“I’m a doctor for God’s sake” The GP as Manager: A Multi-Theory Perspective

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DECLARATION

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law or copyright, and has not been taken from the work of others save to the extent that such work has been cited and acknowledged within the text of my work.

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DEDICATION

This dissertation is dedicated to the memory of my father, Dick O'Riordan. Dad passed away unexpectedly on the same day that our daughter, Tara, was born. He was a man I admired and respected greatly, and someone that I learned much about life and the importance of values from. One of our last conversations was about philosophy, so it is very apt and appropriate that this work should remember him. Dad, we miss you terribly and wish that you were still with us, but we know that you are watching over us and keeping us safe. Thank you for being a wonderful father, friend and a personal hero.

"To live in hearts we leave behind, Is not to die"
From 'Hallowed Ground' by Thomas Campbell (1777-1844)

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ABSTRACT

"I'm a doctor for God's sake"
The GP as Manager: A Multi-Theory Perspective

Chris O'Riordan

The primary care sector is nationally and globally recognised as being important in the efficient and effective delivery of healthcare. A key component of this sector is the General Practitioner, or GP. As a clinical professional, the GP has a traditional focus on the needs of patients. While this may constitute their primary role, GPs are also in business, creating other needs as well. Therefore, the GP – and owner specifically – is not just a clinician but is also a business manager. While previous studies have examined this latter role empirically, further theory-informed research is needed to acquire a deeper understanding of both the role itself and the context within which it exists.

This study is based on semi-structured interviews with 35 GPs, thematically analysed and underpinned by literature from management, professions and role theory. The research finds that GPs manage principally at an operational oversight level, where the owner is a dominant force and in close control though potentially lacking in formal management training. While supports exist, and are valuable, they appear to be underutilised in a management capacity. Role conflict can be experienced by those GPs with managerial responsibility, as they seek to balance expectations stemming from organisational and professional demands. A lack of time compounds their difficulties in this respect, potentially giving rise to role overload and the need for some compromise. In seeking to understand what underlies the work performed and the conflicts encountered, the study also identifies a number of key influences.

Contributions from this research include a more theory-based, empirically-informed understanding of the managerial role in a professional context, and a consideration of the value of such a role where resource constraints are salient concerns. In addition, the study highlights the need to consider how Organisational-Professional Conflict is conceptualised, and adds to the debate surrounding whether doctors are altruistic or self-interested. Practical implications for general practice are also identified, including the need to reconsider the role of practice managers and to address the capacity for new GPs to apply their training in a management context.

LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
DCU	Dublin City University
DOH	Department of Health
DOHC	Department of Health and Children
GMS	General Medical Services
GP	General Practitioner
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
IMO	Irish Medical Organisation
JD-R	Job Demands-Resources
NAGP	National Association of GPs
NCHD	Non-Consultant Hospital Doctor
NHS	National Health Service
OHM	Office for Health Management
ORT	Organisational Role Theory
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
STC	Special Type Consultation
SWOT	Strengths, Weaknesses, Opportunities, Threats
UHC	Universal Health Care
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

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Chapter One

Introduction

Chapter One: Introduction

1.1 Introduction

The overall objective of this study is 'To determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role'. A feature of international healthcare policy has been the contention that doctors should be more active in management (Riordan and Simpson, 1994; Hoff, 2001; Clark, 2012), raising the relevance of joint clinical-management roles. In secondary care (i.e. hospitals), the clinical director position (Dickinson and Ham, 2008) is well established. However, less attention appears to have been devoted to clinical-manager (or ‘doctor as manager’) roles in primary care, and within general practice specifically. This is notable given the policy emphasis on primary care nationally (Department of Health and Children (DOHC), 2001), where 90-95% of health needs should be met (Department of Health (DOH), 2012), and the levels of public spending on the sector. According to the Health Service Executive (HSE, 2013), total 2014 government spending on primary care in Ireland will be €3.16 billion. This amounts to 24% of total estimated public health expenditure, without taking account of private spending by individuals.

The clinical-manager role is founded on the argument that enhanced medical engagement in management may have beneficial outcomes for multiple stakeholders (Thorne, 1997a; Llewellyn, 2001; Dickinson and Ham, 2008), such that clinicians as managers can be a valuable organisational resource (Dunham *et al.*, 1994; Hoff, 1999a). It must also be acknowledged that any such management role exists in addition to the traditionally defined core clinical/patient role, which represents the GP's primary focus (Gregory, 2009; World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), 2011). Therefore, occupying a ‘hybrid’ role (Kippist and Fitzgerald, 2009) can present challenges (Willcocks, 1994; Schneller, 2001; Hallier and Forbes, 2004). In this regard, while the clinical-manager role may lead to beneficial outcomes for patients, it can also have significant and potentially negative implications for the role occupant and others.

This chapter provides an introduction to the current study. Initially, a summary overview of the context of this research is presented. The case is then made for the relevance of research in primary care/general practice, before focusing on the specific research gap identified in this study. Justification for the research is presented, from both a theoretical and practical perspective. Stemming from this, the research objective and research questions are outlined. A short rationale for the methodological approach adopted is then presented. The chapter concludes with a summary of the key contributions being made by this study and an overview of the dissertation structure.

1.2 Context for the current research

The context for this study is the GP, with a particular emphasis on the Irish system of general practice (though also incorporating international literature where appropriate and relevant). While a detailed review of this context is provided in Appendix A, Table 1.1 below produces a summary of the key points raised in the appendix.

The structure of Irish general practice
▪ GPs are either owners or non-owner employees; non-owners can have limited involvement in practice decision-making and management ▪ Ancillary staff are also employed, including practice managers ▪ There has been growth in the size of Irish practices, with a move towards partnerships/group practices
Remunerating GPs for their services
▪ Depending on the economic status of the patient, GPs are paid per visit by the patient ('private') or by the State as capitation ('public'); the majority of patients are 'private' ▪ Universal Health Care (UHC) is due to be introduced by 2016, whereby all patients will have free GP care at the point of delivery, paid for by the State
Working hours and GP co-operatives
▪ GPs are known to perform administrative tasks at home ▪ Working hours for GPs appear to be less than those typically required of hospital doctors, which is an attraction of general practice ▪ Out-of-hours demands on GPs have reduced considerably, arising from the establishment of regional co-operatives (rota arrangements)

Defining the role of the GP

- The role of the GP, as primarily a clinical professional, is regarded as clinical and care related
- As a secondary role, the GP can also have an involvement in practice/business management

Qualification and training

- Aspects of the training of GPs are delivered experientially within the practices
- The GP curriculum, while clinically focused, addresses practice management; there are some concerns expressed as to whether this is sufficient
- Some specific formal post-qualification training programmes in management are available for GPs; most of the programmes offered appear, however, to be clinically related

The national Primary Care Strategy and development of primary care teams

- A national strategy was developed in 2001 with the goal of enhancing the effectiveness and capacity of primary care to deal with the vast majority of health needs
- The development of inter-disciplinary primary care teams is central to the strategy and this is ongoing; increasing involvement with these teams may have management and leadership implications for GPs

Challenges facing the profession

- GP incomes have been reduced in recent years as a result of the economic recession and Government spending cuts; this may impact services
- The increasing feminisation of the profession and growth in part-time working, accompanied by large numbers of full-time GPs approaching retirement and an insufficiency of training places for prospective new entrants, has capacity implications
- At the same time, demand for GP services is increasing such that GP per capita is below European averages; this is in spite of the strategic importance attached to the sector
- Measures are being implemented at present in an attempt to address these challenges

Table 1.1 – Summary of the key points raised in Appendix A addressing the context of this study

1.3 Research rationale, gap and justification

1.3.1 Healthcare, primary care and the GP: the need for relevant research

Health systems worldwide are faced with the challenge posed by an ageing population and increasing demand for services, accompanied by the need to carefully evaluate and control spending (Hansen, 2011). In Ireland, this is further compounded by rising incidences of chronic illnesses and increasing numbers of people who are dependent, within a period of severe contraction in government spending (DOH, 2012). Thus, a deliberate shift towards the provision of services in primary care is driven by health, social and economic considerations (Starfield *et al.*, 2005), seeking to relieve pressure on the more expensive parts of the system (Schafer *et al.*, 2011). Strong primary care systems are associated with improved population health and reduced premature mortality (Macinko *et al.*, 2003; Evans, 2004) in a cost-effective manner (Nolan and Smith, 2012), emphasising their value both to patients and to society generally.

Thus, research is essential in the primary care domain to improve patient care by addressing questions that are relevant to daily practice (De Maeseneer and De Sutter, 2004), to facilitate better understanding and practice of the primary care function (Mold and Green, 2000), and to strengthen the discipline itself (Van Royen *et al.*, 2010). As a consequence, important, fundamental and complex questions should be the hallmark of primary care research (White, 2000). While it is understandable that much of this research is focused on clinical practice and patient care, it is also recognised that studies of organisational and financial aspects of primary care (De Maeseneer and De Sutter, 2004; Schafer *et al.*, 2011) and how quality and effectiveness can be improved (Mold and Green, 2000) are relevant. This acknowledges that patient care is provided through organisations that must be managed and administered; how they are managed/administered is relevant to how they operate and, ultimately, to how they deliver essential services.

The cornerstone of the primary care system in Ireland and many European countries is the General Practitioner (Lionis *et al.*, 2004), recognising that a well-developed GP system can enhance the quality of care provided to patients (Gillies *et al.*, 2009). This was affirmed, in an Irish context, in 2001 with the publication of a national strategy

entitled *Primary Care: A New Direction* (DOHC, 2001[1]). The strategy provides political and financial support for the development of primary care groups of healthcare professionals to deliver integrated and comprehensive care to patients by way of preventing and managing their transition into acute care. Central to this is the GP, acting as both a gatekeeper to services and a generalist with an in-depth knowledge of medicine built upon years of intensive study and multi-disciplinary training, who is often the first port of call for patients care needs. In this regard, it is unsurprising that their paramount responsibility is to the patient (Medical Council, 2009) though their involvement as owners and employees of profit-seeking small businesses must also be acknowledged (Lynch, 2012). The current dissertation contends that this latter, though important, aspect of the GP's role is insufficiently addressed in prior literature and therefore warrants further study.

1.3.2 The GP: looking beyond the 'clinician'

From Laing *et al.* (1998), primary care management is a relatively neglected field in the context of research. This is consistent with Fitzgerald and Sturt (1992), who remark on the limited research evidence available on clinical management roles generally, and Hoff (1999a), who notes a lack of evidence on how doctors in managerial roles think and act in carrying out their work. Indeed, this does not appear to have improved significantly in recent years, with Ireri *et al.* (2011) commenting on the lack of both empirical and theoretical literature concerning how doctors function in a management context. Such a deficit was recognised in the UK in the National Health Service (NHS) National Institute for Health Research's (2008) call for research, which highlighted management practice in healthcare (including primary care) as a research priority. The Institute notes a lack of prior research on the roles and work of healthcare managers, and identifies key themes for study, including the need to support the engagement of clinicians in management, to understand and improve managerial practice, and to address the realities of managerial life. Therefore, the role of the clinical-manager remains on the research agenda across all areas of healthcare.

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1 The strategy (p.15) defines Primary Care as "an approach to care that includes a range of services to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social well-being".

Looking at general practice specifically, Descombes (2002) indicates that knowledge concerning the business side of medical practice is lacking, even though commercial aspects do inevitably come into clinical decisions (Perry, 2010; Irish Medical Organisation (IMO), 2012). Consequently, there is a need for a better understanding of the nature of managerial work performed in practices (Fitzsimmons and White, 1997; Laing *et al.*, 1997). Although operating as a manager is not typically viewed as a fundamental function within the doctor role, equally it is acknowledged as a relevant task that clinicians undertake (IMO, 2007; WONCA, 2011) as poor management is likely to adversely affect the efficient and effective use of limited resources (Dadich, 2012). Thus, Lionis *et al.* (2004) and Hummiers-Pradier *et al.* (2009) contend that research on aspects of practice management should form part of the European-wide general practice research agenda. To this end, Van Royen *et al.* (2010) suggest that management in a broad sense should be recognised as a dimension of general practice, while Weight (2001) calls for more research addressing how to maximise the contribution that clinicians generally can make to the management of their organisations. This helps to emphasise the importance of the role in general practice, while highlighting a relative lack of previous research attention to this area and an incomplete understanding of what the role entails and adds.

1.3.3 Identifying the research gap: the GP as manager

Therefore, this dissertation seeks to address a gap in existing knowledge regarding the managerial role of the GP; as Greener *et al.* (2011: 31) note, "Practice management appears to be an area where there is very little dedicated research". While some previous studies exist, further research is required (O'Riordan and McDermott, 2012[2]) to more deeply understand the role itself as well as the context within which the role is carried out. This is acknowledged by Braithwaite (2004), who indicates that previous work has tended to address how doctors *should* manage as opposed to how they *do* manage, identifying a lack of empirically-grounded and testable models for how clinical-managers work.

2 This article (Clinical-managers in the primary-care sector: Do the benefits stack up?, *Journal of Health Organization and Management*, 26(5): 621-640) was co-authored by the researcher. Evidence and ideas from the article are used in the dissertation.

Hoff (1999a) notes the need for individual clinicians in management to speak of their experiences of the role (also Thorne, 1997b), highlighting how a qualitative approach would be beneficial. Echoing this, Forbes *et al.* (2004: 168) state "There has been very little attempt to examine this development [doctors as managers] from the perspective of the individual clinicians entering management, their attitudes towards management and managers, or the balancing act necessary to combine clinical and managerial roles", emphasising the need to also move beyond a description of the roles themselves (Braithwaite, 2004). While the authors refer to secondary care, this is where the bulk of research on clinicians in management appears to have been conducted (see chapter two). Thus, it is reasonable to argue that this is even more the case in the less researched domain of primary care.

Kippist and Fitzgerald (2009) note that filling such hybrid roles can be both complex and pressurised for individuals, such that there is a need to develop an understanding as to how they negotiate the roles and the implications of this for their organisations. In addition, the authors acknowledge that this may not necessarily be the most effective means by which to manage in general (also Checkland, 2004). Therefore, by studying GPs at an individual level, in terms of how they view management and operate as managers, there is scope to develop greater knowledge of the clinical-manager role in primary care, while also allowing consideration of the value of such a hybrid role in practice.

In an Irish context, the level of primary care research is modest by international standards (Health Research Board, 2006) and tends to be focused in the areas of health services and public health. However, from the researcher's review of prior research, management in general practice has not been adequately addressed in Ireland, which is surprising given the emphasis on primary care. While acknowledging that international research on clinical-managers exists, this is mostly in secondary care and may not be wholly relevant to independent owner-managed enterprises. International studies specific to management in general practice are reviewed, though differences in national contexts may also be relevant.

1.3.4 Justification of the research at a theoretical and practical level

The previous sections have identified why studying the GP as manager is warranted and relevant in the context of a lack of substantial and local research in this specific area. Equally, this study is also justified from a broader theoretical and practical perspective.

Firstly, while existing research that specifically examines the managerial role of the GP is informative (e.g. Gatrell and White, 1997; Holton *et al.*, 2010), these studies mostly lack a base in established management theory. In this respect, they largely identify what they perceive that GPs as managers do without relating this to existing management theory of what managers generally do and why (Hales, 1999; Flóren, 2006). Therefore, the current research seeks to underpin the discussion of the findings with established theories (notably Fayol, Mintzberg and Kotter) of the work of managers to identify if GPs are managers, to what extent are they managers in the traditional sense, the way in which they manage and why they manage in this way. In addition, contextual influences which may have a bearing on how GPs manage – notably, the nature of their training in management (Ireri *et al.*, 2011) and the support of key ancillary staff (Laing *et al.*, 1997) – require some consideration.

Accordingly, the study attempts to provide a more complete understanding of the nature of the managerial role of the GP than previous research. In doing so, this study acknowledges that static theories have their weaknesses and may not individually capture the realities of what managers do. To address this, a process approach (Chapman, 2001) is adopted, utilising Carroll and Gillen's (1987) integrating model of the manager at work as a means of bringing together different perspectives to provide a more comprehensive view. In this regard, the study seeks to develop and extend an existing model by empirically grounding this in a context where such models are lacking (Braithwaite, 2004).

Secondly, the dissertation acknowledges that GPs are primarily clinicians and professionals and only function as managers in a secondary capacity. Thus, it is imperative that their professional role is accounted for, which is not reflected in Carroll and Gillen's (1987) original model, requiring consideration of the literature on professions. In this sense, the professional role is built upon a set of values and behaviours that clinicians ascribe to, addressing areas such as education (Freidson,

1988), self-regulation (Hoogland and Jochemsen, 2000), ethical codes and peer associations (Hall, 1968). Of particular relevance to this study are the professional hallmarks (Hodson and Sullivan, 2012) of autonomy (Barber, 1963) and altruism (Royal College of Physicians, 2005). However, opposing these are the more business-oriented elements of bureaucracy (Ritzer and Walczak, 1988) and self-interest (Tussing, 1985), stemming from traditionally independent, GP-owned structures. In addition, literature on the career stages of professionals (Dalton and Thompson, 1986) should be considered. This highlights how professionals can gradually evolve into a deeper and broader managerial involvement in their organisations, which may affect their capacity at higher levels to engage in more traditional professional duties. Consequently, any model addressing the GP as manager should consider these features of the professional role, which may influence the nature of their managerial role.

Thirdly, by introducing the professional role in conjunction with the managerial role, role theory (Katz and Kahn, 1978) becomes relevant in the context of how GPs address the expectations associated with fulfilling multiple roles (Biddle, 1986). A central element of role theory is role conflict (Kahn *et al.*, 1964), arising when multiple roles are in some way inconsistent or incompatible with each other (Barnett and Baruch, 1985). Because of the interactions between the GP's professional and managerial roles, each of which stems from differing and potentially opposing value bases (Kippist and Fitzgerald, 2009) and with different demands on the GP, role conflict is a possible outcome. However, this does not feature in Carroll and Gillen's (1987) original model, highlighting the possible need for adaptation for context. Therefore, the potential implications of role conflict for the GP as manager, and how these may be addressed or resolved, are important to understand in the current study. While acknowledging that role conflict has been studied in the context of clinical-managers in secondary care (Willcocks, 1994) and in large primary care organisations (Checkland *et al.*, 2011), there appears to be limited research as to how such conflict might manifest itself within the GP practice.

Therefore, this study takes a multi-theory perspective in seeking to determine the nature of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role. By combining three separate lenses (management, professions and role) in this manner,

a more comprehensive understanding is obtained, while also allowing greater scope for theory development in how each interacts with and informs the other (Fondas and Stewart, 1990). This is justified by the fact that exploring the managerial role without considering the professional role would ignore the clinical and patient-related activities of the GP, encompassing particular values and behaviours, and the implications of this for how they manage. Similarly, by considering both roles and acknowledging how they may potentially oppose each other, without then considering role conflict, would reduce the scope of this study to deliver a comprehensive understanding of how the managerial role 'fits' within general practice.

Stemming from this, the study seeks to address a gap in healthcare research generally (Montgomery, 2001), and in primary care specifically (O'Riordan and McDermott, 2012), relating to the value of the clinical-management role. In this context, 'value' is considered in terms of how clinician involvement in the managerial role may be of benefit to stakeholders. As noted in section 1.1, there is a lack of consensus as to the merits of the hybrid clinical-manager role, such that the GP as manager might not offer anything more valuable than a non-clinical manager can (Hoff, 1999a). Given the current context of increasing service demand and a lack of sufficient supply of working practitioners (Thomas and Layte, 2009), it is imperative that the costs/benefits of GPs as managers be weighed up as non-clinical managers are becoming increasingly prevalent in expanding practices (O'Dowd *et al.*, 2006a; Bourke and Bradley, 2010). Furthermore, as GPs transition from a typically practice-based, owner-controlled environment into wider inter-professional primary care teams as well (DOHC, 2001), the suitability and feasibility of their existing approaches to management requires some consideration. To date, primary care research has not explored these issues in the context of GPs as managers. Consequently, this study contends that there is an important benefit in addressing this gap in knowledge, potentially helping to inform future approaches to work, training and management. This recognises that whatever GPs do – clinical or non-clinical – affects service delivery and thus patient care, highlighting the relevance of this study for the wider primary care domain.

1.4 Research objective and questions

Arising from the above, the research objective of this dissertation is as follows:

To determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role.

This gives rise to the following research questions:

1. What work roles (professional and non-professional) do GPs undertake and where do their priorities lie?
2. What is the managerial role of the GP and how is this performed?
3. What factors influence the managerial role of the GP?
4. How do the GP's roles interact and what are the implications of this for the GP in terms of potential role conflict?
5. What is the value of the managerial role of the GP?

Further elaboration is provided regarding the specific rationale for these questions in section 5.3.

1.5 Methodological perspective and research design

The methodological approach adopted in this study (chapter five) is qualitative in nature, using an exploratory research design. Adopting such a design recognises that the issue being researched may be partly understood, allowing for the development of a preliminary model, but that gaps in this model remain which can only be addressed through detailed exploration (Sekaran and Bougie, 2010).

Domegan and Fleming (2003) suggest that qualitative data is most suited to exploratory designs, allowing for a deeper understanding of the phenomenon being investigated. Therefore, the researcher utilises semi-structured interviews (Bryman and Bell, 2003) as a means by which to capture the thoughts, experiences and perspectives of individual GPs across career stages as they relate to the overall research objective. In this context,

35 Irish GPs were interviewed, with initial topics and questions influenced by key themes identified in the literature.

Adopting a semi-structured approach allows the researcher to ensure coverage in each interview of specific topics, while also providing scope for interviewees to introduce different and novel perspectives (Legard *et al.*, 2003). Primarily, interviews were conducted by telephone, stemming from the researcher's early observations regarding the positive effect that this medium had on data quality (Sturges and Hanrahan, 2004). Thematic analysis (Braun and Clarke, 2006) was used to identify, surface and unravel relevant themes within the interview transcripts, with NVivo utilised as a means of facilitating the researcher in this process.

1.6 Contributions of this study

The contributions made by this dissertation, and practical implications arising from the study, are discussed in sections 8.4 and 8.5. A summary of the theoretical, empirical and practical contributions is provided in sections 1.6.1 to 1.6.3 below.

1.6.1 Summary of theoretical contributions

The study utilises Carroll and Gillen's (1987) integrating model of the manager at work, but extends and augments the theory in a number of ways by combining three analytical lenses (management, professions, role) to generate a wider understanding of the managerial role in a novel context (the GP). As primarily clinicians, certain characteristics of professionals – including autonomy (Brint, 1993) and altruism (Pellegrino, 1987) – are influential in shaping the GPs managerial role. The combination of a professional and managerial role can lead to role conflict (Biddle, 1986), which may have implications for the individual as they adopt an approach to managing that achieves their objectives within a time-restricted context. In addition, the extended model incorporates the two-way involvement of managerial supports (Westland *et al.*, 1996). The model developed in this study can also potentially be adapted for other contexts where professionals fill dual roles.

This study suggests that Organisational-Professional Conflict (Kippist and Fitzgerald, 2009), which is currently conceptualised and measured as a single dimension (Aranya

and Ferris, 1984; Shafer, 2009), might also be viewed as consisting of two separately identifiable, though associated, forms of conflict, namely Commercial-Professional Conflict and Operational-Professional Conflict. Consequently, future studies addressing and measuring conflict between organisational and professional roles may need to consider using scales which treat this not as a single dimension but rather as two dimensions.

The current research highlights the potential influence of control on the GP's experience of role conflict, suggesting that seeking to be in control (Majorbanks and Lewis, 2003) may result in conflict being catalysed. This has implications for the work undertaken by the GP as manager, and can subsequently give rise to role overload (Kahn *et al.*, 1964) as multiple expectations are addressed in a time-limited context. In this regard, while control as a resource may be a means by which to relieve role conflict (Shenkar and Zeira, 1992), it may also be a factor in the role conflict itself occurring. This extends the Job-Demands Resources model (Demerouti *et al.*, 2001; Bakker and Demerouti, 2007) by suggesting that control is not only a resource to buffer demands, but can also – at high levels of control and responsibility (Bakker *et al.*, 2005) – increase demands for the role occupant.

1.6.2 Summary of empirical contributions

The study has helped to increase understanding of how GPs address the apparently opposing motivations stemming from being altruistic (Cruess *et al.*, 2002) and self-interested (Pockney *et al.*, 2004), and the implications of this. The current research brings some contextual clarity to the debate, noting the co-existence and influence of both motives (Batson and Powell, 2003) and finding that GPs may seek a balance (Gillon 1986a; 1986b; Maier and Shibles, 2011) between the needs of patients and their own need for profit. This study argues for the positives in this situation for both patients and GPs, finding that GPs may be viewed as 'part altruistic, part self-interested'.

This study is, to the best of the researcher's knowledge, the first to empirically examine Carroll and Gillen's (1987) integrating model of the manager at work. While extending and adapting the model (see first theoretical contribution above), the study finds support for the original structure and the attempt made at linking the work of Kotter, Mintzberg and Fayol in an integrated manner. Thus, some empirical evidence is provided that helps

in demonstrating the relevance and applicability of the original model.

The study provides further evidence to support the existence in the literature of Organisational-Professional Conflict (Gunz and Gunz, 1994) in a novel context where such research is lacking (Kippist and Fitzgerald, 2009), and identifies how the GP as manager can seek to address this. In this regard, the GP can pare down the managerial role (Fitzgerald and Sturt, 1992) to deliver their desired objectives while focusing on the professional role.

There is a dearth of international research that empirically addresses the managerial work of the GP (e.g. Fitzsimmons and White, 1997), with few of these studies underpinning this with supporting theory from a broader management context. As far as the researcher can establish, this is the first study of GPs as managers that empirically identifies what they do and the purposes of what they do, framed within the context of established management theory by way of indicating how this compares to managers in general. The findings highlight how GPs as managers focus on a sub-set of the roles and functions of 'traditional' managers.

1.6.3 Summary of practical contributions

This study considers the under-researched (O'Riordan and McDermott, 2012) topic concerning the value of the managerial role of the GP and whether this warrants their active involvement in the context of increasing pressure on resources (Thomas and Layte, 2009). Evidence is found that suggests that the GP as manager is valuable and can be of benefit to stakeholders. However, while a commercial involvement is viewed as important, effort spent on more operational activities may contribute limited value given the lack of available time.

The study highlights the under-utilisation, by GP owners, of existing managerial capacity in their organisations and contends that greater delegation to suitable personnel may be of benefit by further expanding the practice manager role (Verrill, 2005). This is an important consideration, as practices become busier, larger and more complex organisations (Layte and Nolan, 2009; Checkland and Harrison, 2010).

The research considers the timing (Hunter, 1992) and largely experiential nature of

management training for new GPs, and highlights how benefits might accrue to GPs (Sibbett *et al.*, 2003) and practices (Gerada, 2008) by providing greater opportunities to practically apply this training post-qualification.

1.7 Structure of the dissertation

This dissertation is structured around eight chapters. Chapter two is the first of three literature review chapters, wherein the initial focus is on the managerial role of the GP. The chapter considers key theoretical perspectives of management within the context of Carroll and Gillen's (1987) integrating model of the manager at work. Literature is then critically reviewed that specifically examines the clinician in management in primary and secondary care. The small business context of general practice is addressed, along with management training for clinicians and the supporting role of the practice manager. The chapter closes by introducing the debate surrounding the value of the clinical-manager role, noting a lack of previous consideration of this in primary care.

Chapter three examines literature regarding the professional role of the GP. Firstly, the professional desire for autonomy is addressed, before considering the implications of bureaucratic control. Literature is presented that acknowledges how these ideologies may clash but may also co-exist and be accommodated, and how professional organisations are structured. Secondly, the core professional value of altruism is examined. Literature is critiqued which suggests that clinicians can put patient interests first, while also finding support for the existence of financial self-interest. The prospect of balancing these motivations is considered. Finally, the relevance of career stage for the professional is outlined, in the context of their evolution into an expanding managerial role and the implications of this for their professional work.

Chapter four is the final literature chapter and deals with role theory. The nature of role conflict is specifically examined, which is of particular relevance in this dissertation. In the context of the interaction between the GP's managerial and professional roles, prior research pertaining to Organisational-Professional Conflict is critically analysed. This suggests that conflict may arise between ideologically opposed roles in these two domains, though there is also evidence to suggest that both roles can beneficially co-exist, particularly at senior levels. Acknowledging the lack of specific research in this

area in general practice, literature from retail pharmacy is briefly assessed. The chapter concludes by presenting the preliminary model for this dissertation.

Chapter five explains and justifies the research methodology used in the study. The philosophical assumptions underpinning the researcher's position are discussed, before explaining the research objective and questions, and addressing the use of an exploratory research design and a qualitative approach. The rationale for utilising semi-structured telephone interviews is presented along with operational details concerning sample selection, protocol design and data collection. The researcher's approach to analysis is outlined, as well as how validity, reliability and research ethics have been addressed.

Chapter six presents the findings of the study, based on semi-structured interviews conducted with 35 GPs across different career stages. The findings are structured around themes identified during the data analysis phase, addressing the nature of the GP role, management learning, managerial work performed by GPs, supports availed of and clinical/managerial role conflict. Rich and relevant quotes from the interviews are integrated with the researcher's analysis of the data to clearly illustrate the themes and the various perspectives, issues and nuances within these.

Chapter seven takes the findings, in the context of key themes identified, and discusses these in conjunction with the context of the study (Appendix A) and the literature reviewed. The discussion addresses three core areas: the nature of the managerial role of the GP and role performance; the interaction of the managerial role with the professional role of the GP, the conflicts that arise and implications for the GP as manager; and factors influencing the GP role as manager. Within each of these areas, the discussion builds an evolving argument, culminating in the presentation of a final model of the GP as manager, informed by both theory and empirical data.

Chapter eight presents the conclusions from the study, through initially answering the five research questions by way of addressing the overall objective. The chapter outlines and discusses the contributions made by this dissertation and the implications of these, before identifying the limitations of the study and recommendations for further research, ending finally with some concluding comments.

Appendix A presents the context for this study, being the General Practitioner in Ireland, which should be read in conjunction with the main body of this dissertation. Initially, the structure of Irish general practice and how GPs function is outlined. The appendix closes with a critical analysis of the key challenges currently facing the profession, highlighting how these are affecting the GP role in the context of growing resource limitations. Specific issues of particular relevance identified include the growth in inter-professional team working, increasing practice sizes, the move towards 'free' GP care (Universal Health Care), and issues of insufficient GP capacity nationally to adequately meet rising service demands.

Chapter Two

Management and the General Practitioner

Chapter Two: Management and the General Practitioner

2.1 Introduction

This chapter reviews literature pertaining to the managerial role of the GP, in seeking to address the nature of the role and performing the role. Key themes identified include the managerial activities undertaken by clinicians and support for such activities in the shape of the practice manager, clinical-manager training and the value of clinicians as managers. However, a deficit in GP-specific literature is the lack of core management theory underpinning studies that outline the 'managerial' activities undertaken. In order to address this, the chapter begins with a short review of three core management theories within the context of Carroll and Gillen's (1987) integrating model of the manager at work as a means of more comprehensively illustrating 'what managers do'. This model forms an important component of the dissertation, though recognising that – in the context of specific literature on the clinician as manager and related themes – it requires further development.

2.2 Perspectives on management

2.2.1 Fayol's functions of management

Along with Taylor, Gilbreth and Weber, Fayol is regarded as one of the key classical management theorists[3]. While some focused on scientific management in studying work processes, Fayol (1988) concentrated on the management of the organisation, reducing management to five primary functions. Support for the continued relevance of these functions can be found in Carroll and Gillen (1987), Wren (1990), Fells (2000), Hales (2001), Lamond (2003; 2004), Parker and Ritson (2005) and Wren and Bedeian (2009). Fayol (1988: 13) held that all managers perform these functions and summarises them as:

- To plan: examine the future and lay out the actions to be taken.
- To organize: lay out the lines of authority and responsibility; build up the dual structure, material and human, of the undertaking.

3 Parker and Ritson (2005) note that Fayol's text has elements of what would later be more modern approaches, including strategic and flexible planning and worker participation.

- To coordinate: lay out the timing and sequencing of activities; bind together, unify, and harmonize all activities and efforts.
- To command: put the plan into action; set the work in operation.
- To control: monitor and correct; see that everything occurs in conformity with established rules and expressed command.

A more detailed description of each is provided in Appendix B (p.289).

From Carroll and Gillen (1987: 48), the classical functions "still represent the most useful way for conceptualizing the manager's job", and that performing the functions is associated with higher organisational performance; indeed, Wren (1990: 140) finds that "managers who were both successful and effective" devoted substantial time to these very functions. In this respect, Fayol represents what managers '*should*' do (Lamond, 2004).

2.2.2 Mintzberg's managerial roles

In 1973, Mintzberg published *The Nature of Managerial Work*, in which he criticises Fayol's functional assertions as being overly vague and unhelpful in trying to make sense of the complexity of managerial work. Rather than being 'reflective' as the functional view would suggest, managers work at an unrelenting pace, bring work home with them, and deal with activities that are brief, varied and fragmented and with little pattern. In this respect, the manager responds to situations as they arise. Thus, Mintzberg portrays the world of the manager as somewhat chaotic and consistently active, with little free time[4]; ultimately, his concern was with what managers '*actually*' do (Lamond, 2004).

Mintzberg developed a set of observable roles that can be used to describe the work of all managers. The ten roles[5], in three sub-groups, are outlined in Table 2.1 below, with a description of each provided in Appendix C (p.292).

4 Florén (2006) indicates that this can also be the case for managers of small firms.

5 Hales (1986), from a review of studies, identifies nine common strands that bear considerable resemblance to Mintzberg's roles (with the addition of Planning).

Interpersonal Roles	Informational Roles	Decisional Roles
Figurehead	Monitor	Entrepreneur
Leader	Disseminator	Disturbance Handler
Liaison	Spokesman	Resource Allocator
		Negotiator

Table 2.1 – Managerial roles (Mintzberg, 1973)

Mintzberg's later work (1994; 2000; 2011) further emphasises the significance of these roles. While he re-labels and reformulates some, they are much the same as his original set[6] with one key addition. This further role (Conceiving; Mintzberg, 1994) recognises that the manager operates within a frame, which consists of their purpose (what the manager is seeking to do fundamentally), their perspective (their overall approach to managing the business) and their positions (more concrete views on how the specific work will be done). Mintzberg indicates that managers engage in 'conceiving' this frame, which entails thinking about purpose, perspective and positions in the context of their organisation.

Mintzberg's work has drawn both support (Guo, 2003; Braithwaite, 2004; O'Gorman *et al.*, 2005; Florén and Tell, 2013) and criticism (Snyder and Wheelen, 1981; Stewart, 1982). Strengths of his roles include the fact that they are grounded in reality (Carroll and Gillen, 1987) through observation, and that they provide extensive detail. However, criticisms have included issues with his overall approach (Snyder and Wheelen, 1981), that only Chief Executive Officers (CEOs) were studied (Lamond, 2003), and the lack of a theoretical framework to guide his assertions that the identified activities are 'managerial' (Lamond, 2004). In addition, the relationship between the different roles and organisational effectiveness is not made clear (Carroll and Gillen, 1987).

2.2.3 Kotter's work agenda

Kotter (1982: 60) indicates that managers set agendas, which is what they need to do and consists of "a set of loosely connected goals and plans". These often differ from formal organisational plans and tend to be more detailed in the context of strategies,

6 For example, 'Controlling' encompasses the Entrepreneur and Resource Allocator roles, while 'Doing' addresses the roles of Entrepreneur and Disturbance Handler.

focusing on a broader time frame and containing goals that are less interconnected. Much of the work involved in the creation and modification of this agenda is mental and continuous. Agenda items can be specific or vague and may carry different priorities, set by the manager or others. The agenda can focus on tasks or on people, and the personal style of the manager is relevant. Characteristics of the manager's job also have a bearing, such as the volume and scope of their work.

Agenda items are addressed by the manager but also through their contacts, who action the agenda as well as feed information in to it. Thus, from Kotter, the work agenda (as a manifestation of the manager's frame (Mintzberg, 1994)) represents the underlying priorities of the manager in terms of what they are working towards, reflecting both their goals and the tasks necessary to achieve these (Carroll and Gillen, 1987). These priorities fall within the responsibility of the manager to either undertake or pass on, with the support of others. In this respect, the work agenda is a representation of their broad objectives and intentions, shaped by multiple influences (Carroll and Gillen, 1987) including characteristics of the individual and of the role, which impacts upon their actions.

2.2.4 Carroll and Gillen's (1987) integrating model of the manager at work

While the theories of Fayol, Mintzberg and Kotter can appear incompatible, some suggest that they may be related (Snyder and Wheelen, 1981; Carroll and Gillen, 1987; Hales, 1986; 1999). Fells (2000) and Lamond (2003; 2004) ‘map’ Mintzberg’s roles and Fayol’s functions, as Mintzberg “fills in the fine detail of the practical manifestations of Fayol’s more abstract functions” (Lamond, 2004: 331). Similarly, Tsoukas (1994) suggests that Mintzberg and Fayol operate at different ontological layers rather than opposing each other; thus, while roles are observable, functions underlie their existence.

However, the somewhat static nature of such theories (Hales, 1986; Chapman, 2001) can mean that the integrated process of managing is not adequately reflected. Chapman (2001: 60) outlines how processes “provide a vehicle to connect seemingly unrelated activities into more coherent sequences, which are connected to the broader organisational context”. Thus, Carroll and Gillen (1987) propose an integrating model (Figure 2.1), connecting these theories as part of a coherent process.

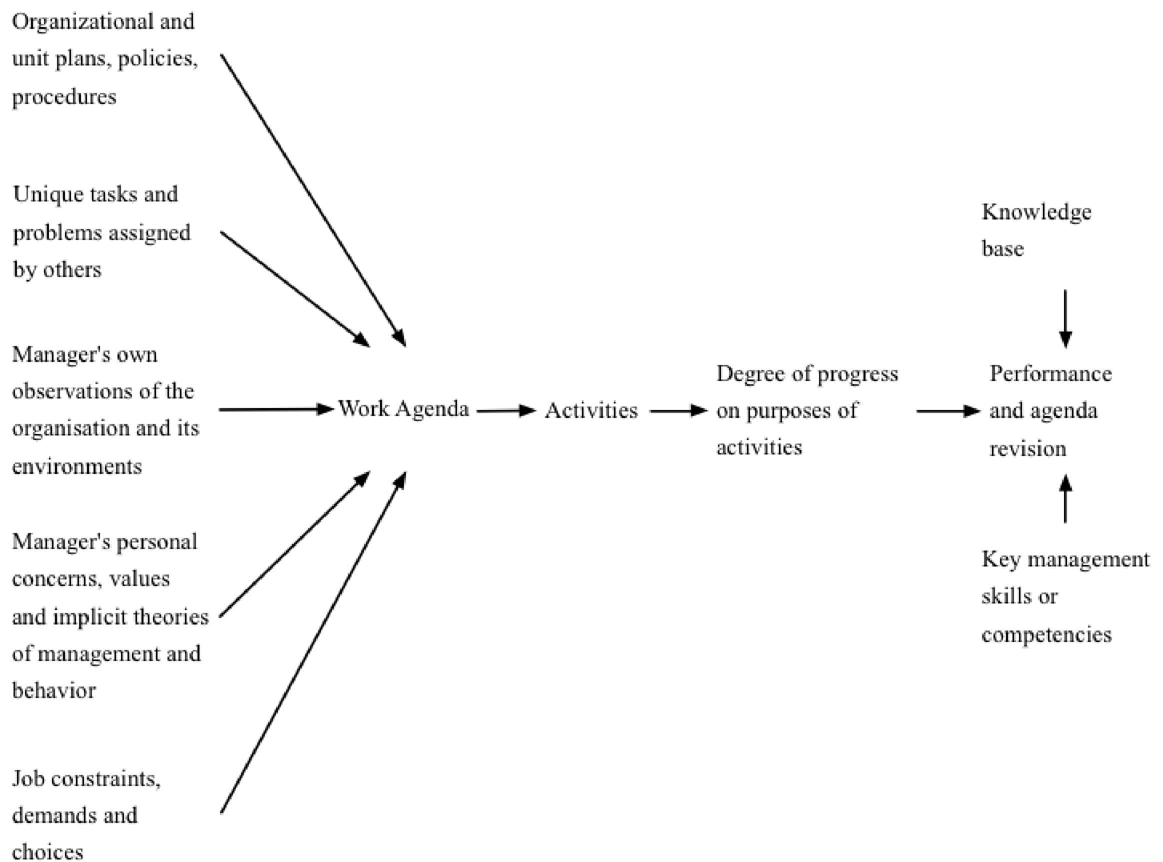

Figure 2.1 – A model of the manager at work (Carroll and Gillen, 1987: 47)

From Figure 2.1, five factors are believed to influence the manager's *work agenda* and, thus, their intentions. Some of these are personal to the manager, including their own goals, theories and values and the opportunities they observe, while others concern organisational plans and the agendas of others. Stewart's (1982) notion of demands, choices and constraints is also an influence; while managers' agendas are subjected to the demands of the job and to various constraints, they also have some discretion. The incorporation of a work agenda and influences into the model helps to address Hales' (1999) criticism of standalone management theories that do not consider why managers do what they do.

The work agenda impacts upon the activities of the manager[7]; the act of talking to a colleague about a work matter is the manager pursuing their work agenda, which may involve them providing leadership, disseminating information, solving a problem etc. In

7 Although Carroll and Gillen (1987) do not specifically refer to Mintzberg's (1973) 'roles' in their model, these were utilised by Mintzberg to categorise the activities undertaken by managers and are used here in this context.

this regard, the activities purpose "can be stated in terms of carrying out the various unique managerial functions"[8] (Carroll and Gillen, 1987: 46), as managers engage in the various 'roles' while carrying out their 'functions' (Hales, 2001; Lamond, 2003). The extent to which progress is achieved on these functions (e.g. achieving, revising or agreeing the plan; reorganising staff; efficient scheduling of resources etc.) is considered and performance assessed; this may give rise to a revision to future agendas. Performance is affected by both the knowledge and skills of the managers, highlighting the importance of management development.

Thus, the key elements of the model (as relevant to this study) are the influences, work agenda, activities (categorised as roles) and purposes of activities (represented by the managerial functions). In essence, the influences affect the work agenda of the manager, which can be understood as what they intend to do in a general sense, thus impacting upon *why the job is the way it is*. The agenda is actioned through the manager undertaking various roles, which represents *what they do in a practical sense,* given the way the job is. In carrying out these roles, the manager is performing the traditional functions of management. These functions are *the purposes of what they do* and thus reflect the particular reasons for the activities undertaken, consistent with the manager's broad agenda. A refined version of the model as a process, incorporating these core elements, is produced in Figure 2.2.

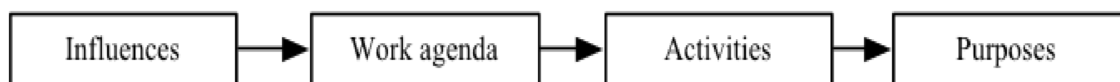

Figure 2.2 – A refined model of the manager at work. (Adapted from Carroll and Gillen, 1987)

In combining the work of Fayol, Mintzberg and Kotter, a more complete understanding of the work of the manager is revealed. However, the generic nature of the integrated model must be acknowledged; as Florén (2006) notes, the influence of context can be

8 Carroll and Gillen (1987: 46) illustrate as follows: "When talking with others, managers attempt to develop plans that will be effective in reaching an objective, may try to determine progress on previous plans, or correct deviations from unit plans, or build the competence of subordinates for future staffing needs, or direct others to carry out their roles in an organizational plan". In each case, the act of talking – depending upon what this entails or what it is about – has a clear purpose.

important. This is recognised in the current study, which uses Carroll and Gillen's (1987) original model as a base upon which to build a more context-sensitive variation for the GP as manager. In this regard, the review now turns to specific literature on the physician in management.

