going to be thrown at you... that can be terrifying - but it's stimulating!*" (Mr DJ). It is argued that barristers may become 'addicted' to the high arousal levels associated with life at the Bar and that with experience, may come boredom. This point is illustrated by Ms CS who is quoted, once again, below:

CS (♀ family): "...I think you... reach a level where you have mastered what you do, the adrenaline drive... and the constant terror of getting it wrong... is gone..."

With regard to context satisfactions all ten barristers spontaneously mentioned ***pay***, with the emphasis, for most, on the inherent uncertainties of the Bar. As Ms KG explained if "*...you're not working, you're not earning*". Moreover pay varies widely according to individual specialisms, with the criminal Bar very much the 'poor relative' and the commercial Bar the richer one. Hence 'others-inside' were barristers' main



referent group with only one including an external comparison, eg

HA (♂ crime): "...after six years call, I felt that... my earning weren't as high as I'd expected... doing jobbing crime - bread and butter work... it is much more likely that you'd be living next door to your local bank manager... certainly next door to your local GP, rather than next door to your local consultant surgeon."

So Mr HA was clearly disappointed with his pay and implied that he had expected to earn the same as a consultant surgeon, rather than a GP. In terms of earning-power, this might suggest that general practice is regarded as less prestigious than hospital medicine in Britain, as well as America (eg Rosoff and Leone, 1991).

When the sample talked of their *job security*, the general consensus was that life at the Bar was, like the pay, a precarious existence. All barristers were asked whether they felt they had job security and Mr CM answered for most, eg "*God no! That's the antithesis of life at the Bar - you couldn't be in a more insecure profession...*". The main difference related to the way individuals dealt with the lack of security. Some were fairly pragmatic, eg "*that's part and parcel of the job... I don't worry about it too much.*" (Ms KG), whilst others were less relaxed, eg "*...you're only as good as your last case, and work can fall away very quickly if something goes wrong...*" (Ms BF). Interestingly it seems that even barristers can be sued, although the two who raised the issue did not seem unduly concerned. Overall, it appeared that autonomy, not security, represented the career anchor for this group (eg Schein, 1975 cited in Robbins, 1993).

In terms of *co-worker relations*, of the seven barristers who spontaneously raised the topic, six appeared to enjoy good working relationships. However the potential hazards of chamber-dynamics were spelled out by Mr DJ, in terms of the "devastating" effects of a relationship breakdown on individuals careers.

DJ (♂ family): "...it's a difficult balance if you have twenty fairly self-confident people trying to work together... quite regularly chambers are ripped apart by personality clashes which is devastating to people's careers... chamber's meeting can be very difficult... on the whole, ours work very well here..."

[and later]:

"...one doesn't always see eye-to-eye with the clerk, because obviously they have an interest in you working as much as possible, because they get a cut. It gives them an incentive to get the work in."

There were also indications that some working relationships may lack the trust and closeness of friendship. For example, Mr HA described the atmosphere in his particular chambers where he felt he could only ever discuss his successes, not his failures, which he found isolating. Barristers' accounts of relationships within



chambers were generally too vague to judge whether or not they had a (relational) psychological contract with colleagues. There was, however, some evidence to suggest that they might have a contract with solicitors on whom they depend for work. For example Mr CM, when talking about barristers' job security, explained: "*...it's only going to take two or three of the ones who provide the regular work to... abandon me, and you could perhaps collapse.*" Two other individuals spoke the importance of 'keeping in' with solicitors, eg "*...you need to keep well in with solicitors because they're the ones who send you the work...*" (Mr UR).

With regard to *supervisory practices* the Lord Chancellor, the Home Secretary and the Government in general, all came in for criticism by half of the sample. The five barristers who spoke out represented a variety of specialisms and were not predominantly criminal barristers, as expected. In all cases, criticisms centred on the government's cost-saving practices, eg

PC (♂ civil & family): "I think the times are a-changing and family work will... pay... as Legal Aid has for criminal work... it really has been axed significantly... it's money-saving... it's the government trying to balance the books... and Legal Aid is something which they think can be pared back... it all boils down to money..."

One barrister feared that the government might dispense with the Bar altogether, eg

CS (♀ family): [*Do you think the roles of solicitors & barristers will merge?*] "Yes, probably... I think it will happen where it is, from a government point of view, cost effective... it's cheaper to have one advocate with nobody backing them up, and I think this is all about saving money for government."

Despite barristers' obvious resentment of the Government's cost-cutting policies, they did not construe these as a personal attack on themselves as a profession. Nor did they appear to have any sort of relationship (ie psychological contract) with the Lord Chancellor or the State. Nevertheless, from the point of view of the State governing barristers' fees through the legal aid system, there could be an argument for claiming that the government must therefore assume a supervisory role. Legal aid, however, only affects certain types of work such as family and criminal law. Moreover, as was apparent with the sample, some barristers will choose a mix of specialties and will offer, for example, family/crime *and* civil law (eg Messrs PC and MR). It is also important to remember that independent barristers (as opposed to those employed by the Crown Prosecution Service) are sole practitioners and do not contract their services to the State. So whilst the Government might dictate the terms of fees in certain cases, the notion of them taking a supervisory role with the independent Bar, seemed implausible. Certainly, if supervisors or managers can be defined as having responsibility for the guidance and motivation of subordinates, as suggested by



Hackman and Oldham (1980), then barristers are supervisor-less. Exceptions may apply to occasions when a junior barrister is 'led' by a QC in a particularly difficult or serious case, but that is beyond the scope of the present study.

### 5.1.1 *De-professionalisation issues*

In Chapter 6, two solicitors spoke of the way their profession had lost some of its traditional kudos with the public (section 2.2.2, consumer power). Although barristers did not talk in terms of 'consumer power' (they have no direct dealings with the public), two of the sample spoke of a general de-valuing of professions, eg

CS (♀ family): "...I think it [the Bar] used to carry an enormous amount of status... I think being a barrister is going the same way as being a GP or a teacher, which is sort of down, in terms of appreciation... The professional figure no longer inspires the sort of 1950s awe."

HA (♂ crime): "...I think there is a general de-valuation of professions... people don't sort of look up and kow-tow to professions in the way everyone once did. I mean there was a time when doctors were... next to God and barristers were probably thought of in the same way and that's no longer the case..."

Mr HA's choice of words almost match those of senior partner, Mr BM, who talked of people becoming "*far less willing to just genuflect at somebody who's got a professional qualification...*"

Interestingly, this was the first sample in the study where nobody complained of work-overload. It was not clear whether this reflected good organisation on the part of chambers generally, or whether it bears testimony to the degree of autonomy enjoyed by barristers in terms of deciding their workload.

## 5.2 *Positive effects*

Except for the QC (not asked due to time constraints) all were asked whether they considered their training (eg *knowledge and skill*) to be relevant to their present job. A common theme for over half of the sample (seven) was the fact that advocacy, like surgery, is an apprenticeship comprising "on-your-feet" experience, eg "*...there's no substitute for actually being in court and learning by your mistakes and successes...*" (Mr DJ). However, there were two interesting 'asides': one female barrister extolled the strengths of a barrister's training in terms of its applicability to the wider job market, whilst another stressed the different personality factors required for different



specialities, eg

UR (♂ crime): "...there was a young man... we interviewed... and we rejected him, despite a tremendous CV - academically... it was clear, however bright he was, he was never, ever going to be a knock-about criminal advocate... for... things like... dealing with a drunken Grimsby fisherman charged with some rape and pillage..."

Barristers, as with other groups, were asked what *personal attributes* were necessary for their work. Half of the sample pointed out that this tended to depend on the type of specialty, as different fields of law favoured different skills. Perhaps surprisingly, when the four women were asked whether there were any special attributes needed for women to succeed, only two stressed the need for extra determination. One female barrister thought women may have to make a determined effort to stand their ground more *"because I don't think women in general stand their ground in either a home... or a work environment... and it's a very confrontational profession, I mean that's what it's all about, really..."* (Ms BF).

When all the named attributes were collated, the following picture emerged:

***A good barrister should:***

- **be** *"...articulate... able to talk to people on a level they will understand..."* (BF ♀ police) *"...if you're somebody who can't put your ideas forward clearly and economically, then you're stuffed..."* (MR ♂ crime & civil) *"...communication ...able to talk to a jury..."* (UR ♂ crime) have *"...an ability to get on with people... have some empathy with them..."* (HA ♂ crime) be able to *"...retain some sort of sensitivity... where you're dealing with people who are at a low point in their lives..."* (DJ ♂ family)
- **have** *"...a clear mind... when you've had everything crowding in... to stand back and say that's what matters - helps."* (Silk ♀ crime) *"...an ability to think on your feet... to respond well under pressure..."* (CS ♀ family) *"...presence of mind - being able to respond to developments in the court case, as they happen..."* (CM ♂ banking)
- *"...be very competitive..."* (CM ♂ banking)
- *"...be sufficiently detached... to go home, at the end of the day and say - oh that was awful and be able to live with that..."* (PC ♂ civil & family) *"...have a detachable thick-skin which you can put on when necessary..."* (DJ ♂ family)
- **have** *"...confidence..."* (UR ♂ crime) *"...give the impression of being confident..."* (HA ♂ crime) *"...confidence and conviction in yourself..."* (KG ♀ common law)



- have "*...an ability to organise your time...*" (HA ♂ crime) "*...the ability to work independently...*" (KG ♀ common law)
- have "*...integrity...*" and "*...a sense of humour...*" (Silk ♀ crime)

So good communication skills, a clear mind, an air of confidence, with an ability to detach oneself from the proceedings and to work independently were the main qualities that emerged. It appears that different specialisms require different skills, ranging from a flexible approach in dealing with criminal cases and a more sensitive attitude in cases of family law. With a growing trend toward specialisation, there is an increasing need for barristers to recognise and capitalise on their strengths, if they are to build a successful 'territory'. Again, Bennis' "Competencies of Leadership" (Bennis, 1984) applied to barristers, as they had to surgeons in Chapter 7, but this time they were applicable to a wider range of specialisms:

- **a compelling vision or sense of purpose** (CS [family]: "*...there are... cases where you find yourself passionately believing... this child should be with this parent...*")
- **ability to communicate this vision to others** (MR [crime & civil]: "*...Your job is to persuade somebody, be it a client, ...a judge, ...a witness... that the way you're seeing things... is the most attractive and the most sensible way...*")
- **consistency and focus in pursuing their vision** (DJ [family]: "*...when you've got very young children being asked what they want, it's a huge... responsibility. Basically, they're being asked to choose between their parents... obviously you've got to listen... but that doesn't mean you therefore act literally on what they're saying, it's more complicated than that...*")
- **a knowledge of own strengths and how to capitalise on them** (BF [police]: "*...I think people must specialise... pin their colours to the mast and say this is what I'm good at, and this is what I do.*")

However, none of the above convey the sense of drama and flair associated with a successful courtroom 'performance'. Perhaps Mr CM, a specialist in banking law, best encapsulated this when he described the Bar as "*...a sort of gladiatorial profession, in that the emphasis is on tactical manoeuvring.*"

## 6 Conclusions

Judging from the sample base, the Bar offers enriched and highly motivating work - for those who have the courage to live with uncertainty. As examination of moderator effects revealed, this is not a job for those who are security-orientated. Erratic pay tied into specific job lots (ie 'briefs'), no job security, learning via public 'performance', the inherent difficulties in co-operating as sole practitioners within a collective, all spell out a high-risk lifestyle. Moreover, examining work-related growth-needs revealed that almost half of the sample enjoyed the 'terror' of the courtroom.



Thriving on a life of uncertainty and risk, barristers appeared to challenge Kanter's (1989) neat dichotomy of professional and entrepreneurial careers. For example, demonstrating the classic hallmarks of a profession, they possess specialist skills which form the basis for association (as opposed to a common employer), and progress through expanding knowledge and reputation. Conversely, according to Kanter, *"entrepreneurs have only what they grow"* (Kanter, 1989 p516) and the entrepreneurial career is defined as having:

- a high degree of control over work (*"..I'm in control of what I do - I can decide..."* BF)
- the thrill of growing something out of nothing (*"...the surprise was how difficult it was to get established... you don't... realise that... it's going to take quite a lot of work to lift you off that initial threshold into something more established..."* KG)
- monetary rewards tied directly to accomplishments (*"...the Bar is piece-work, we are entirely dependent on... solicitors..."* CM) and
- greater uncertainty about the future (*"...it's a bit like show business, where you are dependent on your last performance..."* CM)

Barristers, it would appear, have a foot in both camps being professionals *and* entrepreneurs.

It could be argued that barristers also challenge Hackman and Oldham's Job Characteristics model. Certainly, in the normal course of events, the preponderance of negative moderator effects could be expected to reduce the overall motivating potential of barristers' work. However, this did not seem to apply to the present sample. These were people who appeared to relish incertitude, and are best described as entrepreneurial professionals. It is difficult to establish whether or not the sample seriously challenge the assumptions underpinning the JCM. For example, the question that arises is just how representative of workers - professional or otherwise - are these people? Maybe they are just too maverick a group to compare with anyone, apart from actors. Indeed, two barristers mentioned their love of drama: *"I would have liked to have been an actor..."* (Mr DJ), *"...I've always enjoyed acting - showing off. Chefs, barristers and actors are much the same... I enjoy all three..."* (Mr MR).



# Chapter 9

## An overview of the four groups

The purpose of the present chapter is to summarise the key findings for each group, highlighting the similarities and differences where they occur. The section begins with an overview of Chapters 5 and 6 which focused on the work of GPs and solicitors, respectively.

### 1 A comparison of general medical and legal practice

The table below outlines the two groups' perceptions of their work, as analysed within the JCM:

Table 18                      *Overview of GPs' and solicitors' work*

| Critical Psychological States | GPs | Sol's | Moderator Effects     | GPs | Sol's |
|-------------------------------|-----|-------|-----------------------|-----|-------|
| Meaningful work               | x   | ✓     | Knowledge & skill     | ✓   | x     |
| Autonomy & responsibility     | x   | ✓     | Growth-needs          | x   | ✓     |
| Knowledge of results          | x   | ✓     | Context satis'ns: pay | ✓   | ?     |
|                               |     |       | job security          | ✓   | x     |
|                               |     |       | co-worker relations   | ?   | ✓     |
|                               |     |       | supervisory practice  | x   | x     |

? = some problems

#### 1.1 The Critical Psychological States: GPs versus solicitors

Analysis within the JCM enabled a brief synopsis of both group's work to be drawn up. As demonstrated in the table above, there was a 'grey' area in the analysis of moderator effects, as depicted by '?'. Such areas were considered to be ambiguous, insofar that they defied categorisation as a straightforward 'plus' or 'minus'. In the case of GPs this was co-worker relations and, for solicitors, it was pay. Looking at the job characteristics, to the left of the above table, it is clear that GPs and solicitors were diametrically opposed in relation to the three Critical Psychological States. It will be recalled, from Chapter 5, that whilst doctors appeared to enjoy variety there were problems relating to task identity (eg time and resource constraints) and task significance (eg being overwhelmed with the problems of the 'worried well'). Nor was any consolation to be found in their perceptions of autonomy and responsibility. Doctors felt that their autonomy was being squeezed by rising consumerism on one side, and increasing government intervention on the other. As if that were not enough, patients were not even grateful, eg doctors seemed to be denied the extrinsic feedback



that was so important to them. In other words, making people better might be satisfying, but doctors also needed patients to express their appreciation of their efforts.

Solicitors, on the other hand, had all three Critical Psychological States potentially 'activated'. Interestingly as a profession, solicitors had already suffered - and survived - aggressive government intervention with the removal of many restricted practices, resulting in increased competition from 'outsiders'. Yet the overriding difference between general medical and high-street legal practice, is the latter's personal autonomy. Legal firms operate as autonomous commercial entities, free to shape their services according to local demand. This, of course, is denied doctors in general practice who must follow the dictates of the Department of Health and their local health authority. In terms of knowledge of results whilst solicitors may like to be thanked, it is not their main concern. Whilst acknowledging increasing consumer-demand, solicitors still enjoy ongoing intrinsic feedback with winning (or losing) their case and the tangible reward of seeing their bill paid at the end of it all.

When moderator effects were taken into account, further differences between the professions emerged. These are considered, and compared, each in turn below.

## ***1.2 Moderator effects: GPs versus solicitors***

### ***1.2.1 Knowledge and skills***

Despite completing the postgraduate Legal Practice Course solicitors did not feel adequately prepared for their work, especially the marketing and public relations aspects. Doctors, on the other hand, had no such qualms. Indeed, there were signs that GPs may even be overskilled, for example the reported rise in demand for inappropriate or 'trivial' complaints. Moreover, one of the GP sample specifically complained of a lack of opportunity to use his knowledge and skills.

It was also interesting to note that two solicitors showed an awareness of their own market value, in terms of having skills that were transferable to the wider job market, eg *"I may try and move... towards... company secretariat work... in a private company...which would be using quite a lot of the same skills, but outside the legal profession."* (Ms AE). This ability to lift one's head for a moment, and to consider the applicability of one's professional skills to a broader work perspective was noticeably lacking in the GP sample, as one of the sample noted retrospectively, eg *"... you're marketable when you've got a medical degree.... but you never think of yourself like that, because it is so vocationally orientated, that all you ever think of yourself as, is a doctor..."* (Dr AP).

In terms of personal attributes, GPs' listed decidedly 'people' orientated qualities, compared with solicitors, with six of them stressing the need for good communication skills (compared to only two of the solicitors). This was surprising because both professionals need to sometimes convey complex ideas in a clear, straightforward way to people who may not always be particularly well educated or articulate. However, another explanation for the difference may lie in doctors' heightened awareness of the



need for improved communication with their patients. For the past two decades doctors' communication skills have been the focus of widespread criticism, and this has led to a plethora of research (eg Roter, 1977; West, 1984; Ley, 1989; Botelho, 1992). It is to be hoped that those who are responsible for the medical training curriculum will have sought to address these concerns, and that it is the results of their endeavours that are evidenced in the present study.

### ***1.2.2 Growth-need strength***

In terms of growth-needs, of the eight solicitors who raised the topic, the majority seemed to enjoy a sense of challenge and fulfillment in their work. Gender differences were apparent in both groups. It appeared that women with young children may experience a shift in values, in terms of how central work is within their value system. It was hypothesised that this may be a temporary situation, affecting women with very young children in particular, with work-centrality returning as their families mature. Gender differences apart, there appeared to be fairly serious problems regarding doctors' growth-needs being met by their work. Three complained of the lack of intellectual challenge in their work, with half of the sample feeling that outside work (3 doctors) or interests (2 doctors) were vital to their sense of wellbeing.

### ***1.2.3 Pay***

Turning to context satisfactions, for the three solicitors who expressed dissatisfaction with their pay, there was a definite sense of unmet-expectations. In contrast, GPs' vague 'grumbles' about their pay suggested that it might be more of a hygiene factor for them (eg Herzberg, Mausner and Snyderman, 1959). Neither groups compared their pay with that of related professionals, ie hospital doctors or barristers respectively. The apparent reasons for this were very similar, for example "*I never regarded myself as clever enough to be a consultant*" (Dr WA) and "*Why not the Bar? I don't have such a high opinion of myself... I'm not that bright.*" (Mr HD).

### ***1.2.4 Job security***

Analysis of job security was unambiguous; GPs have it and solicitors do not. Apart from two doctors expressing a growing awareness of litigation concerns (as did two solicitors), there were few grounds for comparison. For example, none of the doctors had experienced redundancy (compared with three of the solicitors) and, for the time being at least, there was no real sense of threat from non-professional outsiders.

### ***1.2.5 Co-worker relations***

Co-worker relationships and supervisory practices were interrelated for the purposes of comparison. All the GPs were parity partners, so disagreements over working arrangements (eg maternity leave, part-time hours) were much more of a central issue for doctors in their relationships with each other. The solicitors in the sample, however, represented different 'ranks' within their respective firms. Hence tensions over work schedules tended to be focused 'up' towards management, ie the senior partners. This meant that relationships with colleagues (ie non-partners) were free of such considerations; non-partners therefore spoke of 'friendly' and 'sociable' colleagues. There were, however, problems regarding gender equality. Unlike GPs, who have the



advantage of part-time working facilities being built into their contract with the State, women solicitors were left to fend for themselves in such matters. There was also evidence that women may progress more slowly in their legal careers than men, and that this was not always related to their taking 'time out' for their families.

### ***1.2.6 Supervisory practices***

Related to co-worker relations, 'supervisors' were interpreted differently for GPs and solicitors. For the former, it was clearly the NHS, ie the State. For the latter, however, it was senior partners and the structures which they directly imposed on their employees.

## ***1.3 Comparison of GPs and solicitors: Summary***

Overall, it would seem that legal practice has completed its metamorphosis from privileged profession to commercial enterprise, and is now seated firmly in the world of business. A professional qualification is no longer enough: junior solicitors must be prepared to accept an uncertain future, to work gruelling schedules over which they have little control and, above all, to approach their work with a keen commercial awareness; an entrepreneurial eye for the main chance. Senior partners rule within these microcosms, and it is they who decide who will step foot on the hierarchical career ladder toward greater autonomy and status. For solicitors, the psychological contract was clearly a transactional one.

The picture was very different for general practice. Examination of job security showed doctors still belonging to a privileged profession where a professional qualification is everything. But the overriding theme emerging from the study was that of a profession in flux. Indeed the *"times they are a-changing"* (Arnold, 1997, p20) and for GPs, most assuredly, the *"wheel is still in spin"*. This was first apparent during analysis of GPs' autonomy, where the sample complained of rising consumerism among patients coupled with increasing government intervention. It became clear that doctors assumed a relational-style psychological contract with the State. The tone of recent changes had shocked many of the sample; the medical profession had traditionally led the nation's health service and suddenly the Old Order was changing. The Government was now making all the decisions. Worse, they lacked even the courtesy to consult with practitioners first; the doctors' anger was almost tangible. Over half of the sample had described the importance of their independent contractor status - it was part of the appeal of general practice - and now it seemed to be disappearing before their eyes. They were *"becoming employed in all but name"* [Dr WB]. In other words, the story of general practice was one of a rather stately profession, now wrestling with the harsh demands of a new, commercial world. The changes that were being imposed appeared brutish and impertinent. The sample conveyed a general sense of instability; that the changes were not just impacting their work, but also the way in which doctors viewed themselves. One GP summed up his feelings on the matter as, *"... the... threat from reorganisation after reorganisation... and the feeling really of lack of control over that..."* [Dr TM].



