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What is the effect of non-clinical change  
on Australian GPs? : a survey of  
regional and rural general practitioners

Andrew Dalley  
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WHAT IS THE EFFECT OF NON-CLINICAL CHANGE ON AUSTRALIAN GPs?  
A Survey of Regional and Rural General Practitioners

A thesis submitted in partial fulfilment of the requirement for the award of the degree  
of

DOCTOR OF PUBLIC HEALTH

from

UNIVERSITY OF WOLLONGONG

by

Andrew Dalley MB BS DipRACOG

GRADUATE SCHOOL OF PUBLIC HEALTH

2007

This work is dedicated to the very gentle, the very beautiful, the  
very loving and the very loved

Megan Joanne Dalley

*Chops*

(2<sup>nd</sup> October 1988 – 11<sup>th</sup> November 2007)

who has another father now.

## ACKNOWLEDGEMENTS

I wish to acknowledge with gratitude anyone who reads this work. Beyond that, I need to acknowledge my family before too many more run off to be married. If you don't know them, they are five lovely ladies, one of whom is a GP and the other four are wise enough to be otherwise occupied.

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And around Australia there is a group of academic GPs who one day found themselves agreeing to be electronic oracles. My thanks therefore to Professors Mark Harris, Claire Jackson, Peter Schattner, Justin Beilby and an anonymous contributor.

Dr David Perkins has retained his stiff upper lip under all sorts of duress in being my Honorary Supervisor Emeritus for all of the last 8 years and has my greatest respect as an academic and friend.

But the initial bars of the opus were played by Professor Kathy Egar when she first made the suggestion that I find something to keep my mind occupied, and Professor Denis Calvert who so politely overlooked my lack of academic virtuosity.

My thanks also to my brother, Bill Dalley, who edited the entire document and who, unfortunately, was able to locate only a small portion of his work.

And, of course, the anonymous GPs who told their stories, and did so willingly, with passion and often with humour.

Thank you, all.

Please see print copy for this quote

Charles Darwin

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## **ABSTRACT**

Australian General Medical Practices have undergone substantial change over the last two decades. This thesis identifies those changes and examines how a cohort of regional and rural general practitioners has responded to them. It also identifies the impact of environmental change on the GPs, their practices and their patients.

The methodology is largely qualitative, based on interviews with 20 practicing GPs in the Illawarra and Shoalhaven regions of Australia. Case studies were developed with the assistance of a group of GP academics from each mainland state, meeting as an electronic Delphi group. The case studies were selected to be of relevance and importance to most GPs in order to stimulate discussion about a defined environmental change.

The data were categorised using a stem-based framework supported by the software product Nvivo. Themes were identified and refined as the transcript of each interview was analysed. Themes were then categorised according to the response of the GPs' to change and the impact of change on the GP, the general practice and the general practice patient.

The findings help in understanding how a cohort of GPs have responded to changes in their environment, how government has introduced reforms, and what response can be made to benefit the longer term delivery of primary care services in Australia.

# **CHAPTER ONE**

## **Introduction**

### **1.1 Rationale for the study**

Change is an inherent element of the Australian general practice environment but little is known of the way in which general practitioners (GPs) meet the challenges of change. There is a body of knowledge, albeit not large, around the manner in which GPs manage clinical conditions. There is a much smaller literature about the manner in which GPs manage changing clinical conditions as opposed to clinical conditions per se. These studies do not support an optimistic view of GPs' willingness or ability to accommodate to change even in the familiar clinical context. This is an interesting suggestion given that GPs are, a priori, clinicians. However, GPs deliver their clinical care through a business infrastructure (McColl et al, 1998) which has been the subject of great change, perhaps turmoil. There is no reason to believe that either the general practice environment or the business processes of GPs are conducive to good management, particularly in changing times.

It has been suggested that the best clinical care will only be provided by redesigning work practices (Morrison and Smith, 2000, p1541). But perhaps we need to go beyond work practices and understand the context of change, why GPs have responded to it in the ways that they have, and what the impacts of those changes have been. This thesis attempts to do this by examining the effect of certain non-clinical changes on a group of Australian GPs.

## **1.2 Non-clinical changes in general practice**

Changes that do not directly influence clinical outcomes, or “non-clinical changes”, have been frequent and at times distressing for the Australian general practitioner (Shattner and Coman, 1998). This thesis is concerned with these non-clinical changes, the responses of GPs to them and the impacts of those changes on the GPs themselves, their practices and their patient care.

In order to discriminate between clinical and non-clinical change, clinical processes will be deemed to be those associated with direct patient care, viz., the taking of a relevant history, the examination, the investigation, the diagnosis and the treatment of general practice patients. Apart from these clinical processes there are many indirect influences on the outcome of care delivered in general practice. These represent the non-clinical elements of general practice. They include, inter alia, patient access to care, practice systems and their regulation, consumer empowerment, coordination of multi-disciplinary care, the use of information, the demographics of the general practice workforce itself and the personal circumstances of the practitioner.

At times the boundary may not be strictly definable. Many non-clinical processes directly support clinical processes. For example, patient recall systems closely support chronic disease management and screening. Other processes such as patient billing, will usually be further removed from clinical processes, relating almost entirely to the business functions of the general practice, whilst at times influencing patient access. All these, and many more non-clinical factors, may

influence the manner in which an Australian GP delivers clinical care to her community.

### 1.3 Thesis logic

This thesis initially describes changes as they have recently occurred in the Australian general practice environment. It then examines the context of the individual GP to whom those changes have occurred, it explores how a cohort of GPs has responded to some of those changes and investigates the impact of those changes on the GP, the patient and the practice.

It therefore explores the processes as described in Figure 1.1:

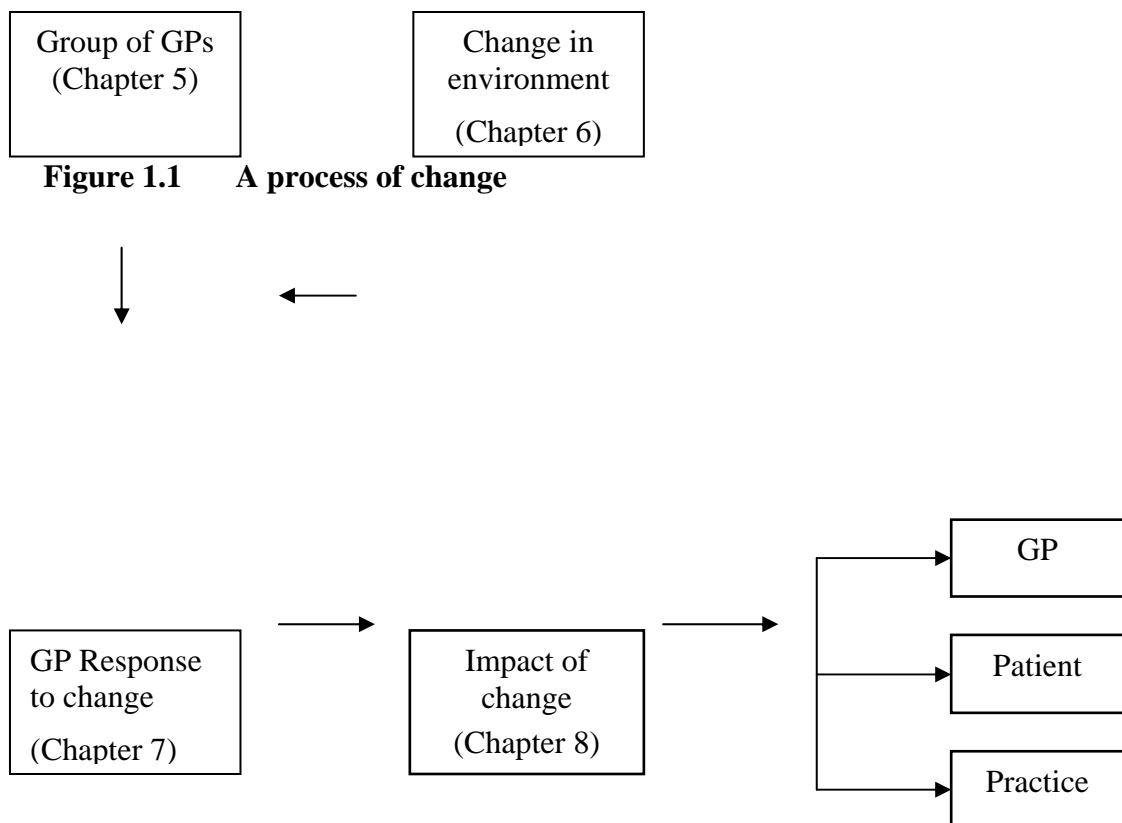


Figure 1.1 describes a simple flow of events in that a change in the environment will impact directly upon an individual or a group of GPs. The GP may or may not respond and the nature and magnitude of the response may modify the impact of the change. That impact may occur on either the GP, the patient or upon the practice itself.

Accordingly, I have sought to understand something of the nature of those GPs (Chapter 5), to identify changes that have actually occurred to them (Chapter 6), to determine how they have responded to the changes (Chapter 7), and to determine the impact of the changes on the GP herself, the practice and on patient care (Chapter 8).

## **1.4 Thesis framework**

The next chapter, Chapter 2, is an overview of the general practice environment that has fostered change. Within Chapter 2 many changes are identified, some of which were later used to construct case study vignettes to assist in data collection.

Chapter 3 is a literature review which examines how GPs have managed change. It does so in both the clinical and non-clinical context as there is little literature specifically concerning GPs' management of change.

Chapter 4 describes the methodological basis of the study. It outlines the processes undertaken to develop a set of case studies refined and prioritised by a Delphi group of general practice academics (oracles). It contains a description of the process of case study selection; a blend of case studies derived in part from the Delphi group and in part from cases arising from Chapter Two. These case studies



were the basis of data collection from a series of face to face interviews with a cohort of practicing GPs.

Chapters 5, 6, 7 and 8 present the results in terms of a description of the GP participants, what changes GPs reported that they actually have had to face, how they responded to changes described in the case studies and what the impacts have been.

Chapter 9 is a discussion of the results presented in the previous chapters drawing conclusions from the data derived from the case studies.

Chapter 10, the final chapter, is a critical appraisal of the methodology.

In all, the framework of the thesis is designed to answer three principal questions:

1. What non-clinical changes have been experienced by a cohort of Australian GPs?
2. How has the cohort responded to change?

How has change and the way the cohort of Australian GPs have responded to it, impacted on the GP personally, on the practice as a whole and on health outcomes for the patient?

## CHAPTER TWO

### The Environment of Non-Clinical Change Affecting the GP

#### 2.1 Introduction

This chapter describes the environment in which change has taken place in Australian general practice. It allows identification of many of those changes, some of which are later utilised to generate case studies to be placed before a cohort of GPs to form the basis of face to face interviews with a confidence that the case studies are relevant to their experience of general practice. The criteria for selecting particular changes for development as case studies are:

- The change in question must have occurred recently and at the earliest, since 1980
- There must be a high probability that the large majority of GPs at that time would have had to make some response to the change in question.
- There must be a high probability of impacting on the large majority of GPs practising at or over that time.
- The change must be readily definable.

The structure of this chapter has been influenced by my own observations of general practice as it relates to the Australian health system and of my examination of the published literature. The headings do, however, closely resemble those found in the more detailed documents, *General Practice in Australia: 1998, 2000, 2002, 2004*. These three documents, published by the

Commonwealth Government represent the only body of literature examining Australian General Practice at regular points of time.

The documents referred to in this chapter are of three types. The major source of information was derived from documents produced by the Commonwealth government, in particular the Department of Health and Ageing (in its many forms as it has existed in the past<sup>1</sup>), the Australian Medical Workforce Advisory Committee which reports on differing aspects of the medical workforce annually, and various ad hoc reports such as the *Red Tape Enquiry* and *The Future of General Practice*. The second major source was that of Australian general practice research, published largely in the *Medical Journal of Australia* and less commonly in the *British Medical Journal*, the third source. To a lesser extent reference will also be made at times to the general practice tabloids, in particular *Australian Doctor* and *Medical Observer*, which may both reflect GP opinion and also shape it. There is, therefore, no systematic approach to the literature supporting this chapter, as that would be an epic and historic, rather than academic, exercise.

Through this chapter, it is therefore intended that the reader will have a picture of Australian general practice that is accurate though not definitive. Accordingly, it is anticipated that the reader will, by the end of the chapter, have recognised the milieu of general practice and will appreciate the reasons for choosing certain changes upon which to base case studies to present to GP participants.

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<sup>1</sup> Such forms include the “Department of Health and Family Services” and “Department of Health and Aged Care”, “Department of Health and Ageing”.

Perhaps the greatest influence over the nature of general practice in Australia has been the introduction of Medicare in 1980; though a means of underwriting medical costs the introduction of Medicare typifies the power of the Commonwealth government in wielding financial reforms. It is therefore fitting to commence this overview of change with reference to the Commonwealth government's role in controlling and changing Australian general practice.

## **2.2 Control and change in Australian general practice**

The “author” of Medicare, Richard Scotton, has stated that that the modern health system is both effective and expensive (Scotton (a), 2000). More crudely, it works but it costs. For both those reasons, Scotton argues, medical practitioners are increasingly coming under government scrutiny and persuasion. Nowhere is that more evident than in general practice where GPs not only contribute to health costs directly but they are often seen as gatekeepers to the remainder of a system that is generally much more expensive. However, levers of change available to the Commonwealth are largely restricted to its involvement in the health sector as funder. Therefore attempts by the Commonwealth to make general practice more accountable for its expenditure or for its outcomes are largely restricted to financial incentives or disincentives. It will become apparent that the Commonwealth uses this economic lever extensively.

Australian general practice is perceived as being largely self-regulatory, and is practiced largely in the private sector. Although there is an increasing array of preferred standards and quality-associated targets and financial incentives for meeting them, Australian GPs, by and large, are free, at least in principle, to accept or reject these. Ironically, unlike the United Kingdom, where GPs are said

to regard themselves as “autonomous” (Marshall, 1999, p167; DHFS, 1998, p235; Pringle, 1999, p546), Australian GPs have no contract with the national government nor do they have a relationship with a Health Maintenance Organisation (HMO) as may be the case in the USA (Bindman and Majeed, 2003). And unlike Canadian GPs, Australian GPs have few controls over how great an income they may derive from their practice.

Medicare provides a consumer subsidy that has been a strong driver of demand for general practice services. If demand increases beyond the capacity of a market to meet that demand, pricing controls exerted by consumers are to some extent negated by unmet demand for services. Such appears to have been the case with Australian general practice which has seen an increase in patient charges in excess of the subsidy between 1984 – 2002 of 68% (Richardson et al, 2005, p52), a decline in patient access to GPs, and an increasing interest by the Commonwealth in GP charges. As Government has no control over general practice pricing, apart from increasing or reducing the Medicare subsidy, price control largely rests in the hands of clinicians who operate in the main as small business owners, the Australian GP.

### **2.3 The Australian GP**

The Australian GP is consulted by over 80% of the Australian community each year (Pegram, 2000, pxxix). As principal referrer to specialist services she is regarded as the gatekeeper (Bloom, 2000), though she herself is also officially regarded as a specialist. The Australian GP is ageing (p29) whilst the general practice workforce is becoming more feminised (p36).

Issues of gender, morale and working conditions may be important determinants of the manner in which GPs respond to change. Morale amongst Australian GPs is reported to be low (Schattner and Coman, 1998; Holt, 1999, p16; Chew, 2001, p85; Neuwirth, 2002) and many see the Commonwealth government as the major villain (Nelson, 2001). They are over-represented as a group self-administering opioids (Cadman and Bell, 1998). Australian GPs, the majority of whom are self-employed, enjoy few of the benefits of, for example, their UK counterparts such as time off for continuing professional development, sick leave, holiday pay and intra-practice locum relief.

The Australian GP sits within a relative vacuum with respect to direction of her profession. It is therefore appropriate to discuss general practice strategy at a national level.

## **2.4 General Practice Strategy**

An Australian General Practice Strategy exists only as *The Report of the General Practice Strategy Review Group*, published by the Commonwealth Department of Health and Family Services in 1998. At the time of writing it is eight years post publication and represents the position of the Commonwealth rather than a consensus position of major stakeholders on the future of general practice. The Australian Divisions of General Practice (ADGP) has, in both 2002 and 2003, held national summits to determine a strategy for general practice with the release, in 2006, of a strategy for primary care (ADGP, 2005). The Commonwealth's lack of strategic direction is ironic given that all GP representative organisations (of which there are many, cf p19) would have their

own strategic plan divorced from an overarching strategy. Therefore Australian GPs are coping with change in the absence of policy and in the presence of perhaps multiple and conflicting strategies.

Devoid of an effective strategy, general practice also occupies an uncertain position within the Australian health care system.

## **2.5 The position of general practice within the Australian health system**

Australian general practice is a major element of the health care sector, providing a large number of health services. However, its position within the health care sector is frequently defined, usually inaccurately, and many of its health outcomes are unproven. For example, General Practice has been variously described as the “cornerstone of Australia’s health system” (Pegram, 2000, pxxix), as “being at the heart of both the primary health care system and the health system overall” (DHFS, 1998, p17) and as “pivotal to the success of primary health care” (AMA, 2001). General Practitioners have been described as playing “the pivotal role in our health system” (Wooldridge, 2001) and “as the doctor who is central to health care in Australia.” (*FGP*<sup>2</sup>, 1992, p10). The impression portrayed is that of a dynamic organisation at the hub of a health system upon which the rest of the system depends. However, it is difficult to reconcile this perspective with the autonomous and private nature of general practice previously reported. Perhaps it

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<sup>2</sup> Department of Health and Family Services, 1998, *Changing the Future Through Partnerships Report of the General Practice Strategy Review Group*; Commonwealth of Australia, Canberra

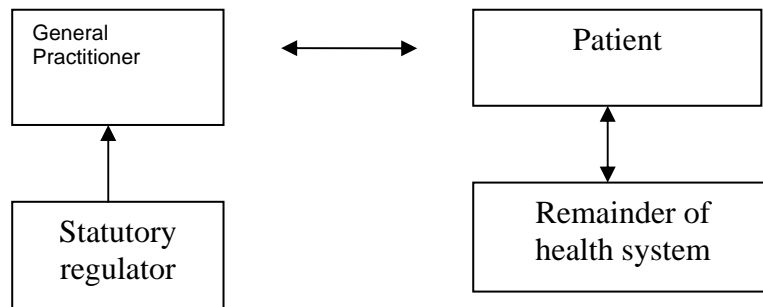
is not really known where general practice sits in relation to the health care system.

Milton et al (1984, p7) suggest that a system has a number of parts which are related to one another interdependently. By this definition it may therefore be that Australia does not have a genuine health “system”. Indeed, John Menedue in his foreword to the NSW Government’s Action Plan for Health (*Report of the NSW Health Council*, 2000) suggests that “linkages” exist between hospitals and GP services. Though this term does not convey a sense of interdependence, where those linkages exist they can act as levers for change, in situations where governments wish to lever change. To the extent that there is an undersupply of GPs in Australia, GPs are, in theory, free to choose to ignore that lever, by isolating themselves from hospitals, and to ignore patient demand and government incentives.

Australian general practice has also been reported to be “ruggedly” independent with “links primarily with the individual patient” (Pringle, 1998). This relationship is demonstrated in Figure 2.1. Indeed, the basis of accountability of Australian General Practice in economic terms is markedly at odds with that of public health institutions where the public dollar ideologically is expended to achieve the most good for the community as a whole. In this context Australian general practice is dissimilar to its UK counterpart (Edwards et al, 2002). Australian GP services may be regarded as being provided to produce the best health outcome for the individual patient (*AMA Position Paper*, 2001), despite the cost to the community and perhaps, with little improvement in the general health.



**Figure 2.1 A model representing independent general practice**



This model (Figure 2.1) of an independent general practice offers minimal capacity for governmental-induced change as change can only occur spontaneously, directly from the patient, indirectly through the patient or through the blunt process of regulation. This model sees financial and quality control resting entirely between the GP and the patient whilst other health services are provided independently of the GP. A model that depicts general practice at the centre of the health system, as described in Figure 2.2, maximises the likelihood of change given the number of provider agencies exerting an effect over the GP.

**Figure 2.2 A model representing general practice at the centre of the health system**

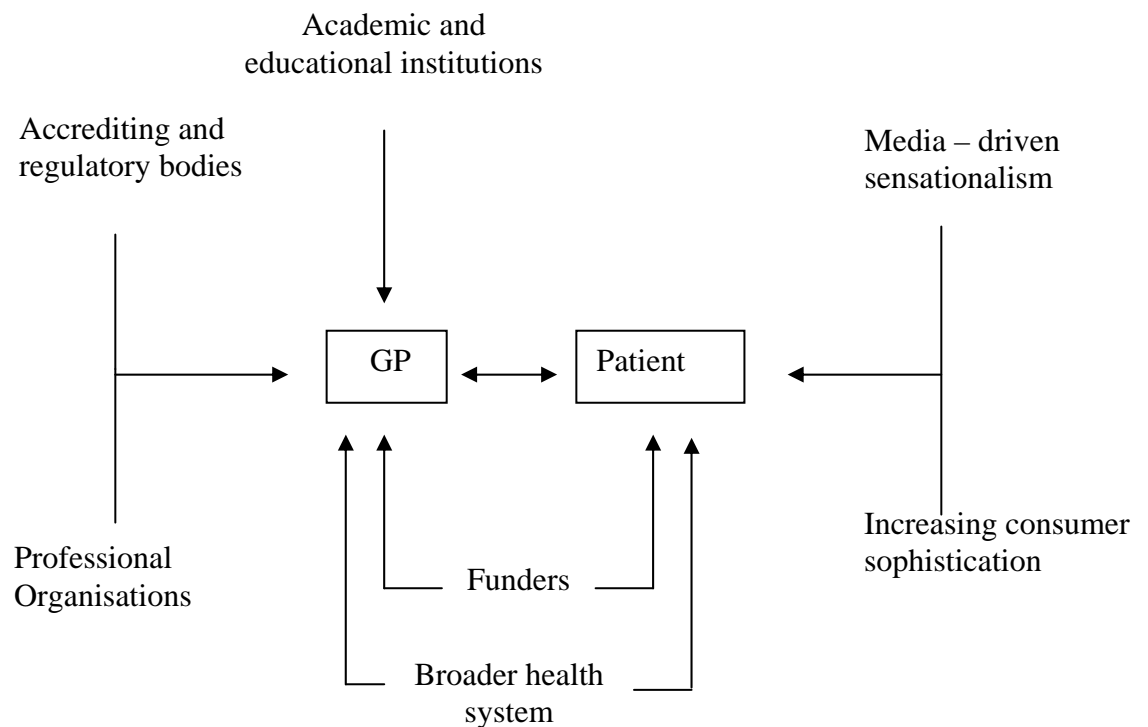


Figure 2.2 demonstrates that the more central general practice is to the health system, the more it becomes subject to potential influences of change to the way it manages patient care.

If we accept the theory of systems described by Milton et al, then it could be conceded that the “parts” of a functioning system have some internal integrity. Australian general practice may not meet this criterion as it exists in its simplest and most concrete terms as the sum of its many and varied general practices. These practices are widely diverse and continuously diversifying. Anecdotally, it appears that general practice, in part, is diversifying into specialty areas including skin cancer clinics and impotence clinics, thereby perhaps diversifying beyond general practice. The capacity to reform such a disparate and diffuse “system” without upheaval must be limited.

In summary, there are at least three perspectives as to the position of general practice in the Australian health system. It has been reported:

- to be independent and autonomous,
- to have “linkages” with the health system, and
- to be central to the health care system.

In fact, general practice does not easily fit into a classic model of a system. This means that attempts at improving the quality, efficiency or effectiveness of general practice need to be applied universally, not just at points of weakness within a cohesive system. Such attempts may be viewed by GPs as being invasive, cumbersome and coercive, making them reluctant to adopt reforms, particularly those perceived to be economically rather than service driven. On the other hand they may be welcomed by a weary group of professionals whose enthusiasm for

the job has waned with declining numbers, a declining workforce and a breakdown in the relationship between the profession and the community (Edwards et al, 2002, p835). Wherever general practice sits, its response to major changes will determine, to an important extent, the final form and function of the healthcare system (Sprogis, 2001).

However, Australian general practice is more than the sum of its practices. Australian general practice has a complex structure which will now be explored.

## **2.6 The structure of general practice at the macro level**

The structure of Australian General Practice is complex and expensive to maintain. It will be discussed in terms of statutory bodies, Commonwealth organisations concerned with general practice and general practice representative organisations. It will also be discussed in terms of its workforce.

### ***2.6.1 General Practice Organisations***

The conduct of the practice of Medicine is overseen by the various Medical Boards of each State. Each State Board is responsible for the registration of its medical practitioners. Nationally, the Commonwealth financially supports many activities of general practice, a support that is not offered other specialties. For example, the Commonwealth has funded several general practice bodies to advise it on matters concerning general practice (GPCG, GPPAC and GPFG) and outlays approximately \$79 million annually to support Divisions of General Practice ([www.budget.gov.au](http://www.budget.gov.au)). This activity possibly reflects the Commonwealth's

intention to participate in and influence the conduct of the profession in which it invests so much.

A large number of GP-aligned organisations exist in Australia. Some of these, those largely funded by the Commonwealth in particular, are established to promote change, others resist it. In an organisational context, Australian general practice at the macro level is relatively, almost uniquely, well structured as a medical specialty, standing in stark distinction to its structure at the micro level. It may be that it is over structured and that the complexities of the structure create their own confusion for GPs. Some of these GP-aligned organisations include:

### **Royal Australian College of General Practitioners**

Whilst other medical specialties have their own Royal Colleges, none has the size, and arguably the political influence, of the Royal Australian College of General Practitioners (RACGP). The RACGP has been instrumental in the establishment of:

- The standards for Practice Accreditation,
- The standards for continuing medical education for practicing GPs
- The standards for the Fellowship of the Royal Australian College of General Practitioners, the most common means of being recognised as a General Practitioner.

The RACGP has also been responsible for substantially modifying all of the above within the last decade.

## **Divisions of General Practice**

Divisions of General Practice (DGPs) have been described as agents of change (*General Practice in Australia*: 2000, p205). DGPs are GP-controlled private sector regional companies, funded largely by the Commonwealth Department of Health and Ageing (DOHA), to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals ([www.phcris.org.au](http://www.phcris.org.au), accessed 19.01.2005). It has been reported that they have supported GPs by ameliorating their isolation, assisting their business processes and “given them practical ways of meeting the challenges and demands of change” (Phillips, 2003, p 6).

Divisions exert no direct control over their members and must win reform through trust rather than by coercion. Australia’s 119 DGPs “vary greatly in geographical size, number of GPs and population in their area, as well as in resources, infrastructure and their range of activities” (*Primary Health Care Research and Information Service*, 2003.) No such equivalent exists for other specialties.

Services provided to members may include:

- information technology support,
- advice on the best use of medicines, and
- provision of allied health staff support to practices and regional health programs for the support of quality programs promoting the management of chronic disease such as diabetes and heart disease (Modra et al, 2003; DHFS, 1998, p191).

It has been suggested that if DGPs are to improve health outcomes on a population basis by working with their GP members they will be required to encourage GPs to introduce chronic disease registers, utilise evidence-based clinical guidelines, coordinate planned services and to report on health outcomes (McColl and Roland, 2000). These activities represent substantial reform for many Australian GPs and may be seen to add to what are already regarded as high levels of red tape. Divisions therefore have potential to be, and may already be, powerful agents of general practice change, particularly in the non-clinical environment.

### **Australian Medical Association**

The Australian Medical Association (AMA) is a member-based organisation for all Australian doctors regardless of specialty and is best recognised for its industrial and political roles. In particular, it seeks to protect the “academic, professional and economic independence of the doctor/patient relationship” ([www.ama.com.au](http://www.ama.com.au), accessed 12.11.2003). In some ways the AMA is an organisation resisting change, in particular in so far as change may threaten the fee for service form of remuneration and private health insurance<sup>3</sup>. Some of its more recent work has involved emphasising to the Commonwealth that a shortage of GPs did in fact exist in Australia and advocating for reform of medical liability legislation (*AMA Annual Report*, 2002, p3).

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<sup>3</sup> A past President of the AMA defined the role of the AMA as “to defend the economic and professional interests of doctors in relation to the power of governments which, whatever their political complexion, and whether we like it or not, licence all doctors in Australia and finance the great bulk of health care (Pickering, 1987, quoted in Mackay, 1997, p349)

## **Rural Doctors Association of Australia**

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice ([www.rdaa.com.au](http://www.rdaa.com.au), accessed 29. 12. 2003). The RDAA web site states that the organisation “advocates for highly skilled and motivated medical practitioners who are adequately trained, remunerated and supported, both professionally and socially.”

In 1996, RDAA created the Australian College of Rural and Remote Medicine (ACRRM), as a separate organisation, to determine standards, training requirements and continuing medical education for rural doctors ([www.rdaa.com.au](http://www.rdaa.com.au), accessed 29.12.2003).

## **Australian College of Rural and Remote Medicine**

The Australian College of Rural and Remote Medicine regards itself as the peak professional organisation for rural medical education and training in Australia. The College reports a membership of around 2000 Fellows and GP Registrars who practice in regional, rural and remote Australian communities ([www.acrrm.org.au](http://www.acrrm.org.au), accessed 29.12.2003). The RACGP and ACRRM have found themselves in competition for the support of rural GPs (Kamien (a), 2000, p525), many of whom were dissatisfied with the RACGP’s conduct of rural general practice training (Phillips, 1998, p10).

## **Doctors Reform Society**

The Doctors Reform Society (DRS) is an organisation of Australian doctors and medical students established to protect Medicare. ([www.drs.org.au/leaflet.htm](http://www.drs.org.au/leaflet.htm), accessed 29.12.2003). As much of the rationale for

the existence of the DRS seems to have been exhausted with the success of Medicare (Mackay, 1994, p365) this organisation may have little relevance to Australian general practice.

### **General Practice Computing Group**

The General Practice Computing Group (GPCG) was the only GP special interest group funded by the Commonwealth until funding was lost in 2005. It was established as the peak body of general practice computing for clinical and administrative purposes ([www.gpcg.org](http://www.gpcg.org), 29.12.2003). Its mission, as stated on its website, is “to improve the health and quality of life of the Australian community through the systematic introduction of more effective management of information in general practice and between general practice and other sectors of the health industry.” Therein, of course, lies the tacit presumption that GPs desire more effective management of information and, in particular, that they want it between themselves and other sectors of the health industry.

In summary, the macrostructure of Australian general practice is unwieldy, at times competitive and self-interested. Such a situation is not conducive to a universal vision of a future form of general practice or a systematic approach to change (Mackay, 1994, p364). More importantly, the number and disparate purposes of so many GP representative organisations has created competition for GPs’ support whilst weakening general practice’s ability to deliver a consistent or cohesive message to government.



## ***2.6.2 Australian general practice workforce structure***

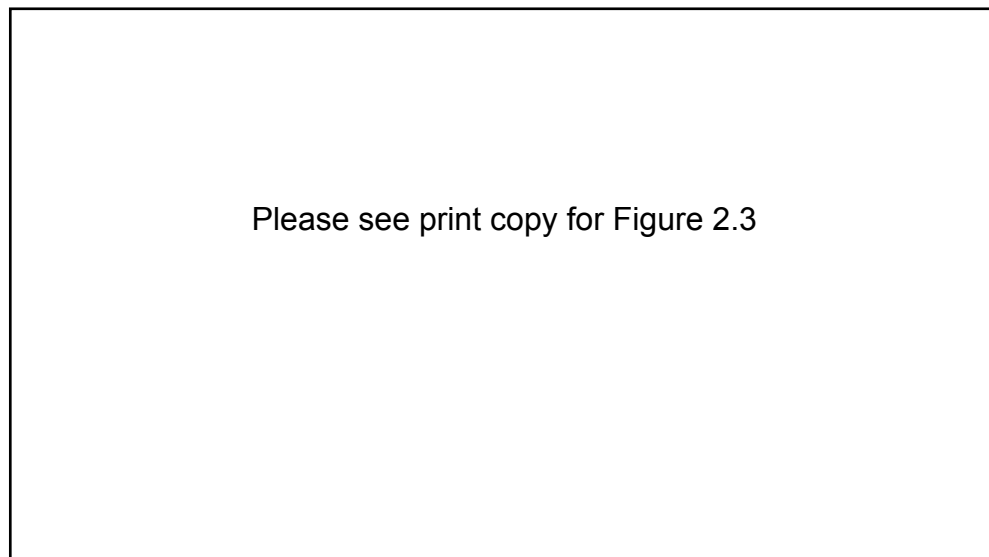
The Australian general practice workforce has undergone important changes in the last 25 years. These are described under the headings Age, Number, Gender and Distribution to demonstrate the increasing workload of the Australian GP which itself will influence their ability to manage change.

### **2.6.2.1 Age of Australian GPs**

Age may be a determining factor for the amount of work a GP is willing to do, is able to do or needs to do (Sibbald et al, 2003). One may surmise that age is also related to the ability to work after hours or to engage meaningfully in on-going continuing professional development or skills maintenance (McLaren et Shelley, 2002). It may also be related to a GP's willingness or ability to adapt to change, to adopt new clinical or business protocols or to develop new business cultures in order to meet changing consumer requirements or market demands.

The average age of primary care practitioners in Australia increased from 46.3 years in 1997 to 48.9 years in 2002 (*AIHW*<sup>4</sup> *cat no. HWL 30*, p5). The age of the GP workforce is illustrated in Figure 2.3.

**Figure 2.3 Age of the Australian GP workforce and GP trainees (2000)**



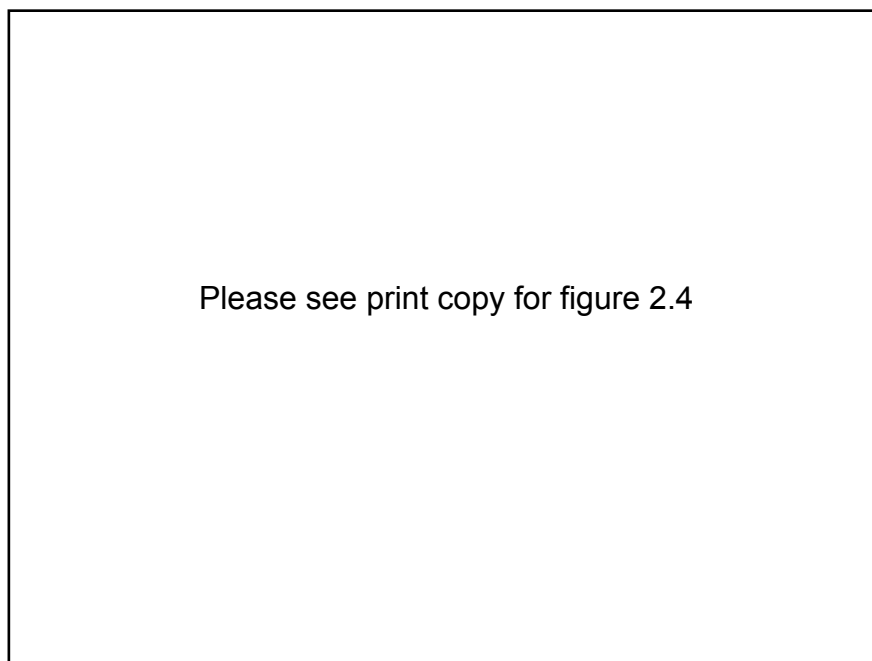
AIHW from GPA 2004, p105

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<sup>4</sup> Australian Institute for Health and Wellbeing

Figure 2.3 demonstrates that the vast majority of Australian GPs were over the age of 45 years in 2000 (54.5%). This is further defined in Figure 2.4. A breakdown into gender shows a worsening figure for male GPs in that in 2000, 32.8% (3528) of the nation's 10762 male VR GPs were above the official retirement age of 55 years (Harding, 2000, p48). Resistance to government interference, increasing medicolegal risk or declining income may be sufficient to trigger a critical proportion of these GPs to retire (Morrison and Smith, 2003). A retirement spiral would be damaging for rural Australia in particular. In an intriguing statement the Australian Medical Workforce Committee (AMWAC) reported that "Between 1994 and 1998 there was strong growth in the numbers of GPs in the workforce aged 70–74 years, 75–79 years and 80–84 years" (*AMWAC Report*, 2000, p5). Implications for such an ageing of the male GP population may include inability to maintain consistency and quantity of work output.

**Figure 2.4** Age of Australian GPs as a percentage of the total number of GPs (2000).



Source: *GPA 2004*, p105

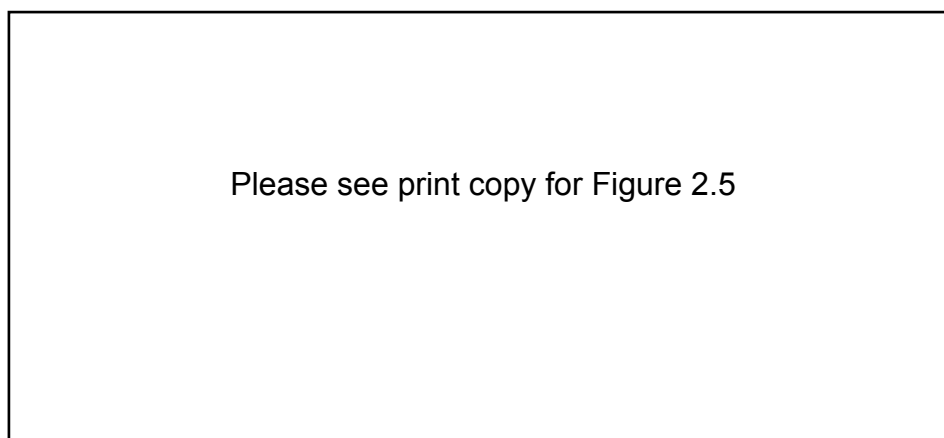
Figure 2.4 demonstrates that a large minority (25.6%) of the Australian GP workforce was over the minimum Australian retirement age of 55 years in 2000 (as determined by the minimum qualifying age for superannuation). At the other end of the age spectrum, only 14.8% of Australian GPs were under the age of 35. (The proportion of GPs aged less than 35 in 1991 was 22.3%, in 2003 that proportion was only 10.0% (Charles et al, 2004, p86)). The proportion of GPs aged less than 45 years decreased between 1997 and 2002. The proportion of males in this age group declined from 46.9% to 41.1% and the proportion of females declined from 72.1% to 62.9%. As explained later (p59), GPs are entering general practice at a later age due to a longer training period as well as the fact that many universities are moving to postgraduate medical training, thereby reducing the proportion of young GPs over time.

In conclusion, the GP workforce is ageing. Older GPs entered a general practice that looked very different to that of today. These GPs may well have commenced general practice conducting obstetrics, performing general surgery and providing anaesthetic services. It is not known if they have embraced the change to a clinic-focused general practice where the opportunity for work variety has diminished and the demands of business administration have increased.

#### **2.6.2.2 Number of Australian GPs**

It has been reported that there is an overall shortage of general practitioners in Australia (*AMWAC Report 2005.2*, p8; Richardson et al, 2005, p56; Smith, *ADGP Conf Proc*, 2002; *Australian Doctor*, 15.11.2002, p4). GP supply is depicted in Figure 2.5.

**Figure 2.5    GPs per 1000 population**



Source: *AMWAC Report*, 2003.

Figure 2.5 demonstrates that the number of both full time (F/T) and part time (P/T) GPs has declined since 1995/96. Figures from AMWAC reveal that the number of general practice trainees declined by almost 25% between 1994 and 2003 whilst the number of trainee positions remained constant (*AMWAC Report 2003.4*, p9). There is no evidence as to why this is the case, but the implications for general practice are ominous.

Declining numbers of trainees, an ageing of the GP population, an older cohort of medical graduates and a reduction in the number of full time equivalent (FTE) GPs (driven by an increase in the proportion of female GPs) are major supply side drivers which will determine the workload and perhaps the work ethic of Australia's GPs.

AMWAC suggests that the "most notable supply side drivers are the ageing of the workforce, changes in participation (as measured by hours worked per week), and the increase in female participation (*AMWAC Report, 2003.4*, p1). However, in the Australian context, equity of access is an important political consideration for Government. Equally important is the recognition that not all

primary care services are, or need to be, provided by GPs. For these reasons, a broader but limited discussion of the general practice workforce environment may be beneficial. This discussion will identify a number of issues pertaining to non-clinical change where future research could assist. Factors to be considered include the effect on demand of a heavily subsidised medical benefits system, GP distribution, competition from other primary care providers, supplier induced demand and a freedom for patients to consult as many doctors as they want.

### **Demand as a function of subsidy**

The traditional economic philosophy would suggest that the lower the supply of GPs the less the competition in the market place. However, the Australian “health market” is centrally subsidised from a goods perspective (eg pharmaceuticals subsidised under the PBS) and from a services perspective (clinical, diagnostic and hospital services subsidised under the MBS). Such a heavily subsidised market does not behave as a free market; consumers accessing services (many of which are free at point of delivery<sup>5</sup>) until opportunity cost, (the costs associated with time lost getting to and waiting for the consultation), plus any co-payment outweigh perceived advantage. In practice, a Bandaid from a doctor may be cheaper for the consumer than buying a Bandaid from the pharmacist, but of much greater cost to the public purse as pharmacists are not paid on a fee for service basis by the public purse. A service therefore supplied through general practice will cost the patient less than an equivalent service

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<sup>5</sup> Patients have a right to assign their benefits under Medicare to their treating doctor. This is known as “bulk billing”. The level of that rebate is set at 85% of the “scheduled fee”; a fee determined by the Commonwealth from time to time at a level believed to reflect the value of a consultation. A doctor is free to accept that benefit, but in so doing forgoes any right to raise any other levy against the patient for any component of that consultation

available elsewhere in the primary care sector not subsidised by the Commonwealth. Therefore a shortage of GPs in the context of a centralised subsidy is likely to disproportionately increase demand and reduce access.

### **Equity of access to GP services**

Under the Australian Constitution, the Australian Government has no capacity to conscript. Accordingly the government can only encourage GPs to move to under-doctored areas; it currently does so by financial incentives. It is not known how GPs respond to such incentives nor is it known whether GPs who respond to financial incentives function adequately as rural GPs.

### **Competition for services**

There are many other primary health care providers in the Australian community but none, apart from optometrists, experience the subsidy for their services that Medicare offers to GPs<sup>6</sup>. Historically, competition between GPs has been one factor that has produced a high level of bulk billing (DHFS, 1998, p129) as bulk billing leaves the patient with nil out-of-pocket expenses for the consultation. However, the rate of bulk billing has declined (Figure 2.7, p48) as GP shortages have become evident and demand has increased, thereby allowing more variation in billing. It is possible that GPs are looking to diversify billing methods, for example by working with other primary care providers for GPs to maximise patient care and practice efficiencies, but we don't know.

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<sup>6</sup> This altered in 2006 when certain allied health providers were given access to Medicare rebates under limited conditions.

### **Practice clinical support**

The UK system allows for patients to consult allied health professionals working within a general practice. To some extent, a similar relationship exists in rural Australia under the More Allied Health Services (MAHS) scheme which sees rural Divisions of General Practice funded to employ allied health staff to work in rural general practices. This represents a means of service substitution or enhancement and allows rural GPs to use their skills more efficiently. However, it is not known how GPs relate to these allied professionals who may have little experience of the general practice culture and who may even regard themselves as competitors to GPs.

### **Supplier induced demand**

Supplier induced demand (AMWAC, 1998, p30) in theory allows the GP to influence the frequency of patient attendance more firmly in times of surplus supply. This may take the form of encouraging the patient to return for repeat prescriptions and results of investigations. Again, it is not known whether, as supply diminishes, GPs manage patient demand or merely react to it.

### **Lack of general practice population enrolment**

There being no system of patient enrolment in Australia patients are free to consult as many doctors as they wish. This freedom, often unbounded by cost, would tend to increase workload with no means to compensate by increasing supply. Those GPs who respond to rising workload by “closing their books” equally have no legal requirement to provide care for the non-urgently ill.

In general, Australia has been a net importer of GPs. As other countries also experience crises of workforce (Cross, 2002) and make corresponding significant investments in general practice, Australia faces the daunting prospect of being a net exporter of GPs, thereby further reducing GP numbers.

In summary, there is a broad field of knowledge about the behaviour of the Australian general practice market that is yet to be investigated. Understanding how Australian GPs are responding to this changing environment may be critical to our ability to maintain an adequate GP workforce.

### **2.6.2.3 Gender of the Australian general practice workforce**

A majority (50.3% in 1998) of medical graduates are female, and female clinicians in general are consistently reported to behave in a different manner to male clinicians in that they tend to work less hours (DHFS, 1997, piii) (66% that of males) and retire earlier (*AMWAC Report 1996.7*, p11; Shanley et al, 2002; Phelps, 2003). This phenomenon is magnified in general practice where 65.5% of trainees are female (*AMWAC Report 2003.4*, p37) and are reported to practice clinically in a manner characterised as “tears and smears” (*AMWAC Report 2005.2*, p16). The trend toward a feminised workforce tending to work less hours and performing a differing clinical role will therefore have important implications for workload, particularly on older male GPs. It may also mean that female GPs may have less time for non-clinical general practice activities such as practice management, or that they are able to deliver care which is more culturally aligned to the needs of a community.

In 1994, female medical practitioners of all specialty types worked 39 hours per week as against their male colleagues’ 51.4 hours (*AMWAC Report*



1996.7, p48). Given that women GPs are more likely to be raising a family than their male counterparts, the demands of a stressful family life together with a demanding work life, may allow little time to adapt to changes and little impetus to do so. However, the female GP prefers to enter general practice because it allows improved access to day care centres for children, flexibility in annual leave and ability to job share or work part time (*AMWAC Report 1996.7*, pp15,16; *AMWAC Annual Report, 1998–1999*, p18). This implies that female GPs have more roles to play in the community than their male colleagues. It is not known how well female GPs contend with the demands of such important competing roles.

Compounding the demands on many female GPs, is the fact that the majority (53%) of female GPs believe that their partners' careers impacted on their own careers whereas only 15% of male GPs felt this way (*AMWAC Report 1998.4*, p37). Nonetheless, more than 50% of female GPs choose general practice as their first preference (*ibid*, pp 49, 50, cf Table 2.1).

A comparison between male and female clinicians' geographic distribution demonstrates that the majority of female medical graduates enter urban or city general practice (primary care). This is demonstrated in Table 2.1.

**Table 2.1**                      ***Primary care practitioners' (PCPs) type of work by gender***

	% clinicians working as PCPs	% PCPs who work in major urban centre / city	% PCPs who work part time
Male	41.9	77.5	23.3
Female	54.4	83	65.5

(Derived from AMWAC Report 1996.7, p9)

Table 2.1 demonstrates that most females work as primary care practitioners (column one), and that most of them work part time in numbers

relatively well above their male counterparts (column 3), and that they are more likely to work in an urban or city centre.

Freeman et al, suggest that an increasing (part time) female GP workforce is associated with a disruption of continuity of care as patients are less likely to be able to see one particular doctor. They suggest that not only continuity of care is at risk but there must also be an accompanying duplication of history taking, risk of varying or incorrect diagnosis or advice and consequent loss of trust (Freeman et al, 2002, p880). On the other hand the authors fail to acknowledge that the provision of care by a single practitioner, whose patients are not subject to review by other doctors, may more likely be related to missed or incorrect diagnoses. That is to suggest that there may be a balance to be drawn between quality of care and continuity of care.

Not surprisingly, with the demands of part time work and domestic commitments, women GPs are more likely than men to be salaried and therefore less likely to be partners in the practice (DHFS, 1997, piii). The prospects are therefore that, in the future, a large number of GPs will be in an employee relationship with little say over the conduct of the practice or the manner in which the business of the practice is carried out.

Female GPs are more likely to feel that they are underpaid (DHFS, 1997, p64; Kilmartin, 2002, p89; Huby et al, 2002), to spend more time in each consultation than male GPs (Britt et al, 1996, p403ff; *AMWAC Report 1998.4*, p 64; Kilmartin, 2002, p89) and to deal more frequently with complex psychosocial problems (Taft et al, 2004). Payment is particularly important for part time GPs as indemnity costs rise reducing the net return from practice (Walters, 2003). Female

GPs may therefore be more sensitive to demands being made upon them either by government or by an employer if those demands threaten income or threaten to increase the complexity of clinical work.

It has been reported that Residential Aged Care Facilities (RACFs), formerly known as nursing homes and hostels, are becoming increasingly dependant on a declining number of older male GPs (Lewis and Pegram, 2002, p86). In March 2004, the Commonwealth Government announced incentives to entice GPs back to RACFs ([www.health.gov.au/medicareplus/about.htm](http://www.health.gov.au/medicareplus/about.htm), accessed 24.05.2004). These incentives failed to identify means of meeting patient demand in practices whilst GPs attend RACFs. Should the Commonwealth succeed in placing more GPs in RACFs it will have also succeeded in increasing the workload of GPs, though perhaps distributing it more equitably across the profession.

In summary, the face of change in Australian general practice is perhaps no better illustrated than by the female GP. She feels she provides longer and more sophisticated consultations than her male counterpart, has to make significant adjustments to her personal boundaries to accommodate the needs of patient, family and self and has significant concerns over remuneration and the ability to cover costs of indemnity, registration and training when performing relatively under-remunerated tasks in a stressful environment. Australian general practice may be witnessing a changing of the “old guard”, as the workforce becomes increasingly feminised and different lifestyle options are being adopted. It may mean that workforce shortage becomes the main driver of service delivery

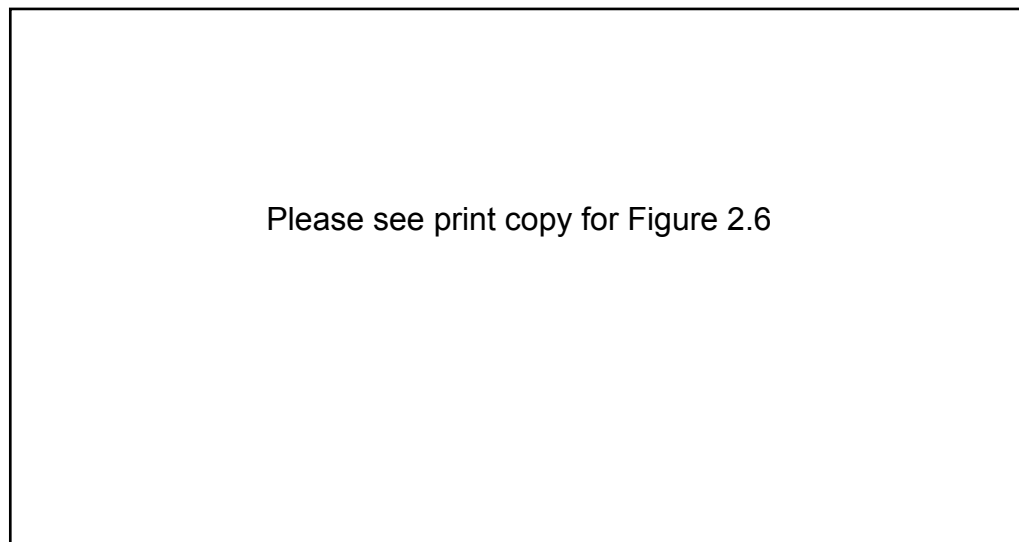
whilst those services are provided through general practices governed in ways in which female GPs, the majority of GPs, have little say.

#### **2.6.2.4 Distribution of the Australian GP workforce**

Distribution of the general practice workforce is an important consideration in a nation as large as Australia in which much of the population resides on the coast in capital cities (A<sup>7</sup>.2.1). Access to this workforce is commonly a problem for rural communities and for the indigenous community who tend to live in areas of high rurality (A.2.2). Failure to access a GP may mean much more to a community than loss of medical care. Communities may require the presence of medical care in order to attract and retain their own population.

In Australia there are variations between States in the distribution of general practitioners (A.2.3); however this table hides some of the distribution discrepancies that occur in rural Australia which are better demonstrated in Figure 2.6.

**Figure 2.6 Primary medical practitioners per 100 000 population**



Source: *General Practice in Australia: 20004* p62

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<sup>7</sup> References to "A.X" are references to the Appendix.

Figure 2.6 demonstrates that the number of GPs per head of population declines with increasing remoteness. This carries certain implications for GPs as well as the community. Figure 2.6 fails to identify any maldistribution that occurs within capital cities where certain lower socioeconomic status suburbs may have absolute shortages of GPs. However, such maldistribution can be more easily overcome in the city as compared to rural centres where transport systems are less extensive.

Maldistribution of GPs has attracted the interest of government. The rural vote is an important one in Australian politics and there has been a strong political will to encourage GPs to work in rural areas. Should the government be successful in encouraging more GPs to rural areas, we may witness a change in the delivery of rural GP services. Those GPs who move to rural areas on the basis of financial incentive alone may have less willingness to be part of rural communities than do those who choose to live in rural communities for lifestyle reasons, or if they have grown up in a rural community. In particular, it is less easy to “hide” in a rural community, particularly one that may have expectations that the doctor will provide his or her services in-hours and after-hours, if there is no structure to provide after-hours care.

### ***2.6.3 The structure of after hours service delivery***

No uniform structure exists for after-hours service provision in Australia (Dunt et al, 2002, p45) despite the fact that after-hours care provision is a requirement of practice accreditation. Generally, the same doctors who work in general practice during the day are the same doctors, working on a roster basis, who provide after-hours services (personal observation).

After-hours services may be provided by individual GPs representing their practices, by a group of practices sharing after hours arrangements, by a co-operative of GPs, by services collocated with local hospitals (Hunter Urban Division of General Practice, 2002) or by corporate practices offering services from their own premises. The *National Evaluation Report of the After Hours Primary Medical Care Trials* (NERAHPMCT) reports that some solo practices simply lock up at night, making no ongoing arrangements after-hours. The report also states that GPs in rural areas and city fringe areas not enjoying deputising services commonly provide their own care or care in cooperation with other community GPs (Commonwealth of Australia, 2002,p3).

In response, GPs are witnessing increasingly frequent interventions by the Commonwealth in the area of after-hours care<sup>8</sup>. Attempts that have been made to standardise after hours care may have enticed GPs to further increase their workloads and subsequently eroded their lifestyle. On the other hand, they may have encouraged greater efficiency of service provision where GPs have already been providing after hours services; we don't know.

#### ***2.6.4 The structure of locum services***

Whilst incentives exist for GPs to work overtime in providing after hours care, no general incentives exist for locum doctors who, at times, represent the only opportunity for GPs to holiday or gain access to professional education. However, disincentives for locums have been introduced in the form of CPD requirements and indemnity concerns (*AMWAC Report 2005.2*, p25).

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<sup>8</sup> Round the Clock Medicare: Investing in afterhours GP services (IAHGPS) Program ([www.health.gov.au](http://www.health.gov.au))

Again, no structured national approach exists for the provision of locum services in Australian general practice. Little work has been done in the area of locum relief, particularly in the important context of manpower relief. The GPPS reported that 44% of practices could not obtain the services of a locum when required (DHFS, 1997).

In general, locums are males. The concept of a female GP who may work 9:00 to 3:00 Monday to Friday seeing what may be a very selective group of patients being replaced by a male locum who charges for sessions that would usually extend into the evening may be too expensive for practice owners and unpopular with patients who prefer a female doctor. Therefore it is highly likely that practice principals (who are more likely to be male (Kilmartin et al, 2002)) are more likely to be relieved by a locum than a female assistant or partner who works less hours per session (AMWAC, 2000) and who may see a more predominantly female group of patients.

### ***2.6.5 Conclusion to the structure of general practice at the macro level***

Australian General Practice appears to have established a consistent structure at the macro level. However, elements of that structure have competing priorities and some have opposing strategies. The general practice workforce, represented by a plethora of organisations, has been the subject of many changes. It is ageing, is in increasingly short supply, is increasingly becoming dominated numerically by female doctors who may regard themselves as having broader social responsibilities to their family and community, and is unevenly distributed across the nation. Their workload would therefore appear to be increasing at a

time when they are increasingly being encouraged by the Commonwealth to provide that care.

Having discussed the workforce, it is now appropriate to discuss the general practice itself

## **2.7 The structure and function of general practice at the micro level**

The majority of individual general practices are conducted as independent small businesses (Phelps, 2003; Bloom, 2000). Such a pattern of unrelated small business units is not easily amenable to the introduction of standard systems nor is it a favourable environment for other primary and secondary care providers to develop efficient linkages.

Thus, at the individual practice level, the traditional general practice is still viewed by many as a “cottage industry” (IBM Consulting, 1997, p 21; Kosterich, 2001). On the other hand, a large minority (between 40% of Perth practices but less than 20% of Sydney practices (Fitzgerald, 2002) are owned by publicly listed companies often referred to as “corporates”. Corporate general practices feature a well-defined management structure and the use of a clinical infrastructure within which individual GPs maintain separate practices but contract to work within the constraints of a roster while adhering to a common system. In addition, patients attending a corporate general practice are generally seen by “the next doctor” rather than be “their doctor”.

In an environment where corporate general practice assumes the management demands of a traditional practice and in which there is a shortage of hospital doctors who are well paid by GP standards, there exists in the twenty-first



century a choice of career styles never before available to Australian GPs. Whilst new GP graduates have the welcome opportunity of a broader career choice, GPs in more traditional forms of practice may find the choice of multiple career styles more daunting. In comparison with other professions, a move from one type of practice to another may not be seen as a welcome career move; however, it may be that some GPs have been reluctant to make changes which may impact on a perceived need for independence or a desire to maintain the traditional continuity of patient care.

The features of Australian general practice will be discussed in terms of structure, practice size, GP income, the rising burden of medical litigation, computerisation, workload and a trend to a business focused orientation.

### ***2.7.1 Practice size***

Practice size represents an important determinant of structure at the micro level. As general practices increase in size, overheads per GP decline. (Campbell Research, 1997, pv). In Australia, between 1991 and 2003, the proportion of solo GPs nearly halved (25.5% to 13.7%) There was a concurrent increase in the number of GPs in larger practices (4 or more GPs) from 34.3% to 59.8% (Charles et al, 2004, p85). The trend to larger practices was associated with a decline in the willingness of GPs to own practices (*AMWAC Report 2005.2*, p19) but an improvement in practice efficiency (Campbell Research, *ibid*).

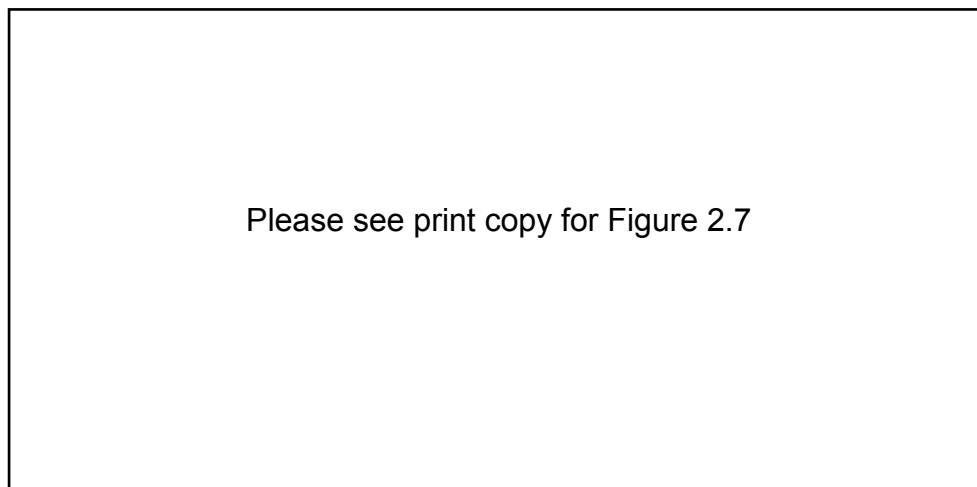
If increasing efficiencies are related to a systematic approach to business, then larger practices may be more able to adopt elements of the Enhanced Primary

Care package<sup>9</sup>, changing both the form of remuneration and the type of care delivered to the chronically ill. If this is embraced as a popular outcome by the profession then there may be an increasing trend to further practice amalgamations and an opportunity to place allied health providers in general practices to reduce isolation and provide new models of care (*AMWAC Report 2005.2*, p10).

### ***2.7.2 Changes in the form of GP income***

Australian medical practitioners are free to charge their patients any amount the market will bear (DHAC, 1999, p17) or they can elect to invite the patient to assign their rights to an MBS rebate to the practitioner. This latter process is known as bulk billing. GPs have been responding to market forces by ceasing to bulk bill as demonstrated in Figure 2.7.

**Figure 2.7      Percentage rate of bulk billing by Australian GPs 1999 - 2003**



Source: *Australia's Health and Ageing Fact Sheets* – May 2004 Update

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<sup>9</sup> The Enhanced Primary Care (EPC) package was released in the 1999/2000 Federal Budget (*DHAC fact sheet 2*, 1999). This program was designed to address the needs of older patients and the chronically ill. It allows Medicare payments for additional planned GP services including health assessment, care planning and case conferencing for longitudinal care. In all, 30 EPC items have been introduced (Beilby et Furler, 2005, p136). A description of the EPC can be found at A.2.3

Figure 2.7 demonstrates an absolute decline in the national GP bulk billing rate of 9.9 percentage points over a four year period. This decline may herald a significant price barrier to vulnerable populations such as the elderly, the adolescent and the indigenous populations. We do not know if GPs who abandon bulk billing observe such a change in patient demographics.

Severe pressures exist upon the bulk billing rate (Knowles, 2003; Pollard and Metherell, 2003), particularly in the context of rising medical indemnity charges and workforce shortage (Walters, 2003). Perhaps further compounding this pressure is the fact that patients are unaware of the amount of the rebate the bulk billing doctor receives and of the real cost of the service. We do not yet understand why it is that some GPs move to autonomous billing practices but most do not despite significant drivers to do so.

Individual financial transactions (“fee for service” - FFS) are the economic basis of most non-salaried general practice, whether bulk billed or not. GPs’ income is most commonly derived from Medicare either directly as bulk billing or indirectly through rebates to the patient. Other funding sources include Workers’ Compensation, insurance companies and Veterans’ Affairs, amounting to about 7.2% of GP income in 1994/95 (DHFS, 1998, p237). Both workers compensation services and services on behalf of insurance companies attract substantially greater remuneration per service than do the services remunerated by the Medicare rebate. Additional forms of income include services to hospitals as GP Visiting Medical Officers (VMOs) but this opportunity has all but ceased in non-rural areas. Teaching of medical students and GP trainees has become another

means of generating income but impacts on a GP's time to treat patients, perhaps to the detriment of gross income (*AMWAC Report 2005.2*, p25).

Under the FFS model, the more complex the service the greater the fee attracted as determined by the Medicare Benefits Schedule (p93). Increasingly, GPs are attracting income under the "blended payment" system<sup>10</sup> (p87), also subsidised through Medicare. However, reporting requirements for the blended payment system are more rigorous than the simple process of bulk-billing for reactive care services (*AMWAC Report 2005.2*, p22), an administrative burden equivalent to about 5% of GPs' income (Richardson et al, 2005, p81)

A reasonably sophisticated accounting mechanism is required to track all these sources of income for taxation purposes particularly as the Goods and Services Tax (GST), introduced in 2000, applies to all services not associated with the direct provision of health care such as insurance and disability reports. The introduction of the GST therefore may have presented a significant challenge to GPs' management capacity in moving from a paper-based system to a sophisticated software program (Light, 2000). It may also be that some GPs were tempted to pursue better remunerated services such as insurance reports but may have seen them as too complex from an accounting perspective and retreated entirely into the familiar Medicare framework which is GST-free and therefore requires no change in accounting methodology.

The Commonwealth has abandoned any benchmark for the MBS rebate for GP services, regarding adjustments to the level of rebate as a political matter, rather than an economic one (DHFS, 1998, pp238, 244). There is no evidence that

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<sup>10</sup> The term "blended payment" refers to the combination of payments made for reactive services provided on request of patients as well as payments made for the planned interventions available under enhanced primary care package.

the public has an understanding of the level of that rebate though there is a strong consumer push for GPs to bulk bill (*AMWAC Report 2005.2*, p24). It may be that the valuing of GP services by political imperative rather than socio-economic worth would be a matter of some distress to GPs who may perceive the level of rebate as a measure of their value to the community. That is not to say that increases have not occurred, but that the lack of indexation means that GPs are unable to predict either the occurrence or the quantum of any rises in the rebate and hence of their income<sup>11</sup>. In such an unpredictable environment, the only mechanism to provide for planned increases in income is to move to a private billing system.

In summary, opportunities have arisen for GPs to move well beyond the simple fee for service funding model but at the cost of increasing reporting requirements, of changing management systems and of adopting new work styles, an unintended but perhaps serendipitous outcome.

### ***2.7.3 The rising threat of medical litigation***

General practice has been conducted against a background of rising awareness of the threat of medical litigation (Niselle, 1999, p577). There appears to be general agreement that litigation against Australian medical practitioners, including GPs, has been increasing although perhaps not to the extent reported by the media (Tito, 1996; Blomberg, 1997). It has been suggested that between 1990 and 1994, the risk of an Australian GP being sued doubled (Keaney, 1996, p178).

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<sup>11</sup> This is strictly only true for GPs who bulk bill. GPs who charge privately are somewhat immune from the level of patient rebate.

Possible effects of a rising trend in litigation, or even a perception of such, are discussed with respect to patient care, the GP as care provider and the practice in which the care is provided.

### **2.7.3.1 Medical litigation and the patient**

It has been suggested that GPs, due to time pressures inherent in a fee for service model, do not communicate adequately with the patient (Neuwirth, 2002, p77; Niselle, 1999, p577) regarding the need for a test, the side effects of a test or what may arise from an abnormal test result (Hammett and Harris, 2002). It appears that litigation as an opportunity for unearned and opportunistic wealth has permeated the Australian patient culture such that attention to patient rights in Australia may exceed that of comparative countries (Panjwani, 2000).

### **2.7.3.2 Medical litigation and the GP**

Fear of medical litigation has been identified as a major concern for Australian GPs (*AMWAC Report 1998.4*, p70; Schattner and Coman, 1998; Blomberg, 1996) but paradoxically is also a reason that medical graduates seek a career in general practice (Shanley et al, 2002), perhaps because of a perception that other specialities are at even greater risk. Medical indemnity in general practice may have become a source of psychological distress as GPs tend see a higher number of patients than many other specialists and that the nature of many of the disorders seen by GPs is undifferentiated and therefore of indeterminate risk.

Whilst Schattner and Coman's article is an excellent one (A.3.7.2.1), it does fail to tease out exactly what GPs fear. Given that costs are almost

universally met by the insurer leaving the doctor with few residual costs, it may be that GPs fear most the public exposure and loss of respect of colleagues.

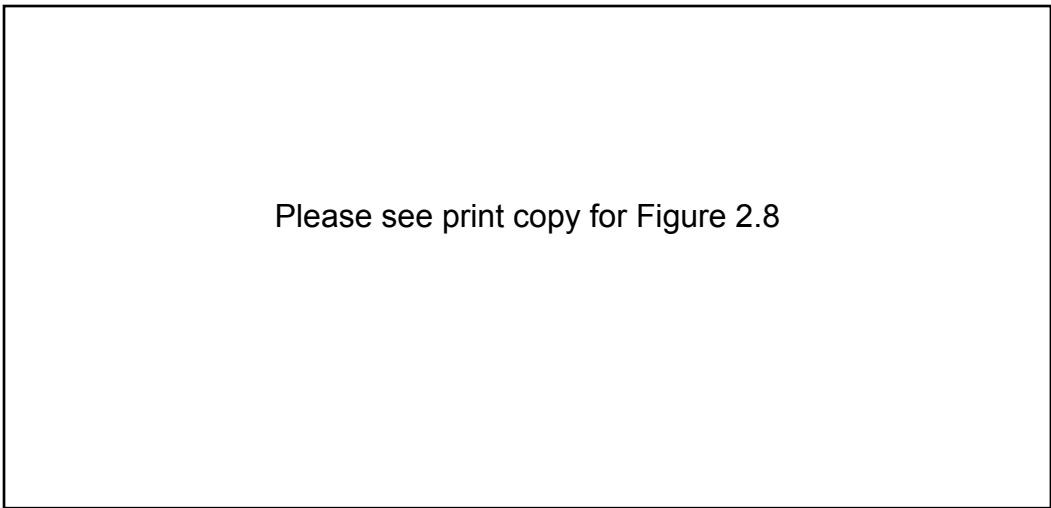
Indemnity costs are an important consideration for GPs who wish to perform procedures. A substantial indemnity surcharge has been applied to GPs who perform even minor surgery of some types. As such, GPs may be leaving even simple procedures to consultants, increasing the cost to the Commonwealth and reducing access to care for the patient and satisfaction for the GP. If this is the case we might expect progressive loss of skills and self-esteem. Again, we do not know.

GPs have responded to concerns about litigation in a number of ways. They increase diagnostic testing (Girgis et al, 1999, p362; Little, 2004), increase referrals, increase patient follow-up and give more detailed explanations to patients (Summerton, 1995, p27).

**2.7.3.3 Medical litigation and the practice**

Increases in the amount of medicolegal compensation are demonstrated in Figure 2.8 which displays the claims payment index rising dramatically with time.

**Figure 2.8      Indemnity claim payments change with time (all doctors)**



Source Davies, F., 2002, *Medical indemnity – the story so far and the way forward*,  
AMA, quoting Trowbridge Consulting.

Figure 2.8 is indicative of a societal trend toward increasing medical litigation matched by a rising trend in the cost of medical indemnity insurance. However, there is no component of the MBS to compensate for this cost. The potential net income of the GP has accordingly been eroded. Reports in the medical press suggest that there has been significant pressure on medical practitioners, in general, in Australia to re-evaluate their reasons for working beyond the usual retirement age (Mackey, 2002; Phelps, 2003), to ensure that they are not working solely because they cannot afford to retire. How GPs respond to the challenge of perceived financial pressures on one hand and perceived medicolegal risk on the other may well be of interest to both patients and their GPs.

Increasing reliance on diagnostics may be a means of protecting against litigation rather than practicing good medicine. This risk minimisation process places additional cost burden (Blomberg, 1997) on both the patient and the Commonwealth which, through the Health Insurance Commission (HIC), monitors all GP diagnostic costs and has the regulatory authority to sanction high users (HIC, 2003, p166, cf p93). This monitoring and regulatory role may pressure GPs to refer patients to consultant doctors merely as a means of ordering diagnostic tests vicariously.

*Due to its potential to heighten anxiety in GPs, to increase their costs, to alter patterns of clinical care and to alter the nature of the trust relationship between GP and patient, litigation ranks as one of the major challenges of change*



*for the Australian GP and will represent the first case study identified for this thesis (cf p103).*

#### ***2.7.4 Computerisation in Australian general practice***

Information management is a major function of general practice (Mitchell and Sullivan, 2001) and “efforts to build GPs’ capacity to use information technology are well under way in Australia” (Harris et Mercer, 2001, p92). Electronic technology has the potential to assist in general practice reform with clinical and economic benefits, and with benefits as well for an increasingly consumer-focused community (Morrison and Smith, 2000). Most immediately, computers may offer GPs as a group the opportunity to “get our present record system into order” (Tait, 1988, p10). General practice computerisation provides six important opportunities to facilitate the integration of general practice into a multidisciplinary primary care system. These include:

- decision support systems (DHAC (2), 1999),
- recall and reminder systems,
- provision of aggregated information used for planning, focused service delivery, quality assurance (AMA *Position Paper*, 2001, p14) and
- the production of an electronic health record.

There is a capacity to manage disease at a population level (Douglas, 2001), a capacity to broker knowledge for patients (Clayton, 2001) and redefine the practice management process (Pringle, 2001). The extent to which GPs utilise new technologies for information management may determine whether they embrace a broader perspective on patient care.

The General Practice Computing Group (GPCG, 2005, p8) has defined an “Information hierarchy” consisting of six levels of information. Whether such refinement has relevance to Australia’s GPs must be somewhat dubious. In fact, the lengthy transition of what was once merely an aide memoir, to what is now a nationally evolving electronic health record, currently known as “Health Connect” ([www.health.gov.au/internet/hconnect/publishing.nsf/content/home](http://www.health.gov.au/internet/hconnect/publishing.nsf/content/home), accessed 17.05.07), involves an enormous cultural leap as well as a large technological investment for Australian GPs. Further technological and business sophistication would be required of GPs if they wish either to make records available to patients over the world wide web or even consult via the web (Eysenbach, 2000).

*Due to its capacity for interconnectivity, clinical and practice system enhancement and to facilitate accountability, computerisation also ranks as one of the major challenges of change for the Australian GP and will be used as the basis of the second case study for this thesis (p104).*

**2.7.5 Workload in Australian general practice**

The structure and function of Australian general practice should be applied to the services delivered by GPs thereby determining the workload faced by GPs. GP workload in simple terms of services delivered is detailed in Table 2.2.

**Table 2.2                      Services per full time GP**

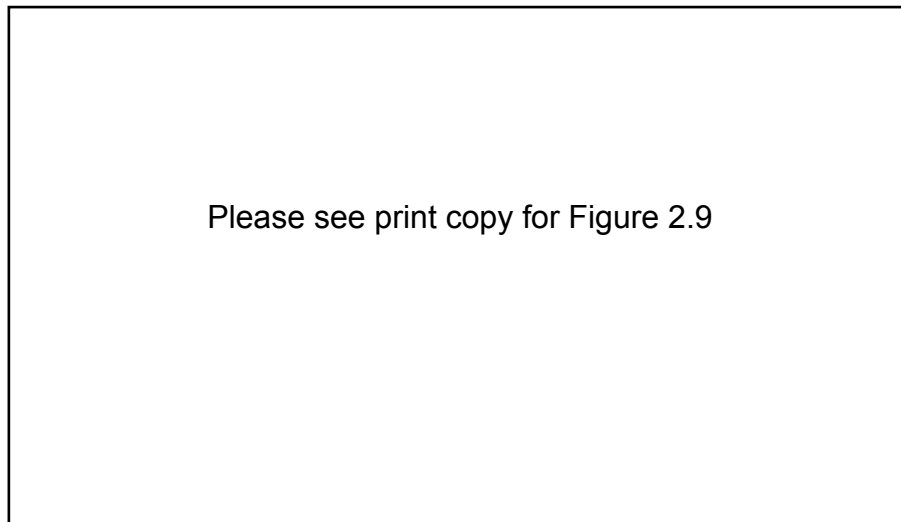
<div>Please see print copy for Table 2.2</div>
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*GPA 2004, p56*

Table 2.2 suggests that, on a prima facie basis, the workload of GPs has reduced by 3.6% over a 7 year period. However, perhaps due to the ageing of the

population or to fear of medicolegal litigation, the time spent in each consultation has tended to increase, as illustrated in Figure 2.9.

**Figure 2.9      Composition of GP consultations (%) by service type**



GPA 2004, p 62

Figure 2.9 demonstrates that Australian GPs are conducting more long and prolonged consultations and fewer brief and standard consultations. The trend toward lengthier consultations may explain the apparent reduction in workload (Figure 2.7). This trend may indeed be even stronger if the number of EPC items performed by GPs were to be considered, given that EPC items did not exist in 199 –1993 and are a separate item to that billed for the length of consultations.

Although the Australian general practice workforce is highly skilled, its most frequent activities require relatively minor technical or professional competence. These activities include blood pressure monitoring, provision of immunisations and the treatment of respiratory infections (Britt, 1999, p18). Increase in workload would appear to be related to a relative decline in GP and a

burgeoning of elderly population, ie those most likely to suffer from chronic and complex conditions, is starting to burgeon (Australian Bureau of Statistics, 2002).

A heavy workload is associated with low morale (Edwards et al, 2002). A simple solution would be to increase the acuity of the work the GP performs by displacing lower acuity work so that it is managed systematically under the auspices of allied health staff. That change may not come easily however, as it has been suggested that high workload blunts GPs' ability to respond to change (Huby et al, 2002).

Workload may be seen as a function of the trend to deliver patient care in the community rather than in hospitals (Hillman, 1999), the ageing of the population (cf p81ff), efficiencies of practice management, a decline in the number of FTE GPs, increasing consumerism (cf p79f) and an increasing burden of paper work. The contribution by each of these trends will now be discussed as it has affected changes in the workload of the Australian GP.

#### **2.7.5.1 Relocation of service delivery as a determinant of workload**

Due to the Federal nature of its constitution, Australia experiences a complex health system (Scotton (b), 2000) driven by a national funder (the Commonwealth Government) which partly funds the hospital sector with the States but which funds most other medical care in the community. This funding structure presents the States with budgetary incentives to transfer care to the community where most care is funded by the Commonwealth (NSW Health (c), 2001). Furthermore the personal caring structure tends to be voluntary within the community; professional and expensive within hospitals. The community is thought to be a cheaper place to manage the elderly (Access Economics, 2001,

px). Whether the prime motivation is cost shifting, (Powell Davies et al, 2006) improved outcomes or care provision efficiencies, health care is being devolved from the hospital to the community (Hillman, 1999) and attempts are being made to involve GPs in early patient discharge, in streamlined admission processes and in attempts to co-locate GPs in hospitals for the provision of after hours care (IPART, 2003, p10; Dunt et al, 2002).

