

What General Practitioners Find Satisfying in Their Work: Implications for Health Care System Reform

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ABSTRACT

PURPOSE We sought to explore general practitioners' satisfaction with their patient visits and the congruity between this satisfaction and new models of practice, such as those implicit in the new general medical services contract in the United Kingdom.

METHODS We undertook a qualitative study using audio recordings of patient visits and in-depth interviews with 19 general practitioners in Lothian, Scotland.

RESULTS Doctors' reports of satisfying and unsatisfying experiences during consultations were primarily concerned with developing and maintaining relationships rather than with the technical aspects of diagnosis and treatment. In their most satisfying consultations, they used the interpersonal aspects of care, in particular their sense of knowing the patient, to effect a successful outcome. Success was seen in holistic terms—not as the prevention, treatment, or cure of a disease, but as restorative of the person. Positive experiences were implicated in maintaining their identity as "good" doctors. Negative experiences sometimes challenged this identity, and doctors resisted this challenge by finding explanations for unsatisfactory experiences that distanced themselves from their source or cause.

CONCLUSION The attributes of a satisfying encounter found in this study derive from a model of practice that prioritizes the distress of patients, which cannot be measured, above the technical and quantifiable in diagnosis and treatment. Preoccupation with that which is technical and measurable in health care system reforms risks defining a model of practice with purpose and meaning not congruent with doctors' experiences of their work and may result in further destruction of professional morale.

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INTRODUCTION

In the past 15 years the United Kingdom has undergone radical change in the management and delivery of general practitioner services. These changes, organized around new contracts between doctors and the National Health Service (NHS),¹ have been paralleled by shifts in the rhetorical focus of general medical practice. First, there has been a move away from a physician-centered model of practice in which professional knowledge and authority took precedence toward a patient-centered model of care.^{2,3} Second, evidence-based medicine has replaced clinical experience as the dominant rationale for choice of therapies.⁴ As a result, clinical care is more explicit for patients and more routine for doctors, with individual physicians supported, and sometimes disciplined, in their application of evidence-based solutions to clinical problems by decision-support tools, such as guidelines.

These changes imply that best practice is constituted by the patient's view of quality⁵ and externally defined clinical and organizational qual-

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ity indicators. This approach is not a problem for doctors if the primary purpose of clinical practice is to satisfy and empower patients; if quality in clinical practice is standardized, homogenous, and quantifiable; and if doctors find their work meaningful and satisfying. High achievement in quality and outcomes (Table 1) during the first year of the new general medical services contract in the United Kingdom suggests clinicians can be motivated to integrate this model of care into their practice. The underlying assumptions of this approach, however, pay little attention to doctors' preexisting values, beliefs, and expectations or to the context in which primary care consultations take place. Continuing and personal responsibility for patients for extended periods has been central to general practitioners' work during the last 50 years in the United Kingdom. Furthermore, general practitioners have long recognized interconnections among the physical, psychological, and social aspects of their patients' ill health, and have acknowledged that objective biomedical technologies alone are often insufficient to alleviate patients' suffering. In this context, the ongoing intimate relationship between doctor and patient has been seen as therapeutic in its own right—a notion that serves to highlight the personal investment made by general practitioners in their clinical work.

In this article, we use general practitioners' accounts of satisfaction with clinical encounters to explore what is meaningful in their work. We use our findings to discuss the potential impact of policy interventions, such as the new general medical services contract, on doctors' professional fulfillment and sustainability of their work.

METHODS

To examine how general practitioners obtain satisfaction from their consultations, we undertook a qualitative study involving audio recordings of consultations and semistructured interviews with 19 general practitioners. This study was conceived and conducted before implementation of the new general medical services contract in the United Kingdom in April 2004. The study received local ethical committee approval.