Having appraised the main components of general and legal practice, the second section focuses on the findings reported in Chapters 7 and 8 which considered the work of hospital doctors and barristers, respectively.

2      **A comparison of hospital medicine and the Bar**

The table below provides an overview of the two groups' work-perceptions, as analysed within the JCM:

Table 19      *Overview of hospital doctors' and barristers' work*

| Critical Psychological States | Hosp med | Bar | Moderator Effects       | Hosp med              | Bar |
|-------------------------------|----------|-----|-------------------------|-----------------------|-----|
| Meaningful work               | ✓        | ✓   | Knowledge & skill       | Selves ✓<br>Juniors ✕ | ✓   |
| Autonomy & responsibility     | ✓        | ✓   | Growth-needs            | ✓                     | ?   |
| Knowledge of results          | ✓        | ✓   | Context satis'ns    pay | ✕                     | ✕   |
|                               |          |     | job security            | ?                     | ✕   |
|                               |          |     | co-worker relations     | ?                     | ?   |
|                               |          |     | supervisory practice    | N/A                   | N/A |

? = some problems  
N/A = not applicable

2.1      *The Critical Psychological States: consultants versus barristers*

In terms of basic job design, both hospital consultants and barristers experienced their work as vital, challenging and rewarding. The most noticeable convergence related to perceptions of autonomy; restricted only by the codes of their professional associations, the Bar and hospital medicine confer immense autonomy and responsibility. The two groups' perceptions of autonomy were explored within French and Raven's five power bases. Consultants appeared to exhibit four of the five, whereas barristers appeared to have all five, including the power to dominate others through fear (ie coercive power). It was also clear that doctors and barristers relished their power, autonomy and responsibility, leaving little doubt that this was an important career anchor for these professionals (eg Schein, 1978). Moreover, both professions appeared to offer incumbents the same clearly defined career path, as outlined by Dalton, Thompson and Price's Career Stages Model (1977, cited in Arnold, 1997), eg

Stage 1: Apprenticeship

*Normally works under the direction of another professional, doing most of the detailed and routine jobs. Pupil barristers work under the guidance of a pupil master at the beginning of their careers. In hospital medicine, specialist registrars work within consultant-led specialist 'firms'.*



### **Stage 2: Independence**

*Goes into more depth in one specific area, taking responsibility for a definable part of a larger project/process and develops credibility and a reputation.* In the period immediately following tenancy, new barristers tend to be generalists but, as they grow more established, most tend to hone down their skills to one, or two, specialist fields. Newly appointed hospital consultants are already specialists in their own right. Both types of professionals can go on to develop their expertise and reputation in their chosen fields.

### **Stage 3: Mentoring**

*Develops greater breadth of technical skills and understands the wider applications of his/her skills. Stimulates others through ideas and information and serves as a mentor to younger professionals.* Established members of the Bar and hospital medicine have the opportunity to develop their expertise further, in addition to taking on the role of tutor/mentor to newcomers, ie pupil barristers and specialist registrars, respectively.

### **Stage 4: Strategic**

*Provides direction for a significant part of the organisation, exercises significant formal and informal power, represents the organisation to outside others and sponsors promising individuals to help prepare them for key roles within the organisation.* Barristers who take Silk and consultants renowned for a specific expertise, can both acquire star status. As "masters" of their art, they have the opportunity to lead their field, and will certainly hold an influential role in shaping the future of their profession.

Hence both barristers and hospital doctors have clearly defined goals set within a well established career structure. Moderator effects were then explored to allow further comparisons between both the individuals themselves and their satisfaction with the contextual aspects of work.

## ***2.2 Moderator effects: consultants versus barristers***

### ***2.2.1 Knowledge and Skills***

In terms of the two groups' views of the adequacy of their training, hospital doctors were divided on the strengths of their training, and it is possible that their reflections were influenced by the recently introduced Calman training programme. Three doctors criticised the excessive length of their training, which was one of the very issues that the new programme was designed to address. Another three, however, strongly defended the Old Order, extolling the virtues of their protracted and arduous training on the grounds that it ensured competence through years of experience. All four surgeons in the sample believed that "hands-on" experience was a crucial element of training and were unanimous in their view that the new style training, combined with the reduction in junior doctors' hours, was a recipe for disaster.



The notion of surgery being an on-the-job apprenticeship was echoed by the barrister sample. The majority stressed that advocacy was not really amenable to training, but had to be learned the hard way; "on-your-feet" in court.

Both samples were asked to name specific personal attributes which had contributed to their success and again, there were similarities between surgeons and barristers. Surgeons had exhibited all four of Bennis' Competencies of Leadership. It was clear that surgery, in particular, demanded a strong sense of purpose and an ability to make decisions under pressure. Barristers who, it must be remembered, also tend toward specialisms, showed no such differentiation. Bennis' Competencies of Leadership appeared to apply across all specialties. So it would appear that the skills demanded of surgeons who perform in an operating theatre, may be similar to those of barristers who perform in a court of law.

### **2.2.2 Growth-need strength**

In terms of work-met growth-needs, there were only three apparent exceptions in the hospital sample. One was a young working mother who, it was suggested, may be experiencing a temporary 'glitch' in her work-centrality, whilst another two male consultants appeared to have pre-determined views on how their work should be. For example, one felt that his work should fit within certain 'boundaries', whilst another was disappointed at the lack of research opportunities that his present job offered.

With barristers too, there were just three exceptions to work-met growth-needs. Like one of the doctors, there was a barrister who felt academically frustrated, and a further two who appeared to be adapting-out of the job's initial challenges. However, a major factor emerging from interviews was that barristers are motivated by uncertainty and, it would seem, fear. These were people who seemed to thrill to the idea of being tested with every 'performance'. The overriding impression was that the very appeal of a court appearance was its uncertainty. If it was easy or predictable, then it was not fun. This impression was supported by the sample's attitude towards pay and job security, which will be discussed next. As stated in Chapter 8 it was not possible to establish whether the two barristers, who implied they were becoming bored, were adapting-out of the job's initial challenges or suffering the physiological effects of lower adrenaline levels.

### **2.2.3 Pay**

Interviewees were not asked direct questions about their pay, so analysis was limited to those who spontaneously raised the topic. Neither doctors nor barristers were particularly happy with their remuneration. Of the five doctors who talked about their pay, only one appeared to be satisfied, eg Dr SU (the enterologist), who had exclaimed with a grin, "...*I never expected to make so much money!*". Of the remainder, one believed it inevitable that his pay would "...*become gradually eroded over the years...*" because that was the modus operandi of the health service (Dr FN), whilst the other three felt they could earn more in the private sector, or abroad. The fact that these doctors actually chose to talk about their pay, is sufficient indication that the topic was of importance for them, but it should be noted that for two, in particular, the issue



aroused passion. The colorectal surgeon described how he had the equivalent of "*...five university degrees and a lot of experience and tremendous responsibility... for which I get paid a very small amount, in commercial terms.*" (Mr DJ). Ironically, a physician became equally excited when he compared his pay with that of surgeons, expressing a strong resentment of surgeons (and their private lists) who, he claimed, were motivated by money (Dr GP).

All ten barristers spoke of their pay, and the unpredictable time-scales for receiving payment were a common complaint. For example, one civil and family law barrister explained that Legal Aid can sometimes take "*...years and sometimes you never get paid...*" (Mr PC). The inequity of the system seemed to arouse the most indignation. It appeared that different specialties are accorded different values, and members of the criminal Bar felt unfairly discriminated against. All four criminal specialists complained of the Legal Aid rates of pay, explaining that "*...if you compare the criminal Bar to the civil... the commercial, ...the chancery and family, ...we're less well paid and we work just as hard, if not harder...*" (Silk). So, in terms of pay, whilst surgeons might be the envy of physicians in hospital medicine, criminal specialists represented the inverse story for barristers; they felt everybody else earned more.

#### **2.2.4 Job security**

For hospital doctors, job security was ambiguous. While six believed their futures to be secure, four expressed reservations. The issues causing concern were advances in medical science outpacing current skills, and organisational change threatening staff quotas. Barristers, on the other hand, appeared to have no real job security and comments such as "*...that's part and parcel of the job... I don't worry about it too much.*" (Ms KG) and "*I try not to think about it... my biggest fear is that something will happen... which means I can't physically do my job...*" (Mr MR), implied they were masters in the art of denial. Both doctors and barristers can be sued, and it appeared that doctors were more concerned about this than the two barristers who mentioned it. As a family law specialist put it "*...at least when I make a mistake the worst that's going to happen is that I'm going to get sued... but if you're a doctor... the worst that's going to happen is that your patient's going to die...*" (Ms CS).

#### **2.2.5 Co-worker relations**

The essential difference between doctors and barristers, in terms of evaluations of co-workers, was the fact that doctors expected co-operation and support from colleagues. Barristers gave the impression of being much more free-spirited - and alone. For them, 'working together' related to chambers' meetings where administrative issues were discussed, and liaising with clerks about the workflow.

For example, barristers spoke about co-worker relations in a very dispassionate, detached way, eg "*...chamber's meeting can be very difficult... on the whole, ours work very well here...one doesn't always see eye-to-eye with the clerk, because obviously they have an interest in your working as much as possible...*" (Mr DJ) and "*...I like the people I work with here, they're a good bunch...*" (Ms BF). Only one of the sample mentioned the more personal aspect of co-worker relationships, Mr HA



lamented the fact that he could only discuss his triumphs and not his worries with colleagues, eg *"...you've got to talk a good fight... I suppose that is a very male thing..."* Doctors were more intense and spoke in more personal and, sometimes, emotional terms, eg *"...I've just appointed a new colleague... it's like getting married, without the option of divorce..."* (Dr GP) and *"...if I see a patient... I've got colleagues that I can chew the fat with..."* (Ms CJ).

The difference may reflect the fact that doctors work alongside their colleagues within the same locality, ie a busy hospital department. Barristers, on the other hand, often travel considerable distances to the courts, returning to chambers only to pick up briefs and catch up with paperwork. They are therefore unlikely to have the same degree of contact as doctors.

### ***2.2.6 Supervisory practices***

Hospital doctors and barristers converged on attitudes toward trusts and government, respectively. In both cases, criticisms centred on cost-saving practices which they felt operated to the detriment of patients/clients. However, these seemed to be perceived as 'nuisance' factors, and there was little evidence to suggest that either hospital doctors or barristers considered their trust, or the Government, to be their 'supervisors'. As previously stated, the enormous autonomy awarded to these elite professionals appeared to insulate them from the 'slings and arrows' of adverse external influences.

## ***2.3 Comparison of consultants and barristers: Summary***

So although both professions offer a well-defined career path, with work high in motivating potential, analysis of moderator effects highlighted some important differences. In particular, it was the analysis of growth-need strength which illustrated a fundamental difference between doctors and barristers, and this difference put barristers' context satisfactions (or lack of them) into perspective. The overall impression was that doctors' high growth-needs were continuing to be met by their work, and that these were people who wanted the "loose ends" tidied too, eg they needed to know that they would be justly rewarded for their efforts, and that their jobs will be their's for life. Hence the flavour of doctors' dissatisfactions appeared to relate to their just world beliefs (ie procedural justice). Apart from barristers' obvious annoyance about pay disparities, the overall impression they gave was of a maverick group of professionals who were, by nature, high risk takers. Hence barristers' dissatisfactions with pay, job security and co-worker relations appeared to be much more akin to hygiene factors. As discussed in Chapter 8, these were entrepreneurial professionals who never expected to have everything laid out before them nor, indeed, would they particularly want it.



3 A comparison of general practice and hospital medicine

Overview of GPs' and hospital doctors' work

Table 20

| Critical Psychological States | GP | Hosp med | Moderator Effects      | GP | Hosp med              |
|-------------------------------|----|----------|------------------------|----|-----------------------|
| Meaningful work               | x  | ✓        | Knowledge & skill      | ✓  | Selves ✓<br>Juniors x |
| Autonomy & responsibility     | x  | ✓        | Growth-needs           | x  | ✓                     |
| Knowledge of results          | x  | ✓        | Context satisfactions: |    |                       |
|                               |    |          | pay                    | ✓  | x                     |
|                               |    |          | job security           | ✓  | ?                     |
|                               |    |          | co-worker relations    | ?  | ?                     |
|                               |    |          | supervisory practice   | x  | N/A                   |

? = some problems  
N/A = not applicable

3.1 The Critical Psychological States: GPs versus consultants

The most striking difference between general and hospital practice related to the motivating potential of the basic (ie unmoderated) job design, where GPs were seriously disadvantaged. As stated in Chapter 7, consultants' apparent lack of concern (or awareness) regarding rising patient-consumerism is probably due to the filtering job performed by GPs on their behalf. Therefore it was argued that hospital doctors have a greater likelihood of experiencing task significance than GPs. However, perceptions of autonomy possibly pinpointed the most important difference between the groups; a bizarre situation considering both are members of the same profession. Hospital doctors appeared to enjoy immense autonomy, with GPs very much the 'poor relative'.

3.2 Moderator effects: GPs versus consultants

The theme carried through to *growth-need* strength. It was clear that the majority of hospital doctors enjoyed an ongoing expansiveness and challenge in their work which was commensurate with their high-growth needs. In contrast, half of the GP sample pursued interests outside their work, despite their general practice work spilling over into non-work time. Moreover, three GPs complained of the lack of intellectual challenge in general practice. It was suggested that an apparent lack of career structure may deny GPs any tangible measure of personal growth and development. Hospital doctors' careers, on the other hand, follow a clearly defined path as demonstrated in section 2 (eg Dalton, Thompson and Price's Career Stages Model, 1977). The fact that GPs do not specialise will also deny them the chance of 'star' status. It is a harsh reality that the Christiaan Barnards of this world are not general practitioners, they are specialist surgeons with all the associated media acclaim and glamour.



Another noticeable difference between the two groups related to opinions about *pay*. There was no discernible pattern in GPs' grumbles about their pay. For example statements ranged from it being 'enough were it not for the stresses', through to one particularly angry comparison with 'others-outside' the profession, eg solicitors. Nevertheless, two of the women conceded that out-of-hours work actually "*pays quite well*" (Drs RJ and LA). Consultants, on the other hand, seemed to have a clearer idea of their worth (ie according to their perceptions). For example of the four who expressed dissatisfaction, the general consensus appeared to be one of not being paid their worth, eg "*the money is not anything like what I would get if I was in a commercial or... non-government sector...*" (Mr DJ), "*...we do deserve more than we actually get...*" (Dr GP), "*I think the pay could be better...*" (Dr MA). Perhaps the radiologist epitomised the sample's standpoint with his observation, "*you'll never get any power salaries...*". In other words, consultants felt that their power and autonomy were not adequately reflected in their remuneration.

There was an interesting link between *knowledge of results* (ie feedback) in general practice, and *co-worker relations* in hospital medicine. GPs seemed to look towards their patients for emotional support, ie patients had to demonstrate their approval of the doctor, and his/her performance, with overtly expressed gratitude. Hospital doctors, on the other hand, seemed to turn towards colleagues for their emotional support and these were defined within narrow parameters; co-workers had to be of equal standing in terms of status and knowledge and skill. None of the hospital sample spoke about patients' personal characteristics or behaviour.

Finally, from the researcher's viewpoint there were other important differences between GPs and hospital doctors. As noted in Chapter 5, GPs had struck the interviewer as intense, serious individuals who needed to talk about themselves and their work, despite their notorious time pressures. The hospital sample were much easier to access, and gave the impression of being composed and in control. Certainly, hospital doctors appeared to lack the earnest, sometimes desperate 'edge' that so often crept into GPs' demeanour. Whether these individual differences were the cause of GPs leaving hospital practice in the first place, or whether their work in general practice had effected the difference, remains open to question.

### 3.2.1 *Hospital doctors: GP or not GP?*

During the course of interviews, it transpired that half of the hospital sample (3 women and 2 men) had previously considered a career in general practice. In view of the apparent differences between GPs and hospital doctors, it seemed appropriate to include a brief analysis of this area in the present section.

Reasons for not pursuing general practice were as follows:

1. reluctance to make a lifelong commitment at age 27 (1 doctor)
2. hospital practice became more attractive with time (4 doctors)



Two women, the paediatrician and clinical geneticist, had first-hand experience of GP training, with the former having completed the course. The geneticist, however, changed her mind half-way through:

HS (♀ clinical geneticist): "...I did half a GP scheme because... I wasn't sure I wanted to be involved in a competitive race... but then having done that, I realised actually my love was hospital medicine and so I had to get on and do it..."

However, the doctor who completed her GP training thought all hospital doctors should do it:

WC (♀ community paediatrician): "...it was a very good... general grounding... and I think it's something that all people should do before going into hospital medicine... a lot of people who trained all the way through hospital... have no idea of the work out in the community... and it makes them very arrogant... you can have very... well informed GPs with masses of experience, ringing a newly qualified houseman and they can be really arrogant and rude..."

Dr WC gave her reasons for not using her GP qualification:

WC (♀ community paediatrician): "...I didn't want to settle into a practice at... twenty seven... it was like a lifelong commitment, so... I started looking for more paediatric jobs with the idea of going back to general practice... and I just sort of fell in love with... paediatrics..."

The third woman, a surgeon, described how she changed her mind about becoming a GP after changing hospitals:

HL (♀ vascular surgeon) "...I just wanted to get out [of London] and have a career outside hospital, so being a GP seemed... a jolly good idea. But... I did my house jobs at Swindon... and Poole... and I loved working in those hospitals. I thought - this it it... I'll be a surgeon instead!"



Finally, the two men described how they saw general practice, today:

FN (♂ radiologist): "...I think hospital practice is a bit more attractive and GP is a lot less attractive. I think the original set-up was wrong, and they've finally realised that they can't be everything to everyone, and it's very, very stressful for them..."

MA (♂ pathologist): "...I... applied for some general practice post initially, and then decided to change tack and go into pathology... I'm glad I didn't go into general practice."

[*Why, specifically?*]

" I think the job's changed... it's more like managing a business rather than looking after patients, which wouldn't have appealed to me. I think it's a bit of a grind actually, from the point of... getting grief from patients... you're more at the mercy of what the patients want... compared to those of us who work in hospital medicine."

The overall impression was that general practice was considered something of a last resort - a safety net - if things failed to work out in hospital medicine, rather than being seen as a legitimate career option in its own right. This interpretation was borne out by the findings reported in Chapter 5 (see 1.1 Job satisfaction - 'if you had the chance again') where the majority of the GP sample cited disenchantment with, or barriers to success in, hospital practice. Only two GPs gave wholly positive reasons for choosing general practice, one of whom offered his own opinion on the high level of disillusionment in the profession. Again, there was an underlying sense that general practice is for 'also-rans':

Dr SD ♂ "...people may fail a hospital career and then opt for general practice because they didn't think they could do anything else... that's where people get disheartened because they've failed at one thing... it can be very rewarding, but some people find it incredibly draining because their heart isn't in it..."

Furthermore, this impression extended to non-medics too. For example barrister, Mr HA, expressed disappointment over his pay, in terms of it being much more likely that he would be living "*...next door to your local GP, rather than next door to your local consultant surgeon.*"

### **3.3 Comparison of GPs and consultants: Summary**

So a combination of diminishing autonomy, unfulfilled potential (ie growth-needs), lack of career structure and an image of being 'second best', appeared to represent the main differences between doctors in general practice and those in hospital consultancies.



## 4 A comparison of legal practice and the Bar

### *Overview of solicitors' and barristers' work*

Table 21

| Critical Psychological States | Sol's | Bar | Moderator Effects      | Sol's | Bar |
|-------------------------------|-------|-----|------------------------|-------|-----|
| Meaningful work               | ✓     | ✓   | Knowledge & skill      | ×     | ✓   |
| Autonomy & responsibility     | ✓     | ✓   | Growth-needs           | ✓     | ?   |
| Knowledge of results          | ✓     | ✓   | Context satisfactions: |       |     |
|                               |       |     | pay                    | ?     | ×   |
|                               |       |     | job security           | ×     | ×   |
|                               |       |     | co-worker relations    | ✓     | ?   |
|                               |       |     | supervisory practice   | ×     | N/A |

? = some problems  
N/A = not applicable

#### 4.1 *The Critical Psychological States: solicitors versus barristers*

Both groups experienced work high in motivating potential with all three Critical States potentially 'activated'. As stated in Chapter 6, solicitors professional autonomy has recently been eroded by fierce government intervention. Nevertheless, their personal autonomy as high street practitioners remains high; operating as independent commercial units, they can develop various specialisms according to local markets. Barristers, on the other hand, appeared to be totally free agents, confined only by the in-house constraints that are agreed within chambers. However, total autonomy equates with total responsibility not only work-wise, but also in relation to their sole-practitioner status; barristers must make their own arrangements in terms of sickness/maternity cover, holidays, pensions, *etcetera*. Like hospital consultants, barristers also have the opportunity to earn themselves 'star' status, for example as high court judges.

#### 4.2 *Moderator effects: solicitors versus barristers*

In terms of *growth-needs*, most of the solicitors in the sample found fulfilment in their work, whether it be the satisfaction of running their own business, or realising their own potential/enjoying professional status. For barristers the story was not quite so straightforward. As stated in Chapter 8 barristers appeared to thrive on risk and uncertainty, and there was tentative evidence to suggest that once the fear had been conquered (eg with experience), then so too went the joy.

With regard to the next moderator difference, *pay*, solicitors' opinions were divided. Whilst four were obviously satisfied with their level of remuneration, three experienced unmet expectations. For example there were clear indications that in general, the legal profession conveyed a popular stereotype of 'fat cat' salaries, as illustrated by some of the comments, eg "I mean that's why I chose law..." (Ms DJ), "I don't think either I, or



*many of my colleagues, are earning the sort of figures we thought we would...."* (Ms HJ), *"I don't live 'the life' - I'm not on holiday all the time or driving a flash car or anything like that! ..."* (Mr ED). Moreover, none of the solicitors compared their pay with that of barristers which, it was suggested, was due to barristers' work being perceived as intellectually more challenging than that of solicitors. Barristers, according to the sample, seemed free of such preconceptions. For example their main 'gripes' were directed toward the inherent injustices of the system, whereby different specialisms were accorded different rewards as noted by the Silk in section 2.2.3. Another common complaint was the unpredictable time-scale for receiving payment. Nevertheless, as previously stated, barristers' dissatisfactions with their unpredictable lifestyle (eg pay and job security) seemed to be, essentially, all part of the attraction for them.