#### **2.7.5.2 Practice management as a determinant of workload**

As a reflection of the “autonomous” culture of general practice, Australian GPs have traditionally managed their own practices. This behaviour is changing (Charles et al, 2004) as the gender balance alters in favour of female GPs and as organisational management responsibilities are increasingly delegated to corporate practices (AMWAC Report 2005.2, p19). Even as early as 1997 it was reported that 11% of general practices had changed ownership structure in the previous twelve months (DHFS, 1997, px)

Female GPs do not express the same need for autonomy as male GPs (Shanley et al, 2002), nor are they as likely to be general practice business owners (AMWAC Report 1998.4, p64). Therefore as the number of female GPs rises the management of traditional Australian general practice may be being concentrated in the hands of a declining number of male GPs who may be approaching an age at which they feel unprepared to maintain the responsibilities of management.

#### **2.7.5.3 Consumerism as a determinant of workload**

Consumerism may have little room for expression in a general practice environment in which pressure of work is a stronger driver than consumer

expectation (Little et al, 2001). However, it would appear that patient expectations about what constitutes a reasonable waiting period to see a GP are high (*AMWAC Report 2005.2*, p24) and much higher in Australia than in the UK (Panjwani, 2002). This patient expectation for access is supported by GP accreditation standards (*RACGP Accreditation Standard 1.1*) and local State based strategies (eg *NSW Chronic Care Program*), acting to increase the pressure on GPs.

#### **2.7.5.4 Red tape as a determinant of workload**

The management of a general practice and even the clinical performance of a GP are regarded by GPs as being burdened with bureaucratic requirements (*AMWAC Report 1998.4*, p70; Phelps, 2003; DHFS, 1997, pix). This has become known colloquially as “red tape”, a description that implies an excess of paperwork in response to bureaucratic demand.

The Productivity Commissioner has found that the Commonwealth “contributes significantly to the time and cost spent on red tape by GPs” (*Productivity Commission*, 2003) and that “governments generally made increased use of GPs to control demand and to improve quality (ibid).” The AMA suggests that red tape “steals valuable patient time from GPs and is making their practices unprofitable” (AMA, *GP Network News*, Issue 03). This is an interesting interpretation of red tape which, both the Privacy Commissioner and the AMA suggest, centres around 3 programs, viz,

- Vocational Registration (VR),
- the Practice Incentive Program (PIP) and the
- Enhanced Primary care Program (EPC).

As these 3 programs represent a substantial proportion of income for some GPs and together account for 10% of Commonwealth MBS payments (Productivity Commissioner, 2003, p5), it may be that GPs are faced with a strong incentive to avoid the red tape burden by opting out of the blended payment system altogether, to “cherry pick” the easier forms of blended payment or to increase patient co-payments to remove themselves from the need for financial incentives of the Commonwealth.

In conclusion, the burden of red tape is presenting today’s GPs with an opportunity to explore new economic frameworks for their businesses but may also be associated with improved patient care if the Commonwealth’s expectations bear fruit. On the other hand, that burden may also be producing a cynicism among GPs as to the amount of paperwork that is required at the cost of traditional clinical care. *For these reasons, the burden of red tape appears to be another of the major challenges of change for the Australian GP and therefore represents the third case study identified for this thesis (cf p103).*

#### **2.7.5.5 Workload as a function of satisfaction**

In Australia, GP workload is a function of many changing and independent variables including the expectations of government, the demands of practice management and of the consumer. However, we know little about the relationship between workload of the GP and work satisfaction. A large workload need not imply poor work satisfaction. The environment in which the work is performed, the quality of the work performed or perhaps the outcomes produced by that work might be more important measures of work satisfaction. Therefore we are confronted with a number of questions:

- Are GPs delegating less satisfying or less effective elements of their workload?
- Do GPs recognise and implement quality clinical services in the face of an increasingly chronically ill population?
- Are GPs adopting new work environments in which to conduct general practice in the new century? Data gathered during this thesis may shed light on these questions.

Workload is, therefore, a function of government expectation as to hospital or community care, the efficiency of practice management which appears to be directly influenced by GP gender, consumers and, particularly, red tape. In an intricate way, it is likely that all of these play a part in determining GP satisfaction with his or her work.

Whilst workload is changing, so its focus is also in that there is evidence to suggest that the profession of general practice is leaving the cottage industry and entering the marketplace of health service delivery.

### ***2.7.6 An increasing market focus on service delivery***

The market place exerts an important function in shaping the direction of general practice. There have been strong pressures for Australian GPs to move to an efficient, commercially sophisticated structure (Catchlove, 2001). Reflecting this has been an increasing move to corporatisation (Sprogis, 2001).

Corporatisation typically involves the acquisition of GP services by a third party. In Australia this has often, though by no means always, been followed by listing as a public company. Other features may include the payment of substantial incentives to GPs to join a corporate practice and the maximisation of flow-on of



benefits to shareholders through the referral of patients to diagnostic service providers owned by the corporate organisation (Sprogis, *ibid*). Using this strategy it is possible for a company to make a loss on GP services whilst generating significant profits through diagnostic service providers. Corporate financiers, if no one else, have come to recognise the importance of the gatekeeper role of GPs (Aloizos, 2001; Ferguson, 2001).

This commercial focus may mean that the “caring face” of traditional general practice is being replaced by a market image of the corporate general practice world. Corporatisation therefore may represent an ethical challenge for Australian GPs. Australian corporate GPs, for the first time, work under a legislative structure that requires their managers to deliver profits for company shareholders as its prime concern, as distinct to the traditional medical role of placing the patient’s interests above financial interests (Sprogis, 2001).

### ***2.7.7 Concluding comments about the structure and function of general practice at the micro level***

Many factors drive change at the micro level of Australian general practice. Whilst workload appears to be increasing (Figure 2.8), it is doing so over time allowing GPs the chance to adjust. However, changes such as computerisation, litigation and red tape appear to have been more dramatic than others. These changes then appear to be of major importance to Australian GPs working within the microclimate of Australian general practice.

That microclimate is delivered over a very large geographical area. For many countries the concept of rural practice may not exist or it may not vary greatly from urban practice. Geographical isolation has meant that the

microclimate of rural practice in Australia can vary greatly between city and country. The next section deals with Australian rural general practice.

## **2.8 Australian rural general practice**

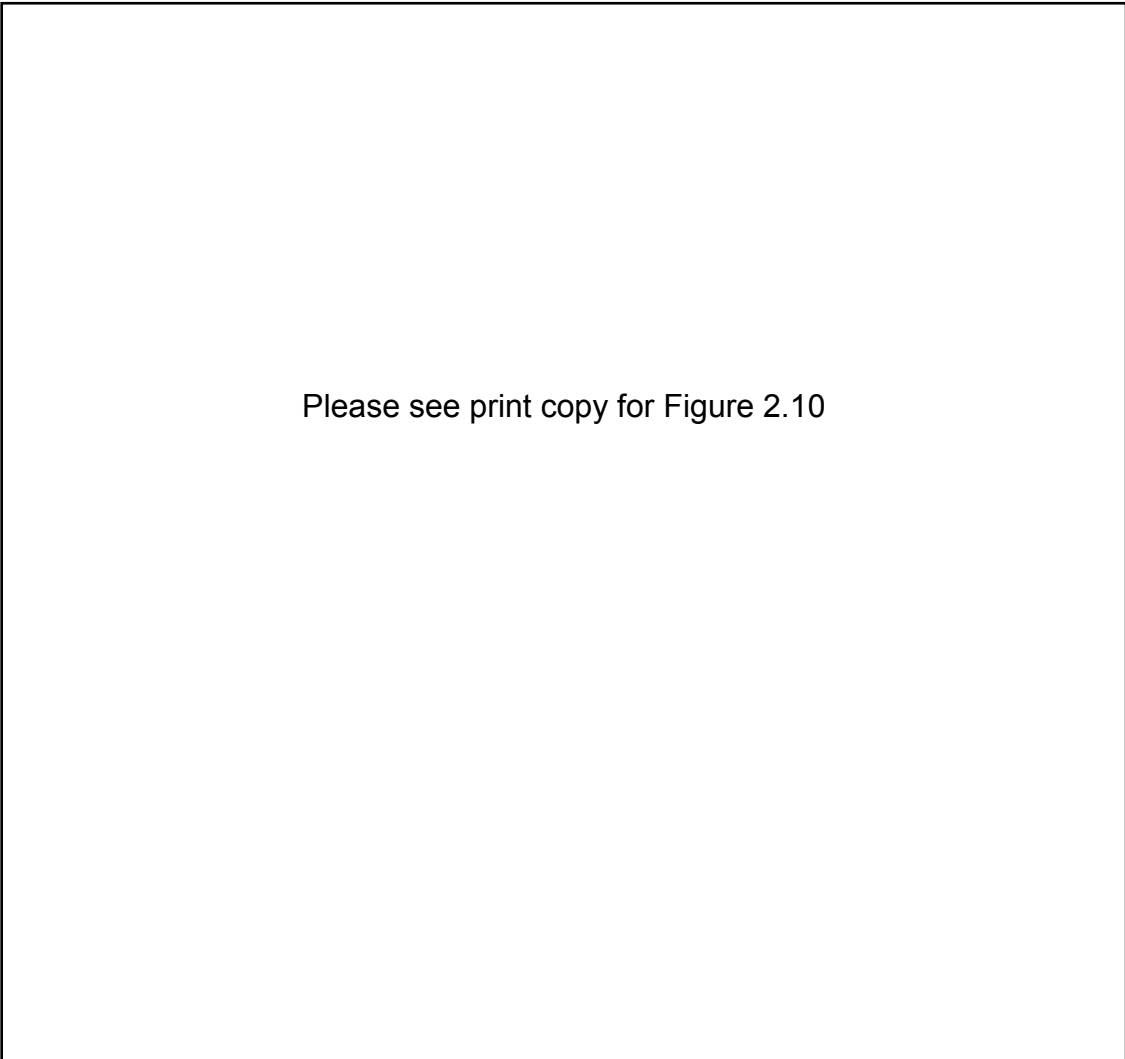
Consideration of rural general practice is important, as it has seen less change than has urban general practice. Nonetheless, rural GPs still face litigation, they still manage information and the Commonwealth makes no discrimination to the red tape attached to its incentives. There is no literature to assist us to understand whether rural GPs, many of whom have retained traditional general practice clinical hospital roles, have resisted or embraced changes.

Australians tends to live either in capital cities or in other metropolitan centres (A.2.1). This trend is exaggerated with respect to the Australian general practice workforce (Figure 2.9), and generally, rural GPs work in communities with much higher GP to population ratios (AMWAC, 2000, p4; Figure 2.6) than in urban communities. They also tend to work in an under-resourced environment (AIHW<sup>12</sup>(b), 1998, p77). An adequate supply of nurses and consultant specialists may be able to compensate for an undersupply of GPs particularly in large rural centres. Figure 2.10 demonstrates the number of vocationally registered (VR) GPs per 100,000 population, the number of registered nurses per 10,000 population and the number of surgeons per 100,000 population as they were distributed geographically in 1996.

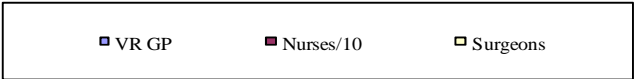
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<sup>12</sup> Australian Institute for Health and Welfare

**Figure 2.10 Medical workforce per 100,000 population by RRMA classification<sup>13</sup>, 1995-**



Note: Nursing numbers have been reduced by a factor of 10 to allow comparison



Source: AIHW (b), 1999

The graph demonstrates what appears to be a very large nursing workforce, almost ten fold greater than that of GPs, more evenly distributed across

<sup>13</sup> Rural, Remote and Metropolitan Areas (RRMA) classification is a means of distinguishing Australian geographical regions on the basis of isolation, size and medical resources.

the zones. The proportion of surgeons is low in small rural centres in stark contrast to major rural centres. It is not surprising that the GP in small rural communities performs relatively higher numbers of surgical procedures, than their city or large rural centre colleagues.

The total general practice workforce in Australia is boosted by Other Medical Practitioners<sup>14</sup> (OMPs) and by Temporary Resident Doctors (TRDs). These are particularly important in rural areas as are GP trainees. In 1995–96, 980 doctors (not all of whom were GPs) entered Australia to commence practice in areas of workforce shortage. This number rose to 1597 in 1996–97 (*AMWAC Report 1998*.8, p41). The introduction of GPs from differing cultures to the Australian “Outback” may provoke a cultural dilemma for the OTDs not accustomed to small towns, isolation, and the management of a small business.

GPs are more likely to provide in-hospital patient care in rural Australia than they are in urban Australia (Bolton et Mira, 2000, p119). Despite the medical workforce shortage in rural Australia, the number of public hospital beds per capita available to rural communities tends to be higher than for capital cities (AIHW (b), 1998, p78). Expenditure per hospital bed is inversely related to the number of beds per capita (AIHW (b), 1998, p80). Reasons for an increase in the number of rural beds include a relatively lower number of nursing home beds in rural Australia and the need to treat patients with chronic illnesses such as diabetes and asthma in hospital rather than in the community due to the long distances and time resources involved in travelling to scarce community resources

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<sup>14</sup> OMPs are medically qualified and registered doctors who have chosen not to adopt or adhere to the requirements of vocational registration. Medicare rebates are substantially lower for services provided by OMPs than by VR GPs.

(AIHW (b), 1998, pp77,78). In addition, hospital admissions for injury are up to 145% higher in rural communities than in capital cities. Motor vehicle accidents are a prominent cause of this variance (AIHW (b), 1998, pp19,20). The shortage of both GPs and consultant specialists (with the exception of RRMA 3 (large rural centres) as demonstrated in Figure 2.10) in rural communities means that already-busy GPs are attending more patients in hospitals than their urban colleagues and/or providing more post hospitalisation after-care. It may be postulated that such clinical priorities prejudice non-clinical roles within the general practice.

Corporate investment is rare in rural Australia as an economic supply of general practice providers is unavailable. However, there are many factors associated with rural general practice apart from maldistribution and lack of corporate influence, that make rural practice different to urban general practice. These factors may tend to inhibit the rate of change in Australian rural general practice, and are discussed in the following six subsections.

### ***2.8.1 Lifestyle factors EFFECT ON CHANGE IN RURAL PRACTICE***

A rural workforce shortage has resulted in increasing workload. This acts as a disincentive to other doctors to enter rural general practice (*AMWAC Report 1998.8*, pp4,5) and is associated with problems with isolation particularly in towns large enough only for a solo practice (AMWAC, *ibid*, p17). Social isolation is reported to be more of a problem for female GPs than for male GPs. In particular, female GPs report a lack of peer support (Tolhurst et al, 2000, pp119-120) as an important problem. It has been suggested that female GPs are more likely to work in rural areas because of their partner's job than are male GPs, not because female

GPs have primarily chosen rural medical practice (*AMWAC Report 1998.4*, p61). It has also been suggested that female GPs experience poor access to women's health services for their own well being (Tolhurst et al, 2000) partly because there are fewer female GPs in rural areas and the distance between them is often great. Particular disadvantages to working in rural areas include access to school education (AMWAC, *ibid*, p62), difficulties in filling practice vacancies (AMWAC, *ibid*, p63), access to childcare and Continuing Professional Development (CPD) (Tolhurst et al, 2000, p120) and security of after hours home visits (*ibid*). Despite these difficulties, both male and female rural GPs are more satisfied with their lifestyle than male GPs living in urban communities. (*AMWAC Report 1998.4*, p24).

In summary, there is no suggestion that rural lifestyle for GPs has altered to the extent that the general practice environment has altered. However, the gender ratio has altered and this may alter lifestyle if more female GPs enter rural practice or, conversely, if they fail to replace ageing rural male GPs.

### ***2.8.2 THE EFFECT OF LENGTH OF TENURE ON CHANGE IN RURAL PRACTICE***

There is a high turnover of the general practice workforce in rural Australia largely due to the completion of contracts of Temporary Resident Doctors (TRDs) filling positions categorised as Areas of Workforce Shortage (*AMWAC Report 1998.8*, p50). In an effort to retain other rural GPs the Commonwealth introduced the Rural Retention Program in the 1999 Budget. The program provides payments to rural GPs who practice beyond the current average of two years (HIC, 2003, p104). To this time there is no evidence as to any direct

effect such incentives have on rural retention or how GPs in general feel about accepting financial incentives for activities they would otherwise prefer to not be involved in.

### ***2.8.3 Other workforce incentives AS A DETERMINANT OF CHANGE IN AUSTRALIAN RURAL PRACTICE***

The very fact that medical practitioners of all types are difficult to attract to rural areas has induced the Commonwealth to fund the More Allied Health Services (MAHS) initiative. This program makes funds available to rural Divisions of General Practice to employ allied health professionals to provide services to patients of regional GPs. Whilst this may have eased some of the work pressure of GPs and broadened the service base of rural general practice, it has meant that rural GPs have had to learn to work with, and coordinate services of, other health professionals with whom they may not otherwise have worked.

The government has also established rural clinical schools, dedicated 200 national GP training places to rural trainees, makes “Rural Incentive” payments to GP registrars who train in rural practice (HIC, 2003, p105) and has established the Rural Medical Family Support Scheme (Patterson, 2002). Such incentives may attract GPs to rural areas who otherwise feel inadequately skilled or alien in rural Australia.

### ***2.8.4 After hours care in rural practice AS A DETERMINANT OF CHANGE***

Whilst city practices generally have an association with an after hours service, the size of many rural towns is insufficient to attract GP numbers

adequate to form after-hours cooperatives. The distance between towns also precludes smaller towns sharing after hours support. Hence rural GPs may make themselves available to patients for periods of up to 168 hours per week; a condition unchanged for decades. Such a clinical commitment may not be shared by younger GPs with different lifestyle aspirations.

### ***2.8.5 Consumer out of pocket expenses AS A DETERMINANT OF CHANGE IN RURAL PRACTICE***

The very nature of the rural medical market means that billing practices are largely private in nature. Due to the undersupply of rural GPs, rural bulk billing rates are consistently lower than those for urban GPs (Knowles, 2003). For example, women living in urban areas are more than twice as likely to be bulk billed than their rural counterparts (Young and Dobson, 2003, p122). The cost to the rural consumer of general practice services therefore tends to be higher than for the urban consumer. It may therefore be that the strength of consumerism, and the pressures for change that consumerism can apply to rural GPs, is relatively weak.

### ***2.8.6 Treating the rural community***

Mortality rates rise with increasing rurality, whilst indigenous death rates are approximately twice that of the general Australian population for all RRMA regions (AIHW (b), 1998, p14). Mining, transport and farm work constitute a significant risk for work-related injury and premature death (AIHW (b), *ibid* p17). Homicide rates and other forms of interpersonal violence also increase with increasing RRMA status (AIHW (b), *ibid*, p28). The psychological resources



required to handle this burden of trauma (Wilson, 2002, p14) may well be beyond the capacity of a small community to deal with, let alone a solo local GP.

### ***2.8.7 Concluding remarks about rural general practice***

The rural general practice endures an array of difficulties in providing care to its local community. By and large, these difficulties have remained unchanged over the years, including isolation, workload, professional development, education and child support, and recruiting other medical staff. More recently, however, Australia has seen a government response which has provided some significant incentives to attract and retain rural GPs but these may also add to the burden of paperwork, increase the need for coordinating care and attract GPs culturally unprepared to enter rural practice. In particular, increasing participation of females in the workforce may result in fewer GPs practicing in rural communities. All in all, change appears to have been relatively slow to influence the rural GP community and a declining workforce may entrench a resistance to change.

Having completed a brief overview of Australian general practice at the micro and macro level, the next section examines the educational system that produces and sustains the skills of Australian GPs.

## **2.9 General practice education and training**

Medical education has typically been delivered within a disjointed framework. In Australia, General Practice education occurs at four levels, viz,

- the undergraduate (now increasingly postgraduate) or University level,
- post medical graduation (hospital based) training,

- vocational apprentice-type community based training<sup>15</sup> and
- continuing professional development throughout the career of the GP.

This section explores each of these levels as they relate to the changing nature of general practice.

### ***2.9.1 Undergraduate education***

Undergraduate education occurs largely in the university and hospital (Hillman, 1999) and is focused on acute care of major disorders (Nair and Finucane, 2003). However, hospitals are treating a declining number of patients of increasing complexity (Hillman, 1999) thereby placing logistical pressure on universities and their associated hospitals to provide more general practice or primary care based placements. This potentially exposes students to a different genre of care. In the hospital system the word of the senior physician dominates, in general practice students are more likely to be exposed to interdisciplinary teams (Nair and Finucane, 2003), planned care and patient empowerment.

General practice placements positively influence the choice of medical students to enter general practice (Shanley et al, 2002). Therefore increasing exposure to general practice may encourage more students to enter general practice. All universities provide rural placements. Such placements are reported to be effective in influencing students' geographic career choice (Shanley et al, 2002).

There appear to be five main drivers of change in undergraduate education. These are:

1. Financing of undergraduate education

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<sup>15</sup> Trainees are referred to as GP Registrars

The Commonwealth Government has moved to a user-contribution system in Australian tertiary education. The introduction of the Higher Education Contribution Scheme (HECS) has meant that most graduates leave university in debt. This is higher in more expensive courses and in longer courses, such as Medicine. For example, 45.6% of all Australian medical graduates graduating in 2000-2001 had incurred a debt in excess of \$14,999. This debt may be carried into vocational training where debt levels tend to be higher in the case of doctors with a rural background and in the case of single doctors (AMWAC, 2003, p59).

The Commonwealth, in introducing a user-contribution system for higher education, may be altering the nature of the workforce entering general practice, disadvantaging rural students and those from lower socio-economic backgrounds. We may therefore see an homogenising of the medical workforce dominated by urban students of higher socio-economic status. Perhaps even the structure of general practice management itself will alter as recent graduates find themselves unable or unwilling to afford to become financial practice partners (Kavanagh, 2000, p516). In that event, practices would tend to be owned by ageing GPs who may not wish to carry the financial risk and to shoulder the responsibilities of business, or practices may increasingly be owned by corporate entities, a trend previously identified (p30).

## 2. Gender balance and undergraduate education

There is a general “feminisation” (increasing participation of females) of the general practice workforce. In 2002, 65.5% of general practice vocational trainees were female (AMWAC, 2003, p62). This may be related to a relatively high rate of part-time training and a “job sharing” training rate of 19.7 % in general

practice, exceeded only by that of Medical Administration trainees (25.0%), Occupational Medicine trainees (29.2%) and Population Health trainees (33.3%). (AMWAC, 2003, p62). The gender imbalance of trainee GPs may mean that there is a smaller full time workforce in general practice and fewer rural trainees.

### 3. External competition in undergraduate education

Reductions in Commonwealth financing for universities has meant that medical schools are seeking funding through the recruitment of foreign full fee-paying students. Two hundred student places are offered undergraduate status under this scheme each year despite the fact that such graduates are generally prohibited from practicing in Australia (Hays et Piterman, 2000, p349).

Reliance by medical schools on external students as a funding source may act as a deterrent for medical schools to increase the number of places available to local students at a time of increasing workforce shortage. In turn, this may mean that vocational graduates may be entering a stressed and demanding workforce (Smith, 2001) unable to meet the needs of the community. This may be a source of dissatisfaction to new graduates.

### 4. Ageing undergraduate workforce.

Recognising that academic achievement per se should not be the sole arbiter of entry into undergraduate medical training (Hays et al, 2005, p272), medical schools are moving to a postgraduate training format in order to attract more mature students. One can therefore assume that undergraduates as a group are ageing relative to their predecessors. This may mean that issues of child rearing (and therefore of broader family support) may be of more importance to today's

graduate in deciding where to work and how many hours to work (Hays et al, 2005, p286).

#### 5. Acquisition of clinical management skills

As the incidence of chronic illness rises in the community, so different skills are required to manage the condition rather than treat the illness. Training is therefore required in assessment and management as well as diagnosis and treatment (Nair and Finucane, 2003). Teaching those skills in the community may be an unwelcome additional role for GPs (Hays et al, 2005, p285). GP attitude to teaching is poorly researched in the Australian literature.

Undergraduate medical education therefore faces significant challenges to graduate students who have the financial, social and vocational skills to successfully integrate into the milieu of change of Australian general practice

#### ***2.9.2 Post graduate hospital based training***

Postgraduate hospital-based training is provided “with little reference to health service delivery in the community” (Phillips, 1998, pp13,65). This is significant as 58.9% of graduates undergoing vocational training in 2002 decided on their speciality during post graduate (hospital) years 1, 2 or 3. (*AMWAC Report 2003.2*, p65). It may therefore be that more graduates would consider general practice as a career if they had greater exposure to it during hospital based training (as compared to medical student training). On the other hand, a large proportion of graduates are entering general practice vocational training with little understanding or experience of general practice. Importantly, experience of hospital-based treatment gives future GPs little exposure to the experience of long term management of patients or to planned care.

### ***2.9.3 Vocational training***

Prior to 1996 no regulatory controls existed to limit the number of doctors entering general practice. It has been reported that general practice was seen as the “default option” for those unable to enter a specialty (Phillips, 1998, p7). However, the Vocational Register was introduced in 1989 (Macklin, 1992) as a means of rewarding registrants (who were required to agree to a program of ongoing education) by offering a higher patient rebate<sup>16</sup>. The Health Insurance Amendment Act (No.2) [(Cwth)] was introduced in 1996 legislating that only specialists and GPs on the Vocational Register could attract full Medicare rebates for their patients (Phillips, 1998). The pathway to the vocational register was limited to those GP trainees (GP Registrars) who underwent a formal training program and attained the award of the FRACGP. For the first time entry into general practice was rationed competitively on the basis of merit.

Until 2000, this vocational training was provided exclusively by the RACGP. Responsibility then passed to a number of regional independent consortia contracted to an independent company established by the Commonwealth known as General Practice Education and Training (GPET) (Hays et al, 2005, p285).

The stimulus for regionalisation of GP training was reported to be improved support for rural vocational training (Phillips, 1998, p59). This was based on a recognition of a rural workforce shortage (Phillips, *ibid*, p55). The solution to this shortage was seen to be a “vertically integrated” (Phillips, *ibid*,

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<sup>16</sup> The strategy of rewarding GPs by increasing the patient rebate seems to be predicated on the basis that, as most GPs bulk bill, their income would rise by the amount of the increase in the patient rebate. The corollary is that GPs who bill privately above this amount derive no benefit though their patients do. A similar strategy was announced by the government prior to the 2004 election in an effort to encourage higher levels of bulk billing.

pp57,59) system of education at the levels of undergraduate (university), post graduate (hospital), vocational (GP attachments) and continuing professional development (CPD), focused on the rural community. Anecdotally, at the end of 2003, many rural training positions were vacant, urban posts were filled and formal vertical integration was not in evidence.

In summary, very significant infrastructure expenditure on a new regionalised training program has as yet brought about little in the way of change at the micro (practice) level. Regionalisation represents a higher risk strategy given that some graduates may be wary of committing to a rural training program often far from urban support structures and familiar surroundings.

GPs participating in interviews will therefore be unlikely to have experienced the relatively recent regionalised form of vocational training. This may, to some extent, impact on the generalisability of the study.

#### ***2.9.4 Continuing Medical Education***

Continuing medical education, now known as continuing professional development (CPD), is provided to Australian GPs by an array of providers and monitored by the RACGP. An end point of CPD is to maintain vocational registration and it is the RACGP which is the accrediting body for this (RACGP, 2001, p21).

The most frequent providers of CPD are Divisions of General Practice, the RACGP and the pharmaceutical industry, though many other providers exist. The effect of this piecemeal approach to ongoing education is to provide an uncoordinated series of educational events lacking apparent direction or common

purpose driven by reported gaps in knowledge or pharmaceutical industry interest. There has been no formal evaluation of the program. In addition, such an approach fails to recognise education needs that a GP fails to recognise themselves (Hays et al, 2005, p298). In failing to provide a comprehensive curriculum, important aspects of education may be overlooked. It may be that GPs are merely attending educational activities in order to meet the requirements of the Vocational Register rather than to improve clinical care or practice outcomes.

Access to ongoing education for rural GPs has been reported as being a problem (AMWAC, 1996, p16). To some extent this can be overcome through satellite technology, though one would expect that workshops and clinic formats would occur less often in rural communities.

No matter the nature of general practice education in Australia, one critical question must be asked. If, in an environment of innovation, GPs change, do they change in direct response to that innovation or does the education system champion the change and direct its activities in support of that change (Martin and Rohan, 2002)? In other words is general practice CPD itself driving change in Australian general practice? If that were to be the case, then the major suppliers of GP education, viz., Divisions of General Practice, the RACGP and the pharmaceutical industry represent powerful institutions for change.

Discussion about CPD and its outcomes provides a backdrop for further discussion about quality in general practice.



## 2.10 Quality in general practice

General practice is reported as not being at the forefront of quality initiatives in Australia health service delivery as initial attempts focused on hospital services (Seddon et al, 200, p152) and more latterly, on community health services (*GPA:1996*, p125). Defining, measuring and achieving quality in general practice still remain elusive goals (DHFS, 1998, p184; Richman, 1987, p85). Furthermore, the perverse incentives of subsidised fee for service mean that GPs who provide the highest number of services in the shortest period of time are rewarded most (Richmman, 1987, p234; DHFS, 1998, p240; Taft et al, 2004). This perversity also means that longer consultations are more likely to occur in populations with higher socio-economic status (Furler, 2002). This may be explained by an increasing demand from poorer populations with worse health, more frequent consultations and hence less time to provide care. We do not know how GPs are managing this inequity. It has been suggested that older GPs are less able to apply evidence-based guidelines and have less factual knowledge as well as poorer patient outcomes (Choudhry et al, 2005). It appears that older doctors are less able to make adjustments to patient management techniques, such as self care, care coordination and community resource utilisation (Lewis and Dixon, 2004). Perhaps they struggle to provide adequate care for chronic illnesses in shorter consultation periods.

In 1980, Avedis Donabedian identified three approaches to the assessment of quality of care: structure, the care process and the outcomes of care. (Garrigan, E., [http://www.qualityaustralia.aoq.org.au/Garrigan\\_1.html](http://www.qualityaustralia.aoq.org.au/Garrigan_1.html), 08.09.2003; *GPA:1996*, p122; Campbell et al, 2003). This framework will be utilised to examine the

change approaches to quality and its measurement in Australian general practice in the context of structure, process and outcomes.

### ***2.10.1 Structure as a determinant of quality***

It has been estimated that over 11% of the population consult with 5 or more GPs in any one year (*AMWAC Report 1998.8*, p48). Lack of formal relationship with a defined patient population (i.e. patient enrolment), as would occur in a UK Primary Care Trust or a US HMO, means that, in Australia, quality cannot be attributed to an intervention by a particular GP as any number of GPs (and consultants) may be involved in delivering a patient's care. For example, a patient may have her cervical screening performed within one general practice and her chronic disease management within another. Despite this difficulty of attribution, 2 national structures have been established with the specific purpose of improving quality in general practice (DHAC, 1999, p41). These are the vocational register and practice accreditation.

#### **Vocational registration**

Vocational registration (VR) status defines a vocationally registered GP as a specialist (DHFS, 1998, p192). It recognises a structured pathway of learning to vocational registration, that pathway culminating in the award of the Fellowship of the Royal Australian College of General Practitioners (FRACGP). It distinguishes the GP from the OMP (Other Medical Practitioner) and the TRD (Temporary Resident Doctor). New graduates are required to be vocationally registered in order to qualify for a provider number without which a GP's patients cannot access Medicare rebates. Older GPs were invited to join the vocational register, at the time of its introduction, without further training requirements<sup>17</sup>. For GPs declining to join the Register the patient rebate was frozen and has not risen with rises in the VR GP rebate. This has meant that patients face a larger copayment if a non-VR GP privately charges them, or that the GP receives a lower rebate if he/she elects to bulk bill the patient.

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<sup>17</sup> A process referred to as the "grandfather clause".

In order to maintain vocational registration GPs must meet the requirements of the RACGP's CPD Program, a mixture of medical education, clinical audit and other voluntary activities such as teaching, research, peer review and clinic work. This latter group may also include "leadership and advocacy, medico-legal skills, management, including practice management, computer training that does not focus on clinical computer use and self-care skills" (RACGP, 2001). This represents an important recognition of the need for quality activities in non-clinical areas of general practice.

No information is available about the success of VR in improving quality (*GPA:1996*, p128). However, time spent meeting the requirements of vocational registration reduces the time available in the consulting room as well as time spent in lifestyle pursuits (DHA, 2003). On the other hand, the outcome of CPD may be improved quality of care and a broadening of skills and knowledge base, thereby improving job satisfaction. We do not know.

### **Practice accreditation**

Accreditation is a form of peer review of practice compliance to a set of minimum standards covering a comprehensive range of non-clinical processes that may or may not support good clinical care. Formally introduced in 1996, the

review occurs every three years and within that period a practice is expected to undergo a quality review cycle whereby opportunities for improvement are identified, processes for improvement put in place, and a review made of the success of the process. Practices successful in gaining accreditation can market that status to the public (DHFS, 1998, p208), a very novel concept for many Australian GPs.

The standards by which the practice is tested, are made up of the following 5 categories: practice services, the rights and needs of patients, quality assurance and education, practice administration and physical factors (DHFS, 1998, p211). Practice accreditation therefore has little to do with the clinical process of patient management, focusing as it does on the structure and organisation of practices (DHFS, 1998, p207).

The concept of accreditation of Australian general practices has introduced into general practice a peer-mediated arbiter of standards<sup>18</sup>. Failure to meet standards carries substantial penalties in terms of access to other financial incentives (cf A.4). On the other hand, the cost of meeting increasingly strict standards is substantial in both time and money. Accreditation also focuses the GP's attention on matters pertaining to business standards rather than clinical standards. *For reasons of potential impact, practice accreditation has been chosen as the fourth case study determined by literature(cf p103).*

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<sup>18</sup> In July, 2004, the Commonwealth provided funding of \$927,000 to the RACGP to develop standards of accreditation for Australian general practice (Department of Health and Aged Care Media Release, 11.07.2004)

### **2.10.2      *Process as a determinant of quality***

There have been a number of processes introduced recently into Australian general practice to enhance quality. However, these processes have little or no evidence base; rather, they “appear” likely to produce improved quality. Two such processes that have been linked to quality are the Practice Incentive Program (PIP) and the Home Medications Review (HMR) Program. These programs represent an attempt to recognise and reward quality service provision rather than throughput. Payments to GPs under these types of incentive have been referred to as “blended payments” and have been criticised by the AMA in particular as increasing the workload of GPs by increasing red tape requirements (Ferguson, 2002, p4), an argument supported by the Red Tape enquiry (DOHA, 2003).

A brief description of these incentives follows:

#### **Practice Incentive Program (PIP) and Service Incentive Payments (SIP)**

PIP is based the concept that the money follows the patient which “is aimed at encouraging and rewarding quality rather than fast throughput of patients” (DHAC (b), 1999). PIP payments are made available in the following areas: Information management and information technology, after hours care, rural and remote practice, teaching of medical students and targeted incentives such as immunisation. SIP payments are made for the defined management of defined chronic conditions (Beilby et Furler, 2005, p138). Seventy five per cent of general practices participate in the PIP and of those 3900 have signed on for SIP payments for asthma, diabetes and cervical screening (Light, 2003, p24). Provision of after hours emergency care is another element of the PIP which offers more money to GPs who are willing to work longer hours. It is therefore

difficult to decide if GPs are adopting these incentives for reasons of quality or of finance. Professor Ian Hickey, Chair of the Committee for Incentives in Mental Health, is reported to have stated that some GPs find certain parts of the three-step mental health initiative “cumbersome” (Ferguson, 2003, p21). Whilst there appears to be no attempt to determine if, in fact, these incentives have led to higher quality outcomes, there has been criticism that the disease based indicators are “narrowly focused” (Davies et al, 2006).

### **Enhanced Primary Care (EPC)**

The Enhanced Primary Care (Building Better Care) initiative offers GPs the opportunity to charge at risk patients for health assessment, care planning and case conferencing (*RACGP Patient Information Sheet*) under Medicare. Importantly it allows other allied health professionals to assist GPs. EPC therefore represents one of the first initiatives of the Commonwealth that allows the doctor to benefit from the work of an allied professional. This was followed by the Medicare Plus initiative which allows defined health professionals to issue a Medicare rebatable invoice to specific patients referred under Care Plans. Though payment has been extended to non-doctors, it nonetheless exists within the fee for service environment (Davies et al, 2006).

A table describing the EPC package is enclosed as A.2.3.

### **Home Medications Review (HMR)**

The HMR, introduced in 2001, offers GPs a financial incentive to refer patients to a local pharmacist for a review of medications undertaken in the patient’s home (DHAC, 2001). This process may be seen by many GPs as being

another chore involving liaison with yet another health care professional or it may be welcomed as a high quality initiative some GPs are keen to embrace.

We do not know how GPs view the concept of blended payment incentives. They may regard them as superfluous, as a means to expand income, a mechanism to enhance patient care or as just another addition to the work burden. A US study suggests that changes there had made no improvement to the difficulties of the 1980s (Dunstone and Reames, 2001). Indeed, Beaulieu ominously suggests that “the difficulty of introducing organizational changes in health care environments without intensive support of the change process has been established” (Bealieu, 2001). The Commonwealth has offered very little in the way of support in implementing these “quality” based changes.

Specifically, there is no evidence whether the changes have become an integral part of the practice infrastructure or a bolt-on used whenever a GP seeks an extra income source. This study may add some insights into these matters.

### **2.10.3        *Outcomes as a measure of quality***

Despite the difficulties involved in measuring the quality of outcomes in general practice (DHFS, 1998, p187) and the costs involved (Blomberg, 1996), the Commonwealth Government has moved toward encouraging an outcomes based approach to health care (*GPA:1996*, p139; DHAC(a), 1999, p23).

The measurement of outcomes in general practice may appear deceptively easy. For example, one measure may be the rate of childhood immunisations a GP delivers. Even this measure is, however, complex as it involves the collection of information that an appropriate immunisation has occurred to a known and identifiable patient by a known and identifiable GP. Apportioning reward for an

outcome is made more difficult if the child has seen a number of providers for completion of the recommended course of injections. This difficulty of attribution highlights the problem without patient enrolment. Nor does the recording of the intervention of immunisation assist in determining if the “cold chain” to protect the vaccine has been prejudiced on its way to the patient.

Since 2001, incentives have existed to achieve specific immunisation and cervical screening rates (HIC, 2003, p102). Though these incentives may appear to have been successful there can be no certainty that the program has not merely improved the rate of reporting of the intervention rather than the frequency of the intervention.

Quality in the delivery of medical services has, in many cases, an evidence base. Evidence based medicine (EBM) is a relatively recent attempt to improve clinical outcomes for patients (DHAC, 1999, p23). EBM does however have difficulties in its application and uptake (Hirst et Ward, 2000; Tomlin et al, 1999). A GP may ensure that her patient adheres to a clinical pathway for the treatment of diastolic heart failure but if the diagnosis is incorrect the successful outcome of strict adherence to a guideline has little clinical validity. There is unfortunately scant evidence that GPs as a group apply the learnings of evidence based medicine (van Der Weyden, 1999). This has not stopped a national emphasis on EBM (DHFS, 1998, p215), which not only impacts on GPs but encourages consumers to expect certain outcomes (DHAC, 1999, p24).

It has been suggested that adherence to clinical guidelines may be protective from litigation and the stress associated with such a challenge (DHFS, 1998, p220); conversely, failure to adhere to such guidelines may be damning.



Therefore, in order to protect themselves, GPs would need to be not only aware of the evidence base for what they do but also to systematically incorporate the evidence into the delivery of their care. We do not know how GPs are responding to this challenge.

#### ***2.10.4 Concluding comments about quality in general practice***

The intent to improve quality in Australian general practice has resulted in a broad array of initiatives involving GPs. These include education, accreditation, vocational registration, adherence to clinical management guidelines, disease registers and financial incentives for efficient patient recall and screening, patient assessment, care planning and case conferencing. Many of these move well beyond the classic role of a GP providing responsive care to a patient presenting with a problem. Of particular significance to this thesis is the importance of non-clinical systems required to support the use of guidelines and rewarding their use.

Having raised questions as to the quality of services delivered in Australian general practice, it is appropriate to consider costs relating to those services.

### **2.11 The cost and financing of general practice**

The costs of general practice in Australia are largely met by the public purse (DHAC(b), 1999, p16) as are the flow-on costs of investigation and consultant referral. Funding incentives are the major tool of reform and control in general practice and are increasing the substantial amount drained from the public

purse. The Commonwealth has spent up to \$515 million per annum in non-fee-for-service funding initiatives such as for Divisions of General Practice and the Practice Incentives Program (Richardson et al, 2005, p72). Accordingly, GPs have become more accountable for their expenditures and blended payment systems are offering incentives to perform work that otherwise may not be performed. These issues are addressed in more detail in the following sections discussing GP accountability, blended payments for GP services, and perverse incentives in general practice.

### ***2.11.1 Accountability for expenditures***

Apart from direct funding of GP-based MBS services, the Commonwealth funds Divisions of General Practice, general practice research, general practice training and an array of other general practice related reforms and institutions. Parliament requires government to be accountable for general practice funding, particularly in a general environment which has seen more interventionist government (Brown, 1995, p99) and therefore tighter economies (Degeling, 1995, p58). In 1998-99 MBS expenditure on GP items alone amounted to \$2.39 billion (Fry et Furler, 2000, p390).

The Commonwealth has expressed its accountability for these funding types and amounts by the agency of the Health Insurance Commission (HIC). The HIC monitors the number of patients seen by a GP, the number and type of prescriptions and the number and type of diagnostic services requested. Variances to a norm are identified and controls placed upon erring GPs. The scrutiny of the HIC becomes more relevant to GPs as their patients age and require more investigations and as the number of patients seen increases relative to the GP

workforce. As yet, we do not know how GPs respond to increasing surveillance of the cost of their clinical conduct.

### **2.11.2      *Blended payment system***

The blended payment system recognises that GPs can claim rebates for fee for service activities as well as payment for activities associated with vocational registration and practice accreditation, preventative care, chronic disease management activities associated with the Practice Incentive Program (PIP) and planned care associated with the Enhanced Primary Care (EPC) package, each element of which carries its own reporting requirements. The use of EPC items has risen from an average of 3.3 per GP in 1999-2000 to 23.8 in 2001-2002 (Richardson et al, 2005, p81). However, some GPs may ideologically oppose the concepts of the EPC, some may be too busy under the FFS system to add to their workload and it may be that some have never considered the economics of adopting blended payment. Some may adopt them purely for their economic value. We simply don't know under what circumstances and for what reasons GPs will adopt reforms.

Of particular importance, the Health Assessment item permits GPs, for the first time, to raise rebatable charges against a patient for services performed by an agent of the GP. There is evidence that in response to this package, GPs will use the items on an ad hoc basis, but may not incorporate them in a systematic way of doing business (Martin et Rohan, 2002).

Where there is no incentive to substitute GP services with services provided by allied health clinicians, new reforms may merely add to the GP workload, albeit increasing their income, and perhaps their costs. Options

available to the Commonwealth to bring about change are almost exclusively linked to financial incentives and to some extent these are mitigated by GP workload and the amount of effort required to claim the rebate. It may therefore be that any such changes are resisted. We simply don't know.

The extent of the Commonwealth's activities in general practice financing is detailed in A.2.4, where it will be seen that the Commonwealth is deeply involved in providing incentives across a broad spectrum of general practice activities.

### **2.11.3      *Perverse incentives of the fee for service model***

The reforms which the Commonwealth is pursuing are not facilitated by the fee for service model. This model offers severe disincentives for GPs (Fry and Furler, 2000, p409) to take time out of a consultation – driven environment for important and professionally rewarding activities such as research, audit, population health activities (Beaulieu et al, 2002, p14) and professional development (CFTP, 1998, p234; Beaulieu et al, 2002, p14). A fee for service model rewards quantity and is unrelated to quality except in so far as it limits it (Rodwin, 2004). Reforms may impact only where they offer a significant proportion of a GP's income. Whilst minimal paperwork ("red tape") surrounds the simple reactive fee for service model of care, an abundance of paperwork surrounds incentives associated with blended payments. GPs are caught up in this complex set of drivers depicted in Figure 2.11.

**Figure 2.11 Drivers and barriers to the two major funding models**

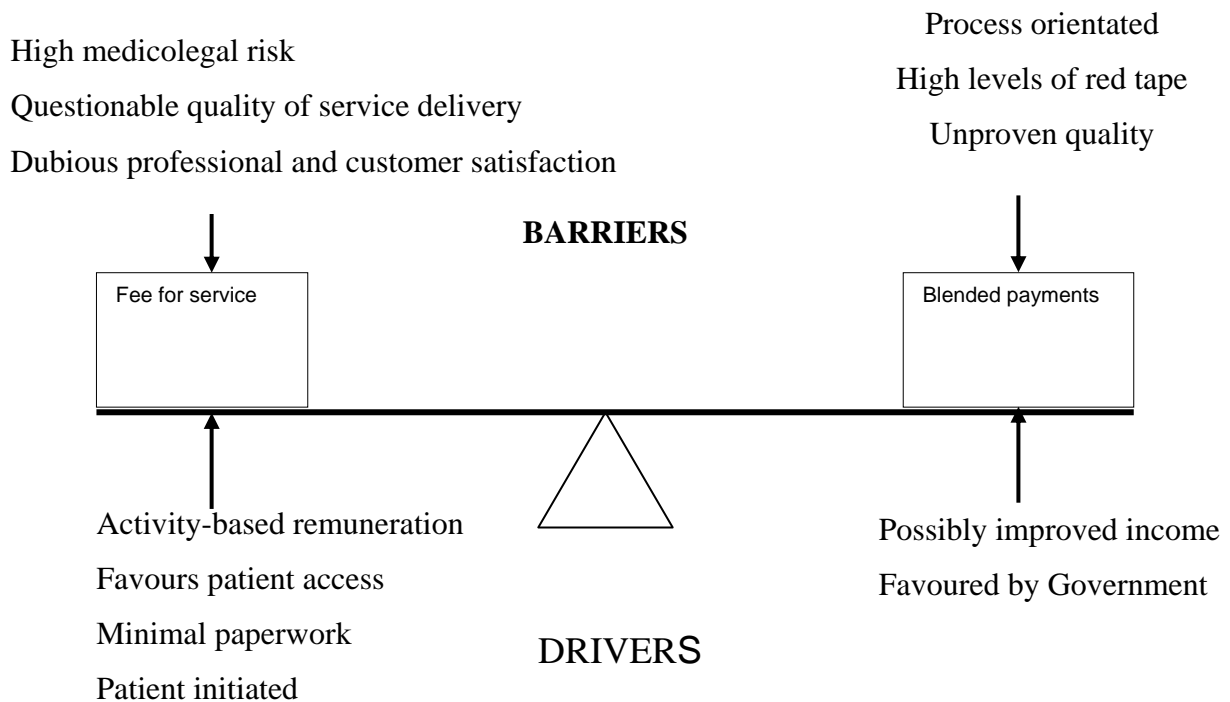


Figure 2.11 demonstrates the many barriers that prevent the uptake of the blended payment system by GPs (process orientated, high levels of red tape, unproven quality, requires systems support) in contrast to the strong drivers that favour the uptake of the traditional FFS system (minimal paperwork, activity-based remuneration).

In conclusion, the average Australian GP has witnessed spending on general practice greatly broadened over the past 10 years. This broadening of funding has not altogether been embraced by GPs some of whom may resist such changes firstly on principle that fee for service should be the sole mechanism for GP remuneration, and secondly, at an operational level, by those GPs who perceive that the red tape involved in claiming any financial rewards is too

burdensome. In any event, broadening funding methods have come at the cost of greater scrutiny and control.

It is this scrutiny and control which is reviewed in the next section.

## **2.12 Regulating Australian general practice**

Regulation of general practice occurs at Commonwealth, State and Local Government levels. At each level different drivers influence the delivery of general practice care. As jurisdictions overlap, the integration of clinical relationships has been a difficult and complex task (Scotten (b), 2000). Whilst the Commonwealth has driven primary care change, the States have voiced their intention to be more involved whilst even local Government has had some influence over general practice.

### ***2.12.1 Local government***

Local government is responsible for adequate standards of sites from which general practice services are provided. Its greatest impact on general practice appears to be in limiting the number of professionals who can practice from a medical clinic zoned “residential”. (Many of the nation’s smaller practices are to be found in residentially zoned areas.) This zoning strategy tends to limit GPs to the “cottage” type practice. To expand beyond this size, many practitioners are required to pool their resources in order to construct premises within more expensive commercially zoned areas. Thus practice size is becoming bipolar in Australia with the retention of small cottage practices and, at the other end of the

spectrum, larger commercial premises are owned by commercial interests or by an amalgamation of more entrepreneurial GPs.

Large practices require a more systematic business approach to clinical care, with an increasing number of non-medical staff (AMA, 2001, p11). Thus the structure of a practice, which in some ways is a function of local government, influences and constrains the function of the practice.

### ***2.12.2 State government***

States provide the ultimate regulation of medical practitioners, that of registration. Registration is a function of the various State Medical Boards, there being no national system of registration. Some states are more regulated than others; for example, NSW registration is conditional on medical indemnity insurance and upon continuing vocational training. For constitutional reasons, the state is responsible for the health of its citizens, however it plays little direct role in general practice.

In 2000, the New South Wales (NSW) government introduced, for the first time, a General Practice Policy. It seeks to promote “collaboration and partnerships between general practice and the NSW public health system.” (NSW Health (b), 2000) This statement is paradoxical in the context whereby GPs have been discouraged from the hospital system since the 1980s (*FGP*, 1992, pp31,36; Phillips, 1998, p1). The State’s relatively recent interest in general practice is explained in the policy which acknowledges GPs’ newly found role in population health which, one presumes, if successful may reduce hospital admission rates. However, as stated in *The Future of General Practice* (FGP) in 1992, “GPs do not

currently participate in a systematic way towards either the setting or the achievement of these (population health) goals (Macklin, 1992)

A decade later this is not necessarily so, with Divisions of General Practice providing support for population health activities which include cervical and breast screening, asthma management, diabetes screening and lifestyle interventions. Nonetheless, whilst there is a significant proportion of GPs who have not been trained in population health and whilst there is no way of determining a GP “population” (as there is in the UK) epidemiological data which underlies population health must be difficult to attribute (Fry et Furler, 2000, p394) and therefore to reward.

The Strategy also suggests that the State seeks to “expand shared-care programs and increase the involvement of general practitioners in pre-hospital assessment, in-patient management and discharge planning” (Fry et Furler, *ibid*, p6). Interestingly, the General Practice Policy provides no assessment of the effect these four interventions would have on the workload of GPs themselves. Nor has there been a meaningful examination as to the relative efficiencies of either the primary or the secondary (hospital) sector to fulfill these functions.

### ***2.12.3 Commonwealth government***

The General Practice Strategy Review Group, through its 1998 report, *Changing the Future through Partnerships*, recommended, *inter alia* “that GP organisations and governments endorse a quality framework for doctors working in general practice that requires all such doctors to achieve, maintain and demonstrate their competence for this” (DHFS, 1998, pxxx). Whilst the PIP and SIP reward the Commonwealth’s perception of quality, regulatory controls exist



where it appears that GPs have failed to achieve, maintain or demonstrate such quality.

Commonwealth regulatory control of general practice is best defined around its financing system. For practical purposes this means the Medical Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS).

### **Medical Benefits Schedule**

The Commonwealth regulates usage of the MBS through the Health Insurance Commission (HIC). The HIC's role in regulatory activities is to identify GPs who "over service". Since Medicare began in 1983, the median annual number of services for a full time GP has remained in the range 5908 to 6245. However, 10% of GPs provide over 10,000 consultations per year, generating almost 25% of rebates for all GP consultations (DHFS, 1998, p 234). GPs who over service may face disciplinary action by the Professional Service Review Tribunal, which can remove a doctor's rights to attract Medicare benefits.

### **Services referred to other providers**

The PBS is a focus of the Commonwealth in its attempt to control "downstream" costs (DHFS, 1998, p244). These are costs to the Commonwealth under Medicare derived from GP consultations. They include prescribing, diagnostic imaging and pathology. For example, services ordered for these three provider categories rose by 50% between 1991–2 and 1994–5, while Medicare rebates to GPs rose by only 23% in the same period (DHFS, *ibid*, p245). As a response, the HIC now monitors all prescribing and investigative referrals by GPs (but not by consultant specialists) and will counsel GPs who are outliers from a

statistical pattern generated in comparison to peers with similar patient demographics. Failure to comply may result in a review by the Professional Services Tribunal. In 2003-2004, 11 GPs had their records seized for investigation by the HIC, whilst only one consultant specialist had records seized (HIC, 2003, p167)

In conclusion, Australia's three-tier system of government provides for a fragmented approach to general practice. This provides an inefficient framework from which to encourage accessible general practice care within a service oriented rather than business oriented environment. At the local government level, GPs experience disincentives to amalgamate, State governments have expectations that general practice will assist in shared care arrangements, and the Commonwealth seeks to promote quality service delivery within a funding framework that encourages high patient turnover.

The next section discusses the target of general practice structure and function, the consumer and the new dynamic of general practice consumerism.

## **2.13 Consumers and consumerism**

Two major factors exist to drive change in the way doctors address the needs of consumers. The first is benchmarking. The advent of evidence-based medicine (Eysenbach, 2000) has allowed consumers, either directly with the GP or through the internet, to access information about generally acceptable methods of care. The second is consumerism. Consumerism has seen a response by society (Morrison and Smith, 2000), that commenced in the 1980s (Coulter, 1999), that is being increasingly directed at the health care sector (Blomberg, 1997) to close the

power gap between patient and health professional. In other words, consumers appear to be moving away from a relationship of dependence (“what the doctor ordered”) with respect to their GP. Little suggests that this process is a result of the “effective colonisation of morals and politics by money and commerce” which has seen the concept of service replaced by “duty of care” (Little, 2003).

However, the elderly population still displays characteristics such as friendship, faith and trust that may indicate such a relationship still exists amongst that cohort (Keller and Slee, 2001, p36, Little et al, 2001). Richman suggests that cultural changes have even seen a new assertiveness of teenagers but that the real impact of consumerism that has fed into the patient consultation is feminism (Richman, 1987, pp86,87). Within the practice itself, consumerism is expressed through patient responses to surveys as, under the requirements for practice accreditation, each practice is required to survey its patients for levels of satisfaction with services provided.

It may also be that, as GPs become more focused on health markers and process measures such as the PIP, they are becoming focused on technical performance rather than on customer satisfaction or dissatisfaction (Nisselle, 1999, p576; Neuwirth, 2002, p77). It has also been argued that patients want communications, partnership and health promotion (Little et al, 2001) and GPs better skilled in IT (Mott, 2001, p75), areas in which GPs have had little training. Others suggest that most Australian GPs do utilise patient-centred models of care but give no explanation as to why (Martin and Rohan, 2002). Some suggest that there is a community expectation that GPs should be constantly available (Buchanan, 2001).

Patient empowerment, in Australia, has to some extent been facilitated by the medicolegal system. The need for informed patient consent can no longer be ignored even in matters previously regarded as minor. But in a relatively short consultation it may not be feasible to determine patients' preferences and sensitivities whilst providing full and unbiased assessment of patient options (Elwyn et al, 1999).

This section presents a brief discussion of a trend to increasing empowerment of consumers, the significance of ageing of the consumer population suffering more complex illnesses and the role of the GP as gatekeeper to the consultant specialist.

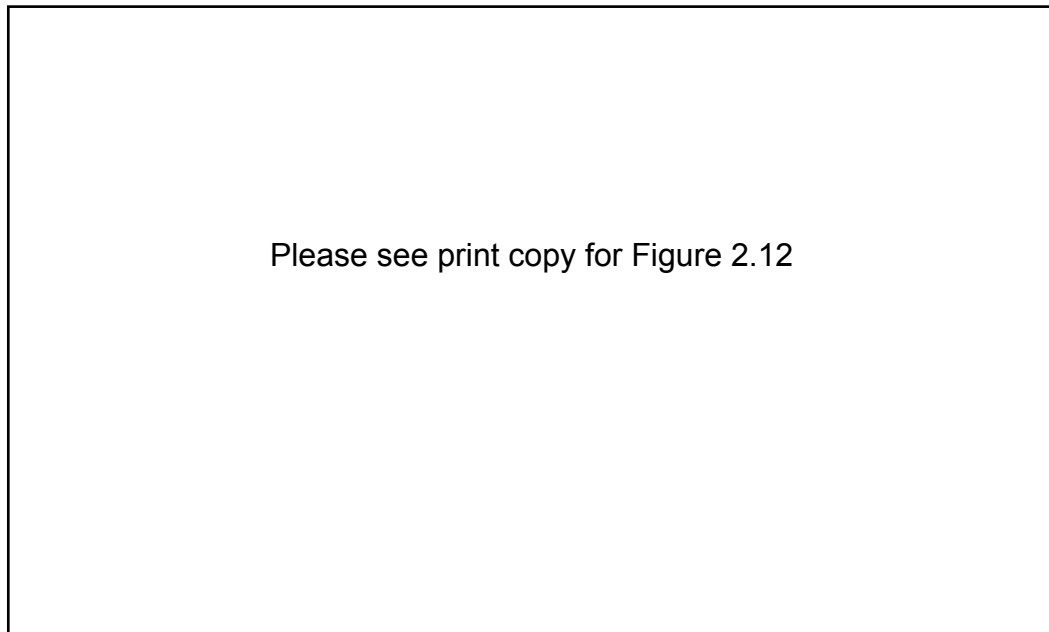
### ***2.13.1 Changing demand on GP services***

Consumers will present to GPs either because of need or because of want. Unfortunately, consumers are not necessarily good judges of clinical priorities and perceived needs of a consumer may, through the eyes of the health practitioner, be nothing more than a “want”. The wealthy have long enjoyed greater access to health care providers, whether for services they need or just ones that they want. The less wealthy of the community, since the advent of Medicare, are less restricted by financial considerations and now also able to access general practice care, whether needed or just wanted. Thus the rise of “consumerism” in Australia has brought pressure to bear on GPs to meet patient-determined needs rather than doctor-determined needs. The two, to some extent, may be in conflict.

### ***2.13.2 An ageing consumer population***

As demonstrated in Figure 2.12, Australia's population is living longer whilst Figure 2.13 demonstrates that the population is ageing as a whole.

**Figure 2.12 Life expectancy at birth 1901 - 1990**

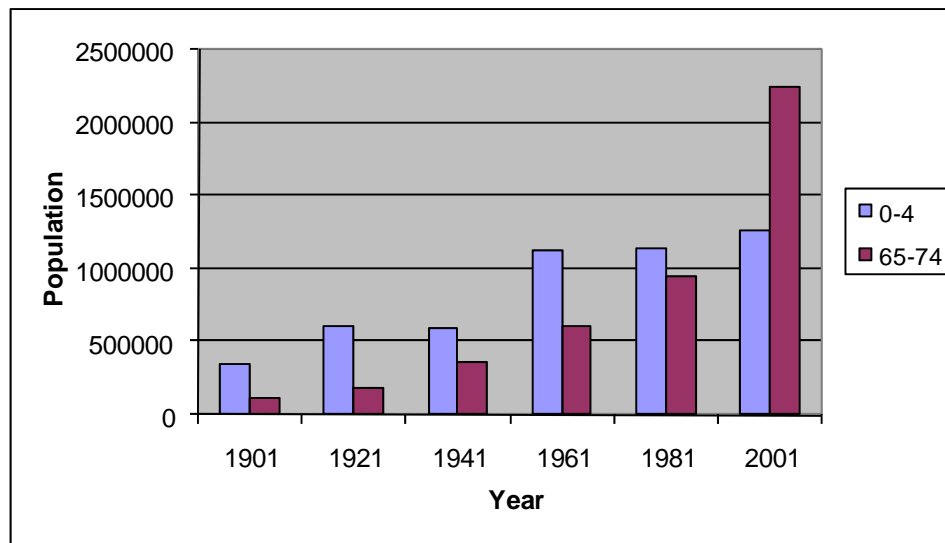


Source: AIHW Statistical tables quoted from ABS Cat No. 3302.0

Figure 2.12 demonstrates that life expectancy in Australia has increased by almost 20 years during the 20<sup>th</sup> century.

As the population ages and experiences more chronic illnesses, need for services increases. That is not to say that everyone who is old is ill, just that illness is more likely in an older population. An ageing population is likely to suffer increasingly complex illness patterns, handicap or disability and may also become increasingly reliant on a health system that can respond to, or even prevent, chronic illness and its sequelae. For these reasons investment has been made through screening and lifestyle programs, largely encouraged through general practice, to keep the elderly well for as long as possible (Macklin, 1992, p19).

**Figure 2.13 Change in population of infants and elderly 1901 - 2001**



Source: Derived from AIHW Statistical tables quoted from ABS Cat No. 3301.0

Figure 2.13 demonstrates that the rate increase of the number of elderly Australians has outpaced rate of increase of infants. The result has been an increasingly elderly population.

It is possible that people who have developed chronic diseases require the primary care system to work beyond the medical model, meeting their need for independence, mobility and self-determination rather than cure or treatment (Gething, 2001, p2). Such a demand may find the GP who is trained in a purely medical model lacking in such skills or unwilling to enquire into patients' non-medical needs (Creasy et al, 2001, p10). Indeed, general practice may be perpetuating an illness model in a healthy older population. For example, the decision to treat a consumer's hypertension may be based entirely on the fact that the consumer has hypertension. We do not know to what extent that GPs are

explaining to their hypertensive consumers how many patients with hypertension would be needed to be treated to avoid one suffering a stroke. It may therefore be that GPs are using a “medical model” of care with which they are comfortably familiar and which sits well with a proportion of the community but which may sit less well with the needs of the elderly population (Degeling and Anderson, 1995, pp66-68).

An ageing consumer population is also more likely to be unable to attend a GP practice either for reasons of dependence or because societal changes have dictated that carers may be more likely to be employed today than 30 years ago and less able to assist in transport. An ageing patient may also be reluctant to visit their GP as there may be likelihood that the GP will refer the patient to an external allied health professional thus increasing the complexity of health care access and cost for that person. This option was not a significant feature of general practice 30 years ago prior to the advent of community based services.

Without changes, an ageing population will attract a greater pension cost to the community (Access Economics, 2001, pix). Greater numbers of concession card holders may increase demand on those GPs who bulk bill and will tend to relatively reduce incomes for those GPs providing concessional treatment. It may even be that the elderly or disabled, no longer in the working environment, adopt the sick role as a means of identity (Richman, 1987, p87) In addition, to control costs, there appears to be a tendency for aged care to be delivered in the community rather than in institutions (Access Economics, 2001, px). This may put increasing pressure on primary carers, particularly if funding fails to follow care.

### ***2.13.3 Increasingly chronic and complex illnesses patterns***

As illness patterns become more complex and intertwined (Creasy et al, 2001), the patient may need an increased understanding of their illnesses or disabilities, mechanisms for coping with handicap, and methods for utilising a wide variety of medications and interventions within a complex health system (Gething, 2001, p11; Morrison and Smith, 2000). The fee for service method of service delivery may not be well suited to produce a satisfactory result for this patient group since it favours a reactive model of care (Oldroyd et al, 2003, p30) and tends to break up a natural longer consultation into a less efficient series of short consultations (Martin and Rohan, 2002). Some illnesses which predominate in the elderly, for example cancer, are related to increased demands on not only the time of the GP but also on the GP's emotions. The answers to the basic questions of life such as "If humans need painful stimuli for protection, why do I have it when I'm dying?", are not to be found in medical texts (Richman, 1987, p88).

It may be that illnesses in the elderly are best treated differently or at least for different purposes, than for younger populations. For example, treatment of cardiovascular disease in the elderly may aim to prevent multi-infarct dementia rather than attempting to prolong life (Creasy et al, 2001, p14). Training for older GPs may not have allowed for a different perspective of disease management for the elderly chronically ill patient.



#### **2.13.4      *The GP as gateway and guide to secondary care***

It has become apparent that the generalist consultants, for example the general physician, surgeon and paediatrician are becoming increasingly uncommon in the face of increasing specialisation. Commonwealth legislation controls access by consumers to specialist consultants. As subspecialist consultants, such as thoracic surgeons and renal physicians, become more numerous than generalist consultants, the range of work performed or of skills exercised by these subspecialists becomes more limited, and probably of a higher quality. GPs, regarded as the “gateway” to the secondary and tertiary sectors of the Australian health care system (Britt et al, 2004, p1), are increasingly required to understand something of the fields in which subspecialists practice but also the relative values of their skills and procedures with respect to the needs of patients. For example, the last 30 years have seen the introduction of the Nuclear Medicine specialist who provides an imaging service in the same way as a radiologist but using very different techniques for differing purposes. Older GPs will have had to come to terms with this new technology, its application and complications in order to provide the best advice to their patients. We know little about how well that adaptive process has proceeded or even if it has proceeded. Similarly, as pathology and radiology investigations become more specialised and expensive or invasive, patient expectation may be that GPs will ensure that investigations are kept to a minimum. It may even be that several consultants are required for some of the more complex conditions. In this case the GP may be required to coordinate her advice, informing each subspecialist of the work or advice of others. In the

past era of generalist consultants this was far less often the case; the patient was referred either to a surgeon or to a physician.

In conclusion, over the last 30 years health consumers have experienced increasingly complex access to an increasingly complex health system in which their GP is playing a more clinical management role. Barriers to access have declined with the introduction of a universal health insurance system, but that system has failed to some extent in rural Australia. It has more recently been argued that access is declining due to an undersupply of GPs thus complicating a maldistribution of GPs. The complexity of specialist care may have seen the consumer more reliant on the GP for assistance in ensuring that specialist care is appropriate and well informed.

Today's GP, therefore, is being asked to adopt longer-term management techniques rather than episodic treatment techniques in the presence of complex illnesses (AMA, 2001, p7). Such an approach may not sit easily within a payment framework designed around itemised interventions or a practice setting largely dominated by medical practitioners when disability support may be of a higher priority to the patient. This thesis may give insights into the response of GPs to consumerism, and the concomitant trend to quantitative measures of service quality. What little is known on this subject is directly and inversely proportional to the consequences of failure to manage the changing nature of consumerism.

## **2.14 Concluding remarks**

As stated in the document, *Changing the Future through Partnerships*, "The changing environment has increased the variety of roles GPs play, with

associated diversity in the scope and structure of general practices. Attempts to define, measure and improve general practice are often thwarted by the absence of clearly defined boundaries around the role of the GP and general practice” (DHFS, 1998, p187). The tools that the report recommends to help GPs provide high-quality care include: improving patient linkages, marketing quality, enhancing information technology and information management, and adjusting the finance and remuneration system to better reward quality (DHFS, 1998, p191). In the context of this thesis, it is salutary that all these are non-clinical processes.

In 2007, many of those changes are being wrought on a community of GPs who believe themselves overworked and who are older than the Australian community may like to acknowledge. How they respond to these non-clinical changes will determine the quality of general practice and the quality of the life style for those who choose to stay within the profession.

This chapter has therefore provided a review of the field of non-clinical change in Australian general practice. It has identified key changes in the GP’s environment. These changes have been prioritised according to criteria listed in section 2.1. A list of changes identified in this chapter, and their ranking scales are tabled in A.2.5. The five changes of highest priority are listed in Table 2.3.

**Table 2.3** *Non-clinical changes confronted by Australian GPs as identified from literature*

<b>Non-clinical changes identified by literature</b>
Red tape
Medicolegal litigation
Computerisation
Introduction of quality incentives (e.g. PIP)
Introduction of practice accreditation

These changes will be compared to those identified by the Delphi group to determine the final case studies placed before a cohort of GPs in order to determine how that group of GPs has responded to change and how change has impacted upon them.

## **CHAPTER THREE**

### **Literature review**

#### **Clinical and non-clinical management in Australian (and UK) general practice**

##### **3.1 Perspective**

This thesis presents an examination of non-clinical change in general practice as it has influenced a group of Australian GPs. It examines the changes they have experienced, the GPs themselves, their responses and the impact of change.

The Australian experience of change is by no means unique (Glasgow et al, 2005, p97) in that general practice is being redesigned the world over. The environment of change is universal in nature and is a milieu of universal political, financial and societal forces (Sibthorpe et al, 2005, S77). These forces have wrought changes in the population being treated in general practice, the availability of an adequate GP workforce, team based approaches to general practice care, changes in funding GPs, and the increasing persistence of informatics reform.

Martin and Sturmberg identify the need for Canadian and US general practice to “define” itself (Martin and Sturmberg, 2006; Moore and Showstack, 2003) in response to general practice’s evolving roles that include team and organisational dynamics and the apparent need for stronger leadership within the profession. Hutchison et al (2001) suggest that as a consequence of so many changes, system

change has failed to eventuate in Canada because of attempts at “big bang” reform as distinct to incremental structural change. A much more favourable view of meso level reform is reported by Dunbar et al in commenting on outcomes arising from New Zealand’s Independent Practitioners Associations (IPAs). (Dunbar et al, 2007). Arguing the case for micro reform in the US, Scherger suggests that new models of office practice will inevitably follow the increasing trend toward comprehensive care, preventative care and chronic disease management (Scherger, 2005). Indeed, the condition of those patients presenting to US practices is reported to be increasingly complicated and severe (St Peter et al, 1997). Patients are reportedly consulting a declining number of GPs, particularly in Canada where a flow to the US has been observed (The College of Family Physicians of Canada, 2000).

Not only is there an international shortage of GPs but the nature of the GP workforce is changing as more females enter the primary care workforce so that 76.5% of GPs in the UK aged under 30 years are women (BMA, 2007). Whereas 94% of male GPs work full time, only 59% of UK female GPs work full time (BMA, 2007), thereby exacerbating the workforce shortage.

Despite large investments, the introduction of primary care based IT systems world wide has been challenging. Expectation exceeded outcome in the UK (Adams et al, 2004, p871) and human factors lead to the demise of the Kaiser Permanente electronic medical record system in Hawaii (Teasdale, 2005, p1316), whilst Africa’s “biggest medical informatics project” in Limpopo, South Africa, was a failure (Littlejohns et al, 2003, p860).

IT is but one cause of the universal trend to rising health costs without necessarily benefiting primary care providers, with the consequent risk that, in the US at least, current payment systems may “contribute to a deterioration of primary care” (Green, 2004, p113) in favour of secondary providers. Indeed, a strong trend to improve quality or primary care services world wide has seen Australia, and other countries adopt blended payments or to consider them (Green *ibid*). Even in the Netherlands where “GPs have been jealously protecting capitation payment” (van Weel, 2004, p110), patient co-payments have been considered as well as payments to GPs salaried to other GPs (van Weel, 2004, p111).

Indeed, in this climate of “continual change” there is reported to be “unrest” throughout the English NHS as a new patient-doctor dialogue is developing and as doctors are becoming more accountable through contracts based upon a newly introduced “Quality and Outcomes Framework” (RCGP, 2007)

However, this thesis relates specifically to the Australian context in which there is a broad and helpful literature around changes that have occurred in Australian general practice. This is reviewed in Chapter 2. There is very little literature about Australia’s GPs themselves except at the crudest of levels. There is also a limited body of literature that explores GPs’ response to change and it is generally limited to the context of management. In a general way, this literature answers the question, What do GPs manage? There is little to help understand “feeling” response, i.e. what do GPs feel about change? More precisely, the literature is more likely to identify how *well* GPs respond rather than how they respond. There is very little in the literature about the impact of change on GPs.

The purpose of the following literature review is to assist in understanding how GPs manage change so that we are better informed as to how they more generally respond to it.

The review does not limit itself to the non-clinical environment as that would be a very small net to cast. It therefore also includes the clinical environment as GPs would see themselves, a priori, clinical managers rather than business managers. Nor is it limited to change as, again, that is too small a net. Accordingly, this chapter attempts to provide a review of literature relevant to Australian GPs in their management (as a surrogate measure for response) of both clinical activities and non-clinical activities generally, and both clinical and non-clinical activities in a changing environment. There are, therefore, four quadrants to consider. These are depicted in Figure 3.1.

**Figure 3.1 The quadrants representing the literature review**

1	Literature related to management of unchanging clinical	Literature related to management of unchanging non-clinical	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

Whilst the shaded quadrant represents the specific area of interest in this thesis, an examination of the other quadrants as a literature review will be helpful in shining some light into an area that has been only lightly explored.



Indeed, exploration is particularly scant in the Australian context. A systematic review of published studies assessing the quality of non-hospital clinical care provided in UK, New Zealand and Australian general practice, Seddon et al found that of 90 papers only six came from Australia (Seddon, 2001). The relative paucity of Australian research implies that any purely Australian review would be problematic. For this reason I have chosen to review UK literature as well as Australian. This is not an ideal methodology as there are systematic differences in general practice structure between the two countries. However, the two Royal Colleges of General Practice have a common ancestry and heritage.

Whilst little is known about the quality of clinical care provided in the community (*ibid*), it is rare to find anything in the literature about GPs in any country managing non-clinical change. This thesis may provide a small contribution to this specific literature.

The bulk of the literature reviewed has been derived from a systematic review, in 2002-3, of each electronic edition of the Medical Journal of Australia (MJA) and of the British Medical Journal (BMJ), prior to data collection. These journals were chosen in particular as they do not have the clinical emphasis of their national counterparts, viz., Australian Family Physician and Lancet. A detailed critique of all relevant articles is presented in the Appendix as A.3.

Much of the research that has occurred into Australian general practice has focused on clinical activities using quantitative data (Peterson and Martin, 2000). The leading research in this field in Australia is the BEACH study authored by Britt et al (Britt et al, 1998-2003). The BEACH study is an on-going study of

approximately 1000 GPs into, inter alia, the conditions treated by GPs, the tangible end product of the consultation (treatment, prescription, referral, investigation) and the consultation length.

This approach has yielded a valuable profile of GP activity however there is no identification of patient outcomes and little detail of the management that lay behind them.

The BEACH study followed the Australian Morbidity and Treatment Survey (Department of General Practice, University of Sydney, 1991), which intermittently sampled the activities of 495 Australian GPs over a one year period. These studies have yielded an interesting profile of “activity” but have not examined patient or other management.

The following represents a summary of findings; a detailed literature review is presented within the Appendix.

The first area of examination is GP management in an unchanging clinical environment.

### 3.2 GP management in an unchanging clinical environment

1	<div>Literature related to management of unchanging clinical</div>	<div>Literature related to management of unchanging non-clinical</div>	3
2	<div>Literature related to management of changing clinical conditions</div>	<div>Literature related to management of changing non-clinical processes</div>	4

A number of studies examine quality of patient management with respect to single diagnoses. Ignoring comorbidities simplifies the methodology but may fail to capture the complexity of general practice. The diagnoses will be discussed as specific headings after a précis of general determinants of quality patient care reported in the literature. The insights they provide are suggestive that GPs who wish to provide quality care may have to respond by examining more closely their non-clinical context.

### ***3.2.1 Determinants of quality management in general practice care***

Determinants of quality in general practice have been identified by four studies (Veale and Fahey, 1997; Campbell et al, 2001; Pollock and Grime, 2002 and Freeman et al, 2002). Campbell et al recognised that the markers of quality chosen for their study may be problematic. This is true of all four studies and underlines the complexities of determining a definition of quality in a manner that can be measured (McColl et al, 1998).

Patient satisfaction was a common measure and found to be related to issues of access (waiting times, consultation length, home visits, facilities for children, and respect for the patient). Consultation length was reported to be particularly important for those patients with chronic diseases (Freeman et al, 2002) however, the relationship between chronic disease and patient age was not discussed and it may be that older people simply prefer more time with their doctor. However, Pollock and Grime suggested that consultation length was not

related to quality. As participants for that study all suffered from depression their finding may be less generalisable than the others. Effectiveness of care was reported to be related to the provision of patient information, appropriate clinical care and preventative activities.

The British context of some of these studies is important. A reasonable argument has been established that the more time a GP spends with patients the better the care. However, that argument looks less reasonable in the Australian context where access to specialist care may be more readily available. In the Australian context, it may be that the more time the patient spends with the specialist, the better the quality of care, independent of the GP who may only be required to generate the referral.

It is interesting to note that most markers of quality of care identified by the authors are generally non-clinical markers, perhaps because it is too difficult to judge clinical prowess, or perhaps because it is too difficult politically to judge clinical prowess. In the Australian context, GPs are never officially examined on clinical skills or knowledge.

### ***3.2.2 GP management of clinical presentations***

This section will review the literature concerning GP diagnosis, treatment, use of guidelines, patient self management and the doctor-patient relationship.

### **3.2.2.1Diagnosis**

Patients with mental health problems commonly present to Australian GPs (Britt et al, 1998–2004) and the appropriate management of these conditions is an important measure of the quality of general practice service delivery. Hickie et al, 2001, suggest that less than half the patients presenting to Australian GPs with depression will be diagnosed with this condition. The authors fail to acknowledge the complexity of general practice by not exploring the extent of screening for other diseases perhaps regarded as more important by both patient and doctor. They do not explain that screening is not an item claimable under the Medicare Benefits Schedule, nor do they explore the patient response to requests for screening activities by the doctor. Nonetheless, this study identifies a number of non-clinical factors that are associated with best practice when identifying mental illness. Two such factors include GP education and better organisation within the general practice to facilitate mental health assessments. Nazareth et al also suggest that there is some evidence that diagnosis of sexual dysfunction is sporadic in general practice (Nazareth et al, 2003). However, this is difficult to establish conclusively as some diagnoses such as sexual and mental health disorders may not be recorded in the medical notes by GPs in order to maintain confidentiality.