The doctors were recruited into the study after a personal telephone call from the first author. The sample was a maximum variation sample. Nine doctors were female; 10 were male. They had been practicing general practitioners for between 2 and 29 years, and their ages ranged from 30 to 55 years. One doctor worked single-handedly, the rest worked in group practices of 2 to 9 doctors. Sixteen of the 19 doctors were partners in the practices in which they worked. The practices were in areas ranging from great socioeconomic disadvantage to affluence.

Table 1. Quality and Outcomes Framework

- Reflects ethos that higher quality care is most likely to be achieved through use of incentives
- Practices can receive additional funding to reward achievement of range of quality standards
- Higher standards are rewarded with incrementally higher rewards
- Four domains in framework
 - Clinical: 10 disease areas
 - Organizational
 - Additional services: cervical screening, child health surveillance, maternity services, contraceptive services
 - Patient experience
- Quality indicators in each domain are evidence based

The participants were invited to record between 25 and 30 office visits with consecutive consenting patients. They were then asked to score each consultation according to how satisfying they found it on a scale of 0 to 10, where 0 was maximally dissatisfying and 10 maximally satisfying. Audiotapes of all encounters were analyzed by the first author, and notes were made on the content of the 2 most satisfying, the 2 least satisfying; 2 additional consultations were chosen at random for each participant. These consultations formed the basis of an in-depth interview conducted with each participant within 1 week of the recorded encounters. The purpose of the interviews was to clarify the details of each doctor's 6 consultations and to elicit and discuss those issues that were important in contributing to the doctor's satisfaction with each encounter (Table 2). Interviewees were given the name and age of the patient whose office visit was to be discussed; if they were unable to recall the details of the encounter accurately, the researcher's notes were used to stimulate recall. These interviews were tape-recorded and transcribed verbatim. Verbatim extracts from transcripts are reported in this article with names changed to protect confidentiality.

We focused our analysis around the development of propositions that explained how and why general practitioners derived satisfaction from their consultations. We then analyzed the data by means of constant comparison.⁶ Initial data analysis was contemporaneous with later data collection.

We read transcripts of the initial 5 interviews and identified emerging themes and patterned ways of accounting for the experience of the consultation, eg, knowing the patient, evaluating the patient, and success of the consultation. The timing of the study meant that references to the new general medical services contract did not feature in the interview data. Data collection in later interviews allowed us to explore the emerging themes in greater detail. At the end of data collection, we read all transcripts and agreed upon and

categorized the final themes within the data. After the first author applied category codes to the data, we then examined excerpts of data coded to the same category within and across transcripts to identify the properties of each category. We devised a properties' coding scheme, which the first author applied to 5 transcripts. The second author reviewed and approved the coding of these 5 transcripts, and the first author then applied the coding scheme to all transcripts.

In this article, we describe the broad ways of accounting for the experience of consultations that emerged from the data and interpret and discuss these findings in the context of implemented and proposed health care reforms.

RESULTS

The major factors influencing the satisfaction doctors derived from consultations were the perceived outcome

for the individual patient, the interpersonal relationship between doctor and patient, and the impact of the experience of the encounter on the doctor's identity.

Outcomes of Office Visits

Doctors' satisfaction was related to the perceived outcome of the consultation. Most satisfying were encounters in which the doctors perceived successful outcomes. Although the doctors expected to be competent, accomplishing technical diagnostic or therapeutic tasks was rarely seen as satisfying in itself. Doctors saw "making a difference" or "moving things forward" for an individual patient as signifying a successful outcome. It was clear they perceived successful outcomes, not as the prevention, treatment, or cure of a disease, but as restorative of the person. As 1 doctor said:

"I knew that having been to see me would have a good effect on him and that he would go home thinking, 'Right, I feel happier.' I felt there was something else I had contributed to him, the contact had been worthwhile" (General practitioner [GP] 1).

Interpersonal Relationship

Doctors typically reported feeling satisfied when they had practiced a style of medicine that values the interpersonal relationship between doctor and patient.

The opportunity for the doctor-patient relationship itself to be instrumental in improving the patient's well-being meant doctors often compromised on evidence-based practice to preserve their relationship with the patient.