**Co-worker relations** marked another difference between the two groups. Solicitors appeared to enjoy friendly social relationships with colleagues, whereas this seemed to be lacking for barristers in chambers. Chambers' relationships appeared to be mainly business-based where individuals could sometimes feel quite isolated, in terms of being able to share their concerns with colleagues (eg Mr HA who was quoted in section 2.2.5).

Finally, in terms of **job security**, both groups agreed that they had little, if any, security. For example solicitors felt that their security depended on their meeting billing targets and an ability to attract new business to the firm, whereas barristers felt they were *"dependent on their last performance..."* (Mr CM).

#### **4.4 Comparison of solicitors and barristers: Summary**

In Chapter 8 it was noted that barristers manifest the hallmarks of both professionals and entrepreneurs. Although it was argued that solicitors have lost one of the centrally defining characteristics of professionalism; ie the monopoly of specialist knowledge, as senior partners of their own law firms it can be argued that they too are entrepreneurs. For example, they have:

- a high degree of control over their work
- the thrill of growing something out of nothing
- monetary rewards tied directly to accomplishments
- a greater uncertainty about the future.

Nevertheless, these days solicitors are rarely sole practitioners, and it would be difficult to find a professional occupation which offered greater uncertainty than the Bar. Nor did solicitors demonstrate the veritable appetite that barristers appeared to have for an all round high-risk lifestyle.

## **5 Evaluation of the research design: medicine versus law**

As stated in the Introduction, the rationale for including both doctors *and* lawyers in the study was to establish what was different about doctors and, more specifically,



what was different about GPs. For example where did the problem lie - with the doctors themselves - or with general practice?

The initial aim of the study was to examine and compare doctors' and lawyers' career expectations. To the author's knowledge, no previous study had been carried out in this field, and yet both professions shared much in common. For example, as previously noted, there were striking similarities between the roles of GPs and solicitors, and between hospital consultants and barristers. Hence the purpose of the study was to identify any common expectations within and between the professions, the extent to which expectations were realistic, and perceptions of any barriers to the realisation of these.

As explained in Chapter 4, after preliminary examination of the data it was decided to look more broadly at doctors' and lawyers' work, within the theoretical framework of the Job Characteristics Model.

How useful, then, was the research design in the light of this change?

In terms of similarities, GPs and solicitors had more in common with each other than GPs had with hospital consultants, or solicitors had with barristers. Consultants and barristers were similar because of their immense autonomy and responsibility as sole decision-makers. Quite apart from their obvious similarities in terms of being the first port of call for the public, and the fact that both operate a referral system for specialist cases, there were other similarities between GPs and solicitors. For example there were hints, from both groups, that their jobs were not quite on a par with those of consultants and barristers, respectively.

However, the most useful point of the exercise related to the apparent differences between general medical and legal practice. It was clear that GPs lagged behind solicitors in coming to terms with the changing workplace. For example solicitors appeared to have adjusted well to the 'new' transactional psychological contract, resigning themselves to working long hours, to defined targets, with few assurances for the future. GPs, on the other hand, were still in fighting mode. Judging from the sample base, doctors had two important expectations regarding their work in general practice:

- a relational psychological contract with the State
- deferential, appreciative patients

Both had been ravaged; the Government's recent changes had left them feeling betrayed and exploited, and patients had become demanding consumers who took the doctors' kindness for granted. Unsurprisingly, doctors could see little personal advantage in the changes sweeping through the health service. Rather, it was all about diminishing autonomy, extra work in terms of health authority dictates and rising patient-demand, with no appreciation - from either the Government or patients.

Solicitors had perhaps already faced the unimaginable: the loss of their monopoly of specialist knowledge which, as previously argued, is a centrally defining characteristic



of a profession. Nevertheless, although half of the sample described rising consumer-demand (eg clients wanting more value for money), and almost half complained of competition from 'outsiders', solicitors' concerns were very down-to-earth. They had identified marketing skills as a key to expanding and maintaining a *business*, and were concentrating their efforts on developing that aspect, rather than lamenting the loss of professional status. In terms of expectations again, for solicitors, it was very practical; they had expected to be earning more.

Comparisons of GPs and hospital consultants' work-perceptions highlighted important within-group differences. In terms of a fulfilling career it was possible to establish just what was missing in general practice, eg career structure, autonomy, lack of personal challenge and kudos. Furthermore, it was possible to identify differences in the doctors themselves. For example GPs appeared to be more emotionally involved in their work and this was revealed, not only in their need for patient-appreciation, but also in the way they spoke about their work.

As the above would suggest, the decision to compare doctors and lawyers was considered to be well-judged. The study of general practice benefited from the contextual background afforded by the inclusion of other professionals, ie the between-groups comparison with law and the within-groups comparison with hospital practice.

### ***5.1 Evaluation of the JCM in the light of the present study***

Hackman and Oldham's Job Characteristics Model has undoubtedly provided a valuable framework for the comparative analysis of doctors' and lawyers' work. For example, it has highlighted several inherent problems in doctors' core job characteristics. According to the model, these findings should not only explain doctors' low morale, but should also point the way in terms of work redesign in general practice.

In terms of its applicability to the wider world of work, it is difficult to see how hard-pressed organisations, still trying to come to terms with the after-effects of 'downsizing' and 'delaying', would react to notions of job-enrichment programmes for employees. Today's legal firms closely resemble the business world at large, which has been transformed by changes in the economic climate. This may explain the transactional approach which some of the solicitors demonstrated, in terms of their psychological contract with their employers. By today's standards, Hackman and Oldham's preoccupation with job enrichment seems almost naive. It certainly seems more aligned to the relational psychological contract of bygone days, and assumes that organisations have a vested interest in the psychological wellbeing of their employees. Whilst for some (small) firms, this may still hold true, the prevailing philosophy today tends to be more: if you are not satisfied in your work then the fault lies with you, not the job (eg Herriot and Pemberton, 1995; Hiltrop, 1996). This, of course, is the very attitude which Hackman and Oldham set out to address in the late 1970's, eg basing their work on the ideal of fitting jobs to people, rather than fitting people to jobs.



It is perhaps only in times of labour shortage, that it becomes appropriate to ask how people *feel* about their work, eg is it enriched? ... and what can be done to improve job satisfaction? Although medicine is atypical insofar that it is still extremely competitive, in terms of entry to the profession, the fact that doctors are voting with their feet clearly indicates that something is very wrong with general practice. So despite reservations about the model's wider applicability, for the purposes of the present study, the JCM provided a sound framework in which to begin unravelling some of the key issues in this troubled profession.

## 5.2 *Some problems*

Nevertheless, there were instances where the full model (ie including moderators) could not explain the entire picture regarding work in general practice. There were three such instances:

1. work volume
2. work-centred growth-needs
3. global measures of job satisfaction

### 5.1.1 *Work volume*

There were several cases of work overload appearing throughout all groups, except for barristers. In the case of solicitor, Ms HJ, it was obvious to the researcher that the woman's persistent and relentless workload was threatening not only her motivation and job satisfaction, but also her psychological wellbeing. Yet Hackman and Oldham only referred, very briefly, to excessive *quantity* of work. Even then they chose to emphasise the detrimental effects on the *quality* of work, rather than acknowledging detriment to the worker.

Interestingly, they identified two different styles of organisation management, which they called, 'Route One' versus 'Route Two'. The first route refers to a people-centred approach, ie embracing the job-enrichment philosophy of fitting jobs to people, whilst the second route refers to a productivity-centred approach, where the job comes first, and people are secondary, ie fitting people to jobs. The authors project the world of work into the late 1980's for both scenarios, and gave a chillingly accurate prediction of working life in the 1980's/early 1990's, according to 'route two': "*...the employee is faced with contingencies that specify, "The harder I work, the more negative I feel about myself and what I'm doing... and the more likely I am to get praise from my supervisor and significant financial bonuses." ...having strong positive and strong negative outcomes contingent on the same behaviour - prompts some people to engage in maladaptive behaviours such as drug usage and alcoholism, and to exhibit signs of "craziness."...*"

Nevertheless, even in this case, Hackman and Oldham used as their example, "*...a man currently working on an undemanding, repetitive and routine job... someone who matches checks and invoices and then clips them together to be processed by another employee...*" (Hackman and Oldham, 1980, p265-266). However, although the choice of worker might be inappropriate, the example of an employee driven by performance-



related rewards, is still pertinent to one of the samples, eg solicitors' billing targets. Paradoxically, however, it is doctors who have problems with drug abuse and alcoholism, rather than solicitors (eg Cooper, Rout and Faragher, 1989) and their work can hardly be described as performance-related. Although it is true that GPs have community health targets, these were fairly low-profile for the sample, being mentioned by just one GP.

### **5.1.2 *Work-centred growth-needs***

The JCM assumes that work is a central value for satisfying high growth-needs and this may not always be the case. The point was illustrated by both a lawyer and a GP (eg the 'traveller' GP and Mr ED, the solicitor, who valued his hobby as an 'aeroplane enthusiast'). It is argued that not all individuals with high growth-needs will have a high work centrality. Some might have an instrumental approach to work, ie considering it as a means to an end. However, even in cases of high work-centred growth-needs, the situation may not remain constant over time. For example, as illustrated by the study, women with previously high work-centred growth-needs may experience a 'glitch' when they have children. Similarly, length of tenure may also have a bearing on how well work satisfies high growth-needs. As suggested in Chapter 5, with increasing tenure people may 'adapt out' of the challenges that the job may have initially presented. General practice is a good case in hand, as there is no career structure to provide individuals with a sense of progressing and developing over time. The job that GPs enter at age thirty, is essentially the same one from which they retire at sixty (eg Richards, 1991). In summary, growth-needs may not necessarily be work-centred, nor can it be assumed that they will remain constant throughout a career-span.

### **5.1.3 *Global measures of job-satisfaction***

The JCM's global measure of job satisfaction fails to take account of dissatisfactions with a fairly major part of a job. For example, one of the GP sample appeared to enjoy all aspects of his work as a GP, except for the patients. Nevertheless, his critical psychological states were activated by his feeling efficacious and responsible for work perceived as important and meaningful, ie the administrative side of running a business. This is clearly not an ideal outcome and one which is considered to represent a possible flaw in the model. It would seem to suggest an approach which is, perhaps, *too* worker-centred; one that is in danger of losing the aims and objectives of job enrichment, ie to achieve the ideal match between the needs of the worker and the demands of the job.

## **5.2 *One more time: What is wrong with general practice?***

As a necessary prelude to the second part of the study, the research question is brought back into focus: *what is wrong with general practice?*

It has been established that those who enter the medical profession are likely to have high expectations (eg Kim, Price, Mueller and Watson, 1996), and high growth-needs. Whilst hospital practice appeared to fulfil these requirements, general practice was clearly lacking in motivating potential. Key issues were as follows:



- ***lack of career structure*** denying doctors any measure of development and progression
- ***an inflexible career path***; GPs perceived it to be extremely difficult to switch practices, or to return to hospital practice, if they felt they had made the wrong career choice
- ***lack of intellectual challenge***, as evidenced by half of the sample (5 doctors) pursuing outside work/interests, despite long hours in the surgery
- ***a sense of shrinking autonomy/professional status***, as reflected in reports of increasing Government intervention and spiralling patient-demand.

There were also anomalies regarding feedback/co-worker relations. Whilst hospital doctors spoke of turning to colleagues for support, GPs appeared to rely on their patients for this. Indeed, the need for patient-gratitude seemed to make doctors particularly vulnerable in terms of their feelings of self-efficacy and self-esteem.

Moreover there were strong indications, from the study of both hospital doctors and GPs themselves, that general practice was considered something of a last resort; a job for 'also-rans', rather than a specialty in its own right.



# Part III

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## **Chapter 10**

Introduction to Study 2

## **Chapter 11**

Method

## **Chapter 12**

Results & Discussion: GP registrars

## **Chapter 13**

Results & Discussion: Specialist registrars

## **Chapter 14**

Overview of the Two Groups



# Part III

## Chapter 10

### Introduction to Study 2

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Having established that general practice can represent something of a last resort, in terms of career, then what were doctors expecting when they first entered general practice? Were they aware of the lack of career structure; that the job they enter at thirty would be the same one they will retire from at sixty? If so, what did they think would compensate for this? For example, did they imagine a Dr Finlay-type scenario where the family doctor was revered as an important, central figure in the community?

In an attempt to answer such questions, Part III of the study explores the career expectations of trainee doctors in hospital and general practice.

The Job Characteristic Model was used as the theoretical framework for analyses of the experienced groups, the strengths of which were discussed in section 2 of the Introduction. For example, because of the model's emphasis on using participants' subjective accounts of their work, the researcher was able to piece these data together and to build a detailed and more objective overview of the jobs in question.

However, when considering the focus of the second study; investigating the expectations of trainees in the same line of work, it was decided to take a different approach. The researcher wanted to ask much more specific questions which were outside the model's remit, eg did hospital doctors ever consider a career in general practice? Did GPs ever hanker after a specialist job? What were the attractions of their current specialty choice? As trainees, it was assumed that such career decisions will have been made fairly recently, and were therefore probably more reliable than the retrospective accounts of the experienced samples. In other words, the present section employed a more 'pick and mix' approach where the findings of the first study, based on the JCM, were used to inform the design and direction of the second.

Finally, it will have been noted that the legal samples have been dropped from the second study. Although data had been collected from trainee solicitors and pupil barristers, in view of the focus of the research (ie *what is wrong with general practice?*), it was decided to hone the samples down to doctors alone. Hence the sample base in Part III included two groups:

1. **GP registrars** with a mean of 2.5 years in GP training (range: 0 - 2 years 9 months)
2. **Specialist registrars** with a mean of 5 months in specialist training (range: 1 - 30 months)



After the Method in Chapter 11, the study begins with the discussion and analysis of GP registrars in Chapter 12, and then moves on to the discussion and analysis of specialist registrars in Chapter 13. Part III then concludes with a brief overview of these two professional groups in Chapter 14.



# Chapter 11

## Method

### 1 Semi-structured depth interviews: overview

As previously stated in Chapter 2, individual semi-structured depth interviews were judged the most appropriate means of data collection for Study 1. For example, they follow a definable course, ensure consistent data sets across groups, and help to orientate interviewees in terms of the general purpose of the meeting. In view of the successful outcome of interview procedures in the first study, there seemed to be no justification for changing the formula in the second. Therefore interviews with the trainee sample followed an identical format to that of the experienced sample. Participants were interviewed individually and, despite the researcher's 'agenda', were encouraged to expand on topics as they so wished.

### 2 Participants

Nineteen people (11 men and 8 women) participated in the study. Two trainee groups of doctors were represented: GP registrars and specialist registrars. The sample were selected to represent trainee GPs currently undergoing their one year's secondment in an actual general practice, and trainee hospital doctors undergoing the first year of their specialist training. Full details of the two groups (including demographics) are summarised in the table below.

*The Sample (trainee doctors)*

Table 22

| GP Registrars                                                                                                          | Specialist Registrars                                                                                                                            |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Total:</b> 8<br>5 men, 3 women<br><b>Mean age:</b> 28 years (range: 27 - 29)                                        | <b>Total:</b> 11<br>6 men, 5 women<br><b>Mean age:</b> 31 years (range: 27 - 37)                                                                 |
| <b>Mean time in GP training:</b> 2½ years<br>(range: 0 - 2¾ years)<br><b>PQE mean:</b> 3 years<br>(range: 1 - 4 years) | <b>Mean time in specialist training:</b> *3 months<br>(range: 2 - 6 months)<br><b>PQE mean:</b> 7 years (mode: 8 years)<br>(range: 3 - 14 years) |

In terms of age, the specialist registrar group were marginally older than the GP registrars, but this was explained by several exceptional cases as stated in Chapter 1 (section 4.2.3). For example, a female paediatrics registrar (from Nigeria) was having to repeat her higher training in the UK, and a respiratory medicine registrar who had changed specialties was also having to repeat certain aspects of his specialist training.



All participants were drawn from three neighbouring counties; Northamptonshire, Buckinghamshire and Oxfordshire. The researcher had difficulty in finding enough GP registrars in one county alone and resorted to approaching a second, in an attempt to achieve a reasonable sample size. Eventually a total of 8 registrars were recruited through liaison with regional training organisers in both Northampton and Milton Keynes.

The specialist registrar sample was achieved through various means. The Postgraduate Dean of the Oxford University and Regional Training department provided a "random" (his description) selection of names from a list of specialist registrars. However, the list was almost devoid of surgical trainees and these were eventually acquired through the good will and co-operation of a consultant surgeon known to the researcher. The sample were drawn from three district general hospitals in the counties of Northamptonshire and Buckinghamshire, and a larger regional teaching hospital in Oxfordshire. There were 4 selection criteria:

1. ensuring that GP registrars were actually working within a general practice at the time of interviews, and that specialist registrars were at the beginning of their training (eg within the first twelve months)
2. attempting to achieve representatives of both surgery and medicine in the hospital sample
3. achieving, wherever possible, a gender balance across both groups
4. ensuring all potential participants were located within reasonable travelling distance of the researcher.

Efforts were made to recruit samples of similar size to those in the first study, ie 10 per group. However, difficulties in finding sufficient GP registrars (unsurprisingly, given the research question), led to a slight shortfall with a sample of 8 trainees. Eleven specialist registrars were eventually recruited to the hospital trainee sample.

### **3 Participant recruitment**

Following much the same format as Study 1, all potential participants received an introductory letter explaining the purposes of the research and requesting their co-operation with regard to being interviewed. Interviews were described as likely to last between forty minutes and an hour, at the most. After assurances of confidentiality and anonymity (of both interviewees and their workplace), the letter concluded by stating that the researcher would telephone the doctors in a week's time to establish their intentions regarding participation.

All specialist registrars received letters direct from the researcher. For GP registrars however, the format was slightly different. GP trainers (ie GP principals who have additional responsibilities as trainers) were written to first, seeking permission to approach their registrars. Enclosed with the letter to the trainer, was a second sealed envelope addressed to the GP registrar. Trainers who approved the researcher's request were asked, in their letter, to pass on the enclosed envelope to their trainee. As with



the first study, practice managers also received a courtesy, introductory letter outlining the researcher's intentions. It was also explained that the researcher would be telephoning the practice, within the next week, to establish the trainer's and registrar's response. In subsequent follow-up calls, the researcher always spoke to the trainer first and, where appropriate, the trainee second.

### **3.1 *GP registrars***

As already stated, finding enough GP registrars had been a problem. At the time of participant recruitment there were only 6 trainees in Northamptonshire (out of a total of 20 potential training places), all of whom were approached. Four were successfully recruited to the study. Another 4 trainees were then approached in the neighbouring county of Buckinghamshire, of whom all agreed to take part, rendering a total of 8 GP registrars for the sample. The two doctors lost to the study were both women. Of these one was on leave when the researcher telephoned, having left a message to say she was "*not very keen*", whilst a second declined on the grounds of "*stress and exams*". Interviews took place during February and March 1997.

### **3.2 *Specialist registrars***

In the specialist registrar group a total of 19 doctors were approached, of whom 11 agreed to be interviewed. Of the 8 (males) not included in the study, 2 had left the hospital, 2 had never been heard of by the switchboard staff, a further 2 surgeons had proved impossible to contact, another was on leave and a final registrar had to be dropped because it was discovered that his consultant had taken part in Study 1. In the latter case, although the young man in question was nevertheless willing to be interviewed following an explanation of the situation, the researcher thought it ethically unwise to interview a trainee and consultant (ie his boss) from the same firm.

Nine medical and 2 surgical specialties were represented in the sample and these were: paediatrics, geriatrics, endocrinology, palliative care, medical oncology, respiratory medicine, pathology, psychiatry (2), urological surgery (a new specialism) and general surgery. Both surgeons were men. The reason for including two psychiatrists was due to the fact that both responded to the invitation to participate in the study. As explained in Chapter 1, after asking people for their co-operation, it was felt important that those who agreed should then be given the opportunity to join the sample. Interviews took place from early April through to mid-June 1997.

## **4 Participants' choice of venue**

All interviews took place in a work setting. GP registrars were interviewed in their practice surgeries, whilst interviews with specialist registrars were a little more varied. For example most hospital trainees chose a small ward office, but 2 chose boardrooms in their postgraduate training centres. A further 2 however were interviewed "on-the-job". One of these took place in a pathology laboratory and another in a busy day-surgery unit. In the latter case the interviewee, resplendent in full theatre 'greens' and white wellingtons, led the researcher through to an eight-bedded examination area.



This was a cystoscopy clinic where patients were awaiting surgical exploration of the bladder and urinary tract. Here several gentlemen, scantily clad in white hospital gowns and perched on bedside stools, watched on nervously. The researcher was shown to a spare bed whereupon the area was curtained off (what now - should the researcher get undressed? What were the 'other' patients thinking?). The doctor drew up two chairs and the interview was conducted there, behind the floral curtains. Moreover there were two interruptions from a nurse resulting in the interviewee hurrying away, presumably to continue his surgical duties. In less time than it took for the researcher to finish her 'polo', he would mysteriously reappear and the interview would be resumed. Nevertheless, the interview was both full and useful, with the registrar showing no signs of being inhibited by the situation. As the researcher was to learn later, doctors seem to have a remarkable penchant for divided attention. The interview concluded with the surgeon asking the researcher for a lift into town to collect his car from the garage.

## 5 Interview procedures

Interviews followed the same format as those in the first study. After formal introductions, the researcher restated the aims of the study and the purpose of the interview. Participants were asked if they had any questions in relation to the study and/or interview. Permission was then sought to tape-record the interview, with reasons given for this. At this point, interviewees were assured that any quotations used in the study would be unattributed. Assurances of confidentiality, given in the introductory letter, were reiterated. Finally, participants were informed that they had the right to not answer any question they felt uncomfortable about, and the right to terminate the interview at any time. Although most interviewees seemed to appreciate these final words of reassurances, there were some exceptions.