2.3 The Physician in management

Physicians who manage are variously referred to in the literature as 'physician executives' (Hoff, 1999a), 'doctor managers' (Hallier and Forbes, 2004) and 'clinical-managers' (O'Riordan and McDermott, 2012) amongst others. The term 'clinical-manager' is used throughout this study. While literature on the clinical-manager is extensive[9], this review focuses on four prominent themes: the managerial tasks performed by doctors, the support provided by practice managers, management training for doctors, and the value of the managerial role of the doctor.

2.4 The managerial tasks performed by doctors

2.4.1 Doctors as managers: the secondary care context

Betson and Pedroja (1989) identify three task categories for hospital clinical-managers. They engage in policy management at the strategic level involving guidance and leadership; programme management consisting of administrative actions and policy execution; and resource management in carrying out and managing the administrative and support functions. The authors suggest that a lack of involvement in resource management may be because this is largely handled in specialist departments, though Fitzgerald and Sturt (1992) believe that an active role in resource allocation is essential. Some of the prominent management tasks identified relate to the management of staff and other physicians, emphasising the importance of HR for clinical-managers (also Schneller *et al.*, 1997). Financial management was of less relevance, being an area where they had limited responsibility. The authors indicate that this may be due to a lack of requisite skills or a conscious choice, though noting "physicians must increase their involvement in this area if they are to reach their potential as managers" (Betson and Pedroja, 1989: 365; also Walker and Morgan, 1996).

9 The literature reviewed here is taken from both primary and secondary care domains. While the focus of the study is on general practice, research on the hospital clinical-manager appears to be more prominent.

In terms of specific roles, Betson and Pedroja (1989) indicate that clinical-managers are responsible for coordinating, conflict management and decision-making. Fitzgerald (1994) suggests that managing change and operational roles, including the management of process improvements and organisational performance (Guthrie, 1999), fall within the remit of the clinical-manager. However, Fitzgerald *et al.* (2006) observed limited involvement in either service improvement or change management. Kippist and Fitzgerald (2009) draw attention to the knowledge and understanding of budgets and the ability to lobby for resources, while Willcocks (1997) identifies the need for a customer focus and Bodenheimer and Casalino (1999) highlight the capacity to solve problems.

The role of negotiator is noted by Schneller *et al.*, (1997), as well as active involvement in strategic planning and capital decision-making (Fitzgerald, 1994; Ong, 1998; Bodenheimer and Casalino, 1999; Sherer, 1999). In this context, Hyde *et al.* (2013) suggest that the overall role has become more proactive and externally oriented. However, Dawson *et al.* (1995), Joyce (1998), McKee *et al.* (1999) and Fitzgerald *et al.* (2006) indicate that the dominant focus still remains on operational matters, with Llewellyn (2001) suggesting that greater delegation of such tasks would facilitate increased strategic involvement. Broadly reflecting the preceding perspectives, Braithwaite (2004) summarises that the clinical-manager's core pursuits are managing finances, staff, organisational matters and customers, with other aspects including strategy and planning, external relations and the management of data, processes/systems and quality as secondary. Thus, the literature from a hospital context indicates that the managerial role of doctors is wide ranging, encompassing operational, tactical and strategic elements.

2.4.2 General practitioners

2.4.2.1 General practice as a micro/small business

While the secondary care literature is helpful, the distinct nature of general practice must be considered (Cowton and Drake, 2000). The majority of Irish general practices are micro-firms, employing ten or less employees (O'Dowd *et al.*, 1997), and typically owner-managed. This is significant as such firms tend to display simple structures (Mintzberg, 1981), few layers, and informality in both their communication (Kelliher

and Reinl, 2009) and management practices (Devins *et al.*, 2005). As these organisations grow, additional staff are appointed which facilitates delegation, but also necessitates increased coordination, planning and formalisation as well as greater consideration of structures to deal with the added complexity (Greiner, 1998).

Owner-managers are critical to the small business (d'Amboise and Muldowney, 1988) and play a key role in management, undertaking strategic planning and holding centralised decision-making control (Kelliher and Reinl, 2009). They have a desire to maintain control and can struggle with the notion of delegation, while possibly focusing attention on those tasks they enjoy (Hales, 2001; Florén, 2006). However, their day-to-day involvement in the core work of the business (Florén and Tell, 2013) may have negative implications for strategic planning; a lack of time can mean that small firms possess insufficient resources to explore longer term objectives (Kelliher and Reinl, 2009).

In addition, owner-managers' involvement in strategic planning can mean that strategies are informal. Although plans and objectives may exist, these are not always written down or clearly communicated (Kelliher and Reinl, 2009); as Emery and Trist (1965) note, for small organisations in relatively unchanging environments, there is no real difference between tactics and strategy, potentially mitigating the need for a formalised, long-term focus. Thus, strategic planning can be limited (Mintzberg, 1981; d'Amboise and Muldowney, 1988) and largely emergent (Mintzberg and Waters, 1985; Mintzberg, 1987), even though devoting time to strategic planning has benefits for small firms (Ward, 1988; Kotey and Meredith, 1997). Therefore, small-business literature highlights the central and important role of the GP as an owner-manager, as well as a typical lack of time for, and focus on, formal strategies and plans.

2.4.2.2 Empirical literature on the managerial role of GPs

Although there is extensive literature on hospital clinical-managers, there is considerably less research on the GP as manager; given Dadich's (2012: 4) observation that most of her interviewee GPs "were unable to describe the ways their general practices were managed" and rarely referred to their own styles of management, this

may be unsurprising. A review of the international literature[10] identifies few empirical studies that address the tasks and duties associated with this role.

Fisher and Best (1995) explore the dimensions of management in general practice. Firstly, they identify *management values and methods*, relating to how the GP believes resource allocation decisions should be made and how the practice should be managed, including the usage of techniques such as business plans and SWOT (Strengths, Weaknesses, Opportunities, Threats) analyses. Secondly, is a *concern for operational efficiency and income maximization*, reflecting the extent to which the GP pays attention to the financial and operational management of the practice, such as cost control, measuring efficiencies and seeking new income sources. *The focus of service delivery* is also relevant, whereby those with a managerial focus will look upon the needs of patients as being met by the team rather than the individual. Finally, c*linical standardization and the relationships between clinical principals* are identified. According to Fisher and Best (1995: 51), "A managerially inclined GP would be interested in the systemization and standardization of clinical practice", such that protocols/clinical audits are introduced, while in terms of communications between partners, managerially-focused practices ensure that regular formal discussions occur. Those who are more active in management are likely to rate highly on all four dimensions.

Gatrell and White's (1997) research derived task characteristics, classified into five clusters of capabilities and skills that GPs should have to effectively manage:

- *Contextual awareness*: This is the understanding and ability needed to operate within the wider context. Thus, the GP requires a familiarity with sources of funding, the operations of other stakeholders and an understanding of the structure of their own practice.
- *Strategic thinking*: The GP needs to understand and apply strategic processes in their organisation, including developing a practice vision and strategic plans, and linking activities to these.

10 There is a lack of available academic research on management in Irish general practice, which mitigates the author's ability to search in a more localised context.

- *Functional and operational skills and knowledge*: The GP is required to play a part in a variety of activities associated with the daily operation of the practice. Included here are staff management, quality management, negotiations, planning/budgeting, problem solving, decision-making, monitoring activity and practice development.
- *Interpersonal and team skills*: A wide variety of skills are indicated here, including team-working, communication, chairing/contributing to meetings, external liaison and representation, staff discipline, conflict resolution, delegation and goal-setting.
- *Self-management skills*: These pertain to activities such as communication, time-management, dealing with uncertainty, reputation management and ethical management.

Fitzsimmons and White (1997) indicate that relevant areas to be addressed in modern practices include strategic planning, establishing multi-disciplinary teams and the development of management systems for monitoring and control. At the *operational level*, day-to-day and routine decisions are made; this encompasses much of the work of the practice manager, though as Checkland *et al.* (2011) observe, most of the GPs in their study of a large primary care organisation focused at this level. The *tactical level* involves addressing short to medium-term objectives, requiring input from others and greater change management. Practices also need to take a more ‘corporate’ view of their activities and the development of resources at a *strategic level*. Thus, an essential managerial activity is monitoring the external environment to ensure that the practice is in a position to match the demands this brings. The authors (1997: 129) refer to this as a “complex and dynamic activity” and note that practice managers “may carry less weight and cannot so easily contribute to the strategic level”. Therefore, this may be the appropriate level for the GP to function at.

Holton *et al.*’s (2010) research on Australian general practices identifies the elements that contribute to effective patient management in the context of delivering quality care[11]:

11 The authors do not differentiate which elements are dealt with by GPs specifically.

- *Organizational and administrative processes,* including the recall of patients for follow-up, systems for internally sharing information and written job descriptions;
- *Human resources/staff development*, related to how the practice applies HR principles e.g. formal staff appraisals, reviews of strategic and business plans, patient targets;
- *Marketing analysis*, which includes the use of planning and marketing techniques and implementing appropriate strategies;
- *Business development*, entailing running the business in a professional manner that ensures continued growth and development. This includes formal assessment of service viability, financial planning, staff training and regular meetings.

From these studies, it is important to note a lack of core management theory underpinning much of the research[12]. This is consistent with Florén (2006), who argues for greater integration between small business and general management research. Thus, a gap in the existing GP literature is the absence of relating what studies have found GPs do as 'managers' to what managers actually do or should do; as Hales (1999: 337) notes, it is important to take context-based descriptions and "link these particular accounts to the wider body of evidence on managers generally". Consequently, identifying GPs as 'managers' and in what way, without a theoretical basis for this, maybe somewhat premature.

The review indicates that some parallels can be found between the secondary and more limited primary care literatures. As with their hospital equivalent, the GP is involved in most aspects of staff management and financial management. Decision-making, problem-solving, team-working and conflict resolution fall within their remit, as well as quality, systems, change and meeting management. A role in monitoring and controlling practice activity is apparent, and the GP is involved in operational management across the practice; this is consistent with the situation in small owner-managed businesses. Betson and Pedroja (1989) and Fitzsimmons and White (1997) both identify the

12 Gatrell and White (1997) use the work of Burgoyne and Stuart (1976), on management skills and qualities, and Boyzatis (1982), on management competences, in developing their model. The remaining papers appear to lack a clear management theory base.

different organisational levels of management, implying that the clinical-manager's focus should be mostly at the strategic level, though this might not actually be the case (Braithwaite, 2004; Checkland *et al.*, 2011). While planning, practice development, and liaising with external stakeholders are viewed as relevant tasks, a lack of time and resources for strategic planning in small owner-managed businesses can present challenges (Kelliher and Reinl, 2009). As part of the wider management function, Fitzsimmons and White (1997) and Holton *et al.* (2010) both draw attention to the importance of the practice manager. This particular position in general practice will now be addressed as, to understand the nature of the role of GP as manager, it is critical to also understand the involvement of others who contribute to management in small business (Florén and Tell, 2013) and any ensuing interactions.

2.5 The role of the practice manager

The practice manager has administrative and managerial responsibilities and acts as a bridge between the clinical and non-clinical sides of the practice (Royal College of General Practitioners (RCGP), 2006). In a hospital context, the role of the manager is seen as critical in "joining up care, and making sure that patients are able to move between care services in as seamless a way as possible" (Greener and Harrington, 2010: 8), with a focus on organisation and coordination. In general practice, the practice manager has a similar role; Westland *et al.* (1996) found that responsibilities included the daily running of administration, incorporating non-clinical elements of practice planning, finances, staff matters, IT, communication and patient complaints. Thus, as business managers support hospital clinicians in their management role (Buchanan *et al.*, 1997), the practice manager can similarly support the GP as a resource to relieve job demands and challenges stemming from their extensive workload (Bakker and Demerouti, 2007).

The significance of the practice manager role is relatively recent in Irish general practice (O'Dowd *et al.*, 2006a) compared to the UK, where the position is more established (Grimshaw and Youngs, 1994). Laing *et al.* (1997) see that the role has evolved into a business management role, involved in planning and coordinating activities (Fitzsimmons and White, 1997), facilities and compliance management (Laing *et al.*, 1997), managing budgets (Laing *et al.*, 1998) and monitoring performance (O'Donnell *et al.*, 2011). However, Grimshaw and Youngs (1994) found that

responsibilities tend to revolve around operational and tactical matters, while Laing *et al.* (1997) and Verrill (2005) indicate that strategic practice managers are lacking. Fisher and Best (1995) note that practice managers often have little access to the core finances of the practice, restricting their role to operational management, while Laughlin *et al.* (1994) note that some are ostensibly ‘administrators’. Although they may play some part in financial control, overall responsibility for this remains with GPs (Broadbent and Laughlin, 1998), with practice managers primarily implementing and administering decisions (Laing *et al.*, 1998) as opposed to personally making organisational improvements (Laing *et al.*, 1997).

Practice size is a factor (Westland *et al.*, 1996; Newton *et al.*, 1996; Newton and Hunt, 1997; King and Green, 2012), with larger practices having more formal structures and approaches and greater role definition; in some large practices, managers proactively plan, consult with partners and make some decisions. Thus, as Verrill (2005) notes, practice management can take a ‘traditional’ form (GP-controlled; 'manager' is administrator), a ‘transitional’ form (daily management by manager, focusing on information provision while GPs retain considerable control over decisions) and a ‘progressive’ form (participatory management, with managers contributing to key decisions and given greater freedom). However the ‘progressive’ form was rare. This is consistent with Laing *et al.* (1997) who suggest that, while the manager’s span of control may have increased, their freedom to manage has not; where they possess decision-making authority, this can be relatively limited (Newton and Hunt, 1997) and in conjunction with owners (Newton *et al.*, 1996). Reflecting Hales *et al.*’s (2012) description of service managers in secondary care, the practice manager can end up filling a ‘residual’ role that deals with routine aspects that clinicians choose to offload, thus curtailing its value potential.

This raises the question as to why practice managers do not ‘manage’ in a broader sense. A concern expressed regarding the enhancement of the role (Laing *et al.*, 1997) is whether GPs will accept being ‘managed’ (Fitzsimmons and White, 1997), as it is the owner who defines the boundaries (Checkland, 2004) and is in authority (Laing *et al.*, 1998; Verrill, 2005). Consequently, the legitimacy of the practice manager is potentially limited (Checkland, 2004; Verrill, 2005), who can be largely subservient (Laughlin *et al.*, 1994). Laing *et al.* (1997; 1998), Calnan *et al.*, (2000) and Checkland (2004) note

that, even with managers present, GPs can still seek to stay in control, which may be a source of frustration for managers (Broadbent and Laughlin, 1998), challenging their capacity to actually ‘manage’ (King and Green, 2012). In this regard, it appears that GPs may struggle with delegation (Guthrie, 1999), potentially stemming from their traditional clinical independence in decision-making, their desire to remain in charge and the status associated with control (Calnan *et al.*, 2000).

Overall, the literature indicates that the practice manager role may be growing in significance, and provides a potentially important support to the GP as managers, but that it remains at a largely operational and administrative level with limited responsibility[13]. A factor in this is the desire for GPs to remain in control of key areas and their struggle with delegation, consistent with owner-managers of small businesses (Florén, 2006). While ensuring that the practice manager does not possess the power to pursue conflicting goals, this approach imposes greater managerial responsibility on the GP instead. The practice manager’s involvement in strategic management appears limited, suggesting an area where GPs should focus in terms of management (though literature in section 2.4.2 questions this). Thus, given their apparent dominance of management beyond routine matters, it is necessary to establish in what way the training undertaken by GPs equips them for such a role.

2.6 Management training for doctors

In a medical context, the notion that management is straightforward and that doctors do not need training in the discipline is unrealistic (Fitzgerald and Sturt, 1992; Hadley and Forster, 1995; Joyce, 1998; Forbes *et al.*, 2004). Although aspects of their medical training may contribute to their management role (Ireri *et al.*, 2011), this is insufficient (Allen, 1995; Buchanan *et al.*, 1997; Kippist and Fitzgerald, 2009; 2010). Thus, it is increasingly recognised that doctors need to develop leadership and management competences (Stergiopoulos *et al.*, 2010a; Ireri *et al.*, 2011), particularly at more senior levels (Vera and Hucke, 2009). Where formal training is undertaken, experiences can be positive amongst clinicians as they are exposed to areas and aspects (e.g. literature) that were previously unknown but relevant to the role (Fitzgerald, 1994; Kippist and

13 Literature reviewed here on the practice manager mostly stems from the UK, where the role is more developed. Thus, in an Irish context, it can be expected that this is even more the case. However, a lack of local literature prevents comparisons.

Fitzgerald, 2010) giving rise to identifiable improvements for participants (Ireri *et al.*, 2011; Snell *et al.*, 2011). However, Forbes *et al.* (2004) note that there can be limited availability of relevant training for the clinician entering management, with Walker and Morgan (1996: 31) describing this as "haphazard and sparse". Development can often happen on-the-job (Thorne, 2000; Checkland *et al.*, 2011), which is important but insufficient on its own (Guthrie, 1999).

According to Kumpusalo *et al.* (2003), 85% of the physicians they surveyed believed that they did not have enough management training during post-graduate specialist training, even though they were in executive positions. None of Buchanan *et al.*'s (1997) sample of hospital clinical-managers received advance training for their new roles, while Joyce (1998) found that only 28% of her sample of Irish consultants had attended a management course in the previous five years. This lack of training seems to relate to a variety of factors beyond availability and opportunity as a lack of time (Fitzgerald and Sturt, 1992; Stergiopoulos *et al.*, 2010a), positive action (Kippist and Fitzgerald, 2009), awareness (Checkland *et al.*, 2011) and relevance (Fitzsimmons and White, 1997; Stergiopoulos *et al.*, 2010a), as well as a preference for clinical training (Gallen *et al.*, 2007; Ireri *et al.*, 2011) are also noted.

Hunter (1992), Russell *et al.* (2010) and Ireri *et al.* (2011) call for management and leadership training to be provided early, possibly at undergraduate level (McClelland and Jones, 1997; Joyce, 1998; Varkey *et al.*, 2009). However, Walker and Morgan (1996: 31) comment that clinical demands on students mean that management training at this level is "almost non-existent", while Martins *et al.* (2005) indicate that, although students recognise it's relevance, concerns were expressed regarding the additional workload. While the scope for skill acquisition may be greater at post-graduate level, the challenge to integrate management training remains an issue and students perceive training gaps in many areas (Stergiopoulos *et al.*, 2010b). Preferred learning approaches for trainees (Stergiopoulos *et al.*, 2010b) include workshops, web-based and interactive small groups, as medical students and educators regard experiential training as most effective (Varkey *et al.*, 2009). Stergiopoulos *et al.* (2010a: 311) note that shadowing experienced administrators and mentors can complement this, as well as having management learning "integrated into their clinical activities to provide the context for skill acquisition and knowledge consolidation" (also Martins *et al.*, 2005). However,

Sibbett *et al.* (2003) found that trainees can feel under-prepared to deal with practice management at the end of their training and that this can be a factor in a reluctance to enter into partnership. Instead, Kindig (1997) suggests that in-depth training should wait until the role becomes more salient (also Dopson, 1994), as trainees can perceive the skills acquired as being more for future use as opposed to in early career (Gallen *et al.*, 2007).

At levels beyond trainee, Willcocks (2004) and Spehar *et al.* (2012) call for a structured career path towards management and more formalised development activities. However, generic management theories or programmes are not viewed as sufficient, as context is critical (Greener and Harrington, 2010; Greener *et al.*, 2011). Even still, Hadley and Forster (1995) argue for some grounding in theory and concepts, in conjunction with experiential learning, as a means of making the training lasting and transferable. In a similar vein, Cowton and Drake (2000) recommend that consulting the body of knowledge on small business management would be of benefit to GPs. Training should thus allow doctors to challenge management concepts, relate these to real issues and provide opportunities for 'learning by doing' (Walker and Morgan, 1996). In this respect, doctors need a structure "which can help them to understand what they have been doing and also hopefully manage better" (Allen, 1995: 48). Based on Hoff (1999a; 2000) and Montgomery (2001), relatively few clinical-managers have formal management qualifications. However, Kindig (1997) and Hoff (2001) argue against simply enrolling doctors in standard management programmes.

The nature and context of the organisation is important – as Sheaff *et al.* (2012) note, transferring managerial practices into organisations, without adaptation, can have adverse outcomes. Thus, in a general sense, Evans (2004) indicates that the overall curriculum for GPs needs to reflect their particular requirements. However, as highlighted previously, a central issue for small-firm owner-managers is that they work in time and resource constrained environments (Down, 1999), affecting their scope for exploration and reflection (Florén, 2003). Combined with their scepticism regarding the value of training offerings (Down, 1999) and their self-perception as business-people rather than managers (O'Dwyer and Ryan, 2000), these factors can make small-firm owner-managers reluctant to engage in training (Down, 1999). Instead, development can be informal and incidental, arising from 'learning by doing' and problem solving

on-the-job (Weight, 2001; Devins *et al.*, 2005). Therefore, the small firm context of GP practices is important and may further limit the scope for formal development. However, few studies appear to address management training at the practice level (e.g. Willcocks (2004) looks at the broader primary care team context).

Thus, the literature[14] indicates limited training in management amongst doctors, for a variety of reasons. Where training occurs, the importance of context and timing is emphasised. A practical, 'on-the-job' approach is preferred; there is apparently less interest in more formal means, though literature suggests there is merit in this. In general, management training for doctors is acknowledged as being important, but with some debate also around when this should happen career-wise. For the GP as manager, these issues may be influential in terms of the nature of their managerial role. Collectively, this also raises a broader question in terms of the value of the management role undertaken by the clinician, given the apparent disconnect between the importance of the role and acknowledged need for development, and the seemingly limited actual engagement with formal training. In this regard, if doctors are not adequately equipped for a management role, in what way are they of value as managers and thus benefit stakeholders through their involvement?

2.7 The value of the clinical-manager role

As clinical-manager, the clinician wears 'two hats' (McConnell, 2002), operating within and between separate cultures (Thorne, 2000; Llewellyn, 2001). However, Hunter (1992) notes that there can be limited interest amongst doctors in the managerial role (also Dopson, 1994; Gatrell and White, 1997) and with greater certainty about whom they are in a clinical context (McDermott *et al.*, 2013). In this regard, it is interesting that even clinical-managers may view themselves as clinicians first and managers second (Willcocks, 1994; Kippist and Fitzgerald, 2010). Bruce and Hill (1994), Buchanan *et al.* (1997) and Russell *et al.* (2010) find little enthusiasm amongst hospital consultants for management, while a lack of willingness to engage can also be found in primary care (Laing *et al.*, 1998); thus clinicians may be largely 'reluctant' managers (Scase and Goffee, 1989; Dopson, 1994). The supposed benefits arising from their involvement can seem unclear to doctors themselves (Office for Health Management

14 Consistent with section 2.4, elements of the literature reviewed here are from secondary care, where the debate surrounding management training for doctors seems to have featured more prominently.

(OHM), 2002), their organisations (Montgomery, 2001) and other staff (Braithwaite and Westbrook, 2004). Thus, Bruce and Hill (1994: 54) warn that clinicians "may quite simply be very expensive and inexperienced managers" such that they might not utilise their skills and time optimally (Fitzgerald and Sturt, 1992), be organisationally effective or efficient (Kippist and Fitzgerald, 2009; 2010), and may have no meaningful role (Hoff, 1999b).

However, Clark (2012) highlights that greater engagement of clinicians as managers and leaders, while challenging, is something that needs to be secured, with positive outcomes for multiple stakeholders (also Thorne, 1997a); from Goodall (2011), hospitals with physician CEOs outperformed those led by non-physicians. The Royal College of Physicians (RCP, 2005) suggest that clinician involvement in management is an important element of professionalism, as they play a key role in how limited resources are deployed and combine expertise from different perspectives (Fitzgerald and Sturt, 1992). By acting as a vehicle for knowledge connectivity and development, a source of challenge to the dominant logic and as the key link in both internal and external networks (Harrison and Miller, 1999), the clinical-manager plays a potentially important strategic role. Thus, Dunham *et al.* (1994: 62) found that both clinical and non-clinical managers viewed the role "as making valuable contributions to the effectiveness and performance of their health care organizations". To be valuable, though, the clinical-manager should ideally contribute something beyond that which doctors and managers individually offer (Hunter, 1992; Hoff, 1999a; Fitzgerald *et al.*, 2006); otherwise, it is arguable that management be left to managers and 'doctoring' to clinicians.

The literature now reviewed indicates both positives and negative aspects associated with the clinical-manager role.

2.7.1 Positive aspects of managerial involvement

2.7.1.1 Organisational benefits

Key knowledge, skills, understanding and experience, specific to the clinical context, vest in the clinical-manager (Raelin, 1989; Allen, 1995; Kindig, 1997), with "the ability to know things that others involved in management do not know" (Hoff, 1999a: 55).

This is not “grounded in generic ideas about how to run organisations” (Greener and Harrington, 2010:2), but is instead relevant to healthcare organisations. In addition, the clinical-manager has a greater understanding of what their staff and colleagues are experiencing (Forbes and Prime, 1999) and need (Barber, 1963). Thus, the most suitable group influences key decisions (Buchanan *et al.*, 1997; Schneller *et al.*, 1997), as non-clinical managers may be individually unable to carry out all of the relevant tasks (Fitzgerald, 1994) or have an inappropriate focus (Llewellyn, 2001). This includes ensuring that a quality service is delivered (OHM, 2002), service improvement and innovation is supported (Dickinson and Ham, 2008; Snell *et al.*, 2011) and resources are managed (Dopson, 1994). Furthermore, managerial involvement provides doctors with greater awareness of the broader context (Thorne, 1997b).

2.7.1.2 Representing the needs of patients

From Schneller and Kirkman-Liff (1988), cited by Hunter (1992), clinical-managers have a legitimate authority that other managers lack and can deliver benefits to patients through their involvement in management (OHM, 2002). Hoff (2000) indicates that such hybrid managers retain a steady commitment to their profession, while Kindig and Lastiri (1986) note that over one-third chose the role because they wished to have an impact on healthcare delivery and to ensure the quality of patient care. Thus, having a say in policy-making and decisions (Montgomery, 2001), a strategic influence (Ong, 1998, Harrison and Miller, 1999; Spyridonidis and Calnan, 2011), and acting as an advocate (Kippist and Fitzgerald, 2010) can help to ensure that clinical and patient concerns are properly addressed (Dunham *et al.*, 1994; Buchanan *et al.*, 1997; Martins *et al.*, 2005). In this context, “The ultimate justification for doctors' becoming more involved in the management process is thus that the care to patients will be improved” (Joyce, 1998: 221), reflecting a key motivation for clinician engagement (Snell *et al.*, 2011).

2.7.1.3 Resolving conflicts

A lack of trust between clinicians and managers can exist (Fitzgerald, 1994; Greener *et al.*, 2011), with doctors adopting a more individualised patient focus in contrast to the wider view of managers (Dickinson and Ham, 2008). Thus, clinicians may be uncomfortable with non-clinicians making decisions around patient care (Hunter, 1992; Fitzgerald, 1994; Buchanan *et al.*, 1997) and conflict can arise. Clinical-managers can

assist through their scope for boundary-spanning/mediating (Kindig, 1997; Hoff, 1999a; 2001; Thorne, 2000; Montgomery, 2001; Llewellyn, 2001; Spyridonidis and Calnan, 2011) and capacity to encourage physician participation (Guthrie, 1999). In this context, clinical colleagues may view the clinical-manager as a ‘protector’ (Hoff, 1999a; 1999b; 2001), while also responsible to (Burgoyne and Lorbiecki, 1993; Hoff, 2001) and trusted (Montgomery, 2001) by both groups. However, this can also mean that the clinical-manager absorbs and internalises what was previously external conflict between groups (Thorne, 1997b), as a burden of operating at the boundary.

2.7.2 Negative aspects of managerial involvement

2.7.2.1 Lack of time

Willcocks (1994) notes that vesting clinical and managerial responsibilities in one person can give rise to incompatible roles when trying to satisfy the needs of multiple and divergent stakeholders. A lack of available time amongst clinical-managers can mitigate their capacity to undertake management duties (Walker and Morgan, 1996; Buchanan *et al.*, 1997; OHM, 2002; Checkland, 2004) or impede their clinical/personal activities and development (Dawson *et al.*, 1995; Thorne, 1997b; Hoff, 1999a; Harrison and Miller, 1999; Willcocks, 2004; Checkland *et al.*, 2011; Dadich, 2012). In this context, Kippist and Fitzgerald (2009) note that there is a tension between being effective in management while being able to undertake clinical work, as clinical responsibilities remain the focus (Fitzgerald *et al.*, 2006). Thus, Fitzgerald and Sturt (1992: 142) contend “the [management] role should be pared down to the minimum tasks required” with delegation important (Weight, 2001; Spehar *et al.*, 2012), although relinquishing control to others can be difficult (Thorne, 1997b). Even where management time is allocated, this is often within a tight clinical schedule (Forbes *et al.*, 2004) and may be insufficient, though Hallier and Forbes (2004) also suggest that a lack of time may be an excuse for not fully engaging with a disliked role.

2.7.2.2 Negative motivations for assuming the role

Hoff (1999b) indicates that those who take on management roles for negative or protectionist reasons might potentially be harmful to the business, as various forms of resistance to organisational needs and initiatives were identified. From Forbes *et al.* (2004), clinical-managers can be 'reluctants' or 'investors' in terms of their additional

role. ‘Investors’ embrace management, have an agenda they wish to pursue and see opportunities for influencing service delivery, with some even viewing the role as a means of moving away from clinical work. However, ‘reluctants’ lack commitment to the role and have a negative view of how management intrudes into the clinical domain. Therefore, they may not wish to be associated with a management identity (Checkland *et al.*, 2011) nor managed by those they object to (Dopson, 1994; Kippist and Fitzgerald, 2010) and view their expanded role as, in ways, a ‘necessary’ burden to minimise (Hunter, 1992; McConnell, 2002). Willcocks (2004) finds similarly in primary care groups, with some GPs viewed as 'enthusiasts', while others lack motivation or interest.

2.7.2.3 Being viewed as a ‘defector’ by peers

Greener *et al.* (2011) note that clinical-managers can feel that they lack the respect of colleagues. However, collegiality amongst professionals is valued and the prospect of being isolated from peers (Riordan and Simpson, 1994; Fitzgerald, 1994; Schneller, 2001) or viewed with suspicion (Braithwaite, 2004) is a concern. Ham and Dickinson (2008) comment that those who fill hybrid roles face the challenge of crossing between different cultures (Ireri *et al.*, 2011; Witman et al, 2011) and risk being seen as having ‘gone native’ (Schneller, 2001), as ‘defectors’ (Hallier and Forbes, 2004) and no longer ‘real’ doctors (Hoff, 1999b). Hoff (2000) highlights that this may particularly be the case if the clinical-manager gives up medicine as maintaining a connection to practise helps the physician to stay on the inside as well as providing essential insight into operations (Johansen and Gjerberg, 2009) and credibility (Burgoyne and Lorbiecki, 1993). However, where the clinical-manager does not emphasise the managerial role and support organisational goals, they may not be meeting the needs of others (Schneller *et al.*, 1997).

Thus, research remains divided as to the value of the clinical-managerial role, in terms of how stakeholders may benefit from clinician involvement. While gains may potentially arise for the organisation, patients and clinicians themselves, these can come at a cost in a lack of time for, and interest in, the role as well as concerns regarding peer reactions. In healthcare generally, the value debate appears unresolved (Montgomery, 2001; Fitzgerald *et al.*, 2006; Dickinson and Ham, 2008; Fulop, 2012) with limited evidence either way (Goodall, 2011); in primary care specifically, debate seems lacking

to date (O'Riordan and McDermott, 2012). However, the literature reviewed provides a useful means of considering value in this study by identifying positives and negatives associated with the role. In addition, the literature highlights the significance of the professional (clinical/patient care) role of the clinical-manager as this affects their perceptions of what is important. Furthermore, the issue of conflict arising between the clinical and managerial domains in the organisation is revealed, each of whom may have different agendas. As the clinical-manager acts as a 'boundary-spanner', they are exposed to this conflict. These issues – the influence of the professional role and implications of role conflict – are not addressed within Carroll and Gillen's (1987) model and will need to be considered further in the context of the literature.

2.8 Summary

This chapter began by outlining established management theories central to this study, in the context of Carroll and Gillen's (1987) integrating model of the manager at work. The model helps to illustrate how the manager's activities are influenced by their work agenda and that, stemming from these activities and their underlying purposes, the manager carries out the functions of management. From this, an initial model is presented which partially addresses *why the job is the way it is, what is done and what are the purposes of this* by way of a more complete understanding of the work of the manager. Specific research on the managerial work of doctors identifies a wide variety of tasks; however, there is little attempt made in the literature to relate this back to established management theory. This is important in the context of research question two. It is suggested that Carroll and Gillen's (1987) theory-based model can assist in generating an increased understanding regarding the nature and performing of the managerial role, while responding to Florén's (2006) call for greater integration between small business and general management research.

However, it is also apparent that the refined model (Figure 2.2) can only partly address the manner in which GPs manage. Adaptation may be required for the administratively-focused supporting role of the practice manager, as the presence and involvement of such a resource may influence the work of the GP in a managerial capacity. In addition, the limited, primarily experiential management training undertaken by clinicians and owner-managers may have implications for how GPs engage with management

responsibilities and tasks. These issues have been identified in the literature as potentially having an influence on the nature of the managerial role of the GP and are relevant in the context of research question three. Literature on the value of clinicians as managers is also critiqued in terms of whether clinician involvement in the role is of benefit to stakeholders. Debate on this is lacking in general practice specifically, which is significant given the national policy importance of primary care (O'Riordan and McDermott, 2012) in a challenging environment (Thomas and Layte, 2009). This is important in the context of research question five. In addition, prior research reviewed in this chapter highlights two further areas to be addressed in the current study, namely the influence of the professional role on the work of the clinician and the conflict they experience between their clinical and managerial roles. These will be considered in subsequent chapters, with the professional role firstly addressed in chapter three.

Chapter Three

Professions and the General Practitioner

Chapter Three: Professions and the General Practitioner

3.1 Introduction

This chapter addresses the professional role of the GP, which was identified as their primary role when outlining the general practice context (Table 1.1, p.3). Therefore, the influence of this role needs to be addressed in developing a comprehensive model of the GP as manager, before considering the implications of the interactions between their professional and managerial roles using a role theory lens (chapter four). Two core aspects of the professions are focused on in the current chapter – autonomy and altruism – and the implications of these for the GP in how they undertake their work. Literature on career stages is then outlined. This highlights the evolution of the professional career, as professionals can gradually assume increasing managerial responsibility in their organisations. However, this may also have implications for their capacity to remain engaged in traditional professional duties.

3.2 Professions and professionals

The word 'profession' has its foundation in the Latin word 'professio', meaning the declaration of an oath, while the Concise Oxford English Dictionary (2002: 1141) explains 'profession' as "a paid occupation, especially one involving training and a formal qualification" and as "a body of people engaged in a profession". A professional is expected to demonstrate professionalism, which is central to being a good doctor (RCP, 2005). Van de Camp *et al.* (2004) indicate that, of the elements commonly associated with professionalism, altruism is referenced most often in the medical literature. Altruism is viewed as a core value (RCP, 2005) and important to the clinical profession (McGaghie *et al.*, 2002; Wicks *et al.*, 2011). In this regard, clinical professionals are assumed to traditionally be about public service and altruistic behaviours more so than self-interest and economic goals (Cruess *et al.*, 2000; 2002; Vera and Hucke, 2009)[15]. A further dimension of professionalism is autonomy (Bartol, 1979). Brint (1993) notes that a professional in practice has limited control over policy-making, lacks significant capacity to define the needs of the general public and their

15 It is acknowledged that 'altruism' is less commonly associated with more commercially-oriented professions (e.g. accounting, engineering) though the principle of placing the interests of the clients above others remains relevant. The focus of this study is the medical profession, where altruism retains some significance (Vera and Hucke, 2009).

problems, and possesses little power over how resources are allocated except for those immediately at hand. In spite of this, Brint recognises that their autonomy and power over individual clients and access to resources is significant.

This brief section has highlighted two aspects of particular importance to this study – autonomy and altruism – which are amongst the four hallmarks of professions (Hodson and Sullivan, 2012). The significance of autonomy is suggested by an underlying theme of professional 'control' from chapter two (GPs as owner-managers, with limited delegation), while the relevance of altruism is based on the fact that general practice is a commercial business as well as a vehicle for patient-service delivery and care (Lynch, 2012), which may not be entirely compatible.

3.3 Autonomy and the professional

3.3.1 The desire for autonomy

According to Barber (1963), autonomy is one of the key attributes of the professional role, existing at both the collective and individual level (Dupuis, 2000). Trust is essential, as the professional is allowed to perform without direct supervision, while the profession is trusted to regulate its members[16] (Freidson, 1988; Halpern and Anspach, 1993).

Raelin (1989) indicates that autonomy has three components. At the *strategic* level, autonomy concerns the choices of goals and policies to guide the organisation, while at the *administrative* level, this pertains to responsibility for managing activities and coordinating tasks. *Operational* autonomy relates to carrying out the work within strategic and administrative constraints. Raelin suggests that professionals can cede autonomy at the strategic level (though sometimes play a role) and may do so at the administrative level (if they feel supported and not encroached upon), but tend to retain operational autonomy. Thus, while professionals may lack control over the goals and ends of their work, they largely retain control of the process and means (Derber, 1983).

16 Naturally, there are limits to this as professionals are subject to national laws, while doctors are also subject to the requirements and rules of the Medical Council. However, this does not negate the fact that professionals, individually and collectively, possess considerable autonomy. The focus in this study is autonomy at the individual practitioner level.

For the individual practitioner, the ability to operate autonomously is fundamental (Brint, 1993) and a core part of their professional identity (Elina *et al.*, 2006). Horner (2000), in a medical context, views it as implying the existence of an individualised contract between physician and patient, based on improving the patient's health and protecting them from others who seek to control this (Jochemsen and Ten Have, 2000). GPs themselves believe that they "should have the freedom to control all dimensions of patient care without external interference" (Majorbanks and Lewis, 2003: 2236), as part of the medical culture is for doctors to want to be in control (Descombes, 2002). However, in a bureaucracy, such control may be eroded.

3.3.2 The bureaucratic structure

The bureaucratic form (Weber, 1947; Gerth and Wright Mills, 1997), encompassing rules, hierarchies, formality and specialist management, can be associated with dysfunctional aspects including poor communication, delays in decisions, rigid rules, internal conflict and alienation (Henslin, 1999; Hales, 2001). However, Weber indicates that the structure has advantages in terms of precise operation, carried out more expediently in an unambiguous manner; thus, it is not that bureaucracy is inherently dysfunctional, but rather "badly-managed bureaucracy, where there is an excess of regulation and hierarchy" (Hales, 2002: 53). Freidson (1984: 10) notes that bureaucracy "connotes efficiency through the meticulous supervision and control of its members and the careful planning of activities", representing a rational approach to how work activity is organised (Newton *et al.*, 1996). In this respect, where tasks can be reduced to routines, a bureaucratic approach can be effective (Volti, 2008). However, the creative, complex and unstructured work of professionals tends to be less suited to this form (Hales, 2001).

3.3.3 The professional in a bureaucracy – conflicting ideologies

Operating within a bureaucracy means a potential loss of autonomy (Organ and Greene, 1981; Lorsch and Mathias, 1987; Leicht and Fennell, 1997) by professionals, with more of their activities under the direction of non-professional managers to whom they are subordinated (Scott, 1965; Ritzer and Walczak, 1988) and with limited participation in management (Stoeckle, 1988). This is not the traditional preference of the professional (Majorbanks and Lewis, 2003; Spyridonidis and Calnan, 2011; Snell *et al.*, 2011) who

wishes to remain in control without their freedom constrained (Barber, 1963; Stoeckle, 1988).

Ritzer and Walczak (1988) and Horner (2000) indicate that the professional can experience a conflict between their ideals and values and what the bureaucracy demands. Von Alemann (2003) notes that problems can arise in professionals' interactions with administrative staff, while La Porte (1965) acknowledges that restrictive procedures are a key source of tension. Consequently, bureaucracy can present challenges for the professional (Hall, 1968) as cultures, goals and values may clash (Lebell, 1980; Hunter, 1992) with managers and non-professionals focusing on financial priorities (Ritzer and Walczak, 1988; Stone, 1997; Granter and Hyde, 2010), and targets (Hyde, 2010) over vocational service.

The professional may resist attempts to be managed (Bate, 2000). Kitchener (2000) and Reay and Hinings (2005) indicate that changes in professional roles forced on physicians were opposed, while Exworthy *et al.* (2003) note that imposing performance indicators on GPs was viewed, by some, as an erosion of their autonomy. Similarly, Calnan and Williams (1995) found that GPs can resent interference with their freedom to arrange their own work. However, viewing managers as loyal only to organisational interests may be an over-simplification (Golden *et al.*, 2000); Granter and Hyde (2010) note that managers are also focused on patient care, possessing "a moral responsibility for health care" (Ten Have, 2000: 504). As Checkland *et al.* (2011) found, where the GP experiences what they regard as 'good' or appropriate external management, they will work with the manager. They did not observe any GPs who seemed to resent being managed, but rather viewed the manager's role as part of being successful.

3.3.4 Combining the competing ideologies

Freidson (1990) observes that today's health care systems can be regarded as a mix of both the professional and bureaucratic models (also Ten Have, 2000). In this structure, professional and administrative spheres are largely separated (Vera and Hucke, 2009) but interdependent (La Porte, 1965; Montagna, 1968) and potentially collaborative (Bate, 2000). Thus, different models need to work together to control costs and performance, but not in such a way that the benefits to the client of professionalism are lost, which should remain central (Freidson, 1990). Organ and Greene (1981) note that

levels of bureaucracy may be limited to accommodate professionals, as management make concessions (Leeming, 2001) to support professional activity (La Porte, 1965). This can entail creating special roles and sub-structures and using professionals as managers and leaders (Barber, 1963; Thorne, 1997a), avoiding direct challenges (Griffiths and Hughes, 2000), and engaging professionals in decisions (Rendall, 1985).

Organisations may adopt an 'enabling' bureaucracy, where professionalism is encouraged and formalisation facilitates the professional by addressing routine tasks, as opposed to a 'coercive' bureaucracy of inflexible rules (Adler and Borys, 1996, Hyde, 2010). Thus, where formal procedures are consistent with professional values, this is not viewed as problematic (Organ and Greene, 1981; Lait and Wallace, 2002). Lorsch and Mathias (1987) indicate that formal systems are required to ensure that key performance measures are taken, while Hall (1968) suggests that a degree of bureaucracy may be complementary, as a means of maintaining social control and facilitating communication (Blau *et al.*, 1966).