Kessler et al, 2002, add to the findings of Hickie et al by reporting that, though many patients with depression were not diagnosed initially, over a three year time frame most were, in fact, diagnosed. Perhaps these studies hint at a failure of GPs to work systematically with their patient populations.

### **3.2.2.2 Treatment**

Despite the fact that bleeding in early pregnancy (threatened or real miscarriage) occurs as frequently as 20% of pregnancies (Everett, 1997, p33), it tends to be managed in a haphazard fashion in Australian general practice (McLaren and Shelley, 2002) as does work-related stress (Russell et Roach, 2002, p367). As diagnosis tends to be somewhat random so does treatment (Sudlow et al, 1997; Campbell et al, 1998).

However, Meadows suggests that GP treatment of mental health patients is at least as good as hospital clinic care (Meadows, 1998). This study was flawed in that hospital clinic care was provided in the clinic whereas GP care was provided in the community. It may be that the community setting as much as anything was preferred by patients.

### **3.2.2.3 Use of clinical guidelines**

One way to reduce the variability of treatments in general practice is to use best evidence collated in the format of clinical guidelines. However, general practice not only seems to avoid the use of guidelines but the many guidelines that exist (Smallwood and Lapsley, 1997) sometimes conflict with each other (Sladden and Ward, 1999). It has been suggested that existing guidelines fail to appreciate the complexities of chronic disease management and its management in the community (van der Werden, 1999).

The use of information in general practice requires further investigation but we know that GPs make poor use of scientific information available electronically (Young and Ward, 1999) and generally fail to apply available

information systematically (McColl et al, 1998). However, in the context of this thesis it may be salient to consider that evidence-based performance indicators may not look so compelling in the light of a waiting room full of patients, scheduled and urgent home visits, and personal lifestyle stress (Sibbald et al, 2003, p22). GPs view guidelines as a challenge to their autonomy and discount their value because they are championed by government. They defer to their own experience or that of their colleagues (Mayer and Piterman, 1999).

#### **3.2.2.4 Patient self management in general practice**

Most General Practice patients do not appear to have a sufficient capacity to manage their own chronic illnesses. They lack both adequate knowledge and the care plans to put knowledge into practice (Abduladud et al, 1999; Ruffin et al, 1999). However, where that knowledge and planning does exist patient outcomes, for some conditions, can be as good as if the patient had been under the continuous care of the GP (Fitzmaurice, 2002).

These studies suggest that GPs may not be utilising the skills and motivation of patients to reduce their own personal workloads whilst benefiting patient outcomes.

#### **3.2.2.5 Clinical relationships**

Whilst Hickie et al, 2001, found that part-time GPs had higher screening rates for depression, Russell and Roach, 2002, noted that in dealing with workers' compensation patients suffering from work-related stress, GP-employer liaison "seemed particularly challenging for full-time practitioners." However, the

significance of this study is stressed by the authors in stating that it is unlikely that suboptimal management practices by GPs are confined to occupational stress.

The failure of general practice to manage relationships in a predictable and comprehensive fashion was emphasised by Taft et al, 2004. The authors reported that, when dealing with victims of intimate partner abuse, all but one of the six GPs in the study overlooked the impact of violence on children. They also suggested that some doctors used practices that were potentially harmful to the victim such as breaking confidentiality and being judgemental. Some preferred to avoid the problem in an effort to maintain the relationship. Most doctors were said to have exhibited a lack of expertise and were unable to debrief whilst others were unaware of the effect their gender, attitudes and beliefs had on their practice.

There is evidence that GPs place the importance of the patient relationship above that of the appropriate treatment. It has been identified that GPs will prescribe antibiotics inappropriately in order to “keep the patient happy” or to “maintain a good relationship with the patient” (Stocks and Fahey, 2002).

In summary, the literature is not supportive of GPs’ clinical management skills in the context of an unchanging clinical environment. The second area of examination is GP management in a changing clinical environment.

### 3.3 GP management in a changing clinical environment

1	Literature related to management of unchanging clinical conditions	Literature related to management of unchanging non-clinical processes	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4



The Australian and British literature is also scant with respect to the response of GPs where clinical management is changing. However, two clinical areas of change where research is more abundant include those of congestive cardiac failure (CCF) and diabetes. The management of CCF has altered since the widespread introduction of echocardiography to confirm the diagnosis and the use of “beta blocking” medications as pharmaceutical therapies. Diabetes is a chronic condition which has undergone many clinical management changes in relatively recent times with insulin delivery systems moving from patient-loaded syringe delivery, to pen systems of delivery to innovative inhaled systems. But more particularly diabetes lends itself to a patient recall system as this disease can affect many body systems (RACGP, 2004).

Studies confirmed those findings described in section 3.2 in that the frequency of diagnosis was often erratic, the diagnosis inaccurate and patients often went under treated (Krum et al, 2001). GPs found that clinical change occurred too rapidly in that they were unaware of the new treatment and diagnostic modalities. Of importance to this thesis, management decisions were made on the most tenuous bases and without recourse to evidence and indeed, there was a general unawareness of the existence of evidence (Fuat et al, 2003).

On the other hand, Griffin reported that diabetic patients who were treated by GPs in a systematic way did at least as well as diabetic patient treated in the

hospital environment. However, the author also noted that where appropriate infrastructure did not exist, diabetic patients attending general practice had poorer outcomes (Griffin, 1998).

In summary, these studies highlight the difficulties GPs face when change is rapid and unsupported by good information and adequate infrastructure.

The third area of examination is GP management in the unchanging non-clinical environment.

### 3.4 GP management in a constant non-clinical environment

1	Literature related to management of unchanging clinical conditions	Literature related to management of unchanging non-clinical processes	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

The Australian and British literature is limited with respect to the ways GPs manage processes that are not clinical. In the UK context this is somewhat surprising given the tumultuous changes the NHS has been through. The one study available to us, *General Practices Profile Study*, reveals that only a small majority of GPs seek external advice on practice management and only one in six

seek planning advice; fewer GPs seek human resource management advice. (DHFS, 1997)

This study is consistent with others presented in this chapter that suggest GPs are unprepared to plan and reluctant to seek advice. None of these studies assist in understanding why this may be the case.

The last area of examination is GP management in the changing non-clinical environment.

### 3.5 GP management in a changing non-clinical environment

1	Literature related to management of unchanging clinical conditions	Literature related to management of unchanging non-clinical processes	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

There is little in the literature that deals with Australian General Practitioners managing non-clinical change. International literature is more helpful in discerning the many aspects of managing non-clinical change. Much of it indicates that GPs have not managed non-clinical change well and have suffered emotionally as a consequence.

GP morale has been impacted by increases and type of workload caused, in particular, by red tape, consumer expectations and transferring hospital care to

the community (Huby et al , 2002; Shattner and Coman, 1996). The trend towards a higher proportion of female GPs (pp29,30) has meant that some of the inequalities relating to clinical and business roles in a practice have become more apparent. Some of these gender inequalities include more complex work, lower incomes and less control of the business (Kilmartin et al, 2002). However, this may be a generational phenomenon as younger female GPs are tending to work the longer hours of their male colleagues (*AMWAC Report 1996.7*).

However work practices instituted within a practice could be significant modifiers of stress. These work practices included the way the business accommodated GPs of varying styles and speed of consultation as well as the management and support of part time GPs, particularly female GPs (Huby et al, 2002). Part-time employment of itself was seen to be protective of stress. It was suggested that time pressures generated by poor business flows such as phone interruptions could spill over into clinical consultations generating errors of management (Schattner and Coman, 1998).

In seeking to identify precursors of GP stress, Sibbald et al, 2003, suggested that: “the principal causes of general practitioner discontent lie within the wider environment. The organisation and governance of general practice has greatly changes in recent years, and doctors may be experiencing difficulty in adapting to these changes.” The importance of these non-clinical stressors was consistent with the views of Schattner and Coman, 1998, who found that it was the “job context” rather than the “job content” that was so stressful.

### **3.6 Barren grounds**

The literature is silent or scarce in a number of critical areas. For example, we know little about GPs as managers. A number of studies exist which describe the relationship between doctors and managers (BMJ, 22 March 2003). However, these are usually in the context of the hospital consultant and the hospital manager working within the British NHS or of the clinician and the management of the Health Maintenance Organisation in the USA (Kassirer, 1998). We know even less about GP as managers of change.

### **3.7 Concluding remarks**

There is a broad field of activity which has been the subject of little enquiry but which, nonetheless merits such enquiry. The work that has been done in the field of GPs managing change has been done largely in the clinical setting. Nonetheless, three conclusions may be drawn. The first is that the literature does not depict GPs as providing systematic predictable clinical care, particularly in the face of a changing clinical environment. Secondly, GPs do not have a habit of seeking assistance in providing clinical management. Lastly, a number of studies emphasise the importance of the non-clinical environment in determining GP stress and their ability to cope with change.

In approaching the matter of non-clinical change management, I do not seek to provide a definitive study. The main outcome of the thesis is to identify further productive strands of enquiry and to identify areas worthy of intervention. Whether my findings will be generalisable will be determined by the consistency of the findings and the detail by which I can identify the type and context of GPs

interviewed and the practices in which they have worked and others with whom they have worked (Britten et al, 1995, p 110). Unfortunately, it is likely that I will not be able to compare my findings with other comparable qualitative studies to aid generalisation (Baum, 1995, p464), as these do not exist at the time of writing.

Consideration of matters such as generalisability and validity is to be found in the following chapter, Chapter Four. This chapter will justify the use of a qualitative methodology to answer the thesis question and will provide an outline of the study itself.

A detailed literature review is attached as A.3.

## **CHAPTER FOUR**

### **Methodology**

#### **4.1 Introduction**

The research was designed to answer three questions that formed a subset of the thesis question, “What is the effect of change on Australian GPs?”. Those questions were:

1. What non-clinical changes have been experienced by a cohort of Australian GPs?
2. How has a cohort of Australian GPs responded to change?
3. How has change and the way a cohort of Australian GPs have responded to it, impacted on the GP personally, on the practice as a whole and on health outcomes for the patient?

It did so by using case studies or vignettes as exemplars of the processes that take place when GPs confront change. The case studies were presented to GP participants and discussed in face to face semi-structured interviews. These interviews then formed the data source for thematic analysis.

In this way an explorative process was undertaken with the intention of providing a foundation for further research into an area that has been little explored. Thematic analysis led to certain conclusions that may be useful to the further enquiry in this intriguing area. Ultimately, this fulfils the first aim of social research as described by Sarantakos, viz., “to explore social reality for its own sake or in order to make further research possible” (Sarantakos, 1998, p15)

## **4.2 Justification of qualitative methodology**

We are concerned, in this study, with describing and explaining a social phenomenon occurring within organisations, in this case general practices. As little is known about this phenomenon, it was important to determine what is known and what is not known. This is a task suited to a qualitative methodology (Holman, 1993, p30; Pope et al, 2000) which not only allows an analysis of how a process occurred, but also why it occurred. (Baum, 1995, p464). A qualitative approach assists in understanding the context in which the processes of change occurred (Steckler et al, 1992, p2) by picturing the “lived experience” (Borkan, 2004) of a participant through “exploration of a range of human experiences” (Schneider et al, 2003, p140).

A qualitative approach is desirable because of the complex nature of the general and specific environments in which GPs have to conduct their business (Kellehear, 1993, p27; Marshall 1999, p167) as quantitative studies do not necessarily lend themselves easily to unravelling complex systems (as distinct to complicated systems) given that examination of the quantitative paradigm may yield a sum whose parts are not necessarily the whole (Ellis and Crookes, 2004, p53). This applies equally to the complex process of decision-making (Steiner et al, 1986, p138; Britten et al, 1995, p105). A qualitative approach also assists in the understanding and description of the close relationship between the value systems and beliefs of the doctor (which may well be quite idiosyncratic) and the modus operandi of the business as it is affected by those systems and beliefs (Robbins and Barnwell, 1994, p375). Indeed, in solo practices there may well be a strong overlap between value systems of the doctor and those of the practice.



A qualitative study is most applicable because of the often undifferentiated nature of the presentation, consultation and complex nature of the doctor-patient / business-customer relationship (Baum, 1995, p459). Importantly, a qualitative approach facilitates the identification of further areas of enquiry (Holman, 1993, p35; Borkan, 2004).

In any study, the language used by the researcher and understood by the participant is vital (Bulmer, 1998, p159). Qualitative methodologies maximise the potential for the researcher to test language equivalence (Mays et Pope, 1995, p110) or shared meanings (Sim et Wright, 2000, p73) across the participant group thus reducing the possibility of incorrect interpretation.

Finally, a qualitative methodology lends itself to an understanding of a phenomenon or question about which little is known (Strauss et Corbin, 1990, p19; Britten et al, 1995, p104). Such is the nature of this study.

However, the study does rely on a quantitative element in deriving a rating scale for determining the most important changes GPs had experienced. This by no means undermines the integrity of the study in that the use of quantitative methodology to inform qualitative methodology (and vice versa) is commonly seen to enrich both (Morgan, 2007, p71; Johnson et al, 2007; Liebscher, 1998; May, 1997, p136). Indeed, the subtype of methodology utilised in this thesis is most accurately described as “qualitative dominant” (Johnson et al, 2007, p124).

### **4.3 Retrospective study**

The study design is retrospective and self-reported in that it relies on GPs’ accounts of their experience. By using a retrospective technique it was possible to place before GPs defined examples of change in their specific environment. A

careful selection process of case studies was required so that each GP participant would have experienced the particular changes had he/she been in practice at or over the period of the change. The advantages of a retrospective study relate to intrusion and efficiency. A retrospective study is minimally disruptive to work flow of the participant as observation and intermittent sampling or survey do not occur; it is also time-limited in the context that memory recall may not be extensive.

However, retrospective studies are also “ex post facto” and may not definitively link cause and effect (Schneider et al, 2003, p306), an important consideration when investigating change and its sequelae. Indeed, in this qualitative study, each of the participants was different in personality, situation and experience, hence cause and effect must always be affected by those characteristics. To overcome this problem Chapter 5 was written in order to describe the GPs undergoing change and their own particular circumstances.

#### **4.4 Errors, bias and validity**

The deficiencies of a retrospective study generally relate to memory if not able to be supported by extant documents. Memory may be poor, incomplete (Tierney, 2000, p544) or fallacious. Similarly, a self-reported study may suffer from participant exaggeration (Denzin and Lincoln, 2000, p650), understatement (Taylor and Bogden, 1984, p98) and, at times, even intent to mislead (Marshall and Rossman, 1989, p83).

Errors in data recording may occur through poor quality equipment, a noisy environment, poor placement of the microphone, or muffled replies. To

allow for these factors a high quality recording machine was utilised with careful placement of the microphone and a brief test run at the start of the interview. Nonetheless, minor difficulties in transcription were encountered either due to the use of English as a second language by some participants, by the noise of cleaners in a nearby room in one case and by two concurrent air conditioners during one interview in a tiny solo clinic room.

Clerical errors may occur in data transcription and for that reason the services of a professional transcriber were obtained. The opportunity was offered to return the transcript to each participant for review, but only one participant requested this opportunity.

Selection bias may occur when there are systematic differences between participants and the population from which they are derived (Schneider et al, 2003, p308). This is less of a problem in an explorative study in which findings are nonetheless valid, if not generalisable, and assist in the development of further research.

Due to the inadequacies of self-reported retrospective studies some method of verification is important. In some studies that may be triangulation (Mays and Pope, 1995) by means of reference to historically contemporaneous documents, something highly unlikely in this case as GPs are not recognised on the whole as adequate record keepers (Wilson and Fulton, 2000, p78). Possible reasons for lack of consistency, apart from inaccurate recall or reporting, may include that learnings had been made from past management errors or some other experience, educational or otherwise, had occurred to alter his or her attitude toward planning.

Validity may be enhanced where “the respondent knows the answer and is motivated to report it accurately” (Mechanic, 1989, p150). By identifying and addressing the most important issues to general practitioners, it may be anticipated that motivation would be as high as could be expected. This may be reflected in the low rejection rate for interview (two GPs).

Validity may also be threatened by the experiential background of the researcher which, in my case, is that of a general practitioner. Britten et al address this problem suggesting that GPs spend much of their time taking histories that enable the GP to place the patient’s story and examination findings into known diagnostic categories. They warn that the reverse is needed for true qualitative work, ie that stories make their own categories and it is the story teller who is the expert (Britten et al, 1995, p109).

However, this is a double-edged sword in that the insights gained from experience can assist in describing the complex environment in which change is taking place (Marshall and Rossman, 1989, p147; Strauss, 1989, p11). Indeed, a closeness between the research and its elements and the researchers are regarded as inherent in qualitative research whilst subjectivity should be made transparently apparent in order to maintain validity (Sarantakos, 1998, p19). Therefore, validity was enhanced by the reporting of consistencies and inconsistencies and by extensive data collection “to capture the complexity of reality” (Strauss, 1989, p10). In writing the analysis of the data it is hoped that a detailed description of “complexities of variables and interactions...embedded with data derived from the setting” confirm the findings’ validity (Marshall and Rossman, 1989, p145).

Interpretation of data is to some extent subjective. Subjectivity was minimised by the use of a structured software mechanism, Nvivo, and review of interpretation of the transcripts (Mays and Pope, 1995) by my supervisor, Prof Don Iverson. Bias is addressed in other studies by using a number of interpreters or raters (Sim and Wright, 2000, p337) a technique not possible in this setting.

## **4.5 Generalisation**

It is suggested that generalisation, or external validity, will occur when findings from analysis of data existing in a context or framework are translated to a similar context or framework (Marshall and Rossman, 1989, p146; Mays and Pope, 1995). However, there appear to be two possible exceptions to this rule. The first is if there is no internal validity of the findings. This has been discussed in the previous section (4.4). The second is if the framework is unnecessary and the findings are generally consistent and independent of a framework. To the extent that participants “share in broad patterns of belief, opinion, behaviour and so forth” (Sim and Wright, 2000, p73) then the aggregation of individual findings may be a valid means of allowing generalisation. Such an unlikely possibility may have occurred in this case, for example, if all doctors were of the same social class, attended philosophically similar schools and came from families of similar backgrounds. There is, of course, no certainty that GPs share in such broad patterns for any identifiable reasons, though the randomly chosen GPs interviewed in this research tended to come from similar (older) age groups.

Some may argue that a population whose average IQ is so skewed would be likely to act in an individualist, unpredictable and inconsistent manner and that

no amount of generalisability is possible. This argument may be supported by reference to the large proportion of solo practices, particularly in the Illawarra (40%) (*Illawarra Division of General Practice Annual Report, 2004*). However, it may be that GPs as a group tend to favour solo practices as an efficient and effective means to conduct business; an argument unable to be sustained by the data in this case.

Some argue that data lose meaning once abstracted from their context (Sim and Wright, 2000, p74). To avoid this risk each interview allocated approximately equivalent time for contextualisation as for the case study. Attention to contextualisation, its recording and linkage to other data is essential not only for a meaningful study, but also for one whereby readers can decide for themselves how generalisable the findings are.

In summary, the study was a retrospective qualitative study conducted by a researcher with a close understanding of the context of the participants using technical measures to minimise transcription errors.

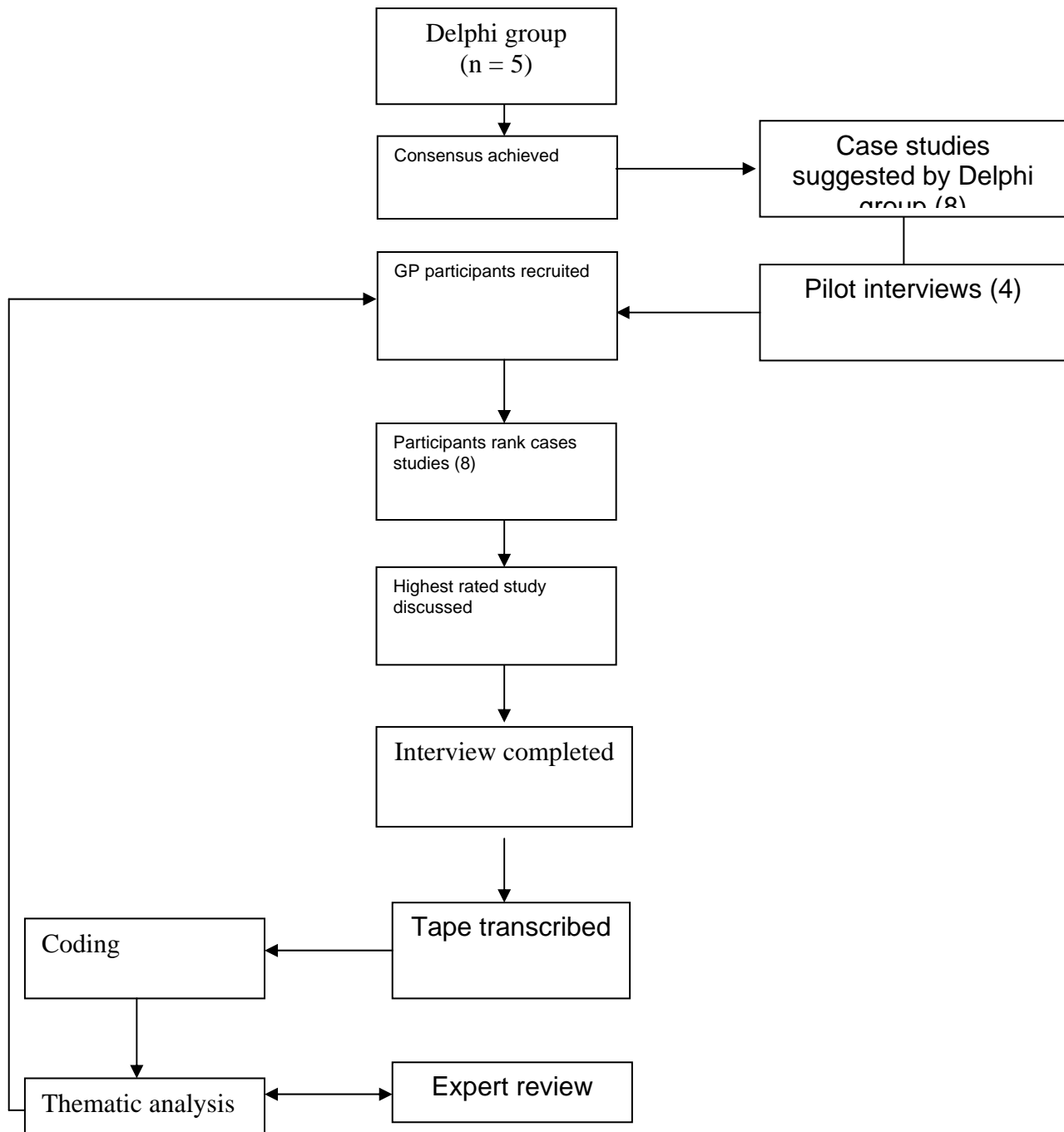
## **4.6 Study outline**

Consent was gained from the Human Research Ethics Committee of the University of Wollongong.

The following sections describe the processes involved in determining the topics for the case studies, recruitment of participants and conduct of the interviews. This process is depicted in Figure 4.1. As demonstrated, the process involved development of case studies assisted by a Delphi group of academic GPs, recruitment of GPs, prioritisation by GP participants over time, interview,

transcription and analysis, in a cyclical fashion. With time, the number of case studies was refined to ensure that the most important changes experienced by GPs were identified and explored.

**Figure 4.1** Overview of the intended study methodology



#### ***4.6.1 Study instrument***

The case study was chosen as an instrument to trigger discussion on a topic of importance to the participant GP. The case study is a familiar format of learning for the GP, a fact which was expected to encourage active participation.

The use of case studies is described by Marshall and Rossman as being used in qualitative research “with the purpose of describing an organisation or a subculture.” (Marshall and Rossman, 1989, p44). In particular, case studies are “employed for the purposes of exploration” (Sarantakos, 1998, p192). Case studies permit a richness of detail and a depth of analysis (DiCenso, 2001). However, in the context of this thesis, the case studies used constituted what Stake describes as “collective case study” (Stake, 2000, p437) whereby the case itself is not directly the subject of research rather that examination of the individual cases are expected to lead to an understanding of a larger picture and enable “better theorising” (Stake, *ibid*). This is a different perspective to the argument adopted by Sim and Wright who suggest that in using the case study we do not seek to understand other cases. However, there is agreement in that the representativeness of findings is “theoretical, not statistical” (Sim and Wright, 2000, p278; Mays and Pope, 1995).

Such an argument means that a number of cases are required to be studied but does not assist in determining just how many that number is. In the first design, it was intended to restrict the number of case studies to four to allow adequate data collection to provide a richness of description whilst enhancing generalisability, given that generalisability is not the main goal of the study. The number could not be too large as that would have mitigated against comparing and



categorising replies. In their study of models of chronic disease management in Australian general practice, Martin and Rohan successfully used four case vignettes with a total of 16 GP participants (Martin and Rohan, 2002).

Case study selection is a critical component of the methodology. Certain criteria are identifiable from literature. Denzin and Lincoln assert that the case must be specific, though it may be complex and it may be a system. In any event it exists in relation to its environment (Denzin and Lincoln, 2000, p436). It must always be borne in mind that, in this thesis, the particular case is not the subject of study. The subject of the study is the means by which GPs responded to change and what effects change has on those GPs. The final criteria for case selection are detailed in A.4.4.

#### ***4.6.2 The Delphi group***

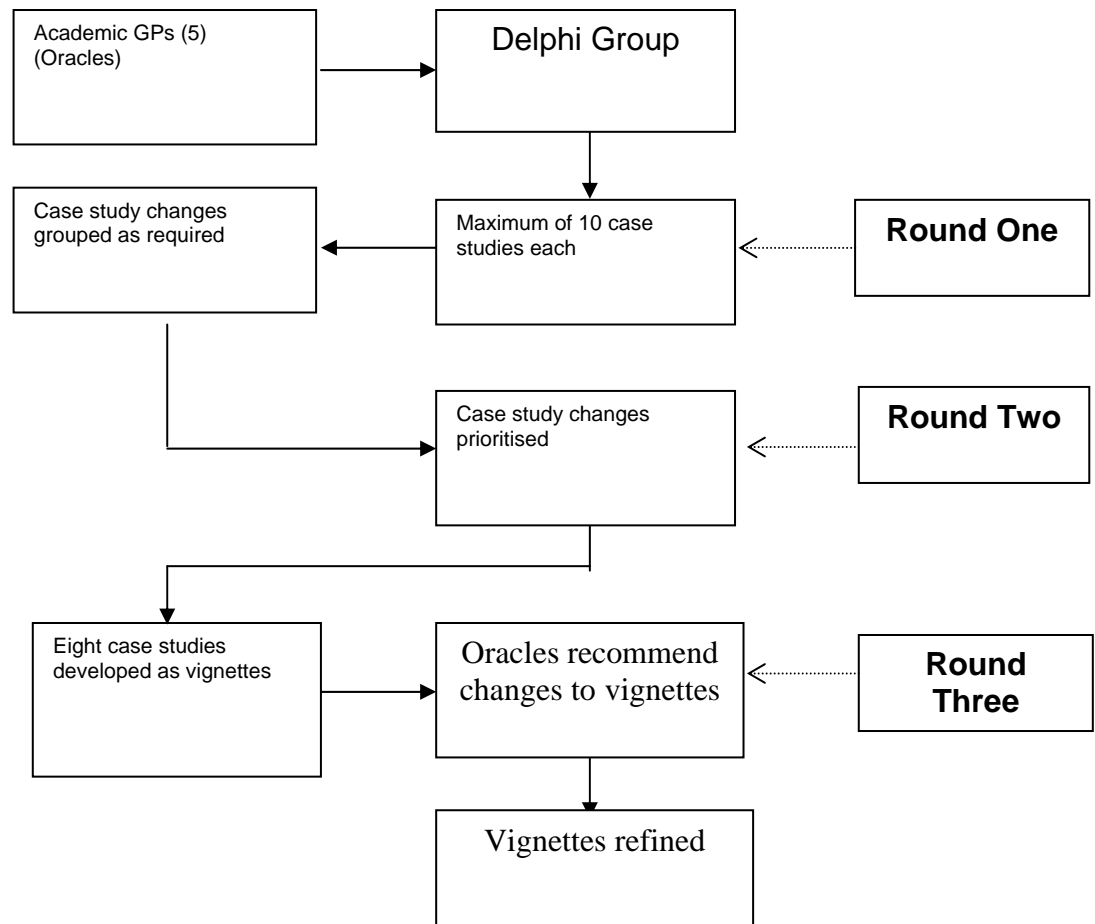
As the methodology was originally designed, the theme and content of the case studies was to be determined by a Delphi group. Elites (or oracles) are ‘the influential, the prominent, and the well-informed people in a...community’ (Marshall and Rossman, 1989, p94). A danger in seeking the advice of experts in this manner is that they may have a perspective which is inherently different to that of the “average” participant (Martin and Rohan, 2002). The Delphi group provides a means to avoid dominance of personalities (Jones and Hunter, 1995) which may occur for example in focus groups, and maintains anonymity (Kilmartin et al, 2002). While Delphi groups have been used to give a consensus opinion with respect to a question or topic (Sim and Wright, 2000, p80), in this study the Delphi group was asked to determine the case studies used to answer a question or inform on a topic.

The Delphi group consisted of one general practice academic from each of the mainland states. Each oracle was identified by Prof Mark Harris of the University of New South Wales School of Community Medicine, a person well recognised nationally in health service research. Each oracle was recommended on the basis of expertise in the topic (Sim and Wright, 2000, p80). Of the 5 oracles, three were male, four were medical practitioners and one was a full time academic with extensive experience in general practice research. Oracles were each telephoned by the researcher and invited to participate. None declined the invitation. An outline of the study was then forwarded by e-mail, together with a consent form.

Of the four cases requested of the Delphi group, two were designated “impulse” cases, ie cases that had occurred over a single or brief period of time. The other two cases were designated “longitudinal”, i.e. cases that had no clear start or end points of change. Longitudinal cases were intended to be utilised if GP participants had not been in practice at the time of an impulse change. (Details of the definitions of cases for the Delphi group may be found in A.4.5).

The group met by e-mail over three “rounds” or iterations (Jones and Hunter, 1995; Campbell et al, 2003). They were given a week to respond in each round as the process was not considered time critical (McMurray, 1994, p64). The process by which the Delphi group worked is depicted in Figure 4.2

**Figure 4.2**      **Process of case selection**



In round one, the group was asked to “list up to five non-clinical impulse changes in general practice and up to five longitudinal changes that most GPs have had to respond to, at that time, within the last thirty years.” Oracles replied by e-mail. Similar changes were grouped.

In round two, the oracles were asked to prioritise all of the changes by a simple ranking process according to the four criteria detailed in A.4.4. However, the changes identified by each individual oracle in round one, were excluded from the list supplied to that oracle. This meant that each oracle prioritised only the

other oracles' suggestions. Again, oracles replied by e-mail. Results were aggregated and the four changes (two impulse and two longitudinal) with the highest rankings were then chosen for case study development. Case studies focusing on those changes were then drafted. Criteria for a case study were that:

1. The major themes of the case in question are identified.
2. Statements are able to be justified by reference to literature.
3. Views expressed are balanced.
4. In round three, the draft case studies were e-mailed to the oracles. The oracles were invited to suggest changes. These modifications informed the final drafting of the vignettes.

#### ***4.6.3 Modifications to the process of case selection***

The Delphi group produced four examples of changes in General Practice. These were developed into vignettes (case studies) to present to GPs. In round three oracles made suggestions to improve the vignettes.

It was the intention that those cases be presented to GPs in face to face interviews so that each GP had one case study to consider (Figure 4.1). However, during pilot interviews (Sarantakos, 1998, p291) it became evident that some of the cases chosen by the Delphi group were of little relevance to GPs. Therefore, a second set of four cases was derived from the literature (specifically from Chapter 2) to give a broader array of case studies to present to GPs to ensure that all cases were relevant to, and of interest to, participant GPs. Only one case was common to the two sets, that being "Computerisation". Accordingly, the next highest prioritised case (from literature), "Introduction of practice accreditation", was added, which brought the total number of case studies to eight.

Table 4.1 indicates the relative priorities given to the case studies by the Delphi group and by the environmental scan (cf p103)

**Table 4.1** *Prioritisation of cases confronted Australian GPs*

<b>Changes identified by literature</b>	<b>Changes identified by Delphi group</b>
Red tape	Bulk billing
Medicolegal litigation	Introduction of vocational registration
Computerisation	Feminisation of the GP workforce
Introduction of quality incentives (e.g. PIP)	Computerisation
Introduction of practice accreditation	Establishment of Divisions of General Practice

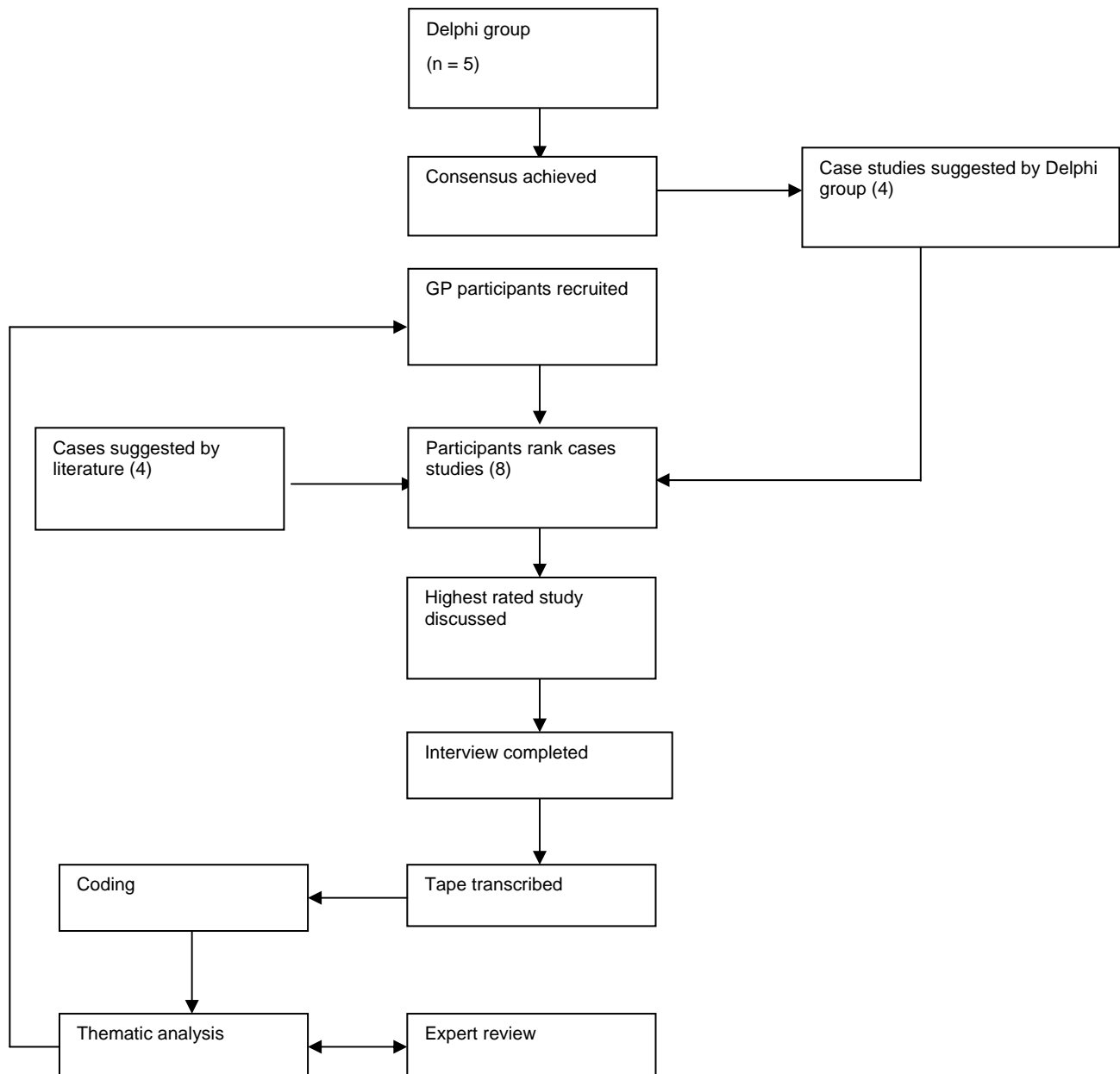
Table 4.1 demonstrates that there was no close alignment between the identification and prioritisation of changes indicated by literature and those indicated by the Delphi group. Reasons for this are discussed in 11.3.3.

The final study methodology was therefore different to that originally planned and is presented as Figure 4.3

#### **4.6.4 Participant ranking of case studies**

Prioritisation by the GP participants themselves occurred as a simple ranking exercise during the face to face interview. GPs were handed a piece of paper listing the eight changes identified by literature and by the Delphi group (A.6.3). They were then asked to place a number between 1 and 10 indicating the importance of the change to them (1=of no importance, 10=overwhelmingly important.)

**Figure 4.3 Revised study methodology**



The final list of changes for which vignettes were written and presented to participants is detailed in Table 4.2.

**Table 4.2** *Changes presented as case vignettes to GPs*

	<b>Case study of change</b>	<b>Source</b>
1	Increasing red tape	Literature scan
2	Increasing medicolegal litigation	Literature scan
3	Introduction of quality incentives (e.g. PIP)	Literature scan
4	Introduction of practice accreditation	Literature scan
5	Computerisation	Literature scan/ Delphi group
6	Introduction of bulk billing	Delphi group
7	Introduction of vocational registration	Delphi group
8	Feminisation of the GP workforce	Delphi group

## **4.6.5 Recruitment of GPs**

### **4.6.5.1 Sample frame**

An emic perspective of the environment of the participant assists in maintaining a valid interpretation of data (Kellehear, 1993, p21; deVaus, 1995, p6). As a researcher who has practiced as a GP in two distinct regions, it seemed to be advantageous to seek participants from those regions so that the process of contextualisation would be made simpler thereby expediting the study itself (Bulmer, 1998, p157) and increasing the accuracy of the analysis. Those regions are the Illawarra and Shoalhaven regions of New South Wales. The former contains the regional centre of Wollongong in which I work as a health administrator. The latter is an adjacent rural area. A decision to recruit GPs from these two areas was favoured by the fact that the two areas allowed an excellent geographic spread which included city based GPs, suburban GPs and rural GPs.

GPs in these two regions are represented by the Illawarra and Shoalhaven Divisions of General Practice.

#### **4.6.5.2 Sampling technique**

Qualitative sampling strategies generally do not seek to identify a representative sample of a population (Pope et al, 2000). Though “relatively uncommon in qualitative investigations” (Mays et Pope, 1995) sampling of GP members of each Division was random. This technique was used to remove the investigator from any suggestion that “willing colleagues” were favoured for interview which may have been the case had a purposive sampling approach been taken.

#### **4.6.5.3 Sample size**

Qualitative sample size is determined by data saturation (Schneider, 2003, p174) and the resource limits of the researcher. An expanded sample size may only achieve a more cumbersome dataset (Pope et al, 2000). For these reasons the sample size was determined by data saturation or upon reaching a maximum of 24 interviews. Data saturation was defined by an assessment that no further substantive evidence had been gained from four consecutive interviews.

The sample was stratified on a Division of General Practice basis; the Illawarra having approximately 2.4 times the number of GPs (220) relative to the Shoalhaven (90). Accordingly, a maximum of 17 GPs were to be recruited from the Illawarra and 7 from the Shoalhaven.



#### **4.6.5.4 Sampling**

The Board of each Division was asked to support the research by permitting a staff member to generate a random list of GP member names utilising the random number generating function of Microsoft Access. To allow for a high rejection rate, a list of 50 GP names was generated for the Illawarra and 22 for the Shoalhaven.

Table A.6.2 lists the types of practices represented by recruited GPs.

#### **4.6.5.5 Gaining agreement to participate**

Selected GPs were requested by mail (May, 1997, p89) to participate in the study (as detailed in A.6.1). It was intended that two letters per week be posted to ensure that the number of replies was consistent with my capacity to conduct interviews. This was unrealistic as transcription and analysis of the data, conducted following each interview, markedly exceeded this timeframe. To maximise response (McAvoy and Kaner, 1996), a week after posting, a follow-up phone call was made to answer any questions, inform the GP that interviews would be taped and to seek consent for participation. Where consent was gained a time and place was determined by the participant for the interview to be conducted. No incentives were offered to encourage participation, though after the interview participants were presented with a University of Wollongong key ring as a token of gratitude for participation.

Of the 72 GPs identified by random selection 16 (22%) could not be traced through the telephone book while six (8%) failed to return phone calls and only 2 of the 22 GPs approached (9%) declined interview. It was intended to conduct the

interviews in the “natural environment” of the participant (Sarantakos, 1998, p194). One interview was conducted in the GP participant’s home, one in the Division office and the remainder at the participants’ clinical premises.

#### ***4.6.6 The interview***

The survey format was face to face interviewing. Face to face interviews have disadvantages in that they render anonymity impossible and that they, unlike questionnaires, cannot be conducted at the leisure of the participant (May, 1998, p90). Anonymity may be less important in cases in which there is little revelation of personal beliefs or failures. May specifies “ethically or politically sensitive issues” as being relevant in consideration of anonymity (May, 1998, p90). Business management fits neither of these categories but may nonetheless have been an issue had the researcher been seen as a competitor.

Face to face interviews allow the interviewer to gain detailed replies, either directly or with encouragement, and to explore appropriate issues. A semi-structured process means that any such exploration does not simply wander (Britten et al, 1995, p106). Whilst in-depth interviews are useful to gather large amounts of ethnographically important data (Marshall et Rossman, 1989, p82; Babbie, 1998, p290) a semi-structured technique was important in this case as I needed to acquire specific information as detailed later. It also means that the participant’s perspective was not dominated by that of the interviewer which may occur in a structured interview, such as a questionnaire (Marshall et Rossman, 1989, p82) or limited to a small number of responses (Denzin et Lincoln, 2000, p649). Face to face interviews also permit the encouragement of replies through

physical prompts such as a nod or a smile, techniques not available to the phone interviewer. May suggests the face to face interview encourages a high response rate (May, 1998, p91) and others that it facilitates the important characteristic of the interviewer, namely that of interested listener (Denzin et Lincoln, *ibid*, p650). Structured interviews tend to be oriented toward pre-coded responses making the process of coding and analysis much simpler. However, the loss of context and richness of detail are too great a price to pay in an environment as complex as general practice. Nor can a structured interview format be modified based on analysis of prior interviews (Rubin et Rubin, 1995, p43).

A GP's response to the rating scale initially determined which case study would be discussed in that interview, in that the highest rating case was selected. In the case of data exhaustion the next highest prioritised case that was not exhausted was selected. In the situation that two cases shared the same priority as rated by the GP, the case less-utilised was chosen for discussion.

#### **4.6.6.1 Conduct of the interview**

In interviewing the participant GP, approximately half of the interview was spent exploring the GPs' experience of and attitude toward change, so that the discussion of the case study occurred within an identifiable framework. It is held that contextual understanding is important in understanding the behaviour which is expressed within the "context of meaning systems employed by a particular group" (Bryman A., quoted in Baum, 1995, p463).

#### **4.6.6.2 Interview structure**

The interview itself consisted of four sections, somewhat similar to those as per Williams, 1997 (pp82, 83): factual, attitudinal, social psychology and explanatory (followed by a verification phase).

##### **Introduction**

In introducing myself I reiterated the content of my letter of introduction to remind the GP of the context and purpose of the interview and of the thesis itself. This may have assisted to create a collaborative environment (Minichiello et al, 1990, p109) and to gain the trust of and rapport with the participant (Denzin and Lincoln, 2000, p655; De Vaus, 1995, p3).

The interview structure was then explained and written consent gained. The participant was then informed of the how long and where their data would be stored, and that questions or concerns following the interview could be directed to my supervisor. Time was made available for questions concerning privacy, consent or confidentiality (Denzin and Lincoln, 2000, p662). The participant was then asked to complete the “Participant Rating Sheet” which listed the changes determined by both the Delphi group and from literature (Chapter 2). The highest rating case study was chosen for discussion except in the case where that study had already been used on five occasions.

In recognising the importance of confidentiality (Britten, 1995, p110) the participant was invited to choose two random letters by which she/he could be referred during the interview process in order to maintain anonymity. For example one participant was known as “Dr MN” to the transcriber.

### *Professional (factual) context*

Simple introductory structured questions eased each of us into the interview and their answers allowed me to relate this participant to other participants (Minichiello et al, 1990, p122) and contributed to a larger picture of the sampled population thereby enhancing generalisability (Britten et al, 1995, p 110). Those questions were:

1. What year did you commence general practice?

This question enabled me to understand how much experience participants had had in general practice.

2. Are you a vocationally registered GP?

This question helped to establish that the participant had an understanding of the implications of vocational registration, particularly the requirement for CPD.

3. Do you have any formal qualifications in business (or general practice) management?

This question helped to establish the qualifications each of the participants to assist in the development of their general practice businesses.

### *Attitudinal context*

During this phase data were gathered to assist me to understand more about the participants in the study cohort. Structured questions were asked in order to focus participants' answers. The label "attitudinal" was not meant to imply a psychological examination of the participant. It merely described the participants'

attempts at describing some of their perspectives on general practice. Those questions were:

1. What do you believe are the strengths of general practice?
2. What do you believe are the weaknesses of general practice?
3. What do you believe you have to offer in your practice as a GP?
4. What do you believe you gain from your practice as a GP?

These questions were semi-structured in order to place a certain degree of structure around what otherwise is a very broad and largely unexplored field. The semi-structured questions were aimed to give participants something to focus on in discussions. Higher order questions such as “What do you think about general practice?” and “How do you see yourself in relation to general practice?” may have been a more grounded approach but may not have been suitable to allow GPs to frame their thoughts.

#### *Historical (factual) context*

In this phase I attempted to elicit a picture of the GPs’ experiences of general practice thus giving each participant’s approach to the case study an historical background (Stake, 2000, p438). The single question asked in this phase was:

1. How would you describe how things have changed in general practice while you have been in general practice in Australia?

In addition, the question allowed the participant to turn her/his mind to the next issue, that of the case study.

#### *The case study (explanatory phase)*

The vignette was read to the participant. Questions were then asked, with respect to the change described in the vignette, to determine the GP's:

- interpretation of the change event
- description of actions taken in response to the change event
- interpretation of the effectiveness of the change processes instituted
- description of how the change affected the practice
- description of how the change affected patient care
- description of how the change affected the GP herself/himself.

Whilst questions unique to each case study were detailed in my notes, they acted more as prompts to ensure no part of the case study remained untouched.

A transcript of one interview is included as A.7.1.

#### **4.6.6.3 Number of interviews**

The methodology allowed for the number of interviews to be determined by saturation, ie the point at which no new information was being obtained. (Sarantakos, 1998, p204). In consultation with my supervisors it was agreed that saturation had been reached by the twentieth interview. Saturation was defined as the absence of further contributory data. Identification of the stage of saturation was enhanced having coded each interview immediately following its transcription and before the next interview was conducted. After the sixteenth interview no new categories were added and further interviews only served to reinforce previous information and the coding frame.

#### 4.6.6.4 Changes to the interview process during the conduct of the thesis

A number of modifications were made to the methodology either because of need, lack of relevance or because of circumstance (De Vaus, 1995, p20). Changes followed periods of circumspection and review, particularly as analysis of interviews progressed.

The original interview process (cf Table 4.3) allowed for the prioritisation of case studies by the GP before the interview proper was conducted. After the sixth interview it became apparent that GPs, when answering the question, “How would you describe how things have changed in general practice while you have been in general practice in Australia?”, may have been giving replies biased by having been exposed to the list of changes suggested by the Delphi group and those suggested by literature. To remove any bias, the “Attitudinal context” and “Historical context” questions were asked before the GP was requested to prioritise the changes.

**Table 4.3** *Changes to the interview schedule*

<b>Original interview schedule</b>	<b>Final interview schedule</b>
Introduction	Introduction
Professional questions	Professional questions
Prioritising of changes identified by Delphi group and by reference to literature (Chapter 2)	Attitudinal questions
Attitudinal questions	Historical question
Historical question	Prioritising of changes identified by Delphi group and by reference to literature (Chapter 2).
Case study	Case study
Verification phase and close	Close

Table 4.3 demonstrates that the interview schedule was altered so that the prioritisation process did not bias answers to attitudinal or historical questions.



#### **4.6.6.5 Changes to the number of case studies during the conduct of the thesis**

After the first ten case studies it became apparent that there was a cluster of five case studies that were rated more highly than the remaining three. As it was important that participants had been meaningfully involved in the process of change (and therefore in the interview) the three lowest rated case studies were excluded from the list of case studies for discussion. However, they remained on the prioritisation list in order to gain an accurate picture of the reliability of the two sampling methods used to determine the case studies. At the 15<sup>th</sup> interview only the four highest ranked changes were included. In this way the number of vignettes was refined to four, namely Red Tape, Litigation, Computerisation and Practice Accreditation.

#### **4.6.6.6 Changes to the verification of case studies during the conduct of the thesis**

In attempting to verify participants' responses I had elected to use a "benchmark" case study that would be common and current to all interviewees. This case study was the introduction of a package of incentives called "Medicare Plus". However, in the existing political climate, the government changed the package three times in rapid succession, largely in response to political pressure. Thus Medicare Plus came and went well before the interviews were completed.

However, there is a strong sense that verification in this study was unnecessary. Very early on it became apparent that GP participants were consistent as a group in their replies to questions concerning non-clinical changes. Without embarrassment or hesitation the entire group gave little indication that

they considered themselves in any way as masters of change. There was no suggestion of hyperbole and certainly none of falsehood. This may raise some concerns that, under these circumstances, understatement may be a problem; however the consistency across the group is reassuring on that point.

#### **4.7 Transcription**

Transcription was performed by an experienced transcriber. The transcripts were then imported into NVivo and each participant's identifier was altered to a single letter in alphabetical order, so that the first doctor interviewed became identified as Dr A and the last, Dr U.

#### **4.8 Coding and analysis**

Coding was assisted by the systematic identification of analytic categories using the software package Nvivo, (Pope et al, 2000, p114) thereby assisting a qualitative methodological approach to analysis (Mays and Pope, 1995). Coding commenced after the first transcript was received and was modified with each subsequent transcript. Themes were identified or reinforced as each transcript was received. In this way, a long list of themes was devised.

Following the completion of the eleventh interview, some days were spent in retreat reviewing the process of coding. At this time the existing coding framework was abandoned as too many codes threatened a meaningful process of analysis. Coding then became a matter of forming a coding tree with branches based upon the phases of the interview process (factual, attitudinal, historical,

explanatory and verification). From these phases, and with the knowledge imparted by the previous coding attempt, a more pertinent list of themes was devised (An example of the final coding frame is included as A.7)

One criteria for selection as a theme was frequency. This meant that transcripts had to be repeatedly reviewed once it was thought that a certain issue may be appropriate to be listed as a theme. A further criterion was that the theme must have been important to those participants alluding to it. This also required repeated review of past transcripts – a task that became less frequent as the number of transcripts increased and as more themes emerged.

Pertinent quotes were used repeatedly as examples of multiple themes where appropriate. However, as far as possible, quotes have not been repeated in the analysis section of the thesis. The coding frame was not tested by my supervisors, or by any other experts, in a blinded process. However, in meetings with the supervisors, the themes were reviewed as the transcriptions were explored jointly.

It was at this stage, too, that the first steps in analysis occurred reflecting the qualitative practice of cyclical planning, data collection and analysis (Britten et al, 1995, p107; Schneider et al, 2003, p171). At that time the four stages were identified as a means upon which to analyse the data. Those stages were: an analysis of the participants' comments about themselves (Chapter 5), identification of changes (Chapter 6), an analysis of the way GP participants responded to change Chapter (7), and the impact of change in terms of GP lifestyle, the practice itself and of patient care (Chapter 8). Those chapters, therefore, began to take shape sequentially after the eleventh interview.

Chapter 5, *The GP facing change*, represents an analysis examining the views expressed by the participants. However, the analysis was not overly demanding as participants would generally express their views in strong and emotive terms. This tended to make thematic analysis somewhat easier than may have been the case with less forceful participants. Chapter 6, *Changes reported by participant GPs*, represents a simple process of describing and justifying the changes that had the greatest number of quotes under each thematic heading. Chapter 7, *The response to non-clinical change*, represents an analysis in which responses have been clustered under headings broader than the vignettes. This allowed “an understanding of a larger picture and enable ‘better theorising’” which is possible when case studies constitute a “collective case study” (Stake, 2000, p437). This collectivism is strongly reflected in Chapter 8, *The impact of non-clinical change*, in which impact of change is examined in the context of the GP, the practice and the patient.

Sarantakos identifies 5 stages of data analysis (Sarantakos, 1998, p321). These are Transcription, Checking and editing, Analysis and interpretation, Generalisation, and Verification. Chapter 9, *Conclusions*, is a chapter in which generalisations are made from the analysis of the content and its themes. It therefore represents an analysis of chapters 5,6,7 and 8 rather than of the original data. The use of original quotes becomes less common as conclusions are drawn and recommendations made on the basis of those conclusions. Those recommendations form Chapter 10.

## **4.9 Concluding remarks**

A largely qualitative methodology was chosen for an area of research that has received little attention and which is complex in nature. Vignettes of case studies were the vehicle by which data was gained from participants in face to face interviews. Nvivo provided the means to develop an adequate framework for data analysis, the subject of Part B of this thesis. Analysis led to a generalisation stage so that the three main questions of the thesis could be addressed, viz,

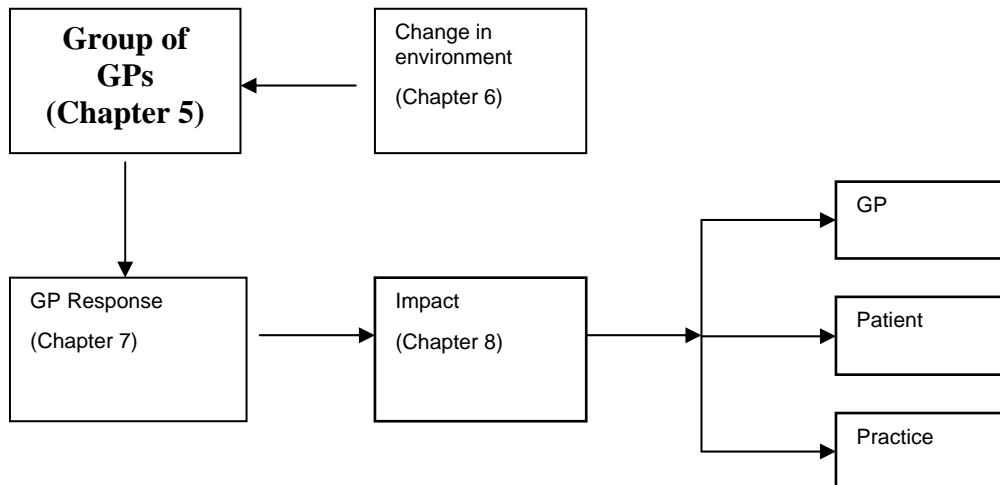
1. What non-clinical changes have been experienced by a cohort of Australian GPs?
2. How has a cohort of Australian GPs responded to change?
3. How has change and the way a cohort of Australian GPs have responded to it, impacted on the GP personally, on the practice as a whole and on health outcomes for the patient?

# CHAPTER FIVE

## The GP Facing Change

### 5.1 Introduction

Chapter 5 presents a picture of the GP participants as a group. It provides an important perspective of a group of people upon whom change took place. With reference to Figure 1.1, it can be seen that an examination of the GPs who have experienced change is the first step leading to an understanding of the impact of change on the participants.



In so doing Chapter 5 answers the question, “Who responded to the changes?” To start to answer this question this chapter will describe the demographics of the GP participants as a group, it will then describe their perspective of important issues in Australian general practice and will end with a description of their own attitudes about themselves as doctors working in general practice. Chapter 5,

therefore, provides a foundation upon which to better comprehend why participants placed emphasis on particular changes (Chapter 6), why they responded to change the way they did (Chapter 7) and why the impact of change has been so profound (Chapter 8).

## **5.2 The participant GP**

The formal structured questions from which data were gained for this section were:

4. What year did you commence general practice in Australia?
5. Are you vocationally registered?
6. Do you have any formal qualifications in business or general practice management?

### ***5.1.1 Participant age***

In order not to offend participants, GPs were not asked their age. However, the 20 GPs had been practicing for a mean period of 21.8 years, equating to an average age of approximately 49 years (using the assumptions of undergraduate admission at age 18, six years in Medical School and three years postgraduate training). This figure is remarkably close to the average age of Australia's GPs in 2002 of 48.9 years. This is also equal to the average age of GP participants in a focus group study by Oldroyd et al (2003, p30) and two years older than GPs participating in the study by Girgis et al (1999) which had an age range of 28 to 70 years. Age groupings are demonstrated in Figure 5.1

**Figure 5.1**      **Approximate age distribution of participant GPs**

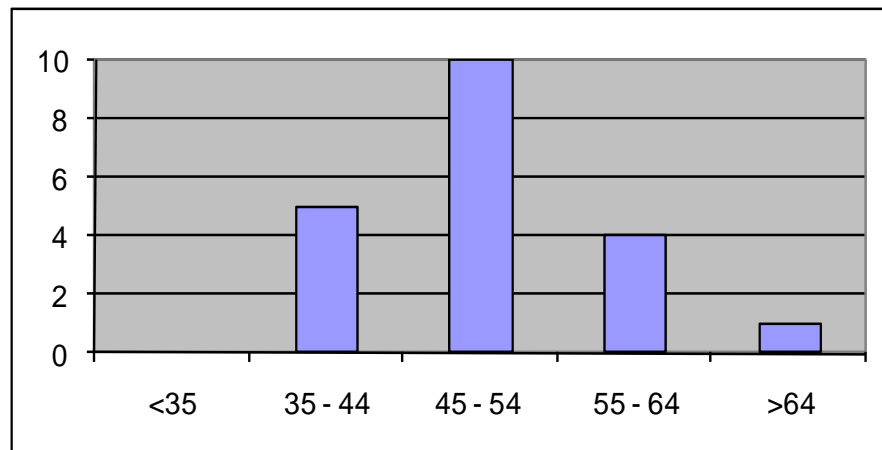


Figure 5.1 demonstrates that, participant GPs' ages were tightly clustered around the mean. Reference to Figure 2.3 will demonstrate that the spread of all Australian GPs is less tightly clustered around the same mean. In particular the age groups 35 – 44 and <35 years are under-represented in the sample population. The polarisation of this sample group may therefore have had biasing effects on the study in that younger GPs may have different experiences of change and may respond differently to it.

### ***5.1.2 Gender***

Four participants were female and 16 were male. Despite the fact that the majority of Australian female GPs are employees (p39) all 4 female GPs interviewed were partners within their practices. This introduces a further possible bias in that the part-time disempowered female GP depicted in 2.6.2.3 found no equivalent in this cohort.



### ***5.1.3 Vocational registration***

All GPs interviewed were vocationally registered and were therefore required to maintain their CPD and QA activities.

### ***5.1.4 Business qualifications***

Only one GP, a female, had qualifications in business or general practice management, that being a Postgraduate Certificate in Practice Management.

In summary, the participant group may not have offered the same perspectives which have been given by younger GPs or of female GPs employed by practices. However, all participants were old enough to have experienced many changes in general practice. Of interest, all worked in private businesses whilst only one had business qualifications.

## **5.2 Participants' views of general practice**

It is important to understand the perspective of the participants about their profession in order to understand their response to changes and how those changes impact. Therefore, the analysis presented in the remainder of this chapter draws directly from statements made by the participant GPs in response to questions from the Attitudinal Context sections of the interview structure (p144). The key questions were:

1. What do you believe you have to offer as a General Practitioner?
2. What do you believe you gain from General Practice?
3. What do you believe are the strengths of Australian General Practice?
4. What do you believe are the weaknesses of Australian General Practice?

The analysis also draws from the total interview record. Replies were coded using Nvivo and the nine most frequently occurring themes are categorised below. It is important to note that this table of *themes* does not necessarily relate to the participants' perspectives of specific *changes* in general practice, though some correlation could be anticipated.

Almost all participants regarded remuneration as important to them. Fifteen participants expressed a desire for autonomy and almost as many expressed a desire to provide quality care. Just over half criticised the new standards including Accreditation and Vocational Registration. Nine of the eleven participants criticising the new standards expressed a desire for changes to be associated with improvements in quality of care.

Eleven participants regarded relationships developed through general practice and through continuous patient care as important, though only five who valued these relationships also expressed support for continuity of patient care. This suggests that relationships within general practice but not necessarily related to patient care, were important to these GPs. This, in fact, proved to be the case whilst the emphasis of relationships, it will be shown, did not often extend to the GP's family.

Eight GPs expressed a desire for affirmation by patients whilst almost as many felt isolated but there was little cross over between the two groups. All participants who felt isolated valued their autonomy and all but one expressed feelings of helplessness in the face of change. This suggests that autonomy comes at a terrible cost.

Participants' strongest views on general practice focused on remuneration, quality of care, the introduction of new standards in general practice, relationships within general practice, and their clinical role.

### ***5.2.1 Participants' views on remuneration***

In answer to the question, "What do you believe you gain from your practice as a GP?" the most common response concerned income. Most participants bemoaned their perception of a low remuneration and rising practice costs. These will now be discussed in more detail by examining what participants thought about the amount of income they received, how they charged, and how they viewed overheads.

Whilst most participants felt their income was inadequate, 3 (male) participants saw income as the prime gain derived from practice. Four GPs compared their income to others in the medical workforce, as typified by Dr K:

*One would be the bridesmaid perception within the medical fraternity, I believe, of general practice as the poorer brothers*

Generally, perception of income was that it was inadequate. If that is indeed the case, GPs may have been primed to explore the new incentives offered by the Commonwealth.

Due to concerns about remuneration, those participants who had continued to bulk bill generally expressed some degree of dissatisfaction with the outcome. Most participants blamed what they reported as a low consultation fee for their relative poor income (as they perceived it). The result could be overservicing, an outcome unwelcomed but not unexpected by participants, including Dr B:

*I think, if they give us a reasonable consultation fee, we might reduce this over-servicing. I think some of the doctors are chasing the dollars because they are paid so little for a standard consultation, so they, in my opinion, they tend to see them again.*

In general, those participants who bulk billed did so for one or a combination of three reasons, including the need to keep overheads down, the threat that patients would attend elsewhere, or for altruistic reasons. Whilst a large minority of participants bulk billed exclusively, most had abandoned that option. Inadequate consultation fee was the main driver. Apart from concerns about patient access GPs who had abandoned universal bulk billing felt satisfied about their decision.

Whilst income per consultation was of prime importance, rising costs were also viewed with concern by participants. Increases in practice overheads were reported to be related to medical defence costs and the cost of meeting “red tape” requirements:

*If we fulfilled every requirement that the College wants, we'd simply go broke.*

Dr L

Whatever the reason, rising costs meant that efficiencies had to be made elsewhere. For some this meant working in larger practices. As sharing overheads is one means of reducing overheads, participants may have been primed to amalgamate with other GPs in the same way that participants may have been primed to adopt the new incentives in order to increase income. Perhaps concerns about remuneration had primed participants to accept the changes that were to come.

### ***5.2.2 Participants' views on quality***

Participants' perceptions of quality of patient care will be discussed independently of their perceptions of standards. This is due to the fact that recent standards introduced by the Commonwealth were, in most participants' thoughts, unrelated to quality. Accordingly, the next section (5.2.3) describes participants' perception of the use of standards and incentives as well as the outcomes generated from those standards.

This section (5.2.2) will establish that quality care was important to participants, will identify barriers which were reported to restrict the provision of quality services and will describe what participants saw as the outcome of the introduction of "quality incentives".

Quality of service provision was a determinant of the pride participants took in their work, as described by Dr J:

*Most of the time I get professional satisfaction from feeling I have managed patients appropriately and that I have improved something and the odd one where I make a very significant difference.*

Quality was reported as an important filter through which participants viewed the Commonwealth's reforms. However, bulk billing and the consequent pressures on throughput were seen as a challenge to delivering quality services. There was an important conflict noted between providing quality services and allowing access. In other words, as the workforce had dwindled and as the population aged, participants were experiencing for the first time the tension between good and quick, something they culturally struggled with.

It therefore appeared that unless participants were satisfied about the quality of a reform they would support it only in principle. The practice was deemed to be more important than the principle in that the gloss of quality incentives was greatly diminished by the associated red tape, as typified by Dr E:

*...but all of this blended payment, I mean the philosophy behind it is, I think it's reasonable. You know, quality service being rewarded. But all of that quality is wiped out by the amount of paperwork and the constraints that are put upon you.*

In general, participants suggested that the quality reforms were introduced at a difficult period of general practice, challenged notions of access and clashed with existing business cultures within practices.

Not only had the timing for reform been regarded as poor but, more importantly, the Commonwealth's attempts to improve quality were generally regarded as a failure. Indeed, there was a very strong perception that the "quality incentives" made no difference to the quality of patient care, with some exceptions:

*I think I'd probably successfully do more flu vaccines for example. I've probably done more Hepatitis Bs for 10 year olds than I would have. I guess I haven't measured it explicitly, but I'm sure it's true.*

Dr Q

In summary, most participants resisted changes where they did not see improvement in the quality of patient care, as distinct to the quantity of patient care. These were, however, anecdotal opinions only, which nonetheless suggest a need for measurable performance outcomes for general practice rather than

throughput measures. Outcome measures would enable the Commonwealth to determine if, in fact, the quality reforms did improve quality and whether they did so at a cost acceptable to the community.

### ***5.2.3 Participants' views on standards in general practice***

Standards and their regulation had been introduced into general practice, largely by the Commonwealth Government working collaboratively with the RACGP. Standards currently exist in the areas of vocational training, vocational registration and practice accreditation. Within the context of these interviews, the move to standards in general practice seems to have been fraught with difficulty and brought into question the direction and quality of general practice leadership. In particular, participants suggested that the GPs involved in representative groups could not represent the needs of full time GPs. This conundrum created confusion as demonstrated by Dr L:

What do you believe are the weaknesses of Australian general practice?

*I think the College of General Practice is the main.*

Because?

*I think their philosophical approach to how general practice should be operated is totally different to mine. They're setting standards that are not realistic.*

Predictably, participants expressed similar views on the introduction of a set of standards in much the same way they expressed their views on the introduction of quality incentives. As with the quality incentives, participants' recollections were

that the introduction of standards had been brought about in haste and without evidence. The end point was generally one of resistance to the benchmarking reform process, perhaps because there would seem to exist a natural relationship between the need for autonomy and an opposition to standards. However, only 8 of the 15 GPs expressing a strong desire for autonomy also voiced an opposition to the introduction of standards. This may be because the concept of standards for the profession was not an issue. What was an issue was the nature of the standards and the fact that standards were only necessary for the weakest link.

The particular standards were also deprecated where they tended to change the nature and flow of the practice in instances in which they were adopted. More often, where standards were seen to be of no benefit they were reported to have been implemented in as ineffective a manner as possible:

*The thing that I found perhaps galling about accreditation was that we were doing all those things anyway and here I was being made to pay money to tinker around the edges. I mean, suddenly we were having to draft bloody manuals and silly things which none of us. I mean I haven't read the manual since the day we put them together.*

Dr T

Of the three areas in which standards had been developed, only in the area of education and training were standards regarded favourably by participants. Although opinions did vary as to the quality of general practice training, participants generally held CPD in high regard and with some degree of pride.



In summary, participants perceived that standards had been introduced against the same background as were the quality incentives, that is hastily and without evidence. Participants were not convinced of their value for themselves but accepted them as important for some, the “weak links”. Specifically, standards were not seen to have altered care or the processes of care delivery. Participant responses do raise the question as to whether standards have improved care delivered or even the process of service delivery. If not, will this prejudice the introduction of further standards in the future?

#### ***5.2.4 Relationships***

In response to the question, “What do you believe you gain from General Practice?” most GPs (11) emphasised the importance of relationships to them. Chief among these was the doctor-patient relationship. Inherent in that relationship was continuity of care.<sup>19</sup> Accordingly these two responses (relationship and continuity) will be discussed together.

Doctor-patient relationships had been built over time and came to encompass not only the patient but also the patient’s family and sometimes the community in general. On the other hand, the importance of the relationship between the GP and their own family was mentioned by only one participant. However, the importance of relationships between GPs and their colleagues was reported more frequently.

This section will therefore describe participants’ views on the relationship between the doctor and the patient, the relationship between the doctor and his/her

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<sup>19</sup> By continuity of care I mean continual care by one doctor over a period of time. This term is used interchangeably with the term “longitudinal care”.

peers, the doctor as he/she relates to the community and finally, the relationship between the GP and his/her own family.

#### **5.2.4.1 The doctor-patient relationship**

The most common response concerned benefits derived from the relationship with the patient. The doctor-patient relationship was seen as giving meaning to the work of the GP and, in one case, the doctor-patient relationship even defined his being:

What do you believe you gain from your practice as a GP?

*Oh, life, relationships, the identity, I suppose. Got an identity with it.*

Dr N

The identity derived from the doctor-patient relationship did not seem to extend beyond the surgery. There was a sense that GPs, practicing within relationships where the power balance was so heavily skewed, developed more fulfilling relationships than they were able to outside the practice.

The critical element of the doctor-patient relationship was longitudinality as typified by Dr Q:

*I think in general practice you get to know your patients and you've got a long-term relationship with them and I think it's looking after those people in the longer term, but you get to know them and it's quite rewarding.*

Whilst a contextual knowledge of the patient was an important outcome of the relationship, a long term relationship was seen to be a therapeutic one, as if the trust and confidence engendered by the relationship were part of the healing

armoury. A second feature of longitudinal care was reported to be a thorough knowledge of the patient which could be easily applied clinically. This is consistent with findings of Gulbradsen et al (1998) who found that in about one in six consultations the doctor's knowledge of the patient influenced their management.

In summary, the evidence available from the interviews indicated that longitudinal patient care has three characteristics. It occurs throughout the time spectrum, it is "deep" at the time of the consultation and it is broad across the patient family. Its virtues were described as lying in:

5. the essential value of relationships (for both the GP and the patient),
6. accumulated knowledge of the patient's clinical problems,
7. contextualisation of patient problems within the larger family dynamic,
8. familiarity that enabled the GP to more readily identify changes in the patient's condition.

In a changing environment, however, there appear to be vulnerabilities to this type of relationship not mentioned by participants. The first of these is the role of trust which seemed to undergird the relationship and to even to generate a therapeutic effect. There is evidence from the Literature Review of chapter 3 that, in clinical terms, that trust may be misplaced. As the longitudinal relationship as described by participants often involved the broader social network of the patient, it may be that relatives or friends of the patient come to exercise the rights of an increasingly empowered consumer culture by questioning the skills and knowledge of the GP on behalf of the patient. Are GPs prepared for this? How will GPs respond if their advice is challenged in the context of a longitudinal

doctor-patient relationship at a time when fear of litigation is an important stressor. There was little evidence from interviews that participants managed doctor-patient boundaries sufficiently to protect themselves emotionally from the increasingly likely event of a challenge to their power, knowledge or skill.

#### **5.2.4.2The GP-colleague relationship**

Participants, to a lesser extent, derived support from relationships with their colleagues. Four (20%) participants found that support in working with GP spouses, whilst others found collegial support through educational or training sessions.

Personal colleague support was also to be found within the practice where that practice was a partnership:

*I have a wide range of relationships that have certainly enhanced my life.*

Through the surgery or through your colleagues, your peers?

*Oh, well, colleagues, peers, partners. I'm very fortunate to have very good partners who teach me things - generosity and other issues and also the stuff of life, you know, rubbing up against people you're committed to, it's like being in a family sometimes*

Dr P

This is consistent with literature which reports partnerships as having a direct and positive effect on GPs (Huby et al, 2002). However these closer relationships available within the partnership were not available to the one participant who worked in a medical centre. In that relationship he regarded his colleagues as

competitors who could place controls over his practice. Another solo GP also expressed the loneliness of isolated practice.

In summary, participants placed a high value on relationships with their peers. Those relationships were central to the worklife of most participants. What was not established is whether this perspective is shared by younger GPs.

#### **5.2.4.3 The GP in community**

Longitudinal care inevitably brought the GP in contact with the wider family group. It was suggested that only when a person is seen in the context of the family dynamic can they be fully appreciated in the holistic sense:

*You develop a longitudinal relationship with patients, so you, when you're treating them, you're not just treating them at one point in time, you know their past history, you know their social, family history and so you can treat them knowing where they fit into their family and community.*

Dr R

Longitudinality, then, was seen to involve the broadening of relationships from the individual patient to the wider family and even into the community. This was particularly so for rural GPs for whom this broadening relationship actually brought engagement with the community. Three rural GPs in particular reported that the value of their role extended more broadly beyond that family group into the community. If valid more generally, it raises questions about the community role of GPs working in larger medical centres shut off from the general milieu beyond. It begs the question, to what extent is GP satisfaction threatened by a declining role in the community? Most GPs, however, did not report any

relationship with the community as a result of their work perhaps contributing to the dissatisfaction in their worklife.

#### **5.2.4.4 The relationship between the GP and the GP's family**

It has been suggested that doctors who work long hours may be held in great esteem by their colleagues, but far less so by their family (Holt, 1999). By and large the families of participants did not always seem to experience strong relationships with their GP spouse/parent:

*Those are the same topics of conversation from older GPs approaching retirement that come up time and time again, of sacrificing family for the work, working long hours, the effect it's had on family and relationships and all the rest of it, the effect on children and all these things and recognising it too late and I think it has been something I've been aware of and, as much as I've tried not to let it happen, I can still see that I come home tired and irritable and sit on the couch and don't help with the kids*

Dr J

The saddest expression of disrupted family relationships was Dr C:

*My time when I go home, I'm buggered, just fall asleep. I do it upside down, so to speak. Very disorganised. I need a doctor, I think.*

Participants reporting dysfunctional relationships at home tended also to demonstrate a more generalised sense of helplessness. This theme of helplessness was to become a major theme of the thesis and, when present, tended to be present quite broadly, as exemplified by Dr H:

*By the time you leave the practice it is about 10 o'clock and then you have to do your paperwork and some medical reports, workers' compensation, CTPs and all that. Then I study and then come back to the practice the next day. Very few holidays.*

In summary, relationships of some type or another were vital to the GP but were conducted with widely differing levels of success across a broad spectrum of community. It may be that the refuge for some GPs in challenging times is to be found in the doctor-patient relationship and to a lesser extent in the doctor-doctor relationship. The importance of family relationships may have been understated by this group of participants who may have been less willing to discuss personal relationships with a researcher related professionally to them.

The observation of the strength of the doctor-patient relationship suggests that, in an era in which care is tending to become more devolved to allied health professionals through the use of reforms such as Care Planning and Case Conferencing, that relationship may also become more diffused. If that were to be the case, it would be of interest to determine whether there were compensatory shifts toward other relationships.

#### ***5.2.5 The GPs' role as clinicians***

Participants generally and almost universally expressed the conviction that they were, a priori, clinicians. For older participants, the clinical role that had once extended into the hospital was now “*reduced to the rooms*” (Dr H). But even in “the rooms” the clinical role was being eroded by other primary health care providers, “*so that people are seeking opinions from homoeopaths, naturopaths, osteopaths, rather than just from their general practitioner*” (Dr I).

Interestingly, the increasing tendency to longitudinal care was an important one in that it limited not only the opportunity to perform medical interventions, but even the challenge of diagnosis, so that the clinical substitute for acute cure had become control of the chronic condition:

*Because a lot of people, they're not here for a diagnosis, they've had that. They're just here for ongoing care, I suppose.*

Dr M

This shift in roles was manifested as a diminishing of their skill set, an issue further developed in Chapter 6.

The evidence presented was that participants believed that the breadth of the GP role was under threat from competitors and other influences to be described in Chapter 6. But if this were to be the case, there are other questions to be answered, as to what problems, if any, this competition really poses for GPs who report being overworked. Do GPs see it as a challenge to their autonomy or is it that the role is becoming more limited because others are supplanting specific areas of it? There seemed to be a sense of loss of identity as a result of others stepping into the roles some GPs thought were theirs. If such is the case then it suggests the question, “What is it that general practice does that makes it unique or defines the role of its practitioners?”

What was not under threat was the workload of the GPs. Whilst variety appeared to be diminishing, there was no suggestion that volume was.