Three of the 11 specialist registrars remained unconvinced by the researcher's assurances and refused to be recorded. Their discomfort was immediately apparent as the researcher broached the subject of recording the interview. They included 2 female registrars, one specialising in paediatrics, the other in pathology, and one male specialising in endocrinology. Although none of them refused outright and none offered explanations for their unease, comments such as "*I would really rather you didn't.*" and "*is that really necessary?*" conveyed their feelings on the matter. The researcher refrained from probing further, for fear that it may be construed as coercion and exacerbate their unease. Instead, the subject was promptly dropped and permission was sought for the researcher to make notes during the interview. All agreed to this. The fact that this attitude was restricted to the trainee hospital sample alone, implies that awareness of litigation risks may have been raised, as part of their training. However, the researcher has been unable to confirm (or disconfirm) this suspicion. Alternatively, they may have feared reprisals from the trusts that employed them. Interestingly, most of the GP registrars (for both counties) were interviewed soon after attending a seminar on medico-legal concerns. They explained to the researcher that they had been advised to expect an average of five or six lawsuits during the course of their careers. Yet all of them happily consented to a recording of their interviews.



For those who expressed concern about being recorded, notes were made both during, and immediately after, the interviews. The researcher was thankful for her shorthand skills on such occasions. Whenever possible, transcripts were made during the same day.

Following permission to tape record the interview, and assurances of confidentiality, the format of the interview was discussed with participants. For example, it was explained that although the researcher had a number of pre-determined topics to cover (for the sake of consistency across samples), the individual should feel free to expand on these and any other topics which they felt pertinent to themselves or the study. At the end of each interview, participants were asked whether they would mind answering a number of demographic-based questions, and these included date of birth, marital status (and number of children, where appropriate), date of registration and dates for both the start and completion of their current training. Interviews concluded with the researcher expressing her gratitude for their time and co-operation, and the customary handshake.

The researcher's agenda, which guided interviews, is presented below:

Table 23

***List of topics covered with each group:***

1. progress to date (eg "how's it going so far?")
2. reasons for choosing their career - the main attractions
3. a) ***GP regs:*** why not hospital practice?  
b) ***Specialist regs:*** why not general practice?
4. what sort of personal attributes were perceived necessary for success
5. a) ***GP regs:*** brief outline of prospective job in terms of *expected* highpoints and downsides  
b) ***Specialist regs:*** outline of *current* highpoints and downsides and how these might *change*, once they become consultants
6. usual hours of work and how these might change on completion of training
7. perceived level of control over working life, in terms of autonomy
8. awareness of the extent of competition at the outset of career/training
9. expected difficulty/ease in finding a position on completion of training
10. views on long-term job security
11. plans to stay in the UK or work abroad
12. where they saw themselves in 7 -10 years time (ie in relation to experienced sample of Study 1)



6 Treatment of data

Although the Job Characteristics Model had been employed to such good effect in the first study, it was not judged to be quite so relevant to trainees.

Findings from the first study had informed the direction for the second, and the researcher had therefore sought answers to specific questions which were outside the scope of the JCM. Because the data were categorised (eg coded) as they were transcribed, analysis was more a pleasure than a chore. The sample's comments were re-categorised, in finer detail, according to their responses to topics.

To illustrate the point, an excerpt from one of the analysis charts is presented below.

| ANALYSIS OF SPECIALIST REGISTRARS: DID YOU EVER THINK OF BECOMING A GP?                                                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1) Dr BP ♂ (Psychiatry) "Never... I like treating extremes, and I really don't like the generics of a mild, worried world - problems that are going to resolve on their own in two weeks' time... I don't see my role in life to reassure people..."                                                                                                                                                                                        |
| 2) Dr CJ ♂ (Palliative care) "...I started off as a GP and thoroughly enjoyed that... I found I really liked the patients who have chronic illnesses... and I wanted to gain more experience... before settling down into general practice... I went on from there to do my first hospice job and I really loved it... you're looking at the whole meaning of people's lives..."                                                            |
| 3) Dr DL ♀ (Psychiatry) "Jack of all trades and master of none... I mean it's keeping your eye on the ball all the time... you may see just one poorly person a week... a person who needs to go into hospital, and if you miss that... everyone's laughing at you... I'm very happy that I don't have their terms and conditions, you know, general patient-expectations, fundholding... it's all things that I couldn't be arsed with..." |
| 4) Dr GC ♀ (Histopathology) "No... because it's boring - just seeing people with snotty noses."                                                                                                                                                                                                                                                                                                                                             |
| 5) Mr JA ♂ (Urology) - <i>offered his opinion re GP before being asked</i> "...I wouldn't do GP. If I had to do that, I would give up medicine and do something different.... I wouldn't like loads of patients coming in with nothing wrong with them, you know, and wasting your time..."                                                                                                                                                 |

Once the data had been separated out, as above, they were then re-categorised according to the nature of doctors' comments. For example, it is fairly easy to see a common thread running through the responses of doctors BP, DL and GC above; the fact that they liked dealing with 'real' illnesses and not the 'worried well' (eg "*people with snotty noses*"), and so on.



## Chapter 12

### Results and Discussion: GP Registrars

The five men and three women comprising the GP registrar group, were all interviewed in their respective training surgeries. Hence all were 'captured' during the general practice year of their Vocational Training Course. Individuals varied in the length of time spent in practice; some were interviewed at the very start of their year, whereas others were busy preparing for the summative assessments which mark the completion of this part of the course. The phrase 'open and honest' frequently cropped up in the field notes for this sample and, on the whole, they impressed the researcher as being friendly and approachable. It was noted that two of the men appeared to be more tense/less friendly than the others (Dr AM and Dr SG). However, this may have been due to the lack of a smile. It was only the absence of a welcoming smile that reminded the researcher of its importance in terms of impression-management. Nevertheless, one of the men had recently lost his father and admitted to feeling fairly stressed at the time. The other registrar was very pleasant and easy to talk to, as the interview got underway, so perhaps it was just the lack of a smile (persisting throughout the interview) which gave the interviewer a sense of impending difficulty.

#### 1 Working in general practice - first impressions

The section begins with responses to the opening question, "*How's it going so far - is it as you'd expected?*" This gave doctors the chance to talk about their concerns regarding their progress to date.

For two males, who had only just begun their general practice year, reactions seemed to be centred around a sense of relief at escaping the rigours of hospital medicine:

Dr CA ♂ "...the reason I'm looking so happy is that the first two months is my induction, so I'm not doing any on-calls, I'm not doing any clinics - I'm very happy!..."

Dr SG ♂ "I've just started my vocational training... I was doing surgery, so I've changed career... and I think I've made the right decision because I'm enjoying it so much... [*and later*] this is the first job I've ever had where I've felt actually wanted and supported..."



For two of the women, however, the transition had not been so smooth:

Dr CH ♀ "...it's more stressful than I was expecting... it doesn't really come home to you, until you're actually working, just how much responsibility you have and we're always being told about the complaints and suing and all of that."

Dr CG ♀ "Very up and down... but more stressful than I'd expected, but that's probably because I'm still sucking it... I find the actual responsibility more stressful - you have far more responsibility for your patients in general practice..."

The same two women also spoke of a sense of working in isolation, compared with hospital medicine:

Dr CH ♀ "...you have to make all the decisions in general practice and so you're autonomous, but I do miss having all the team work... there are fellow GPs you can talk to, but it's different."

Dr CG ♀ "...in a hospital... you worked with a consultant, you worked with nurses, you had a lot of company all the time, whereas in general practice... you're left to... get on with it... in a room on your own..."

Another three talked about the element of uncertainty in general practice, the fact that you cannot know everything:

Dr DS ♀ "...it's as I expected, I've had some time in general practice before this... there will always be some things which aren't quite as expected, but you just take them on board because you're learning... [*and later*] ... the thing is, there's uncertainty because first of all, medicine doesn't know yet... [and] I don't know because I don't have the knowledge... so you're uncertain of what to do."

Dr PS ♂ "...I wouldn't say there's been any huge surprises - I mean it's amazing how much you don't know, but that's one of the things in general practice - there's always going to be something you don't know..."

Dr LN ♂ "I suppose the two big issues for trainees are those of sort of living with uncertainty and time-management really..."



Dr LN quoted above, was about to start work as a fully fledged GP in a much busier practice than his present training post, and was clearly worried about his time-management skills:

Dr LN ♂ "...clearly time-management is something I need to work on, having been twenty minutes late for your interview. The thought of only having sort of seven-and-a-half minutes per patient is quite frightening really... I mean I always run late..."

Finally, for Dr AM, the stresses were both work-related and personal:

Dr AM ♂ "...my father died a few weeks ago so... I've had to sort out a few details so I've been quite stressed over the last month... March is going to be a very stressful - busy time for me, because I've got myself on lots of courses... as part of my training."

So although for two trainees, leaving hospital medicine was clearly a plus, for the remaining six, there were new stresses with which to contend. For example, the frightening notion of making one's own decisions in comparative isolation, the discipline of seeing patients within a limited time allocation and, finally, coming to terms with the possibility of not knowing the answers to everything that just might, or might not, crop up, ie learning to live with uncertainty.

What then, was the attraction of general practice in the first place? It will be recalled, from Chapter 5, that half of the experienced sample cited disenchantment with hospital medicine as a reason for choosing general practice. A further two had spoken of perceived barriers to success in hospital practice, such as not being 'clever enough' or being older than one's peers. How did this future generation of GPs justify *their* decision to enter general practice? This question was approached from two angles; first, the sample were asked "*Why general practice, what was the attraction?*" and next, they were asked, "*Why not hospital practice - did you ever consider a career as a specialist?*"

The following section is therefore divided into two parts; the first deals with reasons for choosing general practice, and the second addresses reasons for *not* choosing hospital practice.



## 2 Why general practice?

Four doctors named variety as the main attraction of general practice, eg

Dr AM ♂ "...there's a lot of variety in general practice, I mean you can have part-time work in labs if you want... as well as having the practice list, it's like running a small business, I mean I'm quite interested in the business aspects as well."

Dr CG ♀ "...I'd rather sort of have the variety of seeing different things all the time..."

Dr CA ♂ "...I think this is my thing, you know, the whole spectrum of illness - normal people..."

Three doctors spoke of the autonomy and independence which they thought general practice offered:

Dr CA ♂ "...being my own boss... "

Dr LN ♂ "...not to be working for a consultant, you know, autonomy and independence really."

Dr PS ♂ "...having to work with a consultant you may or may not like or you may not even agree with... you seem to have more control... over how you work during the day, more control over how you manage the patients..."

Unsurprisingly, two of the married women doctors spoke of the flexibility of general practice:

Dr CG ♀ "...medicine isn't my life, I want to have children... the opportunities in general practice are much better for part-time and job-sharing."

Dr CH ♀ "...it's more flexible, you can do on-call from home - it's more human!"

Three of the sample spoke of the friendships which could be built up with patients, through the continuity-of-care which general practice appeared to offer, eg



Dr CH ♀ "I like the fact you can follow people up and actually get to know them... as individuals... I think you can actually build up a relationship with people and it can be more a two-way thing..."

Dr LN ♂ "The thought of having a couple of thousand people in my care... and to actually sort of, basically, befriend them..."

Dr LN uncannily enchoed the sentiments of one of the experienced sample of GPs when he described his image of a GP:

Dr LN ♂ "...the image of this silver-headed, fifty-year old GP, driving a Morgan in the countryside, having a great time!"

Asked why he had chosen medicine experienced GP, Dr WA, had described his local GP in strikingly similar terms, eg "*...the local GP was well regarded and respected, I suppose.... and I knew him as a silver-haired chap who drove an old Morgan...*" Who was this enigmatic silver-haired GP? Dr Finlay? Whatever, this nostalgic romantic image seemed strangely at odds with today's busy practices.

Although the sample were later asked why they had not chosen hospital medicine, four could not resist raising the topic in their responses to the 'why GP' question. Difficulties included lack of feedback, too much emphasis on the elderly along with too much hard work, a long, uncertain training and the hierarchical/conveyor-belt structure of the training, eg

Dr SG ♂ "...I was finding the surgical approach quite stifling because you weren't getting any patient-feedback really - you're dealing with anaesthetised patients... I wanted more..."

Dr PS ♂ "...I didn't really want to go through a very long career... it's very open-ended in hospitals - the training... you could theoretically end up not getting to the final goal post as a consultant... it's the whole pyramid model of hospital care... dog-eat-dog atmosphere..."

Dr CH ♀ "...I hated the hierarchy! ...it all seemed very like a conveyor-belt to me... I suppose maybe it [*ie decision to become a GP*] was more from what I knew I didn't want to do, than anything..."



So reasons for choosing general practice included positive aspirations such as the variety it offered, autonomy and independence, continuity-of-care and the chance to build long-term relationships with patients and, for the women, flexible working hours. There was also the one doctor who had a romantic image of being something of a Dr Finlay, complete with old Morgan. However, it appeared that half of the sample were drawn to general practice because of their disillusionment with hospital medicine.

In terms of comparing the trainee sample with the experienced GPs, the latter did indeed report skill variety as an important source of job satisfaction. It will also be remembered that, for experienced GPs, autonomy was a double-edged sword. Although the idea of being independent self-employed contractors was very attractive, this was tempered with the perceived rise in demand from both patients and government. With regard to flexible working hours, although part-time work and job-shares are now contractually viable, two of the experienced women GPs had met with considerable resistance when negotiating a reduction in hours. So for those women who are drawn to general practice because of its flexibility, some may find that their ideal differs from the reality.

## 2.1 *Why not hospital practice?*

It was beginning to look as if one of the main attractions of general practice was the fact that it was not hospital practice, eg in addition to the four doctors quoted above, Dr LN had talked about the appeal of *"not to be working for a consultant"*.

So to further test this hypothesis, the sample were asked a second question, *"Did you ever consider a career as a specialist?"*. Their responses are outlined below.

Seven of the eight trainee GPs described the sort of conditions in hospital practice that spurred them to seek a more palatable alternative, ie general practice. For example, six spoke of the long hours, including the heavy 'on-call' rotas:

Dr PS ♂ "...when I started in hospital jobs you were doing, as a junior doctor... over a hundred hours a week, you were working full weekends, over forty-eight hours at a stretch and that... was the final nail in the coffin..."

Dr CG ♀ "...medical jobs now, its - the on-call is just complete drudgery... in the Wolverhampton area, they get about 40 admissions in 24 hours and I'm sure half of them are social problems..."

Dr SG ♂ "...The last job I was on, I was on one-in-three, covering orthopaedics, trauma, plastics, burns and ENT... so nearly all the work was on call... seeing other people's patients..."



In fact one of the six implied that, had he known just what was involved in general medical training, he might have re-considered his career choice:

Dr LN ♂ "...I was...shocked in many respects, because the guidance I had at school - I mean there was no suggestion of you know, people working countless hours, dog-tired, making cock-ups... killing people by accident - that sort of thing, and I think had I so considered those sort of issues, I'm sure I would have been a little bit more cautious about applying and, basically, committing."

A seventh doctor criticised the "*dog-eat-dog*" competitiveness of hospital medicine which was echoed by two more of the sample (see below), whilst another female described how she felt generally under-valued, eg

Dr PS ♂ "...I thought well, I don't think I can handle that for too long... it's just the whole pyramid model of hospital care... the dog-eat-dog atmosphere... in competition with all... the other people at the same stage of their career..."

Dr CA ♂ "... it was a matter of whether I had the resolve to go ahead with five more years of training.... to be moved around from post to post... and to take a whole series of exams while... competing with people who are really not nice to work with..."

[*Dog-eat-dog?*]

"Worse than anything I've ever seen."

Dr CH ♀ "...in hospital medicine you felt that you were having to do what the consultant told you.... you were very much.. the general dogs-body..."

There were also hints of discrimination against aspiring women surgeons, as this female GP registrar explained:

Dr CG ♀ "...I remember a surgical professor who... suddenly started talking to me after a ward round when I happened to be wearing a dress which wasn't particularly low-cut... and the senior registrar came up to the office and said, 'Oh I think the cleavage is a good idea, it could get you along the way' ...it is so much like that... in theatre where you're scrubbed-up - it's like that all the time - it is very difficult - surgery for women."

This view of surgery being hostile to women was supported by a female SHO in Allen's sample (Allen, 1994, p 125): "*A consultant general surgeon... sapped my confidence.*"



*I am quietly spoken and it stopped me speaking out... he... said I would do better in a shorter skirt... I didn't think I could ever have a medical career. It was awful - I was wrong, but so was that surgeon..."*

The competitiveness of hospital medicine reaches its zenith in surgical specialties, and there appeared to be a high price, in personal terms, for committing to such a career and not succeeding. Surviving such an experience clearly leaves its scars, as Dr SG below revealed:

Dr SG ♂ "...I've got this hang-up about being - not aspiring to be surgeon before - but doing surgical jobs, and I keep telling people it's because I drifted into it, and it's true - I never really had the career guidance, I liked it so I ended up doing these jobs, but people keep saying, 'Oh you're a failed surgeon!'..."

Dr SG's apparent paranoia was not totally without substance. During interviews with the experienced sample of GPs, one of the doctors had spoken about a candidate he had recently interviewed for a partnership in his practice, and was less than kind about the doctor's surgical background:

Dr RC ♂ "... he didn't get the job... he came across as a failed surgeon, well he *was* failed surgeon - he was a GP, but he clearly wasn't going to be happy - ever."

The inflexible career structure within hospital medicine has already been touched on by two doctors, eg *"...it's just the whole pyramid model of hospital care..."* (Dr PS) and *"...I hated the hierarchy!"* (Dr CH). This came in for criticism by a third doctor too:

Dr AM ♂ "...it is a very rigid structure... in terms of wanting a few months out to travel... it's very difficult without making some impact on your career..."

Perhaps the only doctor who seemed set on general practice from the outset of her career, was Dr DS. Nevertheless, she too talked about the 'one-way-ticket' aspect of a career in general practice, ie that once chosen, it was extremely difficult to return to



hospital medicine. She also let slip the notion of '*opting out*' into general practice:

Dr DS ♀ "... you can always opt out into general practice. You can't do it the other way so easily... if you enter general practice, you can't then go and say, 'Oh I think I'll work in hospital medicine' - it doesn't work like that.... if you've done a bit of extra surgery, that's fine... or if you've done some extra obstetrics - that could be a special interest for you... in general practice. You bring those skills with you. It's not seen as going the other way."

It will be remembered from Chapter 5 that experienced GP, Dr AP, had described the decision to enter general practice in very similar terms, eg "*...going back into general medicine - or whatever - I think people would be quite suspicious... 'You've been a GP for six and a half years so... what's wrong with it, what's wrong with you?' ...if you've made the wrong choice, then your judgement is suspect...*"

The difference between these two women related to their reported reasons for choosing general practice. Dr AP (ie the experienced GP) had admitted that her decision was "*a compromise*" and that she regretted not continuing with hospital medicine, whereas Dr DS maintained that she had always wanted to become a GP, from the very start.

Finally, three of the sample spoke of the uncertainty of making it in hospital medicine, despite the sacrifices, eg

Dr CA ♂ "... what I didn't want to be was permanently stuck, so I felt there was greater capacity to progress in general practice... it's not everybody who can take the competitive situation in... hospital..."

Dr PS ♂ "...it's very open-ended in hospitals - the training... you could theoretically end up not getting to the final goal post as a consultant..."

So long hours with heavy 'on-call', an inflexible and highly competitive career structure with no guarantees of reaching one's goals, combined with a general feeling of being under-valued, all contributed to these doctors' disenchantment with hospital medicine.

## 2.2 *Reasons for choosing general practice: Summary*

In summing up the sample's reasons for choosing general practice, the table below lists the GP registrars' reasons for both their present career choice, and their reasons for rejecting a career in hospital medicine, respectively:



## *GP Registrars' reasons for general practice versus hospital medicine*

Table 24

| Why general practice?                                                                                                                                                                                                                                     | Why not hospital medicine?                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1) Dr AM ♂ "...there's a lot of variety in general practice..."                                                                                                                                                                                           | "...it is a very rigid structure... in terms of wanting to take time out to travel..."                                                                                                                                                                                                                                                                                                                                                                  |
| 2) Dr CH ♀ "...it's more flexible..."                                                                                                                                                                                                                     | "...you felt that you were having to do what the consultant told you... you were very much... the general dogs-body..."                                                                                                                                                                                                                                                                                                                                 |
| 3) Dr CG ♀ "...I'd rather sort of have the variety of seeing different things all the time..."                                                                                                                                                            | "...the on-call is just complete drudgery..."                                                                                                                                                                                                                                                                                                                                                                                                           |
| 4) Dr CA ♂ "...I think this is my thing, you know, the whole spectrum of illness..." <i>and later</i> "...being my own boss..."                                                                                                                           | "...it was a matter of whether I had the resolve to go ahead with five more years of training... while... competing with people who are really not nice to work with..."                                                                                                                                                                                                                                                                                |
| 5) Dr DS ♀ "...it's what I've always wanted to do...I like seeing babies, I like seeing the elderly, I like seeing men... I like seeing a mixture..."                                                                                                     | "...you can always opt out into general practice. You can't do it the other way round... because of the competitiveness of hospital medicine..."                                                                                                                                                                                                                                                                                                        |
| 6) Dr LN ♂ "...not working for a consultant... autonomy and independence really."                                                                                                                                                                         | "I was... shocked... I mean there was no suggestion of... people working countless hours, dog-tired... killing people by accident..."                                                                                                                                                                                                                                                                                                                   |
| 7) Dr PS ♂ "...you seem to have more control...over how you work during the day, more control over how you manage the patients..."                                                                                                                        | "...you were doing, as a junior doctor... over a hundred hours a week... the whole pyramid model of hospital care... the dog-eat-dog atmosphere... in competition with all..."                                                                                                                                                                                                                                                                          |
| 8) Dr SG ♂ "...I was finding the surgical approach quite stifling because you weren't getting any patient-feedback really... I wanted more..." <i>and later</i> "...this is the first job I've ever had where I've felt actually wanted and supported..." | <p>"...I wanted to find a more rewarding career... I like to talk... you don't have a lot of talking input as a surgeon, you talk to the anaesthetist but they're normally doing the Telegraph crosswords..."</p> <p><b>Note:</b> <i>it must be said that, reading between the lines, the interviewer suspected that the real reason for this doctor leaving hospital medicine, was because he felt rejected/excluded from a career in surgery.</i></p> |

Even allowing for post-decisional dissonance (eg Brehm, 1956), there were clearly genuine problems in the way these young doctors experienced their training in hospital medicine. As previously stated, eight of the ten experienced GPs had cited reasons for choosing general practice as disenchantment with, or perceived barriers to, a career in hospital medicine. The fact that almost half of the trainees gave very similar reasons for choosing a career in general practice, points to problems in both areas of medicine, ie in general and hospital practice. The problem with general practice would therefore appear to be a complex one; hospital medicine is losing good men and women through low morale, and general practice is attracting these disillusioned young people, mainly because it is perceived as an escape from hospital medicine. If, as the data suggest, the two areas are inter-related, then any strategy designed to improve recruitment and retention in general practice, must also address the problem of low job-satisfaction and morale in hospital medicine.