In a GP context, Harrison and Dowswell (2002) found a general acceptance of 'bureaucratic accountability' regarding the need to keep records of clinical decisions. Checkland (2003) suggests that although useful and well-conceived clinical guidelines may reduce autonomy, they can also make the practitioner's job easier and enhance quality (Roland *et al.*, 2006). Greener *et al.* (2011) note that the Quality and Outcomes Framework (QOF)[17] – while eroding clinical autonomy – was not opposed, being viewed as a "credible tool for improving care" (p.29), with significant health gains possible (McElduff *et al.*, 2004). Locock *et al.* (2004) found that GPs appeared to be willing to accept some form of standardisation and control as long as this was in line with good clinical care. Where they did not agree with protocols, GPs wanted to retain the ability to deviate from these protocols. Thus, the form of bureaucracy GPs accepted was where the goals of management were congruent with their goals, being 'enabling' rather than 'coercive'.

The literature indicates that organisations can be bureaucratic as professionals may operate under the influence of lay-managers. While the benefits of an efficient

17 The framework is a UK performance-management system, forming the basis for certain payments to GPs.

bureaucracy are apparent, there is evidence that excessively formalised structures hamper the professional and can generate resistance. However, accommodating and enabling structures are also possible as both ideologies can co-exist (Malhotra and Morris, 2009). In this regard, professionals may seek a suitably efficient organisational form where they have influence.

3.3.5 Professional organisations – alternative forms

The traditional home for the professional is the 'professional organisation' (Scott, 1982), where professionals are in the majority, define and achieve the main organisational goals (Montagna, 1968), and are the primary generators of value (Empson, 1999). Scott (1965) and Hall (1968) outline two contrasting types of professional organisation.

The *autonomous professional organisation* represents the standard for established professions, where "the work of the professional is subject to his own, rather than to external or administrative jurisdiction" (Hall, 1968: 94). Because professional work is both complex and important, "the strategy pursued is to couple capability with discretion in one responsible actor and place him or her as close as possible to the problem situation" (Scott, 1982: 214). Thus, legitimate control vests in the professional at various levels, ranging from informal and personal, to more formalised, position-based control. However, even controls at a formal level may not fully address all aspects of the professionals work – as Scott (1982) notes, this can be limited to administrative control as individual physicians have considerable clinical autonomy. In this regard, Mintzberg (1998) notes that professionals can believe they need limited direct supervision, seeing themselves as being in charge at the top with 'management' as support; non-professionals may occupy largely subordinate roles, performing more routine functions (Mintzberg, 1981).

In the *heteronomous professional organisation*, professionals "are subordinated to an externally derived system" (Hall, 1968: 94), which Scott (1982) suggests is appearing in healthcare as hospital managers increase their powers. Thus, the autonomy of the clinician is compromised as they become subjected to managerial control and conflicting priorities (Ritzer and Walczak, 1988); the focus shifts from the individual to the collective, which can be at odds with the physician's tendency to concentrate on the presenting patient.

Scott (1982) identifies a third form, the *conjoint professional organisation*, where control is more evenly distributed. Different groupings have primacy in different areas, but are also interdependent partners as opposed to one dominating the other (Bate, 2000). Instead of managers supporting and physicians ruling over patient care, physicians focus at the micro-care level while managers operate at the macro-care level, influencing each other more so as equals. The conjoint form attempts to accommodate professional autonomy and goals, while allowing for work coordination in accordance with management needs. In this respect, roles and structures overlap as required and joint decision-making is facilitated, reflecting more of a shared or 'partnership' (Clark, 2012) approach to management.

These distinctions highlight how professional organisations can exist along a professional-bureaucratic continuum (Malhotra and Morris, 2009). One structure arises where professionals dominate and management are mostly subordinate. While satisfying their desire for autonomy, this entails the professional having greater responsibility for management as a cost of control. An alternative structure sees management dominating, with professionals focusing on core activities. This relieves the professional of other duties as expertise is vested in those with managerial responsibility, allowing for the possibility of increased efficiency. However, professional autonomy is then limited, which may be problematic. A further compromise sees managers and professionals operating interdependently, each group maintaining dominance within their own domain and crossing over when needed. Therefore, choices made in terms of organisational form and control may have implications for the nature of their managerial role.

3.4 Altruism and the professional

From McGaghie *et al.* (2002), although a vague concept, altruism still acts as the cornerstone of codes of professional conduct and at its core is compassion. It is such compassion that attracts people to the health professions, as well as sustaining their devotion. However, it is also argued that healthcare is becoming increasingly commercialised in some countries (Mechanic, 1996; Stone, 1997; Relman, 2007) and that money is a factor (Descombes, 2002). Consequently, there is a potential conflict, or tension (Laing *et al.*, 1997; Gillies *et al.*, 2009), between the practice and business of

medicine, threatening the professional identity and image of the clinician (Mangin and Toop, 2007; Perry, 2010).

3.4.1 Perspectives on altruism

Piliavin and Charng (1990: 30) define altruism as “behavior costly to the actor involving other regarding sentiments; if an act appears to be motivated mainly out of a consideration of another's needs rather than one's own, we call it altruistic”. Wakefield (1993: 417) refines this by contending that a cost need not arise: “a motivational state with the ultimate goal of increasing another’s welfare”. Lin-Healy and Small (2013) indicate that, where personal benefit for the giver is involved, the degree of perceived altruism is adversely affected. Indeed, Le Grand (1997) suggests that altruists may reduce/cease their helping behaviour if compensation eliminates the personal sacrifice giving rise to satisfaction, as extrinsic incentives can lower intrinsic motivation (Batson and Powell, 2003). Although Wakefield (1993: 409) concedes that “it may be more difficult to experience intrinsic motivations like altruism when extrinsic rewards like money are attached to action”, he does not accept that it is impossible as motives can be mixed (Batson and Powell, 2003).

Thus, the *dominant* underlying motivation should be altruistic: “a motive to benefit someone else is an altruistic motive only if it is not a means to a further nonaltruistic end” (Wakefield, 1993: 413), suggesting that other possible outcomes should not influence the act (Badhwar, 1993). Midlarsky (1968) (cited by Pilowsky, 1977) indicates that any gain arising should be small, though Hardy and Van Vugt (2006) also argue that an otherwise altruistic act that enhances the perceived status of the giver, with potential for long-term benefits, remains altruistic whether gains are expected or not. In this context, being altruistic, one need not exclude self-concern or they are veering towards martyrdom (Maier and Shibles, 2011).

Therefore, while altruism appears to entail a benefit to others as the primary motivation, it is less clear whether costs or gains for the giver are necessary or acceptable if the act is to remain altruistic. In the context of clinicians, who receive payment but who also subscribe to professional ideals, this may be challenging: “Profit is not immoral, nor is it professionally unethical … Yet doctors have traditionally sought to hide this

motivation for practice" (Descombes, 2002: 165). Therefore, it is important to assess evidence of the existence of both motivations before addressing how they may interact.

3.4.2 Altruistic tendencies: meeting the needs of patients

Vera and Hucke (2009: 80) suggest that "there will be hardly any physicians who attach more importance to economic goals than to quality of care". Indeed, Pellegrino (1987) argues that altruistic behaviour by physicians is an obligation, built upon the nature of illness and their role in addressing this, the non-proprietary character of their knowledge and the oath that they have taken to serve the patient's interests. Thus, the primacy of the patient and their needs is acknowledged (Mechanic, 1977; Pellegrino, 1999; Medical Council, 2009) and money should not be the focus (Hoffenberg, 1987; Hoogland and Jochemsen, 2000).

McDonald *et al.* (2010) accept that money is a motivator for GPs, but the notion that this purely drives them is disputed; income opportunities are sought in conjunction with professional values (Locock *et al.*, 2004). Spoor and Munro (2003) found that GPs, who had the choice as to which secondary care provider to refer patients to, were not primarily influenced by price, even though referring to cheaper providers would mean more funds for reinvestment. Ashworth *et al's.* (2005) research on the relationship between GP incomes and quality of care found no evidence that those who were more highly paid (on patient numbers primarily) neglected specific quality targets. Gartland and Carroll (2004) found that capitation payments were linked to higher physician spending. While savings were achieved in office costs, higher spending on administrative staff, information services and nurses offset this. This suggests that physicians need not engage in behaviour that could be described as 'profiteering', but rather can utilise resources generated to benefit patients (Hausman and Le Grand, 1999) through service enhancement.

McDonald *et al.* (2007) found little evidence that financial incentives for GPs interfered with their professional values, noting that indicators that were rewarded were consistent with what they held to be appropriate. From McDonald *et al.* (2013), a lack of incentives or targets for GPs does not necessarily equate to a lack of care. A 'moral motivation' is present (Marshall and Harrison, 2005) in that economic factors are relevant but as one of many inputs to a clinical decision, including patient health

benefits (Hoffenberg, 1987; Hausman and Le Grand, 1999; Cheraghi-Sohi, 2011; Godager and Wiesen, 2011). This is consistent with Spooner *et al.* (2001), who note that modest incentives were a factor in GPs signing up to a quality improvement scheme, but only in addition to improving patient care, retaining autonomy and professional pride.

Therefore, incentives are most likely to be effective when they are aligned with the GP's own values as a professional (Campbell *et al.*, 2007; McDonald and Roland, 2009; Young *et al.*, 2012). However, where these values are already consistent with the collective best interests of patients, this may reduce the significance of the incentives themselves (Sheaff *et al.*, 2012). Reflecting this, O'Donnell *et al.* (2011) found that while patient care was improving for a sampled incentivised condition, so also was care for a further sampled un-incentivised condition.

3.4.3 Evidence of physician self-interest: income-seeking behaviour

Literature also provides evidence highlighting how income can be an important motivation for action. Commercial interests are relevant as professionals are generally responsive to financial incentives (Young *et al.*, 2012) and value income and prestige. Whynes *et al.* (1999) found that GPs who opted for fundholding[18] were more entrepreneurial but also that all types of GPs responded in a predictably positive way towards financial incentives. They note that over 75% of their sample felt that the financial rewards from general practice were inadequate and that there was a conflict between incentives and professional behaviour, while two-thirds believed that finance had become of greater importance than patients. More recently, Roland *et al.* (2006) comment that a number of their GP respondents admitted that financial incentives were strong motivators. Thus, GPs may be self-interested.

As evidence of this, Pockney *et al.* (2004) identified GPs making extensive use of a surgical procedure that, while more profitable, is no more effective than cheaper alternatives. In Ireland, Walley *et al.* (2000) found that financial incentives associated with prescribing can encourage changes in GP behaviours, while the use of 'fee-for-service' has the potential to induce demand through incentivising repeat visits and over-

18 Fundholding is a system whereby certain UK GPs were allocated a fixed budget from which they would pay certain patient-related costs, being allowed to retain savings for investment in capital assets, staff and services.

provision of care (Tussing, 1985; Gosden *et al.*, 2001; Godager and Wiesen, 2011; Brick *et al.*, 2012). Croxson *et al.* (2001) identified that fundholder GPs availed of 'unintended incentives' by increasing hospital admission activities before fundholding and decreasing them afterwards, providing them with greater financial resources. Consequently, the authors posit, "that fundholders do appear to respond to financial incentives" (2001: 392).

Under the QOF, McDonald *et al.* (2010) note a risk that practices may prioritise profitable activities that give rise to relatively low population health gains. In addition, the Framework permits the exclusion of certain patients from target scores, helping attainment. This may lead to negative outcomes in other parts of the practice (McElduff *et al.*, 2004; Roland *et al.*, 2006; Mangin and Toop, 2007) where incentives do not apply, and for the excluded patients themselves. O'Donnell *et al.* (2011) highlight that, while finding no evidence of un-incentivised conditions being actively neglected, practices had limited slack to fully address these because of time devoted to incentivised areas. The acceptance by GPs of targets may also change the way that presenting patients are viewed; instead of patient concerns exclusively driving the consultation, their contribution to achieving incentivised quotas can be influential (McDonald *et al.*, 2008; McDonald and Roland, 2009).

Fahey (2006) discusses the use of physician practice management companies in US healthcare, where doctors stepped back from managing their practices and received a percentage of revenue/profits, or sold the practice and remained as employees. As many of these companies were publicly traded, physicians gained from increases in stock prices, encouraging profit-seeking behaviours. Stone (1997) suggests that managed care can incentivise physicians to provide fewer services, to see 'sick' patients as a financial liability and to consider how clinical decisions affect their own income, with significant influence over patient care in the hands of non-clinicians. Thus, where medicine becomes 'bureaucratised', as other stakeholder interests are considered in addition to the patient's (Ritzer and Walczak, 1988), Mechanic (1977: 76) notes "Physicians are rewarded more for being good managers and researchers or for coping with a large work load than for providing interested and humane care".

3.4.4 Seeking balance: a duality of interests

Evidence from previous literature is consistent with the models of doctor behaviour indicated by Tussing (1985). Doctors can be self-interested (maximising their own welfare, including income), behave as agents (making decisions that the patient would make with the same information, thus maximising the patients welfare) or adopt a medical ethics approach (following ethical codes to maximise patient health, regardless of cost). In this regard, they are faced with conflicting motivations, such that interplay can exist between the different models; as Batson and Powell (2003: 474) note: "the motivation could be altruistic, egoistic, or both". Thus, GPs confronted by incentives need to consider the consequences of clinical decisions to ensure that patient interests are preserved (Smith and Morrissey, 1994; Marshall and Harrison, 2005) as they can go elsewhere (Hausman and Le Grand, 1999), which may be commercially damaging.

This duality of interests (self and patient) is consistent with Mechanic (1975), who notes that physicians who received a fee-per-service tended to work longer to accommodate higher demand, increasing service availability as well as income, as opposed to those in prepaid practice who tended to work during scheduled hours and could instead seek to address extra demand by processing patients faster. Similarly, Le Grand (1997) indicates that incentivised reinvestment of savings in services by GPs benefits both the doctor (relieved of personal cost) and the patient (enhanced offering). Thus, it would appear that the pursuit of self-interest can be in the interests of patients where an improved service is delivered: "motivation based on self-interest will do a better job of providing benefits to others than will motivations based on altruism" (Rubin, 2009: 408).

Downie (1986a; 1986b) argues that doctors need to make a profit to survive, without being unduly self-interested; this does not prevent them from performing altruistic acts within their role, but simply fulfilling their paid role does not constitute altruism and there is no obligation to be altruistic. Gillon counters (1986a: 59) that doctors have a moral duty to their patients beyond any financial arrangement such that, while self-interest is present, their obligation "is at least in part altruistic in that it is self-imposed by the medical profession not to benefit themselves but to benefit their patients". Thus, while financial returns are a motivator, Gillon (1986b: 172) argues that this is only partial and is balanced by altruism as a further motivation, where altruistic "is simply

meant ‘for the benefit of others’”, permitting the possibility of gain. Consistent then with Jensen (1994), the presence of self-interest does not mean that people lack altruistic motives in the same way that being altruistic does not entail simply doing the bidding of others with no regard for ones own preferences, nor engaging in self-sacrifice (RCP, 2005). Rather, as Maier and Shibles (2011) suggest, some balance between both is needed given that “Positive altruism and positive egoism are always desirable” (p. 241); co-existence and connection as opposed to necessarily in conflict (Badhwar, 1993).

This suggests that a strict and isolated view of altruism is difficult to sustain and potentially unrealistic in modern practice. It may be that some form of compromise or balance is a more appropriate expectation such that benefiting others is not utter self-sacrifice (Bishop and Rees, 2007), accepting that, in conjunction with patient health, financial factors do affect clinician decisions (Fisher and Best, 1995; Godager and Wiesen, 2011). This suggests a context that more closely reflects the simultaneous significance of patients and business (Perry, 2010), recognising that while financial concerns may not be paramount, clinicians remain interested in such matters to succeed and survive (Descombes, 2002).

If altruism represents the traditional, *patient-focused* value of the clinician then the non-traditional value is prioritising the interests of other stakeholders, including the clinician themselves, by being self-interested and *business-focused*. This suggests that physicians operate between two value orientations, though recognising that they need not be polar opposites but “dialectically intertwined” (Maier and Shibles, 2011: 230). A tendency towards one or the other can influence behaviour – the patient-focused physician may emphasise their clinical/care role, while the business-focused physician may place greater emphasis on the practice and managing this. Thus, in the same manner that decisions made with respect to autonomy and bureaucracy may influence the nature of the GP's managerial role, so also might decisions in terms of their emphasis on patient and profit.

3.5 Career stages and the professional

The final element of the professional role considered is the manner in which the professional career evolves and how this influences managerial involvement. Dalton *et al.* (1977) and Dalton and Thompson (1986) identify four stages in the professional career (Table 3.1). The first stage (*apprentice*) signifies the new organisational entrant, who relies on others for direction. Graduation to the second stage (*colleague*) sees increased independence as an equal contributor and competent professional. Supervision is ongoing, but at greater distance as professionals develop their own ideas, take responsibility and make bounded judgements.

Further progression is not automatic and some do not advance because of choice or suitability. At Stage III (*mentor*), the professional takes on the wider role of trainer, helping apprentices and taking responsibility for their outputs. They also deal with people outside of the organisation, such as in the course of developing new business. Roles adopted include mentoring, generating ideas for themselves/others to explore, and – most commonly – formal management. In this respect, the role can be lower/supervisory management, usually “not more than two levels in the organizational structure away from the work itself” (Dalton *et al.*, 1977: 30). Thus, while often managing, they remain professionally active and involved.

	Stage I	**Stage II**	**Stage III**	**Stage IV**
Central activity	Helping Learning Following directions	Independent contributor	Training Interfacing	Shaping the direction of the organisation
Primary relationship	Apprentice	Colleague	Mentor	Director
Major psychological issues	Dependence	Independence	Assuming responsibility for others	Exercising power

Table 3.1 – Central features of the four stages of professional careers (Adapted from Dalton and Thompson, 1986)

The move to Stage IV (*director*) sees the professional take even greater responsibility and actively direct work, moving further from day-to-day matters. Professionals at this juncture are generally upper-level managers, with a remit for shaping the organisation and exercising power. Perspectives are widened as the organisation is viewed more holistically, with strategic thinking emphasised as they engage in mapping the environment, understanding the organisation and managing the decision process. The professional may devote themselves to entrepreneurial activities as they explore new ideas, resource and sponsor these or, alternatively, they may focus their attention on idea generation and problem solving. Stage IV professionals establish key relationships internally and externally, accessing essential outside knowledge while enhancing the visibility of the organisation. They continue to develop others, but through sponsoring and providing opportunities. In essence, many of the differences between Stage III and IV professionals appear to be in the depth and extent of their actual management.

This demonstrates that management roles can tend to gradually evolve after professionals have established themselves, but also that such roles may never arise. Initially, the role is low-level, mostly operational, and with a narrow focus. The third stage acts as something of a training ground for higher management, as occupants assume responsibility for others. For those who advance, this expands into responsibility for the wider entity in mapping direction and strategic decisions. However, this also moves the professional further from core activities. Thus, the career stage of the GP may influence the nature of their managerial role.

3.6 Summary

This chapter has illustrated a number of key themes in understanding the nature of the GP as a professional as, in order to understand the nature of their managerial role, it is important to examine this within the context of their wider work role. It is noted that professionals have a preference for autonomy. Being in control, the professional can function as they see fit and in accordance with their beliefs and values; as manager, this can be maintained (Hunter, 1992; Forbes *et al.*, 2004). A more bureaucratic structure relieves the burden of management, but also reduces the professional's capacity to be in

control. Between these extremes are structural options that can facilitate degrees of autonomy without imposing the full burden of management on the professional.

Clinical professionals have traditionally been viewed as altruistic and focused on societal rather than personal gains; however, contemporary literature questions the accuracy of this as incentives are relevant. If the traditional perspective holds, the clinician would focus on the needs of the patient and place little emphasis on the commercial aspects of being in medicine; a more self-interested view may reverse this. A compromise is to seek some degree of balance.

The career stage of the professional affects the scope of their managerial involvement. Generally, the extent and depth of managerial activity is greatest at later career stages, with the professional moving further from their traditional role. As they advance through these stages, professionals can gradually develop as managers, initially at an operational level but latterly from a wider perspective.

The themes identified in this chapter are relevant to the overall model of the GP as manager as it is important to consider the implications of their professional role, and choices made, on how they function, and how career progression can affect the focus of their work. Potentially, these may influence the nature of the managerial role of the GP and are relevant in the context of research question three. Chapter four will now turn to the final strand of literature, addressing role theory as a means of identifying how the managerial and professional roles of the GP integrate and potentially conflict.

Chapter Four

Role Theory, Role Conflict and the Professional as Manager

Chapter Four: Role Theory, Role Conflict and the Professional as Manager

4.1 Introduction

This chapter addresses role theory, which has previously been used in researching clinical-managers (e.g. Willcocks, 1994; Kippist and Fitzgerald, 2009). Fondas and Stewart (1994: 84) indicate that role theory has potential application in the study of management, "analysing both the influence of expectations on managerial behaviour and the effect of individual actions and preferences on behaviour". In the current study, role theory provides an important lens through which the work roles of the GP (managerial and professional) can be studied, as well as the interactions between these roles and associated expectations.

Initially, role theory and the nature of roles and role episodes are discussed, before outlining the rationale for using Organisational Role Theory in this study. A key issue within role theory is that of actors holding multiple roles. Challenges associated with this are addressed in the context of role conflict, which has much to offer in helping to understand the complex dual roles of clinical-managers (Weight, 2001). Key literature is reviewed and a typology of conflicts provided, illustrating the multi-faceted nature of role conflict. An aspect of particular relevance to this study is addressed, as Organisational-Professional Conflict is explored. The chapter concludes with a summary of the key implications for this study, as well as presenting a preliminary model.

4.2 Role theory and roles

From Biddle (1986: 68), role theory is concerned with the "the fact that human beings behave in ways that are different and predictable depending on their respective social identities and the situation", and with how their behaviour is connected to their social environment (Polzer, 2005a). Conway (1978) indicates that role theory can help to predict how an individual will perform in their role as well as what behaviours can be expected in particular situations. Stryker and Statham (1985), cited in Galletta and Heckman Jr. (1990), view role theory as the study of the extent to which individual behaviour, social interaction and the social person are restricted by the social structure.

Thus, Biddle (1986: 68) summarises that role theory deals with three main concepts: "patterned and characteristic social behaviours, parts or identities that are assumed by social participants, and scripts or expectations for behaviour that are understood by all and adhered to by performers".

Central to role theory is the 'role' itself. In explaining what a role is, Thomas and Biddle (1966: 29) note that it "is the set of prescriptions defining what the behaviour of a position member should be", while Floyd and Lane (2000: 157) describe it as the "set of behaviors that others expect of an individual in a certain context". Thus, roles are linked to expectations (Getzels and Guba, 1954; Biddle, 1986; Galletta and Heckman Jr., 1990; Ilgen and Hollenbeck, 1991; Pandey and Kumar, 1997) and help to determine what is needed to meet such expectations (Polzer, 2005b). Based on Kahn *et al.* (1964) and Barratt (2005), these expectations may come from others (senders) or from the actor's own beliefs and attitudes (self-sent). However, as Hardy (1978) highlights, not all role expectations are equally important – the values of individuals, possible sanctions and the presence of others influence behaviours.

Katz and Kahn (1978) demonstrate how, in a role episode, role senders communicate expectations (*sent role*) to the focal person who is to carry out the role. The sent role is interpreted by the focal person (as the *received role*) and this prompts role behaviour on their part. Role behaviour may or may not be in line with expectations, giving rise to feedback to the sender. Various factors have an impact on the role episode. Organisational factors and characteristics influence the expectations that role senders have of focal persons. The nature of the relationship between the parties and the attributes and attitudes of the focal person both influence the expectations of the role sender and their own interpretation of the sent role. Thus, the focal person's behaviour "is inextricably intertwined with his or her social environment, specifically the preferences held by the role senders who comprise that environment" (Fondas and Stewart, 1990: 11). However, the focal person is not merely a passive recipient of expectations (Floyd and Lane, 2000; Weight, 2001); they also have scope to influence role senders and deliberately shape or modify expectations through action, inaction and communication e.g. rejecting, negotiating, or creating expectations (Fondas and Stewart, 1990; 1994).

4.2.1 Organisational role theory

According to Biddle (1986), role theory encompasses five main role perspectives[19]. Of particular relevance to this study is *Organisational Role Theory* (ORT). ORT addresses roles in formal organisations that "are assumed to be associated with identified social positions and to be generated by normative expectations, but norms may vary among individuals and may reflect both the official demands of the organisations and the pressures of informal groups" (Biddle, 1986: 73). Thus, organisational roles are subjected to multiple influences (Kahn *et al.*, 1964; Guirguis and Chewning, 2005). This is consistent with Katz and Kahn (1978); while role expectations may be formally established by the organisation, they are also influenced by other factors such as the characteristics and values of the actors and their interactions. In this study, the 'GP' is both an individual interacting with and influenced by others (e.g. patients, colleagues) and their expectations, but is also a formal role within an organisational structure with particular duties and responsibilities attached. From Guirguis and Chewning (2005), much of the research in the ORT field has concentrated on concepts such as role conflict and role overload.

4.3 Role conflict

4.3.1 Defining role conflict

Biddle (1986: 82) describes role conflict as "the concurrent appearance of two or more incompatible expectations for the behaviour of a person". This situation can be temporary or permanent (House, 1970), as the individual is exposed to sets of legitimised expectations that conflict, meaning that the adequate fulfilment of all is difficult (Katz and Kahn, 1978; Barnett and Baruch, 1985). Pettigrew (1968) views this as a form of role strain, arising as a result of a conflict between pressures and role orientation. Hartenian *et al.* (1994) and Wincent and Ortqvist (2009) see conflict occurring when the perceived roles of the individual are different from their enacted roles. This may be due to issues with role definition (Willcocks, 1994), the actor filling a role that clashes with their value system (Pandey and Kumar, 1997) or because they are overwhelmed by the amount of information from role senders about expectations

19 These are organisational, functional, symbolic interactionist, structural and cognitive.

(Carson, 2006). Conflict can also arise where the actor fills a 'boundary-spanning' role (Floyd and Lane, 2000; Barratt, 2005).

Role conflict may result from occupying both single and multiple positions (Hardy, 1978; Pandey and Kumar, 1997). Multiple roles can be associated with positive outcomes, being collectively stimulating and enriching (Marks, 1977; Bergin and Savage, 2011), and distress-reducing (Coverman, 1989). However, multiple expectations can also become overwhelming (Kahn *et al.*, 1964) or mutually exclusive (Getzels and Guba, 1954). Where the various roles are each important, actors are likely to be particularly susceptible to role conflict (Ilgen and Hollenbeck, 1991) as participation in all roles can be challenging. This is consistent with the 'scarcity' view, which posits that people may not have enough energy to fulfil multiple roles (Marks, 1977; Barnett and Baruch, 1985).

As an outcome, role conflict is often associated with stress (Kahn *et al.*, 1964; Wickham and Parker, 2007), loss of productivity (Hardy, 1978), job dissatisfaction, tension, lower organisational commitment and propensity to leave the organisation (Bedeian and Armenakis, 1981; Jackson and Schuler, 1985)[20]. Thus, conflict has many negative consequences and is, therefore, resolved where possible.

4.3.2 Resolving role conflict

Van de Vliert (1981) presents a three-step approach to resolving role conflict: preferably, choose one role; if a choice is not possible, compromise by undertaking both; if choice or compromise is not possible, attempt to avoid both roles. In choosing a role, the actor may select that which is most compatible with their needs (Pearlin and Schooler, 1978; Forbes *et al.*, 2004), while considering the legitimacy of expectations to avoid the sanctions of others (Getzels and Guba, 1954; Gross *et al.*, 1966). Each of the roles may be important (Carlson and Kacmar, 2000), although devoting time to all carries with it the risk of role overload (Black, 1988). Bergin and Savage (2011) highlight that when demands enrich each other[21], actors may willingly juggle multiple obligations because they are unwilling to cede any, even to the extent of eroding

20 The outcomes of role conflict identified in previous literature are outlined here to demonstrate the negative consequences that can arise, but are not being specifically looked at in this study.

21 This is similar to Marks' (1977) suggestion that multiple roles can also potentially be energy creating.

personal time as a consequence. Alternatively, the actor might choose to focus their attention on one role primarily and attend to the other role in an incomplete manner. However, this has potentially negative consequences for the secondary role and its outcomes (Hardy, 1978; Hales *et al.*, 2012). Sofer (1970) suggests that scheduling demands in a temporal sequence can also be effective, prioritising the role that is presently most salient (Bergin and Savage, 2011).

Bakker and Demerouti (2007) and Cullinane *et al.* (2012), in the context of the Job Demands-Resources (JD-R) model, indicate that while job demands (e.g. workload, time pressure) may positively impact strain outcomes (such as exhaustion and health issues), job resources can buffer this impact. Autonomy, participation in decision-making and support from others are identified as possible job resources (Demerouti *et al.*, 2001; Bakker *et al.*, 2005). Greater scope exists for those with access to such resources to cope with strain, such as through delegation or self-determining the timing or performance of the work. Thus, having some control and access to supports may be a means of relieving role conflict (Jackson and Schuler, 1985; Schaubroeck *et al.*, 1989; Shenkar and Zeira, 1992).

Interestingly, Bakker *et al.* (2005) also acknowledge that where autonomy is very high, the individual can be exposed to strain (also Greenhaus and Beutell, 1985), because they may have to deal with uncertainty, difficult decisions and take on considerable responsibility. Parasuraman and Simmers (2001) note that although self-employed persons may have autonomy and flexibility because of their positions, their status means that they are also highly involved with their jobs and personally responsible for the business. In this regard, the resources they possess may be insufficient to relieve their experience of role conflict. Additionally, Jackson and Schuler's (1985) meta-analysis finds no correlation between role conflict and autonomy. Although the authors offer no explanation for this, the lack of association might lend some support to the notion that autonomy could have both a positive and negative influence on conflict and strain.

Hall (1972) proposes a detailed model of coping with role conflict, at three levels:

- *Structural role redefinition* – This involves the person changing structurally imposed expectations surrounding appropriate behaviours, while continuing to fulfil the role. This can entail agreeing with role senders revised expectations,

finding some means by which secondary activities (but not the roles) are reallocated and obtaining support from those within or outside of their role set. Thus, as Hall (1972: 474) states "it represents coping … in the strict sense of the term", as the aim is to permanently resolve the conflict;

- *Personal role redefinition* – The person amends their personal concept of the role demands without necessarily agreeing this with role senders, representing a largely defensive response. Thus, their attitude towards, and perception of, their role expectations and associated conflicts changes, without the expectations being amended. Options include establishing role priorities, partitioning roles within domains, choosing not to meet/ignoring specific demands, adjusting attitudes towards roles, meeting the most salient role first and eliminating roles regarded as unimportant;
- *Reactive role behaviour* – The person tries to improve their role performance to more effectively satisfy the demands of others, accepting that demands are unavoidable and conflict must be accommodated. Possibilities include obtaining training in the less effective role (Kippist and Fitzgerald, 2009), or to plan, schedule and organise more efficiently. Alternatively, the person might choose to devote more time and energy to the role, which may have negative personal consequences.

Thus, role conflict reflects a form of inconsistency, incompatibility or disagreement between an individual and others about what it is they will do to fulfil what is required of them. How this manifests itself depends on the context, but the outcome can be an incompleteness of some manner as a role may be inadequately attended to. This can arise because of the choices made and the facts of the situation, such as holding and attempting to address multiple roles. Options are available to the actor in resolving conflict – such as avoiding roles in part or in full – but these may also present challenges.

4.3.3 Types of role conflict

Kahn *et al.* (1964) identify five types of role conflict; these continue to be cited and used in contemporary research (e.g. Pandey and Kumar, 1997; Weight, 2001; Wincent and Ortqvist, 2011). In each case, the role set, reflecting the various role relationships a person is involved in (Merton, 1957), is relevant. Although each type of conflict is

distinct, Kahn *et al.* (1964: 21) note that they all share a common characteristic: “members of a role set exert role pressures to change the behaviour of a focal person”.

Intra-sender conflict arises when the role expectations and demands from a single member of the role set are incompatible, such as a manager asking a subordinate to do something that contradicts a separate request from the same manager. Consequently, satisfying one request means that satisfying the other is not feasible. *Inter-sender conflict* is experienced where the pressures from more than one member of the role set are incompatible, such as two equal superiors requesting opposing tasks to be completed. Floyd and Lane (2000) see this arising where there is lack of consensus regarding which role is appropriate, as role senders’ separate expectations cannot all be met without some difficulty (Wall Jr. and Callister, 1995; Weight, 2001).

The occurrence of *inter-role conflict* means that the role occupant is subjected to incompatible pressures from more than one role set, for example a superior demanding that overtime is worked while the person’s family needs them at home. Alternatively, where the requirements of the role contravene the role occupant’s values (such as an accountant refusing to make an illegal payment), or where the needs of the role occupant give rise to behaviours that are unacceptable to other members of the role set, *person-role conflict* is experienced. A variant of person-role conflict is *role captivity* (Pearlin, 1989) where the role occupant unwillingly fills a particular role; the conflict is internalised within the person by virtue of them wanting to be doing something else.

Finally, *role overload* arises where role senders have expectations that a role occupant perform various tasks within unachievable time constraints; this may be primarily an issue for higher-level positions (Hardy, 1978). Fitzgerald *et al.* (2006) note that an incompatibility between roles may be a cause of the overload. Other possible causes can include too many roles (also Willcocks, 1994), accompanying expectations that are too varied, and inadequate resources (Fondas and Stewart, 1990; Wincent and Ortqvist, 2009; Lindberg and Wincent, 2011). According to Pearlin (1989), when role overload occurs, the demands on the energy and stamina of the role occupant are beyond their capacity; from Rout (1996) and Rout *et al.* (1996), workload and time pressures are identified as sources of stress for GPs. While Coverman (1989: 968) makes the case that role overload needs to be distinguished from other forms of role conflict, they are

related: "a person may experience conflicting demands of multiple roles (role conflict) but, unless time pressure is an issue, he or she will not necessarily encounter role overload". This suggests that overload may be a consequence of otherwise independent role conflict (e.g. multiple incompatible expectations or requirements) occurring in time-restricted situations (e.g. actor attempts to meet all of these expectations/requirements, but with insufficient time available to fully address each).

The review now turns to a specific form of role conflict of significance in the context of the current study, namely the conflict that arises between the organisational and professional roles of the individual professional. In essence, this draws together the strands of literature reviewed in chapters two (managerial role) and three (professional role), and considers the interaction of these through a role theory lens.

4.4 Organisational-Professional Conflict

4.4.1 Defining Organisational-Professional Conflict

Role conflict can arise because the relationship the individual has with their profession differs from the relationship they have with their organisation. This stems from a strong affiliation that members have with their profession (Goode, 1960), reflecting a distinction between the individualist business orientation of organisations and the more community-interested perspective of the professions (Barber, 1963)[22]. Consequently, professionals can be highly committed to their profession (Hoff, 2000; Johnson *et al.*, 2006; Johansen and Gjerberg, 2009; Fitzgerald and Dadich, 2010), which may give rise to a commitment dilemma (Sorensen and Sorensen, 1974). If ideological differences exist, this may lead to conflict (Willcocks, 2004), which can be de-motivating and dissatisfying for the individual as well as costly for the organisation (Harrell *et al.*, 1986; Shafer, 2002; Shafer *et al.*, 2002).

22 Derber (1983) suggests that this may not be the case for all professions, indicating that engineers have assumed 'hybrid' identities where they adopt organisational objectives but remain distinct from other employees through their professionally grounded technical expertise. Professions where this is most pronounced have "historically been entirely dependent on subordinate organizational employment and, at no point, developed a notion of professional calling or moral purpose separate from the commercial interests of corporate employers" (p.331). This, it is argued based on chapter three, is not the case in medicine and specifically amongst doctors.

Thus, Organisational-Professional Conflict can arise when there is an inconsistency experienced by a individual between what their organisation and what their profession separately expect or demand of them by way of behaviour, as goals and values may not be aligned (Sorensen, 1967; Aranya and Ferris, 1984; Harrell *et al.*, 1986; Lait and Wallace, 2002; Shafer, 2002; Shafer *et al.*, 2002; Kippist and Fitzgerald, 2009; Fitzgerald and Dadich, 2010). This conflict has been studied amongst accountants (Aranya and Ferris, 1984[23]; Shafer *et al.*, 2002; Shafer, 2009), internal auditors (Harrell *et al.*, 1986), lawyers (Gunz and Gunz, 2007) and clinical-managers (Willcocks, 1994; Kippist and Fitzgerald, 2009). However, Kippist and Fitzgerald (2009: 644) note that "the literature lacks reference specifically to organisational professional conflict experienced by members of the medical profession", suggesting limited exploration of this phenomenon in a healthcare context.

4.4.2 Professional loyalty and organisational incursions

Gouldner (1957) differentiates between a person's latent and manifest identities, where their manifest identity reflects the norms and expectations of the group while their latent identity is regarded as illegitimate by the group. Thus, an individual may be an organisational member and fill a specific organisational role, but their underlying latent identity may be with their profession (Johansen and Gjerberg, 2009; Spyridonidis and Calnan, 2011; McDermott *et al.*, 2013). If the behaviours and expectations of each role are consistent, the actor can be loyal to both (Aranya and Ferris, 1984). However, if the individual is both a professional and a manager, with divided loyalties, this can give rise to an internalised conflict within the individual (Kippist and Fitzgerald, 2010). As such, the organisational role can intrude on the primary professional role (Kippist and Fitzgerald, 2009; Hales *et al.*, 2012).

Sorensen and Sorensen (1974) illustrate the stresses that professionals working in a bureaucratic organisation are faced with, demonstrating that a combination of a high professional and bureaucratic orientation can lead to conflict. Derber (1983: 322) indicates that professionals "may find that institutional profit imperatives lead to basic

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23 In the study by Aranya and Ferris (1984) and later studies by Gunz and Gunz (1994; 2007), Shafer (2002; 2009) and Shafer *et al.* (2002), Organisational-Professional Conflict has been conceptualised as a single dimension and the scales used in these studies measure conflict on this basis. Brierley and Cowton's (2000) meta-analysis identifies further studies that have used Aranya and Ferris' (1984) scale or variants of it. In each case, conflict is also measured as a single dimension.

organizational practice and goals not consistent with their own ideals", such as focusing attention on those who can pay more as opposed to those most in need, and on cost-efficiency over quality (Pierce and Sweeney, 2004). As a means of addressing such conflict, the professional may even become more committed to organisational goals and reduce their concern with professional interests (Derber, 1983; Gunz and Gunz, 2006; 2007).

In medicine, Ritzer and Walczak (1988) note that the professional orientation of physicians towards patients can differ from what the organisation wants; the two groups come from distinct cultures, with different priorities (Lebell, 1980; Raelin, 1989). Conflict may then arise for hybrid clinical-managers "when requirements for autonomy and patient care clash with organisational needs or financial constraints" (Kippist and Fitzgerald, 2009: 643; also Bodenheimer and Casalino, 1999; Weight, 2001). This highlights how "the business aspects of being a professional present a complex set of ethical challenges in the lives of physicians" (Perry, 2010: 171), as they seek to balance their dual roles (Thorne, 1997b; 2000; McConnell, 2002). Russell *et al.* (2010) note how hospital consultants' values are anchored to the profession and remaining loyal to colleagues, which may conflict with management expectations. However, where clinicians embrace the organisational culture as managers, they risk clashes with professional peers (Thorne, 2000)[24] even if this configuration could be beneficial to both sides (Barber, 1963).

Because of their complex and pressurised relationships with both the organisation and the profession, this increases the challenge of the hybrid clinical-manager role and creates the potential for conflict (Hoff, 1999a; Kippist and Fitzgerald, 2009; Fitzgerald and Dadich, 2010; Hyde *et al.*, 2013). Thus, Organisational-Professional Conflict can arise for the clinical-manager because of their 'boundary-spanning' role between two cultures, as they attempt to mediate differing goals, agendas and expectations.

4.4.3 Dually committing to the profession and the organisation

Bartol (1979) (also Lachman and Aranya, 1986; Gunz and Gunz, 2006, 2007), however, challenges the view that there is an inherent conflict between the organisation and the

24 This reiterates a point previously made in section 2.7.2, whereby clinical-managers may be viewed as 'defectors'.

profession. Instead, she finds that professional attitudes – including autonomy and commitment – are related to greater organisational commitment. Aranya *et al.* (1981) note how studies have found that individuals can score highly on professional and organisational commitment measures (also Suddaby *et al.*, 2009), and that both forms of commitment are positively associated (Wallace, 1993). Baugh and Roberts (1994) highlight that a balanced commitment is beneficial and is associated with high job satisfaction and performance. In this regard, Aranya and Ferris (1984) indicate that high commitment to both the organisation and profession is associated with low role conflict, suggesting that loyalty to both is not only possible but may even be preferable.

Commitment to both the profession and organisation is also found amongst clinical-managers (Montgomery, 2001; Hoff, 2001); Hoff notes that the average clinical-manager rates highly on both, with approximately one-third expressing dual commitment. Hoff (2001) further indicates that those who were dual-committed demonstrated lower role conflict (consistent with Aranya and Ferris, 1984) and higher job involvement. Thus, the perception of professionals in organisations as being caught between incompatible or irreconcilable demands may be an oversimplification (Gunz and Gunz, 2006; Cheraghi-Sohi, 2011). The hybrid professional-manager has influence over their own behaviour and can dynamically present different roles depending on the situation, interactions and context (Rodham, 2000). Consequently, actively balancing ones organisational and professional roles may act as a means of mitigating role conflict (Gunz and Gunz, 2006).

4.4.4 The impact of hierarchical position and status

Research indicates that, at senior levels, commitment/orientation to the organisation may exceed commitment/orientation to the profession. Sorensen and Sorensen (1974) found that as their accountant sample moved upwards, bureaucratic orientation increased and professional orientation decreased. Hoff (1999b) indicates that clinical-managers at higher levels may align their goals more with the organisation than with other doctors. Chapell and Barnes (1984) note that pharmacy owners have higher business orientations than employed pharmacists. Suddaby *et al.* (2009) found that accountants at higher ranks tended to identify more with ‘commercialistic’ values than those at lower levels, while Gunz and Gunz (2006: 270) note that amongst those

lawyers who were more closely involved at a strategic level in their firms, "the less lawyerly their approach to ethical dilemmas".

Aranya *et al.* (1981) observed that the mean organisational commitment of owners of accounting practices was slightly higher than their professional commitment, while non-owners had the opposite profile. Aranya and Ferris (1984) note that, although partners and managers had similar levels of mean professional commitment, partners scored higher on organisational commitment and lower on Organisational-Professional Conflict. In this context, seniority and ownership appear to be associated with less conflict (Aranya *et al.*, 1981). This may reflect the fact that higher-level professionals – particularly owners – have a greater vested interest in the performance of the organisation (Becker, 1960; Cheraghi-Sohi, 2011) and need to reconcile this with other values and interests. Additionally, by being further up the hierarchy, the professional is also afforded greater scope in how they behave when confronted with commitment dilemmas and how they resolve potential conflicts. Perry (2010) found that owner-professionals could be more flexible in their client billing if they perceived the need, an option not necessarily available to employed professionals.

Thus, the literature indicates that conflict may exist between mutually-held roles that are based in the professional and organisational domains. Where conflict arises, this can be because the roles have differing goals and values, whereby the expectations associated with the profession may be incompatible with those of the organisation. However, consistent agreement is not found on this. Past research also indicates that a strong, balanced commitment is both achievable and desirable, and that the degree of conflict experienced may be limited. An additional factor appears to be status and position within the organisation. Owners may demonstrate higher commitment to the organisation but less conflict, possibly because of their greater personal interest in the business and an increased capacity to manage any conflict. Thus, evidence exists of both conflict and balance in the professions generally and in healthcare organisations. However, specific research appears to be lacking on whether such conflicts exist for GPs at the practice level, which is particularly relevant in this study given that they may operate in a commercial business role as well as a clinical professional role. Consequently, it is helpful to look at a somewhat similar profession to establish any experiences there.