### ***5.2.6 Summary of participants' views of general practice***

Income was important to GPs and resulted in pressures to abandon bulk billing, adopt Commonwealth incentives or even amalgamate. Chapter 7 will elaborate on how participants responded to this important driver of change. Relationships,



particularly the doctor-patient relationship, was crucial to participants' satisfaction with general practice. The doctor-doctor relationship was also important, particularly in so far as it relieved some of the isolation of practice. Little information was gathered with regard to participants and their own family relationships, perhaps because of the relationship to the researcher. What information that was identified suggested fragmented family relationships, though more so for male interviewees.

Participants had seen their roles dwindle, some couldn't recognise the work they were currently doing as singularly general practice. Only the workload had not dwindled.

### **5.3 Participants' view of themselves**

Section 5.2 described participants' perspectives of general practice in terms of the important areas of most importance to them, viz, remuneration, quality, standards, relationships and their clinical roles.

It is also important to understand the perspective participants held about themselves in order to understand the framework upon which change had occurred. At times many participants described feelings of helplessness, a desire for autonomy and a paradoxical need for affirmation and feeling of isolation.

#### ***5.3.1 Helplessness***

Helplessness, as a theme for the way in which participants viewed themselves, was coded most frequently. A total of 14 GPs made reference to feelings of

helplessness to some degree. There was a sense, from some GPs, that this attitude was embedded.

This emotion is consistent with the literature in that the threat of litigation was the major stress impactor for GPs despite the fact that it actually occurred infrequently (Shattner and Coman, 1998). What did occur frequently was media exposure of the subject. Helplessness may result in poor coping responses and increases in stress levels (Maier, 1993, pp 210–212).

Some bulk billing GPs exhibited helplessness when faced with the increasingly demanding consumer:

*They want a “grease and oil change”, you know, just for one visit without an appointment and that’s very stressful, when people come in, you know, prepared for a number of complaints and haven’t made a proper appointment to see you.*

Dr B

This vignette is, of course, an example of confusion as to where the cause of stress lies. The cause does not lie with patients presenting with multiple problems, the cause of the stress actually lies in the manner by which the GP manages that situation. Most retailers who are requested for more product or service would manage that situation by charging more or by expansion, particularly where the purchaser had an open-ended funder. This example is consistent with a pattern of learned helplessness.

The suggestion of learned helplessness was further illustrated by Dr D who was a GP who only bulk-billed and for whom patient attendances therefore did not attract a fee to the patient. She felt threatened that taking control of the

consultation by asking the patient to come back may be interpreted by the patient as exacting revenge:

And you don't feel as though you can carve that bit off and say  
"Come and see me again"?

*I feel as if the patient thinks you are just getting them back just  
because you want to charge them again a bit more. I feel  
awkward telling the patients to do that, because all these years,  
you know, sometimes we just do 2-3 things at once*

Mechanic might agree with Dr D in suggesting that "should the doctor-patient relationship have too great a profit taint, the patient will see this as cause to criticise the doctor" (Mechanic, 1978, p117). In this respect bulk billing will always be problematic in that the patient has no awareness of the financial value of the rebate, nor of the quantum of the "profit" derived by the GP. There is no literature to help us understand how much patients believe the GP is receiving when he or she signs the bulk billing rebate form.

One GP blamed the government for not making his life easier. For another, the workload itself was so onerous that it overwhelmed any effort by him to take control: *(Workload) has taken away that flame, it's virtually just about died out.* (Dr G). Indeed, a chronic sense of helplessness was reported to have produced a mindset of weariness as exemplified by Dr K:

What do you believe are the weaknesses of general practice?

*The sense of many of my colleagues of feeling overwhelmed and  
negative about general practice and there's a range of reasons*

*that perhaps, but I think a second weakness would be a sense of malaise that I hear many of my colleagues having*

On the other hand, control over workload was seen as an important empowering activity. Factors affecting general practice workload were described in 2.7.5.

Without a supporting infrastructure, uncontrolled workload could be destructive (“it can become overwhelming if you’re not prepared to delegate”, Dr I). But the workload that was so destructive was not necessarily the clinical load, almost universally it was the work generated by red tape.

The importance of controlling demand was defined as being one of the most important features of general practice. For those GPs who had drawn a line in the sand, the satisfaction from taking control was immense:

*The other aspect of the decision [to surrender hospital visiting rights], was that it allowed me to regain control of my life because general practice, in the way that I was practicing it, was a totally dominant force in my life*

Dr S

Strategies utilised by GPs to take control included ceasing external work (a common stratagem that correspondingly diminished skill and work variety), limiting time worked within the practice, delegating responsibilities to other staff and making patient access more expensive or more difficult. Indeed, participants commonly demonstrated that general practice is by its very nature a conundrum in that its strength is its accessibility which is also its weakness. Sadly, in the case of (a minority) of participants, the exception to the rule of anyone being able to see the doctor, was the doctor’s family.

However, perhaps the most frequent and powerful means of taking control was to move from universal bulk billing to private billing. This was most often used primarily as a method of taking control, with a secondary outcome to limit access or to generate more income. Dr F was less vehement in his comment than some in suggesting the following:

*I think it's a combination of personal choice and remuneration, you know philosophically, we've stopped bulk billing about three years ago, except for pensioners and I just felt more comfortable doing it that way.*

Control was also reported to be threatened by government. GPs commonly and frequently reported that their influence at the level of government had waned. During the Menzies era<sup>20</sup>, and in the period up to the introduction of Medibank, the medical profession enjoyed unprecedented influence at the political level (Mackay, 1997, p350). Many participants were old enough to recall the days when the AMA was a powerful pressure group. Today there are many GP organisations, splintered and often working at odds with each other (p28). As a consequence, the ability of general practice to influence government has weakened considerably as described by Dr Q:

What do you believe are the weaknesses of general practice in Australia?

*I think general practice is extremely politically weak. I think it's fraught with meaningless infighting and a whole lot of people who hold their world view as superior to everyone else's. I find it a bit*

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<sup>20</sup> Sir Robert Gordon Menzies held his second term of office as Prime Minister of Australia between 1949 and 1965 (Crisp, 1972, p 369)

*demoralising seeing the AMA sniping at the ADGP, sniping at the College, sniping at whoever else, or that acronym, I find that a bit demoralising.*

The RACGP has taken on a regulatory role by choice. It has championed, and introduced, practice accreditation and is currently responsible for setting those standards. This is also the case with vocational training where the RACGP not only develops but also regulates those standards. It had therefore made itself a target for disgruntled participants, as suggested by Dr N:

*I think the College has got a lot to blame on the way it's come about and now, what they suggest are proper standards*

In summary, the participants reflected frustration over the failure of their representative organisations to establish a regulatory environment acceptable to GPs and government. Having said that, no GPs interviewed expressed any desire to be involved in political activity, a position consistent with the view that Australian doctors have demonstrated a political apathy apart from times of crisis (Mackay, 1997, p356). Whilst control in the face of increasing workload without the support of the RACGP was important, it is interesting that the issue of control was not so an emotive issue when it centred around the most important factor, control over income.

Most participants demonstrated that they saw options to respond to declining income. They were prepared to bill privately, adopt certain reforms that paid well and to consider amalgamation. It was a minority of doctors who chose not to take more control in the management of their income.

Whilst control over income was not a major issue for most GPs generally (as distinct to the amount of income, which was a major issue), it tended to be even less so for GP couples and for female GPs with adult children. Where it was a concern, it was an almost exclusive concern of male GPs.

In conclusion, participants described feelings of helplessness at three levels. At the deepest level, there was a feeling that help was unlikely. More commonly, some participants felt that they were helpless with respect to their workload or to the way they could charge for services. Others felt themselves helpless at the hand of government.

Those GPs who had found themselves in a “helpless” situation were indeed in a difficult position as they, as GPs, were in a prime position to assist patients who may be suffering from similar circumstances (Judd & Malcolm, 2002). Mechanic suggests that one solution involves developing “some sense of power relative to their interpersonal relationships and social situation.” (Mechanic, 1978, p304). However, it has been demonstrated that, for some participants, relationships were skewed and as discussed in the next section, some participants regarded themselves as autonomous and even idiosyncratic. GPs are known to have greater concerns than the general public about stigma in relation to mental health issues (Jorm et al, 1999; Davidson & Schattner, 2003) and therefore may be reluctant to seek help. Such people are at a disadvantage in simply coping, let alone coping with change.

Where participants had taken control they had done so by reducing workload (in the face of rising demand) or by controlling their billing system, as distinct to their

income. The feeling of helplessness was exacerbated by a perceived failure of representative organisations to influence government.

It is important to note that, almost consistently, participants also failed to seek professional assistance when making practice-related decisions to manage change.

### **5.3.2 Autonomy**

It has been suggested that GPs may choose their vocation “because they do not operate comfortably in hierarchies” and that efforts to maintain autonomy come at the cost of isolationism (Phillips, 1998, p58; Department of Health and Aged Care (2), 1999). Indeed, participants did express an expectation that they should be able to practice autonomously, *I do like my autonomy. I mean, I am capable of compromise, but for good reasons.* (Dr E).

The concept that members of a professional group should be free “to work according to their own preferences” may help to explain the low level by which GPs have adopted evidence based practice (Mayer and Piterman, 1999; McColl et al, 1998).

Within the sanctity of the patient consultation the GPs interviewed had lost some degree of autonomy due to an increasingly demanding consumer population. Consumer empowerment appears to be the only strong driver for GPs to seek out evidence for specific treatments (Mayer and Piterman, 1999, p 632).

Within the practice, autonomy was reported to have been eroded by regulatory control, an area in which more than one doctor struggled, particularly with the concept of dual accountability, i.e. accountability to the patient and to the funder:



*Probably accepting that we're accountable in ways that I wouldn't have thought of 20 years ago. I've always felt accountable to the patient and to my colleagues, but never specifically accountable to the public purse or in terms of having a certificate or a piece of paper or something for ongoing medical education, seeing that as my domain and my choice.*

Dr K

The magnitude of the funder, Medicare<sup>21</sup>, and its “universality” has resulted in an organisation with the economic influence of a very large, almost irresistible, monopsony possessed with the daunting powers of a federal regulator. This was perceived as a threatening combination. However, bulk billing has always been an option available only at the discretion of the GP. It becomes an optional choice for the GP because of competitive market forces, because of altruism, or because, like Dr D above, GPs have an image to protect.

Autonomy has also been eroded by increasing integration with the health system or to what has been referred to as “interprofessional entanglements” (Richman, 1987, p87). Dr S represents most of his colleagues in voicing concerns about the effect of “integration” on autonomy. He described the difficulties of maintaining clinical boundaries between generalists caring for the same patient:

*I find a few things that have irked me. An example would be, say, a nurse making judgements and suggestions about drugs that I would use on a patient, when that's really not their area of training. I think there's a great desire from others to take over what GPs do and to make judgements about that and I think as*

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<sup>21</sup> Medicare has been described as providing “open-ended medical insurance” (Deeble, 2000, p 44)

*long as everyone knows what their job is and to kind of not set themselves up as being experts in other people's fields.*

Professional boundaries may be difficult to define in a genuinely integrated system, particularly where roles overlap. It may be that it is not possible to delineate roles so that GPs and allied health providers (or even other GPs) may have to yield their own autonomy in order to maintain clinical relationships.

Control was seen as a function of autonomy which was in some ways protected by being in solo practice, and sometimes worsened by it. Rural participants portrayed a greater sense of confidence and control of their environment not perceptible in their urban colleagues. This was an interesting impression given that rural GPs are reported to have a heavier workload (2.8). There may be several factors that allow rural GPs to sit above the turmoil that mark them differently to their urban counterparts; all rural GPs billed privately, there was no general practice competition and they had available to them financial incentives to employ practice nurses as well as access to allied health professionals through the MAHS program.

In conclusion, autonomy was generally seen to be desirable but was reported to have been eroded by consumer preferences, by government auditing their investment and by a more integrated primary care setting. This, no doubt, compounded feelings of helplessness and led to the next perception, namely a feeling of loss of control.

Control over workload was therefore seen as an important empowering activity. Factors affecting general practice workload were described in 2.7.5.

Without a supporting infrastructure, uncontrolled workload could be destructive, particularly where it was related closely to red tape.

#### **5.3.4 Need for affirmation**

Many GPs in diverse ways and to differing degrees indicated a need for affirmation. The source of this affirmation was usually the patient:

*That's what's good about general practice, you're a family doctor and people look up to you because of that. They tend to turn to you for assistance.*

Dr B

Where expressed, the affirmation provided in the practice was at sharp odds with the GP's relationships at home, where affirmation faded into the humdrum of existence. For a minority of participants there was a disparity between the professional life where the power relationship was skewed and the private life where relationships were relationships of equality. This was eloquently captured by Dr J:

*I know a colleague, who now wants to come back out of retirement because basically he has nothing to do now he's at home. His life has been medicine. I think there also is the respect from patients and the adoration and reinforcement of patients that particularly long term patients, that keep coming back and keep demanding and keep wanting you to be there and there is this whole cycle of dependency and co-dependency from GPs that need to have that reinforcement every day from patients telling them that you have to be there, if you're not there then I can't get through.*

In a sense the family had not been able to compete nor had the GP been able disentangle himself from that skewed practice environment. The GP-patient relationship was reported to have almost opioid effects. One participant described the feeling as a “*buzz*” of being appreciated (Dr K) whilst “*Everybody loved me*” (Dr T).

In conclusion, those participants expressing a need for affirmation may thrive more normally in a team based environment or equally they may have difficulty coping in the anonymity of a large medical centre where feelings of isolation may compound a need for affirmation. Most importantly, a team based environment may reduce the need for affirmation as less skewed relationships are developed.

### ***5.3.5 Participants’ feeling of isolation***

Macklin suggests that “for many GPs the tradition of independence has given way to a feeling of isolation and a lack of peer support” (Macklin, 1992, p 19). Such was the case for many participants who placed great importance on their relationship with peers and who now have found “*that it’s very lonely being in solo general practice*” (Dr I). Older GPs in particular missed the camaraderie of working in the team environment of hospitals. It was not that being together was satisfying per se, it was that satisfaction lay in working together to meet a common challenge by treating a patient common to the surgical team.

In an environment favouring amalgamation, this represents an important observation. To what extent does office practice allow GPs to work as a team? Does amalgamation merely result in a series of cottage industries existing under

one roof? If larger practices provide integrated allied health care services as a “team” practice, is that as satisfying for the GP as working as a team of doctors?

There was a sense in which the teamwork of former days had an additional effect. Perhaps the former type of teamwork eased the burden of patient care whilst the teamwork expected of today’s GP, and as depicted in Figure 2.2, had increased the burden of care. Dr S was pragmatic about this and thought that GPs of the future will just have to adjust:

*Well, because we’re not running solo any more. I think GPs are now part of the broader health care community and I certainly see that as a trend and will be the trend more and more and more, that we’ll just have to accept the fact that we’re not working on our own and we have to work in concert with the Community Health workers, the diabetes workers, the allied health workers, all the players in health and there’s more and more of them and I see structural changes that will occur in all kinds of ways and they’ll just continue to evolve no doubt.*

Indeed, the current climate of change has offered GPs an opportunity to recover that peer support and collegiality. Times of uncertainty can be used to advantage by sharing them and thereby maintaining self-esteem and producing a more constructive response (Mechanic, 1978, p300). For GPs considering moving to larger practices, issues of “belonging” would appear to be of substantial importance in determining a GP’s satisfaction with general practice.

### ***5.3.6 Participants' satisfaction with general practice***

Determinants of satisfaction changed either with time or age. They were not necessarily associated with changes in the environment although the importance of the doctor-patient relationship was almost universally emphasised. Some activities, such as obstetrics, that had been satisfying and challenging as a younger doctor had lost their appeal with time. On the other hand, the application of new computing skills was embraced as a means of expanding the skill set in a sustainable and on-going manner, as typified by Dr R:

*It's a bit like riding a bicycle. You start by getting on it and see if you can get your balance and then you start to move off and gradually you learn more skills and before you know it, you can do all sorts of tricks, if you keep practicing your skills. Most of it's just stay on the bicycle and ride straight (laughs).*

In general, satisfaction derived from clinical activity changed with time. Satisfaction had come to be related to the acquisition of new skills and the sharing of new knowledge in a social context (particularly CPD activities). The importance of the doctor-patient relationship was unchangingly satisfying. However, there was no suggestion that remuneration was related to satisfaction, though it will be demonstrated that the perception of poor remuneration was related to dissatisfaction.

### ***5.3.7 Summary of participants' views of themselves***

Many participants displayed an interplay of attitudes involving a desire for autonomy, a feeling of helplessness, need for affirmation and a feeling of isolation. There was a clear association between need for affirmation and feelings

of helplessness in that only one participant expressing a desire for affirmation did not express some degree of helplessness.

Not surprisingly, all but one of the seven GPs expressing feelings of isolation also expressed a need for autonomy. This would, therefore, seem a close association. Of interest, five of the seven GPs expressing feelings of isolation, also expressed the importance of quality care. It may be that solo GPs feel a greater sense of need to control quality of care and that GPs who amalgamate do so for economic or other reasons, not for reasons of quality service delivery.

The issue of control, in general, was an important one for participants, though not expressed directly as such. Despite the high number of participants expressing feelings of helplessness, there was very much a sense that control could be exerted in one important area, namely patient billing. As one GP suggested, control in some sense has to be reclaimed by the GP by *“looking at ways in which, giving them back, ‘reclaiming the night’ like the ladies do, reclaiming lost ground, the integration, the hospitals, the skilling”* (Dr K). Indeed, satisfaction was related to what new skills could be acquired.

## **5.4 Concluding remarks**

An undercurrent of dissatisfaction with the way things had become for participants was readily discernible. Contributing to dissatisfaction were isolation of the GP in his/her working environment and concerns about income except where the GP had taken steps to control finances. Whilst the introduction of standards such as Accreditation and Vocational Registration were unrelated to satisfaction, where they were perceived to be needless they were related to

dissatisfaction. A contracting clinical role was not universally dissatisfying, but dissatisfaction was more likely where the participant had lost sight of what their role as a GP was.

The use of clinical skills was reported to contribute to satisfaction. Participants held quality clinical care in high regard but did not state what quality was in their view, or how they recognised it. Relationships with patients over the longer term were directly associated with high levels of satisfaction as were relationships with peers. There was, however, some suggestion that these relationships interfered with the quality of more personal relationships.

A picture has now been painted of this cohort of GPs randomly selected to discuss their experiences of change. Importantly some GPs displayed certain characteristics that would impede their capacity to cope with change. These characteristics included a variable sense of helplessness. For some, desire for autonomy walked hand in hand with a sense of isolation. The desire for strong and purposeful leadership expressed may perhaps be attributed to a personal sense of powerlessness. The apparent close relationship between helplessness, autonomy and isolation, begs further exploration as to whether these characteristics have been acquired in general practice or are characteristics of many of the participants in this cohort.

On the other hand, those participants who had taken control felt empowered by exerting that control and had done so by altering the billing relationship with the patient, by reducing workload or by adopting new skills.

This chapter, then, is not a portrayal of a group of clinicians necessarily primed and ready to face change and particularly not to drive it. Chapter 6 will



now present an examination of change that this cohort has had to face. It will demonstrate that many of the issues of greatest importance to GPs as identified in Chapter 5 also represent the areas in which most change has occurred.

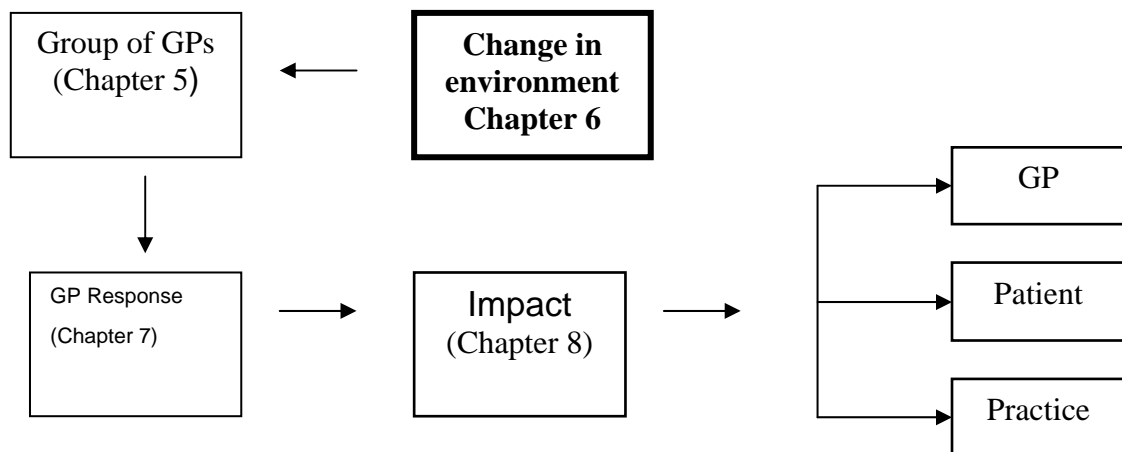
## CHAPTER SIX

### Non-clinical Changes Reported by Participant GPs

#### 6.1 Introduction

Chapter 6 identifies the most frequent categories of change reported by participants. With reference to Figure 1.1, it can be seen that an examination of the changes GPs have experienced is an important step leading to an understanding of the impact of change on the participants.

Figure 1.1 (revised)



Chapter 6 permits an examination as to whether the changes identified by the Delphi method and those changes identified in the literature scan of Chapter 2 were similar to the changes reported by participants. This process therefore permits some degree of triangulation in determining the nature of changes identified by the three different means, viz., the Delphi group, literature review and by the participants themselves. The process is graphically represented as Figure 6.1

**Figure 6.1**      **Methodology utilised to determine case studies presented to participants**

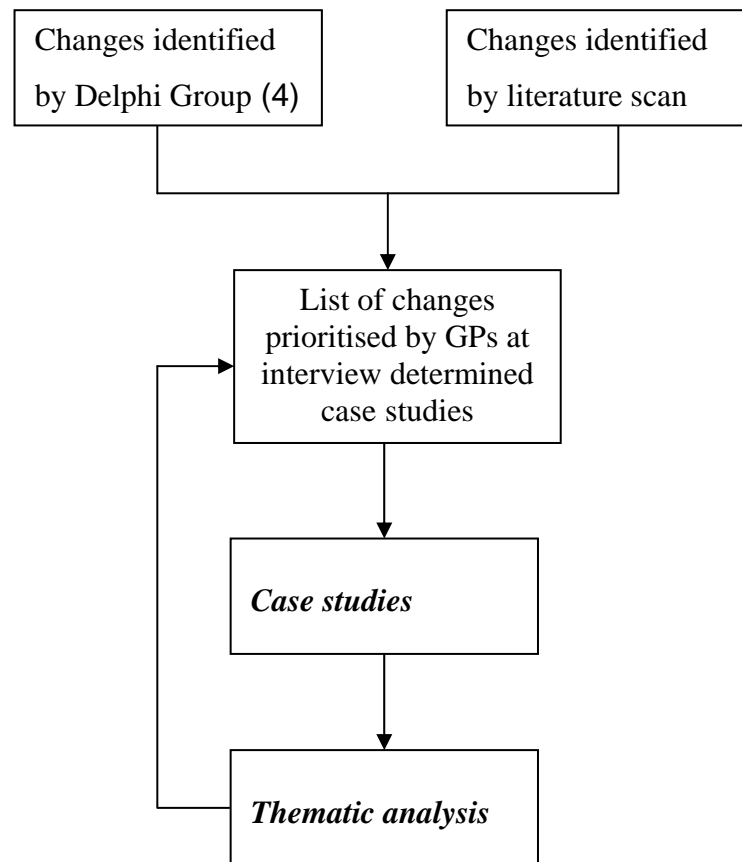


Figure 6.1 illustrates that changes identified by the two methodologies (Delphi group and literature scan) were presented to GP participants for verification by a process of prioritising. Chapter 6 represents an important step to describe a method to allow GPs to be presented with case studies predicated on changes that are of relevance to them. In this way a quantitative methodology (priority ranking) is used to prepare the foundation for a qualitative methodology.

Furthermore, the chapter presents rich illustrations to more vividly portray one of the most important features of the interview process, namely the generally

emotive nature of responses of participants who had experienced change and the depth of consistency of those emotive responses. This depth of consistency is possibly the major reason that saturation was evident from a relatively early stage.

Ten main areas of change were identified on completion of thematic analysis of participant transcripts. These are listed in Table 6.1, together with the number of participant references coded during analysis:

**Table 6.1** *Changes identified by thematic analysis of interviews*

<b>Changes</b>	<b>Number of references</b>
Red tape burden	88
CPD	46
Litigation	33
Remuneration	23
Consumerism	22
Computerisation	18
Business complexity	15
Loss of Hospital rights	11
Work style	11
Workforce shortage	8

Whilst there were consistencies with ratings determined by the Delphi group, by the literature scan and as a result of the participants' own prioritisation (demonstrated in Table 6.2), there were also remarkable variances particularly between the Delphi group and the other techniques. This represents an important observation and is further explored on page 192.

Table 6.2 allows a comparison of changes as determined by all methodologies used in this study to identify the key changes experienced by GP participants.

**Table 6.2** *Table of changes prioritised by all methodologies*

By Delphi group <sup>1</sup>	By literature scan <sup>2</sup>	GP prioritisation sheets <sup>3</sup>	Thematic analysis of GP interviews <sup>4</sup>
Bulk billing (16)	Red tape (18)	Red tape (154)	Red tape (88)
Feminisation of the GP workforce (14)	Medicolegal litigation (18)	Medicolegal litigation (146)	Education (46)
Introduction of vocational registration (12)	Introduction of quality incentives (e.g. PIP) (18)	Computerisation (134)	Medicolegal litigation (33)
Establishment of Divisions of General Practice (11)	Introduction of practice accreditation (18)	Practice accreditation (117)	Remuneration (23)
Computerisation (8)	Computerisation (16)	Introduction of quality incentives (e.g. PIP) (96)	Consumer demand (22)
Increased multidisciplinary care (7)	Advent of corporate general practice (15)	Introduction of vocational registration (88)	Computerisation (18)
Poor coordination between GP organisations (7)	Workforce shortage (13)	Feminisation of the GP workforce (72)	Business complexity (15)
Establishment of Family Medicine Training Program (5)	Increasing workload (13)		Hospital rights (11)
Practice accreditation (4)	Ageing of the GP workforce (12)		Work style (11)
Medicolegal litigation (2)	Feminisation of the workforce (12)		Workforce shortage (8)

### Notes to Table 6.2

1. The following methodology was used to rank the responses by the Delphi group. Each oracle was requested to rank the four most important changes as interpreted by them, in each of the two categories, longitudinal and impulse. The first ranked in each case was awarded 4 points, the second 3 and the third 2 and the fourth 1 point. Thus the maximum possible score for an item was 20. The concept of longitudinal and impulse changes was not carried into other methodologies.
2. The ranking gained by review of the literature was a judgement by the author made after completing Chapters 2 and 3 and using the rating scale defined in A.3.
3. The following methodology was used to rank the aggregated responses by the GPs when requested to complete a rating scale (A.6.4) based on a combination of the changes most highly rated by the Delphi group (method 1) and by the author (method 2). The GP participant was allowed to score each item to a maximum of 10 depending on the quantum of effect they thought that the change had had upon him or her.
4. The rankings derived from coding the GP interviews were simply the number of times the change was coded under that node in Nvivo.

The variances evident in the table form a major finding of the study. An examination of Table 6.2 demonstrates that the areas of inconsistency were as follows:

1. The Delphi Group of GP academics regarded feminisation of the workforce, the introduction of vocational registration and Divisions of General Practice as three of the four major changes in general practice, yet none of these changes were identified following thematic analysis of the interviews of participant or “grass roots” GPs.
2. Increasing red tape was the major change identified by 3 methodologies but it was not explicitly recognised by the Delphi group of GP academics.
3. Increasing threat of litigation was the second most important change recognised by the non-Delphi techniques but was rated least important by the Delphi group of GP academics.

It therefore became important to create a taxonomy of change to take into account the differing perspectives of academic and practicing GPs which appeared to have little in common.

## 6.2 Taxonomy of non-clinical change

The methodology of this study was relatively complex in using multiple means of identifying and prioritising changes. The markedly different findings from the Delphi group and from thematic analysis of the transcripts of non-academic GPs will now be

discussed using the findings from the literature review and from the GP prioritisation sheets as supporting evidence.

All methodologies apart from that of the Delphi group identified red tape and medico legal litigation as major changes facing general practitioners, neither of which was identified by the Delphi group. It is likely that the non-identification of these changes represents a function of categorising at a different level. For example, red tape may be seen as a consequence of the requirements of vocational registration (ranked third by the oracles), increased multidisciplinary care (ranked sixth) and practice accreditation (ranked second last). In other words, the “expert” GPs constituting the Delphi group may have thought in broader terms as changes affecting the broad population of Australian GPs, with participant GPs thinking in more immediate terms as they experienced the immediate consequences of change in their work environment. This dichotomy of perspective illustrates the inherent advantages and disadvantages of the Delphi technique, in which oracles may be far removed from the rigours of day to day practice but have an opportunity to reflect at a system level, and “informers” who, in this case may be too immersed in their own workload to see a “bigger picture”, a possible outcome previously identified ( Martin and Rohan, 2002;cf p131). Both perspectives are equally valid though markedly different.

It is apparent that a hierarchy of change to be valid must reflect general practice change at both the broader national level, ie at the level more closely identified and explored by academics, and at a more direct, consequential level, experienced by general practitioners. The following taxonomy (p194) was derived after periods of analysis and iterative refinement, a process not possible for a Delphi group conducted in only three rounds.

Reference to Table 6.1 reveals that CPD was a major broad category of change. It impacted on only one other area of change (red tape) but was highly important in its own right. Similarly, consumerism was an important area, one which did blur to some extent with the perceived increasing threat of litigation in particular. Increasing business complexity was seen to be a function of increasing red tape burden, the increasing perception of the threat of litigation, computerisation, work style, workforce shortage and changes to methods of remuneration. However, this latter area of change was so strong in bringing about change that it was regarded as a category in itself, particularly when related to the impact remuneration had on GPs' capacity to exert control, its impact on patient access, and particularly its strong influence in determining whether participants adopted the new government incentives.

As a result of this analysis, it would appear that the major changes of general practice can be described as existing within the broad groupings of Increasing Business Complexity, Changing forms of remuneration, Increasing educational standards, and Changing consumer demand as indicated in Table 6.3.

Reference to chapter 5 allows a comparison between these 4 major groupings of areas of change and areas of most importance to participants. Importantly, relationships (including continuity of patient care) were not seen to have changed greatly. On the other hand, clinical role was of major importance to participants but is unable to be included in a taxonomy of non-clinical change, despite important changes that had occurred to the GPs' clinical roles and the heavy impact that had had on participants (8.1.2).



**Table 6.3**      **Classification of major non-clinical changes experienced by GPs**

	<b>Business Complexity</b>	<b>Remuneration</b>	<b>CPD</b>	<b>Consumerism</b>
<b>Effectors of change</b> <b>(identified by the Delphi group)</b>	Feminisation of the workforce	Blended payment  (Quality Incentives)	Vocational Registration	Bulk billing
	Computerisation	Vocational Registration	Divisions of General Practice	Computerisation
	Increased multidisciplinary care	Practice Accreditation		
	Quality Incentives (Blended payment)			
<b>Buffers of change</b>	Divisions of General Practice	Nil	Nil	Nil
<b>Experiential changes</b> <b>(identified by participants)</b>	Red tape	Red tape	Red tape	Other
	Litigation	Litigation	Other	
	Computerisation	Other		

Each of these broad headings will be discussed with reference to their constituent changes identified largely by the Delphi group; termed “effectors” of change. Each of the “effectors” will be discussed with reference to the major changes experienced by GPs, viz., red tape, fear of litigation, and computerisation; referred to as “experiential” changes.

Table 6.3 can be used at three levels:

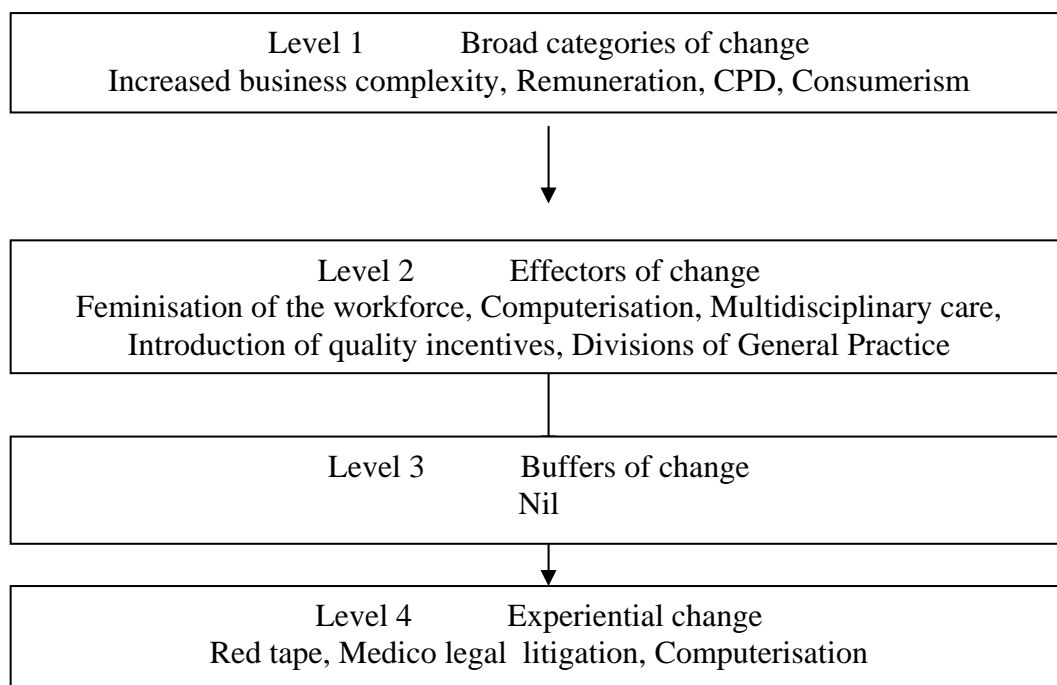
1. It categorises broad areas of major change and their associated elements,

2. It demonstrates that changes to general practice have had synergistic consequences throughout the work experience of the GP. For example, increased red tape associated with remuneration also compounds business complexity and enhances the frustration felt by GPs in their educational experiences.
3. It demonstrates that expected outcomes have not necessarily been outcomes. For example, it may have been expected that consumer demand may have been related to practice accreditation and quality incentives. However, Table 6.3 demonstrates that consumer demand was unrelated to practice accreditation or the introduction of quality incentives (which were only related to funder (Commonwealth) demand). Such changes are of great importance as they have come about from influences external to either the patient or the doctor.

The failure to identify a consistent language to discuss these changes limits the researcher's ability to make valid comparisons. The following hierarchy may provide a useful tool for further general practice research.

Table 6.3 can be summarised into the following hierarchy of change:

**Figure 6.2 Hierarchy of non-clinical change as experienced by Australian GPs**



where:

- *broad categories of change* represent the four main areas in which non-clinical change has occurred in respect to Australian general practice,
- *effectors of change* represent the major drivers of change in general practice as identified by the Delphi group,
- *buffers of change* represent those interventions or organisations that have buffered the impact of change on participants or which could have been expected to buffer impacts of change. In general, there were no buffers of change, and
- *experiential change* represents the net effect of change as experienced by the GP

Discussion of each of these follows:

## **Level 1      Broad areas of GP non-clinical change**

The study has identified 4 broad areas of GP non-clinical change which had occurred in Australian general practice. These are: Increasing business complexity, Remuneration, Continuing Professional Education (CPD), and Consumerism.

### ***Broad area of change 1:      Increased business complexity***

Increased business complexity is the major broad heading of non-clinical change. The heading is the sum of the change effectors (Feminisation of the workforce, computerisation, increased multidisciplinary care and the introduction of the quality incentives, which are in turn, closely related to remuneration changes. However, business complexity was experienced by GPs as increasing red tape and rising threat of litigation.

***Broad area of change 2:            Remuneration***

The form and means of remuneration had changed dramatically. Some of the effectors of change of remuneration had been the blended payments, and the introduction of VR and Practice Accreditation. Changes in remuneration were experienced as increasing red tape, rising threat of litigation and a third category, a confusion in discriminating income from profit.

***Broad area of change 3:            Continuing Professional Development***

VR and Divisions of General Practice were seen as the effectors of changes in CPD. The changes were experienced as increasing red tape and an interesting theme, viz., the increasing personal socialisation attached to educational events.

***Broad area of change 4:            Increasing Consumerism***

Consumerism was seen as a product of increased patient access due to bulk billing and increased consumer knowledge due to computerisation. It was experienced as an increase in red tape, an increased awareness of litigation and a final experiential category of emotiveness.

Each broad area of change had been brought about through a number of “effectors of change”, identified largely by the Delphi group of GP academics. These effectors represent Level 2 in the hierarchy of non-clinical change.

**Level 2            Effectors of change**

Table 6.3 displays the effectors of change, as identified by the Delphi group of academic GPs, which have effected change in each of the four broad areas. These include the introduction of bulk billing with the advent of Medicare, feminisation of the

workforce, computerisation of general practice, increased multidisciplinary care, the introduction of practice accreditation and the establishment of Divisions of General Practice.

***Effector of change 1:                      Feminisation of the general practice workforce***

Feminisation of the workforce was rated by the Delphi group second only to the introduction of bulk billing as being a major change event for Australian general practice. Feminisation of the workforce was also recognised in the literature scan as an important effector of change.

***Effector of change 2:                      Computerisation in general practice***

Computerisation of practices is the only category of change to be represented at both the effector and experiential level. On the prioritisation lists it was placed third in importance by GPs behind red tape and litigation, fourth by the Delphi group and fourth by the literature scan.

***Effector of change 3:    Increased multidisciplinary care in the general practice setting***

Increased multidisciplinary care was seen by the academic GPs to be a function of an “aging population and increased chronic disease management”. It was not identified in the thematic analysis directly, perhaps because it was seen as more closely relating to clinical change rather than non-clinical change.

This study therefore does not help our understanding of how the chronically ill will be managed in general practice. Interestingly, in the period since the interviews were performed, MBS funding has become available for patients to attend, on referral by GPs, many allied health professionals including exercise physiologists, psychologists, podiatrists and dietitians.

Our knowledge of general practice systems that may enhance multidisciplinary care is poor and deserving of greater enquiry<sup>22</sup>. However, as important as the topic is, increased multidisciplinary care will not be further discussed as multidisciplinary care was not a feature of Australian general practice over the period of interviews.

***Effector of change 4: Introduction of quality incentives***

The Delphi group of academic GPs identified specifically VR and Practice Accreditation as important effectors of change. These have been combined to represent “quality incentives” which, from the participant perspective, also included the new EPC items.

***Effector of change 5: Establishment of Divisions of General Practice***

Divisions of General Practice were identified in the literature scan as being “agents of change” (*GPA:2000*, p205) but the introduction of Divisions of General Practice was not identified as being an important change as a result of the literature scan. Divisions of General Practice were only mentioned on two occasions by the 20 participant GPs. However, the Delphi group rated the establishment of Divisions of General Practice as the fourth most important change in general practice.

In each broad area some of these effectors of change will be recognised as contributing to a particular area according to the relative priorities indicated by the Delphi group, the literature scan and by the lists prioritised by GPs

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<sup>22</sup> The author acknowledges his participant role in several NHMRC studies examining the role of teamwork in general practice, the referral to allied health providers in general practice and the role of the exercise physiologist in general practice in managing depression, anxiety and stress.

### **Level 3       Buffers of change**

Buffers of change are those interventions which mitigate the effects of change on GPs. There are no institutional buffers of change although one academic GP suggested that Divisions had a role in mitigating change by assisting practice staff to adopt more sophisticated roles and by assisting with practice amalgamations. No one suggested that Divisions actually did this. Another oracle commented that Divisions had become a “major route for various government initiatives”. If true, this may be a dangerous tag for Divisions which, in acting as a conduit, do not appear to be acting as an intermediary. The RACGP was seen negatively as a precursor of pointless change. The Commonwealth was seen as the source of all things evil.

It was therefore evident that a large discrepancy existed between the decision to reform and the action of implementation. The fact that there was no organisation which was genuinely seen to have the role of absorbing the shock of change is exacerbated by the fact that GPs themselves appear to be poor at seeking help, maintaining an autonomy that resists change.

Ideally, a buffer would have existed between nationally significant changes such as feminisation of the workforce, VR, practice accreditation and computerisation and the GPs working in their practice. The issue of organisations as mediators is an important one and is further discussed in (8.1.4).

This completes the description of typological changes identified by the Delphi group, by the literature scan and by GP ratings, regarded as change effectors and of national significance. Discussion of change will now centre upon the changes as experienced by

GPs and as recognised during thematic analysis of the interviews. Those changes will be referred to as “experiential changes”. These experiential or “hands on” changes for GPs were increasing red tape, litigation and computerisation.

#### **Level 4      Experiential change**

Experiential change represents changes experienced in the day to day workplace of the participant GP. Generally, these changes were increasing red tape, increasing fear of litigation and an increasing interaction with the world of computers. However, there were other experiential changes specific to particular areas.

##### ***Experiential change 1: Red tape***

All methodologies apart from that of the Delphi group identified increasing red tape as the most important change in Australian general practice. The failure of the Delphi group to identify this change may represent a function of categorising at a different level. For example red tape may be seen as a combination of the requirements of vocational registration (ranked third by the oracles), increased multidisciplinary care (ranked sixth) and practice accreditation (ranked second last). Alternatively, the oracles, largely a group of academic GPs, may have had little opportunity to experience the complexities of, or decisions related to, the Enhanced Primary Care package, as few, if any, would have recently worked as practice principals.



### *Experiential change 2: Medico legal litigation*

All methodologies apart from the Delphi group ranked increasing litigation as either second or third<sup>23</sup>; the Delphi group identified it but rated it least important.

The most notable feature of litigation was the fear it held for most GPs. Two participants likened it to the Sword of Damocles. The fear was unavoidable for two reasons. The first was that sensational reminders were all around them in their popular medical journals. Indeed, if it is that litigation has been painted as a threat by the popular medical press then it may be that academic GPs refer less to the popular press for their information and have been less exposed to the emotion surrounding the issue. On the other hand, academic GPs with less exposure to clinical care, may also be less exposed to litigation or may practice in a relatively protected environment such as a GP Training Unit.

The second reason was that the fear expressed was as omnipresent as the patients were ubiquitous. Because any patient was a potential litigant, the threat could come from any direction.

Litigation was almost a matter of being beyond control and, in a group of GPs many of whom needed to be in control, the threat of litigation was a source of anxiety. As pervasive as the threat of litigation was, it appeared to be no more substantial than a threat. No participants reported being involved in litigation.

The threat of litigation, as distinct to the reality, was therefore perceived to be beyond the control of participants, always present and likely to arise from any patient with any problem. Although participants admitted that they were responding to a perception of

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<sup>23</sup> Given that GP interviews identified the threat of litigation rather than the fact of litigation

vulnerability rather than a known reality, their responses were pervasive and evocative. These are the conditions most likely to result in high stress levels and to engender “learned helplessness” (Maier, 1993).

### ***Experiential change 3: Computerisation***

Computerisation was ranked between third and sixth in importance by all methodologies. The literature scan presented computerisation as an opportunity to support increasing practice complexity whilst GPs themselves did not identify a strategic role for computers; though they identified a range of tasks that computers could undertake. This may suggest that GPs are more closely focused on immediate need rather than on strategic alignment.

Each of the 4 broad areas will now be discussed with reference to effectors of change and experiential change. Experiential change will be examined with respect to *themes*, either major or minor. Major themes represent themes mentioned by 7 or more participants in discussing experiential change. Minor themes represent themes mentioned by at least 4, but less than 7, participants. The terms “major” or “minor” do not therefore bear on the strategic significance of a theme. For example a minor theme, mentioned by only 4 participants, may have important and severe consequences.

Having reviewed the categories in general, discussion will now focus on the elements of each broad category of change; the most important of which was increasing business complexity. This is now discussed in terms of its effectors and then in terms of the participants’ experiences as they perceived red tape, increasing threat of litigation and computerisation in relation to increasing business complexity.

### 6.3 Broad category 1: Increasing business complexity

A modification of Table 6.1 illustrates the order of discussion underlying Increasing business complexity

	Business Complexity	Remuneration	CPD	Consumerism
<b>Effectors of change (Oracles)</b>	Feminisation of the workforce	Blended payment (Quality Incentives)	Vocational Registration	Bulk billing
	Computerisation	Vocational Registration	Divisions of General Practice	Computerisation
	Increased multidisciplinary care	Practice Accreditation		
	Quality Incentives (Blended payment)			
<b>Buffers of change</b>	Divisions of General Practice	Nil	Nil	Nil
<b>Experiential changes (GPs)</b>	Red tape	Red tape	Red tape	Other
	Litigation	Litigation	Other	
	Computerisation	Other		

Although increasing business complexity was only identified on analysing GP interviews it is probably a different order of a combination of “Introduction of practice accreditation”, “Increased multidisciplinary care” and “Introduction of Quality Incentives”, all of which were rated highly by either the Delphi group or the literature scan. Indeed, it is largely in these areas that GPs felt that their main concern, “Red tape” was generated.

Business complexity was also impacted by 2 of the 3 other broad categories.

Remuneration, whilst an important area in itself, drove much of the complexity of

practicing, and consumers were a new and indeed foreign concept to many GPs who had previously been used to working with the more malleable “patient”.

It is not surprising that business change should feature strongly, yet so little has been researched about it in medical literature (cf 3.6). Whilst there is a reasonably detailed literature exploring practice structure and GP workload (cf 2.7), we know little about the nature of the business that supports that workload and its effect on GPs.

### ***6.3.1 The effectors of increasing business complexity***

There were certain nationally significant changes that were associated with increasing business sophistication. They include feminisation of the workforce, the establishment of Divisions of General Practice, computerisation of general practices, increased multidisciplinary care, the introduction of practice accreditation and quality incentives. Interestingly, the most important effector of non-clinical change to increasing business complexity in Australian general practice identified by the Delphi group was feminisation of the general practice workforce.

#### **Effector 1: Feminisation of the general practice workforce**

Feminisation of the workforce was recognised in the literature scan in which it was suggested that, as female GPs tend to work less hours than male GPs, “female GPs may have less time for non-clinical general practice activities such as practice management” (p24 ch2).

One oracle suggested that feminisation of the GP workforce “has led to changes in the nature of practices, including ownership.” The ownership of general practices, or

indeed of any small enterprise, is perhaps the single most important catalyst of change. In this case feminisation of general practice is of importance as the “traditional” practice has been, in the vast majority of cases, owned by male GPs (personal observation). A second oracle suggested that competition for workforce (a function of increasing female participation in the workforce) was a trigger for the success of corporatised practices in that, in the competitive market, corporate practices could “buy” their potential workforce on the open GP market. A third oracle saw this as associated with threats to GP ownership and control. Perhaps female GPs feel less need for control and ownership than their male colleagues.

The suggestion is, therefore, that as the gender mix changes, more complex practice management work is being undertaken by a declining proportion of (older) males, increasing the likelihood of either these male GPs abandoning management altogether and moving to corporatised models of practice (2.7.6) or delegating management to administrative staff. It may also be that female GPs have less need to “own” a practice and feel more comfortable working in larger, often corporatised, general practices.

## **Effector 2: Computerisation of general practice**

Computerisation will be discussed at both the effector level of change and at the experiential as it was identified as impacting at both levels.

With respect to business complexity, one oracle suggested that computerisation had altered the basic autonomy of GPs in that, as a technology, it was so far removed from their clinical or cultural experience, GPs had been forced to change their normal self reliant behaviour patterns and seek help. The oracle did not comment on whether this

was good or bad. For the GP sitting at a desk watching his computer crash, external support and therefore reduced autonomy, may be a necessary evil. As a precursor to change, computerisation may represent a revolution in attitude if the oracle's observation is correct. Forcing a culture whereby it is seen to be appropriate to seek external assistance, for a group of participants who so highly valued their autonomy, may have ongoing impact in changing behaviours to seeking help for other professional business related purposes. The concept and importance of help seeking behaviour is further discussed in chapter 7.

### **Effector 3: The introduction of quality incentives**

One oracle suggested that practice accreditation was the first attempt “to introduce standards for general practices as units rather than for individual providers”. This observation is of major importance in considering non-clinical change in general practice. It recognises the growing importance of the larger more sophisticated practice as the place where primary care is carried out and where the GP works. In so far as the observation is accurate, it suggests that the autonomous GP will find life more demanding as clinical requirements are challenged by accreditation requirements (red tape). In contrast, the GP who is willing to delegate responsibility both clinically and in the business context, may have a completely different perspective.

A second academic GP (oracle) suggested that the quality incentives were “linked with complexity, risk management, larger practice size and clinician overload”. Another commented on the importance of the “strings attached” to payments. However, at the microlevel, as will be discussed, GPs were in no doubt that the strings attached to the

quality incentives were, indeed, a major cause of red tape.

This now leads to a discussion of any buffers that were reported to mitigate the effects of change brought about by increasing business complexity.

### **6.3.2 *Buffers to increasing business complexity***

In relation to business complexity, one oracle commented that Divisions had become a “major route” for “practice support and various government initiatives”. Another suggested that “Divisions are slowly providing ways for GPs to perform more non-fee-for-service work.”

In a time of change and for a population who like to be autonomous, it may be that Divisions have been successful in delivering change but unsuccessful in “buffering” the consequences of change by, for example, providing trained practice support for staff to introduce change. Divisions of General Practice may have therefore unwittingly made matters worse for GPs, particularly in the short term.

### **6.3.3 *Experiential changes of increasing business complexity***

As in all four broad areas, experiential change will be discussed in terms of red tape, threat of litigation, and computerisation.

#### **Experiential changes in terms of increasing business complexity 1: Red tape**

It was identified in 2.7.5.4 that bureaucratic requirements were considered a “heavy burden” for Australian GPs. That was also the experience of participants. It was possible to identify four major themes associated with increasing red tape that

contributed to that burden. The first was that the sheer quantum of paperwork was overbearing, the second that red tape was unrelated to quality, and the third that the requirements for compliance with new initiatives were unilateral and founded on a platform of distrust. The fourth related to the emotiveness of participants' opinions in relation to red tape.

The first major theme of this thesis was the sheer volume of red tape.

- Increased volume of red tape – major theme

The increased volume of red tape was a consistent feature of all interviews. It is typified by Dr M who optimistically summed up the generally emotive response of participants to this topic:

*I think it's getting far too complicated and hopefully somebody will take it into hand and fix it up.*

In later chapters it will be demonstrated that the burgeoning volume of red tape presented some participants with the opportunity to make more systematic changes affecting the efficiency of the practice more broadly.

- Red tape and its non relationship to quality – major theme

Most of the red tape burden was seen to sit around the “quality” incentives described in 2.10.1 and 2.10.2. Again, most replies were quite emotive and therefore may have been as a result of the relative “newness” of the quality initiatives or an indication of their passionate feelings about the topic. Ironically, the large majority of GPs failed to acknowledge any relationship between the incentives and improvement in quality. Dr P typifies the frustration of participants in their exposure to accreditation, the benchmark of a quality general practice:



*You know, accreditors come in with a list of criteria that bear little, no improvement in patient care, you'd be the worst doctor in the world and pass.*

The almost universal sense of frustration was a fertile breeding ground for exacerbating the existing distrust of government.

- Red tape was dictated in an atmosphere of distrust – major theme

In bringing about reform, it became evident that the Commonwealth had started from a low basis of trust. For some participants, what trust once existed between them and the Commonwealth had been extinguished with the failure of enquires such as the Red Tape Enquiry (Blomberg, 1996). Sadly, trust was not even a consideration of many GPs who cast Government in the role of villain in its increasingly regulatory function. Dr B, an older GP was more circumspect than many in his comments about the role of the Commonwealth:

*What the government has done in general practice, I don't think that's helped very much. I don't think we have come any better. I like the good old days, you know*

Whilst participants seemed to view that the Commonwealth, as protagonist of the reforms, was not to be trusted, there was a paradoxical sense that many participants wanted to maintain their autonomy on the basis of trust; something they were not willing to grant the government but which they required of the government.

The picture painted is that of a group of individuals who generally valued their autonomy highly but who were being moved to a basis of accountability, albeit in limited and specific areas. They saw the transition failing around the issue of trust. The

interviews did not pursue which elements of autonomy could have been maintained whilst maintaining adequate accountability.

- Responses to increasing red tape in an increasingly complex business environment were highly emotive – major theme

Most notably, interviews were quite evocative, particularly with respect to red tape. Participants generally expressed a sense of helplessness associated with the burden of paperwork and a sense of frustration as to its futility. A comment from Dr E epitomises the sense of helplessness and futility expressed by many GPs and is consistent with the findings of chapter 5:

*The various blended payments, I just consider that as rubbish that I have to tolerate along the way and to me it's similar to the same rubbish I had as an intern in the hospital, having to write out forms, medical discharges, you know. It was structured badly, OK?*

Comments such as this would indicate that GPs as a whole are not going to lead the reform of general practice infrastructure. That reform would therefore come from a smaller group of interested, risk taking GPs, or from the corporate world, or from general practice associated organisations.

There were 3 minor themes associated with experiential change of increasing business complexity. One minor theme was the frustration that participants were being held accountable for their activities, a second was the non-specificity of red tape requirements and a third that increased red tape had not increased patient well-being.

- Red tape as a means of accountability – minor theme

This largely autonomous group of GPs had no desire for accountability. Accountability that sits around the doctor-patient relationship gave no room to what was often considered as implementation of government policy rather than general practice reform. The poor relationship between GPs and government will be discussed in later chapters but, given the amount of Commonwealth funding supporting general practice patients, appropriate accountability is in the taxpayers' interests but was not seen to be in the interests of GPs. Whilst Dr G represents the more extreme end of the autonomy spectrum, he graphically displays the gap between accountability and clinical independence:

What effect did you think that the increasing red tape would have on your patients or the care you gave to your patients?

*First of all, the itemisation of numbers, that puts a lot of brakes on what we can do. Also, the number of patients we are allowed to see per day.*

*They want us to make proper notes of everything we do.*

Perhaps the concept of adherence to standards conflicts with the need for autonomy expressed by many participants (6.3.1). Perhaps some GPs are culturally aligned to a fee-for service model (2.11.4) where boundaries are governed more by stamina rather than by considerations of patient safety or GP well being. In general, the interviews did not pursue participants' perceptions as to what regulation they would accept under ideal conditions.

- Low specificity of red tape requirements – minor theme

Some GPs argued that the Commonwealth had cast a net intended for the worst performers. There was little contention about the validity of this role, participants seeing it as an appropriate role for the under-performers. However they implied that the net had not been specific enough and had caught up all GPs, even the best ones as exemplified by Dr N:

*The weakness is basically the need to show that what you're doing meets some form of certification, accreditation or somebody else's guidelines, because that's so much time consuming. I know that it's required and needed for the weakest links, but anything that stuffs up the strong links just to stop the weak link I think needs to be re-thought.*

There was no sense that meeting government standards was recognition of professional achievement. On the contrary, regulation was seen as offensive as only poor performers required regulation. Regulation of the profession, as distinct to regulation of an individual, was therefore an alien concept to participants; as foreign as the concept of taking pride in meeting regulatory requirements.

- Investment in red tape yielded no clinical dividend – minor theme

One further observation is possible from these data. That is that participants, by and large, could see the cost of paperwork but had trouble identifying a clinical return. For example, the logging of refrigerator temperatures was seen to be a burden void of purpose; signs on toilet doors required by the accreditation standards were interpreted as a burden rather than as an aid to patient satisfaction. In chapter 7 it will be demonstrated that participants invented systems in order to circumvent having to

comply with a regulated system, such as cold chain maintenance. It is apparent that participants had little understanding of the quality cycle or, indeed, of quality being relevant beyond the clinical consultation. The insularity perceptible in many participants, a function, perhaps, of autonomy, was typified by Dr Q who saw, from his idiosyncratic position, that “practice accreditation was forced on us with no prospect of real gain to us”.

In summary, the experiential change that was red tape was generally associated with the new quality incentives introduced by government. The term quality was seen to be a misnomer in that the incentives were not seen to relate to quality. Ultimately this had exacerbated participants’ distrust of government which had already been heightened in that there was a strong need for autonomy expressed generally by a reluctance for accountability. Against this was a sense that the government had a right to be concerned about accountability but only for the underperformers. Where reforms had not focused on clinical patient management (eg signs on toilet doors) they were discounted in the minds of participants. A marked feature was the emotiveness of responses perhaps born out of a sense of powerlessness.

The second experiential change of increasing business complexity was the perceived increasing threat of litigation.

## **Experiential changes in terms of increasing business complexity 2:**

### **Litigation**

Most GPs managed the threat of litigation by changing the nature of their business. There was one major theme and one minor theme associated with increased business complexity. The major theme was a trend to deskilling.

- Threat of litigation exacerbated a trend to deskilling – major theme

Like most GP, older participants had experienced a much broader range of clinical activities in former days (DHFS, 1998, 1998, p123). The trend to deskilling meant that GPs' activities had become broad but not deep. Participants described increased referral to consultants and increased reliance on pathology results, as described by Dr B:

How do you see general practice because of litigation?

*I think there is a lot of deterrent there. There is a tendency, from my point of view maybe, and other GPs to, to make a referral to specialised doctors, which we didn't do a lot in those days. I think it's all because of litigation, the investigations, the referral to specialist and all these are costing the government a lot of money.*

The trend to deskilling was to have a major impact on participants and will be further explored in Chapter 8.

- Volume of patients recognised but not handled as a risk factor for litigation – minor theme
- Business complexity is partly related to the volume of patients seen. Though many GPs referred to patient workload as both a burden and a risk, rarely did GPs give evidence that they had devised efficient ways of handling increased patient turnover, let alone safe systems of patient management as so forcefully described by Dr J:

*I think the more patients seen per day, the higher risk of medicolegal incident and I think, certainly my concerns are, once we're exceeding 50 patients per day and certainly in the extremes of people seeing 60 or*

*70 patients a day, the chances of doing a thorough examination and decent history taking, decent note entry, everything gets short cuts, corners are cut, notes entries become briefer, less details recorded, less questions are asked, the patient's given a prescription, usually to get them out the door quickly and significant pathology can be missed*

The immediacy of the patient seemed a higher priority than managing the threat of litigation, one of the greatest stressors for GPs (Schattner and Coman, 1998).

In summary, participants were generally seeing more patients but with a lower skill set and poorly developed mechanisms for protecting against litigation, one of their greatest fears.

The third experiential change relating to increasing business complexity was computerisation.

### **Experiential changes in terms of increasing business complexity 3: Computerisation**

Computerisation was generally seen by participants as having a role in general practice but that role was poorly defined and was, in some cases, still a novelty. Two minor themes were identified, viz., the use of the computer to reduce the complexity of the business and the use of computers to support clinical systems

- Computer support reduced business complexity – minor theme

With the exception of some older (though not all) GPs, there was a general consensus that computerisation had been necessary to reduce the burden of increasing business complexity. Dr R was typical of those GPs:

*I think being computer literate is necessary in the working world. I don't think we in general practice are any different to any other business anywhere. I mean, every business uses computers now and if you're not computer literate, then very few businesses can survive without a computer.*

However, there was a strong inference that computers had come to be used for this purpose rather than computerisation had been intended for this purpose; ie computerisation had represented a technology looking for an application, illustrating the concept that few participants gave evidence of a broad perspective of the scope and direction of their business.

- Computer support of clinical processes was dubious– minor theme

Participants identified differing clinical roles for computers depending on their own practice systems. Two broad categories were identifiable. These were clinical support (such as prescription generation, referrals) and patient management applications (such as recall and reminder functions). However, there was a small group of GPs who found no place for the role of the computer. Interestingly, there was no concept that computerisation had been embraced by participants, more that computerisation had happened to participants.



#### ***6.3.4 Conclusion about increasing business complexity***

Many participants had practiced in an era in which there was little regulation as, prior to Medibank, there had been no subsidy for patients attending GPs, no entry standards for GPs, and no ongoing educational requirements of GPs. All this had changed in 25 years. In the undifferentiated and autonomous culture of general practice, many participants found the line between appropriate regulation and red tape blurred. They reported no improvement either to their way of life or to their practice of Medicine. They mistrusted the Commonwealth and applied regulatory requirements personally rather than as a means of maintaining standards across the profession. Further enquiry may help establish whether such emotive responses to regulation are generalisable to younger GPs.

With respect to increasing business complexity, GPs were in two camps. Almost all GPs loathed the changes they had seen in business complexity. It was possible to identify 3 major themes relating to participants' frustration with increasing red tape. The first was its sheer volume, the second that it was seen to be pointless in that it was unrelated to improvements in care and the third that the conditions of the red tape were set by government against a context of distrust. Two minor themes were that red tape was generally seen as a means of accountability which impinged on most participants' sense of autonomy and which, secondly, was appropriate only to the underperforming GP.

An increase in patients and a decline in clinical skills had not lightened the threat of litigation which was heightened by the medical press. Computerisation had found a place in the business of the practice but, with respect to patient care, computerisation was less well defined.

Many of these experiential changes were to have major impacts on participants to be illustrated in Chapter 8.

## 6.4 Broad category 2: Remuneration

Change in the form and amount of remuneration ranked fourth in the changes coded from transcripts of participant interviews but was not listed on the rating sheet provided to participants during the interview. It rated as the second highest measure of gain in reply to the question, “What do you gain from general practice?”, despite the fact that a minority of participants (all males) expressed dissatisfaction with their income.

A modification of Table 6.1 illustrates the order of discussion underlying changing remuneration patterns:

	Business Complexity	Remuneration	CPD	Consumerism
<b>Effectors of change (Oracles)</b>	Feminisation of the workforce	Blended payment	Vocational Registration	Bulk billing
	Computerisation	Vocational Registration	Divisions of General Practice	Computerisation
	Increased multidisciplinary care	Practice Accreditation		
	Quality Incentives (Blended payment)			
<b>Buffers of change</b>	Divisions of General Practice	Nil	Nil	Nil
<b>Experiential changes (GPs)</b>	Red tape	Red tape	Red tape	Other
	Litigation	Litigation	Other	
	Computerisation	Other		

Older GPs had noticed most change in their form of remuneration commencing with the advent of bulk billing occurring following the introduction of Medicare. GPs practicing in hospitals had been able to bill hospitals or health funds for their treatment until they had been forced out of hospitals in the late 1980s or 1990s. Finally, the government had introduced a series of “blended payment” reforms to vocationally registered GPs working in accredited practices.

Remuneration will now be discussed in terms of its higher order “effectors” as identified by the academic GPs of the Delphi group, by the literature review and as prioritised by participants.

#### ***6.4.1 The effectors of changing GP remuneration***

Change in GP remuneration was regarded as a function of blended payments, vocational registration, and practice accreditation.

##### **Effector 1: Blended payments**

The Delphi group of GP academics ranked the introduction of bulk billing with the advent of Medicare as the most important change in general practice, but not with respect to GP income rather than with respect to patient access. More important in this respect was the introduction of blended payments which the GP academics saw as moving GPs away from the fee for service model<sup>24</sup>.

Therefore, the Delphi group saw issues of remuneration in terms of type rather than volume. None of the remuneration changes were relevant to GPs without vocational registration status.

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<sup>24</sup> I would personally disagree with this observation. My own perspective is that the blended payments have not moved GPs away from the fee for service model, but they have provided an additional mechanism that has enhanced remuneration.

## **Effector 2: Vocational registration**

A GP's VR status determined whether a rebate is payable at a higher level or not. For bulk billing GPs this was a distinct deterrent to reject VR as the bulk billing rate for non-VR GPs is markedly lower. It was this rebate control that led one oracle to suggest that students "wanted to turn away from general practice fearing the government influence".

The literature scan hypothesised that the opportunity cost for GPs to maintain VR status was unknown but could be substantial (2.1.1.1), a position supported by the Red Tape Taskforce (DHA, 2003).

## **Effector 3: Practice accreditation**

The Delphi group linked practice accreditation to blended payments. The literature scan suggested that "the cost of meeting increasingly strict standards is substantial" (2.10.1.2)

In summary, the Delphi group of GP academics recognised changes of remuneration in terms of mix rather than quantum. Participants themselves were more focused on the quantum and on the red tape associated with the mix.

Remuneration is now discussed in terms of changes experienced by participants. In this case, changes in remuneration were associated with red tape and litigation.

Computerisation was not reported as affecting remuneration.

### ***6.4.2 The experiential changes of remuneration***

Experiential changes to remuneration will be discussed in terms of experiential changes including, but not limited to, red tape and threat of litigation.

## **Experiential changes in terms of remuneration 1: red tape**

Red tape in relation to remuneration was seen by participants as being related to the new blended payments which were generally seen to be redundant. This represents the only theme associated with remuneration and red tape.

- Blended payments were viewed as a redundant form of remuneration – major theme  
Many participants indicated that they were already providing the type of care required under the incentive programs. Therefore any additional payment was for the extra paperwork not for clinical services. Typical of these was Dr L:

*...and then we've had various other things, particularly the PIP stuff and enhanced primary care items that, really, all they've done is cause a whole lot of red tape for us to gain money for things we already did before. We don't actually do anything new, except a whole lot of new paperwork, simply to be paid for what we were already doing.*

Where the activities associated with blended payments were seen to be genuinely different from existing services they were, more often than not, thought to be pointless, exquisitely phrased by Dr G:

Are you happy with that system [of Health Assessment]?  
*I think it's a waste of time. The other things too, you know where you get three or four people coming together ...*  
Yes, that's care planning.  
*You can't do that, it's very hard to get people to do that.*

In summary, the incentives were not seen as being consistent with the core work of general practice, or, where they were, they did not add benefit to the consultation.

Whilst blended payments increased income, litigation fuelled overheads.

### **Experiential changes in terms of remuneration 2: litigation**

Nett remuneration had diminished as a result of well documented increases in insurance fees. This represented the only theme in terms of remuneration and litigation.

- Litigation was a driver of increased costs – major theme

The threat of litigation was reported to have reduced the number of patients seen and, therefore income, by two GPs. However, the threat of litigation was a major theme as it was commonly referred to as increasing overheads in meeting increasing insurance levies.

### **Experiential changes in terms of remuneration 3: computerisation**

There was no identifiable relationship between computerisation and remuneration despite the fact that hardware systems can represent a considerable expense. This is possibly due to the likelihood that participants thought more easily in terms of income rather than costs. Income was readily identifiable, as under the MBS each item number has a dollar amount attached to it. It appeared that costs were much harder to determine and rarely were. Costs will be considered under “Other drivers of remuneration”.

## **Experiential changes in terms of remuneration 4: other themes**

Participants were very strongly focused on their clinical work. It was therefore no surprise that they struggled in matters relating to accounting principles. This was the basis of a major theme.

- Income was regarded as a surrogate for profit – major theme

The inability to determine costs and, in particular relative costs, was a major theme in regard to changing remuneration. Guesses were made whilst audits were not.

Professional advice was never sought and support organisations were never mentioned as a source of advice. Return on investment was never a consideration. The engagement of extra staff was almost always seen as a loss generator. There was no consideration that additional staff freed GPs to generate income clinically. Dr M was typical of this very common set of conceptions:

*Staff costs have risen because I need to have someone out there working on the front desk and then probably, normally on a Thursday, she would spend the whole day working in the other room.*

There were many disgruntled participants such as Dr M for whom investment didn't exist, only costs in the same way that income was a surrogate term for profit.

### ***6.4.3 Conclusion about changes relating to Remuneration***

Government interventions including blended payments, vocational registration and practice accreditation had impacted remuneration both in terms of increasing income and increasing costs. A major theme was that blended payments were seen to be

redundant because participants saw themselves as performing these services anyway. The fear of litigation was also a major cause of increasing overheads, and there was a concept that participants had only vague impressions of return on investment. Computerisation was not seen as either an agent of income or overhead as it was in that complex category of being an agent of both. The failure to seek professional advice was in keeping with other poorly developed help seeking strategies.

### **6.5 Broad category 3: Increasing CPD requirements for GPs**

Change in the quantum and format of education and training rated second in the coded changes experienced by GPs recorded in interviews; it was not listed on the prioritised rating sheet completed by participants, having not been identified as a high priority in the environmental scan or in the work of the Delphi group.

A modification of Table 6.1 illustrates the order of discussion re increasing CPD requirements:



	Business Complexity	Remuneration	CPD	Consumerism
<b>Effectors of change (Oracles)</b>	Feminisation of the workforce	Blended payment	Vocational Registration	Bulk billing
	Computerisation	Vocational Registration	Divisions of General Practice	Computerisation
	Increased multidisciplinary care	Practice Accreditation		
	Quality Incentives (Blended payment)			
<b>Buffers of change</b>	Divisions of General Practice	Nil	Nil	Nil
<b>Experiential changes (GPs)</b>	Red tape	Red tape	Red tape	Other
	Litigation	Litigation	Other	
	Computerisation	Other		

Many participants had witnessed a three-stage transformation of the system for GP education and training which had metamorphosed from the voluntary to the compulsory. They had entered a system in which the only educational standard for entering general practice was a medical degree. In 1973, the RACGP introduced a voluntary system for postgraduate training called the Family Medicine Program (Phillips, 1998, p9). More recently, the relatively sophisticated GP Registrar Training Program has become the minimum standard for entry into general practice (2.9.3), reflecting the standard professional pathway for other medical specialties. Regulation of standards has further seen the introduction of minimum requirements for CPD as an on-going requirement for Vocational Registration.

### ***6.5.1 The effectors of increasing educational standards for GPs***

The Delphi group of GP academics viewed educational standards as being driven by vocational registration and most commonly delivered by Divisions of General Practice.

#### **Effector 1: Vocational registration**

VR was the most important effector of educational standards for GPs. The Delphi group recognised that VR status was necessary to claim the full patient rebate and suggested that VR status was directly related to educational standards which had been introduced as a prerequisite for VR.

#### **Effector 2: Divisions of General Practice**

It was suggested by the oracles that Divisions were an important factor in educational reform in that Divisions have become “the major route for continuing education” (oracle).

### ***6.5.2 The experiential changes of increasing educational standards***

Experiential change of changes to remuneration will be discussed in terms of red tape and a second theme related to the socialisation of the educational experience.

#### **Experiential changes in terms of increasing educational standards 1: red tape**

As for blended payments, there was no concept that education had improved as a result of increasing standards. This had had an evocative effect on participants in that the

system of standards had contributed to increased red tape requirements.

- Red tape was a driver of frustration with increasing educational demands – major theme. Participants had not perceived any logic behind the Quality Audit (QA) and CPD system (2.10.1.1). Many GPs felt that they were already maintaining an adequate approach to CPD without any need for the Commonwealth to intervene. This was to be an opinion expressed frequently by participants; namely that quality was inherent in their work processes and the need for further education could best be decided by them. Dr K, for example, interpreted the Commonwealth's attempts to categorise educational activities as “jumping through hoops”, implying a certain degree of futility.

Education and training, in addition to the quality incentives of the EPC package, had produced resentment of the paperwork involved. The findings of this section are consistent with the concept that participants have not found the need for standardisation or benchmarking; perhaps because they work in the undifferentiated environment of general practice.

### **Experiential changes in terms of increasing educational standards 2: other themes**

With one exception, CPD was not seen to be related to reducing the threat of litigation, nor was the computer seen as a vehicle for CPD. However the new CPD requirements had very strongly become a social resource for many participants.

- The educational experience as a social experience – major theme

Whilst the increasing sophistication of education and training was generally welcomed, participants placed great value on the opportunity educational fora presented to meet with their peers.

Education was generally seen an opportunity to meet the increasing requirements demanded by the QA & CPD program in a socially rewarding environment. It had come to replace the chats in the operating theatre of days gone by. However, there was little sense that the program improved knowledge, patient well-being or GP satisfaction aside from social intercourse. Further research may better define benefits and costs of educational activities for GPs, including collegiality, pride, satisfaction and improved patient care on one hand and lifestyle and compliance costs on the other.

### ***6.5.3 Conclusions about changes relating to CPD***

Increasing requirements for CPD again raised the issue of autonomy and the purpose of benchmarking. With some exceptions, participants were generally willing to forego what they saw as the weaknesses of CPD in order to engage in peer-based social interaction.

This leads to the fourth broad area of change reported by participants, that of increasing consumerism.

## 6.6 Broad category 4: Increasing consumerism

Consumer demand ranked fifth in the thematic analysis of changes mentioned by participants at interview but was not listed on the priority rating sheet presented to GPs.

A modification of Table 6.1 illustrates the order of discussion underlying increasing consumerism.

	Business Complexity	Remuneration	CPD	Consumerism
<b>Effectors of change (Oracles)</b>	Feminisation of the workforce	Blended payment	Vocational Registration	Bulk billing
	Computerisation	Vocational Registration	Divisions of General Practice	Computerisation
	Increased multidisciplinary care	Practice Accreditation		
	Quality Incentives (Blended payment)			
<b>Buffers of change</b>	Divisions of General Practice	Nil	Nil	Nil
<b>Experiential changes (GPs)</b>	Red tape	Red tape	Red tape	Other
	Litigation	Litigation	Other	
	Computerisation	Other		

### 6.6.1 The effectors of increasing consumerism

The Delphi group identified bulk billing and computerisation as the major effectors of change to increase consumerism.

**Effector 1: Bulk billing**

The GP academics regarded bulk billing as the greatest effector of change with respect to consumer demand. There was consensus that bulk billing had acted to increase patient access to the GP.

**Effector 2: Computerisation**

The GP academics suggested that patient access to computerised information was a strong effector of consumer demand.

**6.6.2 *The experiential changes of increasing consumerism***

Whilst two GPs saw themselves in the market of providing consumer information (rather than just providing “advice”), the GP response to increasing consumerism was not well defined as the following suggests:

**Experiential changes in terms of increasing consumerism 1: red tape**

There was no relationship discernable between red tape and consumer demand. This may be because consumers were not instrumental in introducing incentives to general practice. In fact, it is more likely that GPs were requesting certain planned episodes of care of patients rather than patients requesting them.

**Experiential changes in terms of increasing consumerism 2: litigation**

Whilst there was a discernable relationship between consumers and GPs with respect to litigation, the threat had been generated by experience, but by the media, in particular the medical press. Where GPs had seen patients become more litigious it was

against a background of patients demanding more from their doctor, a theme developed below.

### **Experiential changes in terms of increasing consumerism 3: computerisation**

Consumer expectations of access were reported to have risen as their access to health information increased. These reports are consistent with literature (2.13). Consumers were reported as being more informed by the internet (and other media sources). However, as the number of participants reporting this was three, no themes can be derived from this topic.

### **Experiential changes in terms of increasing consumerism 4: other themes**

Only one major theme with respect to increasing consumerism was identified from thematic analysis of participant interviews viz., consumer demand.

- Consumers were perceived as being more demanding – major theme
- Consumers were reported to be demanding. In fact, 7 GPs used the word “demand” (or a variation) in describing their patients. This was therefore a very evocative and readily discernable theme as evidenced by Dr S:

*I think what we're faced with is a community of angry people and that's why it's more litigious. People are more pissed off. They're ruder and they're angrier and I think that comes out of, it's an instant hit society. Society wants things now (snaps fingers), don't matter, if it can't be done they get angry. If I can't get into the doctor now, I'm going to ring up, I'm going to complain*

This observation is critical in the context of the high value participants placed on the doctor-patient relationship. When asked the question, “What do you gain from general practice?”, the most common reply of participants concerned the doctor-patient relationship. This relationship appeared to be crucial to the satisfaction GPs derived from practice and would be at risk if the nature of the consumer were to change. If this is a correct interpretation, there is an array of new challenges which general practices will have to face with regard to access (8.3.2), rationing of services (8.3.3), and litigation whilst providing fewer clinical services but spending more time in explanation (9.6). There is little in the literature to help understand if this is the case and how GPs respond to it.

### ***6.6.3 Conclusions about changes relating to increasing consumerism***

Many participants evocatively suggested that consumers were becoming more demanding. If this is so, such a change may have implications for the nature of the doctor-patient relationship and the satisfaction GPs seem to derive from it, and, in particular, the autonomy also valued by many participants (5.3.2).

Pressure from patients seeking GPs for guidance about information derived from external sources in the context of a more demanding clientele on one hand and a remuneration system that encourages high throughput on the other may represent a challenge for future GPs. These two competing forces are operating within a framework in which the product being purchased (the consultation) is poorly defined in terms of what is being provided and what is being purchased. In such an environment, both consumers and their GPs may experience considerable frustration and misunderstanding.



## **6.7 Concluding remarks**

Categorising changes under four broad headings allowed a taxonomy by which general practice change could be further explored. The taxonomy developed was the product of an iterative process, each stage of which was moulded by further data acquisition and analysis as participant interviews were completed, and by reference to other sources of information; a process intrinsic to a grounded theory model.

The changes identified by the Delphi group stood in stark contrast to the other methodologies used. The Delphi technique seems to have been a most useful resource for identifying areas of strategic or policy importance. However, a focus group of non-academic GPs may have been a better methodology for identifying important changes faced in the day to day environment of “grass roots” GPs.