### 3 Personal attributes for success in general practice

Like the experienced sample, GP registrars were asked what sort of personal attributes they considered necessary to succeed in general practice. When all responses were collated, the prerequisites read as follows:

**A good GP should be:**

- *"...good at time management... clinically competent... able to get on with your partners... able to look after yourself as well, your own health and... wellbeing..."* (Dr AM)
- *"...a real people-person..."* (Dr CA) *"You have to like people - rather than the medicine!..."* (Dr CH)
- *"...have a certain degree of patience..."* (Dr CH)
- *"...a practical person, you have to be able to see the resources that you have..."* (Dr CH) *"...down-to-earth..."* (Dr LN)
- *able to "...think of the person as a whole... you have to know what what they're going to do and what they're not going to do..."* (Dr CH) *"...look at the whole patient..."* (Dr PS) *be able to "...give the patient advice... and let them take responsibility for it as well..."* (Dr CG)
- *"...a bit business-minded as well..."* (Dr CH) *"...have a keen business mind..."* (Dr CA)
- *"...good at communicating..."* (Dr CA) *"Communication skills..."* (Dr SG) *"...sort of empathic and able to listen, to talk to people..."* (Dr LN) *"...listening is very important..."* (Dr DS)
- *capable of "...keeping up to date, knowing when I'm out of my depth... being prepared to say I don't know..."* (Dr DS)
- *have "...a sense of humour...and I think you have to be quite affable as well... you can't come across as a miserable git and expect patients to come to you..."* (Dr SG).

GP registrar, Dr SG, was the only doctor in the present study to mention a '*sense of humour*', which was one of the qualities spontaneously mentioned by some members of the BMA's Cohort Study (ie as an addition to the BMA's list). Interestingly, although three GP registrars spoke of the uncertainty of general practice (section 1), it was omitted from the list of personal attributes.

In terms of the present study, how did this list compare with the experienced sample of GPs?

It will be recalled, from Chapter 5, that just over half of the sample spoke of the need for good communication skills, and this quality was also picked up by half of the trainee sample. Other similarities included a perceived need for patience (2



experienced GPs compared to one trainee), and a liking for people "*...it's people all day long...*" (Dr RJ - 1 experienced GP, compared to two trainees),

The experienced sample also talked about the need for good organisational skills (3 doctors), an ability to live with uncertainty (3 doctors), a need to be independent (2 doctors), "*...hard-skinned... not to let them grind you down...*" (1 doctor) and, finally, to have a "*laid-back*" attitude (2 doctors). None of the GP registrars mentioned these five qualities which, perhaps, reflected their sense of optimism regarding general practice.

Equally, however, there were five attributes mentioned by the trainees which were not included by the experienced sample:

1. *Time-management skills* (1 registrar) and *business-skills* (2 registrars), although these could, at a stretch, be interpreted as the experienced sample's "organisational skills".
2. *Having an holistic view of the patient* (3 registrars).
3. *Keeping up-to-date and being prepared to admit to not knowing something* (1 registrar).
4. *Having a sense of humour and being "affable"* (1 registrar).
5. *Being able to look after yourself and your own wellbeing* (1 registrar).

### 3.1 *Personal attributes for a GP: Summary*

Given the publicity around the topic of GPs and stress, it was perhaps surprising that none of the registrars spoke of the need to have, what the experienced sample referred to as, "*a laid-back*" approach. It was also surprising that only one doctor out of the two groups, a GP registrar, mentioned the need for a sense of humour. However, Dr AM's comment about "*being able to look after yourself*" was an important development showing, perhaps, some awareness of the stresses and strains of general practice. Judging only by the interview, Dr AM himself could not be described as "*laid-back*". Indeed, he had a thirty-year career-plan already set out and struck the interviewer as a serious, deep-thinking young man. It was also heartening to see one of the trainee sample speak of the need, not only to keep up-to-date, but also to be able to admit to not knowing something (Dr DS). At first it seemed that this could be related to the experienced sample's prerequisite of being able to live with uncertainty. However, they described this in terms of being able to "*...live with risk.*" (Dr RC), and being "*...prepared to make decisions without feeling very comfortable with them...*" (Dr TM).

Of course, it was not possible to ascertain the cause(s) of the subtle differences between the two groups. For example, whether they reflected genuine differences in the type of people who are now entering general practice, or whether they were simply



due to a lack of experience on the part of the trainees. It is also possible that there was an element of cynism amongst the more experienced doctors.

Having established how the GP registrars were feeling about their training to-date, and their reasons for choosing general practice, the next question investigated their expectations: what were these young doctors specifically expecting in terms of the 'highs' and 'lows' of their future careers?

## **4 GP registrars' expectations of general practice: the 'highs' and 'lows'**

The sample were asked *"What do you think will be the highs and lows of general practice?"* The 'highs' fell into eleven categories and the 'lows', into just five.

The section begins with the doctors' expectations of the highpoints of work in general practice:

### **4.1 Trainees' main expectations - the 'highs':**

1. **Making people better/helping people (5 doctors):** *"I think the highpoints will be making people better, whether that's psychologically or physically..."* (Dr CH ♀), *"...getting them better..."* (Dr CG ♀), *"...you can see a five-year old with asthma and then see them five years later... well-controlled..."* (Dr SG ♂), *"...helping patients... both in a medical and physical sense..."* (Dr DS ♀), *"...working with the patient and helping them improve their lifestyle and it doesn't necessarily mean that you actually make them better..."* (Dr PS ♂).
2. **Getting to know patients/building relationships/continuity-of-care (3 doctors):** *"...the highpoints are going to be getting to know people and sort of forming relationships with people..."* (Dr CG ♀), *"The best part is getting to know the patients... they'll come back and that's the kind of relationship you don't seem to be able to get in hospital medicine... the continuity..."* (Dr PS ♂), *"...you grow old with your patients..."* (Dr SG ♂).
3. **Grateful patients/feedback (3 doctors):** *"...and when you get thanked for it! I got a bunch of flowers the other week."* (Dr CH ♀), *"...it's getting people who are actually grateful..."* (Dr CG ♀), *"...I mean I like the feedback you get from people..."* (Dr SG ♂).
4. **Diagnostic challenges (2 doctors):** *"...I'll come home at the end of the day and have sort of reward from... how I've managed particular problems... and from diagnosing things..."* (Dr DS ♀), *"...there's always going to be the medical side of diagnosing things..."* (Dr CG ♀).



### Other 'high' expectations:

5. **Flexibility (1 doctor):** *"...the flexibility. I can be very flexible in the number of hours I work in general practice, compared to a hospital consultant... it depends on how involved you want to get in general practice as well..."* (Dr AM ♂).
6. **Financial rewards (1 doctor):** *"...financially as well, I suppose there's going to be financial rewards..."* (Dr CG ♀).
7. **Changes for the better - more autonomy (1 doctor):** *"...I just see a lot more change... more that will be in the hands of the GP... I will be a pioneer for change..."* (Dr CA ♂).
8. **Satisfaction of doing something worthwhile (1 doctor):** *"...one of the highs is that you're doing something that you feel is worthwhile..."* (Dr CA ♂).
9. **Respect and status (1 doctor):** *"...you're based in a community... you have a role and I mean, I think that's a high in itself, because these people (ie the partners in his training practice) ... are pillars of their community, the respect element of it, the recognition of it..."* (Dr CA ♂).
10. **Coping with the workload & enjoying the work (1 doctor):** *"...coping with the workload and generally, hopefully... enjoying general practice..."* (Dr LN ♂).
11. **Teamwork (1 doctor):** *"...I like the idea of working in a team... you don't get that in... hospital jobs... everybody is in this together..."* (Dr SG ♂).

### 4.2 Trainees' main expectations: the 'lows'

1. **Too much paperwork (5 doctors):** *"...the downside of being a GP... for me personally, is all the paperwork..."* (Dr AM ♂), *"...all the paperwork, people who want sick notes the entire time - that's something that annoys me..."* (Dr CG ♀), *"...paperwork has increased to an extent where... you have nightmares about mountains of paperwork piling up, even if you're away for two days..."* (Dr CA ♂), *"...and all the paperwork as well, I'm not looking forward to..."* (Dr DS ♀), *"...too much paperwork..."* (Dr PS ♂).
2. **'Heartsink'/difficult patients/complaints (4 doctors):** *"....other lows are if you get a complaint from some heartsink patient..."* (Dr CG ♀), *"...I think the lows are the sort of patients.... where you just don't feel you're getting anywhere with, you know, the ones where you really just don't know what's going on...it's not solvable..."* (Dr DS ♀), *"...the 'heartsink' patients.... people that you see on the list every week coming in and... they're actually convinced that you're not doing enough for them..."* (Dr SG ♂), *"Downsides, well when people complain when you've done your best, and when you get unnecessary calls..."* (Dr CH ♀).

### Other 'low' expectations:

3. **Awareness of current problems (1 doctor):** *"...looking around me, I see mainly lows... there's poor morale in general practice with poor recruitment, poor remuneration, long working hours... the way that regulations are being tightened up..."* (Dr CA ♂).



4. **A 'war of attrition'? (1 doctor):** "...The low side will be if I feel, gosh, this is a war of attrition and you know, I'm not enjoying this..." (Dr LN ♂).
5. **Too much change (1 doctor):** "...there's too much change... I think they need a time out where they can just sit back and say, okay, enough's enough, let's see where we are at the moment..." (Dr PS ♂).

### 4.3 GP Registrars' expectations of general practice: Summary

The main purpose of the present section was to establish the extent to which 'new' GPs' job expectations were realistic, when compared to the views of those with several years' experience behind them. The experienced sample had also been asked to specify the highs and lows of general practice, and their responses were subsequently incorporated into the framework of the Job Characteristics Model. However, in order to provide a base for comparison, they are re-presented in the table below

Initially, the most striking difference between the samples related to the proportion of 'highs' to 'lows'. Registrars reported twice as many 'highs' as 'lows' (ie 11 highs and 5 lows) whereas the experienced sample, "telling it like it is", recounted a more circumspect 7 'highs' and 9 'lows'. Nevertheless despite their optimism, when the common 'highs' were examined it appeared that, in the main, GP registrars had a good understanding of the more gratifying aspects of general practice.

#### 4.3.1 Comparison of the 'highs' of general practice

In terms of the main 'highs', there were three close similarities:

#### *Main 'highs' of general practice: trainees versus experienced GPs*

Table 24

| MAIN HIGHS                                    | GP Registrars<br>(expectations) | Experienced<br>GPs |
|-----------------------------------------------|---------------------------------|--------------------|
| 1 Making people better/helping people         | 5                               | 5                  |
| 2 Appreciative patients who say 'thank you'   | 3                               | 5                  |
| 3 Getting to know patients/continuity of care | 3                               | 3                  |
| 4 Diagnostic challenges                       | 2                               | 0                  |

Remembering the experienced sample's comments about constraints on their time and resources (in Chapter 5), perhaps it was not so surprising that none of them named diagnostic challenges as a 'high'.



*Lesser 'highs' of general practice: trainees versus experienced GPs*

Table 25

| OTHER HIGHS                                     | GP Registrars<br>(expectations) | Experienced<br>GPs |
|-------------------------------------------------|---------------------------------|--------------------|
| 1 Respect and status in the community           | 1                               | 1                  |
| 2 Teamwork/relationship with colleagues         | 1                               | 1                  |
| 3 Making a profit                               | 0                               | 1                  |
| 4 Independent contractor status                 | 0                               | 1                  |
| 5 Flexibility (eg hours)                        | 1                               | 0                  |
| 6 Financial rewards                             | 1                               | 0                  |
| 7 Job satisfaction (doing something worthwhile) | 1                               | 0                  |
| 8 Changes for the better (more autonomy)        | 1                               | 0                  |
| 9 Coping with the workload & enjoying it        | 1                               | 0                  |

There were also two matches between the other 'lesser' highs (ie categories referred to by only one person): one doctor from each group had talked of the respect and status which general practice conferred and, again, one doctor from each spoke of enjoying teamworking with colleagues. Two of the experienced doctors then went on to talk about the business aspects of general practice, ie the high of making a profit at the end of the year, and enjoying the independent contractor status, respectively.

The trainee sample extended this group of 'lesser' highs to include five more categories, eg flexibility, financial rewards, positive aspects of changes, ie those leading to more autonomy for GPs, job satisfaction and - touchingly - merely coping with the workload. Although the category 'financial rewards' looked, at first glance, to be the same as 'making a profit', there was a difference. The trainee in question had been talking about her potential earnings, rather than the impersonal, business aspect of finances, eg *"...I mean it would be nice to work in a practice that had an average or above sort of payment, but there's such a big range, that's the thing."* (Dr CG). Conversely Dr HJ, of the experienced sample, had been referring specifically to the business side of general practice which he particularly enjoyed.

#### **4.3.2 Comparison of the 'lows' in general practice**

Turning to the lows, there were just two similarities between the groups: both registrars and experienced GPs agreed about the problems of excessive paperwork (although there were only two of the experienced group) and difficult/hostile patients. The table below outlines the differences between groups on the remaining six main 'lows':



***Main 'lows' of general practice: trainees versus experienced GPs***

Table 26

| MAIN LOWS                                      | GP Registrars<br>(expectations) | Experienced<br>GPs |
|------------------------------------------------|---------------------------------|--------------------|
| 1 Excessive paperwork                          | 5                               | 2                  |
| 2 Difficult/hostile patients                   | 4                               | 5                  |
| 3 Rising patient-demand                        | 0                               | 8                  |
| 4 Constraints on resources                     | 0                               | 7                  |
| 5 Constraints on time                          | 0                               | 5                  |
| 6 Responsibility for patients/fear of mistakes | 0                               | 5                  |
| 7 Lack of patient-gratitude                    | 0                               | 2                  |
| 8 Litigation concerns                          | 0                               | 2                  |

It is important to note that although the trainee sample did not mention rising patient-demand and litigation concerns as specific 'lows', several talked about these issues during the course of interviews. For example, four registrars felt that patient-demand had risen, although two of the four had been specifically asked about this by the interviewer. Similarly, one of the registrars had spoken at length about her litigation fears after a medico-legal talk at a recent training session. This then prompted the interviewer to ask three following interviewees about their reactions to the session. A total of four registrars felt there was cause for concern regarding litigation risks.

***Lesser 'lows' of general practice: trainees versus experienced GPs***

Table 27

| OTHER LOWS                                           | GP Registrars<br>(expectations) | Experienced<br>GPs |
|------------------------------------------------------|---------------------------------|--------------------|
| 1 Management responsibilities (staff etc)            | 0                               | 1                  |
| 2 Awareness of current problems in general practice  | 1                               | not applicable     |
| 3 Fear of not enjoying the work ("war of attrition") | 1                               | 0                  |
| 4 Too many changes                                   | 1                               | not applicable     |

In terms of the 'lesser' lows, one other point made by an experienced GP was the burden of management responsibilities and, unsurprisingly perhaps, none of the trainee sample spoke of this. It appeared that GP registrars were "...somewhat protected from a lot of the paperwork and... the business side of the practice..." (GP registrar, Dr DS).



Trainees listed three further lows which were not really applicable to the experienced sample: an awareness of the current problems facing general practice, a fear of not enjoying the work and, finally, the detrimental effects of too much change. Although the experienced sample did not mention change in relation to specific 'highs' or 'lows' it will be remembered, from Chapter 5, that half of the sample expressed dismay at the Government's attitude towards general practice, in terms of recent changes.

Overall, GP registrars showed a tendency to overestimate the highpoints of general practice, whilst underestimating the lows. For example, although some trainees had talked about the problems of increasing patient demand and litigation concerns during interview, none of these issues were raised as potential pitfalls in terms of career satisfaction. Moreover, were they aware of the apparent lack of career structure in the profession? It will be recalled, again from Chapter 5, that half of the experienced sample felt this to be a distinct disadvantage (eg growth-needs). The trainee sample's awareness of, and attitude to, the problem of lack of career structure were therefore explored in the following section.

## **5 Lack of career structure: GP registrars' awareness and attitudes**

Doctors were asked *"How do you feel about the assertion that general practice lacks a career structure; that the job you enter now will be the same one you retire from at sixty?"*

Perhaps surprisingly, none of the sample saw it as a serious problem. All thought they would find enough compensatory factors:

Dr AM ♂ "Fine. I love it."

[*Really? What aspect of it do you like?*]

"Flexibility - that's one of the reasons I went into general practice, the commitment in terms of time - like having a family - its not as great as in hospital medicine..."

Dr CH ♀ "I would hope that if I got into a situation I wasn't happy with, I wouldn't stick around... it does appeal to me that I can actually alter things, do things the way I want to do them.. I guess I feel that I would be in control..."

Dr CA ♂ "Yeah, but at least as a principal, there's nobody above you... whereas in Ophthalmology, you can be stuck at registrar level... constantly kissing arses and getting nowhere..."



This included having outside interests for three doctors, eg

Dr PS ♂ "Yes, that's the main worry about general practice, will you... burn out, will you get bored with it in five or six years time... lots of GPs do other things, some people are trainers, some will do a few sessions in hospital... they try and keep themselves interested by doing other things."

Dr SG ♂ "Well I see in that respect you have to have your own interests to fulfil the other parts of your life..."

Dr CG ♀ "...all the partners here do different things... that's the only way round the career structure because... at the moment there's nothing! ..."

In view of the current shortage of GPs it was, perhaps, worrying to find that five of the eight registrars intended to work part-time, including two of the men:

*[Do you think you'll work full-time?]*

Dr AM ♂ "No I'm quite certain that I won't... I have other interests that keep me stimulated... I'm interested in sort of a health-type business..."

*This registrar already had a part-time post lined up:*

Dr LN ♂ "...I'm half-time, so the rest of my life is mine to do as I see fit..."

Whether the intention to work part-time was, in part, recognition of the lack of career structure, or whether it was merely a reaction to the long hours demanded in hospital medicine, it was impossible to tell. The overall impression was that these young men and women were determined to be in control of their lives, and not to make the same mistake as their predecessors, eg

Dr CG ♀ "... I do want to work part-time and that's the only way I think I'll be able to control my - to control medicine!"

Dr DS ♀ "...I need to be in control... we've seen what it's done to other people... I'm not willing to throw my lifestyle over the edge..."

Dr SG ♂ "...I need to have a healthy balance of career and other things in my life. Nobody thanks you for working your guts out and dying at fifty-five..."



## 5.1 *Future plans*

GP registrars were also asked where they saw themselves in seven to ten years time. Three of the eight doctors were already looking further afield than establishing themselves as GP principals: one young male planned to return to Bangladesh to set up a healthcare centre there and was already investigating potential sponsors, a woman registrar talked about emigrating to Australia or Canada and a third, a male, was seriously considering studying law alongside his half-time work as a GP.

So in terms of addressing the UK's 1000 shortfall in general practitioners (Medical Practices Committee, 1997) out of the eight registrars interviewed, only five saw their futures solely in general practice and, of these, just three anticipated working as full-time principals.

## 5.2 *Planning for the future: Summary*

The interviewer had the impression that only three registrars were perhaps aware of the problem of lack of career structure in general practice, ie that their reactions were not prompted by the researcher's question. For example, Dr CH first declared that she would simply move practices if she was not happy, eg "*...people quite often move...*". Yet the impression given by the experienced sample was that it was extremely difficult to change practices. The problem seemed to be centred around the stigma attached to prospective (experienced) doctors wanting to make such a move, ie the '*damaged goods*' label.

Even Dr CA who claimed to be excited by the '*flux*' in general practice, and who planned to set up his own practice, was only looking to the next ten years by which time he would only be thirty nine.

In terms of expectations for the future, the return on investment for training eight GP registrars looked fairly disappointing: less than half of the sample seemed prepared to work as full-time GP principals in the UK.

# 6 **Conclusions**

So how were these new, up-and-coming GPs different from the more experienced sample? The answer has to be, not very. Taking each analytical perspective in turn it became clear that, allowing for the wisdom accrued from seven (mean) years of experience, these aspiring new GPs were strikingly similar to their predecessors:

***Reasons for choosing a career in general practice:*** it appeared that, like the experienced sample, almost half of the trainee sample chose general practice as a result of disenchantment with, or perceived barriers to, a career in hospital medicine.

***Personal attributes:*** although there were subtle differences between trainees and experienced GPs, this was possibly due to the 'experience factor'. For example, the experienced doctors' attribution choices of good organisation skills and independence



were not mentioned by registrars. Nevertheless, the importance of such qualities were clearly beginning to 'dawn' on the trainees, as they spoke of the added responsibilities and isolation of work in general practice (ie section 1, First impressions).

***Expectations of general practice:*** on the whole, GP registrars appeared cautiously optimistic about their futures in general practice. However, there was little evidence of awareness of some of the fundamental problems facing them, such as career stagnation, lack of intellectual challenge and diminishing professional autonomy.

Taking an overall perspective, the basic flaws in general practice, as identified in Chapter 5, seemed set to trip up the new generation of GPs just as surely as it has their predecessors. The trainee sample had made their career choice on the same grounds as the experienced sample. Although they knew of some of the pitfalls that awaited them, they believed that they could circumnavigate these difficulties, eg with part-time working whilst following other interests/projects, or by setting up practice on their own. The fact that this new generation of GPs seemed aware of some of the potential problems, and were not prepared to give their 'all', marked the only substantial difference between the two groups. Certainly their attitudes seemed to be more akin to the transactional psychological contract, eg "I will give you X number of hours and you will give me X amount of free time during which I will follow my own interests: I work for you, but you do not own me". Whether this level of detachment can be sustained over time, only a longitudinal study would tell. Nevertheless, the researcher was left with the impression that general practice was mainly a second choice for these young doctors and, that having chosen this path, they were reluctant to take on the full responsibilities of general practice if there were other available alternatives. In other words, their overall commitment appeared to be less than that of the experienced group. It may well be true that general practice is perceived "*...as an easy ride in a long dark tunnel.*" (Elwyn, Smail and Edwards, 1998, p 730).