4.4.5 Conflict between the clinical and commercial role

An arena where there has been some informative research concerning the joint undertaking of a commercial and a clinically-related professional role[25] is retail pharmacy. Ralph and Lagenbach (1987: 82) distinguish between the two roles by describing the commercial side as "the physical or tangible elements of the practice and the monetary or commercial aspects involved with any profession", while the professional role is "the purpose of the profession. The service ideal or selflessness is the basic premise of the professional". Quinney (1964) indicates that professional and business (incorporating commercial activities) roles of the retail pharmacist should not be seen as two ends of a continuum, but rather two roles on different levels of orientation. Thus, the pharmacist has four choices when it comes to roles adopted, with professional-business being the most prominent:

Professional	(High professional orientation, Low business)
Professional-business	(Both high)
Indifferent	(Both low)
Business	(Low professional, High business)

Quinney found that over 60% of those with a professional-business orientation experienced role conflict, which he suggests, "illustrates the divergency of the two roles. While these pharmacists orient to both roles, they have difficulty in performing them" (1964: 375). However, Smith *et al's.* (1985) later study found considerably less (29%) of those with a professional-business orientation experiencing role conflict[26]. Based on their findings, the authors conclude that a "realistic, dual role orientation mitigates against role conflict" (1985: 27), suggesting that a balanced approach may be preferable.

Kronus (1975) finds that the idea of the pharmacist being conflicted is overstated and that they can be motivated by both economic and service values, even if they are more

25 The researcher acknowledges that the pharmacist's role is not typically 'clinical' in the precise sense that a GP is. However, the role is clinically-related and, from a professional perspective, should be similarly patient-focused in broad terms.

26 Smith *et al's.* (1985) sample was not limited to retail pharmacists, including others such as hospital pharmacists. Results for role orientations are reported for the overall sample only.

professionally or business-oriented. Chappell and Barnes (1984) conclude that, although both roles do not have to co-exist, where they do, conflict is not an inevitable outcome. In addition, Hornosty (1990) surveyed pharmacy students on their perception of the pharmacist's role. He found that most students viewed pharmacy as being both a profession and a business and that it was possible to fill both roles successfully. According to Hornosty (1990), this indicates that many pharmacy students see no inherent conflict and are well prepared to meet dual expectations (also Smith *et al.*, 1985).

Thus, the weight of more recent evidence suggests that clinically-related professional roles and commercial business roles, though seemingly opposing, need not necessarily conflict and may even co-exist quite comfortably. The distinction between pharmacy and general practice must obviously be acknowledged. Although they are both healthcare professions, concerns have been raised about the strength of the pharmacist's commercial orientation (Spencer and Edwards, 1992) and 'shopkeeper' image when compared to general practice (Hughes and McCann, 2003). However, the manner in which the pharmacist addresses and appears to reconcile and balance these two roles is of interest. From the perspective of the GP, whether such a balance is possible is unclear.

4.5 Summary

This chapter highlights how role conflict is pertinent to the current study where GPs fill multiple roles. Conflict can occur in role episodes where combinations of expectations and behaviours are incompatible and may give rise to strain. In general, role conflict is viewed negatively and actors seek to avoid or manage this if possible. The literature identifies different types of role conflict, commonly linking back to the existence of role pressures on the actor. The main focus in this study is on Organisational-Professional Conflict, being of particular relevance to those professionals who have organisational goals and responsibilities that may be at odds with their professional orientation and values.

It is argued that Organisational-Professional Conflict may be relevant to the GP who functions as a clinical-manager because of their dual role as caring clinician

(professional) and as an individual in business with managerial responsibilities (organisational). Consequently, a role theory lens is a valuable means by which to analyse the interaction of these work roles in terms of implications for the nature of the managerial role itself. By holding dual salient roles, the GP as manager is subjected to expectations from different role senders that may be incompatible and/or difficult to satisfy by way of behaviours. Thus, role conflict may arise unless steps are taken to avoid or mitigate this.

However, the literature is not fully conclusive on a number of aspects, including whether a balanced orientation or commitment to both the profession and the organisation is possible. In addition, there is evidence that status and position may have a bearing on conflict, which could have particular implications for owners. While there is extensive prior research on Organisational-Professional Conflict, the focus of most of these studies has been on professions other than general practice. Thus, this chapter presents a case for establishing the nature and potential implications of Organisational-Professional Conflict for GPs as clinical-managers, in helping to better understand the nature and value of their role as managers. This is relevant in the context of research question four.

4.6 Preliminary model

Based upon the review of literature over the preceding three chapters, which addressed the analytical lenses used in this dissertation (management, professions, role), it is now possible to present a preliminary model. This model incorporates key themes that have been identified as potentially relevant in the context of this research. The research questions associated with this model are explained in detail in section 5.3.

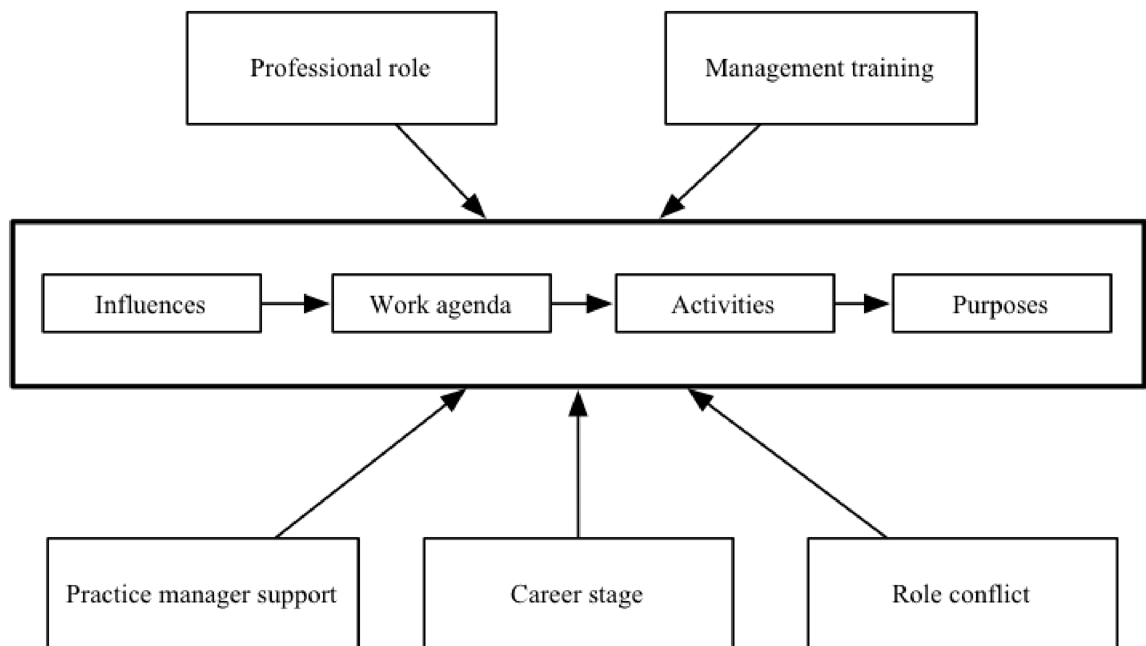

Figure 4.1 – Preliminary model

In summary, the core of the preliminary model is adapted from Carroll and Gillen's (1987) integrating model of the manager at work (Figure 2.2, p.25), in seeking to address the nature of the managerial role of the GP and how it is performed. As noted in section 1.3.4, Carroll and Gillen's (1987) model is incomplete for the purposes of this study as it does not take account of the professional role of the GP nor does it address the prospect that role conflict may arise between this role and the managerial role as an implication of their interaction. In addition, the original model fails to account for the possible influence of the GP's managerial training, their career stage, and their use of supports to assist them in managing the practice. However, based solely on a review of the literature, it is not possible to produce an overall model of the GP as manager at work as the implications of these potentially relevant elements for the model are unclear. In this respect, the preliminary model presents a partial and incomplete picture of the managerial role of the GP and provides a starting point for primary research and data collection. Therefore, by addressing the first four research questions (section 5.3), greater clarity can be attained with regard to the nature of the managerial role and the potential role conflict implications when this role is undertaken in conjunction with a professional role. A final model of the GP as manager at work is developed in chapter seven, integrating all of the elements found to be relevant in the current study, following a discussion of the findings from the primary research.

Chapter Five

Research Methodology

Chapter Five: Research Methodology

5.1 Introduction

This chapter outlines the research methodology and methods used in seeking to address the research objective. Initially, the underlying philosophical assumptions are discussed, as the researcher describes his overall stance and how this affects his methodological choice. The rationale underpinning the objective of the study, and associated research questions, is explained, in addition to the researcher's choice of a qualitative research design to address these in the form of semi-structured interviews. A description of how and why these interviews were conducted is provided, in addition to the manner in which participants were selected. The researcher explains his reasons for using the telephone for most of the interviews and the merits of this in the context of the study, before providing a detailed description of the analytical process applied to the data collected. The chapter closes with a discussion as to how validity and reliability was assessed and how the researcher ensured that ethical issues were addressed.

5.2 Research philosophy

Remenyi *et al.* (1998) cite Hughes (1990: 11), who states "every research tool or procedure is inextricably embedded in commitments to particular visions of the world and to knowing that world". Consequently, the researcher needs to be clear on their worldview and philosophical position as this guides their inquiries (Creswell, 1998) and has implications for research design (Easterby-Smith *et al.*, 1991). Burrell and Morgan (1979) demonstrate that the researcher's assumptions regarding ontology, epistemology, human nature and methodology exist on a continuum spanning the subjective-objective dimension. While representing extreme positions, researchers can also take a more intermediate perspective (Burrell and Morgan, 1979; Remenyi *et al.*, 1998).

For this study, in *ontological* terms, reality is viewed as tangible and external (Burrell and Morgan, 1979; Holden and Lynch, 2004), as well as being shaped by people and existing in multiple forms (Creswell, 1998; Bryman, 2004). This represents something of an intermediate position (Holden and Lynch, 2004), though veering towards nominalism. The exploratory nature of the topic (section 5.4.1) suggests that an interpretivist *epistemological* perspective should be adopted in order to get under the

surface and seek meanings as opposed to measures (Holden and Lynch, 2004), through understanding the points of view of those being directly studied (Burrell and Morgan, 1979). However, the researcher acknowledges their use of a preliminary model (see Figure 4.1), informed by existing literature. This serves as a starting point for the research, allowing the researcher to frame their analysis and interpretation within existing concepts and theories (Bryman, 2004) applicable to the research objective. Consequently, the researcher is neither entirely an insider nor an outsider (Evered and Louis, 1981) as they co-create and acquire knowledge (Burrell and Morgan, 1979; Denzin and Lincoln, 1994). From a *human nature* perspective, the researcher views people as neither entirely deterministic nor voluntaristic (Burrell and Morgan, 1979). GPs occupy specific roles within formal organisations and an external system that partly determine what they do, but are also influential in shaping these roles through their choices and actions.

Methodological decisions are influenced by the ontological and epistemological stances adopted by the researcher as well as their view of human nature (Burrell and Morgan, 1979; Holden and Lynch, 2004). The study adopts an ideographic approach, which tends to be associated with qualitative research (Gill and Johnson, 1997), in developing first-hand knowledge of the research participants (Burrell and Morgan, 1979). This again reflects the exploratory nature of the study, as the researcher attempts to generate knowledge through understanding and interpreting the meanings of interviewees in seeking to represent their roles based on their perspectives and experiences (Snape and Spencer, 2003). However, the researcher acknowledges that the use of a preliminary model may be associated with a more deductive approach to research (Gill and Johnson, 1997).

The researcher reconciles this position by arguing that both inductive and deductive approaches can be accommodated in a single study (Mason, 1996; Snape and Spencer, 2003; Trochim, 2006; Alvesson and Skoldberg, 2009). Before venturing into the field, the researcher recognised that he would need some understanding of salient theories and concepts (Remenyi *et al.*, 1998), as well as an awareness of the context and contemporary issues in order to be credible to interviewees. This knowledge provides initial direction for the research and helps to ground findings in existing literature, without losing the opportunity to explore evolving concepts within the data (Bradley *et*

al., 2007). Indeed, as new issues were surfaced in interviews, the researcher regularly revisited prior literature to help in making sense of this (Alvesson and Skoldberg, 2009), highlighting the evolving and iterative nature of research.

Overall the researcher has taken a somewhat intermediate position (Burrell and Morgan, 1979; Remenyi *et al.*, 1998; Holden and Lynch, 2004) on the *subjective-objective* dimension and across the assumptions regarding ontology, epistemology, human nature and methodology, though veering towards a subjectivist approach. In this regard, a qualitative research design is compatible with the researcher's mainly subjectivist position and this is discussed further in section 5.4. However, before addressing design issues, this chapter will outline the study's objective, questions and the rationale for these.

5.3 Research objective and questions

Considering the gap and justification for the research identified in chapter one and the review of the literature in chapters two to four, the overall objective of this study is:

To determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role.

In this context, 'nature' addresses what the managerial role is, how it is formed and performed, where it fits within the GP's work and priorities, and the component elements of this role. 'Implications' addresses the potential role conflict implications for the GP undertaking this role, in terms of how operating in a managerial capacity interacts with other professional responsibilities. By examining the managerial role in the context of what theory indicates that managers do/should do, as well as the implications of the role for the GP and other stakeholders, the study can then consider the 'value' of the role and its overall relevance.

Stemming from this objective, the following research questions[27] have been formulated:

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27 These are presented as questions rather than propositions, given the exploratory nature of the study.

5.3.1 What work roles (professional and non-professional) do GPs undertake and where do their priorities lie?

This question seeks to 'frame' the managerial role of the GP within the wider portfolio of roles that the GP fills. Contemporary definitions of general practice (Irish College of General Practitioners (ICGP), 2005; WONCA, 2011) focus primarily on clinical/healthcare dimensions and on the centrality of the patient within their broad professional role, in defining the specialism and associated core competencies. 'Practice management' is noted separately as an area in which the core competencies are implemented. Therefore, the research will examine the professional (clinical/care) role of GPs in order to understand the nature of this, and the perceived importance attached to the role, while considering the managerial role. In this respect, question one is relevant in informing and contextualising subsequent questions.

5.3.2 What is the managerial role of the GP and how is this performed?

As chapter two demonstrates, there is a dearth of literature addressing the managerial role of the GP and the researcher is not aware of any in an Irish context. The bulk of literature addressing doctors and their particular management roles appears to be in secondary care (e.g. Betson and Pedroja, 1989; Braithwaite, 2004). This is informative and helpful, but does not adequately address the small business nature of Irish general practice (O'Dowd *et al.*, 1997) where organisations are primarily owner-managed with their own distinct features (Devins *et al.*, 2005; Florén, 2006; Kelliher and Reinl, 2009). While some studies in general practice exist internationally (e.g. Fisher and Best, 1995; Gatrell and White, 1997), these are relatively few in number and may not be fully reflective of the Irish context.

A fundamental gap in existing research on the managerial role of the GP is a general lack of core management theory underpinning this. Consequently, most studies tend to describe activities/tasks/duties of GPs as 'managerial' without attempting to relate this to established theory that outlines what managers actually do or should do. The current study seeks to bridge this gap by relating the managerial role, as described by GPs, to core management theory in order to determine what activities and functions typically performed by managers are (and are not) performed by GPs, and for what possible reasons. In this regard, Carroll and Gillen's (1987) integrating model of the manager at work is important.

5.3.3 What factors influence the managerial role of the GP?

Figure 2.2 (p.25), adapted from Carroll and Gillen (1987), identifies that in order to understand what managers do and the purposes of this, it is necessary to understand 'why the job is the way it is' or the manager's 'work agenda' (Kotter, 1982). This agenda is shaped and formed by the manager, with various factors influencing this; Carroll and Gillen (1987), in the context of full-time managers, identify five such influences (see Figure 2.1, p.24). However, given the part-time nature of the GP's managerial role and differences in context, the current study investigates whether the influences as described require adaptation. Consequently, this research seeks to better understand and document the main factors that shape and form the underlying work agenda of the GP, focusing on their managerial role.

Previous research does not appear to have attempted to identify these factors collectively, nor address their influence on the managerial role of the GP. Thus, while a number of possible factors have been identified from the preceding literature review (Professional role; Management training; Practice manager support; Career stage; Role conflict; see Figure 4.1, p.77), how these might influence the GP's work agenda and managerial role is unclear. Consequently, addressing this question increases our understanding of such influences in terms of shaping the GP's managerial role, and allows for the development of a more complete model of management.

5.3.4 How do the GP's roles interact and what are the implications of this for the GP in terms of potential role conflict?

As questions one and two have identified, two key roles for the GP are their professional role and their managerial role. Thus, from role theory (e.g. Katz and Kahn, 1978; Biddle, 1986; Floyd and Lane, 2000), each of these roles are linked to expectations which prompt behaviours. However, holding multiple interacting roles can be challenging and may lead to role conflict where there is an incompatibility (Kahn *et al.*, 1964; Pearlin, 1989; Floyd and Lane, 2000). In this context, the prospect of role conflict (as Organisational-Professional Conflict: Aranya and Ferris, 1984; Shafer, 2002) is investigated to establish (a) its relevance for GPs and (b) what consequences role conflict has for the GP and their managerial role. From previous literature, the actual implications of Organisational-Professional Conflict seem unclear (e.g. Derber,

1983; Hoff, 2001) with research generally lacking in the medical profession (Kippist and Fitzgerald, 2009) and at practice level specifically.

5.3.5 What is the value of the managerial role of the GP?

The final question addresses a gap in current literature identified in chapter two. In the secondary care context, there has been much debate as to the benefits or otherwise of having doctors involved in management (Dunham *et al.*, 1994; Dopson, 1994; Schneller *et al.*, 1997; OHM, 2002; Kindig, 1997). This remains unresolved (Montgomery, 2001; Fulop, 2012), though the literature review highlights a number of features – positive and negative – associated with managerial involvement. In the primary care context, debate is lacking (O'Riordan and McDermott, 2012) and addressing this forms an important part of the current study. Thus, the managerial role of the GP can be viewed as being valuable when it is of benefit to stakeholders.

Thomas and Layte (2009) raise concerns that GP per capita in Ireland will remain below European norms. This is in spite of the importance of primary care in national health policy (DOHC, 2001) and the challenges encountered in the hospital system (DOH, 2012). Key issues identified in the GP context include insufficient numbers of new entrants, increased part-time working, retirements and population growth. Furthermore, if the Government implement Universal Health Care as planned, with 'free' (State funded) GP care for all being phased in by 2016 (DOH, 2012), the volume of GP visits may also rise given the higher usage rates amongst those patients for whom the State already pays (Layte and Nolan, 2009). While steps are being taken to address these issues, there is nonetheless an increasing likelihood that practices will get busier as fewer available GPs may have to deal with greater numbers of presenting patients. In this regard, there is a need to consider how GPs might free up time to increase consultations without compromising quality or patient safety; one possibility could be a retraction from their involvement in management. This highlights the importance of identifying the value of the GP as manager and whether the value they bring to the managerial role could be delivered by others (Hoff, 1999a), or even improved by altering the nature of the role.

5.4 Rationale for a qualitative research design

This section outlines the reasons for selecting the research design adopted, which represents “a flexible set of guidelines that connects theoretical paradigms to strategies of inquiry and methods for collecting empirical material” (Denzin and Lincoln, 1994: 14). The choice made of a qualitative research design is consistent with the researcher’s intermediate philosophical stance, but with a primarily subjectivist leaning (section 5.2).

5.4.1 Linking research question, design and approach

In determining the optimal research design, it is necessary for the researcher to contemplate whether the chosen approach ‘fits’ the research (Silverman, 2010). Brannick (1997) draws attention to the importance of the research question(s), as this will influence subsequent choices, while Creswell (1998:17) suggests that ‘how’ and ‘what’ questions tend to suit a qualitative approach, “so that initial forays into the topic describe what is going on”.

Of considerable significance is the nature or function of the research, which is linked to the research question(s). Domegan and Fleming (2003) identify three broad categories of designs. *Exploratory* research is “undertaken when not much is known about the situation at hand” and “when some facts are known, but more information is needed” (Sekaran and Bougie, 2010: 103/104). In adopting an exploratory design, the researcher seeks to uncover and reveal, to some extent, what was previously unknown (Domegan and Fleming, 2003; Kumar, 2005). Therefore, in-depth data of a qualitative nature is required to allow for a detailed exploration of the key issues. *Descriptive* research seeks to “offer the researcher a profile or to describe relevant aspects of the phenomenon of interest” (Sekaran and Bougie, 2010: 106). In this respect, the emphasis is on description of what is known as opposed to exploring what is relatively unknown. The third broad design – *Causal* research – focuses on identifying cause and effect associations and relationships between variables (Domegan and Fleming, 2003). Causal research demands large, quantitative samples to facilitate statistical analysis as a means of understanding how variables are linked.

Therefore, the researcher contends that, in this dissertation, an exploratory research design is most appropriate. Adopting such a design recognises that the issue being researched is only partially understood in the context of the study (as evidenced by the

preliminary model) but gaps remain that can only be filled by a detailed exploration of the phenomenon (Sekaran and Bougie, 2010). However, it is acknowledged that some elements of a descriptive design also feature, as the researcher seeks to build upon and apply what is already known in the literature as part of their exploration.

5.4.2 Selecting a qualitative research approach

Following the decision to utilise an exploratory research design, the researcher contends that a qualitative approach is compatible with the design chosen (Domegan and Fleming, 2003), the philosophical stance adopted (section 5.2) and the nature of the research questions being addressed (Creswell, 1998). In addition, it is argued that qualitative research is most suited to gathering the type of evidence required, reflecting the experiences of Locock *et al.* (2004: 28) who note that "Routinely available data and postal survey results cannot capture the full complexity and variety of GPs' experience". Previous studies of clinical-managers have effectively employed qualitative methods in conducting their research (e.g. Thorne, 1997b; 2000; Forbes *et al.*, 2004; Willcocks, 2004; Kippist and Fitzgerald, 2009; 2010).

A qualitative approach allows the researcher to acquire a deeper and more complex understanding (Creswell, 1998; Locock *et al.*, 2004) at the level of the individual GP in their natural setting and in their words, as to the meaning (Denzin and Lincoln, 1994) and nature of their roles and the interplay between these in the process of managing. Acquiring such a 'worms eye view' (Hakim, 2000) brings the researcher close to the data, with the phenomenon being studied in a holistic and detailed manner that a more distant quantitative approach will not permit. Thus, the data gathered has a richness to it that provides the researcher with an important insight into how people behave (Remenyi *et al.*, 1998). This reflects Van Royen *et al.*'s (2010) recommendations regarding general practice research, where they call for qualitative methodologies to assess the perspectives and preferences of GPs.

Having selected a qualitative research approach, the researcher must identify an appropriate research strategy. The next section briefly outlines alternative strategies and explains why the researcher decided not to use these.

5.4.3 Alternative research strategies and reasons for not utilising

Various strategies could have been considered for the study, including ethnography, grounded theory and case studies. An *ethnographic* study would require immersion in the GP's organisation for a considerable period of time as the researcher observes behaviours and customs of the members, even potentially becoming part of the 'tribe' (Creswell, 1998). Such an approach is particularly suited to studies of culture, which was not of specific relevance in the current research. In addition, the time required to engage at this level was not feasible. *Grounded theory* is an established method whereby the researcher develops theory inductively, over multiple iterations and through constant comparison, from the data collected. This continues until theoretical saturation is reached and a theory is generated that is grounded in the data (Creswell, 1998). In the context of the current research, grounded theory was not considered a suitable strategy as, while the overall design adopted here is exploratory, this is partly informed by existing theory and literature (section 5.2). As Creswell (1998: 58) notes, one of the challenges of traditional grounded theory is that "The investigator needs to set aside, as much as possible, theoretical ideas or notions so that the analytic, substantive theory can emerge".

The *case study* is an accepted approach for collecting data (Yin, 1989; Creswell, 1998) and has been effectively used in general practice research in a management-related context (Checkland, 2005). However, this approach was deemed sub-optimal in the current study. The researcher rationalised that attempting to study management practices in a 'live' manner would be impractical as GPs generally do not 'manage' at specific times, but rather throughout the day and beyond (section 6.6.1). Furthermore, the researcher could not realistically be present during consultations or meetings with a clinical element to them because of issues with patient confidentiality. Given the seemingly informal nature as to how management can be conducted in practices (section 6.4.3), limited formal documentation is likely to exist[28] and would provide little in the way of added insight. Finally, the researcher was concerned that case studies might not generate the frank and forthright perspectives that the approach adopted did; for example, would non-owners have been willing to critically appraise features of the

28 In the interviews, there was little indication that formal minutes, which might be suitable for analysis, are kept of meetings.

management approach in their small practices if they knew that the researcher was also interviewing their employer, even with guaranteed anonymity?

Bearing in mind the above, the researcher determined that the most appropriate method for gathering evidence was primarily through interviews.

5.5 Rationale for using interviews

Based on Nunkoosing (2005), interviews are the most widely utilised means of data collection in qualitative research and are of particular benefit when the researcher wishes to study complex areas in depth (Kumar, 2005) and activities that cannot be directly observed (Taylor and Bogdan, 1998). As Kvale (1983: 174) notes, the purpose of an interview is "to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena". By virtue of an exchange with the interviewee about a topic of mutual interest and importance (Kvale, 1983), the researcher is brought into their 'mental world' (McCracken, 1988). Knowledge is then constructed through collaboration between the researcher and the interviewee (Legard *et al.*, 2003), with the nature of the interaction shaping the knowledge generated.

Thus, as King (1994) and Mason (1996) indicate, interviews are appropriate when seeking to explore an individual's knowledge, understanding, meanings and interpretations. Indeed, from Sarantakos (2005), there are many benefits associated with the interview approach. These are summarised in Appendix D (p.295), along with the researcher's particular experiences from application in the current study, by way of helping to affirm the suitability of interviews here.

5.5.1 Using a semi-structured approach

Within the interview method, researchers must choose the degree of structure applied. Bryman and Bell (2003) indicate that interviews may be structured, unstructured or semi-structured. Structured interviews, in pure form, entail the researcher asking a series of questions in a rigid, pre-defined manner with no deviation or modification over the course of the exchange (Sarantakos, 2005). Unstructured interviews are highly fluid and flexible, where lines of enquiry evolve as issues are surfaced within a broad topic area

(Lee, 1999; Kumar, 2005). Although suitable in some studies, for the current research, such extreme positions were not regarded as conducive to the collection of rich data that both addressed the research objectives and questions, while also allowing the researcher scope to explore interesting avenues as they arose.

Consequently, an intermediate (Kvale, 1983; Lee, 1999) and hybrid form may be more appropriate by using a semi-structured interview approach (Berg, 1995; Sarantakos, 2005), particularly where the researcher begins the investigation with a reasonably clear focus on what they want to do (Bryman and Bell, 2003). Based on Bryman (2004), semi-structured interviews permit flexibility. While the researcher has topics that they wish to explore and questions to guide the discussion, ongoing modifications are encouraged as a means of following-up answers and comments, and probing for additional information where appropriate (Legard *et al.*, 2003; Kvale, 1996; Sarantakos, 2005). Thus, allowance is made for the "spontaneity and unpredictability of the interview exchange" (Glesne, 2006: 92), although according to Bryman and Bell (2003), the researcher can still expect to address the questions they had planned to in a similar wording from participant to participant.

On this basis, the researcher is satisfied that the semi-structured interview method (Berg, 1995), while time-consuming and potentially inconvenient[29] for participants (Sarantakos, 2005), was appropriate for the current study and is consistent with an intermediate philosophical position (Mason, 1996). As the research objective and questions require an understanding as to how GPs manage, their roles and influences, and how these interact, it is necessary to seek to access their meanings, understandings and rationales in the context of the phenomena being studied (Kvale, 1983; King, 1994). In this way, the researcher and participant collaborate in creating knowledge (Legard *et al.*, 2003). Semi-structured interviews provide the researcher with a relatively flexible (Bryman, 2004) and natural (Glesne, 2006) means by which they may explore this world and the associated meanings and interpretations. At the same time, interviews in this format retain sufficient structure (Bryman and Bell, 2003) to ensure that the research objective and questions are addressed with some consistency.

29 As section 5.9.1 highlights, the use of telephone interviews helped to reduce any inconvenience.

5.5.2 Use of secondary data to supplement interviews

Primarily, the data for this study was generated from interviews. To supplement this, and by way of corroborating some of the data generated (Remenyi *et al.*, 1998; Bryman, 2004; Sekaran and Bougie, 2010), the researcher also used secondary sources where possible. These included reviewing any practice websites of interviewees and documents or information available through this medium, and conducting general web searches of interviewees for items concerning them or their practices. Searches of the websites of other relevant organisations (e.g. ICGP, IMO, HSE, Department of Health) were also conducted for any documentation, reports or useful information. All material gathered was reviewed and assisted the study in a number of ways, such as providing context (Appendix A) for the findings and discussion, and as a means of supporting and clarifying some of what interviewees said to the researcher.

5.6 Gaining access and sourcing the sample

5.6.1 Access

The study was conducted across three career stages – established owners, new owners and non-owners. In determining criteria for distinguishing 'established' from 'new' owners, the researcher based this upon how interviewees were sourced and their practice tenure. 'New' owners are members of the 'Network of Establishing GPs'[30], while 'established' owners were sourced separately from this, none of whom indicated or suggested that they were current members of the Network. Thus, 'established' owners have all been with their practices for more than five years, while 'new' owners have been with theirs for five years or less, which the researcher regarded as a reasonable cut-off for this purpose[31].

30 The 'Network of Establishing GPs' is an initiative by the ICGP to represent, assist and encourage the participation of 'establishing GPs' who consist of "registrars, locums, sessional, part-time, assistants (GMS or private), new principals and those who have recently completed their training in other countries" (ICGP, 2013). In this regard, owners who are members of the Network would have entered ownership relatively recently.

31 One of the 'new' owners indicated in their interview that they saw themselves as more 'established' than 'establishing' (having been six years with their practice), and were therefore re-categorised on this basis for the purpose of analysis. This helped to affirm the appropriateness for the researcher of the criteria used.

Established owners were sourced at an event, at which the researcher was allowed to attend by the organiser. Initially, the researcher envisaged conducting a mixed methods study[32] and, in this way, the event was being utilised as a means of administering a survey. The closing question on the survey asked if participants would be willing to be interviewed. In total, 36 participants indicated their willingness. Based on Locock *et al.* (2004), because GPs are very busy, it is preferable that prior agreement to be contacted is secured. Thus, no 'cold calling' occurred as prospective participants were informed in advance of the overall intent of the research (Sweet, 2002), were each aware of the institutional context of the researcher and had explicitly agreed to be contacted (Tausig and Freeman, 1988).

The researcher wrote to each of the participants who were willing to be interviewed, reminding them of the study and explaining that the researcher would shortly telephone them to determine if they were still interested and available (Berg, 1995). As is typical of organisational research, the researcher regularly had to negotiate access with 'gatekeepers' (Burgess, 1984; Glesne, 2006). In the case of this research, gatekeepers were typically practice managers/administrative staff. The researcher, in conversations with managers/administrators, made reference both to the letter they had sent to the participant as well as the fact that they had previously indicated an interest in participating.

Of the initial 36, the researcher was unable to speak with fifteen while for a further seven, it was not possible to agree a suitable time or date after a number of attempts because of their work pressures/schedule. Ultimately, fourteen owner GPs agreed to be interviewed by the researcher and arrangements were made in accordance with their schedules. These interviews took place in Autumn 2009.

In early 2010, the researcher made contact with the ICGP and met with a representative to seek means by which to access GPs who were part of the 'Network of Establishing

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32 After carrying out the surveys and reviewing the overall results, a decision was made not to use this data as – given the exploratory nature of the study – the researcher felt that insufficient knowledge and understanding of the phenomenon pre-existed the qualitative phase to be able to develop sufficiently robust hypotheses and test relationships. Thus, it was decided to limit the data to that collected in the interviews aside from some basic demographic details e.g. practice size, years with current practice etc. from the surveys.

GPs'; as Glesne (2006) suggests, an intermediary may be helpful in recruiting interviewees. At this stage, the researcher was still envisaging a mixed methods study and the focus of the discussion was accessing members, initially, to complete a survey. Further discussions took place with various representatives, after which it was agreed that a link to the researcher's survey would be emailed to network members in the second half of 2010. As before, the final survey question asked respondents if they would be willing to participate in an interview.

In total, 38 additional participants expressed an interest in an interview. These were grouped into two categories – new owners and non-owners[33]. Each interested participant was written to, requesting an interview, and this was followed up with a phone call. Ultimately, 21 further GPs agreed to an interview (seven owners; fourteen non-owners) – those who were not interviewed either could not be contacted (thirteen), were no longer in practice (one) or a suitable time/date could not be arranged (three). Interviews took place during Spring/Summer 2011. Overall, 35 separate interviews were conducted, all from different practices. Appendix E (p.297) provides details of these interviewees; in order to preserve anonymity, only basic details are noted.

5.6.2 Sample selection

In selecting the sample for this study, a non-probability sampling strategy was followed (Domegan and Fleming, 2003) as the researcher engaged in purposive sampling (MacDougall and Fudge, 2001; Silverman, 2010). For the purposes of the research, this meant selecting GP participants because they were relevant to the topic being studied (Snell *et al.*, 2011), cognisant of Silverman's (2010: 193) advice that "we think critically about the parameters of the population we are studying" and choose on this basis.

In this regard, the researcher wanted to speak with both owners and non-owners to ensure that multiple perspectives were captured (McKinnon, 1988), consistent with the exploratory nature of the study. The insights of non-owners were required to provide perspectives from the 'managed' as well as the 'managers', in further articulating and assessing the approaches adopted by owners as well as reflecting on their own

33 Non-owners consist of 'assistant' GPs (full-time or almost full-time employees based in one practice) and 'locum/sessional' GPs (employed in more than one practice, or in one practice on a sessional basis).

involvement in management. Additionally, the researcher wanted to access the perspectives both of owners who were established in their practices and those who were more recently after entering ownership to determine what similarities and differences might exist between these in their approaches to work and management. Thus, by studying across career stages, the researcher hoped to get a more rounded picture of management practices than might be obtained from owners alone.

Regarding further criteria, the researcher wanted to speak with owners who were partners (ten) and who were sole owners (eleven). This relatively even split ensured that a broad but balanced range of perspectives was captured, reflecting the typical structures in Irish general practice. Furthermore, the researcher wished to speak with GPs from practices across a range of different sizes. This ensures that the findings are not solely biased to one particular practice size. At either extreme were three practices with twenty or more staff and two practices with two staff, while the average overall practice size was 9.6 staff[34]. When the average number of qualified GPs in the 35 practices (2.83) is compared to Bourke and Bradley's (2010) Irish national study average of 2.7, this provides comfort that a reasonable spread of sizes is captured that appears on a par with Irish practices generally.

5.6.3 Sample size: sufficiency and saturation

As Baker and Edwards (2012: 5) acknowledge, there is no straight answer as to what is a sufficient sample size in qualitative research, though also noting "saturation is central". Therefore, in determining whether sufficient data has been collected for the current study, the researcher consulted literature on sample sizes and achieving data saturation. Based on Kvale (1996), for interview studies in general, a range of between 5 and 25 is considered appropriate. Mason (2010) indicates that, for PhD research specifically, the average sample size is 31 interviews. In his article, Mason also cites other sources that address sample size (Table 5.1):

34 National statistics on Irish practice sizes are not available.

Qualitative approach	Source	Recommended sample size (interviews)
Ethnography/ethnoscience	Morse (1994) Bernard (2000)	30-50 30-60
Grounded theory	Creswell (1998) Morse (1994)	20-30 30-50
Phenomenology	Creswell (1998) Morse (1994)	5-25 At least 6
All approaches	Bertaux (1981)	At least 15

Table 5.1 – Recommended sample sizes when using interviews (Adapted from Mason, 2010)

More important, however, is determining if data saturation has been achieved, which is reaching a state where additional data collected generates no new information in the context of the research (Creswell, 1998; Mason, 2010; Suter, 2012). Guest *et al.*'s (2006: 65) operationalising of saturation is helpful, being: "the point in data collection and analysis when new information produces little or no change to the codebook". In their study, Guest and colleagues found that saturation was achieved after twelve interviews, whereby they had developed 88% of all codes (from the data). Similarly, Francis *et al.* (2010) – with categories pre-determined by theory – found saturation was reached by their seventeenth interview. What these two papers highlight is that data saturation, where the sample is relatively homogeneous and whether codes are data or theory-driven, can be achieved quite early on.

In the context of the present study, the researcher reviewed his data analysis table (see section 5.10.5) during the analysis phase[35] and established that, within each career stage, no new codes or sub-codes were being added in the final interview conducted – thus, no new information was being generated. For 'Established owners' and 'Non-owners', this is consistent with Guest *et al.* (2006), as these consisted of fifteen and fourteen interviewees respectively, and is also close to Francis *et al's.* (2010) observations. While the numbers of 'New owners' interviewed was less (six in total), the overall relative

35 While saturation was formally assessed at this stage, during the interviewing process, it was apparent to the researcher that – in the later interviews for each career stage – the amount of new knowledge being generated was levelling off.

homogeneity of the sample meant that the majority of codes were established relatively early; over 80% of all codes were developed from the first fourteen interviews[36], which is in line with Guest *et al.* (2006). Thus, on the basis of no new information arising in the final interview in each sub-group, the broad homogeneity of the overall group (all practising GPs) and the general consistency with previous literature, the researcher contends that saturation had been achieved[37].

5.7 Interview protocol and piloting

Having decided upon the use of semi-structured interviews for the purposes of this study, the researcher set out to design an interview protocol (see Appendix F, p.298) to capture the relevant perspectives and to act as a guide. The starting point was through a consideration of the literature reviewed and key themes identified (Figure 4.1, p.77), as well as the research objective, research questions and the type of study being conducted (Berg, 1995). Lee (1999: 62) explains that semi-structured interviews have "an overarching topic, general themes, targeted issues, and specific questions, with a predetermined sequence for their occurrence", with scope for the researcher "to pursue matters as circumstances dictate". In this regard, the protocol had a general structure and suggested topics/questions, reflecting areas that were to be covered (Taylor and Bogdan, 1998) while also assisting the researcher to keep on track and on pace (Legard *et al.*, 2003). However, where relevant, the protocol was deviated from (King, 1994) in terms of topics, questions and sequences as additions were made and wordings amended. This allowed the interviewee to more freely express their thoughts and feelings, while also giving the researcher the scope to redirect the interview back to the overarching topic when the interviewee got side-tracked or lost their train of thought (Legard *et al.*, 2003). Conscious efforts were made by the researcher to ensure that questions were kept brief (Kvale, 1996), clearly phrased and asked in understandable language and terminology (Patton, 1990).

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36 This does not negate the importance of the subsequent interviews, at different career stages, which added critical nuances to the initial codes and important insights that would otherwise not have been identified e.g. the implications of the GP owner not being in operational control (section 6.5.4 and 6.5.5) arose in interviews with non-owners.

37 While there was scope for the researcher to return to the field and expand the sample during data analysis if necessary, as saturation was reached, a decision was made not to seek or conduct further interviews.

Thus, the objective of the protocol was to ensure that the researcher addressed key themes and areas of relevance to the research questions and objectives (Berg, 1995; Kumar, 2005), while remaining suitably flexible to allow interviewees to speak about their experiences, thoughts and perspectives in a flowing manner (Arthur and Nazroo, 2003). An initial interview schedule – as part of the protocol – was designed for interviewing 'established' owners based on the key topic areas of the research (see Appendix F1, p.299); this evolved over the course of the interviews, as questions were added and amended. The nature of the schedule ensured a flow from broader topics initially to more specific areas latterly (Brannick, 1997; Taylor and Bogdan, 1998), with questions designed of both a factual and a mostly open-ended nature (Patton, 1990). In addition, possible probing questions and prompts (Berg, 1995; Bryman, 2004) were included as a means of clarifying responses and seeking expansion; Mc Kinnon (1988) advises that probes can help to manage interviewer bias by allowing gaps in their own understanding to be filled by the interviewee as opposed to by their own expectations. The researcher adopted a flexible approach here, introducing further probes as appropriate.

In order to check for understanding, clarity, language/terminology, length and relevance, two experienced academic colleagues and an experienced GP owner went through suggested interview questions and the overall format as a form of piloting (Burke and Miller, 2001; Sekaran and Bougie, 2010; Silverman, 2010), making some suggestions for improvement. Before each interview formally commenced, the researcher thanked the interviewee for their participation, and reminded them that confidentiality and anonymity (Chapple, 1999) would be preserved by using only codes in the interview text instead of names/places and by not sharing transcripts with others. Interviewees were advised as to the approximate length of the interview and were asked for permission to record, before the general format and purpose of the interview was briefly outlined (Patton, 1990). In addition, the researcher advised interviewees that they were welcome to a copy of the transcript from the interview if they wished and that if they required changes, the researcher would make them. These steps ensured that interviewees were immediately put at ease and established some rapport (Legard *et al.*, 2003).

The protocol allowed the interview to develop in a generally conversational manner. However, the researcher was conscious of the fact that the interview itself is not a 'conversation' in the traditional sense as it is designed to address some objective as opposed to a casual engagement. Burgess (1984: 102) describes interviews as "conversations with a purpose", while Bechhofer and Paterson (2000: 69) view them as an "interactional process, an encounter" between strangers often on a one-off basis. Thus, while allowing and inviting flexibility, the protocol also ensures that focus is not lost. Conscious efforts were made to recognise and minimise interviewer bias (McKinnon, 1988) by seeking to avoid leading questions, keeping personal opinions to a minimum and allowing the interviewee to speak relatively freely (Legard *et al.*, 2003). Upon completion, the interviewee was thanked and again offered a copy of the transcript (which was subsequently emailed to those who requested one, with password protection).

The same overall approach was followed with subsequent interviews. An updated interview schedule was developed for 'new' owners (Appendix F2, p.301) and non-owners (Appendix F3, p.303). These remained broadly faithful to the initial schedule, but did seek to introduce some new relevant elements and omit others that were irrelevant. An experienced academic reviewed both schedules and made some suggestions.

5.8 Recording interviews and taking field notes

From the literature, there are strong recommendations that interviews are recorded (Bryman and Bell, 2003; Silverman, 2010), and this was heeded in the current study. Patton (1990) emphasises the importance that the interviewee's actual words are captured, with Taylor and Bogdan (1998) noting that a recording device mitigates the need to rely on memory. Furthermore, the researcher is freed from the task of complete note taking, allowing them to focus instead on listening and probing (Legard *et al.*, 2003), which was a significant help.

However, note taking is still recommended to capture key items as they arise in the interview for consideration at later stages (Patton, 1990; Lee, 1999) and can help in mitigating interviewer bias (McKinnon, 1988). Otherwise, the researcher may forget

pertinent points and not mentally separate data collection from analysis. Thus, the researcher was conscious to take notes of anything that appeared relevant, interesting, or that needed to be pursued later in the interview or at subsequent stages in the research. Taylor and Bogdan (1998) highlight the importance that the interviewer retains attention to the interviewee's words, as using recordings can allow one to drift; brief note taking of interesting items acted as a useful means of maintaining focus. After each interview, the researcher reviewed their field notes and added to these in creating a short interview summary. These were filed and returned to during the data analysis and interpretation stages, adding additional context and reminding the researcher of potentially important and relevant details.