Ultimately, this chapter has demonstrated the advantage in aligning academic general practice with the culture of grass roots GPs so that government policies grow more readily out of a closer awareness of the Australian general practice context in which it must be implemented. It therefore also strongly suggests that research and its findings are better communicated to the Commonwealth as major general practice funder and innovator. Lastly, as suggested through the Delphi group of GP academics, there is a strong preference for some buffer to exist in order to allow better preparation by general practices for change.

As for the GPs reporting their experiences of change, what was most notable was the depth of emotion they used. Change had not come easy for this group who, as determined in Chapter 5, were to some extent, quite vulnerable.

Ultimately, a set of changes faced by a group of Australian GPs has been developed. Having determined these changes, it is important to understand how the participants responded to them. This is the purpose of Chapter 7.

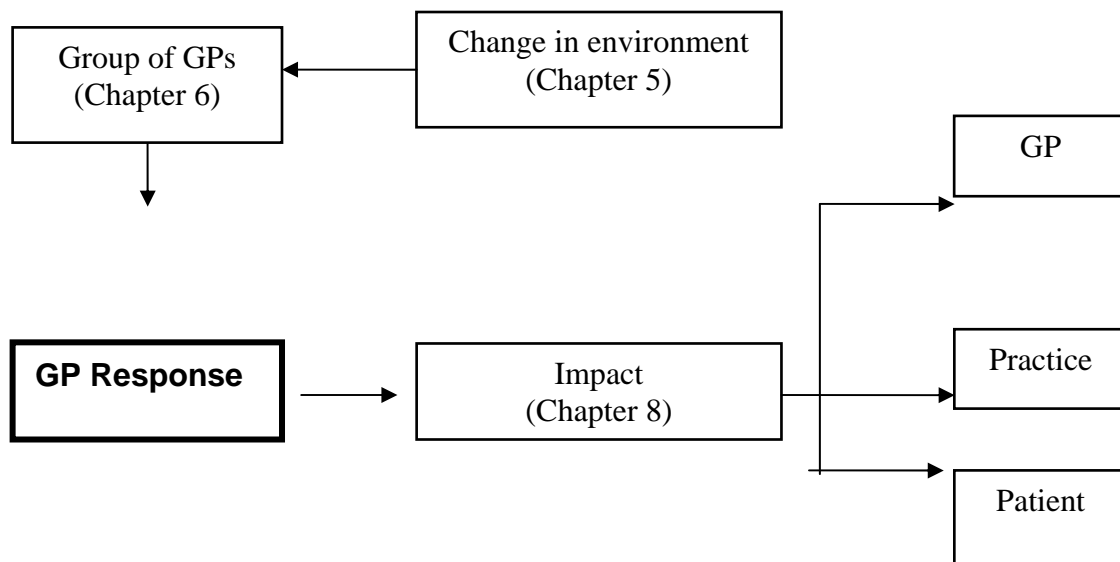
# CHAPTER SEVEN

## Participant Response to Non-Clinical Change

### 7.1 Introduction

Chapter 7 provides an overview of the general responses participants made to change. With reference to Figure 1.1, it can be seen that, having examined changes GPs have experienced and having studied some of the beliefs and attitudes of a group of GPs, it is now appropriate to determine how those GPs responded to change, as indicated below:

Figure 1.1 (revised)

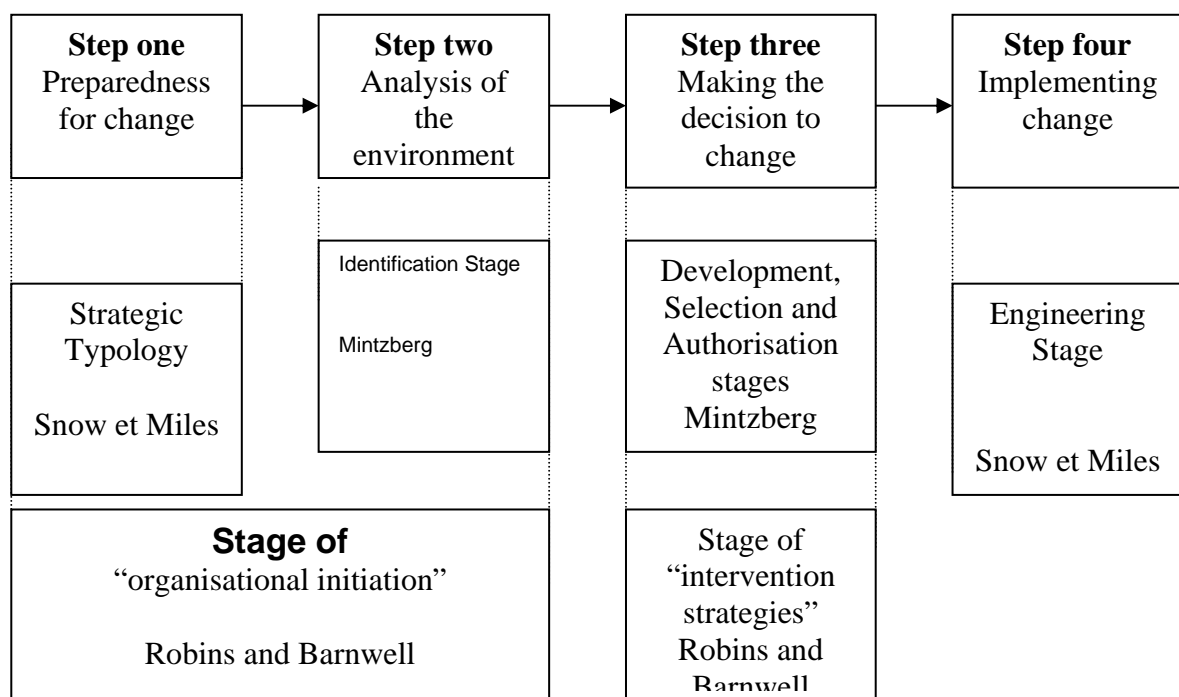


As previously discussed (4.6.2), the intention of the methodology is to generalise from the case studies rather than pursue each case study individually. This aggregated technique is known as the “collective case study” (Stake, 2000, p437). Accordingly, Chapter 7 will present an analysis of the participants’ responses to the changes more generally rather than responses to specific changes. In this way it will be easier to anticipate how this group of GPs may respond to change in a more generic way. In

understanding how GPs responded to change, it will be possible to understand better whether responses are well considered and planned or whether, like much of the medicine they practice clinically, as demonstrated in Chapter 3, GPs tend to respond in an unpredictable manner.

This chapter will examine response to change according to Figure 7.1, which represents a flowchart by which change can be identified and implemented.

**Figure 7.1 A process of change**



This flowchart demonstrates that change will be favoured when an organisation (in this case a general practice) is prepared for it (Step one). An organisation may even be culturally aligned for innovation (Miles et Snow, 2003). This is demonstrated in the "Strategic typology" box. Section 7.2 will discuss what factors enhanced or inhibited the likelihood of GPs implementing change.

Step two recognises that change will generally be driven by changes that are occurring, which may occur, or which have occurred in the environment. The Mintzberg decision

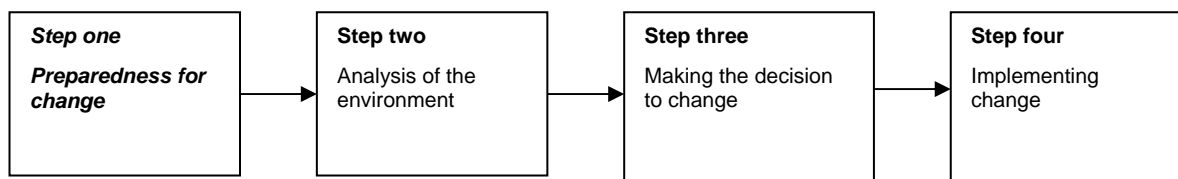
process model refers to this stage as the Identification stage (Mintzberg et al, 1976, quoted in Stacey, 1996, p37) as stakeholders seek to identify those environmental changes. Section 7.3 will demonstrate that participants made little reference to an analysis of their environment. Steps one and two together have been identified as the “Organisational initiator” stage (Robins and Barnwell, 1994, p330).

Step three represents all the elements which contribute to decision making. Mintzberg et al categorised these elements as development, selection and authorisation. Section 7.4 will demonstrate that the participants commonly displayed organisational characteristics best defined as “Muddling through” (Lindblom, 1959, quoted in Stacey, 1996, p39).

Finally, implementation of the change occurs (Step four) by a process described by Miles and Snow as the Engineering Phase (Miles et Snow, 2003). Section 7.5 will demonstrate that many participants brought about change in an autocratic fashion.

## 7.2 Preparedness for change

Chapter 6 demonstrated that major changes had occurred to a particular cohort of GPs who, as discussed in Chapter 5, were generally ill-prepared for change. Preparedness for change is the first step in the change process as indicated in Figure 7.1 modified below:



A number of themes were identifiable in examining participants' preparedness for change:

### **Preparedness for change**

*Theme 1: Participants displayed features of either a defensive or reactive strategic typology - major theme*

The response to Commonwealth reforms generally was a low priority for participants, many of whom saw no need to change a system with which they were comfortable:

*I didn't even know about it because I, you know, I'd rather just practice and try not to let these peripheral issues I mean, I'm glad some people take it up on our behalf, but I'd rather not know about it.*

Dr P

An organisation's cultural and business attitude towards change represents its "strategic typology". Miles and Snow have identified three strategic types that constitute an organisation's attitude to the market, viz., Prospectors, Analysers and Defenders (Miles et Snow, 2003). Prospectors are organisations looking for opportunities for new markets and new products. They invest heavily in surveying the environment. Analysers will follow successful prospectors, investing in better products than prospectors are able to. Defenders largely ignore the environment, confident there will always be a market for their product. Defenders invest in minimising cost and maximising efficiency.

Richman suggests that GPs have adopted "defensive strategies" to "regulate the increasing social turbulence" (Richman, 1987, p92). This may be a relevant observation

for this group of GPs, many of whom appeared almost “shell-shocked” by the quantum of change they had experienced. However, this is supposition as neither this study nor other literature lend light into the reasons for GPs’ strategic typologies.

It has been suggested that people, in making decisions, will favour avoidance of risk rather than seek an equivalent gain (Cox, 2003). That was so of most participants. A conservative attitude to business saw GPs changing their minds only when the gain obviously exceeded the risk. This was exemplified by Dr G:

*For the time being, a lot of people held back, but gradually I think people on their own registered, just to be on the safe side and we were one of them. We held back registration, but eventually we knew that we’d probably be at the loose end, so we’d rather do what the government said and be registered.*

However, many of the interviewed GPs were not prospectors, analysers or defenders. Miles and Snow have described a fourth strategic type termed “reactors”. Reactors respond inconsistently, sometimes inappropriately and often as a last resort.

Participants tended to be reactors in much the same way the Literature Review (Chapter 3) suggested GPs reacted clinically (McLaren and Shelley, 2002; Russell and Roach, 2002; Taft et al, 2004; Krum et al, 1998, Fuat et al, 2003).

In particular, participants tended to be reactors in the area of litigation and risk avoidance. The most common response given a complex clinical problem was to hand the problem to the specialist consultant. However, this process resulted in reversal of

roles whereby the GP who had formerly been expected to guard the gateway to the specialist consultant, and hence control costs (2.2), became the means by which access to the expensive specialist sector was facilitated.

Rural GPs were much more likely to be an exception to the conservative approach to change, all of whom had adapted to change more aggressively than their urban counterparts, as exemplified by Dr T:

*I thought at the end of the day, look it was a good idea to get on that bandwagon because clearly that was the bandwagon we were intending to get on, so you may as well get on early, get it over and done with and move on*

Dr T

Two GPs raised the interesting suggestion that younger generations of GPs tend to have a different strategic typology, one that is almost a null typology. One of those, Dr T suggested that lifestyle considerations are more important to younger GPs than older GPs:

*It's sort of like, crazy. But I represent the over-50 group and I'm not so sure about this new group coming through. They seem to have different aspirations, different desires. They want to work less, take home more and talk about quality time with their families, but the only way you can do that in medicine is to rot the system, because you cannot earn that sort of money without working hard.*

It may be that younger GPs may have different aspirations and may adopt differing risk taking behaviours shunned by their older colleagues. This hypothesis was also untested



in this study but requires further consideration (Tolhurst et Stewart, 2004).

*Preparedness for change theme 2: GPs' defensive strategic typology was reinforced by a jaundiced view of government. - major theme*

Participants distinguished between the principle behind the change and the change itself. The overriding principle was that the Commonwealth had a valid role in general practice. Generally, this was not disputed. The way in which the Commonwealth executed that role was disputed. For example, practice accreditation as a principle was not disputed; how it had been introduced and implemented was. Scepticism was almost universal as justified by Dr O:

*Most doctors are very rational people and if they have to change, they want to see a rational reason for it and if they're not convinced that there's not a worthwhile reason, then they will resent it.*

Inevitably scepticism compounded a defensive or reactive position which was more likely to be adopted if the change was initiated by the Commonwealth. The need for a buffer organisation to negotiate change and to negotiate its implementation becomes more critical in the light of a conservative GP population and a government keen to pursue reform but with little credibility at the grass roots level.

In summary, most participants exhibited a reactive typology with regard to change, a strategic type that was strongly conservative and which would be most likely type to result in ineffective responses in general. A conservative approach to change is predicted by literature (Robins and Barnwell, 1994, pp341,2) and may be particularly

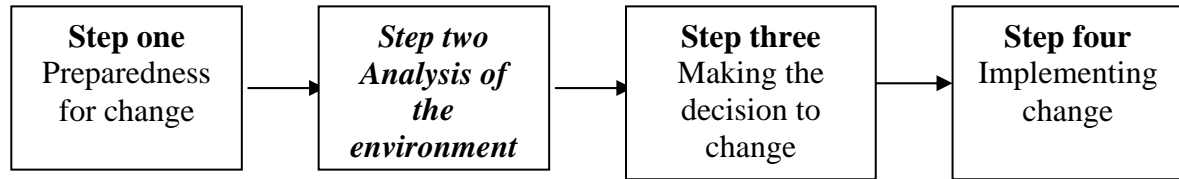
resisted where “reorientations threaten their dominance; .....their high statuses have persuaded them that they have more expertise than other people; their expertise tends to be out-of-date because their personal experiences with clients, customers, technologies, and low-level personnel lie in the past; they get much information through channels which conceal events that might displease them; and they associate with other top managers [read GP colleagues] who face similar pressures.” (Starbuck, W.H., 1983, p100, quoted in Robins and Barnwell, 1994, p342).

If this group of GPs were representative of the wider population then GP buffer organisations would need to:

1. negotiate with the Commonwealth to ensure planned changes were logical in the general practice setting,
  2. develop strategies that maintain GP status,
  3. disseminate unbiased information,
  4. encourage GPs to associate with a broader group of professionals, and
  5. train GPs for specific changes, in order to most appropriately respond to change.
- Participants were typologically unprepared for change. This was particularly evident in that they reported giving virtually no time to an analysis of their environment.

### **7.3 Environmental analysis**

This section will examine how participants responded to changes by analysis of their environment (Step two, Figure 7.1):



Mintzberg and Quinn suggest that “the environment of an organisation in business... is the pattern of all the external conditions and influences that affect its life and development” (Mintzberg and Quinn, 1991, p47). Any organisation is said to be dependent on the flow of inputs and outputs between itself and its environment (Robbins and Barnwell, 1994, p197). Predicting changes in the environment therefore is critical to the success of an organisation unless the environment is unusually stable, and “necessitates continuous monitoring of a company’s definition its business” (Mintzberg and Quinn, *ibid*). This comment introduces the first theme of this section, viz, that participants made almost no reference to their environment.

### **Environmental analysis**

#### *Theme 1: Participants were generally unaware of their environment – major theme*

Participants gave no indication whatsoever that they had the skills, the means or even the interest to anticipate or monitor environmental change despite the fact that change has been such a prominent feature of the general practice environment. A number of reasons became evident for this attitude. These are presented as subthemes:

Subtheme 1: Participants exhibited strong personal bias against taking control – major theme  
Factors increasing stress include loss of control and helplessness (Kanter, 1985, p63), two factors strongly evident in this group (6.4.3, 6.4.1). It may be that a group who feel that they are unable to control circumstances find no value in examining the environment as they couldn't change anything even if they could anticipate its advent.

Subtheme 2: Change, as mediated by the Commonwealth, was perceived as occurring randomly – major subtheme

Participants reported that there was no point trying to predict the environment because the environment changed in a random manner and without warning<sup>25</sup>: However, the charge of “random” innovation cannot necessarily be sustained in the light of Commonwealth documents such as *The Future of General Practice* (Macklin, 1992). That document very explicitly describes the changes that were to occur over the following decade of innovation. It refers in some detail to blended payment models, practice grants for accredited practices to support computerisation of practices, an emphasis on quality and its measurement, the development of Divisions of General Practice and a new model of general practice education and training, all of which came into being. If GPs have indeed been unable to predict future changes then it would appear that their representative organisations have failed to communicate the contents of such documents or to negotiate them with the Commonwealth.

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<sup>25</sup> Changes have usually been announced in the Federal budget papers each year

Theme 2: Participants exhibited poor help seeking behaviours – major subtheme

Failure to capture an adequate breadth and depth of background information may predicate a poor decision making process. Dr O typifies the more general tendency of participants to make decisions based on little evidence:

You made this decision, which will have affected the access of your patients to your care, would have affected your cash flow, may have impacted on your family. Whose advice did you seek? Did you read about it, did you see your accountant? What research did you do before making this decision?

*I don't think I spoke about it to anybody except my wife and my reception staff.*

In a culture that places high priority on autonomy it may be that help seeking is an alien concept. It is evident in this study that there was consistency between the clinically autonomous way Australian GPs are reported to provide services to patients and the autonomous way participants managed changes to the business of the practice. It may be that all GPs who did not seek professional advice about implementing change were acting in an autonomous manner quite unwittingly. It may simply be that participants had not been exposed to a culture of help seeking and that their behaviour is consistent with literature reports of GPs' behaviours in seeking help for their own illnesses (Firth-Cozens, 2001) and in managing clinical conditions (Mayer and Piterman in A.3.5.8). Despite the relationship between threat of litigation and stress, no participants indicated that they had sought expert assistance.

Dr P gives a wonderfully graphic account of his intuitive technique in responding to change:

I don't get the impression you're in a position to be able to delicately weigh up the ins and outs of everything that is suggested to you or comes across your desk.

*Well, I guess you just sort of go off a very brief impression and if you get the feeling it's going to be a waste of time, then you give it very little time and thought and other things you'll put aside and read and assess and say, well yes, this is worth my energy.*

Do you feel you're getting quite gifted in that?

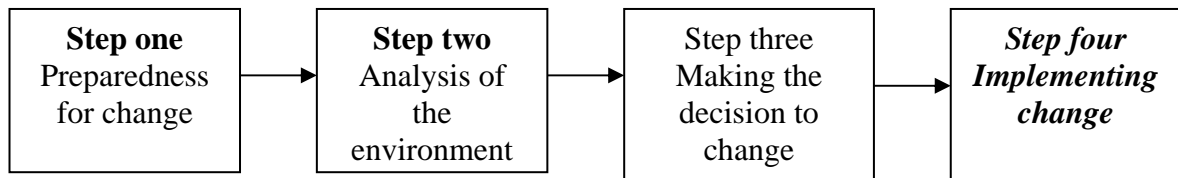
*Yeah, I think so, by and large, apart from that Medicare thing I threw out.*

As predicted by Starbuck (Starbuck, 1983, quoted in Robins and Barnwell, 1994, p342), colleagues were a common source of advice. This can be seen either as a sharing of ignorance or as a healthy strategy in that the sharing of a problem leads to a more certain response (Mechanic, 1978, p300).

In conclusion, change had not been embraced by this cohort of GPs in general and many were not prepared to meet change as they did not relate to the changing general practice environment around them. They perceived change as random and therefore unpredictable. In failing to secure professional business advice, participants approached the general practice environment in the same manner that Australian GPs are reported to seek clinical advice for their patients or professional advice for their personal medical problems. There was a strong sense of helplessness.

## 7.4 Making the decision to change

This section examines how participants made decisions in response to change (Step three Figure 7.1):



Generally, when participants made decisions to change, they did so in the same unprepared manner that they approached change as demonstrated in the two previous sections. Five themes emerge from an analysis of the transcripts with respect to making the decision to change. These are as follows:

### **Making the decision to change**

*Theme1: The decision to change was made in an unsophisticated manner - major theme:*

There was no sense in which participants had developed a business case for adopting change. In particular there was no evidence of risk analysis and none of consideration of opportunity cost, the impact on the participants or on-going costs. Nor was there a sense of a strategic direction of the business and the development of options to the change was almost never a consideration. There was little apparent thought as to the consequences of the reforms in terms of economics, human resource management, risk,

lifestyle or of even retreating from a failed intervention, as evidenced by Dr L:

There've been a succession of these increases in red tape requirements, you've mentioned workers' compensation, the PIP and the EPC for example. What effect did you think, as you saw these come along, what effect did you think it would have on the workings of your practice?

*I don't know what I thought how it would affect us*

*Theme 2 : The decision to change was favoured by increasing income - major theme*

The forces that bear on GP incomes in Australia have been documented elsewhere (Figure 2.10) and have seen a dramatic downturn in the rate of bulk billing (Figure 2.9) and a very high uptake of Vocational Registration (2.10.1.1), without which the patient rebate has been frozen well below rebates for Vocationally Registered GPs. The penalty for not being vocationally registered was too great so that every participant had undergone vocational registration, generally for financial reasons, as illustrated by Dr N:

How was the decision to participate in practice accreditation made in this practice?

*To attempt to maintain as much income as we can through the current system.*

For those GPs who bulk billed exclusively, additional income derived from the new EPC items was a windfall and meant that they could resist the temptation to privately bill. On the other hand, a decision to charge patients privately was universally



welcomed, by those GPs who had made that decision, as a means of increasing professional independence.

Participants appeared to have little appreciation of costs to implement a reform, whilst appreciating the income. The remuneration derived from adopting incentives is a simple calculation. However, determination of costs is much more complex unless the GP performs all clerical tasks in which case the costs of these are simply opportunity costs, eg of not seeing patients. From an accounting perspective these costs represent zero overheads. However, as clerical staff take on these roles, so real costs in the form of salary and overheads become more evident. It may even be that a GP is forced to compare staff costs to lifestyle opportunities for himself/herself. For those participants who had adopted the new initiatives, there had been an apparent improvement in gross practice income and this had been sufficient incentive, indeed often the only incentive, to adopt the reforms, as evidenced by Dr T:

*You've got to remember that accreditation was tied to financial incentives, so the question is if the financial incentives weren't there, would you have gone down an accreditation pathway? Would I have been silly enough to go through accreditation and not getting anything for doing it?*

There was almost no sense that reforms should be adopted because they might result in better business processes and more efficient protocols of care. There seemed to be no appreciation of the normal quality improvement cycle routine to many businesses.

However, a small minority of participants did forgo additional income rather than alter work processes. The fact that the clinical work required by the reforms was already being done was, for them, a barrier to adopt changes by completing the necessary paperwork. Dr D was one of these:

*I mean, with all this PIP and SIP and all, like with the mental initiative, I see so many patients with depression and anxiety and all those sort of problems. And I've done the training, but you wouldn't believe it I haven't claimed even for one single patient just because, I spend the time with these patients, but just because I don't do it in the format the government wants us to do.*

*Theme 3: The decision to change was prejudiced if not obviously associated with improved quality - major theme*

A factor limiting uptake was the absence of any apparent association with quality. This was a very strong association and was exemplified by Dr A:

*I read about the various schemes that were being put and proposed to be put in place and I really avoided accreditation as long as possible, as I felt that it was a paper exercise and that it wouldn't make any difference to the quality of practice.*

However, lack of quality tended to be a weaker driver compared to increased income.

As participants rarely related quality to the reforms the decision to change was determined by remuneration on one hand and the amount of work involved in implementation, on the other. These factors are important in the context of Johnson and

Scholes who suggest the “strategic direction [should be] clearly related to achieving competitive advantage or excellent performance” (Johnson and Scholes, 1993, p416). As the general practice market is characterised by undersupply, competitive advantage is less relevant than is quality. It would therefore seem that government would be wise to place greater emphasis on quality and its measurement as a driver of change.

*Theme 4: Resources for change were always assumed - major theme*

Consideration of material, technical, financial or managerial resources required (Mintzberg and Quinn, 1991, p47) was not part of the decision making process in that they are not discussed in the transcripts. Some of these resources also represent critical elements necessary to implement change. Therefore, this group of participants, in making decisions, seemed to “fly by the seat of their pants”, rarely if ever formally considered the necessary resources, but adopted change for the reasons most organisation do, viz financial gain or improved quality.

*Theme 5: The decision to change was commonly made in isolation - minor theme*

Robins and Barnwell refer to “change agents” as people who lead change in an organisation (Robins and Barnwell, 1994, p333). Kanter refers to them as “idea champions” (Kanter, 1985, p296). However, change agents or idea champions tend to change organisations. Many study participants seemed to have been able to change the way they practiced without affecting the organisation greatly. This non-systematic approach to change was endemic to the cohort. Some would change whilst others in the practice would not. Such a haphazard approach would rarely be tolerated in other

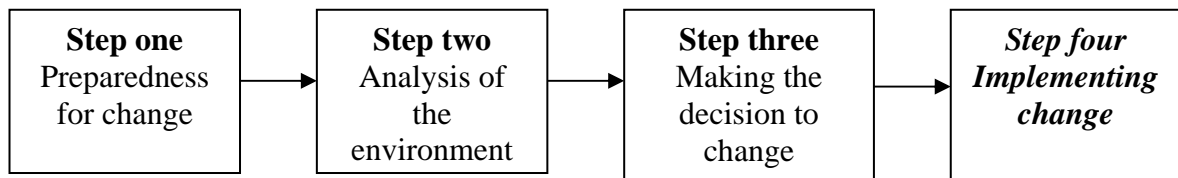
industries, but few industries are centred upon the independence and autonomy of the principals involved. Robins and Barnwell suggest that criteria for change will reflect the “self-interest of the dominant coalition” and that the decision to change “will be made by the dominant coalition (Robbins and Barnwell, 1994, p229). General practices, on the other hand, appear to be able to function as a coalition of independent principals. It appears likely that a non-uniform approach to decision making would prejudice the introduction of a uniform system of business operation. On most occasions there was no consensus for change from others within the practice, nor had any been sought. There were instances where a single GP introduced change into the practice by himself/herself, as demonstrated by Dr R:

*Initially, the way I introduced it (computerisation) was I brought a desktop computer for myself.*

In conclusion, the decision to change, was largely based on intuition with very little clarity as to how the change would impact following implementation. Kanter suggests that intuitive decisions are an important talent and may represent the “artful craft” of decision making as opposed to “technique” (Kanter, 1985, pp303,304). This model may appeal to doctors who have long recognised a distinction between the “art and science of Medicine”. However, Kanter prudently warns against art being misinterpreted for what is really accident or “muddling through” (ibid, p304 and Stacey, 1996, p39). The distinction between participants’ perceptions of rational planning and best guess, and between true art and muddling through has become a major theme of this thesis, deserving of further enquiry.

## 7.5 Implementing change

This section will examine how participants implemented changes (Step four Figure 7.1):



Again, a number of themes emerge as to how participants implemented change.

### Implementing change

*Theme 1: Change was implemented with a paucity of essential criteria – major theme*

Robbins and Barnwell identify four essential criteria for implementing change: people, structure, technology and organisational processes (Robins and Barnwell, 1994, p334). Changes in structure may require a change in the degree of formalisation. It is interesting to note that Australian GPs in general, and this participant group of GPs specifically, have shown marked resistance to increasing formalisation (“red tape” and benchmarking). Technology encompasses not only equipment but also technical demands of the workplace. This is an important observation as this group of GPs commonly reported a declining clinical skill set (8.1.4.1) in that clinical skills had been lost over the years. However, they also reported a broadening skill set (8.1.4.2) in that quasi-clinical skills had been attained but these were no replacement for the application of clinical skills of former years. Organisational process includes such techniques as communication and involvement in decision making. Generally, participants did not demonstrate an awareness or utilisation of these elements. The subtheme of poor communication was also a major one:

*Theme 2: Change was implemented in an environment of poor communications  
– major theme*

Involving staff in the decision to respond to change is reported to be a strong motivator of acceptance of change strategies (Robbins and Barnwell, 1994, p337). There was no sense that staff members were involved in decisions to change, as demonstrated by Dr F:

You made a decision to put computers in. What did you tell your staff?

*I think we just said the computers are going in.*

Robbins and Barnwell describe three levels at which decisions can be communicated. The first and most effective is through staff participation in the decision making process. The next most effective level occurs where staff is persuaded that the decision is a good one. The least successful technique is known as implementation by edict (ibid, p339), and was the most common technique used by participants. This is consistent with findings reported in the literature review in that communication in general practice was regarded as “challenging” (Russell and Roach, 2002). Indeed, participants seemed to communicate to their staff in an identical fashion to that of the Commonwealth in announcing new reforms, ie by edict as graphically exemplified by Dr L:

So you have team meetings?

*Yeah, not formally, but when it's required we hold a short meeting and say this is what you got to do.*

The ad hoc approach was common and represents a minor theme for implementing change:

*Theme 3: Change was implemented in an ad hoc manner – minor theme*

The most common implementation strategy was to trial the innovation but with little preparation and less enthusiasm. As mentioned, it was common for a single reform to be modified for the desires of each individual GP. The only systematic basis of reform was that a reform was adopted. Often each GP would have his or her variation of the intervention. Where planning occurred it occurred only in the mind of a few so that reforms were almost always far riskier than needs be. Dr D was one such victim of a good idea:

What effect did you think that computerisation might have on your practice?

*I had no idea. It was a bit like saying to someone who couldn't drive a car, now go out and buy a car. Saying to someone, here's a computer, how are you going to use it in general practice? It was like, well how deep is the ocean sort of thing. So it was a complete unknown and I would have had no idea that it would impact on virtually every aspect of what I do.*

The concept of one GP having the effrontery to lead another was not in evidence, the last theme pertaining to participants implementing change:

#### *Theme 4: Leadership was by the led – minor theme*

It was notable that once an innovation had been adopted, despite apparent inadequacies in the process of communication, it was not the GPs but rather the staff members who took it upon themselves to ensure that the new process actually worked within the practice structure.

Indeed there was no concept of a single leader discernible from the interviews, perhaps because the structure of most general practices does not lend itself to a single leader. However, Mintzberg emphasises the importance of this role (Mintzberg and Quinn, 1991, p46). A possible compromise may be to place the leadership role in the hands of a single GP whilst giving other important roles to other GPs, or placing it in the hands of a Practice Manager, or simply working in the corporate general practice environment as an employee in which case leadership (and following) may be a very dominant culture.

In summary, participants gave the very strong impression that they expected to be surprised by change, that their response to change was not going to be deeply considered and, that when a decision had been reached, it was communicated as an edict in much the same way the edict had been communicated to them. In the face of diffuse leadership and poor communication it would be likely that implementation would be less effective and that the impact of change may be different to that expected of well-run small businesses.

## **7.6 Concluding remarks**

In summary, there was no evidence that GPs were enthusiastically forging opportunities for change; the prospectors referred to by Miles and Snow. Almost universally, GPs made decisions about change on the smallest amount of information and almost no professional advice and many were predisposed to rely on their own intuition when



making decisions about change. GP representative organisations were not considered a resource for change.

Participants generally responded to change in the same manner predicted by the literature review of Chapter 3. In Chapter 3 it was identified that, at times, GPs manage care in a haphazard fashion (Mclaren and Shelley, 2002; Krum et al, 1998), they make poor use of information (Young and Ward, 1997; Fuat et al, 2003) or fail to access it (General Practices Profile Study, 1997) Perhaps this explains, in part, the anxiety described by participants stemming from loss of control (6.3.3) and a strong sense of helplessness (6.3.1).

Fuat et al describe a striking similarity with the way GPs faced the challenge of new ways to treat heart failure with the way participants approached new ways of “doing business”. The authors described most GPs as being apprehensive about new therapies, that they were unaware about new developments and that major behavioural influences included anecdote and past training “no matter how old” (Fuat et al, 2003).

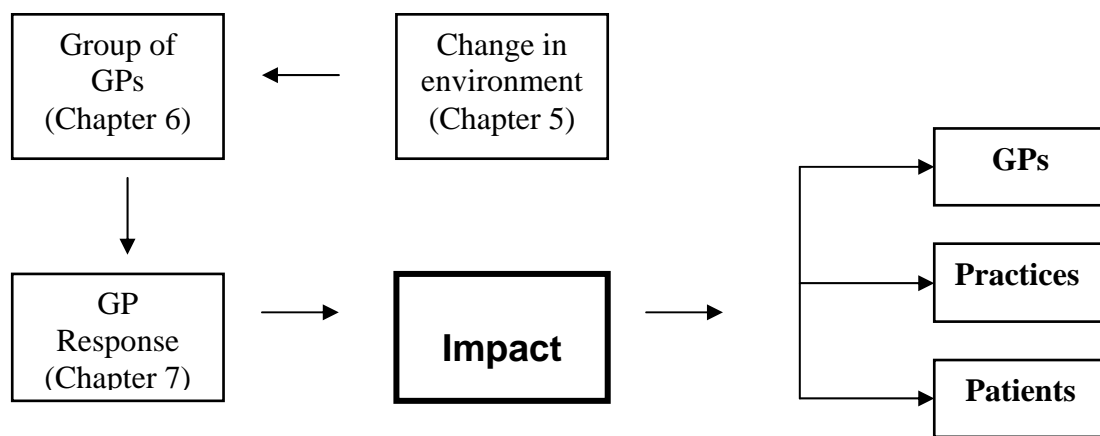
The impact of the changes experienced by this group of GPs, modified by their responses, will now be considered in Chapter 8, where it will be seen that poor responses to change lead to particularly severe impacts of that change.

## CHAPTER EIGHT

### The Impact of non-clinical change

#### 8.1 Introduction

Chapter Seven examined the responses that GP participants had made to change. Chapter Eight examines the impact of that change upon GPs, their patients and their practice, illustrated in a modified version of Figure 1.1.



In the context of a cohort who, with certain exceptions:-

- expressed a high degree of helplessness,
- were generally dissatisfied with their situations, and
- who perceived change as uncontrolled,

it is not surprising that the impact of change had been, in many cases, extremely stressful. Change had pervaded their personal lives, the practice within which they worked, and their professional lives, though in this latter area change may actually have been a catalyst provoking important changes within the practice. Each of these areas will be explored in the following three sections.

## 8.2 The impact of change as it affected the GP

This section deals with the impact of change as it affected the GPs themselves. Impacts were generally well described by participants as affecting themselves, their relationship with patients, their roles within the practice, and GPs' relations with government more generally, as demonstrated in Figure 8.1

The general range of areas of change bearing directly on participants identified through transcript analysis is demonstrated in Figure 8.1 which also indicates specific areas in which change was reported to have impacted most heavily.

**Figure 8.1** The impact of change on GPs

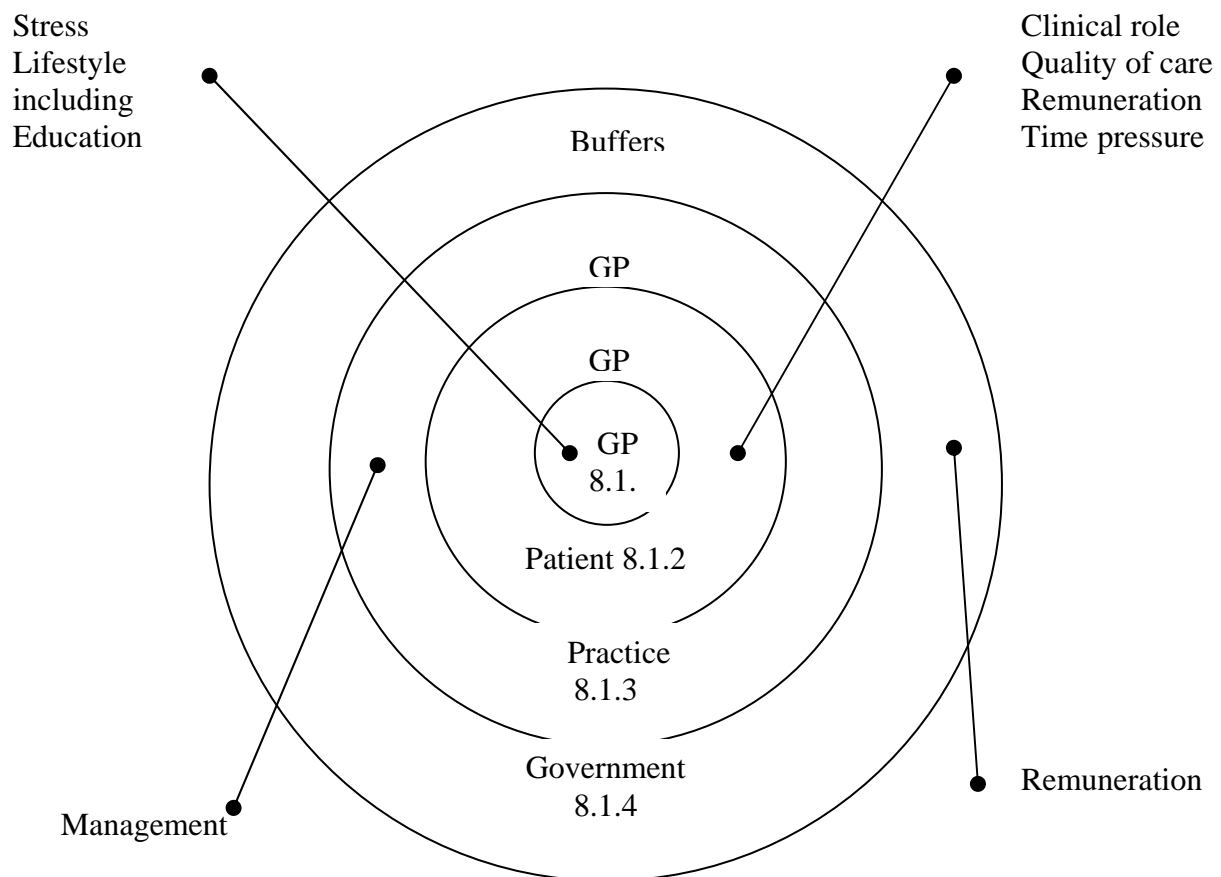


Figure 8.1 demonstrates the areas which were identified in interviews as having been impacted by change: the GP personally, the GP in relationship with the patient, the GP in relationship with the practice, and any buffers between the GP and government. These will now be further explored.

### ***8.1.1 Impacts of change on the GP personally***

(First circle, Figure 8.1)

Change had specifically wrought an increase in stress for GPs, a challenge to their lifestyle and an important impact on ongoing education. These are now presented as themes:

#### *Theme 1: Impacts of change on participants' levels of stress – major theme*

Much has already been discussed about the stress experienced by this group of GPs. Chapter 5 assists in understanding the amount of stress experienced by a group of GPs who, to some extent, could be characterised as feeling helpless, as having lost control, who wished to remain autonomous but who paradoxically require affirmation and who, not surprisingly, felt isolated. They had had difficulty in coming to terms with the increasing role of government in general practice, had seen their form of remuneration change dramatically, were still coming to terms with the concept of standards and had experienced a vast change in their role as clinicians.

These personal characteristics are important in that certain personal characteristics are reported to predispose an individual to stress. For example, individuals who learn cultural goals but fail to achieve them may be less capable of coping (Mechanic, 1978,

p305). Medical graduates in particular may have a heightened sense of cultural or societal expectation. There was an essence of this when Dr I discussed her perception of public expectation of GPs and, more particularly, her own expectations of herself:

What do you believe are the weaknesses of general practice?

*The fact that so much is expected of us ...*

By whom?

*By the public and perhaps by ourselves as well*

The impact of societal expectation on GPs may be an important issue in examining the root cause of stress. It may be no more important than for other professionals but it may well impact other professionals less given that most others produce measurable outcomes (such as a design of a building, legal contract, construction of a bridge). The lack of genuine outcome measures may be adding to GP frustration over the lack of quality they report from the “quality reforms” (8.3.1).

It is important to recognise that not all participants by any means failed to adapt constructively to changes. In particular, the rural GPs had made greater use of allied staff to run more sophisticated practices. This would at first appear to be a paradoxical finding as rural GPs are generally regarded as busier than their more urban colleagues. Perhaps, therefore it was this very fact that provided the greater impetus for reform.

#### *Theme 2: Impact of change on participants’ lifestyle – minor theme*

Section 6.3.4 identified the importance participants placed on relationships, in particular the doctor-patient relationship. However, relationships with family appeared to be less highly valued (6.3.4.5). This section reports on how an increasing workload, CPD demands and fear of litigation impacted on relationships with family and on other aspects of personal life.

Personal time protection was recognised by very few male GPs as a strategy to avoid social disharmony. However, rural GPs were more cognisant of the effect long hours would have on the family and in some ways ensured that their lifestyle determined their response to change, rather than the reverse.

Many male urban participants expressed varying degrees of frustration with their work environment. A few full time GPs had developed strategies to limit their exposure to the demands of practice as a response to increasing workload. Due to the increasing burden of paperwork, some participants worked back long after “business hours”, whilst others tended to take time out of clinical work to complete the increasing amount of paperwork so that it could be left at the office. Whilst work could be left back in the office, anxiety about it could not, *“I’ve never taken notes home to write up. But I can lay awake worrying about it still”* (Dr M). Ironically, for a very few GPs the crisis of work demand triggered a reduction in workload, allowing them more disposable time and a sense of control as a result.

As identified previously, CPD represented a further time demand on participants which was usually met after hours (5.2.2). This placed greater strain on family responsibilities, the most forthright of these was Dr C:

*What do [your family] think about your going out at night for these education sessions? Does that have an effect on them?*

*Of course. My wife hardly sees her husband, my son hardly sees his father. Often I get home, they're in bed already. I have dinner by myself.*

Only two participants reported having found ways around evening CPD sessions in order to protect their lifestyle. On the other hand, most GPs reported that CPD was an important element of their social interaction.

In general, people who ignore the needs of their family will miss the opportunity to gain what support the family can give. As reported elsewhere, families are a major source of resilience. However, frustration, caused by competing demands, and in some cases stretched temperaments for some male GPs, was reported to have affected their families. The following quotation is consistent with the observation that a subgroup of GP participants displayed poor help seeking behaviour thereby rendering them more vulnerable to the negative impact of change and to feelings of helplessness, identified by others as the “Bitter twisted old man syndrome” (Tolhurst et Stewart, 2004, p361). This group would, in the classification of Miles and Snow be identifiable as “reactors” in that they tend to respond inconsistently, sometimes inappropriately and often as a last resort:

*I think, when I was younger, I was able to take the stress. I think stress sort of builds up through the years. When it's built up through the years and you're getting a bit older and you find it really impacts on your life and your temper.*

Right. And do you discuss this with your wife or with your friends at all, how to handle this stress? Have you ever spoken to anybody about it?

*No, I haven't spoken about it. I just worked.*

Dr B

One GP had observed that some younger GPs had a tendency to place very strict boundaries around their daily time in practice by becoming part-time practitioners, “*I mean probably a lot of GPs were over-committed to the job in the old days at the expense of their families*” (Dr P).

In conclusion, male participants generally were less likely to demonstrate an understanding of work boundaries. Those who did guard their personal time inferred that the same control philosophy influenced the way they practiced clinically. Techniques employed by those GPs included delegation and billing privately. It was apparent that female GPs and male GPs handled lifestyle stress in very different ways. This was not further explored in interviews. Somewhat paradoxically, the rural GPs had most embraced change despite what is usually regarded as a heavier workload.

### ***8.1.2 Impact on the GP in their relationship with the patient***

(Second circle, Figure 8.1)

Changes had wrought a distinct impact on GPs in the conduct of their work with patients. Above all, their role as patient carers had changed. They were transitioning from reactive to planned processes of care. In so doing their clinical roles had



diminished. However, it was apparent that the patient had not necessarily benefited from better services, just more services.

Participants were no longer solely reliant on the patient to pay their bill as the Commonwealth had become more directly involved in GP funding and, as a consequence, they had lost much of their relative independence. And there were substantial drivers for increasing patient access to doctors and therefore greater pressure of time. These will now be discussed in turn as themes:

*Theme 1: Participants experienced a declining clinical role – major theme*

GPs had witnessed the range of their clinical activities change. In some areas the range had diminished, in others new activities had evolved but to a lesser extent. Some of these activities were driven by consumers (e.g. knowledge management), some by government (e.g. care planning) and some by the profession itself (e.g. quality audit). However, in general, clinical activities had declined due to either external pressures (e.g. defensive response to threat of litigation) or internal pressures (e.g. red tape compliance).

Participants described in detail that they were becoming deskilled. Many factors were reported to have narrowed the range of interventional services they delivered. The decline in skill set that had commenced with the loss of hospital privileges, was exacerbated by an increasing burden of paperwork associated with specific Commonwealth incentives, and compounded by an increasing array of allied health providers in the community. As a result the sphere that was general practice had shrunk, leaving participants to wonder what general practice had become and where they fitted in.

Whilst loss of hospital privileges per se was not generally bemoaned, (though often fondly recalled), failure to replace these privileges with other clinical activities was an important impact on most older participants. For example, Dr S reflected on a profession which no longer offered expression of his generalist clinical training:

*All I do is write referrals and do prescriptions and I think it must be fairly soul destroying for people in some instances, certainly, anyway.....well I'm just really a pen pusher now and we're being so deskilled that we just write referrals and we're just really gatekeepers and that's all. We're not valued for our clinical acumen or our clinical skills any more*

If this statement is indicative of the level of expertise required for modern day general practice then the Australian community will be challenged to attract and hold new GPs for reasons apart from mere income. Dr R offered a further warning that the deskilling of general practice may be its demise:

*If general practice becomes an area in which you have minimal number of interesting parts to it, then people won't be interested in following that as a career path. I see it as being uninteresting as more like a clerical sort of job rather than an interesting career.*

Many older participants, then, had abandoned an array of clinical skills which, for many, seemed to define their existence as a “general” practitioner. Dr K reported that “my space is becoming smaller and smaller.” Dr T observed, “I think a lot of them aren't quite sure what their role is any more”. Role confusion may be the key factor

that discriminates general practice from any other profession and an important source of frustration for GPs. This may be a strange concept for the general public who simply “go to see the doctor”.

Loss of sense of identity must be particularly acute for a cohort many of whom felt helpless and unable to control their environment (6.4.3, 6.4.4). Process-based and disease-specific activities such as the *Asthma 3+ Plan*, *Better Outcomes in Mental Health* and targeted cervical screening had caused confusion for many of these vulnerable participants as to their clinical focus. There was a suggestion that the clinical role of the GP was becoming focussed around a small number of chronic disorders determined more by the Commonwealth than by either the doctor or the patient. Dr A poignantly captures this concept on behalf of his colleagues:

*I think that with all the programs that are now in place, with preferences for the way you treat certain diseases, the PIP program, it just becomes overwhelming. You lose the plot as to the core of what you're doing.*

Dr A

Not only were these GPs questioning their clinical role, they were now having to come to terms with an environment in which the new medicine of planned care required of them standards of paperwork which they saw not only as unnecessary but, almost universally, as taking them away from their already declining clinical role:

*(Paperwork) makes me spend more time away from patient care, or more time away from my family.*

Dr N

In summary, the declining clinical role was evidenced as declining enthusiasm for general practice and a concern that general practice was losing its identity and equally that they as GPs were losing their identity.

The Commonwealth in attempting to improve care of certain diseases may have inadvertently exacerbated the trend that seems to have narrowed the role of the general practitioner by requiring them to fulfil certain requirements viewed by GPs as “red tape” (5.2). However, if those “red tape” requirements could be met by clerical staff, then GPs would become more available to pursue clinical work. Such a trend would favour growth in corporate practices in which GPs are supported by a more efficient infrastructure (2.7).

*Theme 2: The impact of change was to evolve new quasi clinical skills – major theme*

Whilst the range of general practice clinical activity had generally declined, there were areas of new skill development. Some GPs saw this as part of a broadening holistic approach to practice whilst others enjoyed exploring new technologies whilst preventative care was impacting practices particularly as it allowed greater use of technology. General practice computerisation has been assisted by Commonwealth economic incentives. Some participants expressed excitement in the discovery and conquering of new technology, others embraced the possibility of more efficient ways of providing services.

A new technology had broadened the range of services provided by GPs. These quasi-clinical roles supported clinical care rather than being clinical care. High amongst them were planned care and preventive care, both of which are supported by a computerised

recall register. In turn, that preventive work supported a more holistic approach to patient care.

Not all participants viewed the diminution of former roles as a negative. One GP, whilst not denying the fact of role minimisation, actually welcomed it as a form of specialisation. This position would seem to be the very antithesis of practice that is general:

*What we are doing now is getting narrower and narrower.*

*As you narrow down, what are you narrowing down to?*

*For me, it's preventative care and I'm not at all interested in acute medicine. I don't want to see broken arms and people with chest pain.*

*I don't think that really is appropriate in our style of general practice here.*

Dr L

In summary, the narrowing clinical role was generally being augmented by a broadening quasi clinical role based around interventions intended to improve of prevention of disease and maintenance of health care.

### *Theme 3: The impact of other primary care providers eroded the role of participants – minor theme*

The rise in chronic disease presentations (2.13.3) was to indelibly change the experience of general practice. Not only was there less opportunity to make a diagnosis to piece together the clinical jigsaw (6.3.4.4), in some ways the jigsaw had started to come apart. Continuity of care that had been the province and succour of the GP had come to embrace a continuum of providers described by Dr K as “*the increasing fragmentation of care, where there's clinics for this and clinics for that*”.

Again, this was not the experience of all GPs. Where GPs had adopted more sophisticated practice management systems (8.2) this variety of fragmented activity occurred within the general practice itself, limiting the fragmentation of care reported by other GPs to the practice rather than to the broader community.

In conclusion, the essence of the role of the GP had changed. Many participants questioned the drift from reactive clinical care to planned care and its associated protocols. However, very few resisted this drift, citing economic imperatives as their reason rather than high quality care.

*Theme 4: questionable impact of change on the quality of clinical processes – major theme*

Somewhat perversely, quality incentives introduced by the Commonwealth were reported to be unrelated to improved quality but other changes were recognised as improving quality. For example, computerisation and fear of litigation had combined to improve the processes of care. By promoting systematic processes of care, patient recall had facilitated a safer medicolegal environment.

It has already been suggested that fear of litigation raised concerns in the mind of some GPs that safety lies in seeing fewer patients and managing them more thoroughly.

Though safety for the GP is directly linked to safety for the patient, at no stage was this identified by participants as an important driver, merely a secondary outcome of self-preservation.

Generally, whilst all items associated with the EPC were intended to improve quality of general practice care, there was little evidence given by participants that the use of these items had any impact on quality, *“In my opinion, the care that they were getting*

*before was equivalent to what they're getting now''*(Dr O). However, it was reported that immunisation rates had improved, but whether this was as a result of EPC incentives or because of better IT infrastructure was not determined.

In summary, despite major investment by the Commonwealth in quality incentives, participants were sceptical that any improvement in the quality of their services had occurred as a result. However, practices had improved systems involved in patient care and this was generally seen as improving quality care as had the threat of litigation.

#### *Theme 5: The impact of change on GP remuneration – major theme*

As previously suggested, lack of adequate remuneration was seen as a strong disincentive to participate in government reforms. However, amongst participants there was little awareness of the costs to introduce reforms and compliance; instead arguments were usually made in terms of remuneration rather than net return. Discussion will therefore be expressed in terms of income and costs.

##### *Subtheme 5.1: Blended payments were primarily used to top up income – major theme*

Of significance, practice accreditation and vocational registration had both initially been voluntary reforms. However, the financial loss for not adopting the standards was so great that participants regarded them as compulsory: That is not to say that the financial return had been so impressive that all initiatives had been systematically and

broadly embraced but without doubt many participants had been “cherry picking” the more lucrative incentives.

Fee for service was also changing its nature in that there was a perceptible trend to abandoning universal bulk billing. For those who had chosen to abandon bulk billing, the pressure to adopt the new incentives was not as great. However, the decision to move away from bulk billing had not been an easy one for participants in that they generally understood that such a move impacted on patient access.

You’ve got incentives that perhaps you’d like to introduce but you don’t because you just haven’t got the facility to do it or the resources, the time resources. How does that make you feel?

*It’s just another pressure, really. Because you’re trying to run a business, which I don’t think you should have to do really, in general practice, but essentially you have to and so the costs have skyrocketed because of all the intrusions, governmental intrusions, tax system, etc and so unless you want to bill your patients excessively, which I have personal problems doing, so you want to use these incentives to top up the income.*

Dr P

The compromise response to the dilemma described above was to use the EPC incentives as a means to increase income so that the patient moiety could be kept to a minimum, rather than use the items as a means to deliver better care. The importance of this form of subsidiary income may be that it psychologically distances the funder (the



Australian taxpayer) from the provider and the patient, in that the funder becomes a nebulous entity that won't be offended or transfer allegiance because the charges are too high.

In summary, some participants had abandoned bulk billing and enjoyed better remuneration but experienced concerns about access. Many of those who continued to bulk bill used the new EPC items as a secondary source of income rather than an opportunity to improve care. If such is the case more generally, then it may be that the Commonwealth has merely introduced another volume related form of GP remuneration and that other means of quality incentives are required.

*Theme 6: Perversely, in some cases, red tape associated with blended payments improved practice efficiencies – minor theme*

The component of overheads most commonly mentioned as rising was compliance costs, rather than the cost of equipment. As already discussed, many GPs had taken on additional staff in response to an increasingly complex accounting environment. Rising staff costs in a low rebate environment favoured the formation of larger practices<sup>26</sup>. This trend represented a major impetus to reform business processes in light of the need to address business inefficiencies. Another example is the introduction of the GST in 2000 (2.7.2, cf p48) where additional practice costs included the cost of compliance. The cost was not only in filling out the forms but also in developing a system for collecting financial data so that the forms could be filled out, as illustrated by Dr P:

*There's the financial pressures of... having to fill tax obligations, just with accrual effects system, for instance. You employ someone to*

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<sup>26</sup> This did not necessarily mean more doctors. Whilst one practice was going through the process of amalgamation, others were expanding by utilising allied health service providers.

*actually sort of, like, do your paperwork, because you've got GST obligations, which is absolutely ludicrous for a health provider, I think, even though we're supposed to be exempt, we've still got to put in a BAS*<sup>27</sup>

It can be concluded that a secondary impact of increasing business accountability is that accounting services are more expensive per se but efficiencies may lead to infrastructure reform and reduced overheads more generally. In addition, the cost of doing the paperwork, once it is systematised is not much greater for many clinicians than for a few, thereby favouring a trend to larger practice sizes.

In summary, general practice income and costs appear to have become quite complex when compared to the traditional and much simpler customer-pays system. Of those participants who had adopted the EPC incentives, most did so as a means to supplement income, some to avoid bulk billing. Rising compliance costs had substantial impact on the way general practice was conducted by these participants. In many cases rising costs had provoked some attempt at infrastructure reform. There was little sense that professional expertise was sought externally to assist in gauging net income, appropriate patient moiety or return on infrastructure investment. This finding has previously been noted (p247) and, again is consistent with the literature in that GPs do not tend to seek out external professional advice for clinical matters.

The potpourri of responses was pathognomonic of the fact that participants had little in the way of business acumen. As a result the impact of the new quality incentives was

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<sup>27</sup> Business Activity Statement

diffused, meeting other unrelated agendas, whilst participants were generally confused and defensive. A stronger business approach and the use of relevant professional advice may have resolved much of this confusion. However, the reluctance of many GPs to indulge in work outside their clinical roles would seem to be a severe impediment to developing a stronger business model for general practice. Three strategies are possible to resolve this. The first is to utilise practice managers as practice reformers by allowing them the freedom to initiate infrastructure reform to support a broadened clinical team. The second is for general practice to move into a “corporate” environment where responsibility for practice management is not the GPs’. The third is to incorporate business training into medical schools or GP Registrar Training programs so that GPs appreciate that clinical care occurs within, and is assisted by, an accountable business environment. This third strategy is the only one that would introduce GPs to a world of quality control, efficiency and accountability.

*Theme 8: Impacts of change on time pressure – minor theme*

Time was an important resource as mentioned by participants. They expressed concern about time required to meet “red tape” requirements of new regulations and incentives, time for writing referrals, time required for CPD and even time required to read correspondence from various agencies and organisations. The amount of time participants had available determined their availability to be involved in new initiatives, as well as their levels of frustration and their capacity to think beyond the existing system. The major determinant of time was workload and a major determinant of workload was workforce shortage:

*Well, the great weakness in general practice is the shortage of general practitioners, so that time pressure's always there and so you're not allowing enough time to provide the quality that you want to*

Dr P

Computerisation had not exerted a substantial impact on work output of participants (as distinct to their clerical staff) but had been successful in patient recall, a requirement of the quality incentives. Participants who had once been busy caring for the needs defined by the patient were now also caring for the needs defined by the government on the same patient population. In this sense, the quality incentives appeared to be self-defeating

Time pressures to provide clinical services limited participants' capacity to effectively consider potential changes in the light of improved income or quality, thereby leading to a heightened sense of frustration.

*Theme 9: Impact of changing time pressures to erode the doctor-patient relationship – minor theme*

The relationship between the patient and GP is changing and more is being asked of the GP (2.13). Perhaps consumers are more discerning; perhaps they are simply more demanding. Whilst many participants referred to patients as “demanding”, none referred to them as discerning. The distinction is important. The former is born of power (or powerlessness); the latter is born of knowledge. In any event, many participants saw this change as a threat to the trust relationship between doctor and patient, as voiced by Dr S:

*They don't seem to trust that a GP could simply, you know, take a history, do a physical examination and be reasonably confident in their*

*judgement. They want to be reassured. I think in this day and age, people have a sort of unrealistic confidence and faith in technology*

There is evidence from literature that the doctor-patient relationship is changing on both sides with the strong trend to part time GP work (Charles et al 2004) , exacerbated in part by the increasing number of female GPs (2.6.2.3). This part time work trend was reported by participants as disrupting the continuity of patient care and also of placing previously unimaginably short (by older participants) time boundaries on the consulting day (eg 9:00 to 3:00)

### ***conclusion***

In conclusion, change had seen participants providing less skilled services to their patients. Due to pressure from government, patients were receiving care they had not necessarily asked for and which participants had not necessarily wanted to provide. The impact was that GPs saw their clinical value to the patient declining as they adopted a quasi clinical role to support government initiatives. Many participants found this confusing and frustrating and questioned what general practice had become.

### ***8.1.3 Impact of change on the GP within the practice***

(Third circle, Figure 8.1)

With regard to their role within the practice, participants tended to resist change which threatened their autonomy. To an extent many were increasingly risk averse and had

found the rate of change too great. There was no suggestion that participants had embraced the reform process, the first theme of this section:

*Theme 1: Participants expressed no ownership of the reform process – major theme*

Virtually without exception, there was cynicism about the reform process. Participants had received no evidence of the value in introducing the “quality incentives”. The often reluctant adoption of practice accreditation and other incentives had resulted in about a quarter of the participants introducing secondary systems that met the literal requirements of the incentive but which were virtually independent of existing work practices and hence had impacted minimally on their own professional activities. At times the reactor GP would adopt the change but take active steps to protect himself from its impact, for example by purchasing practice accreditation documents from external agencies or contracting external parties to conduct the requisite work, as evidenced by Dr G:

What have you done in response to the increasing paperwork?

*I don't do a lot of the paperwork.*

So, writing out the notes, doing the care plans, doing all that sort of stuff?

*I give that out to [name of a private contractor], he does it. He comes, checks it and does it and I don't do it.*

Are you happy with that system?

*I think it's a waste of time.*

Ironically, these participants had introduced a second but almost independent system to avoid the change intended by the Commonwealth. This is an interesting response as the Commonwealth it would seem has, in introducing the EPC package and Practice Accreditation in particular, attempted to change the system by which general practice care is delivered.

One GP actively sought to defy the system:

*We tried to avoid the paperwork as much as possible and the way I deal with it now, particularly for [name of a government organisation], is that I give them a minimal amount of information and I make no attempt to make it legible. That's how I deal with it! And generally it gets through their system. They don't like it if you don't do it, but as long as there's some rubbish written on the bit of paper, it seems to be alright.*

Dr L<sup>28</sup>

Lack of enthusiasm for reform was almost universal. What was not universal was the GP experience of increasing practice size. However, some of these preferred the experience of working with others where the environment was supportive but for many participants, working with more people eroded their autonomy.

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<sup>28</sup> Dr L was kind enough to demonstrate his perspective of redundant paperwork. At this stage of the interview he asked me to list three numbers between zero and 50. He then located the form for recording the current month's vaccinations used, wasted and retained. He proceeded to enter my three random values and complete the form, commenting that this was his routine approach to bureaucratic data collection.

*Theme 2: Increasing practice size was seen as a threat to autonomy – major theme*

There was a trend reported that practices, either through amalgamation or by employing additional non-medical staff, were growing larger. This pattern reflects that of English practices (Richman, 1987, p85) and other Australian practices (Charles et al, 2004). Larger practices imply not only more staff but more complex business processes to support the function of the staff. This requires a greater degree of standardisation of processes. Generally, increasing practice size was regarded as a logical sequela to more efficiently utilise the greater management and clerical capacity offered within an increasingly computerised infrastructure. Larger practice size was seen to support more complex functions and hence to reduce marginal overheads. However, there was also a perspective that larger practices offered a supportive environment such as suggested by Dr I:

*I think we're seeing more people decide that it's essential to work together. When I first came into general practice, I was watching practices implode and people go their own ways and go out of group practices into solo practice because of personality clashes, one and thing and another. Having done that for twenty years, people now see it's too hard to be working by themselves, so we're seeing a new wave where really the only way to survive is to come together and support each other, so that's a really interesting difference.*

A few participants strongly rejected this model out of hand.



There were differing perspectives described about larger practices and sense of belonging. It was suggested that larger practices meant that other staff could assist in the GP's work but it was also suggested, somewhat paradoxically that there could be greater isolation within a larger practice. This was exemplified by Dr E:

What do you believe are the weaknesses of Australian general practice?

*The isolation. As much as I've said that I'm part of everything, I'm also part of nothing, for the same reason and that's because we're going to get into bigger and bigger groups to survive, we have to have at least six to a dozen, so then your individuality is lost in that..*

Dr E's comment is important in raising the question as to what constitutes recognition and independence. There is no reason why a group cannot offer more recognition than is offered by working in a small general practice, nor that GPs should lose clinical independence within a group. Perhaps Dr E is looking for more than recognition because it may be that small practices do tend to magnify the importance of the individuals working in the practice, particularly those with authority. It may therefore be helpful to examine the change of power relationships, and the significance of changing power relationships, as practices amalgamate or otherwise grow.

The essential conceptual difference seemed to hinge on whether the larger practice was just a larger practice of more GPs or whether it was larger because there were more non-medical staff. In the former style practice, GPs could be autonomous but isolated

and in the larger they tended not to report isolation and lack of autonomy was not raised as an issue. It may be, therefore, that larger practices per se do not assist in reducing isolation but that practices in which GPs share a workload with other staff members diminish isolation and that autonomy loses its significance.

*Theme 3: Participants had become risk averse – major theme*

Whilst the participant response to innovation can generally be described as patchy, GPs did respond in a far more uniform manner to the perception of threat and they did so by changing clinical processes. In system terms this change of clinical processes in response to medicolegal threat has come to be known as defensive medicine (Summerton, 1995). GPs responded to this perceived threat in one of three ways, each consistent with literature (2.7.3). The first was to increase the amount of diagnostic investigation requested, as described by Dr S:

*The litigation side of things, I mean there's been a lot of stuff about that, with insurance premiums and the sort of era of litigation driving doctors to practice more defensively and investigate a lot more and I think that's true. I certainly have changed that way. I'm much more, I err on the side of ordering more tests and investigations at huge cost to the taxpayer, just to cover my bum*

Some chose to refer more patients to consultants either to share the risk or to ensure clinical management is seen to be thorough. This response is one already identified as being responsible for deskilling participant GPs. The third response, also partly

responsible for deskilling, was to limit risk exposure by ceasing procedural practice or, less commonly, by seeing fewer patients:

And how did you respond to that, how did you respond to the fact your overheads were increasing because of your indemnity costs?

*Well, I started from a procedural GP, now to a non-procedural GP and I've cut down my hours of work so that the more exposure to medical practice, the more chance of being litigated.* Dr B

As suggested previously, unless the role of the GP is to deepen, this trend from procedural to non-procedural will not be experienced by new graduates who may therefore question the place of general practice as a challenging profession.

Participant GPs faced the conundrum of feeling pressured to meet the demand by the public for general practice services knowing that shorter consultations may result in a less defensible outcome and more outcomes that may need defending<sup>29</sup>. Some participants were concerned that litigation could arise from any potential source as diverse as the number of patients seen. The impact was therefore that they became more comprehensive in their clinical work but at the expense of losing their focus on the reason for patient presentation. In this way they would be more likely to act preventatively by pursuing risk factors.

In conclusion, the participants were able to mount a significant response to threat, though perhaps not an appropriate one. Some minimised their risk by minimising their role. More appropriate responses may have been to identify strategies that would have enabled them to practice skill sets safely. Such responses may have included better patient communication, strict appraisal and explanation of the risk to the patient,

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<sup>29</sup> It is interesting that participants did not associate the high turnover of patients as being a risk to the patient, only to themselves.

practicing skills more frequently and allowing more time per intervention.

The three types of responses displayed by participants may represent an attempt to control the effect of external factors in the specific environment that, to some extent, were beyond the individual's control. These external factors included media exposure and increasing indemnity costs. It has been reported that there is a substantial risk associated with an individual placing blame for change on external factors: *“insurance premiums and the sort of era of litigation driving doctors to practice more defensively”* and *“I think it's all because of litigation”* are both examples of external attribution mentioned by participants. That risk, as identified by Mechanic, lies in the fact that such an attitude may reinforce in the GP any sense of helplessness and could therefore represent a major liability (Mechanic, 1978, p303).

*Theme 4: The rate of change had been too great to accommodate – minor theme*

Without doubt, the rate of change had been too great for most GPs to adapt work processes. Each Budget had brought new incentives or regulations for GPs. For some, too much change too quickly had not wrought the government's anticipated outcomes, *“I think too much change too quickly is bad. I'm at a stage where I couldn't really be bothered changing too much more”*. (Dr T). For many of those participants who did change practice function, patient expectations and, to some extent, their own naivety of systematic business processes had overwhelmed their capacity to introduce workable systems. Where it occurred it was palpably frustrating as the GP was attempting to deliver a service which was unrequested by the patient, but encouraged by government

and delivered in a context born of a reactive form of service delivery, as poignantly illustrated by Dr D:

*In the Asthma management one<sup>30</sup>, I find we have so many patients that come in now, they come in now for the first two parts of the Three Plus plan and then don't turn up for the third, so it's such a waste of time. You spend so much time in the first two, getting the spirometrics done and explaining to the patients and, of course, you tell the patient to come and it just should exclusively for their asthma management, but when they come it's only other complaints, you know need scripts for the pill or for pap smears and things like that.*

Dr D, and those like her, seemed confused by this new clinical role. She displayed an interest in the new items but had been unable to work out systems for their implementation. Essentially, the participants did not believe in the value of the reforms and had not devoted the time necessary to implement them.

In general, GPs responded to change by avoiding it, resisting it, being overwhelmed by it, by adopting a piecemeal approach but rarely by strategically adopting those elements that suited their practice style or patient needs. Literature records that, apart from management of the chronically ill, most GPs display a reactive form of response clinically (Beaulieu, 2003). This reactive response was equally in evidence in the non-clinical environment. Those GPs who had not responded to change by strategically adopting those elements that suited their practice style or patient needs (one urban and two rural), tended to display a “reactive” typology in response to change. This did not

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<sup>30</sup> The incentive payment for the Asthma 3+ Plan requires that the patient return for three scheduled visits in a twelve month period before the item can be claimed.

mean that some reactors did not manage to devise workable reforms to structure or process, rather, if they did, they did so without professional advice, in haste and without significant consideration to implementation costs or with a long term practice philosophy in mind. What was not established in the interviews was whether it was physically possible to accommodate the rate of change even under the most favourable of circumstances, let alone those that participants worked under.

*Theme 5: Change had produced a drift for participants away from practice management – minor theme*

Perhaps the greatest impact that change had wrought within general practices was to increase the complexity of practice administration causing participants to be overwhelmed by it<sup>31</sup>. While some practices had invented systems to avoid systems, some participants had adopted the changes in a tokenistic way as exemplified by Dr T:

*If some clown at the College decides there's a new thing that seems to be important and we haven't done it, well we'll adjust, even if we think it's silly. I'm too old to worry about fighting the system. If they want to put silly things up there, we'll do them. At least at the time when the assessor's there and then if we stop doing it after that, who knows, who cares?*

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<sup>31</sup> AMWAC found that all GPs interviewed “agreed that practice ownership has become much less attractive (due to) financial viability, level of responsibility and inability to sell the practice later” (AMWAC, 2005, p19)

However, other participants had taken the opportunity provided by the Commonwealth incentives to improve system efficiencies and manage risk in a more systematic manner. Computerisation had played an important role in supporting practice administrators and had therefore had a major effect on business processes. Many of these effects had been beneficial.

Information systems had enabled participant GPs to more easily change their billing strategies from bulk billing to private billing. Whilst the Commonwealth had, for its own purposes, streamlined the bulk billing process, technology had made the more complex demands of issuing private bills and maintaining account and bad debt ledgers relatively simple. With the aid of information technology, participants' practices had been technically able to adopt the Commonwealth's quality initiatives; however, the technical capacity to change roles was not necessarily matched by clinical willingness to adopt the new roles.

Many participants reported marked changes in practice administration. For most participants workload had increased, but for some of these the increasing workload had been the catalyst for delegating responsibility to administration staff. This work included, for example, following up on pathology tests which had been ordered and not performed, and practice accreditation. If generalised, this may represent an important step in changing the culture of participants to accept that external or internal professionals have skills to facilitate their work. The desire to focus on clinical work was extremely strong and almost universal. Dr A's opinion is typical:

*I want to be a clinician, not a manager, and if I've got to be a manager,  
I'll do what I have to, but I am much happier to delegate that to*

*somebody who's got the right training and experience.*

Where delegation occurred it was not necessarily reliant on highly trained staff and varied between delegating responsibility for Practice Accreditation to the wife of one GP, through a spectrum to practice amalgamation at the other. In any event, where delegation did occur it stood in stark contrast to those GPs who had always done their own bookwork and who always would:

So, perhaps on reflection ....one of the changes that you have seen in Australia is that there's been a greater reliance on administrative staff?

*That's right, yes.*

Because when you started.....

*We were the administrative side.*

Dr M

Importantly, the world had changed for participants and many saw that future GPs, many of whom would be part time, some of whom would be overseas trained, and all of whom would come from a different generation would no longer have the incentive, the interest or the capacity to manage a practice:

*Your modern breed of doctors don't like to commit or they don't mind passing through, they don't mind paying rent, but they don't want to have very much to do with anything else. So I basically, in that practice, was the only doctor who had a vested interest in it. I was the one who owned the building, owned the equipment, bought everything,*



*it was my practice which I happily shared with others working in the building. I didn't have a problem with them having their practices in there, but they..... and we've had probably in the last 15 years, we would probably have had conservatively 10 or 12 doctors come and go through the place and I can tell you now, we've had criminals, we've had crooks, we've had a GP registrar who was a drug addict, we've had a cross-section of the United Nations like you wouldn't believe and none of those people have any interest or desire to have any management role in the place at all.*

Dr T

In conclusion, practice management roles had altered either as a response to change or a response against change. The direction of change was determined by the rate of change, the demands of the change and the existence or non-existence of an efficient infrastructure capable of adaptation. Where participants had responded to changes by delegation to clerical staff, not only those activities that had stimulated the delegation were in fact delegated, but so too were other similar tasks which in the past had been performed by the GP. Where this occurred, GPs felt empowered and perhaps so did the clerical staff. Where it had not occurred participants were often despondent and overwhelmed.

For some at least, it would therefore appear that the introduction of Commonwealth incentives and the advent of improving information technology had been a fortunate alignment that permitted greater time for clinical roles.

### **Conclusion re the impact of change on the GP within the practice**

Change had brought with it important drivers to increase practice size. This was interpreted both as an opportunity to reduce isolation or increase it. Economics of scale was the main factor. Computerisation facilitated this trend which inevitably, together with changes in clinical activity, meant those practices became more sophisticated in

their functions. This in turn led to delegation of non-clinical duties and a trend back for participants to clinical medicine and quasi clinical medicine. Practice staff increased in number in these larger practices and undertook more diversified jobs. However, there was little impact on clinical risk management which largely devolved to a referral process. Business risk was never mentioned.

Therefore, change had made a definite impact on participants. Some responded to it by altering their business approaches satisfactorily, others attempted to circumvent change by making minor changes. Those who suffered most from change appeared to be those who resisted it, though there were exceptions. These tended to be GPs who “cherry-picked” reforms.

Ultimately, increasing practice size may have an important effect on the community. Issues of geographical access by consumers should be further explored if such a trend were verified. It may also have an effect to either integrate care or fragment it, and to cause GP isolation or prevent it.

However, most notably, in some cases, change had been so marked that it had prompted some participants to change the structure and function of the practice itself.

#### ***8.1.4 Impact of change on relationship between the Commonwealth and the GP***

(Fourth circle, Figure 8.1)

In this section I have chosen purposefully to use more illustrations than for other sections. The intention is to convey the emotion that participants displayed in their view of the (Commonwealth) government. Issues of loss of control and loss of autonomy

appear to have become focused when participants commented about Commonwealth-induced reform. The reader will note the emotive terms used by this small sample of participants including the words such as “annoyed”, “indifferent”, and “resent” which would have been repeated one way or another by almost all the participants.

Two themes are readily identifiable in the analysis of transcripts: the first is that the climate between the profession and government was inadequately facilitative to allow constructive change. The second is that this outcome was seen to be partly to do with the failure of GP representative organisations, the first theme in this category.

*Theme 1: A climate of mistrust impeded the success of the government’s reforms  
– major theme*

Two factors have been identified that produce an attitude of trust which could otherwise ameliorate the impact of resistance against change and assist in the adoption of change. The first is for the persons experiencing change to have an understanding of the need for change; the second is good communication (Kanter, 1985). However, participants indicated strongly that the decision by the Commonwealth to become actively involved with change in general practice through incentives such as the PIP and VR had not been introduced after consultation. Though there was an understanding by participants of the need for a funder to be involved in the delivery of the services it funds, there almost no instances of participants welcoming or embracing the particular government-wrought changes.

Whilst the Commonwealth had funded a number of incentives, they had not always continued to support the intervention, leaving participants themselves feeling unsupported. Behavioural testing suggests that failure of an expected reward to occur provokes an aversive response (Maier, 1993, p210). Such was the case with this group of GPs, some of whom came to resist any government-instituted change:

*A lot of doctors find that they're being asked to change frequently for reasons that they would not agree are worthwhile. For instance, the government asks people to alter the way they practice medicine all the time to comply with government guidelines and I think the majority of doctors resent it.*

Dr O

Where the Commonwealth has introduced financial incentives for GPs to adopt reforms, it has also acted as regulator. The dual role of providing both the carrot and the stick was a significant deterrent to developing a trusting and constructive relationship with the Commonwealth and one of the major causes of participant stress.

In fact, participants were strongly of the view that the mechanism of introduction as much as the reforms themselves had worsened the relationship with GPs and, in causing suspicion and hurt, added further to feelings of hopelessness in some cases, as illustrated by Dr Q:

Do you feel that you resisted accreditation for some period of time because of that, or did you see it as inevitable and therefore you went along with it?

*Yeah, went along with it. Got walked over on that one.*

You did?

Yep.

How does that make you feel retrospectively?

*Indifferent. I think my experience of things now is probably when I was starting in general practice I thought that we had more potential to influence our destiny than I now believe.*

The failure of GP representative groups to influence participants' "destiny" was an important minor theme of the analysis.

*Theme 2: GP representative organisations were seen as impotent to cushion the reforms of government – minor theme*

The failure of GP representative organisations to adopt a common position on reform had a dual impact on this group. Firstly it was seen to hinder the mounting of an effective review of the reform agenda of the Commonwealth. Secondly, it had hindered the development and implementation of reforms generated through and by the profession rather than through the Commonwealth. Reforms arising from within the profession may be more successfully embraced than those arising from government. In addition, the Commonwealth had not demonstrated to participants that it understood the environment of general practice.

As suggested, the relationship of participants with respect to the Commonwealth had become one of suspicion. This is consistent with Maier and Piterman's findings (A.3.5.8) that GPs were suspicious that some clinical guidelines reflected a government agenda to control costs rather than improve care. Failure by the Commonwealth to demonstrate that they had consulted with the profession, or even communicated with

the profession, before introducing reforms had left participants feeling angry and frustrated, as typified by Dr L:

*I suppose I get particularly annoyed about it, but what upsets me a fair bit, I suppose, is that these various organisations, mostly government departments, say they've consulted widely with the industry, but really I think, even if they do consult widely, they do what they want to do anyway.*

Failure to find common ground meant that the assessment of the merits of change was to be borne by the individual GP rather than by the organisations whose role might more naturally have been to make that assessment and then to negotiate compromise positions. Medical politics was seen to lie well beyond the practice environment yet impacted it severely. Participants demonstrated little confidence in the ability of their representative organisations to work cohesively in the political environment. Dr M's perspective supported the contention that disharmony between representative organisations is a weakness of Australian general practice (GPA:2000, p205):

What do you believe are the weaknesses of Australian general practice?