## ***6.1 An evaluation of findings in relation to the JCM***

In terms of the Job Characteristics Model GP registrars, like the experienced sample, enjoyed the skill variety and task significance (ie the clinical satisfaction of making people better) and task identity (ie the continuity of care aspects) which general practice offered. With reference to the findings of Chapter 5, there was little evidence of trainees appreciating the constraints on time and resources which impacted task identity, nor the endless 'trivia' which threatened doctors' sense of task significance. Three registrars had also talked about the increased autonomy which they hoped to enjoy, but this seemed relative to hospital medicine where junior doctors have very little. Certainly, there were no indications that the sample understood how experienced doctors were feeling about their *diminishing* levels of autonomy. Three trainees had also spoken of the 'highs' of patient gratitude, of enjoying "*the feedback you get from people.*" (Dr SG). There were no signs, as yet, of just how vital patient-gratitude might become to these young men and women, once they had settled down into their general practice posts.



To conclude, the findings of the present study could offer no guarantees of the NHS being able to retain the three, out of the original eight, trainees who intended to work as full-time principals within the UK.

Having established the similarities and differences between trainee and experienced GPs, the next question to be answered is how did the trainee hospital sample compare? As members of the 'chosen few', were their attitudes substantially different from those of the GP registrar group? Were they fired with commitment and enthusiasm? Chapter 13 focuses on these issues.



## Chapter 13

### Results and Discussion: Specialist Registrars

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The sample comprised five women and six men. As stated in the Method, two women and one male requested not to be tape-recorded. Fortunately the researcher was able to call on her shorthand skills, which resulted in fairly accurate transcripts being attained. Interviews took place in an interesting variety of venues; most took place in a small private office but two were conducted in a pathology laboratory, one in the board room of a smart postgraduate centre, and one in the waiting area of a busy day surgery unit. The female pathologist continued working whilst being interviewed, eg constantly leaping up and peering down a microscope. She nevertheless kept up a lively discourse throughout, never missing a cue. The urologist was also clearly in the middle of his operating list and was called away several times during the interview.

In terms of overall impressions, these young men and women were not as instantly friendly and approachable as the GP registrar group and took time to 'relax into' the interview. There was certainly an initial tenseness and wariness in most of the encounters. Although this may have been due to busy schedules, it may also have been a conditioned response to 'yet another interview', as explained by this surgical registrar: *"I know it's an informal interview, but I still go into interview mode I think!"* (Mr JA, urology). In general terms, interviews went well. There was perhaps one exception; the endocrinology registrar appeared facetious and mocking in some of his replies and the interviewer was unable to break through this 'veneer'. Although disconcerting, this was the only interview throughout the study where it was felt there were problems with establishing a rapport. The doctor had also asked not to be recorded and appeared to derive some amusement from watching the researcher's sometimes frenetic note-taking.

All eleven doctors were 'fully' interviewed in exactly the same manner as GP registrars (as per the researcher's agenda; see Table 23, Chapter 11). However, it was felt that at this stage of the study, the focal area of interest must be the reasons given by these hospital trainees for not choosing general practice. Therefore other interview topics have been provided in summary form only. It was believed important to include these first in order to provide a contextual background to the sample, and to highlight differences in the expectations and perceptions of hospital and GP trainees.

#### 1 Training for a consultancy - impressions to date

As with the GP registrar group, specialist registrars were asked: *"How's it going so far?"*

Overall, it seemed that these young doctors were feeling the pressure of additional responsibilities as they progressed along their chosen career paths. There was an awareness of becoming final decision-makers and of 'the buck' stopping with them, eg *"...it's more pressured... as you get nearer the time you realise what's upon you... that*



*you'll be a consultant soon with more responsibility... and the fact that the buck ends with you.*" (Dr CG ♀, histopathology). Unlike the GP registrar group, there was no mention of learning to live with uncertainty, nor of the pressures of having to see patients within a limited time allocation. It will be recalled, from Chapter 7 (section 1), that four consultants complained of the latter.

As previously stated, half of both the experienced GP and the GP registrar groups had cited disenchantment with hospital medicine as a reason for choosing general practice. Three of the trainee GPs criticised the 'dog-eat-dog' competitiveness of hospital medicine, where they felt there were no guarantees of reaching the top. The following section investigated this phenomenon from a hospital trainee's perspective.

## **2 Long shots and hot shots: competitiveness in hospital medicine**

The sample were asked the question *"Hospital medicine is notoriously competitive, were you aware of this when you first entered medicine?"*.

It appeared that even from the 'inside' hospital medicine was perceived as highly competitive, so GPs' complaints of this could not be dismissed as post-decisional dissonance. With the exception of the two surgeons, it appeared that most of the sample had been prepared for the level of competition they had encountered. As Dr CJ (♂ palliative care) pointed out, this may have been partly due to the high 'A-level' grades demanded of medical school entrants, eg *"I expected it when I went to medical school... I mean basically, its lots of people who do extremely well in their 'A-levels', all coming together and then wanting to do extremely well in their exams at medical school..."*. With regard to the surgeons, it seemed that it was the degree of competitiveness which had surprised them and not the competition *per se*, eg *"...I didn't realise... how hard it was to get the jobs - the jobs you want anyway... you have to call in all your previous bosses... and get them to support you and ... there is a sort of networking..."* (Mr JA ♂ urology). The personal costs of trying to succeed in a career where the odds are so high, were reflected in the cynicism of a psychiatry registrar:

Dr BP ♂ (psychiatrist) *"...in terms of career, the competitiveness is... much more in terms of how much you're prepared to slog, because the competition isn't intellectual, the competition is 'are you prepared to work eighty or... a hundred hours?' ...I would frame it more as being limited in your outlook and losing part of your life, so however many parts of your life you're prepared to drop, you'll be able to stick more medicine in."*

However, not all careers are equally competitive and, as pointed out by registrar, Dr WH, there is a degree of choice involved and surgical specialties are renowned for their extreme competitiveness and heavy on-call. Similarly, if people want a less competitive career, then general practice may offer an attractive alternative to hospital



medicine, eg "...I thought general practice wouldn't be so competitive and I don't think it is." (ex-GP, Dr CJ ♂ palliative care registrar).

3 Specialist registrars' expectations of hospital medicine: the highs and lows

Because hospital specialists train for five to six years, *in situ*, compared to the one year in general practice which GP registrars undertake (the remaining two are in 'approved' hospital posts), the present section employed a slightly different approach. The sample were asked about their current perceptions of their work, eg "*What do you feel are the highs and lows of hospital medicine, as you see them?*" They were then asked "*How do you think these will change once you are a consultant?*".

Experienced hospital doctors were also asked about the highs and lows of their work and their responses have been included, alongside those of specialist registrars, in the tables below.

3.1 Comparison of the 'highs' of hospital medicine

In terms of the main 'highs', there were six similarities between trainees and experienced hospital doctors:

Main 'highs' of hospital medicine: trainees versus consultants

Table 28

| MAIN HIGHS                                                | Specialist registrars | Consultants |
|-----------------------------------------------------------|-----------------------|-------------|
| 1 Spending time with patients/helping people              | 7                     | 6           |
| 2 Interest/challenge (including diagnostic challenge)     | 3                     | 5           |
| 3 <u>Surgery</u> : practical experience/intricate surgery | 2                     | 2           |
| 4 Variety                                                 | 3                     | 1           |
| 5 Relationships with colleagues                           | 1                     | 2           |
| 6 Autonomy                                                | *2<br>anticipated it  | 2           |

*\* it will be noted (later) that two specialist registrars had spoken of anticipating increased autonomy once they became consultants, and this has been included in the above table.*

Judging from the above, specialist registrars' reported highpoints were closely matched by those of their seniors, with 'helping people' and 'diagnostic challenge' high on the agenda. Interestingly, in terms of comparisons with the BMA's Cohort Study (see section 2.3.1 General Introduction), these two qualities came within the top three reasons for choosing medicine as a career (for men only).



### ***Lesser 'highs' of hospital medicine: trainees versus consultants***

Table 29

| OTHER HIGHS                                      | Specialist registrars | Consultants |
|--------------------------------------------------|-----------------------|-------------|
| 1 Technological advances                         | 0                     | 1           |
| 2 Teaching                                       | N/A                   | 1           |
| 3 Not being so frightened/being more experienced | 1                     | N/A         |

There were no matches between registrars and consultants on the 'lesser' highs (ie where only one doctor commented in each category) and, considering the topics, this was not so surprising. For example, trainees were unlikely to comment on technological changes, being too new to appreciate the differences. Moreover, unlike consultants, they have no formal teaching responsibilities. With regard to the third point, consultants are possibly too experienced/confident in their skills to have the self-awareness which Dr WH expressed in terms of relief at not being "*so frightened*".

### ***3.2 Comparison of the 'lows' of hospital medicine***

It may be recalled that there were just two common 'lows' between the two GP samples. Perhaps reflecting the closer 'match' between the two hospital samples, there were four areas of consensus for specialist registrars and consultants:

### ***Main 'lows' of hospital medicine: trainees versus consultants***

Table 30

| THE MAIN LOWS                                     | Specialist registrars | Consultants |
|---------------------------------------------------|-----------------------|-------------|
| 1 Poor conditions/lack of resources               | 5                     | 2           |
| 2 Tiredness/exhaustion                            | 4                     | 3           |
| 3 Operations that go wrong/deteriorating patients | 1                     | 2           |
| 4 Complaints/litigation risks                     | 1                     | 4           |
| 5 Workload/overbooked clinics                     | 0                     | 4           |
| 6 Relationships with some colleagues              | 2                     | 0           |

Ironically, although relationships with (some) colleagues were labelled a low by two registrars, this was a highpoint for two of the consultants.

Another interesting point was the 'low' of litigation risks. Although only one registrar, a pathologist, commented on this compared with four senior doctors, Dr GC's words closely echoed those of the consultant pathologist. For example, "*...the evidence is all kept - all the slides, all the reports, so if you make a mistake, it's impossible to hide*



it." (Dr GC, registrar), and "...the diagnosis we make is preserved for ever, for people to dig out and go over with a fine-tooth comb." (Dr MA, consultant). For this young registrar at least, there was little doubt that her work was providing a realistic job-preview (eg Premack and Wanous, 1985) for her future as a consultant.

*Lesser 'lows' of hospital medicine: trainees versus consultants*

Table 31

| OTHER LOWS                                    | Specialist registrars | Consultants |
|-----------------------------------------------|-----------------------|-------------|
| 1 Postmortems                                 | 1                     | 0           |
| 2 Patients' relatives (ie children's parents) | 1                     | 0           |
| 3 Discontinuity of patient-care               | 0                     | 1           |
| 4 Teaching junior doctors                     | N/A                   | 1           |
| 5 Administration & paperwork                  | 0                     | 1           |
| 6 Drudgery of routine work                    | 0                     | 1           |
| 7 Management problems                         | 0                     | 1           |

In terms of the 'lesser' lows registrars named only two lows compared to consultants' five. Like the 'lesser' highs, it was not difficult to spot the reasons for the apparent discrepancies. For example, as previously stated, specialist registrars do not have the formal teaching responsibilities of consultants, nor do they have the full administrative or management duties, as identified in points 4, 5 and 7. Interestingly, one consultant's 'high' was another's 'low'. Surgeon, Ms CJ, had spoken of enjoying the positive feedback from her teaching whilst clinical geneticist, Dr HS, had declared a dislike of teaching juniors. With regard to the discontinuity of care, the comment here was made by a consultant radiologist; a problem which seemed exclusive to that specialty. Unfortunately there were no radiology registrars in the sample, on which to base a comparison. It is possible that points 6 and 7 were also peculiar to consultants. For example, the drudgery of routine work and management problems are possibly an inevitable part of any senior management position, which specialist registrars may not fully appreciate during their training.

Registrars reported a balance of 6 highs and 7 lows in their work, compared to consultants' 8 highs and 10 lows. Hence it appeared that the work-perceptions of the two groups were fairly similar. This contrasted with the comparisons reported in Chapter 12. For example, when GP registrars' *expectations* were compared to experienced GPs' perceptions, trainees reported 4 more highs and 4 less lows than the experienced sample. Indeed the following section suggests, that in terms of their actual expectations, specialist registrars tended to be grimly realistic about their futures as consultants.



## 4 The future - as consultants

Replies to the question "*Do you think these [highs and lows] will change, once you're a consultant?*" were disturbing. There were six negative compared to just three positive comments. The remaining two replies were 'neutral'; one female registrar spoke of 'stepping back' and becoming a clinical assistant to allow her (surgeon) partner's career to progress, whilst the endocrinology registrar declined to comment.

The most depressing accounts came from the two psychiatrists who could only envisage things getting worse with time, rather than improving with promotion, eg [interviewer: *...we've already mentioned less patient contact*] "*Yeah, well that'll be worse. The difficulty with beds, I mean just as a function of time and the country, I think that will get worse.*" (Dr DL ♀ psychiatry). Whilst another four doctors expected to be working even harder once they became consultants, eg "*...my experience so far is that you work harder as you progress...*" (Mr JA ♂ urology). The only positive comments related to two doctors who were anticipating more autonomy as consultants, and a third who was looking forward to gaining "*some respect*" (Dr NU ♀ paediatrics).

## 5 Personal attributes and specialty choice

As with all previous groups, specialist registrars were asked what personal attributes they thought necessary to succeed in hospital medicine. When responses were compared to those of the consultant sample, specialist registrars tended to describe specialty-specific qualities. Hence psychiatrists spoke of needing to be academically alert and able to contain anxiety, the palliative care specialist stressed the importance of an holistic approach to the dying and the paediatrician, of the need to enjoy working with children. Nevertheless, there were three 'overlaps' between trainees and their seniors:

*Hospital doctors should be:*

- academically able
- conscientious, careful, obsessional
- able to communicate with colleagues

Interestingly there was one important difference; two specialist registrars mentioned the need for doctors to look after their own wellbeing, which was also referred to by one of the trainee GPs (Dr AM). As previously stated, in Chapter 12, this may reflect doctors' growing awareness of the emotional demands of their work. That said, during the course of interviews, there was little sign of hospital trainees wishing to control their hours/lifestyle/'medicine' in the same way as trainee GPs. Only two specialist registrars were interested in working part-time and, although the pathologist was currently completing her training part-time, she declared an intention to revert to full-time hours as soon as her children were old enough.



In terms of Bennis' Competencies of Leadership, there was little evidence of such attributes in these junior doctors. However this may be due to their describing specialty-specific qualities, as opposed to the broader attributes named by consultants. The latter will, of course, have had the benefit of experience which may bestow a more objective insight into both themselves and their work (eg Super, Thompson and Lindeman, 1985).

## 6 Specialist registrars' pay

Seven of the eleven registrars spontaneously mentioned pay, with five feeling they were undervalued. Junior doctors' anger at their out-of-hours pay was epitomised by one of the psychiatrists:

Dr BP ♂ (psychiatry): "...to have worked more than half of my working hours since I qualified for less than... half-rate - or a third when I started, that's just not right... it's the fact that in the modern society, respect equates to money. If you're cheap, you're treated as cheap, which is what happens to junior doctors... they're treated as cheap."

Two registrars, however, demonstrated a more realistic perspective of their hours and pay in terms of the wider workplace. For example one spoke of "*Lawyers, manangement consultants, accountants ... they have to work long hours... I think there's a false perception amongst doctors still, that you can have it easy by doing something else and get paid more...*" (Dr JM ♂ respiratory medicine).

## 7 Why this specialty?

Apart from the pathologist and geriatrician, most doctors appeared to have based their career choice on the nature of the work itself, before taking account of the associated lifestyle. Most of the consultants (ie Chapter 7) appeared to enjoy the expansiveness and challenge associated with work-met growth-needs, and this seemed to be the case for around seven of the eleven specialist registrars, eg "...*I prefer people who are psychotic... I'd rather treat people of extremes.*" (Dr BP ♂ psychiatry), "...*I enjoy dealing with the critically ill... treating an entirety and seeing it get better...*" (Dr JM ♂ respiratory medicine). With regard to the pathologist and geriatrician, again women were making compromises; choosing specialties which would allow them to live a life outside medicine, eg

Dr GC ♀ (histopathology) "...hospital medicine is very difficult when you've got children anyway, so I chose pathology because I thought it would fit in better with a family. I still think ophthalmology would be interesting..."



Dr WH ♀ (geriatrics) "...I want to do geriatrics... because my job is not my life... I want to have children and I want to have a life outside of medicine... I want to be the best at what I do... but I want to do it part-time... I think there is a place for part-time geriatricians..."

In Chapter 12, two of the women GP registrars had spoken of choosing general practice because of its flexibility, eg *"...medicine isn't my life, I want to have children... the opportunities in general practice are much better for part-time..."* (Dr CG). Certainly there were no signs here of the sort of total dedication to medicine, as shown by the two women consultant surgeons, Ms CJ and Ms HL, who had put their personal lives 'on hold' until their forties (see section 5.1, Chapter 7). As one female specialist registrar put it: *"You choose your job. If you want to do cardio-thoracic surgery... and have your work take over your life - that's what you do!"* (Dr WH).

What about general practice then? Were any of the sample ever tempted to 'opt out' of the apparent stresses and competitiveness of hospital medicine? The second part of the section focuses on the sample's replies to this question.

### 7.1 *Why not general practice?*

The non-verbal reactions of three of the registrars spoke volumes, eg the long pause, the raised brow, or wry smile conveying the message 'why are you asking me this?' These were people on the threshold of a successful career in hospital medicine and the question was something of a non-sequitur. General practice was simply not on the agenda:

Mr TS ♂ (general surgery) "Er - no."

*Why not?*

Because I enjoy hospital medicine too much. It's a bit of a come-down..."

Dr DL ♀ (psychiatry) "Er - Jack of all trades and master of none?"

When I was working in professorial house jobs, it was a big joke really...

[and later] patient-expectations, fundholding, you know - it's all things that I couldn't be arsed with..."

Mr JA ♂ (urology) "...if I had to do that, I would give up medicine and do something different... loads of patients coming in with nothing wrong with them, you know, wasting your time..."

The notion of general practice being centred around people who are not ill, was



echoed by four more of the sample, eg

Dr BP ♂ (psychiatry) "Never... I don't like the generics of a mild, worried world - problems that are going to resolve on their own in two weeks time... I don't see my role in life to reassure people..."

Dr LN ♀ (medical oncology) "...I like treating people who are ill... it would just drive me to tears with boredom..."

Another two doctors implied that general practice was something of a fail-safe, if things went wrong in hospital medicine:

Dr JM ♂ (respiratory medicine) "I thought of it - probably at times when I was... feeling hospital medicine was not going anywhere for me..."

Dr NU ♀ (paediatrician) "Yeah, sure. If I found myself stuck at SHO or something like a staff grade where you just go on and on and never get anywhere, I'd have thought of general practice, yeah."

The palliative care registrar had already qualified as a GP, before changing direction, and explained himself as follows:

Dr CJ ♂ (palliative care) "...I found I really liked the patients who have chronic illnesses... and I wanted to gain more experience... before settling down into general practice... I went on from there to do my first hospice job and I really loved it..."

Dr CJ's story sounded remarkably similar to that of the consultant paediatrician, Dr WC, who was also a qualified GP, eg *"...I started looking for more paediatric jobs, with the idea of going back into general practice with a special interest in paediatrics... I did a year in Chester... and that was a brilliant job and I just... fell in love with it..."*. So general practice had lost two of its qualified practitioners to hospital medicine within the present study alone.

For these junior doctors, general practice centred around the 'worried well', as opposed to treating real illness. Moreover, as a career, it lacked the kudos of hospital medicine. Indeed the only valid reason for considering such a move, would be in response to a flagging hospital career, or professional "stuckness" as Kanter describes it (Kanter, 1989).



## 7.2 *Reasons for specialty choice: Summary*

The present sample of junior doctors represented some of the 'chosen few' who had made it through to specialist training, with surgeons possibly feeling even more select than their physician colleagues. Judging from their responses, most doctors seemed to have chosen their specialty because of an intrinsic interest in the work-content. However, two of the women had compromised in order to accommodate 'normal' family lives within their careers. Although Dr WH had not suggested what she would have done instead of geriatrics, Dr GC, spoke of her interest in ophthalmology and explained that her choice of pathology was based on family considerations; she was already the mother of three young children.

As with the consultant sample, general practice had lost a fully trained GP to a hospital specialty. Neither Dr WC (consultant paediatrician) nor Dr CJ (specialist registrar) had been ready to settle-down into general practice when first qualified, and had therefore sought to gain further experience in hospital medicine. The intention had been to bring additional skills with them, as GPs. Instead, they had both 'fallen in love' with the new specialty and had never returned to general practice. In terms of the sample's attitude to working in general practice, the overwhelming impression was that it was something of a last resort rather than a serious career option. One of the surgeons declared that he would rather give up medicine altogether than become a GP and, although a little extreme, it seemed to reflect the general mood of the sample.

Finally, it must be noted that the fundamental concept of medicine as a 'calling', as discussed with regard to the experienced GP sample in Chapter 5 (section 4.3), was also apparent in this hospital sample. The term 'calling' was taken to mean a basic, altruistic drive to help one's fellow beings, as illustrated by experienced GP, Dr BR: *"The highs... are the feeling that you can do something for people, something to help their lives..."*. Seven of the specialist registrars and six consultants described 'spending time with patients/helping people' as a highpoint of their work. Moreover, two registrars described very similar motives for choosing medicine as a career, eg *"...you know if you went to med school interviews... and... said 'well I want to help people'... that's the cliché you're always told not to say but, at the end of the day, that is one of the things that actually gives you the biggest positive feelings about the job..."* (Dr JM ♂ respiratory medicine), and *"...I suppose it's still a bit of that - why you fill in your UCCA form when you're eighteen, you know, because 'you want to go and help people' - it's largely that, you know."* (Dr BP ♂ psychiatry)

## 8 **Conclusions**

So how did specialist registrars measure up against their seniors; the consultant sample? Differently, is the answer. Wary and tense, they lacked the poise and confidence of their elders. Again, it should be emphasised that these young doctors had only been in their current posts for a mean of five months (range: 1 - 30 months; 30 months being the exceptional case of Dr JM who had changed specialties).