Reflecting Sweet's (2002) advice that it is important to establish a good relationship with interviewees in advance, the researcher engaged in some 'small talk' before commencing. All interviewees confirmed that they were satisfied to speak on a speakerphone[38] to the interviewer in a private room (Smith, 2005) and for the interview to be recorded. The researcher had previously used the recording equipment for interviews on numerous projects and was very comfortable with its operation and quality. However, appropriate precautions were taken to mitigate technical or environmental difficulties (Easton *et al.*, 2000), such as outlining the approximate length of the interview in advance, using a quiet room and having a back-up device. Before each interview formally commenced, the researcher tested the recording device with the interviewee (Patton, 1990).

5.9 Using telephone interviews as a means of data collection

5.9.1 Face-to-face and telephone interviews: reflections on early experiences

Three of the initial four interviews conducted with established GPs were face-to-face, in their surgeries and during working hours. Initially, this was the intended manner in which all interviews would be conducted. When arranging one interview, because of difficulties in setting a time, it was agreed with the interviewee that a telephone interview would take place as this gave them the flexibility to re-schedule at short

38 The use of primarily telephone interviews in this study is further discussed in section 5.9. Face-to-face interviewees also confirmed that they were satisfied with the use of recording equipment.

notice. After this, the researcher reflected on his experiences of the initial four interviews and his general sense of the data generated.

One interviewee appeared to have difficulty maintaining eye contact during the interview, looking around the room. In another interview, the interviewee initially apologised for its late starting because a patient had collapsed in the surgery and needed to be attended to; when leaving the interview, the researcher noted that their waiting room was full with patients. However, the interviewee at no point attempted to shorten or interrupt the interview (only after the interview had finished did they acknowledge that they were under time pressure), though nervous laughter from the interviewee was apparent at stages that may have been a sign of some discomfort in the circumstances. During a further face-to-face interview, the GP was interrupted – on a number of occasions – by a phone call relating to a family matter. The researcher could identify that this was bothering the interviewee, but again no attempt was made to end the interview, nor was the researcher asked to leave the room (recording was temporarily paused).

On reflection, the researcher identified that a possible explanation for these observations was that their physical presence in the room, in a questioning capacity, was a somewhat novel experience for the GPs who are more used to asking the questions (of patients) in their surgery. In this respect, the control of the conversation vested more with the researcher as opposed to the GP (Kvale, 1996). This did not hamper the quality of the exchange or the data collected, but the researcher did note that the phone interview seemed to be a more open and frank conversation.

The researcher ascribed these differences to a rebalancing of control over the interview in favour of the GP when the phone was used. Although the researcher still broadly controlled the topics (Shuy, 2002), the GP now had ultimate control in that they could cease the interview at any time if they wished to[39] (Sweet, 2002) and easily reschedule if needed (as happened on three occasions). It is possible that phone interviewees may have been more comfortable with the exchange, not having to feel any sense of social obligation to continue, as might be the case when the researcher was physically in their

39 No interview ended in this manner.

presence. The greater perceived 'anonymity' (Sweet, 2002) accorded by the phone interview may also have made the GP more relaxed and less self-conscious in being in the less common position of being on the receiving end of almost all of the questions.

Subsequent phone interviews were then arranged and conducted and similarly reflected upon. Overall, the same sense was experienced; interviewees appeared to be quite comfortable with an exchange where neither party was physically present in the room with the other. Indeed, in some phone interviews, GPs were quite critical of individuals who, while not named, were identifiable from their comments; this was not as apparent in the face-to-face interviews, which may suggest that being physically present meant that interviewees were that bit more guarded and measured in their words.

A further reason as to why GPs reacted favourably to phone interviews may have been the fact that these could be conducted at any time that fitted into their schedules. Some of the interviews were conducted at night, when the GP was at home, or at other convenient non-work times. These times were selected by the GP themselves; had the researcher insisted on a face-to-face interview, it is questionable whether one would have been possible.

5.9.2 A comparison of the researcher's experiences with the methodological literature

Some authors suggest that in-depth telephone interviewing may be difficult because intensity is affected (Legard *et al.*, 2003), participants lack rapport and encounters can be arduous (Irvine *et al.*, 2013). In addition, it is contended that highly structured and closed ended questions are required in such interviews, complex issues are difficult to deal with and visual cues are absent (Shuy, 2002). However, there are others who have found that telephone interviews are just as effective. Novick (2008: 397) concludes that: "there is little evidence that data loss or distortion occurs, or that interpretation or quality of findings is compromised when interview data is collected by telephone", while Carr and Worth (2001) acknowledge cost-effectiveness and flexibility as key advantages. Thus, it is important to evaluate telephone interviewing as a data collection method.

Tausig and Freeman (1988) and Sweet (2002) note that greater anonymity and less intrusion is facilitated and sensitive topics can be addressed (Wilson and Roe, 1998; Chapple, 1999; Carr and Worth, 2001), while Chapple (1999), Sturges and Hanrahan (2004) and Stephens (2007) indicate that data collected in this manner is rich, detailed and of high quality. Based on Chapple (1999), Opdenakker (2006) and Sturges and Hanrahan (2004), cues are detectable in a verbal and tonal sense, and probing and clarifying questions can be used (Sweet, 2002). Domegan and Fleming (2003) suggest that interviewer bias may even be lessened by the absence of face-to-face interaction. A lack of any prior relationship with interviewees is not perceived to be a particular disadvantage (Chapple, 1999), as a "friendly rapport" (Stephens, 2007: 211) can be established.

In the current study, somewhat sensitive matters (Wilson and Roe, 1998) were addressed in interviews using a semi-structured and conversational approach where the relative anonymity and distance was an advantage, while tone (e.g. sarcasm, discomfort) and hesitation (e.g. reflecting, unsure) was detectable (Sturges and Hanrahan, 2004; Opdenakker, 2006). As the findings (chapter six) demonstrate, rich and detailed data was collected (Sturges and Hanrahan, 2004). Interviewees did not appear to have any difficulties with the medium, requesting clarifications/explanations from the researcher when necessary, while exchanges were friendly but professional. Consistent with Stephens (2007), the loss of visual cues had no noticeable effect on the overall study[40].

Lavrakas (1993), Domegan and Fleming (2003), Sekaran and Bougie (2010), Irvine (2011) and Irvine *et al.* (2013)[41] suggest that telephone interviews are shorter in length than face-to-face interviews. However, Sweet (2002)[42] and Sturges and Hanrahan (2004) report little differences in lengths in their studies, while in the case of McCoyd and Kerson (2006), their telephone interviews exceeded 90 minutes. Wilson and Roe's (1998) telephone interviews lasted between 30 and 80 minutes, with few indications of interviewee burden. In the current study, the lengths of two of the face-to-face

40 In terms of the three face-to-face interviews conducted, aside from the observations noted in section 5.9.1 above – which prompted consideration of telephone interviews in the first place – the researcher did not identify further visual cues of significance to the study.

41 Although shorter, the average length of Irvine *et al.'s* telephone interviews was 80 minutes.

42 Sweet's (2002) interviews lasted between 30 and 70 minutes. The author also notes that the quality of data obtained was not noticeably different to that generated by face-to-face interviews.

interviews were in line with other interviews[43], suggesting that Irvine *et al.*'s (2013) concerns that telephone interviewees may provide less detail or elaboration are reduced. While a further face-to-face interview was longer, this was an interview that the researcher and interviewee both later acknowledged occasionally strayed off-topic.

Thus, there is no evidence that data was lost or compromised through the use of telephone interviewing, or that interviewees had difficulties with the length of exchanges which were in line with other studies. Although Irvine (2011: 212) suggests differences in length "could be accounted for by a reduction in coverage of themes", this was not apparent in the current study; all key topics, as relevant, were addressed in each interview.

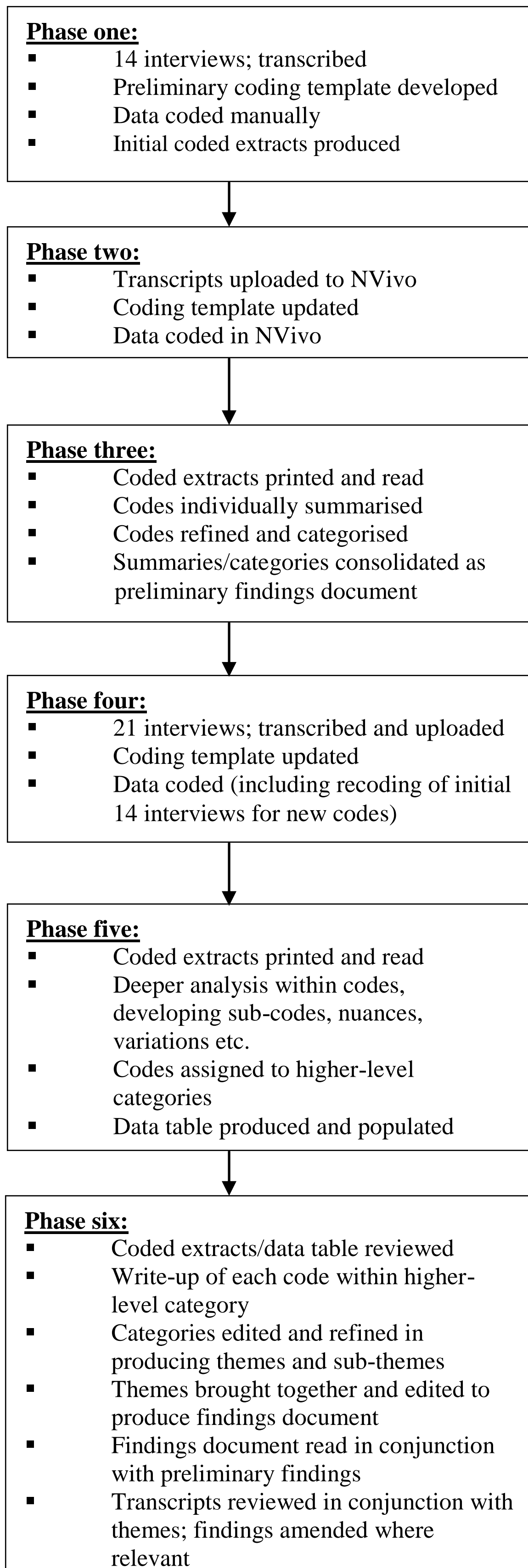
Overall, the researcher was satisfied that the decision made to use the telephone for in-depth interviewing was appropriate and effective. The gains made by this method – in rebalancing control as a means of making the interviewee more comfortable with being the 'questioned' rather than the 'questioner', introducing a degree of anonymity and in allowing interviews to take place at non-conventional times and in non-conventional locations – exceeded the limited losses of visibility and physical presence. While suited to the purposes of this study, the researcher makes no claims to suggest that, generally, telephone interviewing is preferable and further research is needed to explore the observations here. However, given the limited discussion of this approach noted in qualitative research (Chapple, 1999; Sweet, 2002; Sturges and Hanrahan, 2004; Novick, 2008; Irvine, 2011; Irvine *et al.*, 2013) and the criticisms put forward by some, it is useful to add the positive experiences of this study to the debate.

5.10 Analysing the data

The documentation of the analytical process below may give the impression of a linear development. However, the process was also cyclical as the researcher regularly returned to the objectives, questions, literature and transcripts. In this respect, Dey's (1993: 265) description of analysis as "an iterative process", as the researcher moves in recurrent cycles between reading, categorising, linking, corroborating and writing, was apparent. Throughout the process, the researcher was informed by the methodological

43 On average, interviews were approximately one hour in length, ranging from approximately 30 to 90 minutes.

literature, while as an overarching means of "identifying, analysing, and reporting patterns (themes) within the data", Braun and Clarke's (2006: 79) approach to conducting thematic analysis was regularly consulted. As noted in section 5.5.2, some secondary data was also used, though the main focus was on data generated from the interviews conducted. Figure 5.1 provides a diagrammatic summary of the following phases of analysis and key outputs at each phase.



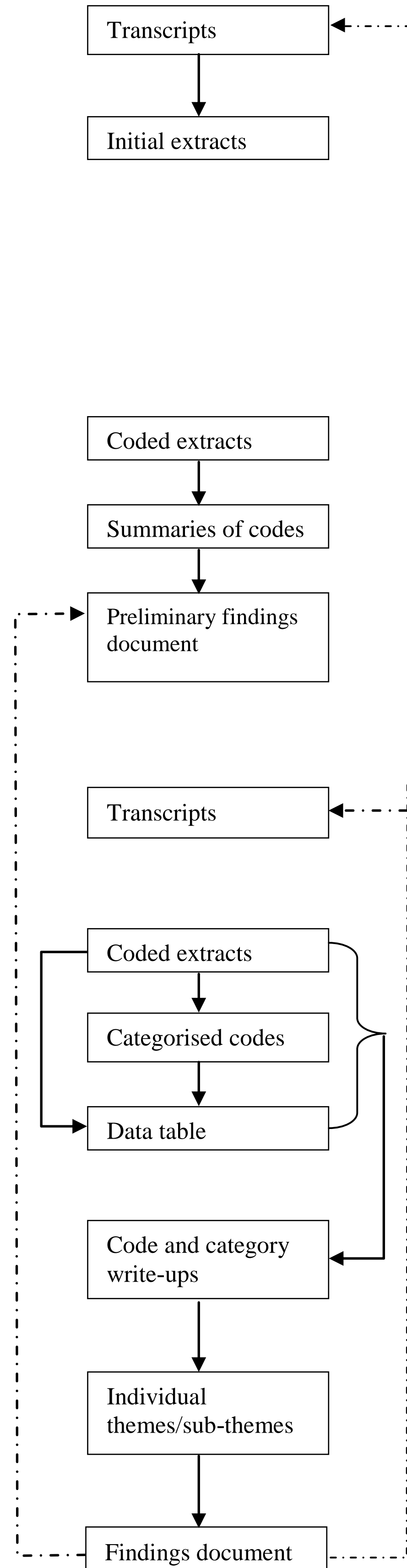


Figure 5.1 – Diagram of the phases of data analysis and key outputs produced

5.10.1 Initial interviews and manual coding

All of the initial fourteen interviews were fully transcribed by the researcher, requiring considerable time (Bryman and Bell, 2003). However, this helped the researcher to absorb conversations in depth and become immersed in the data, representing some early analysis (Braun and Clarke, 2006). Each transcribed interview was read in detail in order to further increase familiarity with the data (King, 1994), while summaries generated from notes taken during interviews (section 5.8) were also re-read. The researcher studied all transcripts collectively and manually identified relevant extracts. In this way, the data was being 'coded', which Patton (1990) sees as a means of classifying data in a systematic manner by attaching labels to relevant sections of text. This is an important means of reducing the data (Miles and Huberman, 1994; Spencer *et al.*, 2003) and an essential part of analysis, as data is 'funnelled' into categories (Dey, 1993).

Coding was cognisant of the study's broad objective, while also allowing codes to develop from the data (Dey, 1993). Such flexibility enabled the researcher to fully explore interviews and capture emergent ideas, without losing sight of the underlying purpose of the study. Extracts were coded by highlighting appropriate sentences/passages, with codes documented in the margins (Burgess, 1984). Consistent with Ritchie *et al.* (2003), this gave rise to a preliminary 'index' or coding template, which could be later refined. Tables were created in Word to bring together relevant coded extracts into individual documents for further study and reflection. While these tables and manual extracts were not used in subsequent stages of the analysis, this helped the researcher to better understand the data and identify some initial patterns and differences across the interviews. The researcher believes that this familiarity enhanced their ability to subsequently code using software (see below) by virtue of having been so physically close to the data itself.

5.10.2 Second coding of initial interviews: Applying software

The second coding of initial interviews was conducted using NVivo[44], with all transcripts uploaded. Mindful of concerns raised regarding the use of software in qualitative analysis (e.g. Seidel, 1991; Barry, 1998; Remenyi *et al.*, 1998; Sarantakos,

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44 NVivo is a software package commonly used in assisting with the analysis of text-based data.

2005), the researcher believes that the merits of appropriate and thoughtful use outweighed these issues. Software can create distance between the researcher and the data and remove it from its context, may unintentionally drive the emphasis of analysis, and can put a quantitative slant on what is qualitative data. However, the researcher consciously avoided these issues by using the software principally as a means of efficient data management and as a tool to facilitate analysis (Spencer *et al.*, 2003), while elements of the analysis also happened outside of the software itself (see section 5.10.5; Barry, 1998). Therefore, the researcher had the benefits of using software by removing some of the burden of manual analysis (Dey, 1993; Creswell, 1998) and allowing ready access to raw data in context (Spencer *et al.*, 2003; Bazeley, 2007), while still retaining the natural 'feel' of the data and control of the analytical process.

The first step in NVivo coding was to establish possible codes under two headings – those based on the interview protocol/schedule as a form of structural coding (Namey *et al.*, 2008; Saldana, 2013) and those from the earlier manual coding template. The researcher suggests that this approach ensured that the study's research objective, themes identified in previous literature, and interview topics were being represented in initially broad analytical codes. However, to ensure that emergent ideas were not being lost, additional codes were also created inductively from the data. In this way, codes were both 'theory-driven' and 'data-driven' (Braun and Clarke, 2006), which is consistent with the intermediate philosophical stance adopted (section 5.2). All codes were created in NVivo; transcripts were re-read within the software and extracts were coded using the new codes, while additional in-vivo codes were added as new ideas emerged. The codes and higher-level categories used in this study are reproduced in Appendix G (p.305).

5.10.3 Reading and summarising the codes

Coded transcripts were printed and read in detail by code, with a summary written to capture the essence of each code. Based on Ritchie *et al.* (2003: 237), in summarising, the researcher "begins to trigger the vital insights into, or questions about, the data that will lead to the later interpretative stages of analysis". Each summary was written in the form of a detailed memo, as a means of further data reduction (Miles and Huberman, 1994). An extensive document was produced, which was read a number of times to increase familiarisation and to help develop the researcher's analytical thoughts. As part

of this process, some codes were eliminated through combining codes and deleting superfluous items; all remaining codes were further reviewed and grouped into initial categories. The summary document was reorganised in line with this structure and populated with relevant quotes from interviews to add richness.

This gave rise to a lengthy preliminary findings document for the first fourteen interviews, which was re-read intermittently. As with the initial manually coded extracts above, the preliminary findings were not directly used in later stages of analysis. However, they were referred to again at the end (section 5.10.6) by way of checking the researcher's perspectives on the complete data set. Therefore, producing a preliminary document importantly helped in bringing focus to the study as the researcher was able to see a clearer picture of tentative early themes but without being 'locked in' to these too early in analysis. This exercise also helped to shape some revisions to schedules for subsequent interviews; as Dey (1993: 37) notes "The resulting data analysis is contingent in character, since it in turn stimulates and is modified by the collection and investigation of further data".

5.10.4 Subsequent interviews and NVivo coding

Twenty-one new interviews were conducted, with all but six of these transcribed by the researcher. The remaining interviews were transcribed by an experienced research assistant (with interviewee permission) and were carefully checked by the researcher for accuracy (Easton *et al.*, 2000; Bryman and Bell, 2003). After transcribing twenty-nine interviews, the researcher felt that sufficient closeness with the data had been achieved that any gains from further transcription would be outweighed by time costs. Each of the new transcripts was re-read in order to increase familiarisation before coding. All new transcripts were uploaded to, and coded in, NVivo. The existing NVivo coding template was used as the initial basis, though additional codes were added in based on the new interviews. These new codes were also investigated in the original fourteen interviews. In addition to the interview data, the researcher used the summaries created after each interview to help with analysis by way of raising observations and thoughts captured at the time (Dey, 1993).

5.10.5 Analysing the complete data set: Drilling downwards and abstracting upwards

All NVivo codes were printed and read through in detail. Sub-codes, variations on codes, negative cases and insights were all identified and noted as encountered, along with the interview where this arose. This entailed a largely inductive and deeper approach to analysis within the existing broader codes (MacQueen *et al.*, 1998; Namey *et al.*, 2008). A short analytical memo (Miles and Huberman, 1994) was written in conjunction with each code to give an overall impression of what had been found in the data, as well as suggestions, questions and points of interest that the researcher needed to follow up or explore further in the data. Codes were assigned to broader high-level categories, representing potential candidate themes (Ritchie *et al.*, 2003; Braun and Clarke, 2006) that reflected their overall nature and content. This was tabulated in a spreadsheet as a visual display (Dey, 1993; Miles and Huberman, 1994), which was used as a basis for an in-depth analysis of the findings in an organised manner, while also providing an overview of the data across interviews and career stages.

The data table was structured with codes as rows and interviewees as columns; a short extract is reproduced in Appendix H (p.307/308). By using a spreadsheet, codes could be easily interrogated and moved around (Dey, 1993). Interviewees were assigned numbers and grouped according to career stage. The gender of each interviewee was noted. Within each code, sub-codes were identified and recorded on the table, reflecting variations and nuances on the code itself. This allowed for a deeper analysis and understanding of each code and revealed greater insight into what was being said and meant in the data. Interviewees were marked on the sheet where the sub-code was present; this permitted the counting of codes/sub-codes to identify prominence as a means of informing and aiding analysis (but not in a statistical sense), while also allowing the researcher to look across codes for patterns and connections (Dey, 1993; Miles and Huberman, 1994; Ritchie *et al.*, 2003). By grouping codes into higher-level categories within the data table, and re-reading and reviewing codes and extracts on this basis (Braun and Clarke, 2006), a clearer picture of the data formed.

5.10.6 Writing the account: Consolidating the themes and achieving coherence

The researcher then moved on to writing up the findings. This entailed immersion in the coded extracts again, in conjunction with the data table, as each relevant code was

written up within the appropriate higher-level category. In this respect, the researcher sought to capture the essence of the 'story' being told by the code by summarising what was being said and meant by the data, and illustrating this with rich and relevant quotes from the coded data extracts (Creswell, 1998; Braun and Clarke, 2006). By moving between the coded extracts and the data table (and original transcripts, when necessary), the researcher ensured that prominent, interesting, divergent, nuanced and relevant features within the data were captured and coherently presented in the interviewees' own words. Once all codes in a category were written up, a further editing exercise was carried out to bring coherence and structure to these codes within the underlying theme of the category.

From Braun and Clarke (2006: 82): "(A) theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set". Codes – individually, or combined with other codes – became sub-themes, while some irrelevant codes were eliminated. These sub-themes connected to the overall themes, collectively forming the theme but also having a particular focus and being important themselves. This editing process did not detract from the richness of the data, but rather ensured that the researcher did not get 'lost' in the considerable volume of data and remained focused on the underlying objectives and questions.

Once each theme was written up, the researcher brought all themes together into a consolidated document where further editing was performed to develop a set of findings that reflected the essence of the underlying data and themes in the context of the research objective and questions. In this way, the researcher sought to produce "a concise, coherent, logical, non-repetitive, and interesting account of the story the data tells – within and across themes" (Braun and Clarke, 2006: 93). This was read in conjunction with the initial summary completed after the first phase of interviews (section 5.10.3) as a means of checking the researcher's perspectives on the complete data set. While broad consistency was found, equally it was apparent that the researcher's thinking and understanding of the complete data set had developed with subsequent interviews, highlighting the importance of interviewing at other GP career stages. In addition, all 35 interview transcripts were re-read in conjunction with the core themes developed, with minor adjustments arising from this review.

5.11 The importance of validity and reliability

According to Remenyi *et al.* (1998) and Patton (2002), validity and reliability are aspects that qualitative researchers need to consider in research design, data analysis and in judging the overall quality of the study. Validity can be understood as whether one is investigating or explaining what they claim to be investigating or explaining (Kvale, 1983; Mason, 1996) and "whether the researcher has gained full access to knowledge and meanings of respondents" (Remenyi *et al.*, 1998: 115). Reliability means that the methods used are appropriate, thorough, careful, honest and accurate (Mason, 1996), and that the researcher is obtaining data that they can rely on (McKinnon, 1988). By producing research that is both valid and reliable, the researcher facilitates others to replicate the study, while recognising that perfect replication of qualitative research is unlikely (Remenyi *et al.*, 1998).

5.11.1 Validity in the current study

A number of approaches were used to assess the validity of the results. Patton (1990) and Sekaran and Bougie (2010) present various triangulation strategies that can be deployed, one of which is 'data source triangulation'. This entails the researcher determining if the data remains the same in different contexts. For example, in the present study, the drawing of samples from different career stages allowed owners' descriptions of management to be compared to those of non-owners in describing management in their practices. In addition, the researcher used some secondary data (section 5.5.2) by way of crosschecking the information (Bryman, 2004) provided by interviewees where this was possible. For example, documents related to management training for GPs were reviewed in light of interviewee comments regarding the nature of such training, while particular facts disclosed in some interviews were corroborated to other sources.

Creswell (1998), Padgett (1998), Lewis and Ritchie (2003), Sekaran and Bougie (2010) and Silverman (2010) recommend that researchers should consider negative cases in their analysis to establish if and how these affect their findings and conclusions. Negative cases – in the context of individual interviews – were considered during each phase of data analysis and in producing the final account as to how they affected

interpretations. For example, in a small number of practices, evidence was found of practice managers being more ‘dominant’ in management than is the case in the wider sample; these negative cases gave rise to some important insights (see section 6.5.4 and 6.5.5).

Creswell (1998), Padgett (1998) and Glesne (2006) propose using others as a means of checking for validity in the study. This can entail member checking and peer debriefing. Member checking typically involves the researcher “taking data, analyses, interpretations, and conclusions back to the participants so that they can judge the accuracy and credibility of the account” (Creswell, 1998: 203). In the current study, interviewees (who requested) were sent copies of their transcripts for review as a check on the validity of the evidence provided “to ensure that it reflects their understanding of the phenomenon” (Remenyi *et al.*, 1998: 115). While some amendments were made, these were minor.

A further check entailed the use of peers for debriefing purposes (Padgett, 1998) throughout the study period. These consisted of experienced academics, with knowledge in areas of relevance to the study, who formally read/discussed various sections of the study and fed back their detailed thoughts and perspectives. Debriefing also entailed more informal and regular discussions with the same peers as the researcher encountered challenges during the process. These sessions allowed the researcher to check interpretations, seek clarifications and test their understanding, while also being challenged to defend their own perspectives in the face of questions posed by the debriefer.

5.11.2 Reliability in the current study

It is necessary for the researcher to adopt strategies that increase the likelihood that the methods and instruments used are reliable, whereby the process of the study should be “consistent, reasonably stable over time and across researchers and methods” (Miles and Huberman, 1994: 278). To demonstrate this, the researcher should document the procedures that they have used in detail (Silverman, 2010), as this chapter addresses. This means that readers, rather than replicating the study, can examine the procedures used as they assess whether the results should be reliable (Dey, 1993). Remenyi *et al.* (1998) recommend that the evidence collected is stored in an easily accessible manner

to allow others to review this; the usage of NVivo in this study facilitates rapid access to original transcripts as well as the codes used, and how they were coded.

McKinnon (1988) suggests that reliability can be enhanced through ensuring that interviewees understand the purpose of the research and issues of access and trust. Regarding the current study, the researcher outlined the general nature of the study in advance of the interviews and what would be needed, explained the structure of the interview at the outset and provided confirmations pertaining to confidentiality and anonymising of transcripts.

The use of interview protocols is recommended as a means of maintaining reliability (Yin, 1989). Based on Silverman (2010), pre-testing of such protocols also helps to instil reliability. Consequently, the researcher developed a protocol and interview questions (that were peer-reviewed before formal data collection commenced) as a means of seeking consistency across interviews, while also allowing for flexibility as appropriate (see section 5.7).

5.12 Addressing research ethics in the current study

In conducting research, one must be conscious as to any ethical implications that may arise in terms of obtaining informed consent from those who are being studied, respecting anonymity/confidentiality and not exposing participants to harm (Remenyi *et al.*, 1998; Lewis, 2003; Silverman, 2010; Sekaran and Bougie, 2010). Bearing this in mind, the researcher ensured that interviewees were made aware of the nature of the research topic and that their participation was voluntary. Each participant voluntarily elected to be interviewed by (a) indicating their interest as part of a survey and (b) subsequently agreeing to an interview having been contacted by the researcher in writing and by phone. In this way, no interviewee participated under any pressure or duress and individuals had a number of clear opportunities to opt out. Confidentiality was respected and assured by anonymising all transcripts, such that names and places are not revealed, and interviewees were made aware of this upfront. Because of the non-intrusive nature of the study, and the fact that those being studied are not a vulnerable group but rather highly-educated and confident professionals who are well aware of the nature of research, there were no issues with exposing participants to harm. The Dublin

City University (DCU) Research Ethics Committee granted ethical approval for this study, as a low-risk project.

5.13 Summary

This chapter set out to explain the research methodology used in the dissertation. In this regard, the researcher has outlined his philosophical position, the research objective and questions, and research design utilised. Stemming from this, the appropriateness of semi-structured telephone interviews as a means of data collection is discussed, as well as the manner in which these were conducted. The data analysis strategy has been described in detail, along with how the researcher addressed validity, reliability and research ethics. The next chapter will present the detailed findings from the current study.

Chapter Six

Research Findings

Chapter Six: Research Findings

6.1 Introduction

This chapter presents the research findings in addressing the objective of the study, which is: 'To determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role'. These findings are presented in accordance with themes and sub-themes identified during data analysis, with the perspectives of owners and non-owners clearly indicated where this is appropriate and relevant. Initially, the nature of the GP role as a clinical professional is addressed, as interviewees detail the work that they do and their motivations for doing this work, including their motivations for becoming an owner. Their approaches to, and attitudes towards, learning the managerial role are then outlined, as interviewees discuss the timing and relevance of such training. Following this, how GPs manage in practical terms is considered as the findings highlight the areas that GPs – and owners in particular – both emphasise and de-emphasise in managing the practice, the reasons for this, the challenges that they face and their overall approach to management. In this context, the importance of supports is noted, focusing on the practice manager and their contribution. The chapter concludes by addressing ways in which GPs experience different, but associated, forms of role conflict related to functioning as both clinician and manager. The implications of such conflicts are identified, as well as how GPs deal with this.

6.2 The nature of the GP role as a clinical professional – content of the work, motivations for undertaking and being an owner

In seeking to understand the nature of the managerial role of the GP, it is important to firstly understand the broader GP role and what this entails.

6.2.1 The attraction of medicine

A general interest in health and science was a regular motivation for choosing medicine, often stemming back to when the person was young: “I always wanted to do medicine, even since I was … since I could speak” (GP 15). The desire to help people was

relevant for some interviewees, not appearing to stem from anything in particular but represented a very personal reason for being a doctor.

> (M)y interview line is to heal the world. I suppose, at this point … yeah … it was an interest in and enjoyment of people. That is probably … would have been my line at this stage, now, 15 years ago and it really hasn't changed. (GP 16)

6.2.2 General practice as a career: an enjoyable experience

A key reason for selecting general practice specifically is the quality of life attached to the role. This is particularly important for those with young families or considering starting a family. In this respect, general practice gives greater flexibility in terms of how it is positioned in the context of the practitioner's life and priorities.

> (F)rom a quality of life point of view, general practice affords you more of a structure to your day and more ...you know, it's more practical [for] family life down the line as well. (GP 31)

As part of their training, the interviewees spent time in hospitals. However, the poor quality of life experienced and expected was discouraging career-wise.

> Oh working in hospitals was horrific … You just would have gone home that night and just slept; as soon as you went home you would have eaten and you would have went to bed and you would have slept; and then you would get up the next day and do a normal day's work. (GP 33)

Hospital medicine could be quite limiting and restrictive. Their bureaucratic nature also created issues for some, who preferred the openness that they experienced in general practice: "I liked the autonomy that comes with being a GP" (GP 19).

> You become a manager more than a patient contact person ... I wouldn't like it to be where you would go to an awful lot of meetings. (GP 22)

Interviewees also noted that in general practice, they are able to adopt a style of care that is more in keeping with their personal conceptions of how good medical care is practised. A number expressed pleasure in being able to deal with the same patient over an extended period of time in the one practice, helping them and seeing their progression up close.

> What brought me into general practice at the very start, and I think what led me to even being a doctor, was this intimacy that we have with people, which is a huge privilege and that is what gives me the buzz. It's being part of peoples lives and general practice brings that in a different level in that we are very much part of the community of peoples' lives. (GP 13)

Indeed, many of the interviewees expressed their continuing satisfaction with being a GP and that they were pleased with their career choice. The work is regarded as interesting and challenging and the variety of different cases experienced means that, even amongst the more established practitioners, they are still learning and discovering.

> When you put your hand on someone's tum [stomach] and you feel a mass, it's a disaster for them, but it gives you a high. Because you found the pathology and you're the first person who's felt this mass. (GP 3)

As with their reasons for choosing medicine, interviewees did not indicate that money affected their decision for selecting general practice.

6.2.3 The GP at work: focusing attention on the professional role

When asked about the work they perform as a GP, all interviewees indicated that they carry out the traditional professional duties of a general practitioner, including consultation, diagnosis, emergency medicine and house calls. This is spoken of in routine, unexceptional terms as being what all GPs do: "I would work as a GP just like all of the others" (GP 1).

Working days are quite structured and organised in such a way that broad tasks happen in a consistent manner i.e. when surgery begins, when house calls are addressed. The indication is that each day is very full and that the GP is busy for long stretches, even

working through breaks. Regardless of whether the GP is an owner or not, the work is broadly the same at a clinical level.

> It's completely variable and uncertain what is going to come across the door and it's a mixture of medical, surgical, paediatric, obstetrics, social problems, psychiatric problems and really it's an unselected mix. (GP 6)

These duties consisted predominantly of activities that would be categorised as clinical and patient-focused care, with the core aims of resolving or managing problems that present. Some practices were involved in teaching and research.

> I tend to see a lot of the younger patients and children, the young expectant mothers, new mums, that kind of thing. I have a special interest in women's health … I also do a couple of things in the practice that weren't done before I joined like cryotherapy. (GP 26)

Standard activities tended to be grouped into chronic and acute care. It was remarked that preventative medicine had become more prevalent and that this had increased the burden of work on general practice. Some GPs also mentioned that they had an advocacy role for their patients, such as assisting them in terms of their entitlements to services.

Beyond their clinical/care work, GPs mentioned undertaking administration and paperwork as it stems from this work. This is largely flagged as a secondary, associated task and consists mainly of letters, forms, referrals, checking returns and prescriptions. Where possible, this is delegated to clerical staff (see section 6.4.7).

> (W)e've no receptionist, we've no nurse, we have no cleaner, no anything else … we do all of the administrative work, everything. (GP 17)

> I fill in social welfare forms, heating allowance forms, clothing allowance forms, I do prescriptions and I'm very much a clinical GP. (GP 20)

In terms of management, a small number of owner GPs mentioned this as an activity. This was generally in passing, with little elaboration or description ("(S)ome input into the management of running the business" (GP 2)), and was not specifically prompted by the question asked.

> I am the CEO here so I make all the decisions concerning the management of everything, from top to bottom. (GP 5)

One GP did speak in greater depth about their management role, which they identified as a key aspect of what they do. While other GPs did, subsequently, acknowledge a management role, this was only when asked specifically (see section 6.4).

> The role is one of seeing patients and dealing with their problems and in addition to that there is a management role in terms of running a practice and making sure that things don't fall between the cracks. Stuff that you have to comply with in terms of legislation, and health and safety and all of that sort of stuff. And, also, in terms of management, just running a business that makes a profit and looking at the bookwork and are things going well or not so well. Opportunities and watch everything in the marketplace, what the market wants and what we're delivering and all of that sort of stuff. (GP 10)

6.2.4 Becoming and being a GP practice owner

In terms of why interviewees choose ownership, the most prominent reasons were control and financial security. A majority of GPs felt that ownership provided them with greater scope to operate as they wished: "(B)eing able to run a practice and care for a population of people in a manner that I liked" (GP 5). Working for others had created a desire for some control of their own: "(Y)ou're given a certain amount of autonomy as an assistant but then it only goes so far" (GP 17). For some, partnership was the preferred option. While this required sharing control with other GPs, working in a single-handed capacity was otherwise seen as a daunting prospect. This arrangement sustained overall clinician control, even if not at the level of the individual.

> (I)t's to set up a stall and know that when you're setting it up, your setting it up the way you want it to be and it's the way it's going to evolve over the next 40

> years as opposed to being in someone else's stall and not really being able to put your own mark on it. (GP 16 - *partner*)

As owners, by virtue of being in control, responsibility for the affairs of the practice is greater ("I find receipts and unexpected bills causing me ulcers when they never did before" (GP 5)) as they need to directly consider the business in decisions. Thus, while non-owners may take a narrow view at times ("I just want to do the work" (GP 29)), owners have naturally wider agendas to consider.

> I remember, when I arrived here, one of the first questions I was asked was 'Well, what contribution are you going to make to the practice? What are you bringing to the practice?' and that wasn't something I had thought about really. So, there is an awareness that you [as partner] need to contribute to the partnership, you need a set of skills and you need to be able to draw in income and attract patients. (GP 2)

Ownership also provides a level of financial security that employed GPs do not have: "there are big advantages to working for yourself, I mean the harder you work, the more you earn" (GP 7). For those with families and outside responsibilities, this security is important: "(F)amily circumstances, you need to have more guarantees and income and certain rights and you can't be just floating around all the time hoping that things stay as they are" (GP 31). While challenging – particularly in setting up ("it's a lot of work and I don't know if I'd go back and do it again, but I'm not sorry that I did it" (GP 17)) – ownership was viewed as rewarding on many levels, with no owner expressing dissatisfaction with their decision, in spite of the extra workload, pressure and responsibility.

6.3 GP management learning and training – approaches, attitudes and relevance

Before considering the managerial role itself, it is important to understand how this role is developed through education. The study next identifies how GPs learn to manage and their views on this.

6.3.1 Limited engagement with formal management training

Formal management training, through a specific course/workshop, was relatively uncommon amongst owner GPs. Seven of the more established GPs had attended courses, with three of these being beyond workshops or single sessions. Amongst new owners, one had undertaken a short, focused course. Therefore, marginally more than one-third of owners had formal post GP-qualification management training, with a minority of these engaging in a programme that led to an additional qualification.

In general, perceptions of training undertaken were positive and that practical benefits accrued. GPs were able to take something from the training and bring this into the practice, giving rise to some small practical improvements in areas such as health and safety (GP 2) and basic system changes (GP 7). Broad based or fundamental amendments to management practices did not appear to result from the training, though the impression is that this is not what was wanted.

> I mean, certainly, there would be a few tips and tricks that Q would have passed on that I think have stood to me over the time. Sometimes they're useful, things like SWOT analysis and this kind of stuff. Simple stuff, I mean. (GP 8)

> (T)here were quite a few things now, like doing a cost analysis of a new service before you introduce it to see is it going to be worth your while and stuff, that was very relevant now for the cryotherapy. (GP 26)

One GP noted that the programme they attended was useful, though they acknowledged that the content could have been more relevant.

> (W)as more geared towards managers than GPs really … Maybe it might have been more helpful for me to do a course like that as a registrar[45] rather than now, five years into the job. (GP 2)

Reasons for other owner GPs not undertaking formal training included a lack of time ("I just don't have the time to do it" (GP 19)) and interest ("I'm not going to put myself

45 A registrar is a GP in training.

through it" (GP 12)), and the cost involved, both for the course itself but also in leaving the practice to attend. In addition, there is a preference that time spent on training would be devoted to clinical courses or areas of personal interest.

> (I)t was primarily time … I did a masters in general practice and then the following year, I did a diploma in therapeutics and that took an awful lot of my time. (GP 1)

However, some non-attenders did recognise that there would be merit in such training: "I felt that I should even do a cert or a diploma course in a non-clinical management course just purely to learn ... I don't feel that it's too late to do it, but I regret that I haven't done it yet" (GP 5). Alternative ways of accessing the relevant knowledge entailed encouraging staff or colleagues to attend and share the learning.

Amongst non-owners, most found the management training that they received as part of GP training to be generally beneficial. However, its immediate importance was questioned ("I didn't find it that relevant at the time, but looking back at it now [*interviewee is becoming a partner*] it is relevant" (GP 35)), as ownership and exposure to management responsibilities would arise later for some more so than others: "It was ahead of itself for us as new graduates coming out" (GP 30). This was consistent with many of the established owners who indicated that, in advance of becoming owners, they had given little thought to management and lacked interest in the area: "I just wasn't interested, I just wasn't aware" (GP 6).

> (Y)ou were very focused [during training] on getting through your clinical exams really. There wasn't the same emphasis on practice management and even what practice management we did kind of went over my head because it wasn't that relevant to me at the time. Then, I was going, well, I'll go locuming – I won't have to worry about this for a while. (GP 19)

A smaller number of non-owners suggested that what they received was not enough and that they would have appreciated more, particularly if it had been focused on aspects that would be more pertinent to their circumstances. For example, GP 30 suggested that she would have benefited from exposure to training in personal management and

interview skills as she was seeking assistant positions. GP 17 and 20, in hindsight now as owners, appeared to concur here, arguing for early management training: “Because, you’re not just a clinical doctor, as I’ve turned into, you are actually a manager and an employer as well” (GP 20).

Such training was largely practical and integrated into clinical education where possible, seemingly with the intention of giving registrars exposure to key elements as opposed to a wide knowledge of the discipline or theories of management. Interestingly, many of the GPs did not appear to initially view this training as 'formal’ management training. However, trainers generally felt that registrars were open to learning about management, with some GPs remarking on how the training has become more structured in recent years. GP 19 noted that current registrars “have projects to do on practice management in the surgery” and can be involved in setting up co-ops, but also conceded “I don’t know that they take it on that much unless they’re in that place themselves, where they think they’re going to be managing a practice quite soon”.

> I would have had with the GP trainer, regular discussions about practice management. You know, how to keep the practice running to keep employed the number of people it has employed, how are they going to manage the losses of various sources of income over the last few years, all of that kind of thing would be regularly discussed. (GP 22)

In terms of non-owner GPs, just one had taken a specific practice management course as part of their training programme, beyond the standard modules. Reasons for not undertaking such training were similar to those of owners, namely cost, immediate relevance (“leave it until I was almost ready to run my own practice” (GP 22)) and time.

6.3.2 The narrow and operational content of formal management training

The findings indicate that any training should have a strong GP focus and address their particular needs, as opposed to being generically designed for general management. Practical learning is emphasised, as opposed to more theory-based approaches, where the focus can be on ‘doing’: “working with intimate groups in small groups of people” (GP 15). It also must be delivered in the language of the GP: “based on the everyday problems that GPs have, it's not airy fairy, there is no management speak, no

unnecessary terminology, it's just straight down the line" (GP 3). However, there is also some recognition that broader knowledge could be beneficial.

> I would have liked to have had a module on practice management, really to reflect on what it means because I hadn't before I got into that role, it wasn't part of what I thought my job was going to be. I've never read anything about it, it's a really practice-based, experiential training rather than ... I'd have liked a little of the theory and theories behind management as well. (GP 6)

In terms of identifying what areas were of greatest importance for training, some GPs noted that they were weak on finance. Having a greater knowledge of basic accounts, day-to-day finances and the taxation system, as well as the ability to interpret financial information ("I can't read them [annual accounts]" (GP 13)), would be helpful.