Compromises, however, left some doctors feeling disquiet about their actions. In the extract below a doctor describes a consultation in which she had prescribed the antiviral drug acyclovir for a patient (Sandra) with a history of cropping mouth ulcers that had been previously treated with acyclovir. The patient had requested a further course of the same treatment.

"I suppose she'd had, by the sound of it, a primary herpes, which you're only going to get once. But you don't necessarily understand everything that's going on, and I didn't think it would be fair [to not prescribe]. I think she's under a lot of stress at the moment as well. She's got wee Caitlin, who has recurrent urinary tract infections and strange symptoms, and Sandra's not really herself at the moment, in general, so I think I wanted to kind of get her onside so that if she did feel like coming back with more, then she would. I thought I had to give her the tablets to do that" (GP 3).

In contrast, greatest satisfaction seemed to derive from consultations in which doctors perceived they personally had contributed to a successful outcome by deploying personal attributes in addition to formal medical knowledge and technical skills. This doctor says:

Table 2. Interview Guide

Section 1: Personal information

1. Personal details
 - a. How long have you been qualified as a doctor?
 - b. How long have you been a GP?
 - c. Postgraduate training?
 - d. Why did you decide to become a GP?
 - e. Can you tell me which practices you have worked in as a principal?
2. Personal interests and motivations
 - a. Can you tell me why you decided to become a partner in /work in this particular practice?
 - b. What do you find particularly interesting in medicine?
 - c. What if any, are your particular interests in general practice?
 - d. Can and how do you pursue those interests?
 - e. What do you "look for in a patient" to satisfy you?

Section 2: For each consultation

I am interviewing GPs about what they find professionally fulfilling/satisfying in the consultation and why it is satisfying/fulfilling. You identified this consultation as either most satisfying or least satisfying, or neither maximally satisfying nor maximally dissatisfying.

1. Can you describe the content of the consultation to me?
 - a. What in particular was rewarding/unrewarding about this consultation?
 - b. What do you think was going on here?
 - c. Why do you think you as an individual found it rewarding/unrewarding/neither?
2. Can you identify any personal characteristics that meant you found this consultation satisfying/unsatisfying/neither?
 - a. In what circumstances, if any, would this consultation be less/more fulfilling?
3. Can you recall a time when you wouldn't have found this consultation less/more fulfilling?
 - a. Experience?
 - b. What would you need to do /what would need to happen or change to make this consultation more satisfying?
 - c. What would the patient need to do?
 - d. Are there external factors?

"I felt there was definitely some possibilities of getting somewhere. I felt I was the right sort of person to be seeing this woman, and I was more likely to be able to get somewhere with her than certainly any of my colleagues ... partly (because of) my experience, both in medicine and previously.... I feel very comfortable with the messy sort of complicated psychosocial problems. I've got a large amount of experience of them, and a lot of different angles that I can sort of employ" (GP 15).

Doctors often attributed perceived lack of success with consultations to difficulty accessing the patient's agenda in the consultation or failure to reach a shared understanding of the patient's problems. Frequently they used their evaluation of the moral status of the patient to account for these failures and perhaps to justify their own actions. Patients who described personal, social, or spiritual suffering in physical terms often had their moral status questioned, particularly if they had difficulty cooperating with psychosocial inquiry. On these occasions, despite envisaging psychosocial causes for patients' problems, doctors frequently felt pressure from patients to provide unwarranted biomedical explanations and solutions.⁷ In the following extract the doctor is describing a frustrating consultation with a woman who makes frequent office visits complaining of somatic symptoms.

"She has a dependent personality and is very juvenile, manipulative to an extent, but mainly dependent....When she is having a bad time, she comes in with these 'I've got pain everywhere' kind of symptoms, and 'I'm taking everything that any doctor has ever thought might be helpful for this condition. None of it works, so therefore you have to think of something new.' And she was in that kind of mood that day. She was demanding something completely new, completely different, given that I had already tried everything that was medically feasible for the kind of thing she was talking about, and she was presenting with things that were unclassifiable—pain everywhere, total distress. She knows that I think most of her problems are psychological, but at the same time she holds on very firmly to the physical model, and I found that more of a strain than usual in that consultation. So I fiddled randomly with some drug—I did some subtle minor change in her drug treatment, which was not very necessary. She will usually accept some minor alteration and go away reasonably happy" (GP 1).