Continuing in the theme of overall, initial impressions, just as GP registrars had struck the researcher as friendlier and more relaxed than their senior counterparts (ie experienced GPs), so the trend was reversed for hospital doctors. Specialist registrars tended to be cagey and suspicious and were very different to their seniors, as verified by the fact that three of the sample refused to have their interviews tape-recorded. Indeed, the paediatrics registrar even insisted on seeing the interviewer's list of topics, before allowing the (non-recorded) interview to proceed. They were the only group, in the entire study (including the legal samples), to take this stance.

Stepping back to survey the picture as a whole, the story seemed as follows:

These young men and women had entered medical school on a highly competitive basis, ie 'A-level' grades. This competition continued through medical school with the emphasis on passing yet more examinations. So the underlying ethos had, up to this point, been purely meritocratic, ie hard work equates to success. However, once qualified the rules of the game change. Progress, within hospital culture, depends on tactics and diplomacy in addition to exam success, "...*hence a lot of doctors creep and crawl and brown-tongue...*" (Dr BP). It was not simply a matter of finding a job; it had to be the 'right' job and this depended on getting known in the 'right' circles. References from powerful others were crucial (eg "*you have to call in all your previous bosses... and get them to support you...*" Mr JA), hence the necessity of 'crawling' and 'networking'.

Junior doctors' hours and pay have been well publicised and the present sample were no exception, despite The New Deal (NHS Management Executive, 1991) designed to address the problem. Exhaustion, lack of resources and poor pay (eg on-call is paid at "*half-rate - or a third*" Dr BP) were taking their toll on morale. Yet despite these considerable odds, what gave these people their biggest 'buzz' was 'spending time with patients' and 'helping people' (ie seven registrars). And so said most of them. Consultants, a further four years (mean time as consultants) down the line, were telling the same story: 'making people better' and 'diagnostic challenge' were the biggest highpoints of their work. The table below summarises the 'number one' high for all four medical groups.

### ***The top ranking high for all four medical groups***

Table 32

| Named 'high'                               | Trainees        | Experienced sample |
|--------------------------------------------|-----------------|--------------------|
| Making people better/helping people        | 5 GP registrars | 5 GPs              |
| Spending time with patients/helping people | 7 Sp registrars | 6 consultants      |



So how did specialist registrars think things would change, once they achieved the coveted consultant post? Reflecting the current problems in mental healthcare, both psychiatry registrars could only see things getting worse, regardless of promotion. Whilst two doctors were looking forward to increased autonomy and another, to more status/respect, a further four could only see it getting "*harder and harder the further you go*" (Dr LN).

Overall, the sample impressed the researcher as earnest, ambitious young people who were looking forward to the challenge of life as fully-fledged consultants, going for the whole deal - 'hook, line and sinker' - just like their predecessors. Perhaps that explains their initial reticence regarding interviews. Maybe it was a case of 'don't spoil things for me now', ie a fear of being quoted publicly, despite the researcher's assurances of anonymity and confidentiality.

So, returning to the question posed at the end of Chapter 9: how did the trainee hospital sample compare with trainee GPs in terms of attitude; were they fired with commitment and enthusiasm? The answer must be that yes, their earnestness and intensity was certainly different to the GP registrars. It was all a very serious business, and their commitment was beyond question, eg "*...the pay's diabolical...*" (Dr GC), "*I'm a doctor and you don't go around comparing that to other professions*" and "*...I would frame it as being more limited in your outlook and losing part of your life so... you'll be able to stick more medicine in.*" (Dr BP). In the case of the latter, ie Dr BP, a lone rugby ball sitting in the corner of a cramped office, dwarfed by stacks of files and papers, said it all.

Were they more enthusiastic? Possibly not, when comments about the future were considered, eg six doctors anticipated life becoming more difficult once they became consultants. Certainly, the researcher's between-the-lines impression of the sample was one of a group of very tired but equally determined young men and women who were 'nearly there'; teeth gritted and eyes fixed firmly ahead. This hunch was supported somewhat by the sample's reaction to the 'why not general practice' question. The degree of reaction seemed to be based on individual differences, ie some doctors were more polite and patient with the researcher than others, but the underlying message was the same (except for former GP, Dr CJ), that the question was daft and irrelevant. General practice was a siding for the 'might-have-been's', a refuge for those who had nowhere else to go and certainly, never, a first option. The GP registrars' easy style and friendliness was suddenly understandable. The sheer relief at admitting 'defeat' and choosing a new and different direction must surely have immense appeal. The image of the silver-haired GP driving around in his old Morgan, took on a different perspective for the researcher; it was possibly a life-line for some of these exhausted young doctors.



## 8.1 *An evaluation of findings in relation to the JCM*

In terms of the JCM, various aspects of the model were glimpsed during analysis of hospital registrars:

**Global job satisfaction:** studying the tables of the common 'highs' of hospital practice, the similarities between the groups was immediately apparent. Specialist registrars appeared to have a very firm grasp of the 'pros' of hospital medicine. One of the most interesting points centred on hospital doctors' (ie both registrars and consultants) enjoyment of diagnostic challenge. It will be recalled from Chapter 9 (section 4.4.1 comparison of the 'highs' of general practice) that two trainee GPs spoke of this, but the figure faded to zero for the experienced GP sample. Indeed three of the experienced GPs had complained of a lack of *intellectual* challenge in their work which, it is argued, may well include that of making a difficult (and subsequently correct) diagnosis. Upon examination of the hospital samples, it appeared that three specialist registrars also enthused about diagnostic challenges and this figure increased to half of the consultant sample. So it would appear that this important element of job satisfaction tends to disappear for doctors in general practice, whilst increasing for those in hospital medicine.

The power of the Job Characteristics Model was still apparent in this second study. But the question which arises is where, within the five job dimensions, would the concept of intellectual challenge sit? For example it does not immediately 'connect' with task identity and task significance, nor autonomy, and yet there is strong evidence that this important aspect of doctors' motivating potential is missing in general practice. The loss of such fine a detail may, of course, be the inevitable cost of a model designed to generalise so broadly to the wider job-market. Indeed, there appears to be a good argument for adjusting the model to suit highly specialised jobs, such as general practice, where a fundamental problem has been highlighted. The argument is further strengthened by findings relating to volume of work and personal values, which are discussed later in the present section.

**Toward increased responsibility:** three doctors spoke of the challenge of increasing responsibility as specialist registrars, eg "... *the fact that the buck ends with you.*" (Dr CG, histopathology) and "...*it's much more responsibility... at night... you are the most experienced person in the hospital and have to make all the decisions...*" (Mr TS, general surgery) There were also three additional doctors who appeared to enjoy the 'extreme' aspects of their jobs, eg "...*I prefer people who are psychotic... I'd rather treat people of extremes.*" (Dr BP, psychiatry) and "...*I found that I really liked working with... those who were dying from very long-standing disease...*" (Dr CJ, palliative care).

**Autonomy:** two registrars were looking forward to increased autonomy once they were consultants, (eg Drs CJ and GC) whilst one, Dr NU, was looking forward to increased status/respect.



**General practice lacking task significance:** comments arising from the 'why not general practice' question reinforced the experienced GP sample's comments relating to task significance (Chapter 5, section 2.3) where six GPs complained of the increasing number of patients who abused their time (and skills) with 'trivial' or 'inappropriate' demands. These young hospital doctors seemed to have a very good, if somewhat cynical, grasp of the problems currently facing GPs, eg "...loads of patients coming in with nothing wrong with them, you know, wasting your time..." (Mr JA, urology), "...I don't see my role in life to reassure people..." (Dr BP, psychiatry) and "...I like treating people who are ill... it would just drive me to tears with boredom." (Dr LN, medical oncology). In contrast, whilst GP registrars acknowledged the potential problem of hostile/aggressive patients, none talked of the mounting 'trivia' regarding the nature of patients' complaints.

**Feedback:** as stated in Chapter 7 (section 2.1.1), unlike GPs, there was no mention of patient gratitude amongst the consultant sample. With specialist registrars, however, there was just one comment from Dr DL (psychiatry), eg "...people aren't overly thankful, but relatives are and that's nice... when relatives say 'thank you'".

**Context satisfaction:** as already stated in section 6, in addition to long hours, exhaustion and poor resources, almost half of the sample complained of the poor level of pay.

**Volume of work:** whilst a well publicised problem among junior doctors, several hospital consultants also reported tiredness/exhaustion (3 doctors) and work-overload/overbooked clinics (4 doctors). Again, this adds weight to the findings reported in Study 1 (eg Chapters 5, 6 and 7), and suggests that volume of work should be incorporated as an additional moderator in the JCM.

**Values:** the concept of vocation/altruistic service ideal, which seemed so important to doctors in the present study, is left stranded on the side-lines in terms of the JCM. Again, this supports the argument for the need to fine-tune the model to reflect the idiosyncratic nature of special-interest groups, such as doctors and lawyers.

Judging from the present chapter, the question that arises is why do these people persevere when the perceived rewards, at the end of all the training, are yet more hard work? According to the analysis of the 'highs' and 'lows', it would appear that the basic altruistic drive of 'spending time with patients/helping people' (ie seven registrars) answers this question. Yet it is well known that prospective candidates for medical school are warned that they should never explain their motives for wanting to study medicine in terms of "*I want to heal sick people*" (eg Ruston, 1996, p 23). Why not? Sometimes the quickest and most effective means of obtaining information, is to simply ask people outright (eg Hollin, 1992). As verified by the findings of both Studies 1 and 2, the notion of healing/helping people is a strong motivator. Medical school selection panels should perhaps take note: it would appear that the basic drive to "make people better/help people" is actually what sustains these young people as they are trundled through the mill in preparation for a career in medicine.



# Chapter 14

## An overview of GP and Specialist Registrars

The present overview of trainees is necessarily different from the overview of the experienced medical and legal samples, ie Chapter 9.

One of the biggest advantages of analysing data within an established theoretical framework, is that a ready-made structure is provided through which to draw comparisons. Nevertheless, interviews with the two medical trainee groups followed a consistent format, and this was used to provide a basic structure to the present chapter. Drawing on the findings reported in Chapters 12 and 13, the present overview therefore addresses the following topics:

Table 33

| Topic area                                 | GP registrars | Sp registrars |
|--------------------------------------------|---------------|---------------|
| 1) Interviewer's impressions               | ✓             | ✓             |
| 2) Progress so far                         | ✓             | ✓             |
| 3) Why this speciality (including GP)?     | ✓             | ✓             |
| 4) Why not hospital practice?              | ✓             |               |
| 4.1) Why not general practice?             |               | ✓             |
| 5) Competition in hospital practice        | ✓             | ✓             |
| 6) Personal attributes for success         | ✓             | ✓             |
| 7) Expectations: the highs & lows          | ✓             |               |
| 7.1) Lack of career structure              | ✓             |               |
| 7.2) Perceptions of present highs and lows |               | ✓             |
| 7.3) The future- as consultants            |               | ✓             |
| 8) Future plans                            | ✓             |               |
| 9) Satisfaction with pay                   |               | ✓             |

Each of the above topics are presented, in summary form, to highlight the similarities and differences between the two groups. The overview begins with the researcher's overall impressions of the registrars.



## 1 Interviewer's impressions

### *GP registrars:*

easy to establish a rapport, relaxed open and friendly.

### *Specialist registrars:*

wary and tense, taking time to 'relax into' the interview. Three doctors refused to have interviews tape-recorded which, in retrospect, was thought to reflect the determination that nothing should 'rock the boat' for them in their strivings for the coveted consultant post.

## 2 Progress so far

### *GP registrars:*

two registrars were still exuberant at having escaped the pressures of hospital medicine. However, for the remaining six there were new stresses, eg the additional responsibility of making decisions in comparative isolation "*in a room on your own*" (Dr CG), learning to live with uncertainty and, for one (ie the only one who showed such awareness), developing time management strategies regarding consultation time/patient-throughput.

### *Specialist registrars:*

like the GP registrar group, two specialist registrars were enthusiastic about their new posts. For the remaining nine, however, there were additional pressures such as getting to grips with new jobs, and a realisation of the increasing responsibility commensurate with becoming registrars, and culminating with a consultancy. Eg "*you... have to make all the decisions*" (Mr TS) and "*the buck ends with you*" (Dr CG).

## 3 Why this speciality?

### *GP registrars:*

reasons for choosing general practice included variety, autonomy and independence, flexible working hours and continuity of care with patients. Like the experienced sample, one registrar described a nostalgic 'Dr Finlay' image of the GP. However, unlike the experienced sample, there seemed little awareness of the problem of *diminishing* autonomy, nor the prospect of career stagnation/lack of intellectual challenge.

### *Specialist registrars:*

most doctors seemed to have chosen their specialty because it reflected their interests, eg "*I love children!*" (Dr NU). Three doctors also described the appeal of treating extreme conditions. Overall, seven of the sample seemed to show the same high work centrality as seven of the consultants. The exceptions were two women doctors (Dr GC and WH) who admitted compromising to accommodate family commitments. Their attitude contrasted



sharply with the two female surgeons in the consultant sample, who had sacrificed their personal lives for career advancement.

## **4 Why not hospital practice? (GP registrars only)**

### ***GP registrars:***

only one registrar, Dr DS, had seemed set on general practice from the outset. For the remaining seven, long hours with onerous on-call duties, an inflexible and highly competitive career hierarchy, combined with a general feeling of exploitation, all contributed to these doctors' disillusionment with hospital practice.

### **4.1 Why not general practice? (specialist registrars only)**

#### ***Specialist registrars:***

like the consultant sample, general practice had lost one of its qualified doctors to hospital medicine in this group too. For the rest of the sample general practice was seen as centring around the "worried well" as opposed to treating clinical illness. Moreover, it lacked the kudos of hospital practice, eg "*Jack of all trades and master of none*" (Dr DL). Two doctors conceded that they might have considered general practice, had they felt their hospital careers were "*not going anywhere*" (Dr JM).

## **5 Competition in hospital practice**

### ***GP registrars:***

three trainee GPs criticised the excessive competitiveness of hospital medicine, eg "*...worse than anything I've ever seen.*" (Dr CA), "*...the dog-eat-dog atmosphere...*" (Dr PS) and "*...you can always opt out into general practice. You can't do it the other way so easily... because of the competitiveness of hospital medicine...*" (Dr DS).

### ***Specialist registrars:***

all of the sample agreed on the competitiveness of hospital medicine, and most seemed prepared for it from the outset. Exceptions to this were the two surgeons who were surprised at the extent of competition in their field. A psychiatric registrar observed that the competition was tactical rather than intellectual, eg "*...I would frame it as being limited in your outlook and losing part of your life... so you'll be able to stick more medicine in.*" (Dr BP).

## **6 Personal attributes for success**

### ***GP registrars:***

like the experienced sample, registrars also talked of the need for good communication skills and patience. However, the more down-to-earth practical attributes named by experienced GPs were missed, such as an ability



to live with uncertainty, being independent and the more cynical attributes for survival, such as being "*hard-skinned*" or having "*a laid-back*" approach.

Registrar, Dr SG, was the only doctor in the entire study to mention the need for a sense of humour in medicine. Another anomaly related to an ability to look after oneself and one's own wellbeing, which was totally omitted in the experienced GPs' list of attributes. This was construed as being indicative of a growing awareness of the stresses of general practice, which may protect doctors against some of the pitfalls (and cynicism) experienced by their predecessors.

### ***Specialist registrars:***

registrars tended to describe more specialty-specific attributes than consultants. Nevertheless, 'overlaps' included the importance of being 'academically able', 'conscientious, careful, obsesssional' and able to 'communicate with colleagues'.

Just as one GP registrar had spoken about the importance of looking after one's own needs, so two specialist registrars described the importance of being able to "*...seek help when you need it...*" (Dr DL), and "*...you need back-up help outside to help you cope emotionally...*" (Dr LN). Hence both samples seemed to show a new awareness of the stresses of a medical career.

### Competencies of Leadership (eg Bennis, 1984)

The results were inconclusive: unlike the consultant sample, where surgeons emerged as 'leaders', there was no discernable pattern in the registrar sample. This was possibly due to the two groups being at different stages of their careers, with consultants better placed to make reflective judgements on their strengths, in terms of person-job fit.

## **7 Expectations: the highs and lows (GP registrars only)**

### ***GP registrars:***

the sample named eleven highs and five lows compared to the seven highs and nine lows reported by the experienced sample. It can therefore be concluded that trainee GPs appeared to be fairly optimistic about their futures. Of the 'main' highs, two registrars named diagnostic challenges as a high, compared to none of the experienced GPs. Moreover, whilst trainees seemed aware of the pitfalls of increasing paperwork, possible litigation risks and hostile/aggressive patients, there was a lack of awareness of some of the other problems, eg there was no mention of diminishing autonomy, the constraints on time/resources, nor the problem of the apparent 'trivial' nature of many patients' complaints, as reported by the experienced sample.



### **7.1    *Lack of career structure (GP registrars only)***

#### ***GP registrars:***

none of the sample perceived lack of career structure to be a problem, although it seemed that only three doctors were actually aware of the issue, and not prompted by the researcher's question. Five of the eight trainees intended to work part-time and thought that they would derive enough stimulation from outside interests. The overall impression was that these new GPs were determined not to be 'sucked in' to general practice like their predecessors, because "*we've seen what it's done to other people*" (Dr DS). There was talk of the need "*to control medicine*" (Dr CG) and "*to have a healthy balance of career and other things*" (Dr SG).

### **7.2    *Perceptions of present highs and lows (specialist registrars only)***

#### ***Specialist registrars:***

specialist registrars' perceptions of their work appeared to closely match those of consultants. Certainly, they were more congruent than the apparent 'gap' between GP registrars' expectations and the reported 'reality' of the experienced sample. However, this may be due to the fact that hospital trainees spend five to six years' in training, compared to the one year spent in general practice (ie out of the total three) for trainee GPs.

### **7.3    *Expected changes once consultants (specialist registrars only)***

#### ***Specialist registrars:***

there were six negative comments compared to just three positive. The two psychiatry registrars could only envisage conditions getting worse as a matter of time, rather than improving with promotion. Although two doctors were looking forward to more autonomy, and one to more respect, a total of four expected to be working yet harder once they became consultants.

## **8       *Future plans (GP registrars only)***

#### ***GP registrars:***

three of the eight doctors interviewed were considering work outside the standard GP principalship, eg two were thinking of working abroad whilst a third spoke of studying law alongside part-time general practice. As stated in section 7.1, five of the sample were intending to work part-time. Out of the total eight trainees interviewed, only three intended to work as full-time principals in the UK.



## 9 Satisfaction with pay (specialist registrars only)

### *Specialist registrars:*

six doctors spontaneously mentioned pay when asked whether they had ever compared themselves to other professions and, of these, five complained. Moreover, they were much more vociferous than the four consultants who had expressed dissatisfaction in Chapter 7. The registrars' dissatisfaction was also thought to be particularly significant in view of the 'main' lows previously mentioned, eg poor conditions/lack of resources, long hours and the associated exhaustion.

## 10 Summary

In carrying out this qualitative study, the researcher has endeavoured to present a clear and robust analysis of the interviewees' accounts of the various aspects of their work.

However, for the researcher, one of greatest strengths (and joys) of qualitative research is the opportunity it offers to actually observe people as they talk about the things that are important to them in their work. This added dimension is, of course, lost in postal questionnaires or telephone interviews (eg Jones, 1985, Miles and Huberman, 1994). It is obviously imprudent to generalise about the necessarily small samples associated with qualitative research. Nevertheless, for the researcher, different groups conveyed a certain style of thinking, a mood, which separated them from other groups. For example, there were very clearly *general* differences between both experienced GPs and consultants, and between GP registrars and specialist registrars. However, these were not in the direction that was expected. As noted in Chapter 5, experienced GPs struck the researcher as intense, rather humourless individuals compared with the poised and socially adept consultant sample. In Chapter 9 the question which remained outstanding, was whether the apparent differences between GPs and consultants were the cause of the former leaving hospital practice in the first place, or whether working in general practice had effected the difference. The trend was reversed for the registrar samples. Trainee GPs gave the impression of being relaxed and friendly, even chatty, compared to the intensity and nervousness of the trainee hospital sample. Why?

The hypothesis offered by the researcher was that trainee GPs were reacting to the relief at 'escaping' the pressures of hospital medicine, whilst the hospital trainees were reacting to the effects of those pressures and to the fact that the end was in sight, ie a consultancy. For example, there was no way that a complete stranger was going to come along, at this late stage, and mess things up in the name of 'research'. This hunch was tentatively supported by the two surgeons' talk of the '*networking*' and '*crawling*' that is involved in progressing one's career. The apparent competitiveness of hospital medicine, calling for much tactical diplomacy, implies a dependence on important others for success. All that hard work could be undone, at a stroke, by an ill-judged comment to the wrong person, at the wrong time (ie from a trainee's perspective). Interestingly, it was not surgeons who objected to being tape-recorded,



rather it was a pathologist, a paediatrician and an endocrinologist. Nevertheless, the underlying philosophy might well apply across specialties.

Returning to the question relating to differences between experienced GPs and consultants, ie why should the GP sample appear so intense and emotional about their work: was this a personality 'marker' common to doctors opting for general practice, or was it their experience in the job that had effected the change? If the present cheerful, outgoing sample of trainees were representative of GPs in general, then it would appear that work in general practice might be responsible for the difference reported in Chapter 9. Of course the samples used in the present study were too small for such generalisation, but further quantitative research might prove fruitful in shedding further light on the effects of stress in general practice.

In terms of the two groups' impressions of their progress so far, there were few differences. Both were feeling the stresses of new training posts, both were aware of the increasing responsibility of their positions. GP registrars however, spoke about learning to live with uncertainty, an important point raised by four experienced GPs in Chapter 5 (section 3.1). This aspect was omitted from both hospital trainees and consultants, presumably because there is less uncertainty associated with hospital medicine.

So what drew them to their respective specialties? According to both groups, the reasons given for choosing their area of expertise was because they liked it and it reflected their interests. GP registrars wanted the autonomy, flexible working hours and continuity of care of general practice, whilst specialist registrars described what they enjoyed about their particular specialty, eg they liked working with psychotics or children, whatever. Similarly, when asked why they rejected general practice or hospital practice respectively, the two groups' answers were again fairly predictable, eg hospital trainees did not like the idea of general practice, just as GP trainees rejected the idea of hospital practice. There, however, lay the crux of the matter.