> I suppose I delegate some of my jobs to my accountant, which is maybe an expensive way to do that. In terms of doing payslips and things like that, I delegate it because I just don't understand basic bookkeeping. I could never grasp it and I've never done any training, but maybe that's something I could. (GP 7)

Other areas of management learning highlighted included an awareness of business and employment law relevant to their circumstances, and improving internal systems. One GP went as far as to suggest that more general business training should be compulsory for GPs entering into ownership, particularly those setting up themselves:

> I'm sure most of the pharmacists have done mini start-up company or done some kind of an accounting or business diploma or night course; there is no way they would be just going in to open up a shop, whereas I think in general practice that's how people used to do it, which sounds hilarious. (GP 31)

Overall, though, where formal training was sought or obtained, the focus appeared to be on operational management and day-to-day matters; no specific mention was made of broader areas such as planning, strategic development, change management or leadership as being desirable or required.

6.3.3 An emphasis on learning by doing

For most owner GPs, the management role was learned largely through experience ("muddling along and making it out as you go along" (GP 8)) and by being exposed to management issues and problems in their day-to-day role as a clinician. This could also entail shadowing senior colleagues.

> I learned on-the-job. I observed, new demands and roles were required. Just in terms of day-to-day, you realise in terms of practice infrastructure, if things run out or wear out or new practice equipment is needed, that decision is yours as a partner. As the practice grows, then you realise that you need more staff, you have to become a financial manager because you have to make the books balance. I would have learned from my senior partner, who was already making these decisions on his own before I came. (GP 6)

There is an acceptance that, by learning 'on the hoof', mistakes will be made but these are also opportunities: "(L)earning by practice and by making mistakes". (GP 13)

> (T)he things that you may not necessarily pick-up on a month to month basis, but when you sit down and look at the end of the year and you think 'where did this loss come from' or 'how come the expenses here are so high'. (GP 15)

In the case of non-owners, the majority have learned management aspects on-the-job and as they progress, even if they have limited opportunity to apply such learning (section 6.4). Some of this, as previously noted, comes from their GP training. Non-owners also learn from other practices they have worked in, observing what is effective.

> I've seen so many different styles and so many different atmospheres for working, so actually you become really well attuned to how things go well and how things go really badly and it's become something that you keep your eyes and ears open for all the time because you become aware of how to stop a problem happening or how to deal with something so that it doesn't turn into a larger problem. (GP 22)

In terms of those on the verge of ownership, some are gradually brought into management by the owner, through involving them in decisions and can learn in this way. However, where the owner is guarded about the running of the practice ("(Y)ou're shielded from the financials and the money work" (GP 8)), learning may be curtailed.

> (T)he [branch surgery] that I went to work in had never had a morning surgery. I opened a morning surgery there so, I suppose, in some ways I learned a lot about the staff that I worked with there. Because I would have had a very big input in that, in the way that I wanted to run things. (GP 17)

6.4 Managerial work performed by GPs – tasks undertaken and approach adopted

The findings next examine the actual managerial role of the GP in order to determine what this entails. By looking at this role from the perspective of owners and non-owners, the views and experiences of both 'managers' and 'managed' are captured.

6.4.1 The difficulties of managing

In general, interviewees find management to be challenging, while also being a clinician: "You have to wear so many hats" (GP 10). Amongst more established owners, the most prominent difficulty is the absence of sufficient time to manage the organisation. From their perspective, time is best spent dealing with patients. In addition, spending time managing the practice does not directly earn an income and, in this sense, adds no immediate value. This is considered more extensively in section 6.6.1.

> I feel that it is a nice thing for me to put a manager's block on my desk and say 'I'm manager this morning' and not see any patients and sit down and have coffee and flick through paperwork. There are guilt issues there, because it is very satisfying to see 20 patients in a morning and go for lunch and say well I worked. I'm uncomfortable a little bit with that [management] role, in that I'm unsure of how necessary it is or how beneficial it will be to the practice. (GP 5)

> I think the fact that medical practice is becoming much more complex and we're having to do much more, it is getting more difficult from my own point of view to get everything done. (GP 9)

A general lack of interest in management also presents difficulties, as GPs are less motivated to engage ("I certainly wouldn't want to spend half my time in practice doing paperwork and doing managerial work, because I like seeing patients" (GP 29)). However, there is a reluctant acknowledgement that this side of the practice is not something they can ignore; this is explored further in section 6.6.3.

> (Y)ou can be a brilliant doctor and not make a living and there is no point in that. (GP 11)

In terms of specifics, staff management presents some challenges ("There can be tricky staff issues" (GP 2)), along with managing finances in a difficult period. However, these were not very prevalent issues and, as noted in section 6.4.4, were two of their main managerial tasks. Thus, it appears that it is not so much the tasks themselves that are challenging, but rather operating as a manager generally.

> (O)ne of the biggest challenges for all GPs now is funding and it's going to get more difficult in the future. We've already lost a substantial amount of [public[46]] income ... and there are difficult times for a lot of private patients. (GP 1)

> It's not difficult, it's not beyond my ability to actually take on some of those roles, but I wouldn't want to. (GP 4)

Amongst newer owners, the issue of time was again highlighted, for broadly the same reasons as the established owners; GP 16 noted that time was "the big one – just getting enough time to do it and to do the patient side of things". In terms of specific tasks, staff management seemed to be a greater challenge for newer owners. GP 15 – who was mostly responsible for practice HR – demonstrated how they 'handled' a situation with an under-performing staff member, where a lack of any real process was apparent.

46 Paid by the State.

> (W)e'd also had a member of staff who just wasn't performing and wasn't engaging with patients and people getting lots of complaints and stuff like that. Patients were unwilling to put forward written complaints, which left us in a situation where it was words being said against the other person. Now, thankfully, the financial crisis eased our issue in that regard because we just couldn't afford to have somebody, to pay for that individual. (GP 15)

With regard to non-owner GPs, their lack of knowledge regarding how to manage was a challenge, mitigated by their general lack of participation. However, there was recognition that GP involvement in management was important.

> At the end of the day, that's [clinical role] what I'm trained to do, but I do think as a GP, you can't be oblivious to the management side of things. (GP 23)

6.4.2 Management structures, styles and decision-making

Interviewee's practices had very flat management structures. One large practice had partners, a practice manager and an assistant practice manager; otherwise, the 'managers' in the practices were generally the owner(s) and practice manager, with limited involvement from others. Practice managers could be full-time or part-time, depending on the size/resources of the practice, and in some cases filled other roles also e.g. receptionist, nurse[47]. Generally, structures appeared to be quite informal ("It's very open like that, but there's no official line of reporting" (GP 28)) with generic titles (e.g. secretary) being used. However, these titles indicated that occupants were clearly subordinate to the owners.

In most cases, it was apparent that the owner was the primary manager and at the head of the organisation, with ultimate say on all matters. Amongst practice partners, management responsibility was largely shared and they worked as a unit. Therefore, management and decision-making tends to be centralised and tightly controlled.

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47 Not all practices had formally appointed practice managers, with administration instead carried out by secretarial staff/receptionists. In some cases, these were 'unofficial' practice managers.

> The management structure in the practice is that I rule with an iron fist, led by the agenda of my practice manager. She brings various issues to my attention, on a daily basis, I make a decision on the spot and we move from there. (GP 5)

> Anywhere I've worked really, I think the GP owners have been the final boss; although in the day-to-day running it might appear that the practice manager is the boss; I mean the final say tends to come, in other practices as well, from the GP owner. (GP 30)

Below the owner is the practice manager, where present. Generally, the practice manager works closely with the owner as well as having their own responsibilities (see section 6.5). The owner broadly determines the scope and tasks of the practice manager. Outside of the owner and practice manager, there is limited management performed by other staff with some input to decisions. In a small number of practices, employed GPs have occasional and specific involvement in certain aspects, particularly where they are becoming a partner as a lead in to the role (see section 6.3.3).

In describing their management styles, there was broad consistency across the owners with a general emphasis on being decisive in how they approached work. Some saw themselves as consultative and inclusive, wanting to involve staff in decision making and taking their input on board. However, the impression is that owners generally make the final calls: "Although I will listen to both of their opinions on practice policy, but it would still have to be me who would decide if it is a good idea or not" (GP 14). The specific involvement of the practice manager is considered in section 6.5.

> (E)verything is discussed and everybody's feedback is got before big decisions are made about anything. (GP 9)

> I would be very much a consultative person, very much listen to what everyone is saying and go for a compromise type of thing. (GP 21)

Others were more direct and even rather blunt in how they managed.

> I manage the practice, I dictate ... I'm the old fashioned dictator. (GP 11)

> I kind of jotted a lot of those things down and said right. I spoke to him [partner] on the phone and asked if this was a goer or not and he said go for it, so we opened up the surgery in 3 to 5 days. (GP 15)

In this respect, owners are in control of decision-making; there is little indication that decisions do not in some way involve them. The nature of the decision also had a bearing on who is involved. Financial decisions tend to vest with owners, while clinical or more routine decisions generate increased input.

> If it's something about whether something needs to be bought, if it's something very definitely just financial, then she's the one who makes the decision and she doesn't usually ask many questions ... If it was something that involved front-of-house, she would consult the receptionist. (GP 26)

GPs who are not owners were asked to describe their own management styles as well as that of their employers. Some had difficulty in articulating a personal style, mostly because they had yet to develop one due to a lack of exposure to management. Those who did tended to have styles similar to the owners, namely decisive and consultative. GP 22 suggested that being decisive is natural for GPs because of their clinical background.

> I think you're forced to be quite decisive, because you have to deal with issues or else you have a mountain of issues to deal with. (GP 22)

In describing the styles of their employer, the most common was again a decisive style, where the owner was keenly involved in most aspects of practice life and made the key decisions: "I am an employee, she's the boss, so she's the one that keeps the money circulating or whatever, so her decision would be absolutely final" (GP 33). This was blended at times with a consultative style, where staff felt included but acknowledged that control clearly remained with the owner.

> Now, because there are practice meetings, things would tend to be discussed a bit more than they would have been. But, I suppose they [partners] make some decisions without necessarily bringing them up at meetings. (GP 28)

However, this style does not imply an overburdening approach by the owner, in that individual GPs are in control within the consultation itself. Thus, owners can tend to be more 'hands-off' when it comes to managing the detail. This is contrasted with a style that only appeared in one interview (GP 30), where an owner that the GP worked for effectively did everything and struggled with passing any responsibility. With regard to this type of style, GP 33 noted a negative perception:

> I don’t think any GP would put up with a micro-manager. At the end of the day, every GP probably thinks that they know as much as the other GP who happens to own the practice. (GP 33)

While the primarily decisive or blended approach was generally viewed favourably, some did demonstrate styles that were regarded as dysfunctional, which essentially entailed the lack of active involvement of the owner in controlling the practice. This is addressed in section 6.5.4 and 6.5.5.

6.4.3 Addressing the control and organisation of the practice

While owners keep a clear control over decisions and activities of the practice, their approach can be quite informal: “Very loosely, I consider myself in the old historical sense, a benign despot if you know what I mean. I keep an overall view on things” (GP 9). However, when the situation necessitates, this is adaptable as they are very conscious of their responsibilities: “If it’s not done, then I’m the one being sued” (GP 18). Some practices acknowledged having more specific procedures for areas including health and safety, staff appraisal and internal problems. GP 20 noted that they manage their staff in a relatively informal manner unless a problem arises.

> (I)f there is an issue, with a patient or another member of staff, they can lift the phone, talk to myself or my husband and we will try and resolve it informally, but they also know that if it’s not resolved informally, there is a standard procedure that will be followed. (GP 20)

The small size of practices and a regular presence on-site is a factor in the informal approaches adopted, as owners can observe and have one-to-one relationships with staff. GP 5 manages mainly “through my daily presence. It is a small business … I am the practice. So I monitor it that way. It also means that I don't formally monitor it”. In addition, work flows through the owner, which means that they are aware of issues early: “(A)ll of the paperwork for the practice goes through me so I will keep an eye on whether it is clinical or administrative issues” (GP 15). As owners, who are actively involved clinically and managerially, they are close to the actual daily work performed in and by the practice.

Their small size also means that they have ready access to staff, so that issues can be addressed in passing. GP 7 indicates that he “would be quietly having words with the staff to see that everything is ok and encouraging them to come to me if there is a problem, to phone me at any time. Even in the middle of consultations”. In a similar vein, GP 8 controls “By talking, I suppose. It's not by dictat, it's certainly not by regulation and it's certainly not by written memos, it's by talking”. Reviewing the work through monitoring measures and outputs – such as patient appointments and waiting times – assists in informing the GP as to any issues that might have arisen or that are pending. The extent and depth of this can vary (see section 6.4.5).

From interviews with non-owners, it is clear that in most practices, the owner(s) are in ultimate control (“[Owner] just has to … frown in our direction, to remind us that she is the boss” (GP 26)), while delegation of routine tasks is prevalent (see section 6.4.7). In this respect, owners generally engage in managerial oversight (“(I)f I had a problem, I would tell them [owners] immediately” (GP 29)) and seek to assign the detail to others.

> (H)er secretarial staff do work quite well together and she has delegated to them specific roles. So, within them, it is quite clear who is responsible for what tasks. So, I think she controls the administration side by … she has given the secretaries quite defined roles, so they all know what their responsibility is and what areas they are responsible for. So, they would report back to her on their specific areas. (GP 24)

In the absence of good control and organisation, the work of the GP is made difficult as their ability to function effectively is compromised. GP 23 spoke highly critically about this, with examples put forward to indicate the seriousness from a patient safety point of view (this is considered further in section 6.5.5).

> We had a case, this is terrible. Two patients, the same name, one man with x and the other not. Results of the guy who didn't, went into the guy who did, which made it look like everything was fine. But, this was picked up and it's like, oh sure that's grand and that's sorted out now. Rather than these things being picked as a critical incident, they're just something bad that happened and isn't that terrible, bad luck. (GP 23)

This is in clear contrast to the case of another GP, who identified a situation where an incorrect prescription was issued to a patient. Having been contacted by the pharmacist, the GP took action to rectify the situation, review their system for improvement and to record its occurrence by way of learning.

6.4.4 Managerial tasks undertaken by GPs: an emphasis on operations

The findings identify a broad range of managerial tasks either fulfilled by the owners or undertaken with their active involvement. These are in addition to administrative work, which is more associated with paperwork, but which some interviewees seem to regard as part of 'management': "I write all the cheques. I suppose what else could you say about the management" (GP 3).

The tasks identified here are operational and tend to concentrate on day-to-day management, rather than more strategic aspects; owners seem to focus on managing resources ("what the money is spent on and what not and people's hours as well" (GP 27)) and monitoring activities. The remaining tasks identified appear secondary, being less significant and/or more intermittent.

6.4.4.1 Staff management

Staff management is a prominent role, encompassing a range of HR-related responsibilities, including recruitment, deciding salaries, staff discipline and setting rotas/schedules. However, there was little evidence of much in the way of process (e.g.

specific disciplinary procedures), indicating a relatively informal approach being adopted (GP 20 and 26 were more exceptional here in terms of discipline, while GP 2's larger practice had greater formality around staff appraisal). In addition, there is evidence of more general elements of staff management in terms of motivation, health and safety and ensuring that staff members are functioning effectively. The practice meeting (section 6.4.8) can act as a forum for addressing some aspects concerning staff, such as general grievances and scheduling.

> I would be in charge of staff, basically supervising them, checking they are clear in their roles, getting feedback from them on any issues they may have, clinical or non-clinical, with the nurses and with the reception staff again. Supervising their roles and duties, any issues that come up anything from holidays to the computer malfunctioning to them being asked to do too much, if they feel they could learn some more about something. So, I would deal with staff issues, if someone is sick, do we need a replacement. (GP 6)

> The nurse has been called in and [owner] has sat her down and had to have a serious talk with her and I believe that she has gotten warnings. So, she does follow the official verbal warning, written warnings, the formal way of doing things, and she does keep a file on each of us for that purpose. (GP 26)

6.4.4.2 Financial management

The management of finances is also highlighted ("what's coming in, what costs we have … to me that's their biggest role" (GP 28)), though owners can do this less directly through monitoring performance measures (see section 6.4.5). In some cases, the owner has direct control over receipts and payments ("I have to count up … the income every week to see is it going the right way" (GP 14)), while others take little specific interest in this area except in overall terms. Financial management does not appear to be carried out in an advanced or particularly precise way by owners, though they maintain clear control with few others (aside from the practice manager) involved: "(W)e would certainly view the accounts at the end of the year and have a chat with the accountants" (GP 2).

There is acknowledgement amongst GPs that they are operating practices in a difficult economic climate and that this gives rise to pressures: “We've already lost a substantial amount of income from the over 70's and then we've lost 8% of our government income and there are difficult times for a lot of private patients out there. There is a lot of people losing their jobs, so there is challenging times ahead” (GP 1). In this context, GP 3 expressed that in his practice: “We've only been in the black for the last three years. We were always in the red [for over 20 years].” Almost half of the practices indicate that they engage in cost-control exercises in order to mitigate difficulties, in some cases at a micro level.

> I used to send out notes to people about abnormal results. If they had an abnormal result, I'd decide what to do with it, I'd do a note and we'd post it out. [Practice manager] said to forget that because the postage was costing us a fortune. (GP 3)

> I sutured somebody there yesterday and I’d say the cost of the materials barely, were barely covered by the fee that was charged. (GP 32)

6.4.4.3 Reviewing information and monitoring activities

As opposed to preparing the detail, the owner reviews relevant information entering the practice and outputs produced by staff (“checking returns, that everything has been claimed for” (GP 6)) as a means of informing themselves about practice activities and to highlight issues (“every few weeks, I have a walk around the waiting room” (GP 10)). This forms part of their oversight and control of the practice, linked to aspects of resource management and performance measurement.

> I look at all the medical issues; all of the post comes through me, all of the blood reports, all of the laboratory stuff. (GP 11)

> (W)e need to find ways to actually inform ourselves but not doing the actual work on it [impact of cuts in income on practice]. (GP 21)

6.4.4.4 System implementation and management

A number of practices implemented systems, either off-the-shelf or basic self-created management systems, with some GPs having specific responsibility for practice IT. The GP's role in these systems can be limited to some implementation and ongoing monitoring (as above) to ensure that they are being used. As a consequence, their involvement can be somewhat intermittent: “I would have been involved in setting up the appointment systems, appointment times, deciding on which computer system we would use, software programmes” (GP 7). Systems implemented include computerised practice management systems and spreadsheets for tracking returns/lab results.

6.4.4.5 Establishing policies

Where key policies need to be established, this can fall within the remit of the GP. These are a combination of general and some business-related policies with the aim of risk mitigation and reduction (clinical protocols/standards are also developed as part of the clinical role).

> Management of policies with regard to patient accounts … following up on bills and that for patients. (GP 24)

6.4.4.6 Facilities management

While some GPs have a maintenance role, this is more in the capacity of flagging issues for others.

> I manage the building, or act as caretaker for the building and manage all of the decisions regarding it with the help of my practice manager. (GP 5)

6.4.4.7 External liaison

In some cases, the owner is the key contact between the practice and external stakeholders. These include large suppliers, hospitals, other practices and the HSE. However, these relationships do not appear to occupy much of the GP's work.

> I also manage our relationship with everybody outside, the HSE, we are tenants in a HSE building. (GP 4)

6.4.4.8 Marketing

Some owners, because their practices had only recently been set-up, have taken on a promotions-type role. However, few practices seem to actively engage in such tasks.

> (W)e did leaflet drops of the local area and signs up and that kind of thing, and we're looking at what we need to do on our website development (GP 19)

6.4.5 Measuring performance in the practice

In terms of assessing performance, GPs use a variety of measures in running their businesses; this can be quite informal in a number of practices. These include financial and non-financial measures, though many in the latter category are associated with financial performance. The most common measures focused on profits, while there were a small number of practices that did not appear to measure this or any variant. The focus was on "the bottom line" (GP 8) with seemingly little attempt to break this down by service/GP. In addition, measures of profit used are generally 'quick' measures, with little indication that anything very formal is considered in most cases except when reviewing annual accounts.

> (T)hat the practice is continuing to be a viable entity, we'd check income balances output. (GP 6)

> (T)hey'd have details of practice income and what it's fallen by and how we are doing regards numbers, medical card[48] patients, numbers of people whose medical cards haven't been renewed because they didn't reapply. (GP 22)

Daily patient numbers are also reviewed. In some cases, greater precision (i.e. GP 12) was extracted but there were few examples of this, even though such information could assist in service decisions and overall management: "we don't really know how much money comes in from each of our resources" (GP 21). Checks are performed to ensure that claims to the State for public patients are paid, though there was no indication of management information being extracted i.e. types/frequencies of claims.

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48 These are patients who are paid for by the State as opposed to paying personally ('private patients'). The terms 'public patient' and 'GMS patient' are also used.

> I'd do analysis of the ... not just numbers of patients seen, but also types of problems seen. I'd be able to say at a glance, after finishing a surgery, how many acute problems were seen or non-acute problems and you kind of get an idea then what exactly the type of problems are that are coming through your door. (GP 12)

Waiting times were less commonly observed, providing a sense of how busy the practice is, as well as the efficiency of the appointments system. In this way, patient satisfaction is considered ("(W)hether we are busy or not and whether we are keeping it reasonable to our time schedule in the way our appointments are set up" (GP 14)) although only one GP indicated that they had previously assessed satisfaction in a formal manner (e.g. survey). Measures of staff performance were rare, with some practices mentioning that formal (e.g. GP 2) or informal (e.g. GP 15) staff appraisals are conducted. In a small number of cases, owners loosely measured staff satisfaction through seeking their feedback or speaking with them in passing, but this appeared to be informally and opportunistically gathered: "Also to see that the staff ... the nurse is happy and the GP registrar is happy" (GP 14).

The active acquisition of external information to support performance measures was not readily apparent from the interviews. While there was an understanding and appreciation of the challenging environment that GPs are operating in ("with the further cuts coming in" (GP 20)), there was no tangible evidence of significant environmental scanning or external benchmarking.

> (Y)ou have a medical card list and that's published [nationally] every year about how much you get … I suppose like everything else, you look at it. We're certainly not in the top half of it. (GP 27)

The use of internal benchmarks and targets was equally limited and appears to be given little consideration, with four practices indicating their usage. In each case, the benchmark was either financial or associated with financial performance. For example, GP 19 referred back to their plan with regard to patient numbers: "We would always, on a monthly basis, review our GMS [General Medical Services] numbers, make sure that we're on target to hit the 500 patients for this year". Where targets exist, there was less

evidence of these being broken down into shorter-term indicators – broader benchmarks appeared to be the preference: “I haven’t seen it [plan] in two years now, so I have no idea what is written in it. But, we’re kind of sticking to it” (GP 17). The lack of targets appears to relate to the absence of formal planning in most practices (see section 6.4.6).

However, one practice (GP 10) had a more refined approach to measurement (though, interestingly, without an underlying formal plan), approaching this in a portfolio manner. Measures fed into GP 10's decision-making process as he outlined that any change or initiative “has to be good for the patient, it has to be good for the practice and it has to be good for the staff.”

> I'd look at, one, what the GMS list is and how its growing and I'd look at that on a monthly basis ... That's my favourite measure as it indicates that I'm ... we're doing well. I look at the bank balance, whether we're solvent. Profit and loss is a little bit harder to do ... The other thing I look at is our private income for the day, just to watch that and see is it holding up or not. The other thing I look at is the number of spare appointments at the end of the day. (GP10)

Clinical measures are commonly recorded in practices and were mentioned here in the context of performance by some GPs. It was noticeable that, in a few of these cases, GPs expressed the nature of their clinical measures with greater clarity than their business measures and appeared to be quite conscious of benchmarks for these. For GP 8, business measures seem almost an afterthought, though clinical measures are expressed with enthusiasm.

> (T)here are clinical measures we look at, various audits we've undertaken as well too. I think by most of the clinical measures, we're doing, I think, reasonably well. Say for example, vaccination uptake, great or as close to 100% as makes no difference; most of the women that we could have done smear tests on, we've done smear tests for. A lot of our chronic disease management is reasonably ok, I think the audits that we've done have proven that. But, on the business side, the only thing I'm really looking at is bottom line. (GP 8)

A trend amongst almost all of the non-owner GPs (including some who are due to become partners) was the limited sharing of performance measures and results with them by the owners: "I don't know if we are making money or if we are not to be honest" (GP 33). Reasons for the lack of sharing were not generally put forward, though as GP 23 below indicates, it may be related to the closed nature of the owners themselves.

> I mean we're told vague things like we're up 10% on last year and we go that's very interesting, seeing as the wages are probably up 50% since last year, you know. We're not really … that's the problem of dealing with a family practice, you don't really know what's going on. (GP 23)

6.4.6 The perspectives of GPs with regard to strategy and planning

The overall impression from interviewees is that long-term strategic thinking is not a major concern for most GPs. Where the future was spoken of, this was in a general sense or entailed plans that were mostly short-term, with little in terms of formal outputs. Across the interviews, four respondents made reference to strategy in a business sense. GP 16 noted that they would have a partners meeting quarterly, adopting quite a narrow view of strategy as being mostly operational and vaguely described.

> (U)sually about staff management, strategy, protocols, strategy around whatever … wages, discipline – those sorts of things … I hesitate to call it strategy, that's a word that's a bit over the top, but that's the word I would have in my head for it. What direction the practice takes and how much we extend ourselves, really, but again in a safe way. (GP 16)

GP 2 indicated that, in their practice, they have a yearly strategic meeting and occasionally more often. The output is an annual service plan and partners' personal plans, but nothing substantial beyond this. In GP 1's case, the only strategy he had in mind concerned his retirement and addressing succession. Anything further was vague and generally left to others.

> [M]ost of the management is organised, is passed upstairs and even long-term planning or long-term thinking on where we're going or what we're doing, I

would discuss it with the two, the practice manager and the personal assistant. (GP 1)

GP 8 was unique in terms of multiple references. He saw one of his core roles in the practice as being "strategic planning, I'd be looking to see where the opportunities are for the practice going forward. The detail I would probably leave to others". In describing what this entailed, however, it appeared that planning had a relatively narrow and evolving focus on specific areas of the practice, as opposed to being part of any deliberate formal strategy for the long-term[49].

> (L)ooking at are there opportunities for the practice to be developed or are there certain sections of the practice that we're involved in at the moment that may or may not have outlived their usefulness … There was a nursing home that we were providing medical cover for, but we found the demands being made on us were excessive and we pulled out of that nursing home. That's the kind of strategic decision-making that I'd be making. (GP 8)

While some broad plans – in a small number of cases, with targets attached – were noted in other interviews, these were generally short or medium-term in nature and revolved around recruitment, expanding/moving premises, adding services, and operational changes such as amending surgery hours. In GP 19's case, there was a greater sense of deliberate strategic thinking as she had carefully thought through their practice location and identified a niche.

> I was really careful about where we set up. I had identified the area a long time ago, I lived in it and I knew that it was desperately short of GPs. I looked at all of the local GPs in the area, what could I offer that they couldn't and the big thing was that I was a female GP and there were no female GPs for miles and there was not really any GMS availability in the area as well. (GP 19)

49 The GP acknowledged that no formal business plan existed for the practice: "I suppose that's a lacking and that's a failing in the system".

However, this was relatively rare, with few other examples of what appeared to be deliberate strategic decisions e.g. GP 10 hired a doctor from a particular culture that had a presence in their locality, who now brings in the most income.

In terms of established owners, a strong majority acknowledged that their practices did not have a formal business plan. Various reasons were put forward, including a lack of time, a lack of consideration, a lack of need or perceived benefit, being unclear as to what one would entail and the fact that the owner is at a stage in their career where the benefits of such a plan are limited (“I've 11 years to go to retirement and I don't need any of that [expansion]” (GP 3)).

> (I)t's difficult to have a sort of financial plan in general practice, bar just everyone keeping an eye on it and everyone working to make sure that the finances are maximised. (GP 2)

GP 10 noted that he had given the idea of developing a practice plan some consideration, but decided against it as he perceived that the effort required would only prove to be a distraction in the face of more important tasks.

> (S)ometimes, planning is great if it's relevant, if it matters and you go ahead and do it and then you reflect back ... Sometimes, the amount of time and resources you have available for planning can be very, very limited and the other thing is that, sometimes, people just do plans and I don't know if you've heard of this 'thinking-doing' gap – you think of this idea and once you've thought of it, you can just look at it and say how wonderful it is. I was conscious that, coming up with a business plan, that we could fall into this trap. (GP 10)

Two practices used the terms 'philosophy' (GP 6) and 'vision' (GP 9) to describe their substitutes for a plan, which essentially meant that they had a general view on where they were going and what they wanted to do, without it being formalised.

> (T)o provide a comprehensive general practice service to our local community, so we define our local community and we are constantly defining what a comprehensive general practice service means. For example, what is required of

> us skills wise is changing all of the time, chronic disease is huge, disease prevention so we are constantly adapting and planning around that. (GP 6)

In this sense, emergent, evolving and somewhat reactive plans could be observed in a majority of the practices ("I don't really do anything more than continuing where we are and taking any problems as they come" (GP 14)), as the owners developed their businesses on an ongoing basis, without taking a deliberate and specific long-term view or putting this in a format that was broadly shared with staff. Such evolving plans tended to be narrow in time frame and dealt with particular items of more immediate importance to the practice.

> I wouldn't say that we have a plan going forward, we're just trying to keep doing what we're doing and if we keep doing that ... Every so often, we come up with little ideas or plans like for instance we're going to do a vaccination programme for teenage girls for the cervical cancer vaccine which can only be bought privately. (GP 7)

Formal planning was present or being introduced in two of the established owner's practices. GP 21 and his partners are developing a plan for their growing practice, with the assistance of a consultant, though this is in the early stages. GP 12 was the only one of the established owners with a formal business plan. This came about as a result of attending a training course, at which participants were asked to develop plans for their practices. The GP still uses this plan (which has not been revised in over seven years) as a point of reference, but not very actively.

> (I)t kind of may have happened as much by accident as by intention, but the plan was formulated and it was written down and when I look back at it ... several of the things that I had stated as being my objectives, I had achieved them ... without going on a plan from A to Z or 1 to 10, a lot of the things evolved. (GP 12)

Many of those without formal plans remained satisfied that these were largely irrelevant for their practices, even though there was some acknowledgement that they might be beneficial.

> I suppose a clearer plan for the future would be important, wouldn't it. I planned to retire when I was 65, my contract says I retire when I'm 65, I don't think so anymore. You just never know what's coming next. (GP 4)

Amongst the newer owners, four GPs had developed formal, written business plans: "a very general thing, it wasn't too specific" (GP 18). In each case, the motivation was either setting up or expanding their practices. A key driver was that they were requested by the bank to secure funding.

> We did get an opportunity to open up in Y, due to the retirement of another GP, and I acquired her list on a locum capacity … So, in order to get that, we had to get our act together and put forward a business plan for banks and funding and also for ourselves to see where we were going. (GP 15)

In terms of using their plans on an ongoing basis to monitor and control the practice and its activity, there was limited reference back to the original source. Some noted that they would not be aware of the specifics, but did keep an eye on its general essence.

> We've tried to keep to it. We watch it, we don't always look at the business plan but we know some of the broad figures … I guess it mainly comes to numbers, you know, keep us right so we know we're doing ok. (GP 18)

From the perspective of employed GPs, the majority of their practices had either a formal or an informal and evolving plan in place. Awareness of this sometimes arose because the owner would speak about their plans and discuss these with the staff ("(W)e'd have a general idea of what we want to do for the next few years" (GP 26)). In other cases, it was more a perception based on the nature of the owner ("I just feel she probably would have one" GP 30). However, it was clear that, in a number of practices, plans are not actively shared with employees or only discussed in general terms ("I suppose she would talk about her plans for the practice in the coming year, in the short to medium-term" (GP 24)).

Even so, many of the non-owner GPs recognised the importance of planning. In the case of GP 35 – because he was entering partnership – the plan for three years had been shared with him. This had been prepared because of environmental pressures.

> She is a fairly proactive, forward thinking, maybe. She is fairly modern. In W, itself, there has been major upheaval in that I suppose the vast majority of the GPs joined together and formed a primary care centre … Maybe that would have been the kick in the ass she would have needed to make sure that she had all her own house in order. (GP 35)

The plan essentially considered where the practice's strengths lay in the context of the competition and sought to exploit these as a means of generating extra private income.

> (W)e have changed our opening hours too to make them more flexible, we have early mornings and late evenings; while the primary care centre is based outside of town and can be difficult for some people to get to [practice is centrally located]. That is our unique selling point as they say in The Apprentice. (GP 35)

6.4.7 Delegation of practice work: offloading routine aspects

Owners are active delegators of work that they regard as non-core, wishing to step back from this where possible. This consists of routine clinical and administrative tasks, but less so management except in some cases where the practice manager is more involved (section 6.5.4). The majority find delegation to be beneficial, as it frees up time to focus on clinical duties.

> (O)ne of the practice nurses … has taken on the role of quarter master … If we need something, she will know where to get it, at the best price and she will do a deal. She does all that and it is brilliant. (GP 3)

However, resources are an issue for small practices. For example, GP 17's practice is too small to support any staff and so the partners do everything, while GP 18 aspires to hire an extra person in time to help with workload but cannot currently afford to.

> (I)f I ever got a nurse, I'd try to give more of the clinical responsibility to them like chasing up on vaccines, chasing people for smears, child vaccinations, some of the clinical stuff where it would be helpful to have somebody who could watch, clinically, what's going on and chase up, generate income, have someone else organise those things. (GP 18)

A small number of owners struggle with the notion of delegation, which appears to relate to their need for control. GP 19 indicated that this was a skill that she needed to develop, acknowledging the importance of effective delegation.

> I think the hardest thing was learning to delegate to other people and just accepting that there is absolutely no way that you can possibly do everything that needs to be done. (GP 19)

Non-owner GPs confirmed that the arrangements in their practices are similar with support staff delegated routine administration, and seeing the benefits of this.

> You have to take more control and use ... you're the person whose time is most valuable within the day (GP 22)

The delegation culture tends to be set by the owners, with non-owner GPs following suit. However, a small number struggle in this regard, again seemingly because of a desire to retain control: "I have to be the watchdog on that" (GP 23). A lack of self-confidence, overloaded administration staff and poor role definitions are also factors.

> I suppose doing my own letters – rightly or wrongly – is probably a bad thing, it adds to the time certainly ... The more I get involved in management, I'll have to delegate. (GP 28)

6.4.8 Meetings as a management tool

The approach to meetings is mixed. For smaller practices, these can be informal, happening in an impromptu, casual manner. A minority of practices acknowledged that meetings do not take place or rarely occur, with some indicating that their small size

means that communications are already sufficient ("(T)here's free time, time when the waiting room is empty" (GP 18)).

For most practices, meetings take place that involve all staff (clinical/administrative), in some cases weekly. Topics discussed are wide-ranging but the main management focus at these meetings appears to be on routine operational matters including maintenance, rotas, holidays, administration and length of appointments. Planning, or anything related to practice strategy, was seldom mentioned. However, there was also a degree of vagueness from some GPs in terms of their meetings where they were unable to provide much detail about what is discussed from a business perspective, suggesting a low priority being accorded.

> Well, even things like out-of-hours, hours that we work, appointments, how to deal with all of the extra patients. When you have full appointment schedules and you have sick kids who have to be seen. (GP 1)

> It would give my staff chances to air any problems as they see it. Solutions that they see to little problems that we might have. It's a good way of communicating with each other and forming the bond. (GP 7)

Partner meetings can address more high-level matters, including strategy and new opportunities, though they also appear to be dominated by routine operational matters ("regular topics are the rota for the following week" (GP 2)) and clinical items. For example, GP 13 acknowledged that these meetings would be "geared to management of particular problem patients and they'd be geared at practice policy regarding medical practice" with staff issues addressed "occasionally ... that we know are going to come up at one of the general meetings". Thus, as a forum for discussing wider management issues, even partners' meetings can be quite limited.

> A lot of the time, it's clinical stuff. A lot of it has to do with patients that are presenting problems to the practice, but then other items as necessary … But there aren't that many business decisions that we'd make as such. (GP 8)

> We would discuss staff issues, we would discuss financial issues, we would sometimes discuss clinical patient issues … We would be discussing, at the moment, a lot of aspects of the new building. All decisions like that would have to be made. (GP 21)

In this sense, meetings can be about gathering information and opinion, communicating perspectives and making largely operational decisions – there was less evidence of major debate concerning specific long-term business issues: “some of our most difficult discussions have been about medical colleagues [as employees]” (GP 13).

> (T)he receptionists would have time together without the practice manager to formulate whatever bug bear they may have or whatever is working or not working ... We may go in at some point during the meeting to hear their opinion on this or that or whatever. (GP 10)

> (A) lot of the focus of discussions in these meetings in the past few months has been the prevailing financial meltdown in GP funding and so some of that involves forewarning about wage cuts and that kind of thing. (GP 15)

6.5 Supports for the managerial and administrative role

While the findings highlight the role of the GP – and owner in particular – in management, it is also apparent that other supports are availed of. Specifically, the role of the practice manager is examined to establish the extent to which they provide support and assistance, and in what areas.

6.5.1 Categorising practice supports

6.5.1.1 Clinical support

This is provided by colleagues and clinical staff in order to reduce the GP's workload but also as a means of dealing with challenging clinical dilemmas. While mostly internal, external supports exist through the wider networks that GPs are linked into: “I think most GPs are quite understanding to each other in terms of on-call and things like that” (GP 15).

6.5.1.2 Social support

Informally, interviewees receive support from their social circle outside of work. This can encompass other GPs meeting in a more collegial capacity, discussing work in general terms.

> I have a very good relationship with some other single-handed GPs in the area ... we meet [regularly] and we kind of share thoughts and problems. If that hadn't been in operation, I could have felt more isolated. (GP 14)

6.5.1.3 Business support

Practice partners are a resource for sharing managerial duties and for discussions; GP 2 and 15 noted how individual partners perform different aspects of the role, based on their expertise and interests. External support is sometimes brought in, though is narrowly focused. Generally, this is restricted to consulting with other professionals (e.g. accountant/consultant) and professional bodies (e.g. ICGP formally or via website/practitioner publications).

> (T)here is a service that we pay for that gives us some advice on various issues and it's a pretty reasonable service. They give some advice and in terms of basically troubleshoot staff problems. (GP 21)

External networking for business purposes with other GPs appeared to be limited and was seldom mentioned. GP 10 raised a potential reason for the lack of such support. While he did network with local GPs, this was not a good opportunity to share business advice, with trust being a key issue: "(Y)ou go to meetings where you are against people who are your competitors and you're their competitor and so there is a natural sort of, not suspicion, but you're not as forthright" (GP 10). Instead, he has found it more beneficial to attend meetings further away from the practice, where greater sharing is possible.

6.5.2 The practice manager as a key support

Across the interviews, the significance of the practice manager support role is clear. Other clerical staff may also assist the practice manager.

> (T)hey delegate a bit as well, you know. They would have one of the front-office girls who does the Mother and Child scheme … And they monitor it to make sure it's done as it should be. (GP 1)

> (O)ne of those secretaries would do a lot of practice management work as well, although she's not officially the practice manager. She would sort of be responsible for looking after things like the wages, taking account of annual leave, you know, that sort of staff management aspects and also doing all of the returns for the GMS claims. (GP 24)

Consequently, the term 'practice manager' is being used here to represent formal practice managers and some equivalents. The range of duties delegated to the practice manager depends on the choice of the owner and practice size (e.g. in a large practice, "The practice manager takes on a lot of that day-to-day business role … the practice manager is also involved in doing staff appraisal" (GP 2)). However, the core duties can often revolve around basic administration including secretarial, scheduling and compliance.

While much of the role may be routine, there is evidence of what happens when a practice manager is not present: "the good practice manager you won't really notice them until they are not there" (GP 32). GP 27 noted that a person on maternity cover, with no previous experience in a GP practice, identified significant unrecorded patient debts. In addition, the practice manager's knowledge of the wider system and their networking with other practices can be valuable to the smooth operation of clinical work.

> (S)he would know not only just to dictate the letter but she would also know who [consultant] has the shortest waiting list and what days they are having clinics. (GP 33)

Occasionally, GPs used different terms to describe the practice manager and their fit within the practice. GP 5 described them as a "Mrs Doyle type of character". This presented the image of a 'mothering' individual, bringing everything together. GP 32 used more direct terminology, with the words "shield" and "buffer" being mentioned at

one stage, in the 'gatekeeper' sense of insulating GPs from patients' demands. Later on, the words changed to the GP owner as a "general" and practice manager as a "field marshal", in the sense that the practice manager keeps the owner informed as to what is going on and feeds information into their decisions so that they don't have to get it themselves. Some owners indicated that they regarded the practice manager as the key person in the practice, individually or collectively with the GPs.

6.5.3 Administrator or manager? The main responsibilities of the role

Overall, little of the practice manager's work, in many of the practices, seems to revolve around actual 'management', beyond some responsibility for the administration function and administrative staff: "(T)he practice manager more or less supervises the reception staff" (GP 6). Identifiable tasks included payroll, ordering stock and handling complaints. While, initially, GP 8 and GP 10's words suggest an extensive management role, they clarify that this is relatively low-level.

> She is the person who runs the show and coordinates everything … keeping an eye on the flow around the practice in terms of making sure that people and patients don't get lost. (GP 8)

> (S)he has authority over the admin staff and has an organisational role there and, in terms of discipline and stuff, there would only ever be at a very low level. Most of the serious disciplinary stuff would come up to the practice owners. (GP 10)

In addition, the role of the practice manager can bypass significant responsibility for the work of doctors (aside from routine scheduling/organising); this usually vests in the owner.

> In terms of how we timetable for doctors and how we timetable for staff, in terms of administration staff, is very much done through the practice manager. She manages that. In terms of managing doctor staff, the doctors have a lot more input on that, but again the actual day-to-day organising of it is done through the practice manager. (GP 21)

Similarly, GP 32 described how the practice manager has some autonomy around scheduling decisions, in terms of managing work-flow. In this sense, they are not 'managing' the doctors but rather 'facilitating' them. Thus, while they were described as "taking charge", this was in the context of moving appointments. Later in the interview, they commented that the practice manager has to "see the big picture" in terms of the practice and highlight issues from a business perspective. However, it is clear that the GP remains in control: "you are not going to turn away a patient if there is a need".

One of the GPs had never employed a practice manager before but, because of an expanding practice and workload, had decided that the time might be appropriate and identified proposed responsibilities. Their narrative indicates that they had thought about this at some length and identified gaps in their practice.

> I would see them, first of all, just looking at our whole structure and trying to streamline it and identify areas of responsibility and focus people more on their areas. The second thing, and we would feel this strongly, is that a practice manager probably would nearly pay for themselves in chasing funding that we should be claiming or are deserving of, but just haven't the time to pursue … And then, the third thing would be they would also have a management role in our new building … so there is an area there that will need management that again we just don't have the time for. A fourth area would be coming up with ideas on how we can provide a better service, but perhaps also to generate more income. (GP 13)

In essence, while identifying various duties, it appeared that the potential manager would fill a largely administrative position, with some 'front-of-house' responsibility in terms of organisation and structures. There is no real sense that the practice manager will have much responsibility or power – even in terms of innovating the practice, it is mentioned that they would come "up with ideas" as opposed to driving changes.

6.5.4 Being more managerial – a double-edged sword?

GP 15 reflected on the differences between the practice manager role in Ireland ("nominal sort of title … docs take the decision-making roles") versus the position in UK practices ("the real boss of the practice"). In his practice, the partners sought to

enhance the role of the practice manager by giving them “more autonomy in the practice and how it was run and maybe decision-making and bring them into meetings that we would have together”. The use of the word ‘maybe’ is notable, as partners retained overall responsibility for key decisions.

Enhancing the role was apparent in a small number of interviews, where management was 'shared' more so, particularly where the manager was the GP's spouse (also section 6.5.5) or the practice was large.