*I think general practitioners are sometimes a bit weak.*

What does that mean?

*They've got no political clout, you know. They're weak in that they're not a unified group and they don't speak as one.*

Ironically, participant GPs viewed themselves in relation to Government in much the same way that consumers may have long perceived their relationship with their own GP, ie one of power imbalance. Whereas there is no consumer advocate for patients, there are many organisations which claim to be advocates for GPs but evidence from these interviews suggested that those organisations have yet to win the trust of their members. Further research into the effectiveness of GP organisations may assist both the organisations and their members prepare better for change.

In summary, the Commonwealth had not engendered a culture of trust with this group of GPs, who generally regarded the Commonwealth with suspicion and, consequently, some GPs expressed a feeling of powerlessness. These factors had combined at times to cause participants to resist change. On the other hand, GP representative groups had failed to negotiate compromise positions. This represents a poor basis on which further reform can take place.

This concludes discussion on the impact of change on the GP and leads to discussion on the impact of change at the practice level.

### **8.3 Impact of change as it affected the practice**

Changes appeared to have had as much impact on practices as they had on the GPs themselves. There was a perception of a changing culture of the business of general practice whether that was represented by the growing presence of corporate practices, a small but definite trend to amalgamation, or merely infrastructure reform within existing practices. This was exemplified by Dr B:

*Medical practice has become a business-orientated thing from my point of view. I think, you walk into a medical centre, you don't always see the doctor, you know, that you want to see, or that they advertised family medicine, but family medicine doesn't exist there.*

Participants were discussing, or undergoing enlargement of practices, staff in many cases had taken on additional roles and becoming more autonomous, the function of the practice itself was undergoing a significant transformation and issues around practice ownership emerged. Notably there were a few participants who both refused to change or to contemplate change in practice structure or function, as represented either by Miles and Snow's typology as "reactors". Where change did occur it will be considered in terms of changes to practice size, function and staffing of participants' practices. These are illustrated in Figure 8.2.



**Figure 8.2**      **The impact of change on the practice**

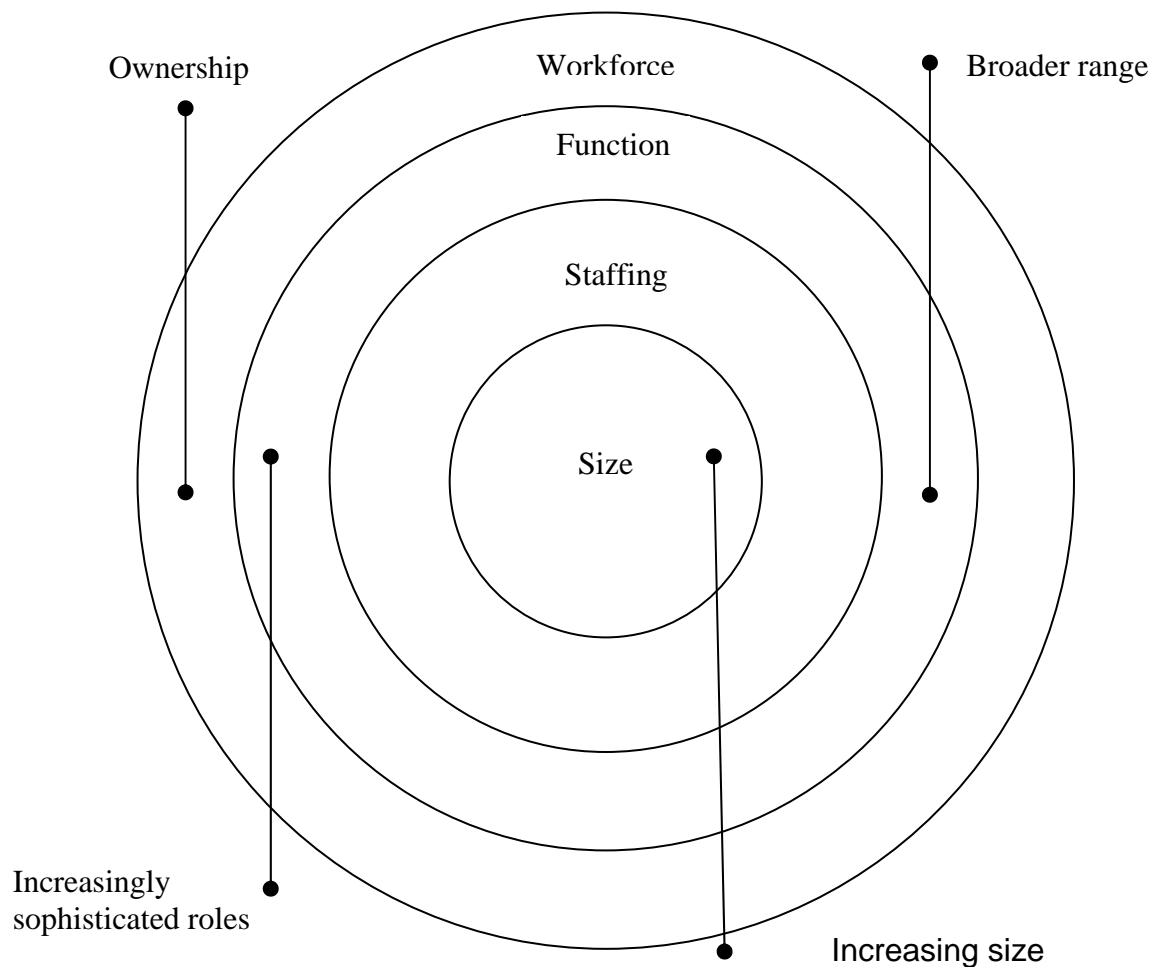


Figure 8.2 demonstrates the areas relating to the practice which were identified in interviews as having been impacted by change: size, staffing, function and workforce. These will now be further explored.

### ***8.3.1 The impact of change on practice size***

(First circle, Figure 8.2)

Analysis of transcripts revealed a trend to increase practice size either by employing more GPs, expanding the number of allied or clerical staff or by amalgamation of

practices. This impact of change will now be discussed in terms of major and minor themes.

*Theme 1: The impact of change tended to increase practice size – major theme*

Participants commonly took a negative perspective on change to their practices. Rarely was change seen as an opportunity, grudgingly it was more often seen as an inevitability. Willingly or not, most participants had considered joining or forming larger practices. In so doing, practice size was reported to be related inversely to autonomy and directly to the perceived need for more efficient business processes. It may be that the current undersupply of GPs favours supportive relationships as each has to support the other in times of high workload. When the work diminished, as in the 1980s, it may be that GPs saw each other as competitors rather than as contributors. Many other factors were described as favouring a trend to larger practices. These are demonstrated in Figure 8.3.

Figure 8.3 Factors associated with the trend to larger practices

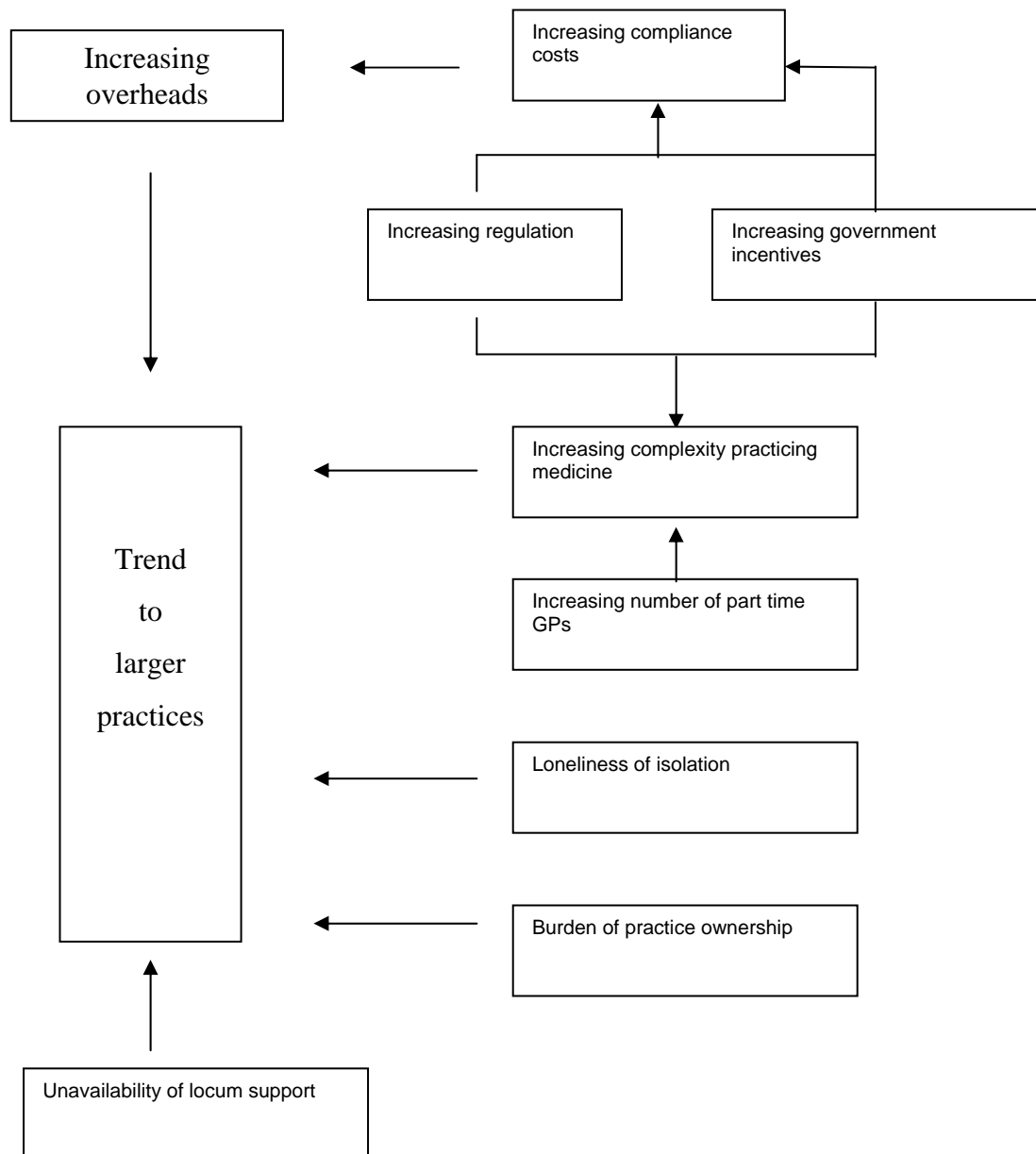


Figure 8.3 demonstrates factors that have been identified, either through literature or through interviews, as influencing GPs to work in larger practices. These factors include inadequate locum support (2.6.4), the burdens associated with practice ownership, and isolation (5.3.5). As more females enter general practice and work less hours (2.6.2.3), there may well be less willingness to work in a complex clinical

environment without the clinical and clerical support staff found in larger practices.

Whilst Figure 8.3 is helpful in understanding the processes that led participants to consider creating larger practices it does not assist in a determination of the functions that occur within the practice, how relationships work within a larger practice, how income and costs relate in large practices, and what factors limit the growth of a practice. These are questions for further research.

In conclusion, whilst not all participants embraced willingly the concept of larger practices, to most it represented a *fait accompli*. Those who had embraced it saw a move to larger practices as offering better ways to do business and more people with whom to share the load by delegation of non-clinical work. The down side of amalgamation was seen, paradoxically, to be isolation. If this finding were to be validated, further research may tease out how supportive teams could be developed in general practices. More particularly, we would do well to understand if larger practices alter the effects of change on GPs through different business processes, infrastructure or staffing.

### ***8.3.2 Impact of change on staff roles and responsibilities***

(Second circle, Figure 8.2)

Perceptions of appropriate staffing levels varied enormously. One three doctor practice was said by a participant to be too small to employ a Practice Manager whilst one solo GP employed a full-time Practice Manager in addition to reception staff. This may reflect differing GP needs and aptitudes for autonomy, decision making, efficiency and

delegation. For those participants who had taken the opportunity reform had offered, their own clerical role within the practice had declined whilst clerical staff had seen their role expand.

*Theme 1: Impact of change to alter the roles and responsibilities of practice staff – minor theme*

Where participants had delegated more work to clerical and allied staff, there had been a compensatory increase in staffing levels. Larger practices were seen to be able to afford more staff. In so doing it was predicted that doctors would be supported in their clinical work. Increasing red tape and the incentives that are supported by it represented the greatest driver identified for increasing practice staffing. Importantly, once a structural change had been made in the form of additional staffing there was no suggestion of regret, no turning back, as the change produced a momentum of its own, as described by Dr O:

*Once you start on it, it's difficult to stop because we've employed a practice nurse who has a lot of her work in keeping this process going. Indeed that is the main work that she does in administering enhanced primary care items and immunisation and I would certainly not want to take on the burdens of immunisation paperwork myself and, indeed, I don't understand it.*

The availability of additional staff for rural participants working under the MAHS program was an important additional incentive to devolve workload.

Increasing practice sophistication and increasing responsibility seemed to make practice staff more enthusiastic about adopting more sophisticated roles themselves. Indeed it

may be that staff who are used to being under resourced might welcome any recognition of their work and any additional resourcing. Those participants who had chosen to adopt a more business-like framework for their practice gave a substantially differing picture to that of participants resisting change. For that latter group, employing more staff simply represented another expense rather than an opportunity to optimise income.

Where practices had adopted more systematic processes of managing, there was a suggestion that not only had the role of practice clerical staff broadened, so had the status of the clerical staff improved. They had become an indispensable member of the organisation, performing functions well beyond that formerly performed by the GP or his/her receptionist.

Whilst Figure 8.3 describes determinants of larger practices, it is additional staff who make a larger practice work. Figure 8.4 summarises the impact larger practices were reported to have on the type of care and how it is given in general practice. Where additional staff had been employed, it was suggested that increasing clerical staff had reduced the burden not only of new red tape but of clerical work traditionally done by the GP. That role was undergirded by a new technology that staff were reported to have embraced to a greater extent and more enthusiastically than participant GPs. Finally, it was suggested that additional clinical staff implied loss of autonomy for the GP.

**Figure 8.4**      **Impact of increased staffing on general practice outcomes**

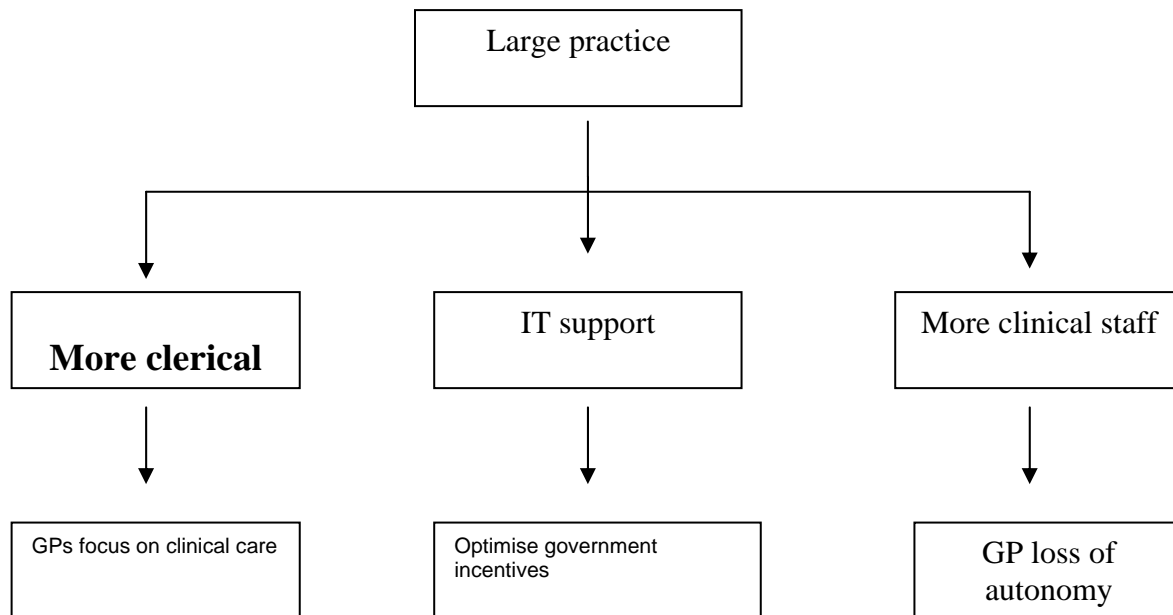


Figure 8.4 demonstrates that the larger the practice, the more clerical staff can be employed in order to reduce the burden of paperwork on the GP allowing him/her to focus more on clinical/ quasi-clinical work. Computerisation had opened the door to a systematic approach to patient care (p216), whilst working in a larger group of clinicians was seen by a few participants as a threat to autonomy (5.3.2) but also as a supportive environment.

It will be noted that none of the impacts depicted in Figure 8.4 directly alters patient outcomes. There is a body of literature suggesting that feedback mechanisms can be a powerful technique for improved quality of care. Such a mechanism is not a feature of existing Australian general practice except at the coarsest of levels (2.10.2). However, the use of IT to support the GP's focus on clinical care would enable the implementation of effective clinical feedback mechanisms.

### ***8.3.3 Impact of change to alter the function of the practice***

(Third circle, Figure 8.2)

Particularly in urban practices, participants had seen their practices transforming from a place where patients went when they were ill to a place where people went when:

- The recall from the doctor came in
- Something needed preventing
- The specialist referral had run out
- The prescription needed renewal
- The blood test needed checking
- Worry overcame wellness
- Another report was required
- Ill and on the way to the specialist
- The media had discovered another disease

With one exception, participants were struggling to come to terms with the new role of the practice. Supporting the new practice paradigm was a relatively new system of financial incentives. I gained the perspective that many participants were going to work rather than expressing their vocation.

There was genuine concern from a small number of GPs that survival of the profession under these conditions was questionable. That view is supported by Tolhurst and Stewart who suggest that the profession will need to develop working structures “that allow a balance of work, family and lifestyle” (Tolhurst and Stewart, 2004, p361)



The changing function of the practice, and that of the GP, would appear to represent a watershed of Australian general practice based on the opinions of this small sample. The interviews raised the possibility that general practices may be the vehicle used to provide primary care to the community whereas GPs had traditionally used practices as their vehicle to provide general medical treatment to the community. Participants were not convincing that they recognised or welcomed the new paradigm.

#### ***8.3.4 Impact of changes on GP workforce in the practice***

(Fourth circle, Figure 8.2)

As mentioned above, a few participants made reference to the absence of young GPs in the workforce, largely because it was no longer an attractive option, or was not attractive on a full-time basis. One other reason given was that general practice is now too complex for a new graduate to establish a practice; the implication being that young GPs either had to buy-in to an established practice (at an age at which they could be expected to have the responsibility of a young family), work as an associate, or to enter a corporate practice, as summed up by Dr R:

*To manage a practice now, the requirements from government....PIP and other programs has increased significantly. The practice accreditation requirements, occupational health and safety requirements, all those things involved in running a general practice have increased significantly.*

An important itinerant member of the practice workforce has been the locum (2.6.4). His or her role has allowed the GP principal time away from the practice to enjoy vacations, attend CPD courses or even to be ill. Whilst it was reported that other support staff had generally increased in numbers, this was not so with locums. Participants, acutely aware of the workforce shortage as recorded in the literature scan (p31) reported on the impact on the smaller practice of the declining availability of locums:

*You can't get locums, so that holiday relief and sick relief is virtually impossible if you're out there by yourself* Dr I

It may be that the impact of the declining availability of locums goes well beyond the solo GP, for whom it must be problematic. Four interviews were conducted with GPs who were married to their medical partners. For these GPs the unavailability of locums must also be difficult. As a lifestyle consideration, the unavailability of locums would seem to be a substantial driver for GPs so affected to consider moving to a larger practice in which holiday or sickness relief can be covered internally.

Change in the nature of the GP workforce forms the second watershed point for Australian general practice. The frustration evidenced by GPs employing other GPs, the disempowerment so evident in (older) solo GPs interviewed and the complexity of practice management would seem to be, and indeed were, strong drivers for GPs to enter larger practices over which they had less control, or even no control in the case of corporate GPs. The obvious consequence would see not only larger practices in fewer locations but practices owned by fewer entities, and certainly by less GPs.

### ***8.3.5 Summary of the impact of change as it affected the practice***

Change had wrought a trend toward practices with more staff. This represented one driver of many to a trend toward larger practices. Within those practices that had changed, additional clerical staff were adopting more sophisticated roles generally enthusiastically. These practices were experiencing a shift in function just as the participant GP had reported a shift in clinical focus (p 9). Increasing practice sophistication existed in an environment of workforce shortage so that larger practices were not only a logical sequela but represented a possible watershed for general practice in challenging the traditional GP-owned practice.

Having completed discussion on the impact of change on the GP and the practice, discussion will centre on the impact of change on the consumer.

## **8.4 The impact of change on the consumer**

A new consumer awareness was evident in discussion with GPs. That awareness centred around the threat of litigation and a new consumer empowerment born not only out of litigation but also from information. The end result, as identified by GPs, and therefore subject to the foibles of third party opinion, was that pressure for patient access was challenging the practice's ability to cope, that patients were more demanding and that the health outcomes for patients had not necessarily improved despite the best intentions of government. These issues, as depicted in Figure 8.5, will now be explored:

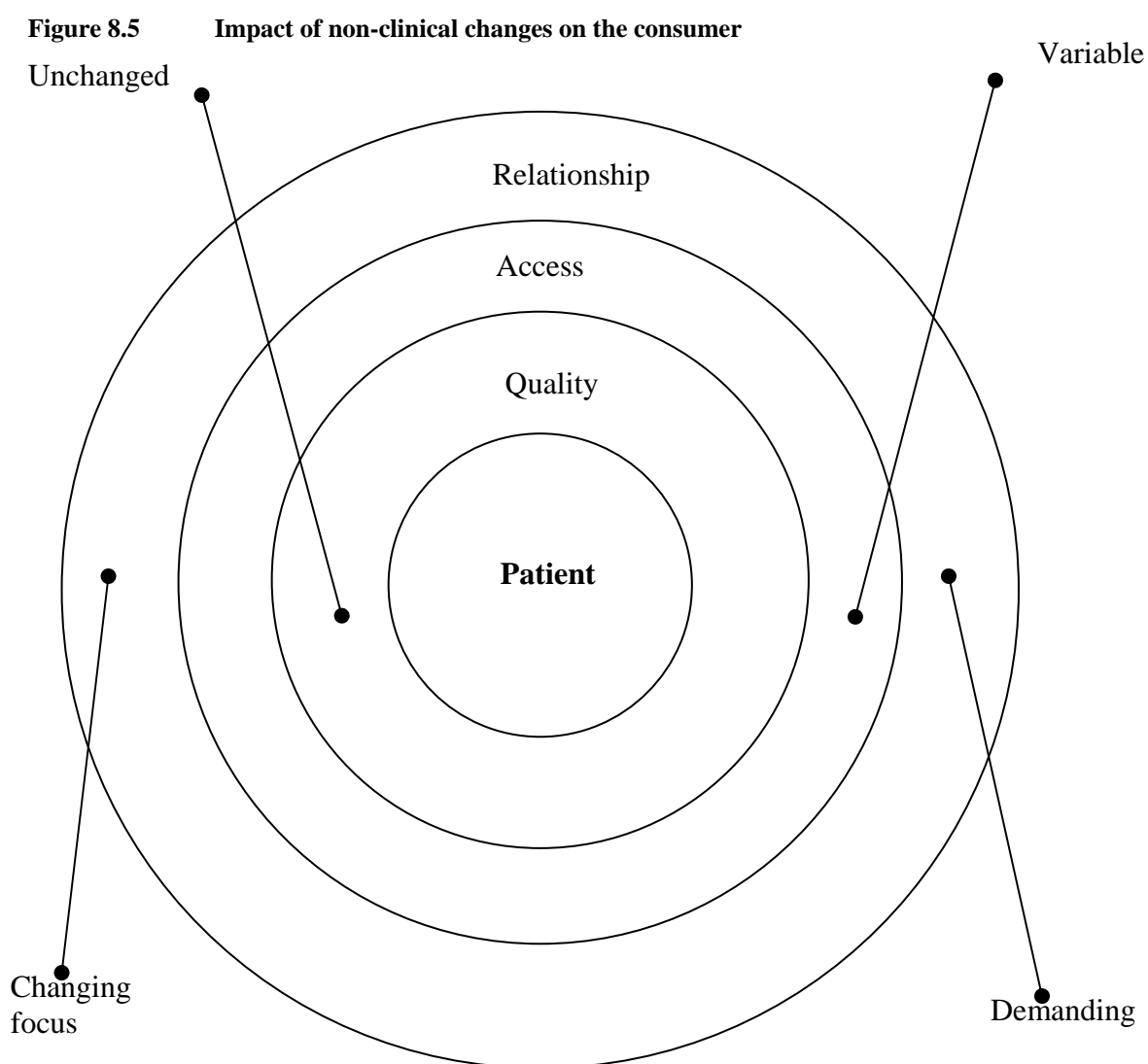


Figure 8.5 represents the new consumerism whereby patient throughput was increasing with questionable impact on genuine access. The public was reported to be more demanding and, at the end of the day, the quality of care had not altered, though efficiencies may have.

The following discussion considers the impact of change on quality of care, on the patient-doctor relationship, and on patient access to the GP.

### ***8.4.1 The impact of change on quality of patient care***

(First circle, Figure 8.5)

Much of the change in general practice had been directed by the Commonwealth at the quality of care. Whilst change had been great, it was not seen to be related to quality; the first theme related to consumers and change>

*Theme 1: Despite all the change, quality of patient care had improved only marginally – major theme*

As previously suggested and somewhat perversely, quality incentives introduced by the Commonwealth were reported to be unrelated to improved quality but other changes (including increased threat of litigation) were recognised as improving quality.

However, generally most participants suggested that there had been little impact to improve care to the patient. Dr M's comment is typical:

Have your patients benefited out of all of this red tape that's come along out of all these government incentives?

*Probably not a great deal. Probably would have gotten the same service anyway*

There was a sense that consumers may have confused quantity of care for quality of care. It may be that consumers respond very well to any professional attention. Dr E captures the essence of this argument:

*I had my sister go and do stuff, I had her write it up, I would then go and consult her and we would work out a plan, she would get community nurses, I'd get the physio, we would do this sort of stuff and then to have it all documented ad nauseam. The amount of time she wasted re-interviewing all of this. Yeah, maybe we might picked up one*

*or two little things, but overall as far as effectiveness, not there.*

What about patient gratitude or bonding, or something?

*They loved it.*

Whilst some participants disagreed, suggesting that patient care had improved in specific areas due to recent reforms, many others suggested that there were reasons to believe that it had worsened as clinical time was now being consumed by EPC items and, to minimise risk of litigation, making detailed clinical notes, apparently perceived by some as not being part of the clinical care process.

Certainly there was no sense that participants either had, or had seen, hard evidence to demonstrate changes in the quality of patient care. Indeed there are structural reasons to suggest that the measurement of quality is very difficult in Australian general practice (2.10.1, 2.10.3.1) and it has been argued that there is not even an accepted definition of quality in the primary care context (Weller et Dunbar, 2005, p12).

Participants had seen processes introduced which had taken their “valuable time” and which sometimes had directed the focus of the consultation away from the patient presentation for outcomes that could only be guessed at:

*They’ve impacted patient care as the College of GPs would see it, but  
whether that’s an improvement from the patient’s point of view ...*

*There’s more ticks in boxes for the ideal consultation* Dr Q

In summary, despite major investment by the Commonwealth in quality incentives, the reforms generally were seen as a frustrating and time consuming side event for the vast

majority of participants. Participants were sceptical that any direct improvement in the quality of their services had occurred as a result. Indeed, without clinical feedback it is difficult to imagine how quality improvement could be appreciated. However, patient safety seemed to have improved whilst practices had improved systems to support patient care and this was generally seen as improving quality care, albeit indirectly, as the direct beneficiary had been the GP. This win-win effect may be important for government in that reform processes that primarily reward GPs for certain outcomes may be adopted by the GP in the interests of the GP rather than the patient but to the benefit of both.

#### ***8.4.2 The impact of change to limit effective consumer access***

(Second circle, Figure 8.5)

Participants were working for the first time in a market where supply fell markedly short of demand. That demand was directly generated by consumers but also indirectly by government incentives. This trend was uncomfortably new for many and represents the next theme concerning consumerism.

##### ***Theme 1: Participants were awakening to the reality of rationing – minor theme***

In the same way as the corner shop has disappeared from the Australian landscape, so too was the local general practice under threat. It is not surprising that patient access was becoming an issue for at least a minority of participants.

Thematic analysis identified 5 changes as limiting patient access to GPs. The first was a trend to centralisation of practices, the second was the reported increase in private billing as supported by literature (2.7.2), and the third is that consultations with more paperwork requirements take longer and therefore there was a trend to fewer consultations with busier GPs. Fourthly, there were fewer GPs and, fifthly, patients might themselves have been generating more demand for screening and preventative activities.

Whilst practices were reported as getting larger they were also becoming less numerous (8.2.1) and geographical rationing of access had commenced. One reason was that the “corner shop” general practice no longer met the standards required for practice accreditation:

*I must say I rather resent the fact that accreditation is such a big thing for general practitioners and that has not been foisted upon specialists, who could afford it very much better than we can so that it's alright to be a paediatrician up three flights of narrow stairs, but if you're a GP you're expected to have railings, disabled toilets, ramps, wide doorways and so that's forcing general practitioners out of the cottages that they worked in and that surprisingly a lot of patients tell me they feel are comfortable and homey.* Dr I

One perverse outcome of the new EPC items reported by participants was they had actually decreased patient access to their GP by increasing the amount of paperwork the GP was required to complete, thereby reducing time available for clinical care. As workload increased, some participants responded by raising their fees and scheduling



patient bookings further into the future rather than extend the length of the working day. Such a strategy impacted on patient access to those GPs. Consumers, it was suggested, responded poorly to the concept that they had the right to “free” health care but only if they could access it. Dr G typified GP participants working in areas with high levels of bulk billing:

*People that didn't make an appointment were virtually kindly told that next time they should make an appointment, in that way it was necessary to make it. They were seen initially, but it was necessary to make an appointment.*

Has this managed to achieve what you wanted to achieve, which is to reduce the number of patients?

*Yes, it has.*

Your work burden, effectively?

*Yes, it has.*

So everyone's happy that have achieved that. What do you think the affect on the patients has been?

*The patients are not happy.*

And have the staff had any problem implementing that policy?

*Oh yes, they've been abused, yes.*

Rationing by scheduling is a method of reducing workload that is equitable assuming clinical urgency is accounted for. Rationing by cost is not equitable and may have resulted in some perverse outcomes not anticipated by the GP in that participants reported a decline in the numbers of children and old people attending the practice, as exemplified by Dr L:

*I really enjoy seeing some of my patients and they're often the ones that, you know, for instance if they have to pay me money to come and see me, they wouldn't be able to afford to come, very often those patients.*

One further reason workload is increasing is that relatively fewer GPs are working (2.6.2.2). Accordingly, there was a reported spiralling of demand on those remaining GPs. There was some evidence that consumers were themselves causing congestion in the waiting room with either increasing demand for lower acuity afflictions or for preventative care. The media and the internet were both identified as resources for the worried well to assuage their appetite for information and to look to the GP for assurance.

In summary, consumers had become more powerful in many ways but not in respect to access. There was, in general, perceived to be a backlash by consumers and many participants, in reporting the increasing wrath of consumers in the face of diminishing access, commonly bemoaned it.

Cost was therefore seen by many as a necessary but unsatisfactory means of reducing access to GP services as no mechanism for clinical triage existed. Access to GPs was also impacted by the trend to part-time practice and the fact that consultations tended to take longer because patients were more discerning.

### ***8.4.3 The impact of change on relationships with consumers***

(Third circle, Figure 8.3)

Relationships were key to the satisfaction participants gained from general practice. Ominously, these relationships were changing.

*Theme 1: Consumers were reported as becoming more demanding - Minor theme*

Consumers were recognised by participants as a strong source of pressure. The traditional power imbalance was reported as being reversed, the GP acting as clerk to the patient's instructions for further investigations or for referral to a consultant. Many participants expressed concern about their perception of the new consumerism which severely challenged the need many of them felt for autonomy and affirmation.

Paradoxically, this may ultimately represent a healthier doctor-patient relationship, compounding an apparent trend away from the traditional consistency of the doctor-patient relationship to a practice-patient relationship

*Theme 2: Consumers were reported as becoming more attached to the practice rather than the practitioner – Minor theme*

The longitudinal patient relationship was reported as being threatened by a third factor, namely corporatisation of general practice (2.7). This organisational structure provides patient access to the next doctor rather than "their" doctor. If this reported trend continues, the longitudinal patient relationship may not be between GP and patient but between practice and patient. However, the critical element of the GP-patient relationship, as suggested by participants, is trust. Is it possible to develop an organisational trust with a patient the same way that commercial businesses or certain brand names may engender trust? If not, then the community may be losing an important element of its fabric as GPs, in that ongoing relationship, reported being involved in holistic patient care as distinct to pure clinical management. Specific areas of concern expressed by 2 participants included assisting the family in end of life

decisions and in timing the transfer of patients to residential aged accommodation. The critical question then is: can continuity of the patient trust relationship survive a trend to an increasing trend to a practice-patient relationship?

In conclusion, the doctor – patient relationship so highly valued by many participants, was seen as changing. Trust was less evident and, if practices do enlarge, then the patient relationship may be expressed toward a number of providers or even toward the practice rather than the practitioner. As the doctor–patient relationship appears to be directly related to professional satisfaction, there must be some doubt as to how tomorrow’s GPs will respond as that relationship becomes diffused within the organisation known as a general practice but with few physical features of a practice of 20 years ago.

## **8.5 Concluding remarks**

Chapter 8 has demonstrated that non-clinical change had severely impacted all participants and, in many cases, the general practice itself. Less convincingly, the chapter demonstrated that change may have had some moderate impact on consumers.

Participants had found the changes to be stressful, and either time or change or both had resulted in declining levels of satisfaction. This was also associated with a change in skill sets impacting on their clinical roles. New skills had been acquired but, to some extent, there was confusion about their role as general practitioners as programs introduced by the Government altered the focus of the consultation from the patient’s presenting problem.

Changes in the method of remuneration had impacted on the way clinical practice was conducted in that where Commonwealth incentives allowed it, GPs could utilise a second source of funding (PIP) thereby avoiding raising charges to the patient.

GPs spent much of their “after-hours” time involved in educational sessions that often doubled as social events for themselves but not their family. Rural GPs were more likely to draw boundaries around their work commitments than their urban colleagues. Apart from that there was little evidence that this older group of GPs had responded to changing pressures of general practice by rebuilding their resilience through relationships of (non-medical) friends and family

The Commonwealth had been perceived to have not introduced reforms in a logical and justified fashion. Some blame for this fell on GP representative organisations.

Nonetheless certain efficiencies of scale had been generated by the Commonwealth reforms, and hastened by a workforce shortage, some participants found a new freedom in this way; others had found larger practices a threat.

Within the practice, few incentives had brought about any perceived improvement to the quality of service delivery. Indeed, some GPs had plodded on in the traditional manner of general practice, where necessary inventing systems to circumvent the systems of benchmarking encouraged by the Commonwealth. However, many factors had favoured a move to larger practices. Where allied health and clerical staff were employed, more time could be spent on clinical care. Where delegation occurred it was embraced by staff. Accordingly, practice costs had risen but to what extent this compared by the GP to income was uncertain. There had been an important impact of

red tape in that some participants had taken the opportunity to streamline business processes allowing more time for clinical work. The concept of managing business risk was non-existent, but that may represent the real place of general practice in a heavily subsidised, high demand market.

Notably, the breadth of skills of the participants had declined whilst they had experienced a broadening of quasi-clinical roles. The net outcome was confused GPs who wondered what general practice was becoming.

Consumers had become more demanding and, in the eyes of the participants, they had not benefited from the reforms instituted by the Commonwealth (though they did enjoy them) and it was reported that access to their GP had become more difficult. Although these findings are disappointing, it must be noted that the process of change continues and perhaps has yet to bear fruit. However, Australia has no framework for General Practice reform and no timetable for reform.

The picture painted confirms the impression of a “milieu of change”. Further research would assist in mapping the change process in a longitudinal fashion. This would assist in understanding the correct pace of change and to identify the resources required for GPs to make those changes. In particular, consumers need to be consulted as to their experience of general practice change.

An important area of research identified in this chapter relates to the impact of change in favouring larger practices. We do not know how practice size affects the personal well-being of the GP nor whether patients tend to see themselves as patients of the practice rather than patients of a particular doctor. In particular, it would be helpful to

understand what issues in respect to patient access arise when practices centralise.

This completes an examination of the changes reported by a cohort of twenty regional, urban and rural GPs. It also completes a description of those GPs themselves, how they responded to change and how that change impacted upon them, their practices and their patients. The following chapter, Chapter 9, will present conclusions arising out of an analysis of the previous chapters.

## Chapter Nine

### Conclusions

#### 9.1 Introduction

In examining the attitudes and opinions of a small cohort of GPs it has been possible to create a picture of change. In exploring the thesis, it was not the intention to focus on specific changes, rather to examine the effect of change on participants more broadly using specific changes as a platform for generalisation. While the study is not generalisable in so far as it involved a small number of GPs, to the extent that it sits comfortably with literature it becomes a more powerful document. Perhaps this uniformity has been precipitated by the almost omnipresent hand of government as the most potent driver of change in Australian general practice.

This chapter highlights an important factor not appreciated at the commencement of this work; viz, that the rate of change is equally important as other factors in the process of change. Therefore Figure 1.1 is more accurately expressed as follows in Figure 9.1

**Figure 9.1** A process of change

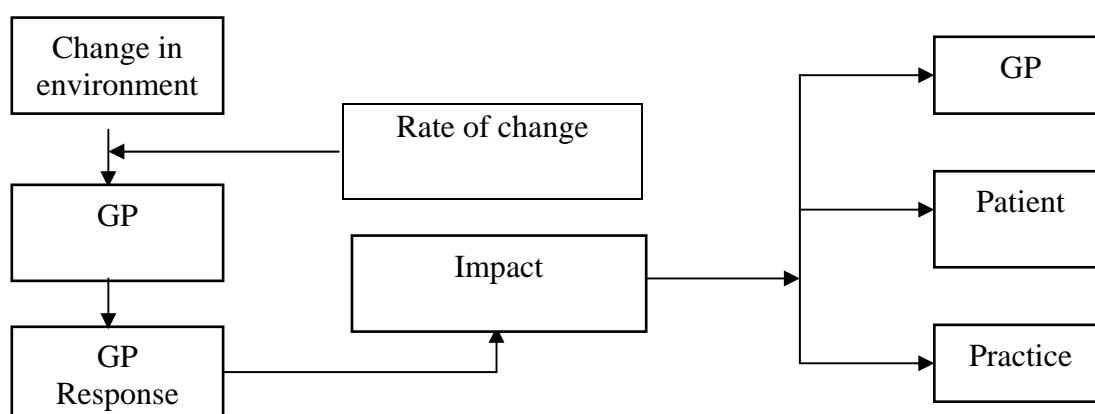




Figure 9.1 suggests that the GP response to change and the impact of change will vary according to the rate at which change is delivered. This suggests, somewhat logically, that the impact of change can be reduced by slowing the rate at which change is delivered.

This chapter also highlights two important themes not fully understood at the commencement of this work. The first concerns the concept of the GP as a manager and the second is the intimate role of government in the specific environment of general practice. Therefore, in six sections, Chapter Nine draws together the analysis of participant data in order to more succinctly answer the question, “What is the effect of non-clinical change on Australian GPs?” The six sections include:

1. the effects of change on the GP himself/herself,
2. the nature of change faced by the GP in general practice,
3. the GPs’ management of change,
4. the effect of non-clinical change on the general practice,
5. the effect of non-clinical change on the patient (from the GP’s perspective) and, finally,
6. the role of government in instituting and maintaining change.

It so doing, fifteen themes are identified, that help understand the effect of non-clinical change on the Australian GP. These fifteen themes are as follows:

1. In general, the cohort of GPs displayed traits that militated against successful adoption of change.
2. Change had rendered general practice increasingly dissatisfying.
3. Changes in clinical roles had caused role confusion.

4. The GP was experiencing a changing relationship with the patient.
5. Changes had exacerbated an increasing in workload
6. Commonwealth incentives were seen to be unrelated to quality.
7. Participants reluctantly adopted reforms to increase remuneration.
8. The rate of change determined the response to change.
9. Participants managed non-clinical change without evidence of management skills.
10. Paradoxically, as GPs delegated more work and as other staff adopted that work, the job satisfaction of both groups increased.
11. Increase in practice sophistication challenged the need for control.
12. Patients were becoming more demanding in their relationship with the doctor.
13. The Commonwealth had failed to make the case for change.
14. Government related innovations were perceived as occurring randomly.
15. GP representative organisations were not seen as buffering change.

Again, the chapter is structured around themes; the first theme is related to the section “Non-clinical change and the general practitioner”.

## **9.2 Non-clinical Change and the General Practitioner**

The first theme relates to the GPs’ emotional preparedness for change. Against this background, GPs were becoming less satisfied (theme two) with their profession due largely to a diminishing clinical role (theme three) and to a change in the nature of the relationships with patients (theme four). Furthermore, their workload was increasing (theme five) due largely to new “quality” incentives which they saw as unrelated to

quality (theme six) but which they reluctantly adopted on the basis of financial imperative (theme seven). Each of these seven themes will be discussed, in turn, under the heading “non-clinical change and the general practitioner”.

*Theme 1: In general, the cohort of GPs displayed traits that militated against successful adoption of change.*

Feelings of isolation, helplessness and a need for autonomy appeared interdependent and associated with a need for affirmation which, in many cases, was satisfied in the practice context rather than in the social context. The power of the doctor–patient relationship therefore had not been mastered by such participants; perhaps they did not recognise it. For a group of GPs who placed great emphasis on the importance of the GP–patient relationship, it was interesting to discern a strong sense of autonomy. This was manifested in five areas:

1. A strong desire to be autonomous of Government, a factor causing resistance to the adoption of Government driven initiatives.
2. A strong reluctance to seek professional advice.
3. A reluctance to adopt clinical guidelines.
4. An unwillingness to adopt leadership roles in the transformation of business processes.
5. To a lesser extent, a failure to engage in a constructive manner within the family.

This is not to suggest that all GPs expressed a need for autonomy. Those who did not were typically rural or female, and were either involved in merger discussions or had

welcomed the opportunity to delegate clerical and clinical duties to additional staff within their own practices. Nonetheless, where a need for autonomy was expressed it seemed to militate against successful adoption of change.

A sense of helplessness was a second characteristic that militated against adoption of innovations. Mechanic (1978) suggests that a buffer against helplessness is to increase power in relation to interpersonal relationships and the social situation. If such is the case, given that many participants acknowledged the importance of CPD as a primary social resource, CPD, as it typically occurs outside business hours, may be a destructive process for those GPs expressing feelings of helplessness. It may be that the normalcy of human relationships as expressed beyond Medicine has been lost by some GPs who find succour in the company of like minds in like circumstances. It must be stated, however, that a small number of GPs regarded family time as inviolate, thus drawing on the strength of family relationships to build resilience and increasing power jointly in natural human relations.

The definition of boundaries was important to those GPs who appeared to place greater emphasis on their personal lifestyle. The expression of any measure of control was generally viewed strongly as a virtue by almost all participants.

Many participants expressed feelings of isolation, withdrawing into their practices. A few were no longer comfortable being home and many complained about the long hours at work but could find no way around the problem; perhaps they preferred not to find a way. Some stated that they could not retire due to financial reasons or patient need; perhaps they were unable to find anything to retire to.

Many of this group then, were people who were already prejudiced in their capacity to make functional decisions. Chapter 5 painted a picture of a group of participants who “displayed certain characteristics that would impede their capacity to cope with change” (p186). Was this then an atypical group of doctors around whom change swirled?

Perhaps not. O’Hagan characterises the medical practitioner profile in the following terms: “Thus we have the stereotype of the grandiose workaholic doctor needing endless patient admiration to support self esteem, denying personal weakness, yet fragile because of excessive emotional detachment and isolation.” (O’Hagan, 1998, quoted in Clode, 2004). This picture is a very close image of that painted in chapter 5 and lends credibility to the findings of that chapter.

Clode (ibid), in seeking reasons for what are described as personal characteristics of doctors predisposing to “emotional problems”, suggests that “selection (into medical courses) of academic high achievers is highly likely to increase the workaholic tendencies evidenced in doctors later in life along with an ability to single-mindedly focus on work to the detriment of other social activities” (Clode, 2004, p27). An hypothesis drawn from this may be that if the job of the GP has changed, the selection criteria for the job should change accordingly. A strong argument of this thesis is indeed that the job of the GP has indeed changed (Theme three).

Identifying the characteristics of the participant GPs facing change was an important activity. There was, however, no understanding gained as to whether certain

characteristics had always been inherent traits of the individual or whether, with time and circumstance, certain traits such as autonomy and helplessness had been acquired. Further work in this area may usefully assist GPs of the future to maintain an equilibrium within relationships.

In conclusion, characteristics perceived from many of the participants suggested that they would regard change as more difficult and uncomfortable than most.

Paradoxically, it was perhaps that many of these GPs resisting change needed change most but were least prepared for it and would find change dissatisfying.

### *Theme 2: Change had rendered general practice increasingly dissatisfying*

Not only were many GPs unable to change, the changes themselves were unappealing. The end result for many was frustration, at times anger, and certainly dissatisfaction; traits readily recognisable in often what were quite emotive interviews. In Chapter 6, several areas were identified in which change had generated either satisfaction or dissatisfaction for participants with respect to their profession. These areas are tabled in Table 9.1

These findings are consistent with those of Skolnik et al who list determinants of satisfaction in UK general practice as including patient relationship and clinical competence, whilst determinants of dissatisfaction included “regulations by third party payers, paperwork, isolation from other physicians, and the threat of a malpractice suit” (Skolnik et al, 1993).

**Table 9.1*****Determinants of participant satisfaction and dissatisfaction***

<b>Satisfaction</b>	<b>Dissatisfaction</b>
Longitudinal care of patients	Meaningless paperwork (red tape)
Collegiateness	Poor remuneration
Higher entry standards into general practice	Loss of control (including risk of litigation, increasing workload and increasing consumerism)
Autonomy	Incentives unrelated to quality
Patient affirmation	Isolation
Computerisation (not a strong factor)	Diminishing clinical roles

These areas, then, become foci of interest in determining the effect of non-clinical change on Australian GPs. On the evidence available from this research, it is possible to argue that the drivers of satisfaction in general practice are diminishing to a dangerous extent. GPs' clinical expression and longitudinal patient relationships are discussed in themes three and four.

### *Theme 3: Changes in clinical roles had caused role confusion*

The workload of GPs had changed (A.8.1) during the careers of participants. In particular, the opportunity for the expression of clinical and surgical skills within the hospital environment had vastly diminished. Only one GP had adopted a subspecialty; that a minor surgical one. Such practical skills are regarded highly by medical trainees in general (*AMWAC Report 2003.4*, p54,) as they had been by those participants who had been in practice in the 1970s.

Specialists were depicted as taking over many former roles of the GP. Indeed, certain pressures, depicted in Table 9.2, had produced a role reversion of the GP whereby the gatekeeper had become the gate opener.

**Table 9.2** *Factors favouring referral to consultants*

Fear of providing suboptimal care
Increased reliance on diagnostics
HIC regulatory monitoring of GP activity
Consumer pressure for expert care
Time pressures for rapid consultations

Table 9.2 describes factors that influenced participants to refer patients to consultant specialists. Many of these factors could be negated if more expertise could be retained in general practice. As a result of the declining clinical role, he or she (to a lesser extent) had become confused about their role as a GP.

Universally the role of the GP had broadened in some areas and declined in others. New quasi-clinical roles have been identified (8.1.3). They included roles as knowledge brokers, care planners and as quality auditors. However, the transition had been a weak one as none of these roles had been adopted with enthusiasm or in any widespread or systematic manner. Far more impressive was the decline in GP roles. Precursors of these changes, are tabled in Table 9.3

**Table 9.3** *Precursors of GP deskilling*

<b>Precursor to deskilling</b>	<b>Impact on participants</b>
Increasing specialisation within hospitals	Major procedural activities denied GPs
Fear of litigation	Increased referral to specialists Increased referral for investigations
Increased cost of medical defence insurance	Minor procedural activities avoided Increased referral to specialists
Increasing consumerism	Increased requests for referral to specialists Increased requests for referral for investigations
Consumer access uninhibited by cost in bulk	Lower acuity services provided by GPs



billing practices	
Increase in chronic disease burden <sup>32</sup>	Acute presentations less frequent

There may be a significant cost to role minimisation in terms of GP satisfaction. For older GPs, the slow decay of their roles may prove sufficient stimulus to retire. For those postgraduates entering the general practice training course and finding little to attract them, their final vocation may be outside general practice:

*If general practice becomes an area in which you have minimal number of interesting parts to it, then people won't be interested in following that as a career path. I see it as being uninteresting as more like a clerical sort of job rather than an interesting career.*

Dr R

The following diagram, Figure 9.2, illustrates the concept of changing roles:

**Figure 9.2 The former role of GPs**



Figure 9.2 demonstrates that the former role of older GPs had been largely clinical with a substantial clerical role. Those roles had changed in one of two ways. For participants who had not delegated roles to other staff, the clerical role had increased due to red tape requirements and a quasi-clinical role had evolved as well. This is represented by Figure 9.3

**Figure 9.3 The current role of non-delegating participant GPs**



Figure 9.3 demonstrates that “reactor” participants who had not been willing to delegate

<sup>32</sup> An increase in chronic disease burden was seen to be related to less challenging clinical practice in that diagnoses had previously been made and management tended to be “more of the same”. An increasing disease burden is directly related to lower acuity services being provided by GPs.

responsibilities had seen their clinical roles contracted as a new quasi-clinical role combined with an increased clerical role, a result of coping with increasing red tape, had impinged heavily on former clinical roles.

Those GPs who had adopted the quasi-clinical role but who had also delegated much of the clerical role had also seen their clinical role decline, but to a lesser extent than those resisting change. This is demonstrated in Figure 9.4.

**Figure 9.4      The current role of GPs delegating duties to additional staff**

CLINICAL	QUASI-CLINICAL	CLERICAL
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Figure 9.4 demonstrates that the role of the participant GPs who employed additional staff included a welcomed contracted clerical role. Nonetheless, the clinical role had also been diminished by a quasi-clinical role involving activities including recall and reminder generation, patient information, screening, assessment and reporting.

Confidence and satisfaction had been eroded to some extent in that the major reason for adopting the new quasi-clinical role was financial and was not related to quality. This was extremely dissatisfying as most participants expressed the view that they were chiefly clinicians.

In summary, whilst the general role of the participant GP had increased to embrace a quasi-clinical role both the range of clinical skills and the depth of their expression had narrowed. A strong case can therefore be made to increase the depth of clinical activity of the GP by displacing the quasi-clinical role elsewhere within the practice. Whilst not the subject of this thesis, the clinical role was longingly and consistently contrasted by GPs to their non-clinical roles.

#### *Theme 4: The GP was experiencing a changing relationship with the patient*

Perhaps the most significant change of all was the apparent trend to alter the doctor – patient relationship; the relationship that was reported by participants to lie at the heart of the source of satisfaction for participants (reinforced by Skolnik et al, 1993).

As the expression of acute clinical skills declined (p267), participants had become the providers of chronic care (2.13.3), care which by definition, results in completion only with the death of the patient. The increase in number of staff within the practice had heralded the shifting of relationship of the patient from a one to one relationship to a one to many relationship. Patients who used only to see a particular GP were reported as seeing practice nurses most commonly to assist with health assessments and care planning, whilst four participants were associated with practices employing allied health professionals who provided clinical services within the practice under the care plans generated by practice nurses. Depending on perspective, treatment by differing providers may fragment care delivery (p271) and ostracise the general practitioner, or it may place the GP at the head of an integrated process of care.

It has already been suggested that the elements of this determinant of satisfaction were chronicity, depth of relationship, and its breadth across the family group (p165). This is an important delineation for this element of satisfaction is born out of relationship, not from clinical outcomes. Indeed, literature suggests that clinical outcomes may suffer in order to safeguard the long-term doctor-patient relationship, for example by prescribing inappropriately (Stocks et Fahey, 200) or by-passing over matters of domestic turmoil ( Taft et al, 2004).

A further threat to continuity of care lies in the trend to increasing part time general practice (2.6.2.3) and engenders two sets of questions. The first set centres around the provision of part-time services. In the face of part-time providers do chronically ill patients respond by becoming part-time patients or do part-time GPs tend to see more acutely ill patients? If so, does this alter work satisfaction? Do part-time GPs tend to crystallise into full-time GPs? Are they immune from matters that were so important to this study sample of doctors, such as professional satisfaction, when they are living a broader life outside medicine? It has been suggested that the clinical care of patients attending part-time family doctors is at least as good as that provided by their full-time colleagues and that patients are indeed at least as satisfied with the care provided by part-time clinicians as that provided by full-time clinicians (Pakerton et al, 2003). Therefore, there do not appear to be strong clinical drivers acting as barriers to reducing the continuity of GP-patient relationships.

Respect was a second key element of GP satisfaction which, in several instances, metamorphosed into affirmation of the GP. In a few instances the price of that affirmation was perceived by the participants as an intense pressure for access to the GP whilst in other instances there was evidence of co-dependency. There was, however, a distinct decline in perceived patient respect of the GP, in that participants perceived that some patients viewed them only as a portal to the specialist consultant or to technical investigations; ie, as a means to an end.

In recognising that most individuals prefer to be respected, it would seem important to understand the nature of respect and how it is engendered. If respect is engendered out of trust, then it may be an endangered species as there was evidence that trust in the GP was also declining. Perhaps trust is to be more profitably engendered elsewhere, for example, within the relationship between the GP and other clinicians working with him/her (Beaulieu, 2002, p26).

Should it be that a basic change is occurring in the nature of the doctor–patient relationship then this would suggest that the most critical determinant of satisfaction for these GPs is under threat. Some may argue simply that if Australian GPs were to find themselves working in a team environment, then healthier and more fulfilling work based relationships may devolve as a result. A counter argument may be put by the Working Party of the Royal College of Physicians which has found a relationship between the “art of medicine” and the “special nature of the very personal patient – doctor partnership” (*Report of a Working Party, Royal College of Physicians*, 2005, p17). If they are correct, then not only have GPs been technically deskilled but they will also have lost much of the Art of their craft. The concept of teamwork as an adequate substitute for both the art and science of medicine may therefore seem difficult to sustain.

### *Theme 5: Changes had exacerbated an increasing in workload*

Workload when uncontrolled was damaging and demoralising to participants. Workload, as identified by a study of the literature, is reported to be a product of the following influences: “Relocation of service delivery”, “Practice management”, “Consumerism” and “Red Tape” (2.7.5). These were many, but not all, of the factors

that participants reported as determining their workload. The factors discernible from the interviews are listed in Table 9.5 in terms of demand and supply.

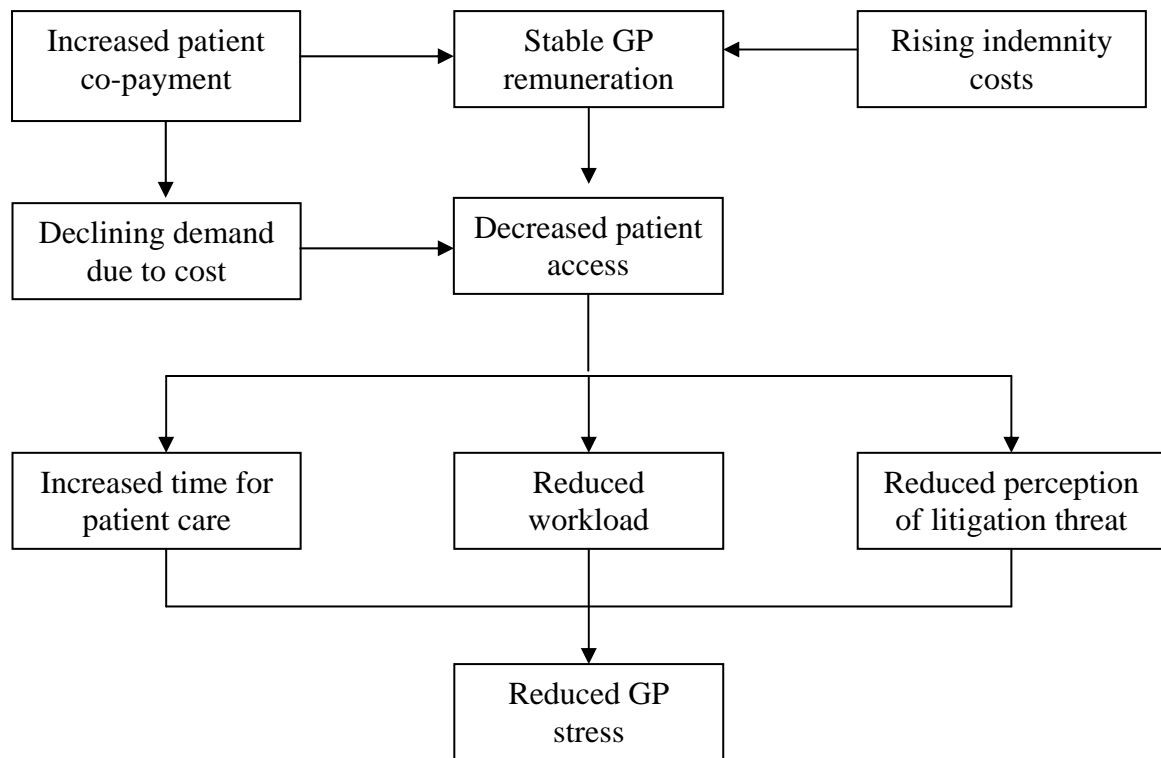
**Table 9.4** *Participant-reported causes of increasing workload*

<b>Demand</b>	<b>Supply</b>
Paperwork associated with Commonwealth incentives	Ageing of the GP population
Paperwork associated with the increasing demands of small business management in general in Australia.	Diminishing number of new GPs
Increasing service quality due to medico legal risk and to consumer pressure	Increased tendency for part time work
Quasi-clinical work associated with Commonwealth incentives	Increased requirements for time spent in educational activities
Increasingly sophisticated practice management requirements	
Ageing of the general population	

As reported by Schattner and Coman (1998) and consistent with findings of this study, workload and fear of litigation were major stressors in participants' work experience. Ironically, reducing workload is also consistent with reducing litigation. The fewer patients seen<sup>33</sup>, the fewer people possible to commence litigation and the more time available to prevent it. This is represented by the cascade as described in Figure 9.5; a cascade triggered by an increasing trend to patient copayments observed in this group of GPs.

<sup>33</sup> One shortcoming of this study was the failure to identify reasons GPs billed patients privately and whether GPs were increasing the patient co-payment. It may be that private billing represents an attempt to control patient numbers (either to control workload and/or to reduce risk of litigation), but it may simply be a method to balance income, workload and quality of service delivery.

**Figure 9.5** Cascade of changes reducing GP stressors



This process was experienced by a number of participants, including most rural GPs, where the impact of worsening patient access could logically be anticipated to be highest (2.8.5) with a consequent impact on population health and consumer equity. Fortunately, possible strategies to limit workload were not limited to increasing charges. Additional strategies utilised are demonstrated in Figure 9.6, which is only viable in the non-competitive climate of a GP shortage.

**Figure 9.6** Five factors utilised to a reduced GP workload

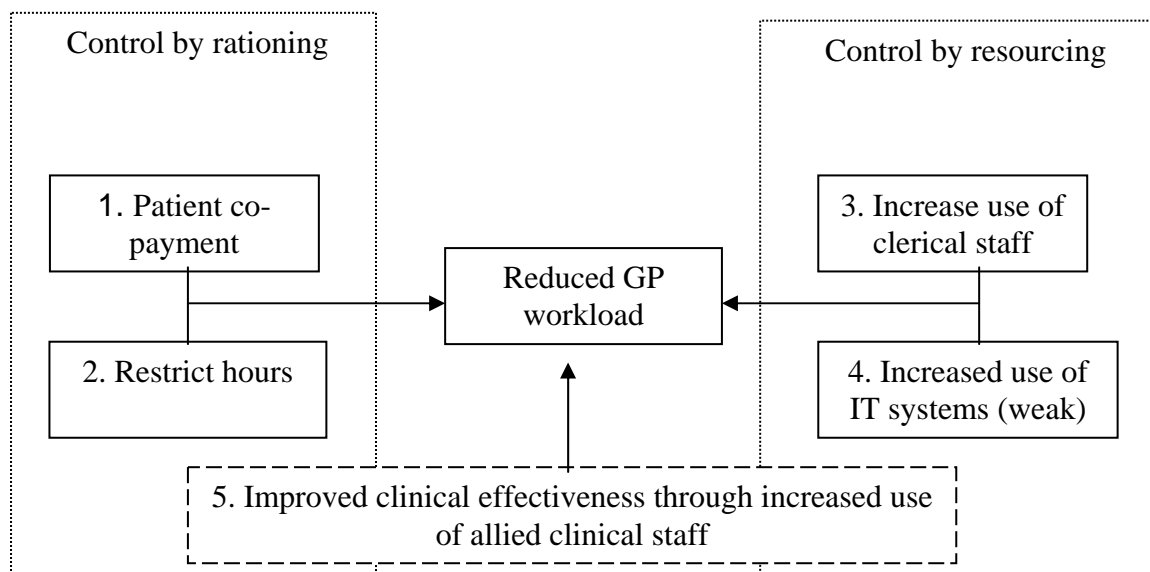


Figure 9.6 describes strategies used by some participants to assist in the control of increasing GP workload. The use of allied clinical staff is represented in both boxes as it allowed expansion of the work of the GP. Specifically this model was used by rural GPs. The model includes the following elements:

#### *Introduction of patient co-payment*

As reported in 2.8.5, rationing by co-payment is a common practice in rural areas and, indeed, all rural participants charged a patient co-payment to most, if not all, patients. Raising the patient co-payment is a form of control by rationing as it reduces demand by limiting access through financial disincentives.

#### *Restricted work hours*

A small number of GPs demonstrated firm control of hours worked; again, by and large, they were rural GPs. In general, those GPs who had taken definitive steps to control the amount of time available for consultation and paperwork, impressed as having increased satisfaction and lower levels of emotiveness than those who responded to patient demand by working longer hours.



*Increased use of clerical staff*

Similarly, increased use of clerical staff was a mechanism for reducing non-clinical workload in particular. It also appeared to be a marker of job satisfaction. What was not certain was if the satisfaction arose from controlling the work flow, from the experience of delegation of work to someone else, or from working with other staff members in a collaborative manner.

*Increased use of IT systems*

Participants tended to use IT systems for administrative purposes (rather than clinical purposes), allowing GPs to move from a bulk billing model to a private billing model . They were rarely used for reducing clinical workload, there being no consensus that computers saved time when used clinically.

*Improved clinical effectiveness using allied health staff*

The hatching around this box indicates that this strategy was least utilised. The allied health staff most commonly used was the practice nurse who tended to be involved in both clinical activities and administrative activities such as preparation for accreditation.

GP workload was perceived as being negatively impacted by the Enhanced Primary Care incentives. The hesitancy of participants to adopt these initiatives was a function of anticipated clinical outcomes (unaltered), financial gain and the amount of paperwork involved. However, whilst remuneration seemed to be the strongest determinant favouring adoption of new interventions, the strongest barrier against adoption was the quantity of red tape involved. Table 9.6 lists the factors that influenced participants in their decision to adopt or reject a new initiative.

Table 9.5

*Factors influencing the adoption of new initiatives*

<b>Factors favouring adoption of new initiatives</b>	<b>Favours mitigating against adoption of new initiatives</b>
Well justified initiative	Large amount of red tape
Initiative seen to link to improved patient outcomes	Initiative not associated with improved outcomes
High remuneration	Poor remuneration
Consumer pressure	Marketing sent to waste paper basket

An examination of Table 9.6 will reveal that, by and large, the amount of clinical work involved in the initiative was not an important consideration whilst the workload involved with the associated red tape was. This implies that participants appeared to be willing to add to their workday by adopting new initiatives as long as the remuneration was sufficient and the red tape not too cumbersome (or illogical).

In conclusion, increasing GP workload appears to have offered general practice an impetus to undergo structural reform. On the evidence from this study, such a reform has commenced primarily in the administrative area, but requires the strengthening of professional relationships with allied clinicians in order to share clinical workload in the new era of planned care. Indeed, the reactive form of practice described by Beaulieu (Beaulieu, 2001) has either been displaced or squeezed by planned care of the chronically ill and preventative care of the well. Where GPs' expectations and interests failed to match new clinical roles, dissatisfaction increased. As the range of skills diminished, confidence declined. As integration penetrated the practice of the GP, some participants withdrew or were reluctant to adopt new practices. However, the opportunity to work with other professionals (as distinct to merely referring patients to other professionals) had offered participants a chance to re-engage professionally as they once did within the hospital environment. Failure to adapt to these new quasi-

clinical roles may see GPs withdrawing further, increasingly reducing their skill set and developing a greater sense of hopelessness (Mechanic, 1978, p299), a trend already evident in a small number of participants. Indeed, failure to make these new roles attractive and rewarding may threaten the recruitment of junior doctors into general practice.

#### *Theme 6: Commonwealth incentives were seen to be unrelated to quality*

Few participants could identify any association between the “quality incentives” introduced by the Commonwealth and quality. Nonetheless, it is possible to discern some general and essential elements of quality and reform as perceived by the participants:

##### *The opportunity cost of paperwork*

The first element is that the perception of quality can be negated by the burden of the paper work (red tape) that supports it. This problem lies partly with the fact that paper work is a burden in itself but, more specifically, time spent meeting the requirements of red tape represented an opportunity cost that deprived the GP of time to provide clinical care, their often stated *raison d’être*. There was a very strong perception by participants that they were clinicians first and foremost and therefore to indulge in activities beyond the clinical spectrum was an invalid activity. Such a position, however, would seem to be at odds with the business world in general where accountability and evaluation are accepted, if not welcomed, as important elements of the quality process.

##### *Non-clinical determinants of quality*

The second element is that participant GPs perceived that quality is delivered clinically and that processes that do not directly improve clinical delivery of care are therefore unrelated to quality. Perhaps that attitude derived from a hospital based training environment in which monitoring of benchmark indicators of technical capacity (e.g. refrigerator temperatures) and of patient satisfaction (e.g. location of toilets) is conducted in an unseen manner by non-clinicians acting independently of clinicians.

#### *Quality and credibility*

Whilst there was no suggestion that the Commonwealth did not have a valid role in general practice reform, there was no suggestion that the Commonwealth had satisfactorily introduced quality-based reforms. Change driven from within the profession appeared to have been a greater incentive than change driven by government, though there was little trust generally for GP organisations. This matter is further discussed later in the chapter.

#### *Relevance of quality incentives*

Incentives needed to be seen to fit the needs of the user. It was suggested that broad-based incentives would become more meaningful if they could be adapted to the local practice. There was an almost universal acceptance that standards are appropriate for general practice but only for the poorest performers. Just how that would be determined without the application of standards was not identified by participants. The application of standards therefore was seen as a negative experience. The concept of pride in exceeding standards was not evident.

#### *Purposefulness of reforms*

Participants inferred a genuine desire for purposefulness in reforms. Some held to the concept that, if a previously unpaid activity was being conducted then the clinician should have no expectation of reward no matter how high the standard of the activity. This concept was more rigidly held if any proffered reward was accompanied by increased paperwork.

With rare exceptions, there was no sense by which participants were able to state that certain interventions were easily integrated into their practices and of benefit to their patients. A second challenge for government then becomes one to simplify the complexity that has become the asynchronous array of incentives, controls, service providers and standards so that the purpose behind each element, and the array of reforms as a whole, is evident.

*Relationship between audit and quality*

As complex as the continuing medical education system was reported to have become, it had failed to introduce GP participants to the value and role of the audit as a tool for both business and clinical improvement. Participants had been exposed to two forms of audit; that associated with the education cycle (QA) and that associated with the practice accreditation cycle. In both instances, the almost universal response had been to perform the audit as a means to meet bureaucratic requirements, rather than as a means for assessing continuing improvement.

*The relationship between autonomy and quality*

Though not the subject of this thesis, the desire for autonomy, as indicated by Mayer and Piterman (1999), may be a driving force behind GPs' reluctance to adopt clinical guidelines (p25). Provision of systematic care was not a feature reported by

participants. It may be that GPs' non-use of evidence based guidelines may simply be an expression of their desire for autonomy<sup>34</sup>.

In conclusion, "quality" though not referred to directly in the interviews, was a critical factor for GPs in respect of the new reforms in that its apparent absence was an important inhibitor to willingly adopt reforms. Where they were adopted, they were adopted to increase income, not to improve quality of care.

### *Theme 7: Participants reluctantly adopted reforms to increase remuneration*

Remuneration was a major issue for most male participants but less so for the female participants, each of whom, by chance, was a practice principal. As evidence exists suggesting that remuneration is a major issue for female GPs (2.6.2.3), more work is required to understand if concern about remuneration is really a gender based concern or one more related to part time and less powerful employed clinicians, most of whom happen to be female.

Most participants who had adopted the Government's incentives had done so for financial reasons rather than for reasons of quality improvement. The absence of persuasive evidence of quality was a severe disincentive to adoption of incentives.

Those who adopted incentives for financial gain alone were quite cynical about that process. Some participants had set systems in place in order to maximise income with a minimum of disruption to the normal functioning of general practice. In other words, systems were generated to minimise any impact on existing systems thereby negating

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<sup>34</sup> Or, inter alia, a limitation of the study size, or the fact that evidence based guidelines may be developed in isolation to general practice.

the intention of incentives such as Practice Accreditation that is intended to permeate the day to day running of practices.

In conclusion to this section, participant GPs were, by and large ill-prepared to adopt any change, least of all the changes on offer. Those who did so, did so for financial reasons despite the increase in workload that accompanied the reforms. Having adopted the changes, GPs then had to accept a new quasi-clinical role which impacted on their clinical expression, already suffering from the pressure of a declining skill base, and heralding an altered relationship with patients.

Having discussed the participants' preparedness for change, it is now appropriate to explore the nature of the change itself.

### **9.3 The nature of non-clinical change**

Chapter 2 portrayed an environment of change, much of which had been orchestrated by government. That change had two characteristics; the nature of change and the rate of change. Whilst the nature of the changes themselves was important to participants, as explained in Chapter 2, perhaps the most important finding of this study is that, for this group, the rate of change was an important predictor of change.

#### *Theme 8: The rate of change determined the response to change.*

Stages of the life cycle of an innovation include identification of (or predicting) that innovation (whilst considering other opportunities or threats), a decision to adopt or reject it, adaptation of the existing organisational structure or process, implementation

of the intervention and evaluation of both the intervention and its implementation. In business terms it is therefore unrealistic to expect an unsophisticated general practice to retool to adopt a new innovation when previous innovations are still being implemented. Such an approach would be a challenge for an organisation with a strategic typology as prospectors, and would be alien to the culture of defenders and well beyond the capacity of reactors. Attempts to do so may result in chaos and confusion within the organisation. Yet, participants almost universally suggested that changes had indeed been rapid and in many cases unexpected.

An argument has been made that rate of change is relative to a social context which becomes the benchmark of whether the rate of change “feels right” (Wilson, 1992, p18). If this is indeed so, the social context of this group of participants is probably one in which change should occur slowly. These GPs had been in the one vocation for a median period of approximately 22 years (6.1.1); in many cases this represented the period of their entire working lives. Relative to that context, change can’t come slow enough!

Indeed, many participants had resisted change. Resistance to rapid change is not only related to the social context (Lamarche et al, 2003, p16) it is also related to the capacity of the organisation to implement change and to an existing culture within the organisation that meeting change rapidly is a desirable strategy (Miles et Snow, 2003). The Commonwealth, in its enthusiasm for change, has perhaps not recognised either the capacity of general practices to adapt to change nor its cultural preparedness to change.



Generally, a leader is required for an organisation to adopt change (Lamarche et al, 2003, p16). Three basic skill sets have been identified for leaders and managers. They are human skills, technical skills and conceptual skills (Zuckerman and Dowling, 1994, p33). Given that only one of the twenty participants had any business training it would not be inconsistent to suggest that these skills may not be part of the GP ethos<sup>35</sup>. In almost all circumstances changes occurred because an individual thought it was a good idea.

Van de Ven, in order to portray the discomfort inevitably associated with change, uses the analogy of the frog languishing in increasingly hot water (Van de Ven, 1998, p109). The frog becomes increasingly uncomfortable and jumps out if the rate of change of temperature is too great; if it is not too great the frog fails to undergo Van der Ven's "threshold of dissatisfaction" which he equates with the term "threshold of action" (ibid), and that frog inevitably experiences an uncomfortable demise.

Such was the picture gained of this cohort of GPs. The driver for change for most participants was the level of discomfort (dissatisfaction) they were willing to tolerate. The participants with the lowest level of tolerance did best in that it was they who made changes to their practices that they would not have retreated from.

Dissatisfaction with the amount of change was universal; however, some participants had reached their threshold of action, others had not at the time of the interviews. The impact on these two groups, whilst similar in quantum, differed almost absolutely in terms of satisfaction. Those who had responded to the rate of change had changed the

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<sup>35</sup> Granted that doctors may argue that they, perhaps above all else, have people skills.

way they worked and the roles of the people with whom they worked. This did not imply however that they were satisfied with their clinical role, just that their clinical role was more tolerable within a different infrastructure.

On the other hand, the other group had become more embittered both because business processes had become too complex and because the clinical role they were now playing lacked the challenge of a former era. Importantly, it may be that general practice is experiencing a polarisation of the workforce; those who have jumped, those who never will and those who have recently entered the workforce.

Whilst two groups were identifiable in their response to change, there was uniformity in that no participants had anticipated any of the changes that were to come. This may have been in some measure due to their universal tendency to ignore the environment; nonetheless, predicting change may have been no more successful than guesswork in that the government had no blueprint for reform.

In conclusion, it was the rate of change that seemed the final arbiter of whether participants undertook their own reform processes. It is apparent that the theoretical strategic typology of Miles and Snow may be somewhat esoteric in this context in which the vast majority naturally resist change. Indeed, it can be argued that, given the rate of change, few general practices would have the capacity to change so quickly and still maintain a high quality product. In part, the rate of change was also beyond a group of doctors who did not possess the skills required of change managers that one may see in primary care trusts in England or in Health Maintenance Organisations in the US. Lastly, one further ingredient was missing, that of leadership. In the current format of

most Australian general practices owned by a number of autonomous practice principals, there may be no concept of a leader, as all are leaders and therefore none are leaders.

#### **9.4 Participants' management of change**

The impact of change can be ameliorated by good management techniques. Only one GP participant had experienced any formal management training. The following section describes the struggle many participants experienced in managing non-clinical change.

##### *Theme 9: Participants managed non-clinical change without evidence of management skills*

The literature review of chapter 3 suggested that GPs were not necessarily good clinical managers. Their outcomes tended to be arbitrary (Krum et al, 1998), management decisions were made on the most tenuous bases and without recourse to evidence, and there was a general unawareness of the existence of evidence (Fuat et al, 2003). The evidence gained in interviews was that almost universally participants were unprepared for change and reluctant to seek advice. Indeed, there was extraordinary consistency across the group in that:

- change was poorly predicted,
- innovations were adopted (or not adopted) without adequate investigation and justification,
- professional advice was not sought,

- plans to adopt innovations were often made unilaterally by GPs often acting in isolation from other doctors in the practice,
- staff were informed of the change as a fait accompli,
- implementation costs were ignored or were too difficult to measure,
- opportunity cost of the doctors' time in managing the adaptation was ignored, and
- considerations of sustainability were rare.

In other words, and on the evidence of chapter seven, the decision to change was often ill-informed and lacked sophistication. In chapter seven, the suspicion was raised as to whether clinical, personal and business decisions were a broader expression of the Art of Medicine, or if in fact many of Australia's GPs were merely "muddling through". If indeed the GP of today is merely "muddling through", then the more regulated environment of quasi-clinical care, appears safer for the patient but less "artistic" for the doctor.

The evidence for muddled responses is strengthened by current business literature dealing with inappropriate (but understandable) responses to rapid change. The first evidence is to be found in a strategy defined by March and Olsen (quoted in Van der Ven, 1998, p107) as the "garbage can model of anarchical decision making" in which information about innovations which do not immediately and easily attract attention are trashed. Whilst some participants had been able to delegate work processes, none had been able to delegate decision-making processes. Therefore, in practices in which participants were generally autonomous, and where opportunities for change were frequent, the garbage can model was commonly reported as the basic tool of decision making.