A (hospital) consultant acquaintance offered to read Chapter 13, shortly after it was completed, and kindly gave the researcher his comments. Regarding section 7.1, where hospital trainees were asked whether they had ever considered general practice, the consultant complained "*That was hardly a fair question - when you asked them why they'd chosen their current specialty, they'd had time to think about the answer. You just caught them off-guard with the GP question!*". The researcher's answer was "Precisely!" The very strength of such a question was that it provoked spontaneous responses, which had not been carefully 'packaged' or checked for political correctness. Rather, these were raw, 'gut' responses. Hence the findings reported in Chapter 9 (section 3.2.1) were further substantiated; that general practice was considered something of a second best, a safety net for a flagging hospital career.

The competitiveness of hospital practice was undisputed. The difference between groups was simply that GP registrars were not prepared to tolerate it, whilst specialist registrars obviously were. Or rather, those were the justifications that were offered. For example, on the question of lack of career structure in general practice (and 'future



plans'), it was noted that only three doctors intended to work as full-time principals in the UK. GP trainees spoke in terms of 'controlling' medicine, and needing a 'balanced' lifestyle. This was a far cry from the picture painted by psychiatric registrar, Dr BP, when he described the competitiveness of hospital practice in terms of being prepared to drop all other aspects of one's life in order to be able to "*stick more medicine in.*". However, as previously stated, this may have reflected post-decisional dissonance on behalf of the GP trainees, eg 'I made the right choice - look what I've left behind!'.

Nevertheless, amongst the high work centrality of hospital trainees there appeared to be generation-related gender differences between women trainees and consultants. Perhaps reflecting today's feminist perspective of 'having it all', two of the women specialist registrars made it quite clear that they wanted career and family life, together, in parallel. Conversely, it will be recalled from Chapter 7, that two successful women surgeons had abnegated family lives for the sake of their careers.

So how did the two groups differ on the sort of personal attributes they believed ideal for their respective jobs? As noted in Chapter 10, specialist registrars named more specialty-specific personal qualities than the consultant sample, for example the psychiatry registrar talked of the need to control anxiety because of the nature of his work, whilst the paediatrics registrar spoke of enjoying working with children. In terms of comparisons with GP registrars, there were five 'overlaps': both groups talked of the need for

- people skills,
- an ability to seek help when necessary (ie "*and not try and cope with everything*" Dr DL)/being able to look after oneself
- patience
- being academically alert/clinically competent
- an holistic approach

Once these common areas were accounted for, what remained for both groups, was a list of specialty-specific attributes. For example, GP registrars talked about the need for a practical outlook, good business skills, efficient time-management, *etcetera*, whilst specialist registrars spoke of qualities such as objectivity/ability to contain anxiety (psychiatric registrar), a need to be careful, obsessional (pathologist), a need to be persistent, confident and enthusiastic (surgical registrar), and so on.

The most interesting point to emerge was an apparent awareness of the stresses of medicine. Both groups talked of the importance of recognising personal needs, such as being able to seek help when necessary, and looking after oneself. Surprisingly only one doctor in the entire study, a GP registrar, spoke of the need for a sense of humour. Perhaps a sense of humour is not readily associated with the clinical aspects of a doctor's work.

In terms of general work expectations/perceptions, reflecting perhaps the longer exposure to their specialty (ie 5-6 years, compared to just one year in an actual practice for GP registrars), specialist registrars were considerably less idealistic than trainee GPs.



The table below outlines the main trends, in terms of highs and lows, for all four groups of doctors. Experienced GPs and consultants were asked to describe the *existing* highs and lows of their work. Trainees differed slightly. Because of their long training, specialist registrars were also asked to describe their present highs and lows, and were then asked how they thought these might change once they became consultants. Because of GP registrars' limited time in practice, they were asked to describe their *expected* highs and lows, once working as qualified GPs.

### ***Doctors' reported highs and lows***

Table 34

| GENERAL PRACTITIONERS |        |        | HOSPITAL DOCTORS |        |
|-----------------------|--------|--------|------------------|--------|
|                       | HIGHS  | LOWS   | HIGHS            | LOWS   |
| <b>Trainees:</b>      | 11     | 5      | 6                | 7      |
| <b>Experienced:</b>   | 7 ↓    | 9 ↑    | 9 ↑              | 10 ↑   |
| <b>Trends:</b>        | 4 less | 4 more | 3 more           | 3 more |

It is important to note that the above table does not include specialist registrars' gloomy predictions for their future as consultants, remembering that six doctors could only foresee things getting tougher with promotion, not easier. Nor does it include their opinions on pay. Junior doctors' anger at their out-of-hours remuneration just compounded their lows of poor working conditions/lack of amenities, long hours and exhaustion.

Clearly it would be a folly to overemphasise the significance of these summary figures, based on very small samples. Nevertheless, they are helpful in providing a cursory overview of the two groups. For example, it appeared that trainee GPs may be underestimating the lowpoints, whilst overestimating the highs of general practice. Maybe post-decisional dissonance was a more central factor in this group's responses than was first estimated.

Interestingly, diagnostic challenge, which three hospital trainees named as a high, increased to five of the consultant sample. This trend was reversed for GPs; two GP registrars described it as a high, compared to none of the experienced GP group. As previously argued, this may relate to the intellectual challenge that appeared to be lacking in general practice, and which was considered to represent a major flaw in the motivating potential of GPs' work. Indeed, judging from the sample bases, it appeared that job satisfaction increased for hospital doctors, whilst decreasing for general practitioners.

Finally, as stated in Chapter 13 (section 7.2), the thread of altruism was seen to be running through all four medical groups. For example, half of both experienced and trainee GPs spoke of 'making people better' or 'helping people'. Similarly, over half of



both specialist registrars and consultants spoke of 'spending time with patients' and 'helping people'. As remarked upon in section 9 of Chapter 13, it seemed odd that medical school selection panels should look negatively upon candidates who describe their motives for studying medicine in terms of 'wanting to heal people'. What better motive could there be for a prospective doctor? Judging from the present sample base it would appear that, without that powerful motivator, the rigours of medical training would be intolerable.

Taking an overall perspective, it has already been established that hospital consultants enjoy enriched, challenging work (ie Chapter 7), despite their concerns about long-term job security and litigation risks. However the story that emerges, from interviews with junior doctors, is one of poor working conditions and low morale. The situation certainly appears to change with a consultancy, but the wonder must be that hospital trainees make it to the finishing post at all.

It would seem that GP registrars might indeed be choosing general practice for the wrong reasons, ie because of the perceived barriers to success in hospital medicine, but who could blame them? The puzzle is that not enough doctors are entering general practice, despite the problems in hospital medicine (ie concerning junior doctors). The clue might lie in the sense of grim determination that emanated from the hospital trainees, eg having got thus far, there was no turning back. Another possibility, of course, is that for hospital trainees the light at the end of the tunnel sparkles more brightly than that which beckons prospective GPs.

There can be little doubt that hospital medicine is a tough terrain, demanding a high price for its ultimate reward (ie a consultant post). The present study suggests that general practice may represent a refuge for the casualties of that system.



## Part IV

## Chapter 15

## Conclusions and Recommendations



# Chapter 15

## Conclusions and Recommendations

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The chapter begins with an overview of the research findings, which leads on to the conclusions to be drawn from these. This is followed by the author's recommendations, outlining potential avenues for future research.

### 1 Overview and conclusions

#### 1.1 *What is wrong with general practice?*

This final chapter re-focuses on the research question; *what is wrong with general practice?* According to the present research findings, the answer can be summarised as follows:

##### 1.1.1 *The doctors themselves*

Judging from the sample base it appears that many doctors choose a career in general practice for less than positive reasons, ie because of perceived barriers to success in hospital medicine (eg section 1.5 in Chapter 5; section 2 in Chapter 12). For example, both experienced and trainee GPs complained of hospital practice in terms of the excessive competitiveness, hierarchical structures, long training tied into uncertain goals, and heavy on-call rotas. Indeed, these views were endorsed by hospital trainees themselves. Hence there is strong evidence to support the statement made in the previous chapter: that general practice appears to represent a refuge for the casualties of that system. As stated in Chapter 5 (section 1.5), it is possible that the widely publicised exodus of experienced doctors from general practice, may reflect the destabilising effects of recent change on people who were reluctant recruits in the first place. Nevertheless, there were positive reasons for choosing general practice, as illustrated by trainees in Chapter 12. These included variety, autonomy and independence, flexibility in terms of hours and the continuity of patient-care.

With regard to trainees' expectations, GP registrars appeared cautiously optimistic about their careers, and overly optimistic about their personal abilities in terms of coping better than their predecessors. Overall, there was a tendency to overestimate the highpoints of a career in general practice, whilst underestimating the lows. For example although trainees seemed aware of some of the problems such as excessive paperwork and difficult/hostile patients, they appeared to overlook many of the other pitfalls. Certainly there was little evidence to suggest that trainees understood the long-term implications of having no career structure, nor the frustrations caused by lack of intellectual challenge and diminishing professional autonomy. However, there was evidence that these new GPs were determined not to repeat the mistakes of their predecessors, despite half of the sample having chosen general practice for exactly the same reasons (ie disenchantment with hospital practice). This seemed to manifest itself in terms of diminished commitment, when compared to the experienced sample. For



example only three, of the eight doctors interviewed, intended to practice as full-time principals in the UK. This seemed to represent a poor return on investment in terms of doctors' training. It also marked an important turning point in doctors' attitude to their work: this new generation of doctors appeared to have a transactional psychological contract, whereby the boundaries between work and non-work were clearly marked.

### **1.1.2 The job**

According to analysis within the framework of the JCM, doctors' work in general practice rates low in motivating potential. Although there was evidence of skill variety, constraints on time and resources damaged doctors' sense of task identity. This was also related to perceptions of task significance. Far from the popular myth of doctors making life-or-death decisions, these experienced doctors were clearly overwhelmed by the sheer volume of patients coursing through their surgeries. For example, eight of the ten GPs interviewed complained of rising patient demand/consumerism. A major source of frustration was the nature of these demands; it seemed that the majority of patients are simply not ill. Nevertheless, it appeared that doctors had to tread warily for (increasing) fear of litigation, eg patients "*...might get nasty and you end up in court*" (Dr WA). Task significance, in turn, related to doctors' sense of autonomy. The 1990 GP Contract, the Patient's Charter, the introduction of the internal market and a continually changing health service, all represented a major attack on doctors' professional autonomy. Hence many of the sample felt that their traditional autonomy was being squeezed by rising patient-consumerism on one side, and increasing government intervention on the other. Finally in terms of feedback, although half of the sample described the clinical satisfaction of helping people get well, six of the ten doctors were clearly disappointed with the apparent lack of patient-appreciation. This extrinsic form of feedback was very important to doctors, as evidenced by the passion the topic aroused. Moreover, two of the sample reported threats of physical violence from patients representing, perhaps, the ultimate in negative extrinsic feedback.

Consideration of moderator effects revealed a distinct lack of career structure in general practice, which appeared to deny doctors any tangible measure of personal growth and development. Examination of 'supervisory practices' suggested that the State, to whom GPs contract their services, most probably fulfils this role. It seemed that doctors' anger at recent changes could be explained in terms of their having, or expecting to have, a relational psychological contract with the State and that this had been violated. It was clear, for example, that doctors felt let down and exploited by a government who appeared to have so little regard for their traditional status, their expertise - and their hard work.

### **1.1.3 Additional factors**

***Lack of intellectual challenge:*** although clearly related to doctors' sense of task significance (eg the increasing degree of 'trivia' regarding patients' complaints), doctors also appeared to lack intellectual challenge. In Chapter 14, for example, it appeared that 'diagnostic challenge' increased for hospital doctors, whilst disappearing for general practitioners. It was argued that this was related to the



'intellectual challenge' which three of the experienced GPs complained was missing in their work. So there appears to be a situation whereby these highly trained people, expert in diagnosing and treating illness, are having their days filled with the demands of the 'worried well'.

***Lack of status:*** in addition to a lack of career structure, it appeared that general practice lacks the 'kudos' of a career in hospital medicine. This was tentatively implied by one GP in Chapter 5 (eg Dr WA who described himself not "*clever enough*" for hospital medicine), but gathered momentum in Chapters 7 and 13. Indeed, hospital trainees demonstrated a very good grasp of the problems facing general practice today, and appeared to regard the option as something of a last resort.

***Lack of mobility:*** four of the experienced GPs described the perceived difficulty in either changing practices, or returning to hospital medicine, if it was felt they had made a mistake. Hence such individuals can find themselves effectively trapped. According to the sample, wanting to make any sort of move implies that they are "*damaged goods*" or that their "*judgement is suspect*" (Dr AP).

## 1.2 Conclusions

Potential recruits may be deterred from general practice by its apparently low status within hospital culture, and the fact that the profession's problems have attracted extensive media coverage. In terms of retention, it would appear that many doctors opt for a career in general practice for negative reasons, ie as a refuge from the rigours of hospital practice. Therefore it was suggested that the turmoil of recent change may have represented the 'final straw' for many older doctors, and early retirement was an effective means of escape. In terms of the future generation of practitioners, there was evidence that these new doctors were less committed than their predecessors. Moreover, despite having based their career decision on the very same grounds as the experienced sample, they appeared confident in their ability to manage their careers more effectively. In other words, they were convinced that they were different. Whether their confidence is justified remains to be seen.

## 2 Recommendations

Several potential avenues for future research were identified during the course of the present work, and these are described below.

### 2.1 Generalising the present findings to a wider population

The present findings have undoubtedly contributed to a greater understanding of the current recruitment and retention problems experienced in general practice. This has been demonstrated by the findings relating to experienced practitioners in Study 1, and the differences observed in the new generation of GPs in Study 2. However because both studies have been qualitative, and therefore limited in size, the next stage would be to establish whether the current findings can be generalised to the wider population



of doctors. However, it is anticipated that this will not be straightforward. As previously explained (section 2.2 in Methodological Considerations), doctors appear to be suffering a case of 'form-filling fatigue' and persuading them to complete a postal questionnaire represents a formidable challenge. Indeed had this not been the case, the researcher would have pursued this course of action during the completion of the thesis.

In terms of generalising the present findings to the wider non-medical population, it must be noted that much of what has become evident amongst doctors also applies to other professionals. Indeed, the medical profession has been one of the last professions to succumb to change imposed from outside (ie from State intervention). As stated in section 2.5.3 in Chapter 1, the corporate restructuring of the 1980s/early 1990s had a devastating effect on career professionals in middle management and changed forever the culture of a 'job-for-life'. Similarly, the teaching profession has suffered continuing change at the hands of successive governments, as politicians attempt to address voters' concerns regarding falling educational standards.

Hence it would seem that professional status can no longer guarantee protection against the "*slings and arrows of the labour market*". Just as professionals who are tied into organisations (eg computing, engineering, accounting) have had to adapt to changes imposed by their employing organisations, so traditionally independent professionals (eg doctors, dentists, lawyers) must now learn to live with State mediation/intervention.

## **2.2    *Selection criteria: are potential GPs identifiable?***

As stated in Chapter 9, there were noticeable differences between hospital consultants and experienced GPs. This was marked by the latter's greater emotional involvement with their work, as evidenced by the need for patient-gratitude and the intensity of their interaction with the interviewer. Therefore the question was posed: is this apparent difference the cause of doctors opting out of hospital medicine, or is it the effect of their work in general practice? After all, medical school intake is equally competitive for both would-be GPs and hospital consultants. There is no logical reason to assume a difference. A longitudinal study focusing on the personal characteristics and expectations of doctors at the pre-entry stage of their careers (ie medical school intake), which then follows them through to their eventual post-registration career choice and beyond, may help to elucidate the issue. More importantly it may persuade medical school selection panels to reconsider their acceptance criteria, in the light of the current shortage of recruits to general practice. For example, if further research can identify an individual type which is more suited to such work, then maybe selection criteria should be adjusted to accommodate this. At the time of writing such outcomes are left to chance.

## **2.3    *A case for fine-tuning the JCM?***

As previously stated, the Job Characteristics Model has provided a valuable and powerful framework for the analysis of doctors' work. It is hoped that the present



study has strengthened the argument for including the full, moderated version which has proved so helpful in identifying crucial personal and situational factors surrounding doctors' work. It is argued that without the inclusion of moderator effects, doctors' perceptions of un-met growth-needs and violation of their psychological contract with the State may, perhaps, never have been identified. Nevertheless, there were several instances where it was felt that the model would benefit from 'fine tuning' to reflect the work and needs of special interest groups, such as doctors and lawyers. These are summarised below.

***Volume of work:*** this was a recurrent problem reported throughout the study, pertaining to all samples, except barristers. As consistently argued throughout the thesis, the absence of this consideration was considered to represent a considerable flaw in the model. There were several examples of the motivating potential of work being seriously undermined by a state of sustained work-overload. Even in the case of enjoyable, challenging work, there appears to be an argument for having 'too much of a good thing' (eg Warr's 9 Vitamins model, 1987).

***Work-centred growth-needs:*** an underlying assumption of the JCM pertains to (a) work being a central value for satisfying high growth-needs and (b) this remaining constant throughout the worker's career-span. The first point was refuted by the cases of a lawyer and a GP for whom work was clearly instrumental, rather than a central value in their lives. The second point was challenged by the experiences of working mothers in both studies. It was suggested that even in the cases of high work-centred growth-needs, a significant life event such as the birth of a child, may cause such people to experience a temporary 'glitch' in work values. Similarly, length of tenure may also have a bearing on the degree to which work meets an individual's growth-needs. As suggested in Chapter 5, increasing tenure may cause some individuals to 'adapt out' of the job's initial challenges. General practice may be a good example, where lack of career structure can deny individuals a sense of progress and personal development over time.

***Global measures of job satisfaction:*** the JCM's global measure of job satisfaction fails to take account of dissatisfactions with disparate, and possibly important, areas of work. This was demonstrated by one of the experienced GPs who appeared to enjoy all aspects of his work, except for the patients (section 1.3 in Chapter 5).

***Personal values:*** the findings of both studies revealed a fundamental sense of vocation/altruistic service ideal among many doctors. In effect, this means that such individuals are vulnerable to changes in the workplace which may not have the same effect on others. For example the growing emphasis on value-for-money within a changing NHS may diametrically oppose doctors' fundamental values, undermining the very reasons they chose a career in medicine in the first place. This important personal factor was neglected by the model, as it certainly bore little relation to existing moderators such as growth-needs strength.



Overall, the present findings support the case for further research into moderator effects within the JCM (eg Fried and Ferris, 1987; Johns, Xie and Fang, 1992)

## **2.4 *Implications for policy change***

### **2.4.1 *General practice as a positive career choice***

As stated in section 2.2, Chapter 12, the problem with general practice is complex; hospital medicine is losing young doctors through low morale, and general practice is attracting these disillusioned men and women because it is perceived as an escape from hospital medicine. It was therefore suggested that any strategy designed to improve recruitment and retention in general practice, must also address the problem of low job-satisfaction and morale in hospital medicine.

The present study has revealed a culture in medicine which holds hospital practice as the pinnacle of career success, and covertly labels those who leave (ie to become GPs) as failures. Hence those who enter a career in general practice are likely to be burdened with feelings of low-esteem and compromise from the outset. The problem may stem partly from the fact that medical students have so little exposure to general practice (ie just 4 weeks out of 5 years), and that doctors' training is essentially hospital-centred. In terms of policy implications the message is clear: steps should be taken to halt, and preferably reverse, this destructive view of general practice as a refuge for failed hospital doctors.

One possible means of introducing change would be to adopt a more holistic approach to healthcare, whereby a community perspective is incorporated into the various specialties during doctors' training. For example, experienced general practitioners could be invited to talk of their experience of dealing with specific problems, as they first present in surgery, and how these patients are managed both before and after their hospital visit/stay. Such an approach may help to promote an awareness of the considerable responsibilities and skills necessary in general practice, so that hospital consultants are seen within a broader and less heroic perspective.

In addition, a general practice rotation (eg six months) could be incorporated into all doctors' post-registration training. This would serve two purposes: (a) it would alleviate the present shortfall in practitioners and (b) it may provide doctors with a realistic job preview of general practice. The outcome may not only serve to increase the number of recruits, but may also teach hospital doctors the value of the work performed by general practitioners. This approach, in conjunction with raising the profile of community healthcare within doctors' training, may reinforce the message that the practice of medicine is not confined to the hospital environment.

### **2.4.2 *The need for audit***

As explained at the beginning of Chapter 1, the absence of any database on the destinations of doctors makes it very difficult to estimate losses from the profession. It is therefore recommended that a system be established whereby doctors must notify a



central body (eg the General Medical Council) of their post-registration location at prescribed intervals. Such records would facilitate research into not only the number of doctors who leave the profession (or the UK) but, more importantly, the reasons behind such a decision.

### ***2.4.3 Introducing a career structure into general practice***

As demonstrated by the present study, junior doctors will tolerate many years of poor working conditions and long hours in order to achieve their prized goal: a consultant post. On the other hand GPs complained of a lack of career structure; once qualified, the job offers no tangible measure of individual growth or development. In other words, there is no personal goal to work towards. It would therefore seem sensible to introduce a career structure into general practice whereby length of tenure and experience were tied into a recognised position or 'rank'. So perhaps after a pre-determined time (and proven experience) a GP should become Community Consultant; a post which may qualify him/her for hospital teaching (ie see 2.4.1 above). This may also help to raise the status of GPs within the wider (lay) community.

As noted in Chapter 5, half of the experienced GP sample pursued interests outside work to satisfy their need for challenge and stimulation. As part of a career-structure strategy GPs could be encouraged to channel their interests back into general practice, with the offer of further training in a specialty of their choice. So, for example, partners who have a special interest in gynaecology and obstetrics could become (formally) recognised community specialists in that field. Others could specialise in ear, nose and throat, or paediatrics and so on. This way general practice could offer a broad spectrum of skills in much the same way as legal practitioners, yet without usurping the hospital consultant's role when the occasion clearly indicates it.

Hence the overall objective is to create a more integrated system of medical training/healthcare, with a blurring of the traditional boundaries between hospital and general practice. As outlined above, this would be achieved via a reciprocal process whereby hospital practice meets the community, via junior doctors' GP rotations, and general practice feeds back into hospital medicine via 'community consultant' teaching posts.

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