That doctors appear to feel more satisfied when they were able to respond to such patients in ways that met the patients' perceived needs, not their requests, raises questions about the legitimacy for doctors of patients evaluating the quality of consultations.

The expectation that general practitioners can and do know their patients was striking and appeared to

be crucial to doctor satisfaction. Knowing a patient, however, was not necessarily based on the doctor's factual knowledge about the patient. Instead, it was based on a sense of knowing the patient as a person, which was founded on a contextual interpretation of the facts about the patient, with the doctor relying on a wider understanding of the patient's behavior and cognitions to emerge within their interactions.⁸ Knowing the patient as a person rather than as a clinical case seemed to facilitate meaningful therapeutic action, and as discussed earlier, perceived therapeutic usefulness was crucial to doctors' positive experiences. As this doctor says:

"Even with a fellow like that, who had certainly had a depressive illness, and he's probably past that now, his major problems lie in his confidence about his own self and finding a direction. He's going through a kind of midlife crisis, because he's this age, he's single, he's wanted a wife, he's wanted children, and he feels he's well past all that stuff now. So you're trying to find ways of him coping with that bit of life he is in at the moment, which aren't hard psychology-behavioral cognitive stuff—but neither are they about taking tablets and this will make you better. So it's trying to find ways that suit him as an individual to get better" (GP 11).

Doctors' Identity

Doctors' sense of themselves ran through their accounts of consultations and was important in determining their satisfaction with encounters. Although clinical competence was an integral part of the doctors' satisfaction, they alluded to personal attributes that contributed to their individual identity as a doctor. This identity seemed to encompass the values underlying their actions within the patient encounter and influence their performance expectations.

The consultation experience appeared to open the doctors' identity to scrutiny and potential maintenance, challenge, or modification. Mostly the consultation experience allowed doctors to maintain a coherent sense of themselves as doctors, and generally these consultations were satisfying. In the extract below, the doctor is describing how he helped the patient understand the link between psyche and body. His actions also maintained his identity as a doctor who has particular strengths.

"The meat of it was that he was someone who was presenting a series of physical symptoms and wanting to make sense of how they came about. I always find those very satisfying, I like doing that. It can be quite a difficult job. Sometimes making the connection between a real physical symptom—like a cramp, gut ache—and stress can be quite hard. I mean, there are lots of cultural things, like if you are saying it's stress, then they are imagining it, and you've got to overcome

that and help them understand how the way they feel can produce quite measurable physical symptoms.... I think it's my strength, particularly that kind of consultation" (GP 16).

Conversely, when the consultation experience challenged a doctor's sense of self, the consultation was often dissatisfying. In their accounts of these office visits, doctors often distanced themselves from the source or cause of dissatisfaction by using negative moral evaluations of patients and contextual factors, such as lack of time. For example, this doctor is reflecting on why she had found dissatisfying a consultation in which she had adopted a narrow biomedical approach to the patient's problem.

"I was forcing myself to be the kind of doctor that I wouldn't ideally be, which is what you have to do when you're under time pressure" (GP 8).

Consultations can be seen, therefore, as part of an ongoing process through which doctors sustain a reality of who they are professionally and that allows them to experience their work meaningfully.