> [Spouse] has been an absolute boon in terms of not just doing accounts and salaries and sending in returns, but in terms of … health and safety legislation, risk assessment, the various kinds of legal things that we have to have. (GP 20)

However, it was clear that owners still remained actively involved in decision-making and shared responsibility and control; in these practices, the practice manager was not dominant but seemed somewhat more equal.

> (T)he practice manager is also involved in doing staff appraisal and the GPs have been involved in that because she has been trying to do 360 degree sort of appraisal. (GP 2)

> In terms of administration, it would be my husband but, to be honest, he would never make a decision on anything without discussing it with me and if it’s not a clinical decision, I would always revert to him. (GP 20)

In some practices, the role had been expanded slightly whereby the owner views the domain outside of the consultation as belonging to the practice manager and limiting their own presence here: “managing staff, payroll, and liaison with patients” (GP 30). GP 22 equated their practice manager to a “hotel manager” in controlling “front-of-house” and ensuring that this works effectively, by taking greater charge:

> (T)he whole goal is to keep things moving and to support the GPs as much as possible. So, basically, she has to get rid of any kind of little kind of aggravating things that might be annoying people [administrative staff] under the surface.

> She’ll have to come straight out, what’s their problem and how can we fix it, have a meeting about that, everyone will discuss it, it will be out in the open. There wont be any little niggly things that annoy people, she’ll pull them out and if someone is irritated by another person, she’ll notice that and she’ll have it fixed. (GP 22)

This was well received by the GP, who did not perceive the practice manager as either a threat or an obstacle to their work. However, this may be due to the fact that the practice manager's remit does not stretch far beyond front-office.

> I would describe her as being very direct and liking to be in control, being good at looking after people … I think she understands her job and I understand mine and we work together quite well. (GP 22)

However, where the practice manager crosses unacceptably into the domain of the GP, this can lead to a clash. GP 32 noted previous experiences of practice managers “that tend to rule the roost, which is not in my book a healthy sign of a practice if the practice manager is very prominent, makes a lot of decisions on a day-to-day basis”. In this respect, the practice manager attempted to tell the GP that they were spending too long with a patient and objectified them: “to see them as names on a spreadsheet that have to be ticked off, and, problems that have to be sorted and packaged in boxes and send off as they come in … The assembly line approach to it, and that is never healthy”. This arose because of the power that the practice manager possessed and a refusal by the owner to confront this: “There is a line in the sand about where the practice manager’s duty or role stops … but there didn’t seem to be any boundary there”.

GP 29 observed that, in their practice, the practice manager “goes on stress leave, very occasionally”. This stems from their position between two practice owners, where there is a lack of clarity with regard to their role and what is expected of them: “if she wants the real answer, she'd go to [one partner] but unfortunately, she doesn't always get the answer. It is very vague ... then she goes off and she's left with this. She comes into my office and she's like what do I do now”. In this organisation, it appears that the practice manager is expected to manage (they had produced an unused business plan) but lacks authority, being prevented from performing the role by those who appointed them

(regarding the plan, the practice manager "couldn't get any consensus between the two of them what to do").

The most prevalent examples of poorly functioning practice managers were found in a few – though not all – of the practices where the owner's spouse filled the role.

6.5.5 The spouse as practice manager: help or hindrance?

In approximately a quarter of the practices, the practice manager is the owner's spouse. This did not appear to fundamentally affect the work they performed in most cases, which still remains largely administrative and operationally focused.

> (L)ook after the financial side of things, the money coming in and the money going out, the payment of wages and bank lodgements. (GP 9)

> My wife was the one who negotiated those roles [with the secretary] and who does what and when and what needs to be done, so like mail coming in, taking phone calls. A lot of interaction between … to the secretary is through my wife. (GP 18)

The specific merits of having one's spouse as practice manager were highlighted by GP 20, who believed that the trust between them allowed her to reduce managerial involvement: "(I)t's almost like being a doctor in a hospital and everything else is being taken care of for you". In addition, GP 23 noted that confidentiality in business matters is preserved: "GPs don't really like other people in the business to know things like how much money the practice is making … I think they feel that if the wife is the practice manager, it kind of keeps all of this stuff sacred and secret".

However, the negatives of this formed a greater part of the interview with GP 23 where there is evidence of what can happen when the practice manager crosses into areas seemingly beyond their recognised domain, or does not deal with issues that are deemed

their responsibility. The interviewee described two examples that caused great irritation[50].

> Barely putting out fires and absolutely no innovation … I arrived into work one week to be told, oh, we've decided this week that one doctor is going to work until 7 every night, with no forewarning or anything, because nobody thought about this. Arrived into work another week and they said that we're going to give you a week's less holidays, even though I'm not technically paid for holidays.
>
> I've had a problem with one particular secretary. She's appalling. You get a note to ring such and such a patient and you look at the phone number and there's obviously a digit missing and it didn't happen once, this happens pretty much every time. You go to the practice manager and say that this can be a problem or that this secretary can be particularly rude to patients … I heard her berating a man for giving her the wrong dates for a cert and she had to redo it and it was terrible. I've patients complaining to me about her so I've done what I did and I've passed it on to the practice manager and you get 'thank you very much for telling me that, I appreciate it' and nothing is done. (GP 23)

The GP in question had tried to address the first difficulty with the owner, but to no avail. A lack of independence in the family relationship meant that the discipline and distance that exists in employer-employee relations in other practices was absent.

> I've talked to them about possibly looking at other ways of saving money and I'm told that that's a nice idea that you have, but don't upset the practice manager because she's his wife. He doesn't want me to upset her. (GP 23)

GP 25 also attempted to make changes in areas where they felt improvements were appropriate and efficiencies were possible. However, the practice manager's controlling

50 Section 6.4.3 also provides an example from GP 23 that highlights the weaknesses in the practice's system, at least partly attributable to a lack of proper 'management', and with issues for patient services.

nature meant that "you get stonewalled and you don't do it any more and you just accept what's happening".

> Something like the appointments system, the fact that it's on paper and you have to walk to the front between every single patient to see what patient is written up. Our computer system that we had, or the programme, had the appointments system that they could just slot it in and you didn't even have to move from your desk, you could see which patients were there and so on. I wanted to initially get that programme running and I think she gave it one day and the receptionists made a mistake and she said well, it's not working so we go back to the old paper system … after a while, one clearly knew that she wanted to do things her way and she's used to it and she's comfortable with it. She doesn't really have to give reasons. (GP 25)

The 'hands-off' approach of the owner – who did not wish to get involved in any of these matters – compounded the difficulty and GP 25 acknowledged that the lack of "boundaries" for the manager stemmed from the husband-wife relationship.

GP 26 noted that, in a previous practice, the owner's wife was an 'absentee' practice manager, in the sense that "she does the practice management from home more or less" while still being "very interfering. Can show up at any time, checking up on people, is very, very tight with money and even something like buying a packet of biros has to run past her first and I think that's too much". Two issues were flagged with this arrangement. Firstly, her lack of presence meant that she had "no feel of what is necessary from a clinical point of view". Secondly, the owner allowed the practice manager leeway that would not have been shown to a non-family staff member and was unwilling to confront these issues even if raised. Indeed, the discipline that a practice manager can bring to an owner was also absent: "you couldn't complain about her to him and you couldn't complain about him to her". Interestingly, the same interviewee reflected on a separate practice where the non-family practice manager was present for over 25 years. When asked if she perceived a difference in the relationship there, GP 26 remarked, "I think there's still a difference, because at the end of the day, he's paying her wages."

6.6 Clinical/managerial role conflict – occurrence and impact

Three areas of conflict that arise between the GP's clinical/care (professional) and managerial roles are identified: insufficient time to fill all roles, the challenge of being simultaneously patient-focused and business-oriented, and a general lack of interest in management accompanied by a reluctant acceptance that the role cannot be neglected.

6.6.1 Lack of time

6.6.1.1 The demands of the working day: seeking balance

The majority of owners noted that they are time-poor in the context of trying to meet the demands of their workloads: "Well, sometimes yeah, things can pile up. There could be a lot of paperwork hanging around" (GP 9). GPs recognise that there is a considerable amount of responsibility attached to their work and this takes time to address: "as an employer … life is much, much more complicated" (GP 5). Long and challenging days are the norm for many GPs ("just feel under pressure for time, there's less time … no time within the day for personal" (GP 24)), though there seems to be almost an acceptance of this fact amongst established owners ("Typically do 10, 11, 12 hour days" (GP 10)).

> I suppose a full-time partner would tend to work in or around 50 hours a week, a long enough week. (GP 2)

> I'm very pernickety, I have to read each letter in detail, its not enough just to say that's from such a person. I can't do that. I've got to sign off on it. (GP 3; *regularly works evenings/weekends*)

A lack of sufficient time to address everything and the busy nature of being in practice ("Before I got an assistant, I was basically running on empty" (GP 20)) can understandably place a strain on GPs.

> Probably the biggest stress I have is there is no fixed finishing time and the finishing time can be very late and that impacts on non-work life. (GP 6)

Amongst newer owners and non-owner GPs, there appears to be a greater sense of trying to balance this and manage their time. Family needs featured prominently, particularly for those with young families.

> I collect my eldest from school two days a week and just making sure that I am able to get up to collect him from school, things like that can sometimes be hard. (GP 17)

The focus of the GP in work is the patient and serving their needs: "being a clinician, I would think that the clinical matters probably take precedence" (GP 8); anything else is regarded as secondary and arises as a result of the clinical role. In this respect, it is accorded less prominence: "Time spent on the managerial role is time not spent clinically and there is never enough time, clinically, anyway" (GP 6).

> I'm too busy seeing patients really to keep everything running smoothly, to be getting involved in the nitty gritty of GMS claims and dealing with health boards or dealing with the HSE. (GP 1)

> We had a man there who was dying and I was looking after him for the last month. He was living 15 miles outside of where we were but he would have been a patient of the practice, his family are all patients of the practice, he was a good man ... and obviously he wasn't making great ... from a managerial point of view he wasn't making, 30 mile round trips taking time and costing money every day to go out and look after him when he was dying, but it had to be done, clinically. There might have been a conflict there but there was never really a conflict, the man had to be looked after. (GP 35)

However, there was also an acknowledgement that time needs to be devoted to management and running the practice ("You find [as an owner] you spend less and less time consulting and more time managing" (GP 11)), even if this is with some reluctance (section 6.6.3). Therefore, priorities need to be flexible: "patient care is number one priority but the day the computer breaks down, that becomes number one priority until it's fixed because you can't deal with patients without it" (GP 3), though striking the balance between dual responsibilities can be a challenge when time is limited.

> There would be times when I would be under serious pressure time wise in terms of very busy surgeries, multiple problems running on, medical problems running on and then being asked about some management issue within the building. There are certain times when you just don't have time to manage. (GP 7)

> Just trying to keep the clinical side of things safe and ticking over but also getting the day-to-day admin stuff done and supervised and working smoothly, because one can't really work without the other … working safely, then the business side of things has to be working as well. (GP 16)

The absence of extensive supports for GP 31's principal compounded their difficulty, as they were forced to fill both roles. In addition, a lack of time precluded most GPs from dedicating resources to enhancing their managerial skills although there was some recognition that time spent here could be beneficial.

> Maybe, at some stage, to get some formal management training just to get it a lot easier and that probably means spending less of my precious time dealing with matters that, through trial and error, I might have the answers or be able to manage a situation in far less time. (GP 15)

> (H)e is taking on two roles really, he is the practice manager as well as being the principal … there would be enough work for another person, in terms of it is a huge commitment and it is a huge, I think, extra workload on top of the clinical job. (GP 31)

Some non-owner GPs identified lack of time as a problem in poorly managed practices: "Ideally he [owner] would like practice meetings, ideally he would like to sit down and chat more, but it doesn't really happen, there isn't the time" (GP 34). GP 23[51] noted that, in their practice, none of the GPs (including the owner) were active in management and it appeared that the entire focus throughout was on the patient.

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51 Issues in the management of this practice were previously outlined in section 6.5.5.

> (Y)ou know you're going to be compromising time spent seeing patients and you know that you'll be put under pressure, sometimes someone will come in and say, oh doctor, I wanted to come in and see you yesterday but you didn't have an appointment and that does put you under pressure. It's just that less importance seems to be devoted to being a manager. (GP 23)

GP 4 disagreed that time was as key an issue as others indicated. He contended that this relates to unwillingness on the part of GPs to actively engage in management as they do not see the importance of it and do not enjoy it (section 6.6.3). In this respect, time remains an issue but is essentially dealt with by choosing one role over the other.

> (I)s used as an excuse by professionals, that 'I don't have any time to deal with management because of all the patient demands, so that's why I don't deal with management'. I mean, that is to some extent an excuse for people who don't feel motivated to do the business side, but they are doctors after all so they look after the patients needs. Is there a conflict? Of course there's a conflict. But, I think to some extent we use that as an excuse for not looking after the things we don't like doing. (GP 4)

Amongst some of the smaller new owners who had more recently set up their practices, time currently appeared to be slightly less of a concern. By virtue of being less busy, as a start-up growing their patient base, they had some capacity. There remained recognition, though, that this was a temporary lull and that, with growth, would come greater demands.

> (T)he practice is still quiet so I have space in my day to catch up on things. Whereas, if I was as busy as the practice is likely to get in time and I'm flat out consulting for 6 to 7 hours a day, then yeah, it's going to cause problems because there isn't space in the day for the managerial stuff that needs to be done. (GP 19)

For non-owners, time sensitivity was also an issue, more so because of the busy nature of being a GP. Some noted that they experienced pressure to see as many patients as possible within a restricted time frame ("in my old practice I had between 5 and 10

minutes per consultation, in this practice I have between 10 and 15 ... it makes a huge difference" (GP 35)), the implication being that this generated more income. While acknowledging that this was part of their job, the workload imposed was viewed as unreasonable at times.

> I think so many of us are oriented, you need to see the numbers; you need to see a certain amount of numbers to achieve your turnover. I would have tried to ... I don't know how ... not focus so much on just that because I think that also affected clinical judgement, because you had to see quite a number of people in a very short time and you didn't have the luxury of spending time with a patient and so on … one of the major premises of me being employed was the number of patients I had to see every day. So, that was a bit of a problem. (GP 25)

There was recognition also that the 'patient' is a 'customer' and must be looked at in that light as well; the consultation is about the service and providing value-for-money. Thus, a lack of time in direct service may adversely affect the perception of quality.

> (W)hen I have 15 minutes appointment, I give that 15 minutes to the patient … I'd rarely see someone in less than 15 minutes. (GP 28)

6.6.1.2 Timing of managerial work and bringing it home[52]

The majority of the established owners tend to address at least some of their management and administrative work out of hours. Such work appears to occur mainly in the evenings and, for some, at weekends. In the case of two GPs (2 and 6), they occasionally come in on days off to do this work to avoid it interfering with other duties, including their families. Broadly, this arises for owners because there is insufficient time during the day when their focus is on consulting: as GP 6 noted, while the patient can't be brought home, management-related tasks could be. Work performed consists of paperwork, decision-making and some thinking about the business.

52 This section addresses working on non-clinical tasks out-of-hours; obligations to provide clinical cover through co-operative/rota arrangements are not considered. While GPs acknowledged that they had out-of-hours clinical duties to fulfil, by virtue of these arrangements, there was no obvious sense of dissatisfaction expressed with giving this time to patients.

> Sometimes, after hours in the evening time, I would do a lot of the paperwork myself, management paperwork. Obviously, when surgeries are on, that would be our focus, during those times we wouldn't have time to. (GP 7)

> Occasionally, we [partners] will meet late, after surgery. It tends to be before and after; we try and avoid things at weekends … If we need a long meeting, we'll meet on a Saturday or a Sunday. (GP 13)

This can also entail discussions with spouses on various matters.

> I do bounce things off him and I suppose I more keep him informed … I mean, he's not a doctor, he's not trained in medicine at all so … but from a business point of view, yeah, I'd bounce stuff off him. (GP 19)

Some GPs have set aside protected time for these activities during the day, though this is rare as interviewees appeared reluctant to compromise consultation time. GP 10 has only recently established this and was reflecting on how to put the time to best use.

> I've sort of been sitting here going, oh, what do I do now sort of thing. Doing it in protected time just sort of ... its very much on the hoof sort of thing, but at the same time, it will be good to have a bit of protected time to see back, even just to think. Go down to a coffee shop and get away from it and sort of grab some distance. (GP 10)

Where protected time is not available, owners do make a conscious effort to address management work or issues when opportunities arise during the day e.g. during breaks, before appointments.

> It would be I suppose during lunchtime I'd imagine, if I didn't have a lot of house calls or whatever. (GP 7)

Newer owners adopted similar tactics, working on such tasks during the day and out-of-hours. However, a reluctance to do this at home is evident: “if I get a chance to do it, I will do it because I try to minimise the amount of work that I have to do at home” (GP

15). As a result, their capacity to devote additional time is limited, though acknowledging some necessity here.

> It’s usually done there and then. I mean, I’ll often get instant messages from staff saying I need to take holidays or I need to take a day off … Those instant messages will arrive to me and I will either try to tackle them during my lunch break … or bring the member of staff in to discuss it at some stage during the day or in the evening time. So, it’s kind of integrated into the day. (GP 15)

Protected time does not appear to exist in newly formed/start-up practices, though the fact that they are not working at full capacity allows scope for accommodation.

> (W)herever there’s a spare minute in the day. I don’t have time set aside for it or anything. (GP 19)

Non-owners have limited, if any, management work though they do have administrative duties (e.g. paperwork). Evening/weekend work is less prevalent again amongst this group, as they focus on finishing work within the normal day. However, they do observe their employers doing so in some cases, viewing this negatively.

> I used to be doing things at home here on the computer but I don’t really any more. I tend to do as much as I can in the practice. I find, really, home is work pretty much free now ... I just can’t be bringing it home. As you can hear in the background here [*baby making noise*]. (GP 28)

> That poor man’s working day is incredibly long. He would do some of it during the working day and I know that he goes in there at weekends and does it, and I know that a lot of his admin stuff is years backlogged. (GP 30)

6.6.2 The business of caring: filling dual roles

There was a general acknowledgement amongst GPs that general practice is a business as well as something more caring: “I think you'd be foolish to go into setting up a practice if you haven't considered how you're going to make money out of it” (GP 19). While a patient-centred ethos was clear (“we charge a very nominal, if any, charge at all

to the private patients who are coming for flu vaccination" (GP 8)), interviewees were also aware that this was linked to business success, but not enough to be successful. In this respect, there is an acknowledgement that while the focus is on the presenting patient, there is a wider context to be considered.

6.6.2.1 Profiting from serving the patient

The challenge from being in business and caring for patients was apparent. GPs generally recognised that, as clinical professionals, they are dealing with something quite sensitive and personal from the patient perspective ("Money isn't really what we are all about, at the end of the day we are all making a comfortable living on it" (GP 33)). However, there was also the wider concern surrounding the continuance of the practice and their own livelihood ("You can't be a clinician and not have any money coming in the door" (GP 23)). This can create something of an internal dilemma.

> It's a business and you have to make a profit, but it's also a service and I suppose those can be in conflict. One can be stronger than the other, depending on the philosophy of the practice. (GP 6)

> Strictly speaking, if they're a 'private' patient, we're obliged to charge them. But, at the same time, if I know in my heart and soul that somebody hasn't got it, I'll either … I'm trying to get out of the situation of not charging at all, which I'm told by colleagues is not the way to go, but what I've said to people is, look, I wont charge you a full fee today but can you fill this in and send it off. If the [medical] card comes through, you won't have to pay again. (GP 20)

GPs may attempt to generate income from other sources, which do not directly affect the patient financially nor hamper service delivery. In GP 32's practice, where they received State payments that more than covered the cost of a service, this presented an opportunity to reinvest in others.

> (W)hen hemochromatosis [*body absorbs too much iron from food*] reared its head as a new condition to look after, it turned out that [health insurers] are paying very good money for taking blood off of people. It's very straightforward

work; most of it can be done by the practice nurse. It pays something like €108 a time; it takes about a quarter of an hour. (GP 3)

(U)ntil the financial emergency legislation came in there the year before last, a lot of GMS practices were able to put in extra services for their patients, certainly their GMS patients, because they were maybe paid more for one thing and paid maybe nothing at all for another thing, but in general it worked because the patient got what they needed somehow, it balanced out. That is happening less now. (GP 32)

Interviewees suggested that too much of a financial emphasis can have an adverse impact on service quality and patient interaction and this can make them uncomfortable: "You have someone who brings their kid in and charge them 50 quid to tell them to keep taking Calpol, they're not going to be interested in seeing you again – they'll want an antibiotic. Desperate way to practise" (GP 18). As GP 30 and 31 highlight, a style of practice where business interests might appear to unreasonably contravene those of the patient can be difficult for doctors to accept.

(I)t was set up because as a private-only practice, really the only income is if you come in and speak to the GP. So [owner] has generated this sort of barrier [*will not typically speak to patients by phone*] that I have huge problems with that happens the days I'm there basically. (GP 30)

The Australian model and how they come in and say "look you are spending too much time there and I want you to..." And as I've heard from many friends that go over there; the advertisement to come work in Australia for so much money is very attractive and then when you get there you are very much told you are not to spend too much on this and if they complain of a second problem you are to bring them back a second day; you know, completely against the ethos of general practice over here. (GP 31)

However, a lack of any emphasis on money is also an issue. This can put a strain on the viability of the practice, particularly in the present climate.

> (T)he main GP, I'd say half of his neighbours don't pay. So, they were never financially motivated, but now things are tight and there's panic. (GP 23)

> (W)hen the last receptionist started, she said that there was €10,000 worth of unclaimed STC's [Special Type Consultation] and stuff just lying around the place. (GP 26)

GP 10 articulated the challenge of balancing business and caring when discussing the dilemma they personally face in prioritising paying or non-paying patients, as they seek to balance multiple issues of a clinical and financial (both in the short and long-term) nature. The use of the word 'tension' is interesting, as it shows their struggle.

> One of the reasons we're here is profitability, so should I bring this patient back for another appointment, they're a medical card patient ... we get paid a capitation which means if I see them less, they chew up less resources, if I see them more, they chew up more resources and therefore our profit drops. That tension between ... even from a purely business point of view. If you send out the message that we don't want to see you, then people are not going to be there when you need them so you won't have any business at all. So there is a tension between doing it right for the person and what is financially advantageous to the practice. That's always there. (GP 10)

6.6.2.2 Service decisions: balancing the gains

The provision of patient services is impacted by the realities of business that practices face, with falling incomes and funding being withdrawn. GPs need to consider the impact on patients of offering/withdrawing services, as well as the costs/benefits to the practice of this, such as closing lists due to workload and not seeing patients who live outside of a specific radius. GP 3's approach had no direct clinical impact and saves money but was a potential inconvenience to patients while, regarding GP 7, the patient benefits were identified, though it appeared that cost might need to come into any final decision.

> We had huge bills for postage. We used to ring up and make appointments for people and send them out their referral letter and their appointment. She

> [practice manager] said to forget that, we're not going to do that any more. Give them the number and let them ring and make the appointment themselves because if we were ringing, sometimes it would be three phone calls to make one appointment … If there is a referral letter, they come and collect it … They were the kind of things that actually made the difference in us making a profit. (GP 3)

> (W)e're going to do a vaccination programme for teenage girls for the cervical cancer vaccine which can only be bought privately. We're going to try and do a deal with the drug company, we're trying to offer that to all of our patients in that age group. (GP 7)

GP 22 noted that a key decision for their practice is whether to continue to run a clinic "that is not making money but that is very good for patients". They described this as an "ethical" decision, which resulted in its continuation "at the moment while they can still afford to do that". Thus, the value of this service – on both fronts – is actively considered by the owner and practice manager, and remains in the balance. GP 32 indicated that, in their practice, the prospect of introducing enhanced income-generating services beyond the basic offering had been considered but not pursued because time was not available to provide this in addition to standard services. This would have required sacrificing a guaranteed source of income for one that was less assured: "you are not going to be able to continue as a full general practitioner with a GMS list and 1000+ patients on that".

GP 28 had proposed that their practice would purchase a particular blood-testing machine on the basis of patient benefits. This was approached in a structured manner and a cost-benefit analysis was performed in advance. A decision was taken to charge for this service. GP 28 firstly explained that the fact that "it was going to cost us money … more than this will make us money" was the issue. However, they also acknowledged that the service has now become profitable because of demand, though "we didn't stop charging patients … but I don't think it was the initial". Thus, while the primary goal may have been patient services, it is clear that cost was also considered and, potentially, profit.

GP 35 introduced a new clinic to their practice, explaining that it was to do with "patient service but there is a financial and a personal element to that as well". In this context, they noted that one of the core attractions was that the clinic would not only bring in new patients, but their families as well, increasing the practice patient base: "there would be a good subsection of the population to target". The GP acknowledged that no costing was prepared for the new project and research was limited to asking patients in the surgery if they would be interested, but commented – at the end of their explanation – "I hope this doesn't sound very cold and calculating". This suggests that patient needs were a clear factor in the decision, but that gains for the practice – both immediate and future – were also considered.

These examples demonstrate how GPs can approach service provision. In no case was the decision to provide/withdraw based solely on patient needs, but financial costs and benefits were also only part of the process. This suggests an attempt to balance both aspects – patient and business – in a palatable, equitable way.

> [Owner] was always open to anything that would bring business into the practice, that would expand the services that we could offer patients without having to refer them on. (GP 26)

6.6.2.3 The payment 'problem': creating distance

An issue highlighted in some interviews concerned payment for services. Some non-owner GPs struggled with the notion of physically taking cash from patients for consultations. This created a degree of discomfort ("I don't like people actually just handing over money to me; I don't like the way that feels or whatever" (GP 33)), as the consultation was viewed as something where the focus was on the patient and their concerns. In this regard, the matter of payment might perceivably cloud and impact upon this, at least in the mind of the GP: "(Y)ou don't want to give them I suppose the impression that you would withhold treatment from them because they didn't pay or that you would temper future consultations" (GP 32).

> I suppose the financial side of things … it's very hard to draw a barrier between, yes, you're dealing with someone and dealing with perhaps their emotional and physical problems and then turn around and say well, that's €45, thanks very

> much … it just seems … not sordid or dirty, but it just seems clinical and cold just to switch over immediately. (GP 27)

GP 28 identified that their attitude regarding payment was in contrast to their near-term desire to be an owner and their motivation to manage. They appeared to struggle with personally reconciling this.

> I suppose it's nearly a contradiction in my own head that I feel I want to become a partner and I find it hard to ask people for money. If you're going to be a partner, you're going to have to be actively involved in finances as well and making sure that people are being charged for relevant services so that the practice can actually function. Yet, I find it hard to ask people for money but I can see the importance of making sure that services are being charged for. (GP 28)

This seemed to be less of an issue for owners, who tended to adopt a more pragmatic attitude; GP 27 described her employers as being "much more forthright about addressing [large outstanding balances] at the end of the consultation". Owners speaking about this issue did not generally make reference to the sense of discomfort felt by some non-owners, though neither did they appear to view the transaction coldly.

> (W)e do expect people to pay, but when people are unable to pay, even the secretary would be told if she gets any sense that someone is in financial difficulties, that they would just give us ... nod us a wink so that we won't be embarrassing people. (GP 9)

> (W)hen patients need to be seen more often and they don't have a medical card, how often do you waive fees and are you setting precedence and that type of thing. I would have problems with the younger doctors not being good at setting fees. (GP 11)

A solution to concerns regarding money matters can be to pass responsibility to the administrative side of the practice, who manage the cash and any necessary pursuit of payments: "We [partners] don't get involved in that at all, really" (GP 21). While

administratively efficient, this also helps the GP avoid having to discuss money in the consultation. Therefore, they can distance themselves from this part of the transaction, putting the responsibility on 'management'. This separation is particularly interesting in the context of GP 1 and 2, who are part of 'management' as owners.

> As a clinician, as you know, we would listen to people talking about their difficult financial problems and whatever and sometimes, very often and certainly in years gone past, we would have said 'Look, don't worry about the fee' and whatever. The management now tend to be more aggressive about sending out bills and … they have to strike a balance somewhere, you know. (GP 1)

> (W)hen patients have outstanding accounts and they continue to present at the practice and they are making no attempt to pay off the balance. That can be an issue and we tend to try and step back from that as doctors and hand it over to the administration management side. (GP 2)

6.6.3 Limited interest in operational tasks

Limited interest in management and administration is evident from a majority of interviews ("I'm a doctor for God's sake" (GP 4)) with few interviewees generally suggesting that they enjoy the work. GPs can appear to find such tasks – particularly the routine – as something of a nuisance and a distraction from core clinical/care work (which they do enjoy; section 6.2.2): "I think it is getting more demanding and the more demanding it is getting, the less interest I have in it" (GP 3). In this respect, GPs may seek to avoid or limit management/administration work where possible ("I'd have no problem being the chairman, but I would want somebody else to be the chief executive" (GP 4)).

> Practice management is a huge area of the practice and I would be the first to admit that it is not my favourite part. (GP 12)

> (F)or all of the will in the world, you can do all of the management that you want, but if you're not looking after the patients, they're going to walk away. (GP 17)

There is little suggestion from GPs that if extra time was available, these are areas where they would choose to spend it. Although some would welcome an allocation of protected time, this did not appear to entail a large time input. Even amongst those GPs who expressed some interest in management, there was no real indication that they were seeking a significantly expanded role. In the case of GP 8, he had preceded the quote below by remarking that he would like time "to reflect and contemplate" and to plan an expansion, suggesting more a change in focus rather than adding to the role.

> I would like to spend more time, to a certain extent, in the management role, but also in terms of teaching and research because these are areas that are of interest to me as well. (GP 8)

> I don't get extra time from the partners for it, even though I would do a good chunk of it but that suits me as it gives me a certain amount of control and it gives me … I get a certain amount of satisfaction out of things running well. (GP 16)

However, there is also some acceptance that this work is unavoidable and important ("You have to have some role to play in the management side of it, otherwise you're not going to be your own boss" (GP 26)) and needs to be attended to for the efficient running of the practice, and to ensure that the expectations of other stakeholders are met. GP 21 noted that they had handed over some of the HR role to the practice manager because she is "so good at dealing with people on a human level". However, staff issues had arisen which led the GP to conclude that "maybe we weren't doing as much as we should have in that regard". Thus, retaining an involvement is necessary.

> (M)aking sure that things don't fall between the cracks. Stuff that you have to comply with in terms of legislation, and health and safety and all of that sort of stuff. (GP 10)

> (A)ll of the paper work for the practice goes through me so I will keep an eye on whether it is clinical or administrative issues, in that regard, in that way. (GP 15)

GPs delegate where possible (section 6.4.7 and 6.5), in particular utilising supports to address areas that are beyond their expertise or that do not require their involvement "so that I can get on with consulting" (GP 19). As previously indicated, this can tend to be the more routine aspects as opposed to particularly core management tasks. While GP 32 perceived "a huge tendency for GPs to move away from [management] and to try and delegate that to their staff", they also acknowledged the need for partners to be "aware of the nuts and bolts of the practice, how it is put together and how it works".

> I'd like to able to delegate more and to have … roles that maybe I'm doing that don't necessarily need my involvement. I'll give you an example of that, some of the data input, letters to patients and stuff, a lot of that could be done by somebody in the practice who is trained up to do that. Certainly, that's what's done in the UK. I think something like that, I would love to be able to have time to do and maybe that will be a role for the practice nurse … she has a lot of other things going on at the minute. That would be one area that I might like to offload. (GP 15)

A small number of non-owner GPs highlighted the existence of conflict that stemmed from the owner not engaging actively in the management of the practice, instead seemingly over-delegating responsibility and control to the practice manager. The interviewees' comments indicate that a manager with clinical/care experience or understanding would not adopt such practices, which were regarded as inefficient, counter-productive and not patient-oriented. This has been addressed in section 6.5.4 and 6.5.5, demonstrating some potential negative implications from the GP owner's lack of interest where this translates into their non-involvement in management.

6.7 Summary

This chapter has provided detailed findings from the study, illustrated with appropriate quotations from interviewees. Overall, the findings indicate that a focus on patient care (as clinical professionals), quality of life and financial security concerns, and a desire for autonomy underpin the GP role. In general, the GPs engage in a limited pursuit of management training and emphasise a 'learning-by-doing' and practical approach, focusing on operational aspects, as opposed to more formal means of development and

higher-end management. This is consistent with their application and performing of the management role, where the emphasis is on operations and managerial oversight. Engagement with forward planning and strategy for the business is generally low, with a focus on emergent and near term plans; in fact, where plans do exist, their usefulness can be somewhat limited. Performance measures are extracted in running the practice, though not necessarily in a very structured manner and are infrequently shared amongst staff, with little use of formal targets.

The practice manager is identified as a key support to the GP, though their actual contribution to the management role can be at a low level, focused on administration and 'front-of-house'; doctors seldom come within their remit. Indeed, where the role extends significantly beyond this and interferes with the clinical functioning of GPs, with the owner managerially inactive in a practical sense, the findings present some evidence of negative outcomes and dissatisfaction. Instead, the GP – and owner particularly – is often the dominant force in managing the practice, as they exert considerable control through their style, approach and the structures adopted. Greater sharing of the role exists in some practices where the owner's spouse is the practice manager, though the GP remains managerially active. Delegation to others does occur, but mostly of routine administrative matters; management tasks are less commonly assigned to non-owner GPs, who can tend to have a relatively limited input as to how the practice is run.

The interaction of the managerial role with the primary clinical/care (professional) role gives rise to a number of conflicts, as GPs address the challenge of balancing patient and commercial interests, filling an operational role can carry limited interest for them but is acknowledged as necessary, and doing all of this within a time-poor context. While the home domain acts as a source of relief for this workload, the findings identify that this is limited; GPs attempt to largely accomplish what they can within the workplace and work day. The next chapter will turn to the discussion of these findings, in conjunction with the literature reviewed and the context of the study.

Chapter Seven

Discussion of Findings

Chapter Seven: Discussion of Findings

7.1 Introduction

The current chapter discusses the research findings in the context of previous literature. Firstly, the nature and extent of the GP's training is considered in terms of undertaking the managerial role. The specific management tasks performed by GPs are discussed, before the role itself is examined in conjunction with established management theories. The relevance of career stage is addressed, followed by the support provided by the practice manager. A model is then presented, integrating these strands, to demonstrate the nature of the managerial role and how it is performed.

The chapter then moves to consider a form of role conflict that GPs can experience, namely Organisational-Professional Conflict. Initially, the discussion addresses conflict arising between their commercial and professional roles. Following this, a second conflict is discussed, between their operational and professional roles. The chapter considers how these conflicts have implications for GPs, given their time-poor context, and a model of role conflict for the GP as manager is presented. Subsequently, the discussion addresses the GP's work agenda, representing their overall role, and the factors that influence this. The work agenda and influences collectively have implications for the nature of the managerial role and how it is performed. Finally, the chapter closes with the presentation of an integrated model of the GP as manager at work.

7.2 Summary of main findings

The main findings from chapter six are summarised in Table 7.1, as five core themes. In this regard, section 7.3 collectively discusses themes 1 to 3, while section 7.4 collectively discusses themes 4 and 5. The final section of the discussion (section 7.5) addresses aspects of individual themes as they pertain to the work agenda.

Theme 1 – Limited pursuit of management training and the implications for GPs
▪ Lack of formal management training; mostly 'learning-by-doing' and an emphasis on operational aspects ▪ Timing of management training appears to be before it can be fully applied in practice
Theme 2 – The application of the management role by GPs: an operational focus
▪ Management tasks undertaken are mostly focused on operations ▪ Limited long-term strategic thinking/targets; emphasis is on emergent planning ▪ Benefits can accrue from the preparation of formal plans, though not regularly used ▪ Established GPs can question the relevance of formal planning; new owners more active ▪ Practice meetings can tend to focus on operational, clinical and short-term matters
Theme 3 – Management styles and structures: the dominant owner
▪ Flat management structures adopted, with mostly professional members as central core ▪ Owners dominant in decisions, some consultation; routine work tends to be delegated ▪ Non-owner involvement in management can be limited ▪ Management styles of GPs tend to be decisive, though can be quite informal ▪ The role of the practice manager can appear largely administrative, often with limited managerial involvement; more active 'sharing' of management noted in some practices ▪ Practice managers can have greater responsibility for front-office matters
Theme 4 – GP role motivations: patient, quality of life, control and financial security
▪ GPs regard their professional (clinical/care) role as their primary role, with quality of life and practising a more personal approach to patient care as motivations for career choice ▪ Motivations for ownership include having autonomy/control and financial security
Theme 5 – Role conflict: addressing competing clinical and managerial expectations in a time-poor context
▪ GPs have a commercial role in conjunction with their professional role, which may conflict ▪ Service decisions are made with patient care and commercial interests in mind, seeking a reasonable balance ▪ Fee collection tends to be delegated; GPs can appear to distance themselves from this ▪ GPs can express limited interest in operational management, though generally accept the need for some involvement ▪ Difficulties can arise when GPs delegate the operational management role extensively, if regarded as inappropriate to do so by colleagues ▪ A lack of time is a problem, particularly for owners with their additional responsibilities ▪ Owners can reluctantly bring work home; what is accomplished tends to be quite limited

Table 7.1 – Summary of main findings by core theme

7.3 The nature of the managerial role of the GP and role performance

7.3.1 Learning to manage: limited formal training and an operational focus

The degree of formal management training engaged in by interviewees is limited (section 6.3.1), even with calls for such training to form part of a clinician's development (Buttimer, 2006), particularly at senior levels (Vera and Hucke, 2009). However, this is consistent with previous research, which finds little or insufficient advance preparation for the role generally (Buchanan *et al.*, 1997; Kumpusalo *et al.*, 2003) and few clinicians with formal management qualifications (Montgomery, 2001). Reasons identified in the findings for this deficit include a lack of time, a greater degree of relevance accorded to clinical training and a general lack of interest in the area. This corresponds with both existing clinician-specific (Fitzgerald and Sturt, 1992; Gallen *et al.*, 2007; Stergiopoulos *et al.*, 2010a) and small business owner (Down, 1999; O'Dwyer and Ryan, 2000) literature. In addition, interviewees cited cost and lost income, reflecting their resource-restricted context, while also indicating a rather narrow view of the potential gains from management training (Down, 1999). Amongst those few owners who have undertaken formal training is a general acknowledgement that it was beneficial at least at a basic level (e.g. preparing a cost analysis), while some non-attenders could see that it might be useful. This highlights the relevance generally of management training for clinicians (Fitzgerald, 1994; Kippist and Fitzgerald, 2010). However, evidence of engagement with training in higher-end management – such as strategy, planning or change management – even amongst owners, was lacking; the focus appeared to be on learning about operational and day-to-day aspects (section 6.3.2).

Amongst non-owners, similar deterrents are found. However, there is again an acceptance of relevance, particularly for those interviewees with near-term ownership aspirations; as Sibbett *et al.* (2003) note, a lack of management training can negatively affect the desire to take on ownership responsibility, which still remains the overall aspiration for most registrars (O'Kelly *et al.*, 2012). For those interviewees who are satisfied to delay ownership, the immediate significance of management training is lessened, questioning its usefulness at this juncture when the emphasis appears to be on learning about clinical matters and patient care (Walker and Morgan, 1996; ICGP, 2007; O'Kelly *et al.*, 2012). This is consistent with Kindig (1997) who believes that training

should wait until it is important, though contradicts calls from Hunter (1992) and Russell *et al.* (2010) for early delivery of such training. Thus, the potential for non-owners to engage with managerial responsibilities appears limited at present. This seems to arise partly from a lack of training, but also it would seem from a lack of formal opportunity to apply such learning (this is further explored in section 7.3.5). In this regard, the current study suggests that if greater scope existed for non-owners to utilise management training, this might make it more attractive and engaging (section 6.3.1), while also benefiting the practice in providing an added managerial resource.

For most interviewees, management training has been largely 'learning by doing' (section 6.3.3) and 'on-the-job' (Thorne, 2000; Devins *et al.*, 2005; Checkland *et al.*, 2011), but this might not be sufficient (Guthrie, 1999). There seems to be a preference amongst interviewees for experiential and practical approaches (Walker and Morgan, 1996; Varkey *et al.*, 2009) as opposed to anything that is perceived to be too theoretical or general (Greener and Harrington, 2010; Greener *et al.*, 2011). Generic programmes will not suffice (Hoff, 2001; Evans, 2004) and can be negatively regarded (section 6.3.2). It appears then that GPs can take a rather reactive approach to learning about management, with elements of this happening opportunistically and somewhat passively. While there is recognition amongst some interviewees of the benefits of a broader understanding (Hadley and Forster, 1995; Cowton and Drake, 2000), these were in the minority. Therefore, the predominant and preferred approach means that GPs can tend to narrowly, informally and reactively learn the role and mostly at an operational level, potentially limiting their managerial capacity. This is further considered as the tasks that constitute the role of the GP as manager are now discussed.

7.3.2 Managerial tasks performed: a comparison to previous empirical research

The findings (section 6.4.4) identify the managerial tasks undertaken by the GPs studied, with staff management, financial management and reviewing information/monitoring activities as the primary and most prominent tasks. Appendix I (p.309) outlines the eight tasks highlighted in the current study and notes previous research where similar tasks were identified, demonstrating some consistency between the findings and the literature. The contrasting low prominence accorded to the more externally directed tasks – liaison and marketing – indicates a focus on internal management and, principally, on operations. This is consistent with McKee *et al.* (1999)

and Fitzgerald *et al.* (2006) and suggests that, in terms of Fitzsimmons and White (1997), GPs focus mostly on operational management and some tactical management.

A recurring theme in previous literature is the importance of planning and strategy development for clinical-managers (e.g. Betson and Pedroja, 1989; Gatrell and White, 1997; Ong, 1998; Sherer, 1999; Holton *et al.*, 2010). Indeed, based on Fitzsimmons and White (1997), it might be argued that this is where the focus of the GP's managerial role should be. However, the findings (section 6.4.6) are mostly unsupportive of such a view. In general, the level of proactive and advance business planning in practices is limited; of the established owners, one (GP 12) had prepared a formal business plan and another (GP 21) had a plan in progress. Amongst the remainder, there was little impression that the lack of a formal plan was a key concern for them. Instead, established owners tended to engage in emergent (Mintzberg and Waters, 1985; Mintzberg, 1987), evolving and relatively informal planning by making incremental, ongoing changes but often without a particularly specific long-term goal beyond some general aspirations.

Amongst newer owners, planning was more prominent though their reasons tended to be at least partly driven by the need to obtain finance. Thus, while plans were loosely monitored and found to be useful as guides, this could be in a somewhat ad hoc manner. However, GP 35 highlighted how the plan prepared in his practice had been important as a means of identifying changes needed to adapt to environmental pressures. In a similar vein, the level of long-term strategic thinking amongst interviewees appears generally limited. Where strategy was mentioned, this was primarily in the short and medium-term and quite specific (e.g. GP 8) as opposed to anything broader (GP 19 was one of the few exceptions here, in terms of establishing a particular niche). Even at practice or partner meetings (section 6.4.8), the focus seemed to be mostly on operational matters (e.g. rotas). Thus, strategic planning appears to be of limited overall relevance and mostly emergent.