The second body of evidence lies in the successful design and adoption of systems to defeat or replace systems encouraged by government. Van der Ven again suggests that innovation can fail when “there tends to be a short-term problem orientation in individuals and organisations, and a façade of demonstrating progress.” (Van der Ven, 1998, p107).

Thirdly, there was an abundance of evidence that GPs found it difficult to put systems in place. One is led to ask why systematic proactiveness was so little in evidence, at least in this small group (and as suggested by literature). There are some possible answers indicated by the participants. First and foremost the GPs saw themselves as clinicians (p169) who were not trained in business (p155) or in systematic proactiveness which is reported to be a business approach foreign to many people working in a defensive environment. Secondly general practice, the “minister” of the most accessible form of public primary care services (Richman, 1987, p 83), appears to be under-resourced both clerically and clinically relative to what the participants perceived is required of them by the regulators.

The fourth is similar in that both the literature and this thesis suggest that, whilst GPs live in a world of uncertainties, they do not necessarily manage uncertainty well. There appears to be a strong case to be made to assist GPs to seek help in making decisions whether at a clinical, business or personal level. This thesis suggests that appropriate help seeking behaviours would assist as much at the clinical level as they would at the non-clinical level, particularly in a changing environment.

Perhaps the first step to reform ought not to have been vocational registration but rather exposure to the necessity for a closer appreciation of the environment, which was so

inadequate in this group, in order to lower the “action threshold” and to assist GPs to “appreciate and pay attention to new ideas, needs and opportunities” (Van der Ven, p108). This may in turn open GPs up to the possibility of self-care strategies including “improved role boundaries, communication skills and stress reduction strategies” (Clode, 2004, p35). Environmental awareness is also associated with the increased possibility of responding earlier, “when there is still time to exercise choice about how and when and what” (Kanter, 1983, p 64). The exercise of choice is the exercise of power.

Finally, there was very little evidence of an important element in satisfactory change behaviour, viz., the taking of time to reflect on change (Peters, 1998, p 1390). Indeed, the evidence was almost exclusively to the contrary in that many participants had little time or emotional energy for such ephemeral activities associated with change.

It may therefore be seen that the participants within this group did not understand the principles of management in general, so that it is logical that their response to change would be poor. Why would it be that GPs as interviewed and as described in the literature are not skilled in the art of management? One answer lies in the shortcomings of their training in which students or junior doctors are not exposed to the principles of organisational theory or of management. In particular, in the hospital environment, doctors are shielded from the processes of management. Patient management occurs in hospitals far less frequently than do diagnosis and treatment. Hospital doctors do not witness the activities of professional auditors, they do not experience risk management tasks performed by the bureaucrat, and are rarely exposed to complaints mechanisms,

staff training and planning activities. Accreditors are seen as an intrusion into the life of a clinician. All these tasks of management are being conducted around the doctors but they lie largely invisible to them, until they themselves become business persons.

Even if the role of business administration were to be devolved from Australian GPs to professional administrators, GPs will still play a vital role in the clinical management of the patient and their illness or their health and in their coordination of care with other health care professionals.

In summary, participants demonstrated little understanding of the processes of management which was generally consistent with their background. They had witnessed an era of rapid and apparent random change events and had done so without the assistance of leadership from their representative organisations or an awareness by government. Whilst these two facets of general practice change will be further discussed in the last section discussion will turn to the effect of change on the practice.

## **9.5 The Effect of Change on the General Practice**

Changes affected both the business of general practices and their staff. A trend toward increasing sophistication of general practices and toward larger practices (Figure 8.3) was evident in that three of the GPs interviewed were actively undergoing the process of moving into larger practices and a fourth had done so already. There was also some evidence of a tendency to a more sophisticated practice infrastructure as has already occurred overseas (Jean-Louis Denis in Beaulieu et al, 2002, p14). The use of allied

clinical staff had commenced tentatively (most notably with practice nurses) but was neither general nor pervasive. Therefore it is not possible to suggest that human resources existed to meet the criteria of a “team”; indeed there was no suggestion that participants had an understanding of what constitutes “teamwork”, even had they a team. However, in working with more clerical and allied health staff, theme ten was identified.

*Theme 10: Paradoxically, as GPs delegated more work and as other staff adopted that work, the job satisfaction of both groups increased.*

In contrast to GPs, not only were practice staff increasing in number they were increasing in job sophistication. Indeed, it is difficult to overlook the enthusiasm practice staff were reported to have displayed whilst adopting more sophisticated roles. The likelihood exists that clerical professionalism, tasking and job satisfaction were enhanced through delegation by the GP. In doing so, those specific participants had become victims of their success, suggesting that they could not go back to the days when, as general practitioners, they generally did everything. These findings are consistent with those reported in the Evaluation of the GP Links program<sup>36</sup> which found that GPs in larger practises enjoyed greater “practice resources, better lifestyle balance” and more clinical independence (Allen Consulting, 2002, p7).

The capacity to delegate is regarded as an important step on the path to organisational maturity (Robbins and Barnwell, 1994, p407) as well as an integral step to overcoming the “crisis of red tape” (Robbins and Barnwell, *ibid*). Delegation to an increasing

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<sup>36</sup> The GP Links Program was funded by the Commonwealth Government in order to facilitate the amalgamation of GP practices during the years 2000 and 2001.



number of non-medical staff was an optimistic sign that the few participants who had exceeded their action threshold were adopting more normal business strategies and that their organisations could behave like functional organisations undergoing change.

Practice staff were also reported as becoming increasingly involved in networking with staff from other practices. This was not further explored and questions relating to increased staff morale, broader knowledge bases and cost to staff or practices need further exploration. It does, however, stand in contrast with the intercollegiate meetings of GPs which were never described as “networking”.

Kanter states the upside of change in that “change brings opportunities when people have been planning for it, are ready for it” (Kanter, 1983). Kanter therefore reinforces the concept that a watershed is occurring at this point. Those GPs who take the opportunity of change will thrive at the expense of those who are resistant to it. Where Kanter does not help us is understanding the participants in the study cohort who were not prepared for change but who went ahead to implement changes regardless. From this study it would appear that, whilst embracing change willingly may be of greatest benefit, undergoing change even as a defensive strategy may also be beneficial. Whilst perhaps none were masters of change, neither were this group victims of it. Sadly, the other participants, the majority of the cohort, did, to varying extents, view themselves as victims.

### *Theme 11: Increase in practice sophistication challenged the need for control*

Many GPs saw amalgamation as a threat to their autonomy. Kanter suggests that “interdependence – and hence dependence – is even clearer in the world of organisations” (Kanter, 1983, p63). In other words, if practices do become more organised, the culture of independence identified in chapter 5, will inevitably be threatened, to devolve into interdependency. In such an environment it would seem likely that those GPs who place a high value on autonomy will be less likely to achieve their “action threshold” to make appropriate changes. Kanter states that this “downside of change” evokes “feelings of loss of control and helplessness” (Kanter, *ibid*). A brief review of Chapter 5 would reveal that that was exactly the case with many participants in this cohort. Therefore, for those GPs who do not move to more supportive practices, it is likely that the result will be worsening dissatisfaction with general practice, and perhaps beyond.

While reforms threatened a loss of power for the GP, they equally threatened the power balance of the doctor-patient relationship itself, as the patient increasingly took on the role of consumer.

## **9.6 Change and the General Practice Consumer**

Analysis of participants’ comments suggests that there are two ways in which to perceive consumerism. The first is to perceive consumerism as a means to address the power imbalance so long inherent in the doctor-patient relationship. In response, GPs seemed to either feel threatened that a patient may doubt their word or that the consumer had simply sought further information about the nature of their health or of their disease. The former response is defensive and would seem to be detrimental to the

doctor-patient relationship. The latter response, identified by other authors (Walsh, 2003, p1333), may be a very constructive response assisting the patient to better manage their own condition for which the doctor acts as an information broker.

The second way to perceive consumerism is to see the consumer as attempting to gain increased access to their doctor. GPs who complained about this problem seemed to take the patient's attitude subjectively (They want to get access to me) rather than objectively (They need to get access to care). In either event, patients were reported to be becoming more demanding of their doctor.

*Theme 12: Patients were becoming more demanding in their relationship with the doctor*

Whilst many participants had been seeking more income, consumers were reported to be seeking more from their consultation. In particular they were seeking reassurance (8.3.2) that "all bases are covered". Participants suggested that consumers now wanted reasons for advice proffered and to understand those reasons:

*It just means that you have to explain everything and do a lot more communication stuff, do a lot more talking with people. The old style of general practice that people used to get away with, which was what the doctor said was OK, didn't have to say much, people didn't have any other expectation, come in, do this, solve it in five minutes.*

Dr S

Participants were therefore (unenthusiastically) spending more time communicating with patients. There was more explanation within the consultation because there was less trust; often a more informed consumer population with conflicting information requiring explanation. Perhaps it was easy in former days to reassure patients that everything was being done that could be done, when both parties understood that little could be done. Today, through media and hearsay, society seems to hold a belief that very much can be done. Indeed, why should a consumer trust a GP, or anyone else, until the image or the test result is at hand? If the benchmark of tomorrow is the test result rather than the professional opinion, does that remove trust from the relationship? Does trust move from a relational trust to a technical trust? (Little, 2003, p433). Perhaps it moves the relationship closer to that of a partnership, but a partnership on unequal terms as the patient is not penalised for requesting too many tests whereas the doctor may be for ordering them.

In summarising the analysis of interviews, there appeared to be significant threats to the integrity of the doctor-patient relationship so valued by participants. These included:

- a move from a relationship of implicit trust. Such a move may be perceived as a threat to GPs who need the affirmation of the patient as a basis of work satisfaction.
- an expectation of the consumer that the GP will access reliable information about their health.
- multiple GPs providing part time care of the patient.
- using the GP as a gateway to consultant specialist services

- more sophisticated practices offering a broader range of non-GP services.

In conclusion, participants reported an important migration in the nature of their hallowed relationship with patients. To come to terms with this concept required a major shift of attitude by some participants, whilst some older doctors had struggled to maintain their self-confidence. In a thesis of many paradoxes, it may be that this change represents the greatest threat to traditional GPs' satisfaction with practice and the most important outcome for GPs who may be forced exchange the satisfaction of continuity of patient relationship for the normalcy of equality of patient relationship.

Whilst participants had been struggling with an evolving consumer paradigm, they were also facing the determined attention of the Commonwealth.

## **9.7 The GP, change and Government**

The relationship between the GP and the Commonwealth government was integral to the pressure GPs experienced and to the extent to which GPs felt they had control. There was absolutely no sense that participants interacted with the State Government in any manner whatsoever. This is interesting in that it is the State Government that is responsible for delivery of health services under the Australian constitution<sup>37</sup>. With or without responsibility, the Commonwealth introduced but failed to justify either the reforms or the process.

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<sup>37</sup> Section 106 of the Commonwealth Constitution states, in part, that State government responsibility includes "Public, school and industrial health services; almoner and social welfare services; public hospitals, clinics, sanatoria, asylums, children's and old folks' homes"

### *Theme 13: The Commonwealth had failed to make the case for change*

Most changes, though not all, listed in Chapter 5, had been driven by the Commonwealth. This is somewhat ironic given that some believe that change is best when driven by an “internal striving for professional competence” (Grol, 1997, p 418). This may explain the inertia many participants demonstrated with respect to government-initiated change as well as the cynicism associated with adopting incentives solely for financial purposes. By and large the case for change had not been made adequately by the Commonwealth, a *sine quae non* for change (Beland in Beaulieu et al, 2002, p30).

There was certainly a sense that, in their dealings with government, not only did many participants wish to remain autonomous but they also reported, in concert with Lamarche, that the Commonwealth had acted in like manner, viz, in an arbitrary and autonomous manner (Lamarche et al, 2003, p16). This is consistent with suggestions that, in bringing about its reform agenda, the Commonwealth had adopted a “top-down approach” (Beaulieu et al, 2002, p12).

The appreciation of quality was entirely unilateral. If the Commonwealth had evidence that their initiatives would improve quality, or could have been expected to improve quality, the participants were not aware of it and were less likely to adopt the reforms accordingly. The exception to this position was practice accreditation which was deemed by many GPs as an attempt to improve the standards of the poor performers but, almost by definition, that did not include them. It would also seem that the inadequacy of data collection (Barracough, 2001, p 616) has handicapped the Commonwealth in bringing about meaningful change where it is most needed, because it is not known where it is most needed. Capacity to collect data and thence improve quality is handicapped by lack of adequate infrastructure (cf Beaulieu et al, 2002, p14).

However, the fact that reforms were unanticipated, added to the dissatisfaction of role confusion, external reform and poor infrastructure, highlighting the absence of a dominant design for the reform process.

*Theme 14: Government related innovations were perceived as occurring randomly*

There had been no blueprint for change that participants had been aware of, no overall direction for change and no timeline for change whilst participants had recorded a litany of unanticipated reforms. Abernathy and Clark suggest that “regular innovation follows the emergence of a dominant design” (Abernathy and Clark, 1998, p73); yet no dominant design for Australian general practice had emerged. This is perhaps surprising given that there has been one (Macklin, 1992) and given the large number of GP representative organisations which, it could be expected, would have made it their business to engage the Commonwealth for this purpose. As a result, the Commonwealth was widely and generally regarded as a villain by the participants and the relationship between participants and the Commonwealth had become one of cynicism and distrust, an attitude that inevitably prejudiced the adoption of change.

However, the Commonwealth’s failure to plan strategically and therefore to introduce reform in a staged and transparent manner does not appear to have resulted from malevolence. Indeed, the economic value participants placed upon the Commonwealth’s financial incentives had been the major, perhaps only, positive stimulus for change. There was no suggestion at any time that the Commonwealth’s financial contribution to general practice in the way of incentives was in any way frugal.

Observations by GP participants indicated a belief that the Commonwealth was unaware of the general practice environment and were not seen to be consultative. On the other hand, the Commonwealth is beset by a broad and competitive array of GP organisations (2.6.1) most of which seek to represent the interest of general practice independently.

*Theme 15: GP representative organisations were not seen as buffering change*

Despite what may have been the best of intentions, there would appear little doubt that the Commonwealth had provoked a confrontational environment by the authoritarian way the reforms had been introduced. Kanter recalls the importance of representative bodies in facilitating reform in stating “there is a strong likelihood that participative methods will be used when an organisation’s prime movers see the impetus for change as internally driven, based on choice and responsiveness, rather than externally imposed, based on coercion and resistance” (Kanter, 1983, p280).

In this respect, participants were not only critical of government, they were also critical of their representative organisations which they saw as either powerless or as too supportive of the reform processes of government. If Abernathy and Clark are correct, then there is a critical responsibility for government and GP organisations to establish a dominant design.

In an understated fashion, Abernathy and Clark identify the risk of untimely innovation, “If the range of demands begins to strain the ability of the existing designs to meet them, firms may find a move away from regular innovation advantageous” (Abernathy and Clark, 1998, p73). Van der Ven is less understated in suggesting that “catastrophes are sometimes necessary to reach the action threshold.” (Van der Ven, 1998, p109). It was noticeable that 3 of the 20 participants were experiencing just those catastrophes.

Given that there is no evidence of Commonwealth malevolence, some may argue that the Commonwealth’s largesse or otherwise toward Australian GPs is irrelevant; a government’s responsibility of care is to the community not to the medical practitioner. The Commonwealth government would appear to have made a strategic decision to stimulate quality outcomes in general practice and may regard the means as irrelevant



to that end. Again, there is no suggestion that is the case. However, the evidence of this study does suggest that the Commonwealth's reforms may have increased output but have not improved outcomes.

This is perhaps not surprising, as improving health outcomes can be difficult to identify in the short term, particularly when the intervention is aimed either at prevention or at minimising disease burden in the chronically ill. However, what was plainly evident from interviews was the very strong perception that almost no health improvements had been generated. Given that health improvements may not be evident in an ageing population for many years the participants may have been (not unreasonably) forming premature views with regard to success or they may have been misinterpreting process for outcome. This latter position may be favoured by Van der Vern who suggests that, "since the correctness of outcomes from innovative ideas can rarely be judged, the

perceived legitimacy of the decision making process becomes the dominant evaluation criterion.” (Van der Ven, 1998, p108).

If such is the case, the logic and process of the decision-making process, and its transparency, is a key to successful innovation in general practice. The interface, therefore, between the Commonwealth government and GP representative organisations appears critical to successful reform within Australia’s general practices. Figure 6.1 depicted a hierarchy of non-clinical change. Of the four levels, one (level 3) was described as a buffering layer. That layer does not apparently exist (though one of the academic GPs of the Delphi group argued that Divisions of General Practice played that role). Whilst Divisions of General Practice have been described as agents of change, perhaps a more appropriate role would be as brokers of change. In any event, in the context that the Commonwealth is not well placed to broker change, there is an apparent need for an organisation which understands and represents Australian GPs to engage the Commonwealth.

Together, a “dominant design” should be identified along with not only incentives but also infrastructure and resources to facilitate change to bring about that dominant design at a rate that recognises GPs’ strategic capacity and typology for change. On the other hand, failure of GP organisations to favourably modify the change process exacerbated a general feeling of powerlessness identified in Chapter 5.

Checkland (2007) is more specific about introducing general practice reform.

Checkland argues that change is best brokered at the practice level as an understanding

of the practice culture is important in determining how change should be introduced to that specific practice (Checkland, 2007, p63). If this argument is sustainable, then Divisions of General Practice, acting as local agents of change, appear best placed to assist in this process<sup>38</sup>.

## **9.8 Summary**

In summary, this thesis has tested the effect of non-clinical change on a small cohort of GPs. The members of this cohort were universally tired of change and suspicious of government. However, it is possible to identify two groups within the cohort. One group begrudgingly took the opportunity forced upon them to change. The changes that resulted appear permanent and possibly form part of a longer evolution whereby those participants are in a better position to meet the challenges of a changing clinical role within a changing practice environment.

The second group responded to change as predicted by Miles and Snow in describing the reactor typology. This group resisted change vehemently for reasons that may be related to personal characteristics that rendered them to regard change less favourably. Their stress levels were higher and their dissatisfaction with their lot in life was greater.

The nature of the general practice itself was reported as starting to change by becoming larger and more complex. Some general practices were clustering in the same way that the corner shop has disappeared as the supermarket came to dominate the market place. If this sample is representative, it becomes important to understand whether

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<sup>38</sup> In my role as CEO of a Division of General Practice, once again I acknowledge a conflict

“clustering” has moved the Australian general practitioner closer to the remainder of the primary healthcare sector or if it is drifting geographically further away from the community.

These findings suggest some obvious recommendations for future enquiry or strategic thought. However, the study has been helpful in understanding that change has been rapid, too rapid for constructive, considered response even had the participants been typologically inclined to respond to a changing environment. The changes had been derived externally and were resisted accordingly, by a group of GPs who had little capacity to seek help, perhaps in any sphere of life.

The result would appear to be that general practice is at a dual watershed. On one hand, the role of the GP had changed so much that the identity of the general practitioner in Australia is under threat. On the other, the general practice appears to be about to undergo irrevocable change, possibly to the benefit of the reluctant GP.

Therefore, in answering the question, “What is the effect of non-clinical change on Australian general practice?”, one is left with the distinct impression that, while most of the effect is yet to be felt, many GPs long for the old days but would never go back. The concern generated by this thesis is whether they will go on.

## **CHAPTER TEN**

### **Recommendations**

Four broad recommendations can be drawn from the conclusions of Chapter 9. These recommendations are to improve the validity of the study by extending its scope to a younger GP population, to improve the training of GPs by teaching management skills, to focus further incentives on quality rather than output, and to conduct further reform in the context of a master design for Australian general practice.

#### **1. Validity**

The data were gathered from a cohort of GPs whose approximate ages were tightly centred around the mean of the general population of Australian GPs. The findings and conclusions should be compared to those of a younger sample of GPs to gain a broader perspective. It is my contention that younger GPs and trainees have very different attitudes to those of older GPs as evidenced by the work of Tolhurst and Stewart, 2004. Without doubt the pendulum has swung; to what extent it has swung and what are the consequences of that swing, are key questions, as all that is old is not necessarily invalid.

#### **2. Management**

The literature review and the data gathered for this thesis suggest quite forcefully that GPs (and possibly all doctors) are not necessarily good managers. Lack of management skills was evident across the clinical/business/personal spectrum, culminating in an obvious and pervasive reluctance to seek help, in either the clinical context, the business context or even the personal context. The generic principles of management should be introduced to the medical curriculum as a matter of urgency as a means to generate substantial improvement in the health of our patients and in the well-being of our doctors.

### 3. Quality

It is apparent that neither the medical profession nor the Commonwealth have come to terms with the concept of quality. This is an important matter for the Commonwealth for reasons of accountability, but it is vital for a group of dispirited GPs whose only measure of quality is the depth of their patient relationships and the amount of money they generate. The Commonwealth should work with GP organisations to determine what constitutes quality in general practice, how it can be measured, what infrastructure is required to measure it and what incentives are available to reward its acquisition.

### 4. Reform

Reform was seen to come too quickly and unpredictably. The Commonwealth has an obligation to reform but to do so in the context of an overarching design. The thesis identified the need for a “buffer” between GPs and the Commonwealth in order to appropriately resource general practices, or other primary care providers, for the challenges of innovation. A grand design could also dispel the role confusion that many of the GPs experienced and could also reskill a highly qualified but dispirited workforce.

## Epilogue

In this work I have sought to answer, in part, an important question, “What is the effect of change on a group of Australian GPs?”. The question was generated as a response to my role as Chief Executive Officer of a Division of General Practice, one of then 121 such organisations established by the Australian Commonwealth Government with an aim to act as an agent of change within general practice.

But this question was not the one I originally sought to explore. That first question was “How do Australian GPs manage change?”. The semantic difference is important as I had no inclination to explore principles and theories of management. I wanted a broader perspective of change, I wanted to understand the milieu of change and paint a picture of how GPs were responding to the rising tide of change.

In retrospect, to some extent that approach was valid, but not entirely so. As I drew near the end of this long process it became obvious to me that my question was somewhat presumptuous, the presumption being that general practitioners do manage. For if they do not manage provision of clinical care, manage their businesses that support that care and manage their lives, then managing change becomes a secondary consideration. Some did manage and did so well, but not because they had been taught those skills, they had to acquire them.

Responding to change then, when one has neither been taught nor resourced to manage generally, must be most problematic, in some cases resulting in feelings of helplessness and anxiety; in one or two in bitterness and despair. I would like to think that modern

medicine wants its practitioners to be able to manage the milieu of change before they attempt to manage the care of their patients.

*Well, doctors are often very idiosyncratic and the sort of people who go in to study medicine tend to be somewhat obsessive. They are often people who like to do things their way and they're not particularly good at change.*

Dr N



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WHAT IS THE EFFECT OF NON-CLINICAL CHANGE ON  
AUSTRALIAN GPs?

A Survey of Regional and Rural General Practitioners

APPENDIX

A thesis submitted in partial fulfilment of the requirement for the award of the degree  
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## **A.1 Definitions and acronyms**

### **Blended payment**

Blended payments represent payment by the Commonwealth of GPs amounts derived through fee for service activities in addition to payment for achieving certain “quality” targets such as a specific immunisation rate or for undergoing specific processes such as care planning. Many of these are listed in Figure A.2.4.

### **Bulk billing**

Bulk billing is the assignment by a patient to their treating doctor of their right to benefits under Medicare. The level of that rebate is set at 85% of the “scheduled fee”; a fee determined by the Commonwealth from time to time at a level believed to reflect the value of a consultation. A doctor is free to accept that benefit, but in so doing forgoes any right to raise any other levy against the patient for any component of that consultation

### **Primary health care**

Australian general practice is one element of the primary health system. The term “primary” refers to those health services that are regarded as being a point of entry into the health system. Primary care providers tend to deal with patients with “undifferentiated” conditions, i.e. conditions that are, at time of first presentation undiagnosed. However, neither of these descriptions is universally true and a more accurate perspective of primary care may be to describe it as care that does not occur within a hospital or as a result of referral from a GP to a consultant medical practitioner. Such care is usually designated secondary. Care that is carried out by a referral hospital is designated tertiary. General practice is most commonly conducted in the primary sector, though GPs, largely in rural areas, do maintain hospital privileges in

some instances. Therefore GPs most commonly practice within the primary sector but also have a significant presence in rural hospitals, but not urban hospitals.

### **Primary care practitioner**

A medical practitioner in general practice or in the primary care of patients. This category includes practitioners recognised by Medicare as VR GPs, RACGP Fellows, RACGP trainees and other practitioners whose main practice is unreferral patient attendances. (AIHW cat no. HWL 30).

### **Scheduled Fee**

The scheduled fee is the value of the GP consultation as determined by the Commonwealth from time to time. Initially the scheduled fee was based upon an amount that reflected the amount paid by private insurers. That figure was initially indexed but is no longer. The amount is now determined by political expediency rather than by economic logic.

### **Acronyms of publications**

#### **AIHW PHE 6**

Australian Institute of Health and Welfare, 1998, AIHW Cit. No. PHE 6, *Health in rural and remote Australia*, Canberra

CFP Department of Health and Family Services, 1998, Changing the Future Through Partnerships *Report of the General Practice Strategy Review Group*; Commonwealth of Australia, Canberra

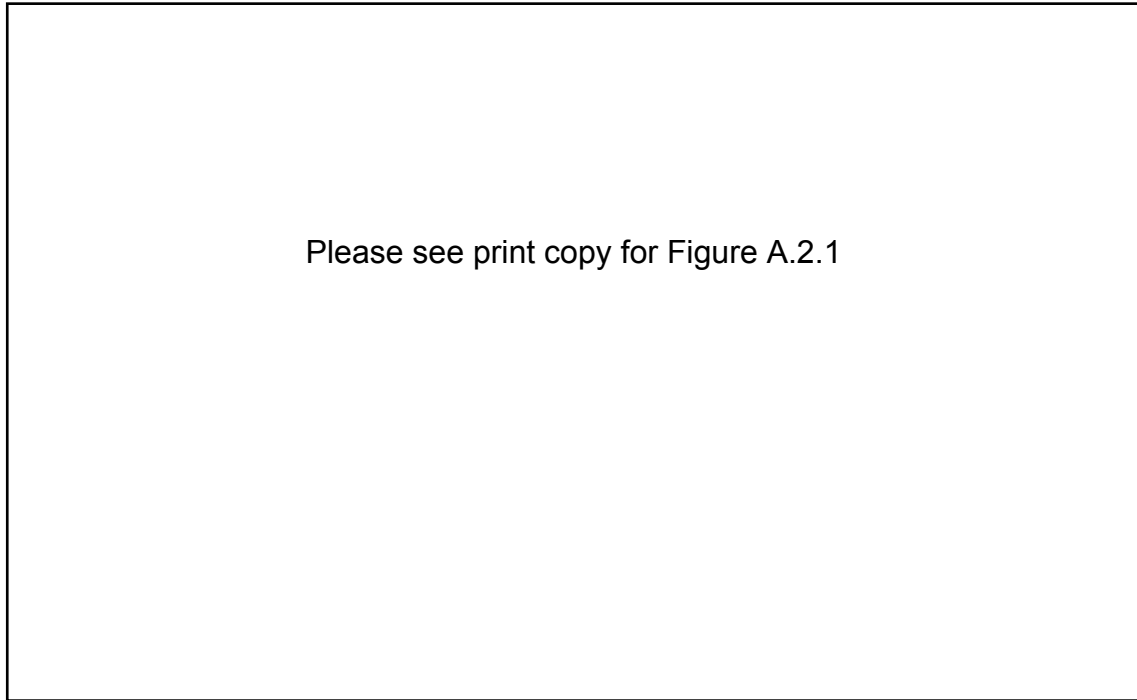
GPE Phillips, B., 1998, General Practice Education: The Way Forward, *Report of the ministerial review of general practice training*; Commonwealth Department of Health and Family Services, Canberra

GPPS Department of Health and Family Services, 1997, *The General Practice Profile Study*, Commonwealth of Australia, Canberra

## **A.2 Documents relating to Chapter two**

### **A.2.1 Distribution of general and Aboriginal population**

*Figure A.2.1 Distribution of Australian population per square kilometre by RRMA category, 1996*

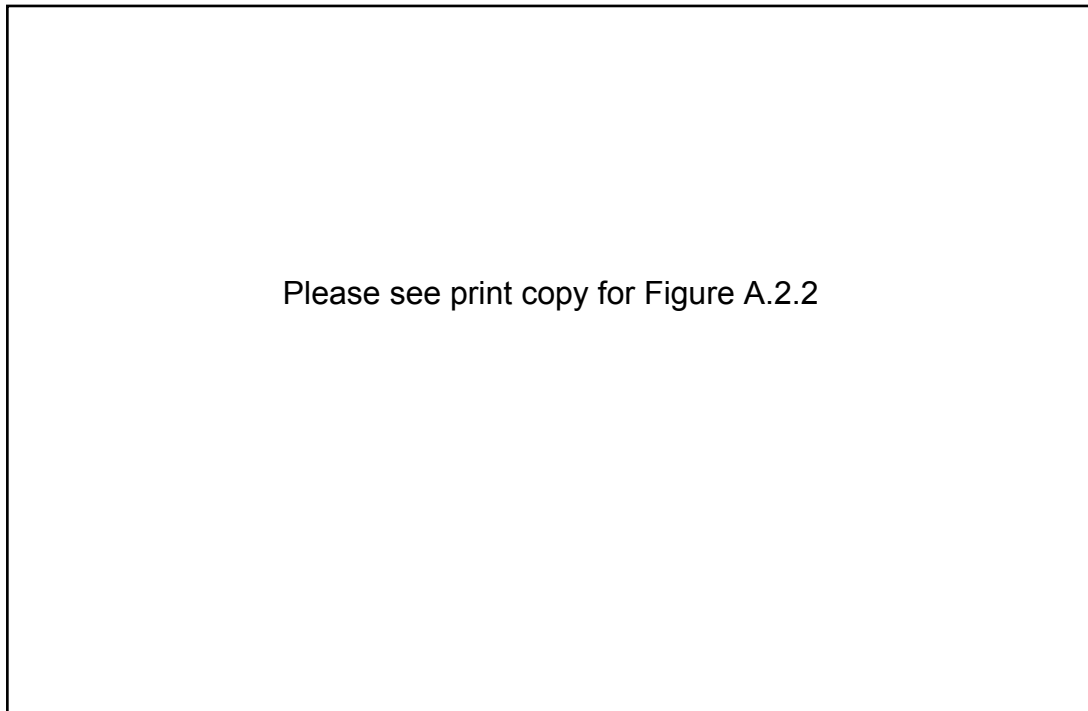


Source AMWAC Report 1998.8. p66

This figure demonstrates that most Australians live in RRMA 1 areas, i.e. major capital cities.



***Figure A.2.2 Distribution of indigenous population per cent of total population by RRMA category, 1996***

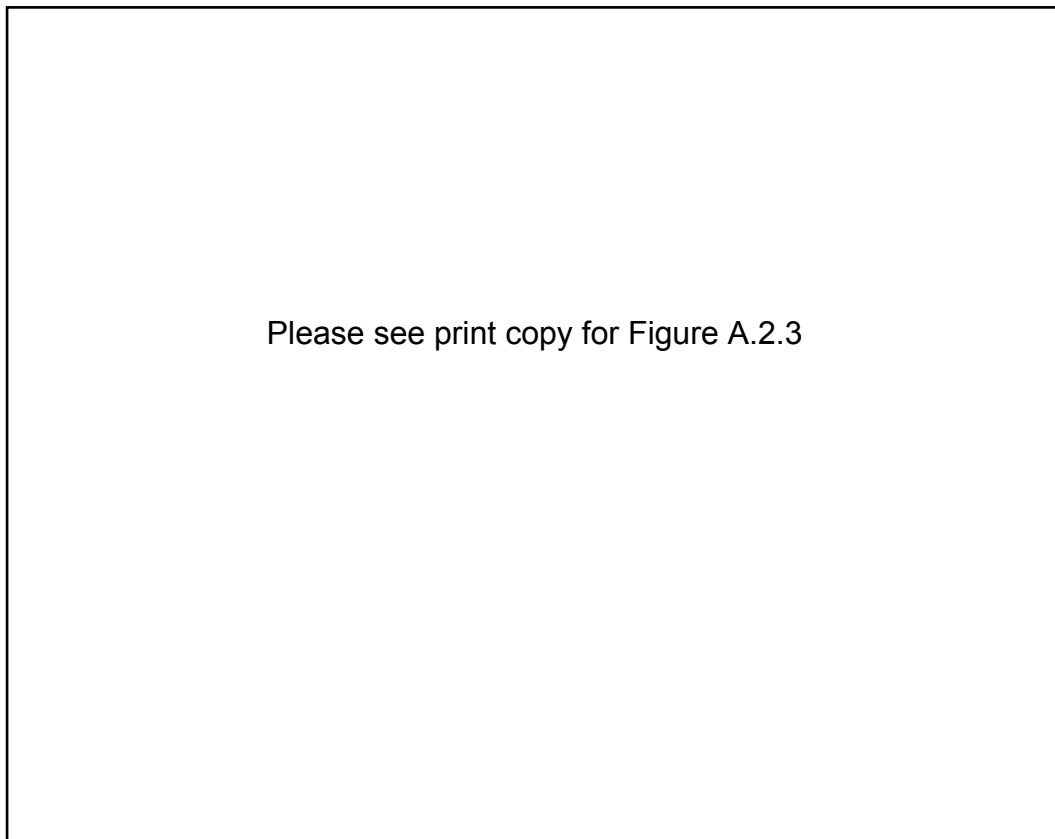


Source AMWAC Report 1998.8, p66

This chart demonstrates that most Australian Aboriginals live in isolated communities and that least Aboriginals dwell in capital cities, where most medical care is available.

Distribution of Australian GPs by State

**Figure A.2.3 GPs per 100,000 population (December, 1998) by State**



Source: *AMWAC Report 2000.2*, p 94

### **A.2.3 The Enhanced Primary Care Package (EPC)**

Please see print copy for Table A.2.3

Source Beilby et Furler, 2005, p136,7

#### A.2.4 General practice payments funded by the Commonwealth (2003)

Remuneration strategy	Form of payment	Conditions	Comment
Traditional	Fee for service	Nil	An activity fee based on the MBS
Vocational registration (VR)	Increased rebate per consultation	Maintenance of CPD & QA	Large rebate differential between VR and non-VR GPs
Service incentive payment (SIP)	Blended payment	Practice must be accredited	Remuneration based on outcome e.g. rate of childhood immunisations
Practice incentive payment (PIP)	Blended payment	Practice must be accredited	Remuneration based on process e.g. providing after hours care to patients, providing planned care to asthmatics
Better Outcomes in Mental Health (BOiMH)	Blended payment	Practice must be accredited GP must have undergone additional training in mental illness to be accredited for BOiMH	Allowed to prepare and charge for mental health care plans
	Infrastructure funding to DGPs	GP must be accredited for BOiMH	For provision of psychological services through DGPs
Enhanced Primary Care (EPC)	Fee for service (usually bulk billed)	Practice must be accredited	Substantial payments for Health Assessment, Care Planning and Case Conferences
More Allied Health (MAHS)	Infrastructure funding to DGPs	Practice must be accredited Practice must be rural	For provision of allied health services through DGPs
Rural Retention Program	Subsidy paid to GPs	Must have worked in rural areas for	Incentive to retain rural practitioners

		more than 2 years	
	Practice nurse subsidy	Practice must be accredited Practice must be rural or Area of Workforce Shortage <sup>1</sup>	Subsidies for rural GPs employing nurses
GP Registrar Training	Sessional	Accredited to train registrars	Commonwealth funding for training registrars is unique to general practice
RACF funding	Retainer	Determined by local DGP	Incentive to increase number of GPs working in RACFs
Divisions of General Practice	Infrastructure funding	Required to meet increasingly complex reporting criteria	Financed to improve capability of GPs to deliver appropriate health services

---

<sup>1</sup> A practice with Area of Workforce Shortage status (determined by the Commonwealth Government) is entitled to a provider number issued by the Health Insurance Commission for an Overseas Trained Doctor (OTD) thus allowing him/her to claim Medicare benefits. A prerequisite is Area of Need Status (determined by the State Government) which allows an OTD to be registered as a Medical Practitioner within that State.

### A.2.5 Ranking of changes identified from literature

<b>Change</b>	<b>Recent occurrence</b>	<b>Probability of response</b>	<b>Probability of impact</b>	<b>Definable</b>	<b>Total</b>
Relational paradigms (2.5.1)	Recent occurrence due to stimulus of EPC initiatives for care planning and case conferencing Rating 4	Complexity means that many GPs will refuse involvement  Rating 2	Impact high where adopted, low where not.  Rating 3	Difficult to define in concrete terms  Rating 2	11
Multiple representative organisations (2.6.1)	Slowly evolving over long period, recent advent of some Rating 4	No groundswell of reaction Rating 1	Fragmentation of representation Rating 1	Well defined  Rating 5	11
Ageing GP workforce (2.6.2.1)	Slow but unrelenting increase in GP age Rating 3	No response apart from reduced hours Rating 2	High levels of dissatisfaction but only of affected GPs Rating 3	Definable statistically but regional variances Rating 4	12
Shortage of GPs (2.6.2.2)	Documented recently but slowly worsening Rating 3	Response limited to active recruitment Rating 2	Workload increasing dramatically Rating 4	Definable statistically but regional variances Rating 4	13
Increasing feminisation of workforce	Documented recently but slowly increasing	Limited responses possible	Workload increasing Rating 3	Definable statistically but regional variances	12

(2.6.2.3)	Rating 3	Rating 2		Rating 4	
Advent of corporate general practices (2.7.6)	Within last 3 years Rating 4	Reasonable take up rates in capital cities <sup>2</sup> Rating 2	High impact to GPs involved Rating 4	Well defined Rating 5	15
Red tape associated with blended payments (2.7.2, 2.7.5.4, 2.10, 2.11)	Rapidly increasing and recent onset Rating 4	Affects all VR GPs financially Rating 5	High impact on administrative component of practice Rating 4	Well defined Rating 5	18
Medical Litigation (2.7.3)	Peaking within the last 3 years Rating 4	Requires a response from all GPs Rating 5	High impact recorded on stress levels Rating 5	Readily defined Rating 4	18
Computerisation (2.7.4)	Peaking within the last 3 years Rating 4	Requires a response from all GPs Rating 5	High impact through consumers and on practice staff Rating 5	Many aspects to computerisation exist Rating 2	16
Increasing workload (2.7.5)	Slowly increasing over lengthy period of time Rating 2	Requires a response from all GPs Rating 5	High impact for those GPs unable to isolate themselves from the workload Rating 4	Has many constituent elements and is therefore quite diffuse Rating 2	13
Changes to education (2.9)	Slowly increasing over lengthy period of time Rating 2	Largely affects undergraduate students and trainees Rating 1	Impact on GP lifestyle Rating 4	Readily defined Rating 4	11
Practice accreditation (2.10.1.2)	Became compulsory in last 4 years Rating 3	Requires response from almost all GPs Rating 5	Large impact on workload and income Rating 5	Readily and well defined Rating 5	18

<sup>2</sup> There is only one corporatised medical practice in the region studied

Regulation (2.12)	Increasing over the medium term Rating 2	Most GPs do not become the subject of regulatory review Rating 2	Very high impact to the small number of GPs involved Rating 3	Readily defined  Rating 4	12
Consumerism (2.13)	Increasing rapidly from a low base Rating 3	In under-supplied market consumer pressure limited Rating 2	Low impact  Rating 2	Difficult to define  Rating 2	9

Changes chosen from literature therefore include increasing red tape, increasing litigation, computerisation and introduction of practice accreditation



## **A.3 A detailed literature review**

### **Clinical and non-clinical management in Australian (and UK) general practice**

#### **A.3.1 Perspective**

This thesis presents an examination of change in general practice as it has occurred to a group of Australian GPs. It examines the changes, the GPs, their responses and the impacts. There is a broad and helpful literature around the changes as they have occurred in Australian general practice and this is presented in Chapter Two. There is almost no literature concerning the nature of Australia's GPs except at the crudest of levels, and little to help us understand the impact of change. There is, however, a limited body of literature that explores the GP's response to change. This is presented in the context of management, a subset of response. In a general way, I would consider this as a marker for "action" response, i.e. What do GPs do, or How do they manage? There is little to help us understand "feeling" response, i.e. What do GPs feel? Indeed, more precisely, the literature is more likely to identify how well GPs respond rather than how they respond. I postulate that if we know how GPs manage change we are better informed as to how they more generally respond to it.

The review does not limit itself to the non-clinical environment, as that would be a very small net to cast. It therefore also includes the clinical environment as, I would argue, GPs are, a priori, clinical managers rather than business managers. Nor is it limited to change as, again, that is too small a net. Accordingly, this chapter attempts to provide a review of literature relevant to Australian GPs in their management (as a surrogate measure for response) of both clinical activities and non-clinical activities generally, and both clinical and non-clinical activities in a changing environment. There are, therefore, four quadrants to consider. These are depicted in Figure 3.1.

**Figure 3.1 The quadrants representing the literature review**

1	Literature related to management of unchanging clinical conditions	Literature related to management of unchanging non-clinical processes	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

Whilst the shaded quadrant represents the area of interest in this thesis, an examination of the other quadrants as a literature review will be helpful in shining some light into an area that has been only lightly explored.

### **A.3.2 Quantum of Australian literature**

In a systematic review of published studies assessing the quality of non-hospital clinical care provided in UK, New Zealand and Australian general practice, Seddon et al found that of 90 such papers only six came from Australia (Seddon, 2001). The relative paucity of Australian research implies that any purely Australian review would be problematic. For this reason I have chosen to review UK literature as well as Australian. This is not an ideal methodology as there are systematic differences in general practice structure between the two countries. However, the two Royal Colleges of General Practice have a common ancestry and heritage.

Whilst little is known about the quality of clinical care provided in the community (ibid), it is rare to find anything in the literature about GPs in any country managing non-clinical change. This thesis may provide a small contribution to this literature.

The bulk of this literature reviewed is derived from a systematic review of each electronic edition of the Medical Journal of Australia and of the British Medical Journal for the 8 years prior to 2004. Other references have been added where appropriate. It is acknowledged that, while other UK publications may be relevant, an emphasis on the British literature may prejudice the review. The other major Australian journal publication is that of the RACGP which is largely clinically focused.

### **A.3.3 Clinical activities of Australian GPs**

Much of the research that has occurred into Australian general practice has focused on clinical activities using quantitative data (Peterson and Martin, 2000,). The leading research in this field in Australia is the BEACH study authored by Britt et al (Britt et al, 1998 - 2003). Researchers conduct an annual study of approximately 1000 GPs into, inter alia, the conditions treated by GPs, the tangible end product of the consultation (treatment, prescription, referral, investigation) and the consultation length. The sample is a rolling sample of approximately 20 randomly selected GPs, altering each week over a 50 week period (approximate total 1000 GPs per year). Each GP records details of about 100 consecutive patients.

Whilst this approach has yielded a valuable profile of activity there is no identification of patient outcomes and little detail of the management that lay behind them.

The BEACH study followed the Australian Morbidity and Treatment Survey (Department of General Practice, University of Sydney, 1991), which intermittently sampled the activities of 495 Australian GPs over a one year period. These studies have yielded an interesting profile of “activity” but have not examined patient or other management.

### A.3.4 GP management in an unchanging clinical environment

(Quadrant one)

1	Literature related to management of unchanging clinical	Literature related to management of unchanging non-clinical	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

A number of studies examine quality of patient management with respect to single diagnoses. Ignoring comorbidities simplifies the methodology but may fail to capture the complexity of general practice. The diagnoses are discussed under specific headings after a brief look at literature-reported general determinants of quality patient care. The insights they provide are suggestive that GPs who wish to provide quality care may have to respond by examining more closely their non-clinical context. A.3.4.1 Determinants of quality in general practice care

#### **Veale and Fahey**

This Australian study reported that patient satisfaction with general practice is associated with respect, waiting times for appointments and for being seen in the waiting room. Patient dissatisfaction is stated to relate to waiting times, ease of obtaining home visits and facilities for children in the waiting room (Veale et Fahy, 1997, pp 24, 25). It will be noted that most of these indicators are related to non-clinical factors.

It is difficult to understand the extent to which consumers are able to assess clinical care as distinct to the clinical environment (waiting times, staff respect etc.). We all understand that some conditions are untreatable or not perfectly treatable. Some treatments hurt, some don't. If consumers are not in a position to assess clinical processes, they are only in a position to assess those (non-clinical) parameters expressed in this study thereby perhaps failing to reflect the importance of the clinical environment.

### **Campbell et al, 2001**

A study by Campbell et al in the United Kingdom suggested that quality in general practice was related to longer consultation times, larger practice size and teamwork. This is an interesting outcome in that it again identified predictors of good general practice that are entirely non-clinical. However, the study failed to identify how these processes or outcomes, such as longer consultation times, had been brought about within the practices studied.

The study was a large one of 60 general practices in 6 areas of England selected by a stratified random process. These areas were chosen so as to be as representative of the national population as possible. Data were taken from medical records to score for quality care of conditions such as diabetes, asthma and angina. Quality markers included measures such as patient information provided, appropriate clinical therapy, and preventative activities undertaken. Quality rating scales were then compared to variables such as waiting time and size of practice.

The authors defined quality in terms of access to care and effectiveness of care. With the assistance of general practice experts they developed a list of criteria that "should" be recorded for systematic care of certain chronic diseases. Care was deemed to be effective where evidence for the criteria was found in the patient record. The use of

surrogate measures for quality may be somewhat problematic. The authors identified further weaknesses of the study as being a small number of disease markers (angina, asthma and type 2 diabetes) as well as an assumption that the medical record was an accurate reflection of clinical activity.

The British context of this study is of some importance. A reasonable argument has been established that the more time a GP spends with patients the better the care. However, that argument looks less reasonable in the Australian context (as distinct to the British context of the study), where access to specialist care may be much more readily available. In the Australian context, it may be that the more time the patient spends with the specialist, the better the quality of care, independent of the GP who may only be required to generate the referral.

### **Pollock and Grime, 2002**

A UK qualitative study by Pollock and Grime yielded interesting results about the use and management of time in general practice consultations. For this group of patients suffering from depression, no correlation between length and quality of consultation was evidenced (as distinct to the findings of Campbell et al, above). Stemming from a low sense of entitlement, these depressed patients appeared concerned about taking too much of the doctor's time and were more likely to take upon themselves the responsibility for managing the length of the consultation, rather than the GP. The patients' feeling of responsibility was heightened by crowded waiting rooms and lengthy waiting times.

Nineteen West Midlands GPs were recruited and these in turn recruited a convenience sample of 32 patients suffering from recently diagnosed mild to moderate depression. The patients were interviewed at recruitment and again six months later (n = 30). A

second group of 30 was recruited from an organisation known as the Depression Alliance. Means of recruitment is not described. The two groups were similar in terms of age, gender, marital status and occupation. All but three interviews were taped and transcribed. The untaped interviews were typed from handwritten records. The data were entered into NUD\*IST. All interviews were conducted in the patient's home.

This is a small study of a vulnerable population and may not be representative of general practice patients as a whole. The findings may therefore not represent a conflict with the findings of Campbell et al. The findings do raise the issue of appropriate management of consultation time by the GP and patient jointly and the importance that has, together with other indicators of time-pressured practice, to patients with depression or other form of vulnerability. Indeed, as the authors suggest, it raises the more general issue of patients and their doctors "in setting boundaries of entitlement and access to care."

### **Freeman et al, 2002**

Freeman et al shed some light on the conundrum of ideal length of consultation time. They suggested the need for longer consultations is particularly important to patients with chronic illnesses. However, they also suggested that younger patients prefer shorter consultations. This is an important consideration for Australian GPs practicing in a fee for service environment which fails to take account of the complexity of presentation.

The authors reviewed 14 (unspecified) papers deemed "relevant" following a separate "systematic review" commissioned by the RCGP. No methodology is described as to how the authors came to their conclusions.

This paper presents a “take it on trust” approach to reviews. Many of the authors enjoy distinction within academic or professional general practice in the UK. The recommendations may more readily be associated with oracles rather than with researchers.

### **A.3.3.2GP management of mental health problems**

A review of mental health studies must be conducted in the context of the findings of Thornley and Adams who, in looking at the quality of over 2000 trials relevant to schizophrenia, suggested that there is generally a concern with quality, duration and utility of the trials themselves (Thornley and Adams, 1998). Perhaps, though unstated, this is due in part to the capacity or the willingness of mental health patients to participate in lengthy trials.

#### **Hickie et al, 2001**

Management of mental health conditions begins with identification of the condition. A large national study by Hickie et al infers that Australian GPs are no more than an even chance in identifying patients with mental health disorders (Hickie et al, 2001). Rate of identification was 44% generally, but for those patients presenting with somatic symptoms alone the rate dropped to 24%. The authors noted that there were characteristics of GPs who were more likely to identify patients with mental illnesses. These characteristics included working in part-time practice (again perhaps a reflection of gender), seeing fewer patients, working in smaller practices and working in regional centres.

The population of GPs recruited had responded to national advertising and was therefore not random. The participant GPs were required to recruit 100 consecutive patients, though those with 50 or more were included in the study. One might



presume that those replying would be more inclined to have an interest in mental health conditions than those who did not reply. This position is supported by the demographics of the GPs involved which indicated an older GP participant population, a smaller proportion of male GPs (57% compared to 69% in the general GP population), and a GP population more likely to be part time (though this may represent a higher proportion of female GPs).

The total population of patients recruited was an impressive 46515. These patients were then screened for mental disease and 21210 patients were identified as having mental health disorders of which participant GPs had diagnosed only 11922 (56%) previously.

This study demonstrates the complexity of general practice and general practice research. It raises the issue of determining responsibility for searching for disease in patients who have not necessarily requested such a service and who may not be willing to pay for a service they have not requested. Hickie does not reveal how much the screening cost but that cost could be substantial. Nor does he recognise that there exists a number of screening tools for many other diseases. He fails therefore to answer the question as to why a GP should screen for mental disorders rather than for cardiovascular or malignant conditions, for example.

Nonetheless, this study identified a number of non-clinical factors that are associated with best practice when identifying mental illness. Two such factors include GP education and better organisation within the general practice itself to facilitate mental health assessments. More broadly, this study identified the importance for GPs to understand the need to thoroughly test the environment in order to manage problems in more embryonic stages.

**Kessler et al, 2002**

This UK study identified what the authors see as a weakness in the above type of cross-sectional sampling. In a small three year follow-up study (179 patients) the authors found that even though many patients with depression did not receive a diagnosis initially, over a three year time frame most were, in fact, diagnosed. Nonetheless, 14% of patients with clinically severe depression remained undiagnosed after three years.

The study was conducted from a single general practice in Bristol, England in 1997. A total of 179 consecutive patients were screened for depression by the authors at time one. Three years later all patients who could be contacted were reviewed to see if the diagnosis had been made in the intervening period. The assessment tool used in this study is described only as “a more detailed psychiatric assessment” (than the SF – 12 survey used initially).

This is a difficult study to evaluate. In the first instance, it is hard to imagine that GPs within the practice failed to modify their behaviour knowing that patients were being scrutinised. Rather surprisingly, the ethics of longitudinal or follow-up studies in undiagnosed mentally unwell patients is not discussed. Furthermore, the authors claim that of the original group, 49% had either anxiety or depression. There is no discussion as to why this figure is so high. Perhaps the assessment tool is too sensitive, perhaps there are unique reasons as to why this group should have such a high rate of mental unwellness. However, the point that diagnoses may be made subsequent to initial presentation is well made. However, the authors have not identified reasons for subsequent diagnosis. Do GPs screen their patient populations intermittently? Do patients reveal their true levels of suffering only after a trusting relationship has been established?

## **Russell and Roach, 2002**

A recent Western Australian study of GP management of occupational stress found that GPs “take a pragmatic and varied approach to the management of work-related stress” (Russell and Roach, 2002, p367). In treating an hypothetical patient, only 44% of respondents chose to initiate a workers’ compensation claim and GPs generally were reluctant to involve the employer in decisions to do with patient management. Though based on an hypothetical scenario, the findings raise important issues with respect to in vivo activities. Whilst 64% of respondent GPs claimed confidence in their management of patients suffering occupational stress only half this number indicated that they understood legislative requirements for lodging a workers compensation claim. It was noted that employer liaison “seemed particularly challenging for full-time practitioners.”

This study was a postal survey of 450 Western Australian GPs “on the mailing list of a GP journal (Australian Family Physician)”. No incentives for GP participation are mentioned. The survey returned a response rate of 50.1%.

Ethics approval was gained from the RACGP, the same organisation that released the mailing list to the investigators. No explanation as to how this was considered consistent with National Privacy Legislation is offered. A weakness of the study lies in the response rate and in the choice of sampling frame, namely that GPs subscribing to the journal were very likely to belong to the RACGP. However the significance of this management study is stressed by the authors in stating that it is unlikely that sub optimal management practices by GPs are confined to occupational stress (Russell and Roach, 2002, p 368). The authors have also identified poor communication as being a barrier to systematic care.

**Meadows, 1998**

In an evaluation of a Melbourne based GP - Mental health liaison project, a survey of patients transferred from public psychiatric care to local GPs found that 90% of patients were satisfied with their management in general practice, with the majority feeling that their health had improved.

A telephone survey of 90 former public psychiatric care patients from a single hospital was conducted. There is no report as to whether the survey was a qualitative or quantitative one, whether trained interviewers were employed or whether patients who failed to answer the phone were followed up. There is no report as to how many patients refused interview. The study does not appear to have been blinded so comparisons with the control (hospital treated) group are not possible.

Unfortunately the paper does not inform us as to which patients were transferred and there must be some suspicion that selection was not randomised and may have been focused to patients most likely to “resemble” general practice type patients. This study also suffers from the drawbacks of self-reported studies that have no other means of verification of outcomes. It deals with a vulnerable population who may want to please interviewers, and fails to take into account any other concurrent but unrelated activities that may have assisted the patients in their transfer of care. Nonetheless, the study is consistent with the hypothesis that, with one group of mental health patients at least, GP management is at least as good, in the eyes of the consumer, as that of public mental health services. Unfortunately, it is also consistent with the hypothesis that some patient groups prefer to be treated in the community rather than in or by hospitals.

**Taft et al, 2004**

In this Victorian study, GPs underwent semistructured interview before and after training in the management of patients who were victims of intimate partner abuse. The GPs' management practices were evaluated against recommended practice. Commenting on their findings, the authors noted that all but one GP overlooked the impact that the violence had on children in the family. They also suggested that some doctors used practices that were potentially harmful to the victim such as breaking confidentiality and being judgemental. Some preferred to avoid the problem in an effort to maintain the relationship. Most doctors were said to have exhibited a lack of expertise and were unable to debrief whilst others were unaware of the effect their gender, attitudes and beliefs had on their practice.

This was a qualitative study of 28 GP participants. The sample was stratified to approximate the urban-rural and female-male ratios of Australian GPs. The sample frame was purposive, consisting only of those GPs seeking training in this field by one of the investigators. Semi-structured interviews were conducted with participants being invited to recall management of patients involved in abuse situations.

This represents a small study with little generalisable capacity, each stratum apparently consisting of only 7 GPs. In particular, it targets a population of GPs seeking assistance for further training in this field, i.e by definition a group GPs who acknowledge a deficiency of skills in this field. One could equally argue that this group represents the more capable GP. The study does, however, raise the need for further investigation as to the way in which Australian GPs identify and coordinate patient care and how they define their role as a "family physician" in the event that something occurs to challenge the integrity of the family unit.

#### **A.3.4.3GP management of threatened miscarriage**

##### **McLaren and Shelley, 2002**

Bleeding in early pregnancy (threatened or real miscarriage) is not an uncommon occurrence, occurring as it does in approximately 20% of pregnancies (Everett, 1997, p 33). One would therefore expect that any condition occurring relatively commonly in the community would be effectively managed in general practice. The results of a postal survey of 700 Victorian GPs did not support this expectation. Despite the fact that responses were skewed in that female GPs and GPs with their Diploma of Obstetrics were over-represented in the sample, the researchers showed “significant variation in the knowledge and reported management of miscarriage by GPs.” In particular they suggested that these GPs were not certain in their use of anti-D (an important therapy to avoid “rhesus disease” in pregnant women). Doctors aged over 50 were even less likely to manage the condition according to accepted guidelines and holders of the Diploma of Obstetrics were found to manage miscarriage no better than their colleagues. With respect to this condition, the authors comment that such is the uncertainty of management that uncertainty may well be manifested elsewhere.

The names of 700 GPs in Victoria were randomly selected from the database of a medical publishing company. Their names were placed in four strata (representing combinations of gender and rural or urban status) of 175 doctors. Of 621 contactable doctors 62% responded. Females were more likely to respond than males and holders of the Diploma of Obstetrics were over-represented. Design of the survey is not discussed.

Though self-administered, the survey is likely to represent an accurate picture as it is unlikely that self-reporting GPs would make themselves look worse than they are.

Furthermore, non-replying GPs are unlikely to be more competent than their replying colleagues. A 62% response rate is a favourable result for GP studies. Length and complexity of survey are important design considerations. There is a suggestion that the survey was piloted by GPs so one must presume that the survey was at least able to be understood by the intended recipients.

#### **A.3.5.4GP management of respiratory illnesses**

##### **Ruffin et al, 1996**

Asthma is a common condition in Australia and is the third most common presentation to general practice (Abduladud et al, 1999). A 1996 study highlighted the need for a systematic approach to the management of this disease and the importance of patient self-management. This South Australian study examining the use of asthma management plans found that the incidence of asthma was 11.6%. The authors report that only 33% of self-reporting asthmatics had management plans. Furthermore it found that more severe asthmatics were more likely to feel they had not been provided with enough information about their asthma, were not comfortable managing their asthma and experienced difficulty accessing their doctor. The authors comment that “The data ..... paint a bleak picture of the effectiveness of asthma management in Australia.”

The survey sample of size  $n = 3010$  was multistage and weighted by age, sex and geographic region to be representative of the South Australian population. Data were gathered by interviewers who approached random households and requested to interview the person in the household whose birthday occurred next. People under the age of 15 years were excluded. Response rate was 71%. Respondents were asked if they had “written instructions of what to do if your asthma is out of control.”

This is a high quality study which relies on a person's self-reporting of a medical condition. Participants possibly may have confused the term "written" with a notion of "hand written" rather than printed. Participants were not asked if they has verbal instructions as to what to do if their asthma is out of control. Nonetheless, this study indicates that where GPs could be using paperwork extremely effective in clinical management, they are not likely to.

**Abduladud et al, 1999**

The findings of Ruffin et al are consistent with those of this Melbourne based study which compared the management of asthma in hospital clinics to that in general practices. It was found that the GP group of patients was less likely to have written asthma action plans and was less capable of managing acute asthma attacks than the hospital group of patients.

The study was a cross-sectional survey with six months' longitudinal follow-up. This study recruited 54 patients nominated by 14 GPs working near the Alfred Hospital, Melbourne. The hospital's asthma clinic recruited a further 61 patients.

The study represents a failure to control for like clinical conditions. Patients attending a major hospital outpatient clinic are likely to be suffering more severe disease than patients treated in the community. Whilst management of acute exacerbations may be handled less well in the selected general practices, by definition these practices have a geographically close association with a major teaching hospital and may therefore prefer to refer acutely distressed asthmatics to expert care. In this respect the practices chosen by the researchers may well be unrepresentative of the general GP population.



**Glasgow et al, 2003**

Neither of the above asthma-related studies provides evidence of a systematic capacity within general practice to manage this common condition. The importance of asthma management plans was demonstrated in 2000 in a study of 225 primary school children in the Australian Capital Territory. The intervention group had significantly more asthma plans written, more GP visits, better forced expiratory volumes and fewer Emergency Department attendances.

The intervention consisted of a one on one briefing of each of the GPs participating in the trial by the chief investigator (a well known former GP). The briefing described and encouraged the use of the Asthma 3+ management plan. The children were identified initially by survey through all Australian Capital Territory primary schools and where a GP had at least three children enrolled they were invited to participate. Only the GP with the highest number of moderate or severe asthmatics was invited to participate from each practice. Of total of 30 GPs invited to participate 24 did so. Practices were randomly allocated control or intervention.

This is a well-designed study which demonstrated the need for a systematic approach to the care of the asthmatic. The two previous studies suggested that a systematic approach to clinical management is foreign to many Australian GPs, whilst this study implied that GPs respond appropriately to peer led evidence based encouragement.

**Stocks and Fahey, 2002**

The treatment of bronchitis in UK general practice was examined by an Australian academic GP and a UK academic GP. (Acute bronchitis was reported as being a condition for which antibiotics are usually ineffective.) The survey indicated that GPs frequently prescribed antibiotics for the treatment of bronchitis for reasons for which

there was “little evidence”. Such reasons were “to keep the patient happy” (46%), to “maintain a good relationship with them” (64%) or even “to end the consultation (32%)”.

A postal survey of all 576 GPs in the area of the Avon Health Authority gained a 73% response rate (n = 419). Non-responders were less likely to have their MRCGP, to belong to a teaching or training practice, and were more likely to be older. The survey is described as a 5 page document with 83 items concerning the diagnosis and treatment of acute bronchitis as well as GP demographic data.

Again, there are inherent deficiencies in self-reported studies, though none seem to be apparent in this case, as replies gave a desultory picture of practice

Though this is a UK study there are no reasons to suggest that similar responses would not be gained in Australia. This study begs the question as to whether GPs can discriminate about what is effective in responding to clinical matters or whether stronger drivers include maintaining the doctor patient relationship or even terminating the current doctor patient encounter whilst maintaining the doctor patient relationship.

### **3.3.5 GP management of cardiovascular disease**

Literature reporting the management of cardiovascular disease by GPs is limited to that from the UK.

#### **Sudlow et al, 1997**

This Northumberland study identified that approximately half of a general practice patient population had appropriate treatment for atrial fibrillation. Atrial fibrillation can predispose to blood clot formation and is treated by warfarin, a medication that hinders the blood clotting process.

The survey recruited an age and sex stratified random sample of patients aged 65 and over registered with a total of 10 contiguous general practices in Northumberland. 1990 patients were identified as meeting the inclusion criteria and of these 1530 (77%) participated. Atrial fibrillation was identified by electrocardiogram in 100 of these patients. After taking into account risk factors that would contraindicate the use of warfarin in some patients, it was found that approximately half the participants with atrial fibrillation were adequately managed by the use of warfarin.

Extrapolation beyond the region covered by the study is difficult. Nonetheless the study suggests that response to atrial fibrillation by this group of GPs is suboptimal particularly given that, as is claimed by the authors, that several randomised controlled trials have demonstrated the efficacy of warfarin in treating atrial fibrillation and thus reducing the risk of stroke.

### **Fitzmaurice et al, 2002**

This UK study indicated that, for patients requiring anticoagulation therapy, self-management was as good as management provided in their general practices.

Six general practices were determined as satisfying study entry criteria. The criteria were not described. Forty nine patients (23 intervention and 26 control) completed the study representing 55% of the target group. Patients were trained to manage their own anticoagulation requirements for a 6 month period and obtained control similar to that of patients treated in the primary care setting.

This study failed to identify if the group of non-participating patients resembled the participant group. It also failed to identify characteristics of the 45% of participants who did not complete the 6 month trial. We are not informed as to the outcomes for patients who failed to complete the study.

The group chosen for a study such as this was an older group and there may therefore be associated factors that mitigate against self-management. Such factors may include disability or lack of a carer. The study also failed to address the needs of patients commencing anticoagulant therapy where dosages tend to be more critical. Indeed, it may be argued that patients who have been on long term therapy understand the nature of their illness and its management experientially and are more likely to be successful than patients anticoagulated over a shorter period. Again, the two groups, responders and non-responders, are not compared.

The study raises the concept that GPs may not be utilising the skills and motivation of patients to reduce their own personal workloads.

### **Campbell et al, 1998**

In this UK study, with the exception of hypertension where 82% of 1562 patients had their blood pressure managed according to clinical management guidelines, generally relatively few general practice patients with heart failure (40%) and raised lipids (17%) followed the correct management guidelines.

This is a regional study of 1921 patient records of patients aged less than 80 years suffering from coronary heart disease conducted in Grampian using a stratified random sample of local general practices. Examination of clinical records and comparison to clinical guidelines demonstrated that “half of patients had at least two aspects of their medical management that were suboptimal.”

This study included a large number of patient records. Reference to records always raises concerns of data accuracy and completeness. The study failed to validate an audit sample of records as either recording the correct diagnosis or the correct

treatment. In this context, one can only make statements about the record of treatment rather than the treatment itself.

Notwithstanding the above, the study is consistent with other studies in suggesting that systematisation and standardisation of care in general practice is still far from perfect.

#### **A.3.5.6 GP screening for colorectal cancer**

##### **Sladden and Ward, 1996**

Sladden and Ward reported the first Australian national survey of self-reported screening methods for colorectal cancer. The authors suggested that GPs were more likely to recommend flexible sigmoidoscopy to screen for colorectal cancer than faecal occult blood testing despite the evidence that indicated that faecal occult blood testing was the more reliable test. GPs were more likely to report that they believed either test was useful than they were to actually use it. The authors suggested the presence of “confusion” about colorectal cancer screening in general practice.

This survey consisted of a random sample of 1271 Australian GPs in 1996. The response rate to the postal survey was 67% overall, with a higher rate for females (75% versus 63%). The authors comment that “Standardised response-aiding strategies were used to follow up non-respondents”. Respondents were asked to tick the response that matched their views.

A quantitative survey that provides a tick box to identify a view that matches the participant’s view runs the risk of not having an option for the participant’s specific view, but such a methodology enhances data analysis. The findings of the study were complicated by the fact that three sets of guidelines for this purpose existed at the time of the study but contradicted each other. Having declared that difficulty, the authors

failed to justify why they believed the guidelines chosen as the benchmark for the study were any more reliable than the other two.

#### **A.3.5.7 GP management of sexual dysfunction.**

**Nazareth et al, 2003**

The authors of a Northern London based study reported that of the 1512 patient participants, 22% of males and 40% of females received at least one ICD – 10 diagnosis of sexual dysfunction on screening. Of the 1080 patients who agreed to allow access to their clinical records, 30% stated that they had discussed a sexual dysfunction problem with their GP. However, only 3 – 4% had an entry related to sexual dysfunction in their record.

This study was based around 13 practices representing areas of high, medium and low socio-economic deprivation, representing 35% of practices approached for the study. 3073 consecutive adult attenders were invited to participate, 2121 satisfied the eligibility criteria and 1512 (71%) consented to participate. Replies to questions pertaining to sexual dysfunction in a structured questionnaire were then compared to their clinical record.

A number of factors in the methodology reduce the reliability of the findings. Self-selection was one such factor and could have been compensated for by comparing the participant group with the non-participant group. Such a process was not undertaken in this study. The authors did not record how the patients were approached for consent for interview and one must presume that the approach was made within the practice itself. Many patients may find this method of recruitment confronting for an issue as personal as sexual dysfunction.

This study also failed to address the issue of the completeness of the written record. The study does not record whether GPs were asked if they deliberately withheld sexual histories from the written record. Nonetheless, the significance of the findings do support the contention that, although high levels of sexual dysfunction occur in the community, systematic identification and management of sexual dysfunction by general practitioners may be very limited.

#### **A.3.5.8 The use of clinical management guidelines in general practice**

A large body of literature exists describing guidelines for the management of clinical conditions (Smallwood and Lapsley, 1997). In acknowledging a low usage of clinical management guidelines in Australian general practice, van der Werden usefully comments that general practice with its focus on the patient-doctor relationship and the milieu of the personal, biomedical and contextual perspectives may not be ideologically aligned with the strict scientific methodologies of randomised controlled trials (van der Werden, 1999). Low use must not be confused with low prevalence and the possibility of GPs being expected to use guidelines which conflict with each other (Sladden and Ward, 1999).

#### **Young and Ward, 1997**

In a 1997 examination of Australian GPs' use of the Cochrane Library, Young and Ward reported that 22% of respondents were aware of the Cochrane collaboration and 4% had used it. The authors noted that awareness of the Collaboration was greater amongst members of group practices and of Divisions of General Practice, suggesting that "peer contact appears to be an important mechanism to promote evidence based databases."

In forming a sample population the authors randomly selected the names of 428 NSW GPs from a “commercial list”. Of these 311 (78%) replied to the postal survey which had been preceded by a phone call from the investigators. Non-responders were followed by up to two mail reminders and a further telephone prompt. Respondents were reported to be similar those of New South Wales GPs, presumably on the basis of age, gender and full time status.

This study is of limited utility for a number of reasons. Whilst the Cochrane collaboration is one means of deriving an evidence base for clinical decision making, it is not the only one. Furthermore, as the authors acknowledge, there is an issue of access to this technology. Finally, we have no picture of how other groups such as private consultant specialists and clinical nurses use this database. The authors’ final comments are important in asking if such databases meet the needs of GPs if they don’t address usefully gaps in GPs’ knowledge. At a higher level, this study raises the question as to what resources, human or otherwise, GPs use to make any important decisions in a changing environment

### **Hirst and Ward, 2000**

Clinical guidelines for best practice have no benchmark for their format. This situation was identified in an Australian study by Hirst and Ward who assisted the National Health and Medical Research Council (NHMRC) to develop guidelines for the management of lower urinary tract symptoms (LUTS). In reporting the work of the LUTS working party commissioned by the NHMRC, they state that there was “no body of empirically derived insights regarding optimal formats for derivative GP guidelines” (Hirst and Ward, 2000, p291). One is left with the impression that GPs managing clinical conditions in accordance with clinical guidelines will find a plethora of presentations and no common means of easily utilising or comparing the



information. Therefore it appears that GPs are not encouraged to adopt an orderly and structured approach to patient management when guidelines themselves are presented in an ad hoc fashion.

This is an interesting paper which suggests that GPs are not driven by a scientific approach to the application of evidence. It does not attempt to answer the difficult question as to what does drive GPs, or if in fact that GPs as the independent beings described in the previous chapter (2.4.1) may actually resist non-peer driven change.

### **McColl et al, 1998**

McColl et al studying the implementation of evidence-based performance indicators for UK Primary Care Groups also found that applying learning from trials and reviews to primary care patients is “complex and challenging” and that “overcoming operational issues and changing clinical behaviour require a multifaceted approach” (McColl et al, 1998, p1360).

The authors searched the Cochrane Database of Systematic Reviews, the Database of Abstracts of Reviews of Effectiveness and Effective Health Care bulletins to identify evidence based primary care interventions suitable for linking to performance indicators for primary care groups. The authors discussed the difficulties in defining primary care and in identifying sensitive indicators of quality. Having defined these indicators the authors then determined the eight interventions most likely to improve patient outcomes. Papers describing such primary care interventions were then searched for.

In listing a number of methodological shortcomings, the authors contended that they used their findings in an “illustrative” way. They accepted that sources of evidence

were not comprehensive and acknowledged the difficulty in determining and comparing indicators.

A study of this nature is useful to determine the status quo, the “what”. Such studies fail to identify the “why”. In the context of this thesis it may be salient to consider that evidence-based performance indicators may not look so compelling in the light of a waiting room full of patients, scheduled and urgent home visits, and personal lifestyle stress (Sibbald et al, 2003, p22).

### **Mayer and Piterman, 1999**

This Australian study considered the use of evidence based guidelines by Australian GPs. They found that GPs placed more credibility in their own experience than in scientific evidence. They were suspicious that some guidelines reflected a government agenda to control costs rather than improve care. The use of guidelines was driven more by the patient in asking questions of their doctor. In particular, the use of guidelines was heavily couched in the limited scientific context of the trial versus the context of the patient, as he/she was known much more broadly by the doctor. They found that GPs were more likely to seek the advice of colleagues and suggest the importance of social interaction with colleagues. Interestingly they “felt that guidelines had the potential to reduce clinical autonomy”, whilst “many feared punitive measures (legal and financial) against those who deviated from the guidelines.

This was a qualitative study using a purposive sampling technique. The 27 participant GPs formed five focus groups. One group consisted of six GPs undergoing a postgraduate course in Preventive Care, another involved three GPs studying for a Diploma in General Practice, another group consisted of five GP academics, and the

last two consisted of eleven GPs from Darwin. We are not told how or why these two lattermost groups were selected.

Recruitment was by letter but we are not told how the GPs consented to involvement. The focus groups were designed to elicit attitudes about guidelines posted to the participants beforehand. An unusual method of triangulation was adopted at the end of the focus group. The participants were requested to rate the statement “All guidelines should present the explicit presentation of evidence on which their recommendations are based.” They then mapped their agreement/disagreement on a Likert scale. A blinded assessor then evaluated the data and compared them to the findings of the focus groups.

The sampling technique seems to have been on the extreme side of purposive; perhaps “convenience” would be a better term. Most participants were undergoing, or had achieved some academic endeavour and one may have expected that this could have introduced some bias into the results. We are told it did not. Perhaps Darwin GPs are no more academically adept as the average postgraduate Australian GP.

The six participants who formed Group one were recruited from a very specific course at Monash University in 1997. It may be that not a large number of GPs were recruited in that postgraduate course in Preventive Care and it may therefore be that anonymity has been prejudiced. We are not informed as to how many participants actually read the pre-posted guidelines. Participants may have not read the guidelines and may therefore have been making opinions uninformed by the examples. The rationale of the means of benchmarking is not explained. Why a correlation exists between the question asked and the results of the focus group is unclear.

Though far from a perfect study, the findings are interesting, providing useful insights about the attitude of GPs for this present thesis.

### 3.4 GP management in a changing clinical environment

(Quadrant 2)

1	Literature related to management of unchanging clinical	Literature related to management of unchanging non-clinical	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

The Australian and British literature are also scant with respect to managing non-clinical change. In the UK context this is somewhat surprising given the tumultuous changes the NHS has been through. However, two areas of clinical change where research is more abundant include those of congestive cardiac failure and diabetes.

#### 3.4.1 GP management of congestive cardiac failure

##### 3.4.1.1 Krum et al, 1998

The management of CCF has altered since the widespread introduction of echocardiography to confirm the diagnosis and the recommendation for the use of ACE inhibitors and, more latterly, beta blocking medications as pharmaceutical therapies. The findings of this Australian study indicate that approximately one in four patients with CCF went undiagnosed and approximately 13% of patients diagnosed with CCF failed to meet clinical criteria for the diagnosis. Less than 50% of patients were taking the correct beta blocker medication, the frequency of use of ACE inhibitors was low and, when used, the dose was low on 60% of occasions.

Echocardiography should be performed on all patients with CCF (NSW Clinical Service Framework for Heart Failure, 2003, p 8). The authors suggested that a reported low usage of echocardiography in this study could be explained by a lack of knowledge of the value of the investigation, concerns about its cost or difficulty of access.

The study involved 341 volunteer GPs recruited on the basis of interest, as determined by pharmaceutical representatives. Each GP was expected to assess 80 consecutive patients over the age of 60 years for CCF. Data were therefore collected prospectively. The GPs themselves acted as their own arbiters to determine if patients had been undiagnosed or incorrectly diagnosed. The geographical distribution of GPs matched that for all Australian GPs, as the distribution of the 22060 patients was similar to the 1996 Australian population over the age of 60.

The use of pharmaceutical representatives to recruit participant GPs needs a degree of transparency not detailed in this study. In particular, the nature of any incentives, either present or future, is not described, however it is stated that the pharmaceutical company was not involved with data analysis. Nonetheless, pharmaceutical companies researching the underutilisation of pharmaceuticals may not represent the arm's length characteristics of best practice. No reference is made to an application to an ethics committee though the RACGP, which has its own ethics committee, is quoted as supporting the study.

There is no suggestion that the study is of a random population. The essential weakness of the study lies in its use of participant GPs as participants and as researchers in that it was the GP who self-reported the identification of previously undetected cases of CCF and any instances of poor management. Despite these reservations, the weight of the findings in an area so important as congestive cardiac

failure leaves the reader questioning the apparently unsystematic approach of Australian GPs to clinical disease management.

#### **3.4.1.2 Fuat et al, 2003**

This study confirms many of the findings of Krum et al. It examines the way in which British GPs have managed congestive cardiac failure (CCF) in the environment of rapidly changing investigations and treatments. The authors suggest that advances in science have been too rapid for GPs to adopt, that GPs have become confused about changing therapeutic interventions, that they have lacked confidence in making the diagnosis, that they hold invalid perceptions about the availability of technology, and that they are unable to understand clinical reports, communicate poorly with cardiologists, are apprehensive of using mainstream therapies and unaware of new therapies. In particular, decisions were made against a background most heavily influenced by former training (no matter how long ago), anecdote, the position of health authorities (such as care trusts) and the influence of the pharmaceutical industry.

The authors recruited thirty GPs from northeast England using a mixed purposive sampling strategy. Stratification occurred at the levels of sex, ethnicity, geographical distribution, employment status (full time or part time) and practice size. It excluded GPs from the same practice. The study utilised four focus groups of six to eight participants. Using a grounded theory model, themes were identified and taken to subsequent groups for refinement.