DISCUSSION

In this study, we explored general practitioners' consultation experiences to understand further what they find satisfying in their work. Most research examining doctors' satisfaction with their work has used survey methods. We believe our approach of using taped encounters as a focus for interviews based on detailed knowledge about specific cases affords deep insights into what sustains doctors in their work. The interviews were conducted by the senior author, whose work as a practicing general practitioner not only provided context for the study but also was a source of preconceptions about what doctors might find satisfying. For example, the emphasis on communication and patient centeredness in writings about the process of the general medical consultation and in postgraduate general practice training led to preconceptions that the perceived technical quality of the communication between doctor and patient would be a source of satisfaction to doctors. Analysis, however, suggested doctors used their global evaluation of the quality of the relationship between themselves and the patient more than a microlevel evaluation of the quality of the communication to explain their satisfaction.

Relatively small number of general practitioners took part in the study, and those who eventually participated were to some extent self selected—many others who were approached declined the invitation to participate. It is possible, therefore, that the doctors' experiences and their responses to them are not typical of the wider general practitioner community.

Nevertheless, this study confirmed above all the centrality of relationships in giving meaning to general practitioners' everyday work—a finding that replicates those findings of Horwitz's narrative analysis of what US internists find meaningful about their work.⁹ In this study, the relationship between doctor and patient mediated the content and the outcome of individual consultations. This finding contrasts sharply with interactions in most other medical disciplines, where the content—in particular the common signs and symptoms and diseases encountered, as well as the technologies used to address them—mediates the relationship between doctor and patient.

The structural features of primary care in the United Kingdom (for example, a registered patient list) have done much to frame the nature of the doctor-patient relationship. Changes in the structural features of primary care, such as those contained within the new NHS general medical services contract and within other UK governmental proposals to widen access to primary care, threaten to undermine this relationship. If clinical care is essentially episodic, the doctor-patient relationship becomes a series of loosely connected interactions, and the relation of each to the other might not be clear. In such a system, meaningful engagement between doctor and patient is more difficult to achieve, and the therapeutic potential of the doctor-patient relationship—so important in this study—may be dissipated and result in long-term consequences for the quality of care. Furthermore, the work required of doctors may not be congruent with their values or with the foundation on which their professional fulfillment is based, potentially leading to disaffection and disillusion. The challenge in any reform of health care, therefore, is to ensure that new conditions of working do not inhibit the development of meaningful relationships between doctors and patients.

This study also shows the importance of 2 other relationships in determining doctors' satisfaction with their work. First is the relationship the doctor has with him or herself, that is, his or her sense of self as a doctor. Second is the way in which the doctor relates to what constitutes good practice and adopts it as the basis of everyday work. To some extent these 2 relationships are intertwined.

The relationship between the doctor and his sense of self is dependent upon and influenced by the events of the patient encounter. Competent practice is a moral imperative for doctors; however, doctors in this study sometimes struggled to reconcile biomedical best practice with the requirements of interactions suffused with complex contextual considerations. These doctors protected their sense of self as competent practitioners by reevaluating biomedically questionable actions as

judicious and responsible in the unique context of the individual patient. The root of their discomfort in so doing arises from an externally imposed view of the consultation as an objective reality that can be identified and evaluated but which doctors cannot always sustain. Organizational arrangements that reinforce and reward the measurable, technical aspects of care—such as the quality and outcome framework in the new general medical services contract in the United Kingdom and pay-for-performance initiatives in the United States—may, in fact, challenge doctors' sense of self as competent practitioners.

Identifying and maintaining a sound knowledge base and discernible philosophy is important if general practice and family medicine are to sustain claims to disciplinary identity and professional status. The Future of Family Medicine project in the United States¹⁰ has recognized this importance in its new vision of the role of family medicine within the health care system when it put patient-centered care at its core. In the United Kingdom the empirical, conceptual, and policy writings about general practice of the last 50 years have done much to define general practice. Nevertheless, attempts to delineate the core activities and values of general medical practice have rarely taken as their starting point observations of what general practitioners find meaningful in their work. As a result, the link between these definitions and the experience of everyday work has not been straightforward, and the relationship between doctors and the discourse about practice has often been uneasy. Systems of care that emphasize standardized clinical care as a means to improving population rather than individual health are unlikely to resolve these tensions. Indeed, they may exacerbate them.

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