Focus groups are reported to be subject to the influence of dominant participants and to the possibility that participants may exaggerate or otherwise disclose the truth in the presence of significant others (REF). This did not seem to occur on this occasion

as at one stage, for example, “most general practitioners indicated that they were unaware of the place for other agents”. The technique utilised in this study of rolling focus groups refining the work of previous groups may limit the breadth of information available from participants by concentrating on the themes of the initial group.

The findings do indicate that at least a small group of GPs UK GPs and a larger group of Australian GPs are challenged in the face of changing clinical conditions.

### **3.4.2 GP management of diabetes**

Diabetes is a chronic condition which has undergone many clinical changes in relatively recent times with insulin delivery systems moving from patient – loaded syringe delivery, to pen systems of delivery to innovative inhaled systems. But more particularly diabetes lends itself to a patient recall system as many areas of clinical care exist (quote from guidelines).

#### **3.4.2.1 Griffin, 1998**

This 1998 UK meta-analysis report suggests that metabolic control of diabetic patients receiving hospital based care was no different to that of patients treated in general practice when structured care was provided. It suggested that where recall was used outcomes favoured patients attending general practices, but that unstructured care in the community is associated with poorer control and worsening morbidity.

Eight bibliographic and research databases were searched, identifying 1200 studies. Of these only five met inclusion criteria which included a relatively short history of diabetes (less than two years) and satisfactory randomisation methods. In all, meta-analysis of randomised trials involving a total of 1058 diabetic patients compared



hospital outpatient care with primary care of diabetes for factors including metabolic control, mortality, hospital admissions and blood pressure.

Tight criteria with strict exclusion criteria often mean small studies. A meta-analysis of only 1058 diabetes patients is not a large one. The authors acknowledge that none of the studies was longer than two years and, therefore, long-term outcomes could not be assessed. As clinical outcomes were similar, it maybe that the ideal arena for the delivery of diabetes services would therefore be determined by cost but costs were not determined. The authors identify the difficulties of researching two distinct provider groups when they become involved in shared care programs. Finally, and usefully, the authors suggest that general practice care was popular with patients. One can only wonder how important this factor is in the long term management of the diabetic.

This diabetes study perhaps gives the impression that where change is moderately paced, general practice can provide adequate modern care, but only in a structured environment.

### 3.5 GP management in an unchanging non-clinical environment

(Quadrant 3)

1	Literature related to management of unchanging clinical conditions	Literature related to management of unchanging non-clinical processes	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

#### 3.5.1 The General Practices Profile Study, 1997

The General Practices Profile Study prepared for the Commonwealth Department of Health and Family Services is a comprehensive snapshot of the microstructure of general practice at that time. In a brief examination of changes in general practices, the report found that only 52% of practices sought external advice on practice management, 17% sought business planning advice and a mere 14% sought human resource management advice. Disturbingly, 11% of practices had undergone changes of ownership structure in the previous year. (General Practices Profile Study, 1997, p71).

The study was a telephone survey of 1243 practices. The questionnaire was developed after qualitative research entailing focus groups with GPs in an urban and a rural community and interviews with 15 GPs and practice managers in three capital cities and a rural region of Australia. Additional information such as practice opening hours and other publicly available information was gained from practices by faxback.

The survey sample was stratified by region and by participation or non-participation in the Better Practice Program current at the time. The sample was weighted for rurality. Of the total sample 53% participated in the practice manager interviews, 36% participated in the GP interview and 26% participated in the faxback. The respondent population matched the sample population on the number of full time and part time GPs, GP gender and practice size.

The study was initially commissioned to measure changes in general practice. Due to financial constraints it established a profile of general practices instead. The proportion of GPs replying to the telephone survey (36%) is problematic in the context of this thesis. The reader is not informed as to the length of the interview. The authors have recognised the need to inform the survey development by face to face interviews and focus groups. We are not informed how they were sampled but that is less important than the study sample. The BPP database was utilised largely because it was there. Its use highlights the difficulty general practice researchers experienced before the HIC developed its comprehensive database.

With respect to this thesis it is relevant that the report suggests that GPs are unlikely to seek expert opinion in matters pertaining to practice business. However, there are no explanations as to why this should be the case.

### 3.6 GP management in a changing non-clinical environment

(Quadrant 4)

1	Literature related to management of unchanging clinical	Literature related to management of unchanging non-clinical	3
2	Literature related to management of changing clinical conditions	Literature related to management of changing non-clinical processes	4

There is relatively little in the literature that deals with Australian General Practitioners managing non-clinical change. International literature is more helpful in discerning the many aspects of managing non-clinical change.

#### 3.6.1 GP response to a changing workload environment

##### 3.6.1.1 Huby et al, 2002

The UK experience of change, whilst differing to that of the Australian GP, has perhaps been at least as significant in quantum and rate as that experienced by Australian GPs. Huby et al set about to examine morale in UK general practice following an increase in workload arising from the introduction in 1990 of general practice work contracts. The authors found that workload factors including red tape, consumer expectations and transferring hospital care to the community, were important in influencing morale. However they also suggested that work practices instituted within a practice could be significant modifiers of stress. These work practices included the way the business accommodated GPs of varying styles and

speed of consultation as well as the management and support of part time GPs, particularly female GPs. The authors stressed the importance participants placed on addressing problems within the partnership and the attendant costs of protected time to do so and available space within which those problems could be discussed.

The study was conducted in South East Scotland. All 897 GPs were invited to participate. Of these 403 agreed to participate. The study was conducted in three phases. In Phase one, 16 GPs were selected by purposive sampling to undergo semistructured open ended interviews “about experience of wellbeing and distress at work, and the relation between work and home.” Phase two was conducted with 10 different GPs, again sampled purposively, to undergo semistructured interviews focusing on issues derived from Phase one. The third phase involved another 37 self nominating GPs who formed a total of eight focus groups. Participants discussed an hypothetical scenario based on issues identified in the first two scenarios and described possible solutions to mitigate distress and poor morale.

This study demonstrates the value of a qualitative methodology. Some of the recorded data provide images that give a graphic picture of feeling, of mood and of culture that a quantitative survey simply could not. For example:

*I went back to work about a year ago (after nine months stress leave), but it took me about nine months to get back up to nine sessions a week and my practice were pressuring me to get back up to nine sessions..... because doing fewer sessions was never an option, partly because, you know, it is basically a male practice.*

This study serves as a comparator to the methodology for this thesis in which issues are identified by two different mechanisms (see chapter 3). The endpoints, I would argue, are similar. They also suffer from the same liabilities. For example, small

studies are open to the charge of bias with limited generalisability. More specifically, this study uses a self selecting group of GPs for Phase three. This group may have self selected because they had “axes to grind” and may be totally unrepresentative. Its greatest failure perhaps is that it chose to include in its sample frame only practice principals. Perhaps assistant general practitioners feel far less (or far more) the stresses of workload when they have no responsibility for (and no control over) the management of a general practice.

#### **3.6.1.2. Kilmartin et al, 1997**

More women are entering the medical workforce than men (Power and Aloizos, 2000) however men have traditionally provided after hours care and to supply rural general practice. How do women respond to workload pressures as the proportion of men in the medical workforce declines? In this Australian study by Kilmartin et al, women GPs reported conducting longer consultations than their male colleagues, an observation confirmed by Britt et al (REF). Women GPs also seem to be experiencing many of the employment inequities of their sisters thirty years ago, in that they reported themselves as less likely to be business owners, commonly work without a contract and are unable to enjoy the benefits of superannuation, long service leave and other modern day basic worker rights. Indeed, some participants claimed to have been driven to “breaking point” in their professional lives and yet had taken no action in response to their professional stressors, though some had, perhaps appropriately, withdrawn to some measure from the workforce, some completely. It seems that many participants managed their professional lives as though change had not occurred in the general practice environment thereby suffering the personal consequences of an inadequate response.

The study utilised the Delphi technique to identify and explore key issues associated with female GPs in terms of their professional and non-professional lives. A purposive sampling technique was used to recruit 40 eminent female general practitioners in each State and Territory. The Delphi group was conducted in three rounds by post. In round one, key issues were identified. These were rated in round two whilst round three identified a consensus ranking. Participants were anonymous. This methodology (Delphi technique) provides an interesting comparison to that used in this thesis which also produced a ranking of issues. It is therefore likely to be vulnerable to a lack of representativeness and differing perspectives of “experts” relative to the general population. Perhaps the lives of expert female GPs are more tense because they have decided to attain further expertise. Perhaps expert GPs are inexpert business persons. A focus group or quantitative survey of a sample of non expert women GPs would have given greater validity to this important study. Interestingly, the authors work has subsequently been supported by that of others (Britt et al; AMWAC, 1996).

### **3.6.1.3 AMWAC, 1996**

The AMWAC Report entitled “Female participation in the Australian Medical Workforce” gives a quantitative picture of the response that may be occurring as a result of the increasing feminisation of the Australian GP workforce (AMWAC Report 1996.7). AMWAC reported that female GPs (7.5%) were more likely to work in the public sector than their male colleagues (4.2%), were more likely to work part time and worked less after hours. However, these effects were age dependant; younger female GPs were more likely to work the hours associated with male GPs. The report is based largely on data collected by the Australian Institute for Health and Welfare. Some ABS data are included and arguments are supported by literature.

Women doctors (including GPs) are reported to work less hours than their male counterparts. We are told that “there are female clinicians who have made the choice to share their male colleagues’ work pattern” (p 18). This bland comment fails to identify some of the issues raised by Kilmartin et al about stress and the conflicting roles of mother and doctor. Importantly, the study ignores the possibility that male GPs will start to behave like their female colleagues by adopting a “female” work pattern, thereby worsening the supply shortage further.

### **3.6.2 Managing stress in a changing general practice environment.**

#### **3.6.2.1 Shattner and Coman, 1996**

In a 1996 random postal survey of 500 GPs Schattner and Coman found that time pressure to see patients was the most frequent stressor for Australian GPs whilst fear of litigation was the most severe stressor. 53% had considered leaving general practice as a result of occupational stress, whilst 12.8% of participants had General Health Questionnaire scores indicative of severe psychiatric disturbance.

Working part time appeared to be protective of moderate or severe stress. Time pressures or workload included management problems such as phone interruptions and paperwork. As the authors note, time pressures are important also for their flow on effects which may explain why patients feel that their GP is not listening to them and may even lead to mistakes in clinical management. Indeed, the authors suggest that practice administration, which is not traditionally taught to undergraduates, causes much more stress than do clinical issues.

Importantly, following workload as a major cause of occupational stress, were economic factors such as income and the running of the business itself. Medicopolitical factors ranked third and these were largely a function of government



pressures and, interestingly, involvement with professional associations. Clinical factors ranked fourth. The importance of non-clinical management of general practice, it would seem, can then not be over-emphasised with GPs commenting that it was the “job context” rather than the “job content” that was so stressful.

In this study 296 GPs participated in a postal survey to identify work-related stressors of Australian metropolitan GPs. Potential participants were recruited from a list, supplied by the HIC, of 500 randomly selected GPs. The sample was designed to demonstrate demographic characteristics similar to Australian metropolitan general practice. Non-responders were followed up by second questionnaire and, if needed, by a later phone call. The questionnaire was in four parts. Part one requested demographic information; part two asked respondents to rate the frequency and severity of potentially stressful events in general practice. The list of 28 potential stressors was developed from both a review of the literature and input from a GP focus group. Part three asked participants to indicate the effects of stressors on job satisfaction, while part four was the 12 item General Health Questionnaire.

This is a well-designed and well implemented study. The authors suggest that a study of rural GPs may have yielded different stressors such as lack of locum relief and isolation. The findings represent a wealth of data for this thesis and in many ways add to the rich fabric of change and its consequences for general practitioners.

### **3.6.2.2 Sibbald et al, 2003**

The proportion of UK GPs intending to leave practice in the following five years rose between the years 1998 to 2001 from 14% to 22%. Whilst the proportion increased by over 50%, the reasons did not change. These included age, job dissatisfaction, having no children under 18 years of age and ethnic minority status. Longer reported working hours were associated with lower levels of satisfaction. Importantly, the authors

comment that “the principal causes of general practitioner discontent lie within the wider environment. The organisation and governance of general practice has greatly changes in recent years, and doctors may be experiencing difficulty in adapting to these changes.”

A random sample of 2000 English GP principals was drawn from a database of doctors which was maintained by the Department of Health. An unspecified standardised instrument of job satisfaction and questions on personal and practice characteristics constituted the questionnaire. Questionnaires were mailed in March 2001. Non-responders were followed as necessary by a further two occasions. Responses were received from 1332 (67%) doctors. Data were compared to that collected from an identical survey of 2064 GPs in June 1998. The two groups surveyed were similar and representative of the populations from which they were drawn.

The suggestion that GPs without children under 18 years of age are more likely to retire, appears to be a tortology. The authors acknowledge that intention to retire may not translate into actions, though they do quote literature that supports the relationship. They suggest that only GPs discontent with their burden may have responded preferentially, though it may be argued that that group would be the one least likely to increase their burden of paperwork by responding.

Given the context of the study, that is GP principals who may be intending to retire in the face of rising workload and increasing red tape, it is logically problematic to suggest a study that may itself increase workload and red tape. Ironically, such also is the methodology of this thesis. The possibility that the study may have had a cathartic effect on the GPs has not been mentioned by the authors.

This is an important study in the context of this thesis, albeit a UK study. If failure to manage change adequately results in a risk of losing such a substantial proportion of the national GP population then clinical care will very quickly become compromised.

### **3.7 Barren grounds**

The literature is silent or scarce in a number of critical areas. For example, we know little about GPs as managers. A number of studies exist which describe the relationship between doctors and managers (BMJ, 22 March 2003). However, these are usually in the context of the hospital consultant and the hospital manager working within the British NHS or of the clinician and the management of the Health Maintenance Organisation in the USA (Kassirer, 1998). We know even less about GP as managers of change.

### **3.8 Conclusion**

There is a broad field which has been the subject of little enquiry but which, nonetheless merits enquiry. That work that has been done in the field of GPs and managing change has been done largely in the clinical setting. Nonetheless, two generalisations may be drawn. The first is that the literature does not depict GPs as providing systematic predictable clinical care, particularly in the face of a changing clinical environment. Secondly, a number of studies emphasise the importance of the non-clinical environment in determining GP stress and ability to cope with change.

In approaching this question of non-clinical change management then I do not seek to provide a definitive study. The main outcome of the thesis is to identify further productive strands of enquiry and to identify areas worthy of intervention. Whether my findings will be generalisable will be determined by the consistency of the findings and the detail by which I can identify the type and context of GPs interviewed and the practices in which they have worked and others with whom they

have worked (Britten et al 1995, p 110). Unfortunately, it is likely that I will not be able to compare my findings with other comparable qualitative studies to aid generalisation (Baum, 1995, p464), as these do not exist.

## **A.4 Documents relating to the Delphi group**

### **A.4.1 Letter of recruitment of oracles**

Dear Prof <SURNAME>

I am a student at the University of Wollongong enrolled in a DPH course. The title of my thesis is "How do Australian GPs respond to changes in their non-clinical environment?"

My method of data collection is by means of face to face interviews with GPs discussing particular case studies. In order to develop these case studies I am inviting one academic GP from each of the five mainland states to form a Delphi Group. The Group will meet by e-mail over three rounds. Details are enclosed as to how the group will determine the case studies. Your name as the potential <NAME OF STATE> "Oracle" has been provided to me by Prof Mark Harris. Should you be willing and available to participate, the enclosed consent form can be returned, with a digital signature, by e-mail or faxed back to my work address, viz., Illawarra Division of General Practice Fax: (02) 4226 9485

Yours sincerely

Andrew Dalley

#### **A.4.2 Form of consent for participation by oracles**

You are invited to give consent to participate in a Delphi group which would form part of a thesis entitled “How do Australian GPs respond to changes in their non-clinical environment?” This study has been reviewed by the Ethics Committee of the University of Wollongong. Any questions with respect to this survey can be addressed to my supervisor, Prof Don Iverson, Faculty of Health and Behavioural Sciences, University of Wollongong. Complaints regarding the conduct of this interview or of this research can be made to the Ethics Officer, Office of Research, University of Wollongong, telephone 42214457.

Information derived from this research will be published in my thesis. In addition, information may also be submitted for publication in a medical journal. Unless you request otherwise, you will be acknowledged as having contributed to the outcomes of this research. The group will meet for three rounds by email (see enclosed diagram). Each participant and their input will be known to myself, my two supervisors (Prof Don Lewis and Dr Rose Melville) and may be known to each Delphi participant. Participation is entirely voluntary and you are free to withdraw from this research at any time with no consequence to yourself. Should you withdraw any material you have contributed will be destroyed or returned to you.

The information will be stored as e-mails in electronic format and password protected for a period not less than five years. No comments will be attributed to any individual author in any publications.

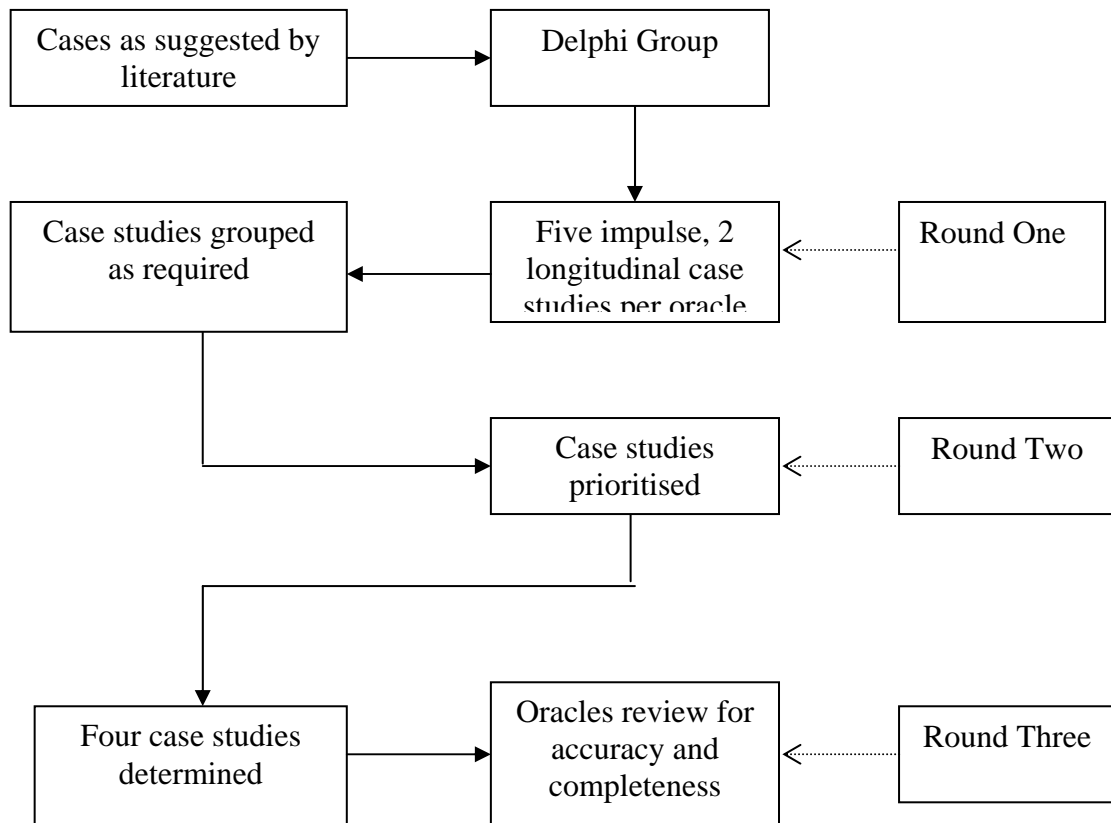
#### **Consent**

I hereby voluntarily agree to participate in a Delphi group as part of the research project, “How do Australian GPs respond to changes in their non-clinical environment?” I understand that any information I supply will be collected and stored electronically. I understand that I may cease participation at any time. I consent to the information I provide being used in the published thesis and in any other publications. I understand that, unless I advise otherwise, my contribution will be acknowledged in any publication but that no comments will be linked to me individually.

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

#### A.4.3 Process of case selection by Delphi



#### **A.4.4 Modus operandi of Oracle group**

The group met in three “rounds” by e-mail and were requested to reply within one week. In round one, the group was asked to list up to five major non-clinical<sup>3</sup> changes in Australian general practice subject to the following criteria:

- The case or problem in question must have occurred since 1970
- The case or problem must have had a high probability of impacting on the large majority of GPs practicing at or over that time.
- The case or problem must have a high probability that the large majority of GPs at that time would have had to make some response to the case in question.
- The case or problem did not arise unpredictably
- The case or problem occurred over a time frame with an identifiable start or end point.

The above process yielded a number of “impulse” cases. The oracles were also asked to identify one example of a “longitudinal” change. The criteria for this included:

- The case or problem in question must have been evolving since 1970
- There were no clear start or end points of change.
- The case or problem must have had a high probability of impacting on the large majority of GPs practicing at or over that time.

Oracles were supplied with examples from the literature which they could ignore or consider at their discretion. Reply was by e-mail. Where changes appeared similar they were grouped.

In round two, the oracles were asked to prioritise each of the changes by simple ranking. Each oracle was invited to review all case examples and rank the five most closely fitting the selection criteria. Results were aggregated and the two impulse changes and two longitudinal changes with the highest rankings were chosen as the basis for the case studies.

In round three the researcher submitted final case studies to the Delphi Group as a means of checking for accuracy and completeness.

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<sup>3</sup> The term non-clinical excludes activities of clinical examination, treatment or diagnosis (but includes processes associated with these activities such as increasing surveillance of prescribing patterns and exclusion of GPs from hospitals for the purposes of patient treatment)



#### **A.4.5 Case criteria for case topics determined by oracles**

##### **A.4.5.1. Impulse case criteria**

The criteria for impulse cases include:

- The case or problem in question must have occurred since 1970
- The case or problem must have had a high probability of impacting on the large majority of GPs practicing at or over that time.
- The case or problem must have a high probability that the large majority of GPs at that time would have had to make some response to the case in question.
- The case or problem did not arise unpredictably
- The case or problem occurred over a time frame with an identifiable start or end point.

##### **A.4.5.2 Longitudinal case criteria**

The criteria for longitudinal cases include:

- The case or problem in question must have been evolving since 1970
- There are no clear start or end points of change.
- The case or problem must have had a high probability of impacting on the large majority of GPs practicing at or over that time.

#### **A.4.6 Prioritisation of changes by Delphi group**

##### **A.4.6.1 Prioritisation of impulse changes**

<b>Change</b>	<b>Total</b>
Medicare	16
Vocational registration	12
Establishment of divisions	11
Introduction of the Family Medicine Training programme	5
Practice accreditation	4
Medical indemnity issues	2

##### **A.4.6.2 Prioritisation of longitudinal changes**

<b>Change</b>	<b>Total</b>
Feminisation of workforce	14
Computerisation	8
Lack of coordination between the various GP bodies.	7
Increased multidisciplinary care	7
Increased prominence of practice management as a key skill / asset in general practice -	5
Fall in income as compared with other comparable age group colleagues	5
Deinstitutionalisation of hospitals	4

## **A.5 Case study vignettes**

Eight case studies were used initially, four determined by the Delphi group and four derived from literature. This section details the case studies as presented to each participant.

### **A.5.1 Vignettes of cases suggested by the Delphi group**

Vignettes were either longitudinal (2) or impulse (2) in nature.

#### **Longitudinal case study one      Feminisation of the workforce**

General practice has seen a continuing increase in the total number of female GPs and an increase in the proportion of female GPs. AMWAC suggests that female GPs, on average, work only about 63% of the hours worked by their male counterpart. This is likely to be a causal factor in a declining GP workforce, meaning that many GPs will have had to increase workload to compensate for an inability to meet workforce requirements in general. In addition, female GPs appear to be less likely to work in a rural community. There is also evidence that GPs working in Nursing Homes are much more likely to be male and that males are more likely to be practice principals. This evidence suggests that administrative workload as well as clinical workload may be increasing for males, all else being equal.

On the other hand, female GPs tend to see a different spectrum of problems than does their average male counterpart. This may mean that males see less in the way of women's health problems and that female GPs may be more restricted in their patients' presentations. This may affect their satisfaction with general practice as a career.

#### **Longitudinal case study two      Computerisation**

General practices are increasingly adopting computer technology to assist in clinical care of their patients and/or to improve business processes. This technology has come at a financial cost for the purchase of hardware, clinical and other software and any necessary networking. Maintenance has been a consideration financially and in finding technical providers with a knowledge of clinical software.

Other financial and opportunity costs include GP and staff training and perhaps an alteration in record keeping. It may be that patients have expectations that their GP

will be able to use a computer. More recently, patients are reported to be presenting to their GP with disease information obtained from the internet.

Computers are also known to “crash”, an event that may interfere with the efficient running of a practice as well as proving to be a source of frustration to their users. Loss of information may occur rapidly; a catastrophe that would only occur in paper based record keeping in the event of fire, flood or other disastrous event.

The introduction of Privacy legislation both Commonwealth and State, has added an extra practice management responsibility which may be affected by computerisation.

### **Impulse case study one                      Medicare**

Medicare was introduced in 1984. Its objectives were to:

- make health care affordable for all Australians;
- provide all Australians with access to health care services, with priority according to clinical need; and
- provide a high quality of care.

There were certain features associated with Medicare:

- It offered medical practitioners the option of bulk billing. This may have placed pressure on doctors to provide services at the level set by the government. On the other hand it may have made GPs who bulk billed more accessible to customers.
- It limited the proportion of the bulk billing amount claimable (or rebate) to the provider to 85% of the “Schedule Fee”. This may have reduced bad debt risk but equally may have acted to prolong the time interval between service and payment.
- Increases in the rebate have not been tied to the CPI and have dropped substantially relative to the CPI

The Medicare rebate does not take into account the rising costs of medical indemnity or of practice accreditation

### **Impulse case study two                      Vocational registration**

In 1989, GPs were invited by the Commonwealth Government to apply for vocational registration (VR) under standards chosen by the government and already established by the RACGP.

The primary goal of vocational registration was to ensure the delivery of quality general practice services. The criteria to continue as vocationally registered GPs are established and monitored through the RACGP QA and CPD program.

Doctors who are unable to meet the criteria for vocational registration are unable to access higher rebates for their patients.

The Medicare rebate for patients who see vocationally registered GPs is currently \$25.05. Patients who see non-VR GPs are rebated \$17.85, a rate that has been frozen at 1989 levels. The Red Tape Study Discussion Paper suggests that vocational recognition of general practitioners accounts for over 30 percent of the compliance costs for general practitioners and general practice.

### **A.5.2 Vignettes of cases suggested by literature**

#### **Longitudinal Case study    Increasingly litigious medico legal climate**

Fear of medical litigation has been identified as a major stressor for Australian GPs. The rising costs of medical indemnity have been reported to have substantially contributed to overheads for medical practices. Generally it may change the way that GPs practice in that they may be generous in their use of expensive diagnostics. It has been suggested that doctors are giving up procedural practice on account of the increasing litigious environment.

#### **Longitudinal case study    Red tape in general practice**

The Productivity Commissioner, Helen Owens, has suggested that one of the pressures on general practice is red tape. At a national GP conference in Brisbane in 2002, she quoted a Melbourne journalist, Lawrence Money, who suggested in *The Age*, on Sunday 13th October 2002 under the heading, RED SUNSET:

“The problem is, GPs are being buried in governmental red tape. They hardly have time to see patients. What to do about it? The Productivity Commission has launched a survey of GPs to determine their ‘costs in terms of time, resources and stress’.”

Included in her preliminary observations she noted “that GPs were ill-equipped to provide some information, that there was confusion about remuneration, little delegation occurring in general practice, that Centrelink forms cause greatest frustration and that governments generally made increased use of GPs to control demand and improve quality. She specifically mentioned Commonwealth disability

forms and the PIP as sources of increased work and in her draft discussion paper she adds to those vocational registration.

#### **Impulse case study   Practice accreditation**

In 1992 the RACGP, Australian Medical Association (AMA) and the Commonwealth Government, proposed “that an independent and voluntary system of practice accreditation be developed to enhance the delivery of services and facilities by general practices through a process of continuous quality improvement.”<sup>4</sup>This led, in 1997 to the creation of Australian General Practice Accreditation Limited (AGPAL). Since that time practice accreditation has been linked with the Practice and Service Incentive Programs as well as payments for after hours care (what about EPC items?)

#### **Impulse case study   Blended payments**

In 1998-99, the Commonwealth government introduced blended payments in the form of Practice Incentive Payments (PIP). The PIP, represented an attempt to recognise and reward quality services rather than throughput. Payments to GPs under this type of incentive have been referred to as “blended payments” and have been criticised by the AMA in particular as increasing the workload of GPs by increasing red tape requirements.

In 2003, 75% (4553) of practices were participating in the PIP and of those 3900 signed on for incentive payments for asthma, diabetes and cervical screening. Professor Ian Hickey, Chair of the Committee for Incentives in Mental Health, is reported to have stated that some GPs find certain parts of the three-step mental health initiative “cumbersome”. The Productivity Commissioner has identified the PIP and EPC items as major contributors to compliance costs for Australian GPs.

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<sup>4</sup> <http://www.agpal.com.au/subpage.asp?page=content&Id=6&subId=38> 31<sup>st</sup> August 2003

## **A.6 Documents relating to the interview process**

### **A.6.1 Letter of GP recruitment**

Dr <<Surname>>

<<Address>>

Dear Doctor

General practice appears to be facing a challenging future. There have recently been many regulatory demands placed on GPs at a time when demand on their services appears to be increasing. The capacity for general practitioners to anticipate and manage change may determine the future relationship between general practice and the community, and the lifestyle and work satisfaction of each general practitioner.

As a doctoral student of the School of Health and Behavioural Sciences, University of Wollongong, I am attempting to determine how General Practitioners respond to such change. There is very little knowledge about this process and, as general practice is not uncommonly described as the cornerstone of the health care system, this matter is of importance to GPs and the community alike.

My thesis entitled “How do Australian GPs respond to changes in their non-clinical environment?” will attempt to define areas that GPs may require assistance in the process of change management and to identify areas where further research would benefit the community and their general practitioners.

I am writing to you as one of a maximum of 17 GPs chosen from the Illawarra region to participate in this research. I seek your consent to be interviewed about the changes you have seen in general practice and to describe more closely how you managed one such change.

The interview itself will last one hour at a time of your choosing. The information gained will be treated in a manner consistent with the national and state privacy guidelines. Your participation will be acknowledged in the thesis document. Should you wish to review the findings of the study I will make a document available to you.

This study has been reviewed by the Ethics Committee of the University of Wollongong. Any questions with respect to this survey can be addressed to my supervisor, Prof Don Iverson, Faculty of Health and Behavioural Sciences, University of Wollongong.

I will be in touch with you by phone within approximately one week to answer any questions you may have and to determine if you would be willing to be involved in this interesting study.

Yours sincerely

Andrew Dalley MB BS DRACOG

Please see print copy for  
further details



### **A.6.2 Consent for participation by General Practitioners**

You are invited to give consent to participate in a face to face interview. This would form part of a thesis entitled “How do GPs perceive and manage change?” This study has been reviewed by the Ethics Committee of the University of Wollongong. Any questions with respect to this survey can be addressed to my supervisor, Prof Don Iverson, Faculty of Health and Behavioural Sciences, University of Wollongong.

Your participation is voluntary and you can withdraw from this research at any time. The interview will last approximately one hour and will be tape recorded. The purpose of the tape recording is to provide a record of the interview until such time that the tape is transcribed into a typed document. You will be invited to make comments on that typed document and to make any changes you wish. Once any changes have been made the tape will be destroyed. The typed document will recognise you only as a pseudonym which will bear no relationship to you. The typed document, when not in use, will be stored in a locked cabinet for a period not less than five years. The only persons capable of identifying you will be my two supervisors and myself. Those persons will undertake not to disclose any information about you or your interview to any other person or organisation.

Should you decide to withdraw your consent, you may do so at any time by contacting my supervisor, Prof Don Iverson, phone 4221-xxxx. Should you make notification that you wish to withdraw consent prior to the destruction of the tape all materials about you will be destroyed.

No other participants will know of your participation in this research.

Information derived from this research will be published in my thesis. In addition, information may also be submitted for publication in a medical journal. You will not be identifiable in any publication.

#### **Consent**

I hereby voluntarily agree to participate in a face to face interview as part of the research project, “How do Australian GPs respond to changes in their non-clinical environment?” I understand that the interview will be tape recorded and that I may cease participation at any time. I consent to the information I provide being used in the published thesis and in any other publications which maintain my anonymity.

If I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Complaints Officer, Human Research Ethics Committee, University of Wollongong, telephone 42214457.

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

### A.6.2 Practice type represented by recruited GPs

	Solo	Dual	Medium Partnership	Large Partnership	Medical Centre	Locum
Expected						
Actual	2	5	9	2	1	1

#### Definitions

Solo	Single doctor
Dual	Two doctors
Medium partnership	3 – 5 doctors
Large partnership	>5 doctors
Corporate Medical Centre	Medical practice owned by a listed company

### **A.6.3 Interview questions**

#### **Professional context**

What year did you commence general practice?

Are you a vocationally registered GP?

Do you have any formal qualifications in business (or general practice) management?

#### **Attitudinal context**

1. What do you believe are the strengths of general practice?
2. What do you believe are the weaknesses of general practice?
3. What do you believe you have to offer in your practice as a GP?
4. What do you believe you gain from your practice as a GP?

#### **Historical context**

1. How would you describe how things have changed in general practice while you have been in general practice in Australia?

#### **Case study – generic questions**

##### **a) The GP's interpretation of the change event**

In order to bring a decision about, a need or an opportunity to make that change must be identified. A generic question to identify this is, "What made you change the way you did when you did?"

These generic question was translated into specific questions as exemplified by the case study related to computerisation, viz.,

1. How did you come to notice that computerisation may affect general practice in some way?
2. What effect did you think it would have on you or your practice?
3. Why did you or your practice first buy computers?
4. Why did you decide to change at the time that you did?
5. What things helped or forced you to decide to manage this change?
6. Did you feel comfortable about making these changes associated with computerisation?
7. What options have been considered?

##### **b) The GP's description of actions taken in response to the change event**

This is the process of change, the "engineering phase" of change (Snow, date). I sought here to establish how GPs go about implementing change. How do they communicate their intentions? How do they coordinate their activities? Who does the

work? This section was intended to establish how the change was implemented (Robbins and Barnwell, 1994, p82). A suitable generic question is, “How did your practice go about implementing this change? Translated to specific questions about introducing computerisation, this single generic question became the following:

1. How did you or your practice go about deciding to introduce computers into your practice? Who advice did you seek?
  - What information did you read?
2. How did you or your practice communicate your intentions?
3. How were the staff’s activities coordinated?
4. Who decided who did the work?
5. What did you do to put them into your practice?
  - Training
  - Patient information
  - Who did the work
6. What did you do to protect the computers and their information?

**c) The GP’s interpretation of the effectiveness of the change processes instituted**

This section posed the generic question, “Did your anticipated change do what you wanted it to do?” Translated to specific questions about introducing computerisation, this single generic question became the following:

1. What finally happened as a result of what you intended?
2. How did it differ from what you planned?
3. Why is that?

**d) The GP’s interpretation of how the change affected the practice**

This section moves to issues related to the change event itself. This section posed the generic question, “How did the change affect the way the practice works?” Translated to specific questions about introducing computerisation, this single generic question became the following:

1. How do you think computerisation has affected the way your practice works?
2. How have your attitudes to the way a general practice should be run changed as a result?
3. What would have happened to the running of your practice had you not computerised?

**e) The GP’s interpretation of how the change affected the practice**

Patient care may be affected by change. Some areas in which this may have occurred include the doctor-patient relationship itself, access to general practice services, and continuity and comprehensiveness of care.

This section posed the generic question, “How did this change may affect the way you care for patients?” Translated to specific questions about introducing computerisation, this single generic question became the following:

1. How do you think computerisation has affected the way you can look after patients?
2. (In what ways are patients better or worse off for this change?)
3. How have your attitudes or beliefs toward patient care changed as a result?

**f) The GP’s interpretation of how the change affected the GP herself**

GPs as a group tend to experience low morale. It is important to establish how GPs are coping with change given that many are reported to be considering leaving the profession. This section posed the generic question, “How did this change affect you personally?” Translated to specific questions about introducing computerisation, this single generic question became the following:

1. In what ways do you think that computerisation had an effect on you as a GP?
2. Have your attitudes or beliefs about general practice changed as a result?

In general, what do you think about the use of computers in general practice?

#### A.6.4 Participant rating sheet

##### Impact of change

##### Participant

##### Participant code

On a scale of 1 – 10, rate the impact that the changes that have occurred in general practice as they have had on you as a GP as a person or on patient care and which you have had to manage.

Change	Rating
Introduction of vocational registration (1989)	
Introduction of practice accreditation	
Introduction of quality incentives (EPC, PIP,SIP)	
Feminisation of the GP workforce	
Computerisation	
Increasing red tape burden	
Medical litigation	
Bulk billing	
Other	

(1- very little to none, 10 – large impact requiring major adjustments)

### **A.6.5 An example of one interview**

#### **TRANSCRIPT OF INTERVIEW WITH DR R.A.**

*Q – Dr RA, what year did you commence general practice?*

A – In 19XX.

*Q – Are you a vocationally registered general practitioner?*

A – I've done the fellowship exam, so I'm – I am.

*Q – FRACGP.*

A – Yes.

*Q – Have you any formal qualifications in business or general practice management?*

A – No.

*Q – In what types of practices have you worked as a GP?*

A – In what sort of practices?

*Q – Yes.*

A – Well, when I was doing my training, I had to do three months in a surgery in XXXXXX and then I did three months in XXXXXX. After that, I joined my husband and have been working here since then.

Q – And how would you describe how things have changed in general practice in that time that you've been a GP in Australia?

A – So when I started general practice, vocational registration was already introduced, so I guess I didn't see what it was like before then. In a way, it's a good thing, I think, that they introduced the fellowship exam and insisted on people being vocationally registered, but I think there are a lot of doctors who have been working for so many years and have lots of experience as general practitioners and I don't think just getting that sheet of paper saying they're vocationally registered is going to change anything in their style of treating patients, so that way is ridiculous and unnecessary.

Q – Have there been specific changes you'd like to reflect on in the last 10 years, apart from that it hasn't changed for some GPs?

A – Well, I think just the expectations from the government, you know from Medicare, the HIC and all, is a lot more, I think. They increased the workload of the doctors. There is so much paperwork, so after we see the patients, it's not just the end of the day, we have to sit and do so much paperwork that's unpaid for and I find patients are more and more demanding and expecting a lot more and in the constraints

of the time that we have, it's not possible to deal with every problem that the patients come with and some patients don't like to come regularly and come once a year, but with a list of their complaints, all of them can be quite serious and you can't take no or postpone discussion of those problems.

Q – So you mentioned three interesting parts of life. First of all, the role of the government. What are some of the things that you think the government has introduced to general practice that have impacted on the way that you work?

A – One is the introduction of the PIP and SIP and all those sort of things. I guess the government, the interior I think it's called, especially like, say, for the Diabetes Incentive Payment, I think it's good. It does make doctors, you know, examine patients in a certain way and make sure they are investigated in a certain way and, you know, that their Diabetes is better managed, but in the Asthma management one, I find we have so many patients that come in now, they come in now for the first two parts of the Three Plus plan and then don't turn up for the third, so it's such a waste of time. You spend so much time in the first two, getting the spirometrics done and explaining to the patients and, of course, you tell the patient to come and it just should exclusively for their asthma management, but when they come it's only other complaints, you know need scripts for the pill or for pap smears and things like that.

Q – And you don't feel as though you can carve that bit off and say come and see me again?

A – I feel as if the patient thinks you are just getting them back just because you want to charge them again a bit more. I feel awkward telling the patients to do that, because all these years, you know, sometimes we just do 2-3 things at once and ...

Q – So you're saying that you've been trained under a system whereby you've learned to provide numbers of services according to the patient expectations. You find that difficult to change now.

A – Yes and I feel the patients think we're just getting them back just because we want that extra \$30 or \$40, whatever.

*Q – Have you asked the patients whether that's true?*

A – No, but I find it's so cheap, actually, honestly and I've hardly got any money for those asthma plans, even though I've seen so many patients ...

*Q – Because you've seen them for two visits, but not three visits?*

A – Yes.



Q – Do you find that the fact that you're giving more care has enabled you to reduce your workload? In other words, if you treat somebody with Diabetes well, do you think that that has a potential for stopping them coming in as often?

A – With some patients, yes. Because they feel good and they think they don't need to come for regular checkups.

*Q – Right. But for other patients?*

A – Other patients – again, they may not be well-controlled but they are the non-compliant kind so no matter how much of time you spend, they don't think they need to do their bit, that they're responsible for their health and just don't bother to come even though you've explained to them how important it is for them to come regularly.

*Q – Do they form a significant part of your practice?*

A – Fortunately, no, but there are some.

Q – Who won't take responsibility for their care. You've suggested that consumer expectations have altered as well over the last 10 years. Can you expand on that a little bit for me?

A – I think people, whether it's due to the Internet, or whether it's due to women's magazines or what the neighbours tell them or their cousins tell them, they come with all these explanations for their illness or, just because a relative of theirs had a problem, they think they have the problem and they expect to be investigated thoroughly for that problem, even though they have no signs or symptoms for that.

Q – You're not the first person to say that. How do you feel about being used in that way?

A – I think if they have a doubt and they're really anxious about what they perceive, some sort of condition they think they have, just to allay their anxiety I'm happy to investigate partly and, of course, if there's any indication, I don't hesitate to go the full way, but often you need to spend more time to explain to them that they don't have something, don't have what they think they have, so that takes a lot of time, because you need to be absolutely sure that what you're saying is correct. If they think they have something and they come with a diagnosis and you just tell them it isn't without some concrete evidence, then ...

Q – You've got problems. You said that you do investigations. Would you do that totally out of respect for the patient, or is there some sense that you're protecting yourself?

A – I guess a bit of both, but really I think more for the patient. That is, if I'm convinced that they don't have it, from the symptoms and all, I don't think they have anything, then for the patient's sake, I'm happy to investigate.

Q – And confirm the diagnosis. We're going to talk about some of the litigation stuff and I'm going to give you a brief run-in about that, which starts "Fear of medical litigation has been identified as a major stressor for Australian GPs. The rising costs of medical indemnity have been reported to have substantially contributed to overheads for medical practices. Generally, it may change the way that GPs practice in that they may be generous in their use of expensive diagnostics. It has been suggested that doctors are giving up procedural practice on account of the increasing litigious environment." Dr RA, what made you first become aware of the increasingly litigious medicolegal climate and the fact that it may affect your practice?

A – I think reading about all these sensational incidents all over the country. Reading Medical Observer and Australian Doctor and reading the journal that is put out by the Medical Defence Union. I think that is so frightening, sometimes you wonder if it's really worth continuing practice because it's so easy for things to go wrong if you're not careful and sometimes, unintentionally, you might do everything you feel is warranted but it's always possible for a doctor to have missed something and things are blown out of proportion and then, of course, it just spirals downhill from there. Fortunately, I've never been involved in anything and I hope it never comes to that. But just reading about it is frightening.

Q – You mentioned a number of magazines, three magazines, is that where you get most of your information about general practice and the outside world?

A – Actually, to tell you the truth, I haven't been reading many of these journals recently because, again, I don't find the time for it and reading the bulletin put out by the Medical Defence Union, I find it so depressing. I mean, I find it so interesting and I think it's very educative, but sometimes it's depressing as well, because you think this shouldn't happen. The way litigation is going is just frightening and so I don't like to read it anymore.

Q – So does that mean you do more reading along the clinical lines or you don't do any other reading at all? Do you prioritise the reading that you do?

A – I might read the medicine and Family Physician and that sort of thing.

Q – *You're more likely to read that than you would say Ausdoctor, for example?*

A – I like reading Ausdoctor because I find you get all the summaries of things and up to date and because you don't have to read the whole article to know.

Q – Yes, that's true. That's really interesting stuff. You said that you do everything that you feel is warranted. Does that mean that you change the way that you actually practice, for example do you ask other people's advice? Is it more likely to get support from somewhere else, to get another perspective, or to do more investigations or something like that? What do you mean by you do everything you feel is warranted?

A – *Well, I might do the basic investigations and if I still find I'm not able to diagnose the problem or relieve the patient of their symptoms and I'm happy to refer the patient to a Specialist.*

Q – You're more likely to do that because of the litigious environment, is that something that's changed? Do you see yourself relying on consultant referrals more often?

A – *No, I think it's more for my piece of mind. Not because of the litigation part of it, but just to make sure that I'm not missing something, for the patient's sake again.*

Q – So you've become aware that there's a general move to medico-litigation, you've done some reading. As you started to become aware of it, did you think it would have any effect on your own practice?

A – *Yes, one has to be careful of course. You know that there's no room for error.*

Q – Right, so is this good or bad for you? What does it mean for you that now you know there's no room for error? How does that ...?

A – *It's good in a way, again because you're not missing anything, but it's a big load ...*

Q – It's always there.

A – *It's like the Sword of Damocles hanging over your head.*

Q – So, nothing's ever happened to you, but that sword is always hanging over the head, that's very interesting. Is there a sense of satisfaction, though, perhaps out of doing everything so thoroughly?

A – *Yes, I find a quite a few of my patients come back and thank me for doing what I've done, even though it's not every single patient, lots of patients you do so much and spend so much time, you don't even get a thank you, but the few that come and say thank you, that makes your day and you feel it was worth it.*

Q – What about the care that they get because you're being so thorough now because of litigation, has that benefitted the patients?

A – *I would think so. Again, a lot may take it for granted and not realise, but a lot do. Some patients who have been to other surgeries or who have relatives who have been treated differently by other doctors and they can tell the difference and do mention it. But there's lots that don't bother to acknowledge anything like that.*

Q – Has anything happened with the way that you run the practice or the practice is run since medicolegal litigation has become more common?

A – *Yes, we make sure that when we do any lab tests or radiological investigations, the girls at the front have a list of all the patients who have had, say, a blood test for that day and they check that we have the results, they come in at a certain time and that we've had a look at the results and then we've advised as to what treatment, what follow-up is required, so we always ensure that the girls do that and we are on top of things, same things if we refer patients to other, to specialists, we ensure that the patients keep that appointment. In fact, sometimes we ring them the day before the appointment just to remind them about it, to pick up referral letters from you, so things like that, just to ensure that no-one, say an abnormal pap smear doesn't just go undetected.*

Q – That's amazing. How did you go about getting your staff to work that way?

A – *From the beginning they used to do some amount of it, like the blood results. Actually, when I started working here I made sure that we do it even for radiological investigations.*

Q – When you started working?

A – *Yes, when I started in 1994.*

Q – So you came into the practice with these ideas of how to run it well?

A – *Yes, I think I did make quite a change.*

Q – Is that right?

A – *Yes.*

Q – Very good. So, you had these ideas, you had to talk to your husband about them?

A – *Well, not really. I just tell the girls. He's quite happy to let me do all this.*

Q – Oh, right. So what staff do you have?

A – *We have two girls. One works part-time, so she does four hours a day, Monday to Friday, and the other is full-time.*

Q – And basically they have a role as Practice Managers, Receptionists.

A – *Just Receptionists.*

Q – Who sees themselves as the Practice Manager?

A – *Well, I do most of that.*

Q – Have you trained your staff at all?

A – *Yes.*

Q – How do you train your staff?

A – *Well just from day to day, as required. They actually take Cardiographs as well, the girls have been trained to do the Cardiographs.*

Q – By you?

A – *Yes, my husband actually trained them. I mean, they don't know how to read it or anything, but they take it properly.*

Q – Does that increase their satisfaction with work?

A – *Yes, for some of them, for one of them definitely, because they find they're not just sitting there answering the phone, ticking this and doing that, so it makes it a little more interesting, I think, for them and they feel a part of the surgery.*

Q – Do you have a philosophy in the way you run your practice?

A – *Well, I just like to keep everyone happy, but we are not doing that very successfully at the moment. I've got problems with my other Receptionist and she's actually on stress leave at the moment.*

Q – But it is in the back of your mind that that is how you'd like this practice to run?

A – *Yes.*

Q – That's fascinating. So, at what cost does it come, for example, to maintain a system that makes sure that patients have kept their appointment or that the pathology has all been checked off? What's the cost to the practice and how have you accounted for it?

A – *Well it takes a lot of time because we send reminders to patients. Like, if they need to come in for a second Hep B injection or something, the girls send a reminder to them, so that's postage and stationery, or a phone call. The same for, to remind them of their specialists appointments. Either we make the appointment for the patient, if it's really urgent, or we tell the patients to make it themselves and ring us back and tell us when it is so we have their referral ready. It's all in the appointment book, so we know exactly when the appointment is due and the day before we write the referral and it's kept at the front and when they pick it up, the girls tick it off so we know they've picked up the referral.*

Q – Is this a paper system or is this in the computer?

A – *We use a computer for the pap smears and all, but for the other reminders, it's all, everything's done on the appointment book, so we have a place on top where we write the referrals, like the date of the referral so the previous few days, the girls will get out the notes, get out the referral letter and put it on our desk for us to write and then, once it's written, it's kept in the front, in the drawer in the front.*

Q – So there's a whole lot of time involved in that process. How do you factor those costs into the charges?

A – *Well, you just have to ... it does add to our costs, like I said we spend a lot of money on postage and stationery.*

Q – And you're a bulk-billing practice?

A – *Bulk-billing for every single patient.*

Q – So are there ways that you go about trying to reduce your overheads or to maximise the income?

A – *I mean, with all this PIP and SIP and all, like with the mental initiative, I see, my husband as well, we see so many patients with depression and anxiety and all those sort of problems and I've done the training, but you wouldn't believe it I haven't claimed even for one single patient just because, I spend the time with these patients, but just because I don't it in the format the government wants us to do, I haven't charged even though I might see ... I've got so many patients, everyday I see a patient with depression and I spend lots of time with them, not just a first visit, but a few visits until I'm sure they're on the mend.*

Q – So there is a possibility that you could be improving your income but you haven't yet ... you've chosen not to change your practice to ...

A – *It's just a little bit more a headache doing it all that way. Like I said, I feel because I know I'm doing the right by the patient, I spend the time and help them get better, but just because I'm not doing it the way the government's doing it, I don't feel I should be actually claiming for it and last year I've seen so many patients and even this year, but I haven't claimed a single one. I've hardly got anything for the asthma and the diabetes, I must have got quite a few, but not for the patients. I know the government means well, I guess it's good in theory and it will increase GPs income ...* Q – If they use it.

A – *If they use it.*

Q – And very few are.

A – *Is that correct?*

Q – Yes, very few are organised to do it, for exactly the same reasons. Very interesting. You've done a lot of work out the front, changing your systems, making sure that patients don't fall through the gaps. What options have you considered apart from upskilling your staff and increasing the work that they do, did you consider doing anything else but that?

A – *For what?*

Q – To make sure that your systems work, you know for example, to make sure that patients didn't fall through and someone didn't have a pap smear and things got filed in the wrong place and something like that. You've obviously come in and made some big changes. Did you consider doing anything else?

A – *To improve the running of the surgery you mean?*

Q – No, for example, a lot of people left general practice and went into corporates. A lot of people would have said, I'll take the risk. A lot of people would have said, let's join a bigger practice.

A – *We have been approached by some of these big medical practices several times and the reason why we didn't want to join was, I think it's nice just running a surgery just husband and wife and it has worked out so well with our hours and, you know, there's no misunderstanding or anything like that and I would hate to be in a big practice like that. I don't think you can do the right thing by the patient, ultimately the patients do get the service they need. The only time I think that seems attractive is because of the problem I've been having with one my Receptionists. I wish I didn't have to worry about administration, enjoy working as a doctor, and I wish I could just do that and not have to worry about staffing problems and this and that.*

Q – Is there a sense to which you see yourself primarily as a clinician and that some of this management stuff wouldn't be your choice of work. I mean, do you essentially see yourself as a clinician?

A – *Yes.*

Q – And do you feel as though sometimes that the other work is eroding your time to spend with patients?

A – *Oh, yes definitely. A lot of time and energy is taken into this.*

Q – How does that make you feel?

A – *Just awful, because I feel that, as a doctor, I feel that it's so degrading that I'm having this problem with a staff member and right now, it seems as if she has the*

*upper hand and she's controlling everything and it just makes me feel so – it's so insulting and degrading.*

Q – With respect to lifestyle, you said that you and your husband practice here together. Is that a good thing for lifestyle? Has that helped? Has it hindered? What's it like to ...?

A – *Well, the only disadvantage is that we can't go away on holidays together so it's hard to get a good locum to work, so we've been taking separate holidays. But otherwise, it has all the advantages. We both work just six hours a day.*

Q – Do you work the same six hours?

A – *No, we work separate six hours and we overlap just for 2-3 hours. Because now the kids are older, but previously we just come in and we could pick up the kids from school and then one is at home.*

Q – You describe a system that it would seem you do have to work longer because of the systems you've put in place to make sure you don't miss anything. Does that affect the way you interact with your family?

A – *Well, we do have less hours to spend with them, but at least one of us are at home.*

Q – When you considered these matters of litigation, did you actually go to any professionals and ask their advice or did you talk to any other GPs or anything else, or is it just that this is how you felt about and you were going to do something about it?

A – *Yeah, I really haven't talked to anyone about it.*

Q – Now that you've put those changes into place, do you think they worked?

A – *Yes, I think it has.*

Q – Do you ever review them?

A – *All the time.*

Q – How do you go about doing that?

A – *Just going to check with the girls that it's been done all the time and then are we missing anything.*

Q – I think we've answered most of these questions. What would have happened to the running of your practice had there not been this medicolegal problem. Do you think that you would have had a different kind of practice? If so, how?

A – *I would like to say no. I wish we would have been doing the same thing because I really like doing everything the right way. Again, it's not because of litigation, but because I always feel if a patient comes here it because they have some faith in you and I think you have to do the right thing by the patient, not just for the sake of ...*



Q – I think what I'm hearing you saying is that the system would still be a good system, that you incorporate here, but you wouldn't have that Damocles' Sword hanging over you.

A – *Yes, that added pressure won't be there.*

Q – With respect to the increasing litigious environment, have your attitudes or beliefs towards patients or their care changed as a result?

A – *Again, I think no because I like to trust people. If they say something, I like to take what they say as being the truth. I know my husband's become very cynical over the years and he always feels that people are putting on an act.*

TAPE ENDS

INTERVIEW CONTINUES

Q – You were saying that your husband does ...

A – *I think over the years, he has grown a bit cynical and he always feels patients are just exaggerating, just because they expect more, especially in work-related, people with work-related injury. But I don't know whether I'm being naïve or anything, but I like to, if patients say they have a problem, I like to take their word for it and so it's a bit awkward sometimes.*

Q – Do you think that the medicolegal climate has had any effect on you as a GP, apart from the Damocles' Sword side of life? I think you've mentioned it's taken up more of your time.

A – *Yes, a lot of money, as well.*

Q – A lot of money as well?

A – *A lot of money, because in 2000 when UMP went into liquidation and then they were not going to renew membership, actually my membership ended on 30 May 2000 and I was supposed to renew it in June and UMP said, no we're taking any renewals, but it was on 1 July that the government came to the rescue and they said they'd be covering UMP members. So, for the month of June I wasn't covered. So I had to join another fund and I had to pay over \$2000 just for that one month because they said it's just for that month and then they'll be renewing it in July. But on 1 July, UMP wrote to us again saying they were going to renew membership and this and that, so I told the second fund, I don't need to renew any more, so just paid for that one month and I'll be right now, I'm going back to UMP. And they said, you can't do that, if you want to exit our fund, you need to pay \$4000 or something like that and, so just for that one month I paid more than \$2500 and then UMP I had to pay the renewal fees*

*from July 2000 and I didn't paid that exit fee of \$4500 to that other fund, but that's what they expected me to do and I was not sure what was the most wise thing to do.*

Q – Have your attitudes or beliefs about general practice changed as a result of medicolegal litigation, do you think?

A – *Yes and no. I mean, I like to say no but ...*

Q – Because?

A – *Again, just the threat of, you never know which patient is going to be unhappy with something.*

Q – In general, what do you think about the increasing litigious medicolegal climate in Australian general practice? We've talked about you. What do you think's going on out there, on the national system? Do you have any thoughts about that?

A – *I mean, from what you hear in the papers and in the journals, it seems as if it's increasing, but someone actually, I read somewhere, I think it was a lawyer who said that, actually, the incidence of these sort of cases have not increased, but that's coming from a lawyer, so I'm not sure how correct it is. I was just thinking, with all these cases, the way the judgements are given, the patients are not given any sort of, not held responsible at all for anything that goes wrong and I think that's very unfair.*

Q – The law. Dr R, there's just one last group of questions to do with your own perspectives about general practice. What do you believe are the strengths of Australian general practice?

A – *I think it gives you an opportunity to have a nice relationship with a patient. You develop that rapport over the years ...*

Q – The doctor/patient relationship?

A – *The doctor/patient relationship, yes. It's nice with the way some patients really respect the doctors and look up to their doctors, but then you find, of course, other ...*

Q – We are talking about strengths. Some people have mentioned, and you're in this particular environment, about the relationship between the patients and their family and the doctor. Is that important to you? Is that one of the strengths of Australian general practice?

A – *Yes, I would say so. It's nice to see a whole family come in and often, sometimes, there are so much of problems in the family and it's nice that you can help sort out some of their differences.*

Q – What do you believe are the weaknesses of our general practice system?

A – *I think, especially with Medicare, because patients come here and they're signing a form, I think it's open to abuse. A lot of patients just come here for really silly things that they really don't need to see a doctor and it's costing the taxpayer more, but of course that's how the system is and I know lots of doctors, I'm sure they abuse the system as well, you know get patients to come in more frequently than they need to and I think that's not nice and again that's abuse as well.*

Q – So, it's open to abuse. Are there any other weaknesses at all?

A – *Again, because patients come and sign a form, I think a lot of them don't respect you as a doctor. I think if you pay for what, you respect what you get if you pay for it, even if it's a small amount.*

Q – Can I now ask you about how well supported you feel in general practice? Do you feel that you're given enough support to as a general practitioner? Or do you feel sort of out there on a limb or anything like that?

A – *I think because you are working in a city like this, you don't feel you're out on a limb, there's always the hospital there, or specialists that you can contact.*

Q – What about peer support?

A – *And peer support, but I don't think we really use that much.*

Q – What do you believe you have to offer in your practice as a GP? And you said some of those things.

A – *Well, I like to listen to patients and give them time and I think that's important because I know a lot of doctors, because they feel rushed, they don't spend enough time and every time I remember what our teachers used to say when I was in College, you can diagnose most of the problems just by the history and I find that is so true, if you only listen carefully, you can pick up so many little hints.*

Q – Dr R, you haven't used the word "quality", but looking back over what you've said, that seems to me to be something that you're really trying to focus on. Is that a fair comment?

A – *Yes. That's what I like to do.*

Q – Are you proud of your role as a clinician?

A – *Yes, I think so.*

Q – Are you as proud to be a GP in 2004 than you were in 1994?

A – *In a way I am. I think maybe if you ask me this in a few years' time, my answer might be different, I hope not, but ...*

Q – Why do you think it might be different?

*A – I think as you grow older and you get more and more cynical, I think. I hope I don't become like that.*

Q – What happens as you become more cynical?

*A – Well, I think it affects your practice. You wouldn't want to spend the same amount of time with patients, you just like to rush them out through the door.*

Q – What do you believe you gain from your practice as a GP?

*A – Satisfaction, but like I said, there are moments when you feel frustrated and you know you're not getting what you deserve, you spend more than what you get.*

Q – And my last question, Dr RA, is do you associate any values with the way you conduct your practice of medicine? Any values?

*A – I think it's hard to put a value.*

Q – Sorry, when you talk about it then you'll have forgotten what it way, but a way that you approach. You said, for example, you want your staff to be happy or work well together, I would regard that as a value. Do you have any other values like that that your approach, that you come to general practice as?

*A – I like my patients to feel comfortable when they come to this surgery and a lot of our patients do remark that it's so pleasant to come here and that the staff are so friendly and very understanding, so that's, I think that is very important that there's patient satisfaction.*

Q – And that gives you some sense of satisfaction yourself, some sense of pride?

*A – Yes, sure.*

Q – That's brought us to the end.

*END OF INTERVIEW*

## A.7 Coding frame example

NVivo revision 2.0.163      Licensee: AndrewDalley

Project: Thesis analysis 2 2

### NODE LISTING

Nodes in Set: All Tree Nodes

Created: 18/07/2004 - 12:16:29 PM

Modified: 18/07/2004 - 12:16:29 PM

Number of Nodes: 125

1	Strengths		
1 1	Strengths	GP	
1 1 1	Strengths	GP	Control
1 1 2	Strengths	GP	Longitudinal care
1 1 3	Strengths	GP	Individuality of GP
1 1 4	Strengths	GP	Relationships
1 1 5	Strengths	GP	Training
1 1 6	Strengths	GP	Patient advocate
1 2	Strengths	Patient	
1 2 1	Strengths	Patient	Choose GP
1 2 2	Strengths	Patient	Relationship with GP
1 2 3	Strengths	Patient	Access
1 3	Strengths	Other	
2	Weaknesses		
2 1	Weaknesses	Patient	
2 1 1	Weaknesses	Patient	Access
2 3	Weaknesses	GP	
2 3 1	Weaknesses	GP	Standards
2 3 2	Weaknesses	GP	Workload
2 3 3	Weaknesses	GP	Red tape
2 3 4	Weaknesses	GP	Shortage of GPs
3	Gain		
3 1	Gain	Lifestyle	
3 2	Gain	Relationship with patients	
3 3	Gain	Satisfaction from clinical care	
3 4	Gain	Income	
3 5	Gain	Identity	
3 6	Gain	Relationship with peers	
4	Offer		
4 1	Offer	Time for clinical care	
4 2	Offer	Clinical skills	
4 3	Offer	Experience	
4 4	Offer	Continuity of Care	
4 5	Offer	Access	
5	Values		
6	Changes		
6 1	Changes	Hospital rights	
6 2	Changes	Remuneration	
6 3	Changes	Red tape	
6 4	Changes	Litigation	

6 5	Changes	Government control		
6 6	Changes	Consumer Demands		
6 7	Changes	Computerisation		
6 8	Changes	Education		
6 9	Changes	Manpower shortage		
6 10	Changes	Role erosion by alternative provider		
6 11	Changes	Skills		
6 12	Changes	Work style		
6 13	Changes	Business complexity		
6 14	Changes	Health outcomes		
6 15	Changes	Morale of GPs		
7	GP response to change			
7 1	GP response to change	Action responses		
7 1 1	GP response to change	Action responses	Alter business processes	
7 1 1 1	GP response to change	Action responses	Alter business processes	
	Change of workflow			
7 1 1 2	GP response to change	Action responses	Alter business processes	
	Amalgamate			
7 1 1 3	GP response to change	Action responses	Alter business processes	
	Staffing			
7 1 1 4	GP response to change	Action responses	Alter business processes	
	Communicating with patients			
7 1 2	GP response to change	Action responses	Remuneration	
7 1 5	GP response to change	Action responses	Communicating with peers	
7 1 6	GP response to change	Action responses	Nil response	
7 1 7	GP response to change	Action responses	Reacting against the system	
7 2	GP response to change	Feeling responses		
7 3	GP response to change	Difficulty of responding to change		
8	Impact of response to change			
8 1	Impact of response to change	On the GP		
8 1 1	Impact of response to change	On the GP	Power	
8 1 1 3	Impact of response to change	On the GP	Power Control	
8 1 2	Impact of response to change	On the GP	Work	
8 1 2 1	Impact of response to change	On the GP	Work Variety	
8 1 2 2	Impact of response to change	On the GP	Work Load	
8 1 2 3	Impact of response to change	On the GP	Work Style	
8 1 2 4	Impact of response to change	On the GP	Work Quality	
8 1 2 5	Impact of response to change	On the GP	Work Role as clinician	
8 1 2 6	Impact of response to change	On the GP	Work Role in practice Mx	
8 1 3	Impact of response to change	On the GP	Professional satisfaction	
8 1 4	Impact of response to change	On the GP	Professional dissatisfaction	
8 1 5	Impact of response to change	On the GP	Relationships	
8 1 5	Impact of response to change	On the GP	Relationships Peers	
8 1 5 2	Impact of response to change	On the GP	Relationships Consultant	
8 1 5 3	Impact of response to change	On the GP	Relationships Family	
8 1 5 4	Impact of response to change	On the GP	Relationships Patients	
8 1 6	Impact of response to change	On the GP	Lifestyle	
8 1 7	Impact of response to change	On the GP	GP income	

8 3	Impact of response to change	On the Practice	
8 3 1	Impact of response to change	On the Practice	Practice Mx and the GP
8 3 2	Impact of response to change	On the Practice	Practice structure
8 3 3	Impact of response to change	On the Practice	Regulation
8 3 4	Impact of response to change	On the Practice	Practice systems
8 3 5	Impact of response to change	On the Practice	Practice costs
8 3 6	Impact of response to change	On the Practice	Practice staff
(8 4)	Impact of response to change	On the Consumer	
(8 4 1)	Impact of response to change	On the Consumer	Informed
(8 4 2)	Impact of response to change	On the Consumer	Time costs
(8 4 3)	Impact of response to change	On the Consumer	Quality of care
(8 4 4)	Impact of response to change	On the Consumer	Patient billing
(8 4 5)	Impact of response to change	On the Consumer	Patient loyalty
(8 4 6)	Impact of response to change	On the Consumer	Lack of responsibility
(8 4 7)	Impact of response to change	On the Consumer	Poor access
(9)	Themes		
(9 1)	Themes	Isolation	
(9 2)	Themes	Autonomy	
(9 3)	Themes	Continuity of care	
(9 4)	Themes	Role of education	
(9 4 1)	Themes	Role of education	Role of medical literature
(9 4 2)	Themes	Role of education	Role of CPD
(9 4 3)	Themes	Role of education	Undergraduate education
(9 4 4)	Themes	Role of education	Postgraduate education
(9 4 5)	Themes	Role of education	Non-clinical training
(9 5)	Themes	Relationships	
(9 6)	Themes	Family practice	
(9 7)	Themes	GP need for affirmation	
(9 8)	Themes	Transaction based practice	
(9 9)	Themes	Helplessness	
(9 10)	Themes	Integral part of community	
(9 11)	Themes	Corporates	
(9 12)	Themes	Quality care	
(9 13)	Themes	GPs discriminate in what they will do	
(9 14)	Themes	Workload	
(9 15)	Themes	Finances	
(9 16)	Themes	Role of popular press	
(9 17)	Themes	Govt change without notice	
(9 18)	Themes	Shotgun approach to incentives	
(9 19)	Themes	Standards	
(9 20)	Themes	Change itself	





## A.8 Documents relating to Chapter Eight

### A.8.1 Determinant of business change

	Adopted	Evolving	Non-existing	Comments
<b>Resources</b>				
Technological	Computerisation			Computerisation had impacted business processes much more than clinical processes
Human		Increasing use of clerical staff  Use of accountant professionals	Increasing use of clinical staff in urban practices	Rural participants had utilised clinical staff provided under MAHS funding  Accountants had taken much of the accounting burden from participants because the financial aspect of practicing had become so complex, however accountants were not used for planning purposes.
<b>Incentives</b>				
Regulatory	Practice accreditation			Practice accreditation is the key to many financial incentives

Financial		Use of EPC items		The use of the EPC items was predicated almost entirely on financial incentives
Quality			Evidence of improved patient care	If the evidence for improved patient outcomes existed participants were unaware of it
Lifestyle			Reduction in workload	The new incentives had failed to reduce workload in other clinical areas
<b>Infrastructure</b>				
Micro		Practices becoming larger  Practices becoming more sophisticated		Whilst this had relieved the day to day burden of practice administration, it had increased the complexity of managing the practice.
Macro			Feedback to GPs of quality of care  Blended payment model has same red tape burden as fee for service model	Participants received no objective outcome reports of their patient care whilst regulatory feedback was reported to be oppressive  Whilst patient demand is high, GPs will favour the fee for service model of payment if its claims mechanism is greatly simpler than the mechanism for claiming blended payments.

## **A.9 An Evaluation of the Methodology**

This section seeks to explore areas in which methodology may have been better applied.

### **A qualitative study**

The choice of a qualitative methodology was appropriate in this case. GPs interviewed were involved in an emotive and complex milieu both professionally and personally. This was captured through the use of a qualitative methodology in a way that a quantitative survey could not.

As the field is relatively unexplored, the use of a qualitative methodology also allowed a richness of definition that would lead more naturally onto a larger quantitative study.

Reliability is regarded as a major criterion of a good survey (Bulmer, 1995, p 163). Would another researcher have obtained the same data using this methodology? In the context that participants generally put their opinions with some passion and with a high degree of similarity, it is likely that similar opinions would have been expressed to other interviewers. Two exceptions to this statement are possible. In the first instance, differing outcomes may have occurred with an interviewer who was not a fellow GP and who therefore may have gained greater insights into lifestyle issues. Secondly, the breadth of the interview was sufficiently large to allow any interviewer opportunities to pursue lines of thought that, because of time, I chose not to do so. In this way, other interviewers may have conducted different but not contradictory interviews.

Would another researcher have reached the same conclusions? Perhaps not. Many of my conclusions were reached in consultation with my supervisors Professors Don Iverson and Patrick Crookes and, in particular with my friend and colleague Dr (PhD) David Perkins. Earlier discussions with Dr (PhD) Pat Bazely in my trips to her Research Farm were immensely helpful.

Validity is a major criterion of a successful survey (Bulmer, 1995, p 163). In this study three different sets of case studies were prioritised, that determined by the Delphi group, that determined by my analysis of the literature and that determined by

the participants themselves. The close alignment of the latter two groups suggests a high degree of validity.

### **An emic perspective**

To what extent was I able to “make sense of the world without imposing preexisting expectations or preformulated theories” (Patton, 1990, p 96) as may be expected in an investigator with experiences so close to the investigated? On reflection, I recall many times when I was “surprised” at what was said in the interview. This suggests to me that I was open to being surprised. There were, too, times when I was excited by new paradigms, new ways of seeing things. Thirdly, there were the times of reflection with my supervisors who are not medical practitioners in which we would identify the same insights or build on each other’s.

Was there any effect, then, on the thesis by my own general practice background? The answer is, I believe, without a doubt. Very few GPs refused interview, though more failed to return calls and were not interviewed. The interviews were relatively relaxed with participants appearing keen to discuss the cases, perhaps reflecting participant assumption of contextual awareness by the interviewer.

### **The Delphi group**

The Delphi group was key to the selection of case studies. Oracle selection and function was critical to the definition of satisfactory case studies.

#### **Selection of the Delphi group members**

Nomination of Delphi members was made by a Professor of Community Medicine known to the researcher. Without a “lead agent” identifying willing oracles recruitment may have otherwise have been a daunting prospect. The group members were blind to each other and were cooperative for the requirements of the study. It is interesting to note the relatively small number of potential Australian oracles that seem to exist with a background of academia and general practice.

#### **Function of the Delphi group**

The Delphi group functioned well in that all members replied within certain periods of time, but well beyond the week requested of them. For research or grant applications conducted in a tight time frame this delay would have presented a significant obstacle.

### **Use of a Delphi group for case selection**

The use of an expert group appears to have produced biases in case selection. Unlike some expert groups which may consist of “craft persons”, academic GPs are not necessarily technical experts. An examination of the Delphi group responses indicates an appreciation of change at a much higher level than that of participant GPs. For example, the argument that feminisation of the workforce has been responsible for a highly significant change to Australian general practice with implications across the nation is not difficult to justify. However, at the local level few practicing GPs would attribute an association between feminisation of the workforce and increasing workload. It is interesting to note that the two most significant changes reported by GPs (litigation and red tape) were not even rated in the top five changes by the Delphi group. This is likely to be due to the fact that less exposure to general practice may have rendered the Delphi members to a less exposure to red tape and concerns about litigation, particularly where those GP academics worked in relatively protected training practices.

A focus group of active GPs may have produced a more valid set of case vignettes (for the purposes of a study such as this) at an earlier stage. However, a focus group would have been significantly more difficult to organise and certainly more expensive. As events transpired, the combination of Delphi-determined case studies and literature-determined case studies provided an adequate list for practicing GPs to validate themselves.

### **Conduct of the Delphi Group**

One major advantage of the ad hoc electronic meeting was that e-mail was used by the oracles during the conduct of a round for the purposes of elaborating areas of uncertainty. However, it was not uncommon to wait several weeks before receiving a reply from an oracle, thus negating one of the most important attributes of e-mailing, viz. speed. A second advantage was that of being able to store replies in electronic format, rather than transcribing recordings.

The above notwithstanding, the use of a Delphi group has allowed a broader examination of change in general practice and the thesis is richer for this. However, it has become apparent that a more effective means, as evidenced by the rating of GP

participants, of producing a prioritised list of changes was to refer (somewhat exhaustively) to the literature.

### **The use of case studies**

Case study vignettes were the nidus of the interview and gave the GP participant a catalyst for an enthusiastic discussion. As a motivator for discussion, therefore, the case study appears to have been a valid instrument, given that the participants were allowed to address a vignette high on their own agenda. This implies that a range of case studies is a valid technique for gaining enthusiastic participation of the interviewee. However, Bulmer comments that “case study methods tend to be weak in relation to (generalisability )” (Bulmer, 1995, p 163). The decision to employ a range of case studies to give a broader picture would seem to have weakened Bulmer’s argument against generalisability.

### **Number of case studies**

It is self-evident that the broader the range of vignettes the more diluted the findings without a compensatory increase in the participant population. The technique of excluding all but the five most highly prioritised case studies at the completion of the first ten interviews overcame this dilution factor.

### **Specificity of case studies**

Case studies fell into two categories, viz., impulse and longitudinal changes. The rationale for case studies of longitudinal change was that any practicing GP would have experienced these on-going changes, whereas one had to be in practice at a particular point of time to experience impulse changes, which by definition were those that occurred at a single point in time.

It has become apparent that case studies of longitudinal change were not sufficiently specific enough in order to gain a good understanding of the participant’s response to the change, as responses tended to be diluted by an evolutionary effect. The impact of the change on the GP however was not affected with participants able to graphically describe impacts of change in dramatic detail in some cases. It therefore appears that longitudinal studies are sufficiently specific to determine impact of change but not the response to change.

### **Bias produced by the case study itself**

In reading the case study to the GP there was a potential source of bias in that GPs may have been induced to accept an argument they may otherwise not have considered, and they may carry those same arguments into the interview. In other words, the case study vignette may have influenced the responses of the GP to the subsequent interview questions.

### **The use of a number of specific case studies to give a general picture**

In adopting Stake's position (3.6.1), it was intended that examination of a GP's response to change could be generalised from an examination of responses to a small number of changes as illustrated by case studies. The work of Milton et al might suggest that this is an oversimplified, though accurate, approach. They suggest, for example, that in this instance, a GP's response to a change in the environment is more likely to be determined by "learning from past experiences" rather than by the change itself (Milton et al. 1986, p22). And attitude, a determinant of behaviour (in this case of response) they suggest, has a "high degree of stability or consistency (ibid, p 28). This would support the hypothesis that responses as described in the analysis of change represented by the case studies are generalisable.

### **Validity of participant prioritisation of change events**

A list of eight case studies was presented to all GP interviewees in order to determine which case study was to be discussed with that GP and also in order to produce a list of case studies prioritised by the GPs themselves. However, it is possible, if not likely, that the list of cases failed to define the significance of the case studied. For example, literature suggests that "feminisation of the workforce" has two major effects. It reduces the available workforce and may interfere with longitudinality of care. (It may be also possible to argue that it improves quality of care whilst reducing patient access.) None of these meanings are obvious in the term "feminisation of the workforce" but all may be implied. Indeed, it may be that participants may have misunderstood the meaning of this term by using it relative to their own context, i.e. whether or not there was a female GP in the practice or in competition.

## **Participant numbers**

The data gathered in the twenty interviews painted a rich and logical picture. In turn the data have helped to identify further areas of research which appear valid and logical. Participant numbers would therefore appear adequate.

## **Use of the semi-structured survey**

The survey questions, particularly as they related to the case studies, were used as a guide only. The questions would often be answered in discussion around the topic before the questions could be formally addressed in the process of the interview. Of more importance were the headings which became visual clues as to areas requiring further exploration.

## **Verification stage**

To some extent the verification case study (Medicare Plus) was not a valid comparator as some GPs required little thought or effort to implement it. This was equally true for bulkbilling in the cases where GPs philosophically or for other reasons wished to pursue this activity. Indeed, for GPs who were already bulkbilling, the benefits of Medicare Plus were significant without any recognisable disadvantages. On the other hand, in the case where a GP was privately billing, Medicare Plus represented a past now abandoned. As no better comparator was available, the verification stage was abandoned.

## **Conclusion**

The methodology employed was adequate for the task. Improvements would have included the use of a focus group of active non-academic GPs to determine the case studies. However, a study of the literature produced a pleasingly accurate reflection of the prioritisation by the GPs involved.