In terms of understanding the difference between the findings and the literature, research on owner-managed small businesses (Kelliher and Reinl, 2009) notes that formal strategic planning can be limited with a lack of time and resources as potentially restricting factors. This is consistent with the current study. Emery and Trist (1965) indicate that in small businesses that are not heavily exposed to change, formal long-

term planning is less important. Thus, the scale of GP practices appears to mitigate the need for, and capacity to, engage in formal planning. However, Ward (1988) and Kotey and Meredith (1997) do extol the virtues of strategic planning in small firms and evidence from some practices would appear to support this, particularly at key junctures (e.g. practice formation/expansion; changing the practice to adapt to external developments). Therefore, the limited engagement with strategic/formal planning by GPs presently could be an issue in the near future. This may particularly be the case during a period of environmental change such as arising from the ongoing implementation of the national primary care strategy and growth in team working, the planned introduction of Universal Health Care, and the rising demand for services in conjunction with insufficient supply.

Thus, as managers, GPs function mostly at an operational and internally-oriented level, with limited and emergent planning of a mainly short or medium-term and relatively informal nature. As previously noted, this indicates a narrower role than some literature would suggest, though is consistent with other studies, as well as with the primarily operational nature of GP training in management. However, as chapter two highlights, previous studies in a GP context have not typically attempted to relate the managerial work of the GP to core management theories to determine if they are, in fact, managers and to what extent.

7.3.3 The GP as manager: Activities engaged in

The findings indicate that GPs as managers are time-poor because of other demands, engage in little in the way of reflection and planning on the job, and can take work home with them. This broadly fits Mintzberg's (1973) image of managers as being highly active. However, in contrast, the working days of GPs are more patterned and structured around their core clinical work (section 6.2.3), highlighting the part-time nature of management.

The findings are considered in the context of Mintzberg's (1973) role typology to establish if GPs as managers engage in these roles[53].

53 The focus in sections 7.3.3 and 7.3.4 is on the owner; from section 7.3.5, non-owner GPs have limited involvement in management.

Figurehead – There was little evidence of this role. While the owner is clearly the 'figurehead' for the practice, specific management activities do not seem to stem from this role.

Leader – The leadership role of the GP owner is clear throughout the findings; this is a fundamental, overarching role deriving from the legitimacy of their status and position. In fact, where this role is absent, issues can arise (discussed in section 7.4.3). Thus, the 'meddling' of the GP as leader is important to both organisational harmony and effective management. Taking responsibility for staff management and maintaining relationships with members of the practice (section 6.4.4.1) is an evident leadership activity, as well as taking the lead on decisions (section 6.4.2), on the management of critical incidents and routine issues (section 6.4.3) and on monitoring performance (section 6.4.5). In this regard, as leader, the owner is active in managing multiple aspects of the business and, in most practices, visibly so.

Liaison – Mintzberg (1973) indicates that this role pertains to the interactions between the manager and those contacts over whom they may not have control, with horizontal exchange relationships formed. For owners, internal liaison is limited to interactions with other partners (section 6.4.8) and with the practice manager where they are their spouse (section 6.5.5), who collectively form the central management team; other practice members are subordinate. In this context, internal liaising is not as directly a managerial activity here as other activities, occurring more so in the background such as at meetings, as part of the collective and centralised act of managing. With regard to liaising with external contacts, while noted by interviewees as a management task (section 6.4.4.7), this appears to be accorded limited importance beyond clinical information and for social purposes (section 6.5.1). There was little evidence found of regular business networking by/with GPs. This might suggest that lower relevance may be attached to external information in supporting management, with seemingly narrow reference to outside sources (e.g. accountants). However, this role may become more significant as the GP's involvement with other professionals – who are not under their direct control (Willcocks, 2003) – increases through their membership of primary care teams.

Monitor – This is identified as a prominent activity as the GP owner is typically the nerve centre of the practice (section 6.4.2 and 6.4.3). Information tends to pass from outside the practice and from other staff through the owner, as well as from the owner's personal observations. This information is actively reviewed by the owner (section 6.4.4.3). As indicated above, their usage of external management information (Fitzsimmons and White, 1997) appears somewhat limited. Thus, the focus – from a business perspective – seems to be on internally generated practice information, including performance measurement. Generally, this is based on a relatively narrow selection of income/profit-based measures, with other measures (e.g. staff performance, patient satisfaction) less prominent. Few practices worked against targets, which is not surprising given the lack of formal planning.

Disseminator – Based on Mintzberg's (1973) description, this role entails the distribution by the manager of information to other internal parties. In the current study, the GP owner is an active disseminator in the context of passing on clinical information (section 6.4.4.3) and instructions as they make decisions and at practice meetings (section 6.4.8), as well as delegating routine work (section 6.4.7). It is interesting to note that owners seemed less inclined to share information with staff on performance and plans, apparently preferring to retain control of 'sensitive' business information.

Spokesperson – This is an externally focused role, involving the transmission of information outwards. In the findings, this role was not evident amongst interviewees in the context of their own practices. As with the lower level of involvement in other externally-oriented roles, this corresponds with the emphasis of owners on internal management.

Entrepreneur – This role, related to managing change, was present as owners regularly took action on decisions, or delegated responsibility to others. Across the interviews, there were indications of changes that had occurred in the past (e.g. acquiring a new practice/premises, reducing staff wages/hours), that were currently in progress (e.g. recruiting a practice manager; developing a practice plan) or that were being considered (e.g. introducing new services; taking on a partner). Owners were central to all of these relatively fundamental changes.

Disturbance handler – In performing this role, the manager is taking action to resolve disturbances and issues that arise (section 6.4.3 and 6.4.4.1). Establishing policies is identified as one of the tasks of the GP as manager (section 6.4.4.5), pre-empting issues and dealing with them in advance through putting procedures in place. In this respect, the owner is a 'problem solver'. At practice meetings, the role is also evident in using the meeting as an opportunity for staff to discuss concerns with the owner, who is then tasked with their resolution. The findings (section 6.5.4 and 6.5.5) provide examples of the difficulties that can arise in practices where owners are not actively involved in resolving problems and visibly making particular decisions. Thus, by allowing problems to develop and operating in a largely absentee capacity when it comes to practical matters, some owners adversely affect their practices through *not* handling disturbances.

Resource allocator – The essence of this role is making decisions regarding the deployment of resources, with three elements: scheduling their own work, programming the work of others and authorising actions. As clinicians primarily, owners tend to focus their attention on clinical matters and generally seek to devote as little time as possible to management (section 6.4.1 and 6.6.3); their resources are firstly allocated to patient service. The challenge associated with striking the appropriate balance here is evident (section 7.4.5), but mostly viewed as necessary. In terms of programming the work of others, this is readily apparent as the owner actively issues instructions to staff and engages in delegation. Regarding action approval and authorisation, again this is demonstrated by the decisive nature of owners and their desire to be involved in decisions, reflecting their central position in the practice. Indeed, two prominent managerial tasks noted (staff and financial management) entail the active management by owners of key resources. Although Mintzberg (1973) identifies budgets as relevant here, there was limited evidence of these in the current study, consistent with the lack of formal plans and a relatively fluid approach to managing.

Negotiator – This final role was not noticeably prominent. While there were some examples of the owner negotiating with staff on pay and occasionally with major suppliers (e.g. banks for funding), they do not tend to be involved in more routine negotiations (e.g. prices for supplies). Instead, the fact that the owner typically sanctions all key decisions and can delegate non-core matters suggests that they may be involved in negotiations in the background, leaving the detail to others.

Therefore, the findings indicate that of Mintzberg's (1973) roles, those that seem to be most prominent are the informational roles of Monitor and Disseminator, the interpersonal role of Leader, and the decisional roles of Disturbance Handler, Resource Allocator and Entrepreneur. In this respect, it would appear that by acting as monitor, the owner acquires information (including measures of performance) to assist in decision-making. When making decisions, their focus is on the allocation of resources and the resolution of any disturbances that arise. The outcomes of these decisions are disseminated to others and acted upon, either by staff or the owner personally, in the course of daily operations as well as in making changes. The leader role (stemming from their status) supports these other roles by giving the owner the legitimacy and capacity to acquire and receive information, make decisions, and ensure that others implement these decisions. In this manner, the leader role creates the context within which the decisional process takes place. The remaining roles are viewed as secondary, less prominent (e.g. Liaison) and occasional (e.g. Negotiator).

Thus, the focus of the GP as manager's activities appears to principally be on acquiring information for decisions, decision-making and decision implementation/dissemination. Figure 7.1 (p.193) summarises this process in diagrammatic form, with the primary roles central. To illustrate the interaction between these activities as a process, Appendix J (p.310) provides a number of extracts from interviews. In each case, the activities involved are detectable from their narrative and are highlighted; while the Leader role is not specifically identified, this is implicit in each example by the fact that these are all owners.

7.3.4 The GP as manager: Functions as the purposes of activities

Section 7.3.3 analysed the findings of this study under Mintzberg's (1973) roles and found that some activities seem to be emphasised more than others. While this is informative, in describing their work in the context of *what managers do*, this does not identify the *purposes of what they do*. Therefore, it is necessary to further analyse the work of the GP as manager using Fayol's (1988) functions.

Planning – From Fayol (1988), formal planning is important; where plans are absent, organisations are potentially exposed to mistakes as a guiding vision is lacking. However, as previously highlighted, formal business planning seems to carry relatively little interest or significance for GPs and is granted limited deliberate effort on their part, appearing instead to be of a more emergent nature or partly driven by external stakeholders' needs.

Organising – This function pertains mostly to the organisation of people by installing reporting lines and levels of authority, ensuring that these are operating effectively and that communication occurs. Consequently, staff management is key and this is a primary focus of the GP as manager, though with some aspects delegated (section 6.5). While staff selection falls within their remit, low employee numbers (on average, less than ten) make this a more occasional requirement. Thus, flat hierarchies and the small size of practices (section 6.4.2 and 6.4.3), where most of the key staff members are professionals and internal communications can be relatively informal, help to simplify this function. In addition, leadership, performance management and decision-making are facilitated by a straightforward structure that suits the nature of the organisation. However, organising does not appear to require much ongoing involvement from the owner beyond basic and relatively informal staff management. Once the structure is set, day-to-day routine activities are provided with an appropriate context within which to be performed by others through delegation, with the owner physically present and stepping in by exception i.e. on disciplinary matters. Thus, organising seems to be largely a secondary, intermittent function.

Coordinating – Through coordinating work, managers ensure that resources are appropriately scheduled and activities happen when they should. In this study, it appears that the coordination function is of relatively limited ongoing relevance to GPs as managers specifically. Although work sequencing and resource scheduling/allocation is important, GPs can tend to deal with this in a broader sense (e.g. starting/finishing times; staff appointments), as administrative staff perform the bulk of the detailed, daily coordination (section 6.5.3). This does not encroach on the clinician's work as the overall parameters remain under GP control. Fayol identifies regular formal meetings as an important means of coordination. The findings indicate that practice meetings are routinely used for this purpose, though do not seem to consume a great deal of the

owner’s time or work effort, with such meetings appearing to take place weekly at most. Thus, similar to the planning and organising functions, coordinating appears to be a mostly secondary, routine and somewhat occasional management function for GPs. However, as with the Liaison role, it is possible that coordinating may become more complex, time-consuming and significant for GPs as their participation (DOHC, 2001) in primary care teams increases, arising from the need to arrange patient services amongst larger groups of independent healthcare professionals.

Commanding – From Fayol (1988), commanding entails the manager serving the best interests of the organisation through the utilisation of the staff at their disposal. As manager, the GP owner is in command and is the authority figure, as their management style (section 6.4.2) and their active involvement in and proximity to staffing matters and issues demonstrates. Some consultation and participation is engaged in, though the owner’s approach to 'command' does appear to be relatively traditional. In this regard, the extent of actual empowerment of others seems quite limited, which can create a burden on the busy, clinically-active owner. Thus, team working in a management sense across the practice appears relatively uncommon. Indeed, non-owner GPs can view this positively, seemingly preferring it when the owner is actively in command organisationally (sections 6.5.4 and 6.5.5), while allowing them considerable clinical independence personally. Delegation does take place, which tends to be of low-level and non-core work, as staff keep the owner informed at meetings and in the normal course of events.

Controlling – Controlling entails checking and monitoring various aspects of the operation of the organisation, and taking action to correct any issues that arise. The GP owner is generally dominant in their practice and central to all aspects of management; while there is some involvement by others, this is primarily in the form of support, information and input/opinion (section 6.4.2, 6.4.3 and 6.5). In some practices, control is shared to a greater extent with the practice manager, particularly when they are the owner’s spouse (section 6.5.4). However, the owner still remains active and involved in this situation. Therefore, owners are largely in control – and typically seek to be – and the findings present numerous supporting examples of this throughout sections 6.4 and 6.5. The lack of formal planning and budgets does not appear to adversely affect their capacity to control at present; their closeness to the work and the small size of the

organisations seem to mitigate the need for considerable formality and allow for more incremental development. Instead, the owner is able to reactively monitor and control activities, and address problems through their daily and central presence.

Having considered the five functions in the context of the findings, it would appear that the focus of the GP as manager is on 'command and control' (Figure 7.1, p.193). This then suggests that the activities (section 7.3.3) that they engage in are predominantly focused towards the dual purpose of directing the practice effectively and making sure that control is maintained[54]. In essence, this might be viewed as getting done what is required (commanding) and ensuring that what is required is ultimately done (controlling). Less effort and importance is currently devoted to other functions which are regarded as either largely unnecessary or of lesser value (planning), of intermittent relevance (organising), or best left to others (coordinating). Thus, as with the secondary activities identified, secondary functions are addressed, but not with the same apparent prominence as commanding and controlling.

Indeed, it may be the case that functions such as planning and organising become more relevant when changes are being made or innovations introduced. Evidence of this can be found in section 6.6.2.2 where GPs 28 and 35 illustrate how new services were introduced, each of which entailed some degree of advance planning (even if of a limited nature), and would have required staffing adjustments internally to implement (e.g. assigning responsibilities). In this context, and acknowledging the fundamental changes facing Irish practices, it is conceivable that those which are currently secondary functions may become more prominent as these small organisations grow and become more complex (Greiner, 1998; O'Dowd *et al.*, 2006a; Checkland and Harrison, 2010).

7.3.5 The relevance of GP career stage in a management context

A theme permeating throughout the discussion is the significant involvement of owners in management and the corresponding relatively limited participation of non-owners. While, clinically, owners and non-owners perform similar tasks (section 6.2.3), when the work is of a managerial nature, owners are dominant and can be less inclusive of

54 In Appendix J (p.310), the researcher provides examples to illustrate this, by identifying the purposes of specific activities engaged in by GPs as managers. These help to highlight the routine prominence of the 'command and control' functions, but also demonstrate that – particularly for more fundamental, though less regular, decisions – other functions of management are sometimes relevant.

others (section 6.4). The exception to this tends to be when employees are being prepared for future admission into the partnership.

In the current research, some evidence of the stages of Dalton *et al.* (1977) and Dalton and Thompson's (1986) career stages model is found. However, while the expectation might be that owners function at Stage IV – directing others, developing strategy, liaising externally, exploring new ideas and moving further from the professional role – the study finds inconsistencies here. There is evidence from the findings of owners providing direction, networking clinically and socially (though less commonly in business terms), and innovating at times (e.g. hiring in specific skills). However, they remain highly active in the professional role while also managing operations, guiding others and retaining a mostly internal focus. In this respect, they may be closer to a Stage III professional, with limited emphasis on formal strategy and planning. Non-owners who are transitioning into management appear to be early occupants of this stage, taking on some responsibilities and can be more participative in decisions. Otherwise, non-owners are Stage I/II professionals, as trainees/colleagues with limited managerial involvement.

This would indicate that, unlike the professions studied by Dalton and colleagues (which did not include clinicians), the managerial career structure in general practice is narrower and provides less opportunity for GPs to develop relevant skills in advance of ownership. Indeed, this lack of opportunity seems to be a factor in non-owners' limited emphasis on managerial training (section 7.3.1; Gallen *et al.*, 2007). Such non-involvement may partially stem from reluctance amongst owners to relinquish responsibility and make the transition into a broader 'director' role, because this might remove them from their preferred clinical/care role.

Thus, career stage is relevant in the context of GPs, as their managerial involvement is greatest at latter stages and virtually absent at early to middle stages, with a noticeably steep transition in between compared to some professions where interim supervisory roles are more common (e.g. accounting). Consequently, as a support to the managerial role, non-owners can have limited current relevance, aside from those who are owners-in-waiting. In this regard, Gerada's (2008) suggestion that non-owner GPs could

contribute to a greater extent to management might be beneficial to time-poor owners (section 6.6.1) and potentially then facilitate a broader role for senior GPs. A more prominent source of assistance presently is the practice manager.

7.3.6 The practice manager as 'managerial' support

From the findings, the role of the practice manager is wide in an administrative sense (Laughlin *et al.*, 1994) but narrow from a management perspective (section 6.5.2 and 6.5.3). The evolution into broader management in some UK practices (Laing *et al.*, 1997) is not as apparent here, while the suggestion that practice managers have limited strategic involvement in their practices (Fitzsimmons and White, 1997) is generally supported. Under Verrill's (2005) typology, 'transitional' managers are identifiable in the findings, operationally managing at a low level, while the 'traditional' manager, who is primarily an administrator, is also prominent. This does not underestimate the importance of the role; having a 'buffer' between the patient and the clinician (also section 6.6.2.3) and an informational role in keeping the owner abreast of matters is valuable. However, this could suggest a lack of ambition amongst GPs for the full 'managerial' potential of this role. Thus, although the numbers of practice managers in Ireland are increasing (Bourke and Bradley, 2010), and the usage of such supports is clearly a positive move, there may be scope for this resource to deliver further value to GPs faced with extensive and growing job demands (Bakker and Demerouti, 2007).

While some practice managers are identified in this study as having responsibility for administrative staff and their work (Westland *et al.*, 1996), they possess no real authority over the activities of the doctors (Laing *et al.*, 1997), who appear to want to retain control over how they function. A domain where practice managers had authority was the management of 'front-office' activities (section 6.5.3 and 6.5.4), where they also had influence in coordinating clinical work and facilitating the GP's workload. However, this also reflected a domain where conflict with clinicians was less likely to arise (Raelin, 1989). Managerial decisions can involve the input of the practice manager and the findings indicate that some owners do engage in more extensive 'shared' management (section 6.5.4), particularly in larger and more structured practices (King and Green, 2012) or where the practice manager is the owner's spouse. Therefore, there is some limited evidence here of relatively 'progressive' managers (Verrill, 2005) as they engage or co-engage with management and make a greater contribution. However,

it is important to note that the GP owners themselves remain managerially active in these practices.

Amongst owners generally there appears to be little obvious interest in widening the practice manager role, even though they acknowledge their own workload issues (see section 7.4.5). The findings are consistent with the literature (Checkland, 2004; Florén, 2006), with an apparent reluctance amongst most owners to cede significant control. As Fitzsimmons and White (1997) highlight, GPs may not be willing to accept being managed by a non-clinical person who lacks legitimacy (Verrill, 2005). This potentially creates a challenge for the practice manager, who has little opportunity to make fundamental decisions (Newton and Hunt, 1997), thus limiting the ‘managerial’ scope of the role (Hales *et al.*, 2012). The findings do illustrate that benefits can accrue from the involvement of a dedicated manager (Checkland *et al.*, 2011) in relieving GPs of routine tasks and activities. However, sections 6.5.4 and 6.5.5 also demonstrate that an overly ‘managerial’ practice manager can create issues through excessive bureaucracy and formalisation (Henslin, 1999; Exworthy *et al.*, 2003) and an inappropriate focus (Ritzer and Walczak, 1988); this is further discussed in section 7.4.3.

Overall, the managerial support provided by the practice manager can appear somewhat limited and variable in many of the interviewees' practices. The findings suggest that GPs largely use ‘managers’ as ‘administrators’, with a focus on low-level and operational work. In this regard, the practice manager’s work supports and facilitates, but does not interfere with, that of the GP (Calnan and Williams, 1995) who retains control (Calnan *et al.*, 2000). Thus, while there is merit to their presence in an administrative capacity, the ‘manager’ title may be overstated, reflecting an underutilised, yet readily available, resource.

There may be an argument in the current study for expanding or enhancing the role of the practice manager through delegating increased responsibility, given that lay-managers are conscious of the importance of patient care (Granter and Hyde, 2010) and that the roles/functions addressed by GPs (section 7.3.3 and 7.3.4) are typical of 'traditional' managers. This may necessitate further training, or practices could contemplate engaging specific ‘business managers’ in addition to, or instead of, ‘practice managers’ (subject to resources). By enhancing the scope of the lay-manager

role, and enabling greater delegation from the GP, issues identified of limited time and excessive workload can be mitigated. This allows the GP to place additional focus on the clinical role (in light of impending demand pressures; Thomas and Layte, 2009), or on higher-end management, such as strategy, change, planning, and managing teams, and obtaining formal training in these areas. However, this is premised on owners relinquishing greater control, something at present they appear less than inclined to do.

7.3.7 Linking activities and purposes: Decisional control

As outlined in chapter two, past literature supports the use of role-based (Mintzberg, 1973) and function-based (Fayol, 1988) approaches in studying the work of managers. However, both have their limitations and represent rather static approaches to understanding management. Carroll and Gillen's (1987) integrating model of management indicates that a more complete picture is possible, by combining these approaches as part of a process. Other authors reinforce this association (Fells, 2000; Lamond, 2003; 2004).

Bringing together the discussion in sections 7.3.3 and 7.3.4, the link between the roles (*activities*) and functions (*purposes of activities*) of the GP as manager is proposed as 'decisional control' (see Figure 7.1). This indicates that the focus of the GP (primarily the owner) is on making the key decisions to ensure that control is maintained in a manner that best suits their overall agenda and intentions (see section 7.5). The owner declines to pass significant responsibility for this to others, instead centralising decision-making. As formal planning is limited, retaining control over decisions allows owners to shape the practice in an emergent manner. The practice manager and administrative staff are supports in the overall process, providing information and assistance, implementing instructions, coordinating workflow, and managing the front office, though with limited involvement in actual decision-making and control in most practices. Thus, by generally maintaining dominance over the decision process, the GP attains 'decisional control', which allows them to achieve their desired purpose of overall command and control of the organisation. As a consequence, it is argued that the GP as manager's role can be described as one that entails both operational oversight (delegating detailed and routine work, but heavily involved in what are largely operational decisions) and close control (the dominant managerial force, 'on the ground' and active in the practice).

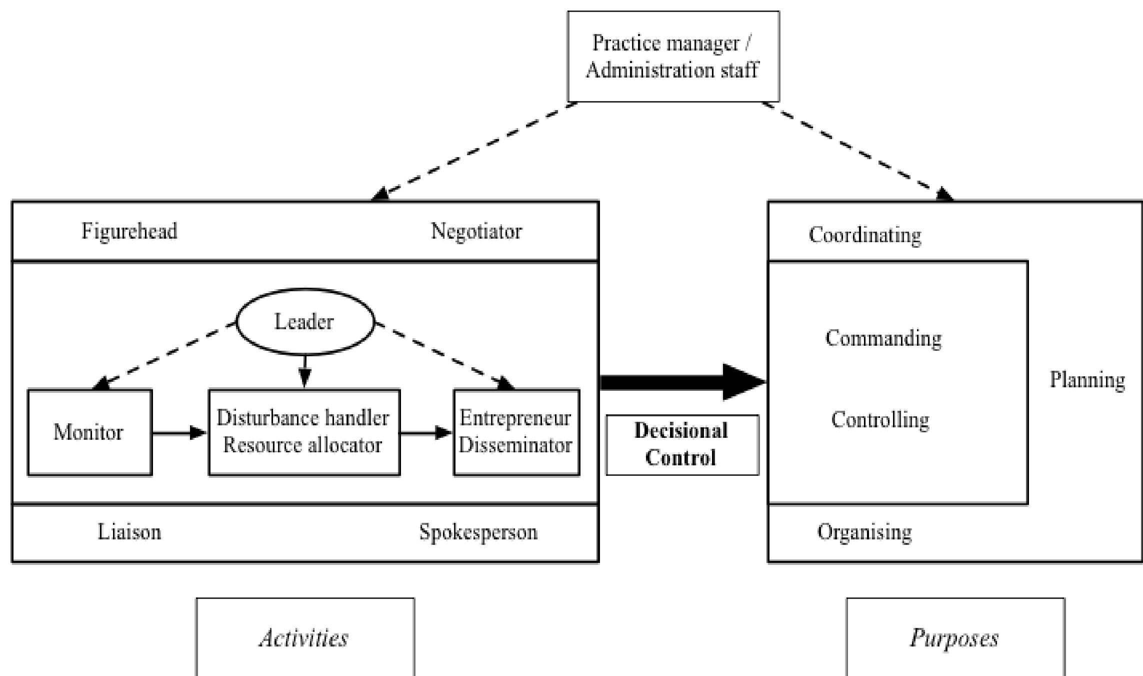

Figure 7.1 – The GP as manager: Linking activities and purposes

In essence, the underlying management approach adopted is quite traditional. However, this also appears to reflect a streamlined approach (Fitzgerald and Sturt, 1992) in that owners do not tend to focus on roles/functions that they regard as less critical (Hall, 1972). For example, as formal strategic planning is accorded limited prominence, so liaising in the external environment has reduced relevance. The emphasis, instead, is on operational management. Given their time-poor nature as practising clinicians (see section 7.4.5), such prioritisation is perhaps understandable. However, because of their desire for control of decision-making, this approach is also restrictive as they are ingrained in management at a day-to-day level rather than adopting a broader and more strategic involvement.

This raises the question as to why the GP owner manages in such a controlling, even limiting, fashion. Previous literature emphasises the importance that the professional accords to being autonomous (Brint, 1993; Spyridonidis and Calnan, 2011), with patient care a factor for clinicians (Jochemsen and Ten Have, 2000; Majorbanks and Lewis, 2003). Therefore, freedom is preserved to practise as they see fit, not being subjected to the control of non-peers (Ritzer and Walczak, 1988) who may have conflicting priorities

(Stone, 1997). Consistent with Hall (1968) and Scott (1982), the GP practice (as an autonomous professional organisation) is structured in a manner that preserves professional autonomy as GPs are dominant, with others in a subordinate and support capacity. Where practice managers have some authority, this is principally over administrative staff or, less commonly, shared with owners. In this context, the practice as a business entity is professionally-controlled and typically protected from non-professional interference (Ritzer and Walczak, 1988; Majorbanks and Lewis, 2003), while individual practitioners still retain clinical autonomy to make patient decisions.

Thus, the study suggests that owners can emphasise autonomy over bureaucracy in line with a traditional professional ethos, though retaining autonomy not only at an operational level but also at a strategic and, to some extent, an administrative level as well (Raelin, 1989). A dislike of excessive bureaucracy and formalisation (Henslin, 1999; Hales, 2002) and loss of control (Majorbanks and Lewis, 2003; Spyridonidis and Calnan, 2011) appears to be of greater importance to interviewees than potential efficiency benefits (Freidson, 1984), mitigating their willingness to pass on significant responsibility. This is the case even with a preference amongst interviewees to focus principally on clinical work (Kippist and Fitzgerald, 2009), reflecting a somewhat paradoxical situation of GPs as reluctant (section 7.4.3) and time-limited (section 7.4.5) managers. However, it is also apparent from the findings that owners are willing to cede some control to lay persons as long as they operate in non-core areas (e.g. routine administration and 'front-office' management) and in a supportive, non-interfering way (Mintzberg, 1981; Raelin, 1989). This is consistent with past literature, which found that erosions of autonomy that do not negatively affect patient care are accepted (Locock *et al.*, 2004), representing a form of 'enabling' bureaucracy (Adler and Borys, 1996) where processes support the work of the professional (Checkland, 2003). In this regard, the managerial role of the GP is shaped both by their traditional desire for autonomy and an appreciation of the merits of subordinate-staffed support structures.

Literature on small businesses draws attention to the fact that owner-managers play a key role in management and decision-making (Kelliher and Reinl, 2009). Consistent with Florén (2006), delegation in GP practices is found to be limited in the context of management work; a tight and centralised core prevails. Therefore, as GP owners are

professionals and owner-managers, their dominant approach to managerial control and decision-making reflects this crossover. Supports are utilised but typically to a limited extent, which may indicate that scope exists to reduce managerial involvement for those willing to engage in shared responsibility and relinquish greater control; some evidence of 'sharing' was detectable in a small number of practices. This would be more reflective of Scott's (1982) conjoint professional form, allowing GPs to focus on patient care and managers to function at an organisational level more so as equals, overlapping and interacting as required. Currently, though, along the professional-bureaucratic continuum (Malhotra and Morris, 2009), GPs feature largely at the professional end in terms of practice structure, approach to control and ethos, tempered with some limited supporting and mostly subordinate bureaucracy. However, functioning in this manner can have implications for the GP, as the next section explores.

7.4 The interaction of the managerial role with the professional role of the GP, the conflicts that arise and implications for the GP as manager

7.4.1 Commercial-Professional Conflict: Seeking to balance opposing values

Interviewees acknowledge that, although they are caring clinicians at their core (IMO, 2007; Vera and Hucke, 2009), they also operate at a commercial level (Fisher and Best, 1995; Descombes, 2002; Lynch, 2012). As GPs, they incorporate two potentially opposing ideologies – the community oriented professional and the more individualist, organisational member (Barber, 1963). These represent different underlying values and priorities and, in this sense, may be incompatible (Derber, 1983; Pierce and Sweeney, 2004; Perry, 2010). Consequently, the 'business of caring' (section 6.6.2) can be a challenge for the GP as they fill a commercial role in addition to their professional role. This is a prominent managerial role as GPs actively engage in financial management, performance measurement, service planning and service development. In this regard, the commercial role entails managing service innovation and the generation of resources, focusing primarily on earning a profit.

GPs at all career stages seem compelled to address the dual goals of patient care and profit generation (section 6.6.2.1). Priorities are mixed; serving the interests of the patient is critical, but so is business growth and sustainability as other interests are also relevant (e.g. self, staff, family). This creates a possible dilemma, as too much emphasis

on one to the exclusion of the other may have adverse effects. Generally, the patient's needs are prioritised, reflecting an underlying patient-centred ethos. However, decisions pertaining to closing patient lists, restricting the extent of the practice radius, cutting/retaining services and adopting cost-effective initiatives (section 6.6.2.2) reflect the realities of what the business can sustain; to serve the needs of patients, the practice must be viable. Indeed, the choice to become an owner (section 6.2.4) is partly founded upon attaining greater financial security, which also brings with it increased commercial responsibility (Parasuraman and Simmers, 2001).

Decisions relating to the provision of additional services (section 6.6.2.2) were initially presented as for the benefit of patients, but when the explanations provided by GP 28 and 35 (both on the verge of partnership) are considered in greater depth, it is apparent that an emphasis is placed on both patient and practice interests. This is not in any negative sense, but demonstrates that commercial logic is applied to patient care decisions. Thus, both perspectives are acknowledged, as without patients there are no profits, but equally with no prospect of financial returns, scope to deliver enhanced or improved services may be limited.

This dual emphasis was also apparent in the context of the sensitive issue of patient payment (section 6.6.2.3) where commercial reality dictates that people pay while recognising that this may be somewhat contrary to a ‘caring’ ethos. As a public manifestation of their commercial role, GPs possess a 'buffer' (administrative support) that limits their need to personally address payments with patients; some owners even spoke of 'management' in this manner as something external to them. This buffer was not required when making commercial decisions, as these happened in private. Thus, while acknowledging that delegation of payment responsibility to non-clinical staff is administratively efficient, it is also contended that this helps to mitigate any sense of discomfort.

Based on the preceding discussion, this study suggests that GPs experience a form of person-role conflict (Kahn *et al.*, 1964), arising from acting in both professional and commercial roles that have different underlying value orientations and expectations. From the findings, the GP – and owner in particular – operates at the intersection of these roles as they seek to reconcile making profits with delivering care. The existence

of a dual orientation amongst professionals is consistent with Bartol (1979), Aranya and Ferris (1984) and Hoff (2001), who contend that an individual can be committed to both organisational and professional interests without necessarily experiencing conflict. Indeed, such a balanced commitment is argued to be organisationally beneficial (Baugh and Roberts, 1994). Amongst senior personnel/owners (Aranya and Ferris, 1984; Hoff, 1999b; Suddaby *et al.*, 2009), a greater commitment to the organisation is possible compared to those at lower levels, consistent with an increased vested interest in success (Becker, 1960; Cheraghi-Sohi, 2011).

Research in the retail pharmacy domain (Kronus, 1975; Chappell and Barnes, 1984; Smith *et al.*, 1985) has examined conflict between professional and commercial/business roles, with studies indicating that a balanced orientation is possible for pharmacists and conflict is not inevitable. However, for GPs, this may not be as natural given their traditional prioritisation of the patient (Pellegrino, 1999; Medical Council, 2009); as GP 10 described, there is a 'tension' between their dual orientations. Indeed, the use of a 'buffer' when dealing with payment can be seen as evidence of actively managing public elements of this tension. A possible interpretation for such a difference is that pharmacy is perceived as a more 'commercial' profession (Hughes and McCann, 2003). This might suggest a greater degree of acceptance amongst pharmacists with adopting a business orientation than perhaps is the case in general practice.

A value conflict can be experienced by GPs at a commercial level in the current study, reflecting Kippist and Fitzgerald (2009) and Perry (2010). However, interviewees also appear to acknowledge this as an unavoidable consequence of the nature of general practice as a business. In this respect, there seems to be an acceptance that some level of dual-commitment or balance is required as the roles are linked, even if they do recognise potential conflict between the core values underlying each. Thus, although not fitting together perhaps as comfortably as in pharmacy, the GP as manager demonstrates the importance of their commercial and professional roles by undertaking and reconciling both. This is particularly critical for owners, given their personal vested interest in practice performance.

7.4.2 Part altruistic, part self-interested: the 'balanced' GP

Further illumination with regard to understanding the owner's attitude towards the relationship between their professional and commercial roles can be found in contemplating the core professional value of altruism (Hodson and Sullivan, 2012). From Piliavin and Charng (1990) and Wakefield (1993), altruism exists when the actor's behaviour entails some form of personal act for another's benefit. This represents their primary reason for acting; secondary motivations may exist, though the presence of payment or incentives can generate suspicions regarding the true nature of one's motives (Badhwar, 1993; Lin-Healy and Small, 2013). Research from the medical sphere provides some support for the existence of altruistic tendencies amongst clinicians in seeking to meet the care needs of patients (e.g. Spoor and Munro, 2003; Gartland and Carroll, 2004; O'Donnell *et al.*, 2011). However, there is also evidence of possible self-interest and the influence of financial incentives (e.g. Croxson *et al.*, 2001; Roland *et al.*, 2006; McDonald *et al.*, 2010). In this respect, the literature appears somewhat inconclusive as to which perspective, if any, is dominant. The current study brings some contextual clarity to this debate.

The preceding discussion (section 7.4.1) suggests that GPs are neither wholly altruistic nor wholly self-interested in filling both a professional and commercial role. This study is supportive of a more middle-ground orientation, with elements of altruism (patient) and self-interest (profit) co-existing (Jensen, 1994; Bishop and Rees, 2007; Perry, 2010; Maier and Shibles, 2011). Based on Downie (1986a), it is reasonable that the GP engages in the pursuit of profits without being unduly self-interested. Gillon (1986a) extends this by asserting that the doctor's treatment of patients, as a moral professional duty, is at least part altruistic and then only part self-interested. In this case, Gillon (1986b: 172) defines altruism as "for the benefit of others", which is more moderate than some traditional views (i.e. gains are *not* excluded) but also consistent with a middle-ground perspective. This recognises that the notion of 'pure' altruism – where the patient's needs are the sole motive and the anticipation of money does not come into the reckoning – is difficult to sustain in a caring profession that is also a business (Godager and Wiesen, 2011).

The current study contends that this presents a more realistic picture of the GP, which does not eliminate the possibility that the individual can exceed their obligations, but

simply that this is not the expectation. Instead, the GP should satisfy the patient's interests because the fulfilment of this moral obligation is linked to their own interests, and thus they should continue to seek further ways in which to profitably serve. This represents a virtuous cycle, as the GP needs profit to continue to grow and survive. Attaining profits benefits patients through the GPs continued availability, as well as their capacity and motivation for service enhancement, reinvestment and growth (Mechanic, 1975; Le Grand, 1997). However, profitability is also contingent on suitably serving the patient and their continued presence as a patient of the practice, controlling levels of self-interest. Excessive commercialism evidently does not fit well with GPs and, rationally where it exists, may adversely influence patient retention (Hausman and Le Grand, 1999). Consequently, the absence of some degree of reasonable self-interest may be indirectly harmful to the needs of patients and, therefore, not ultimately 'altruistic' as the poor performance or failure of the practice is not to the benefit of patients.

Thus, undertaking both a commercial and professional role can be challenging for the GP. However, reconciling the underlying values associated with each, and acknowledging how they relate as well as conflict, helps to reinforce the importance of engaging with and balancing both roles. The personal involvement of the GP in striking this balance should assist in addressing concerns raised (Mechanic, 1996; Relman, 2007) as to the commercialising of medicine and the marginalising of the patient's interest; a dominant non-professional with a different agenda might not seek such a balance (Ritzer and Walczak, 1988). As an advocate of both the patient and the practice, the GP as 'commercial' manager recognises the essential inter-relations between their roles and can ensure a shared prioritisation, protecting the interests of both in the process. Thus, the overall view of GPs as being broadly altruistic remains valid, though needing to be tempered with self-interest in presenting a more realistic perspective as 'part altruistic, part self-interested', with both motives present (Batson and Powell, 2003).

7.4.3 Operational-Professional Conflict: The 'reluctant manager' and the burden of legitimacy

In addition to their commercial role, the findings indicate that most GPs also undertake operational duties, with a primarily internal focus. Features of this operational role[55] include administrative tasks, staff management, reviewing information, systems management, setting policies, managing facilities and meeting management/participation. Therefore, the operational role entails managing service provision and the usage of resources, focusing primarily on running the business.

However, the limited interest of most GPs in such work is evident (section 6.6.3) as they can view elements of this role as a nuisance and a distraction from their primary patient role. This is also apparent by their desire to delegate routine non-clinical aspects to others, as well as a lack of significant motivation for undertaking formal management training. In spite of this, there is an acknowledgement that a complete avoidance of this work is not in the interests of the practice, consistent with Fitzgerald (1994), Schneller *et al.* (1997), OHM (2002) and Dickinson and Ham (2008) who emphasise the benefits to the organisation of involving doctors in management. The findings suggest that owners broadly accept their responsibilities as managers as being necessary and aligned with the goals and interests of the organisation, even if this is not what they would prefer to be doing. Amongst non-owners, this is less of a concern as their involvement, beyond some clinical administration, tends to be limited. Thus, the main focus here is on owners.

The limited interest by GPs in practice management from the findings corresponds with previous literature (Hunter, 1992; Dopson, 1994; Gatrell and White, 1997), suggesting the presence of few real ‘investors’ (Forbes *et al.*, 2004) or ‘enthusiasts’ (Willcocks, 2004). No organisationally harmful motivations for taking on the role (Hoff, 1999b) are noted, which is unsurprising given their status as owners. It may therefore be argued that GPs, as largely ‘reluctant’ (Scase and Goffee, 1989; Dopson, 1994) but nonetheless accepting operational managers, demonstrate role captivity (Pearlin, 1989). GPs can experience this as a form of role conflict, whereby attending to the operational needs of

55 The role also encompasses the more routine ‘commercial’-related elements engaged in, such as counting cash and writing cheques, which some owners appear to retain as part of their responsibilities.

the organisation is inconsistent with the immediate and prioritised needs of patients[56]. This is not an issue of time specifically, but one of being distracted from what they prefer to be doing by virtue of holding dual roles; even with additional time, it is doubtful that the sense of limited interest would fundamentally recede.

Evidence is also found of adverse consequences in a small number of practices where the GP is less active in management and the practice manager unusually dominant. In these practices, the GP chooses to focus on their professional role and passes on primary responsibility for meeting the operational role. GPs regard the owner as the legitimate authority figure, and view overall management as the dominion of clinicians. In each of the negative cases identified (section 6.5.4 and 6.5.5), the central issue could be traced to the 'absentee' nature of the owner on practical operational issues such as staff discipline and addressing systems issues. While it was perceived that the owner might manage in the background, their lack of involvement and apparent interest in matters of importance to the interviewees (extending beyond personal concerns e.g. service quality, inefficient practices, patient interests) was a source of considerable dissatisfaction. Essentially, as a consequence of their choice to delegate away operational responsibility, these owners facilitated a somewhat conflicting relationship between the clinical and managerial/administrative domains of the practice, the latter of which they sought to distance themselves from. In this respect, while focusing on meeting their professional goals (patients), they were avoiding responsibility for operational goals (running an effective, efficient and harmonious business). This contrasts with the more typical scenario identified where the owner retains responsibility as this is expected of them.

Thus, it is contended that where the owner maintains overall operational responsibility, they are acting as a ‘boundary spanner’ and ‘mediator’ (Kindig, 1997; Spyridonidis and Calnan, 2011) between organisational and professional interests and goals. Previous research (Ham and Dickinson, 2008; Witman *et al.*, 2011) warns that occupying such middle ground can be challenging for the clinical-manager, as colleagues may question their loyalty and consider them as ‘defectors’ to management (Hallier and Forbes,

56 The contention here is *not* that the operational role is inherently inconsistent with the professional role, as naturally the patient is best served in a well-run practice. Where the inconsistency arises is because the same individual, who has a clear preference for one, is addressing *both* roles.

2004). However, colleagues can also view operating on the boundary in a positive sense, where they function as a ‘protector’ of professional and patient interests (Kindig and Lastiri, 1986; Buchanan *et al.*, 1997; Joyce, 1998; Hoff, 2001).

The findings show the owner as being typically an active and involved operational manager, ‘protecting’ professional and patient interests from potentially inappropriately focused lay-management control; in fact, 'defectors' appear to be those who are not active and involved. As ‘boundary spanner’, the owner internalises conflict (Thorne, 1997b; Kippist and Fitzgerald, 2010) by somewhat reluctantly accepting the burden of operational management because it is expected of them as the legitimate manager. This avoids an alternative form of conflict as GPs and non-clinical staff members do not therefore clash over issues that they have different perspectives on. As authority figure with positional legitimacy, the owner resolves any issues by taking charge, making decisions and instructing others. In this sense, they address organisational goals at an operational level, by ensuring that the business is properly run in conjunction and compatible with professional goals and values.

However, this can give rise to a form of inter-sender conflict (Kahn *et al.*, 1964; Floyd and Lane, 2000) as the owner is under pressure to be available to patients for consultations and also to staff to address operational issues, which may be concurrently incompatible expectations (Biddle, 1986; Kippist and Fitzgerald, 2009). This can be a challenging endeavour, as they attempt to alternate between dual roles (seeing patients is not managing and managing is not seeing patients; meeting the expectations of one is not directly meeting the expectations of the other) and mentally and physically 'wear two hats' (Thorne, 2000; McConnell, 2002). However, this is a responsibility that most owners tend to accept as important and undertake, even if it is with some reluctance and limited interest.

Therefore, Operational-Professional Conflict arises for owners as role captivity (Pearlin, 1989) because the GP reluctantly takes on operational roles, and as inter-sender conflict (Kahn *et al.*, 1964) as this is expected of them in their capacity as the legitimate manager, while also being expected to fulfil their professional role. Bearing in mind the possibility that GPs may be able to relieve some of their workload through greater delegation, this would require the ‘legitimisation’ as managers of those taking a share of

this burden, as well as their ongoing monitoring in terms of the suitability of their managerial approaches. Otherwise, as has been found in some practices, the resolution of one conflict may create another.

7.4.4 Organisational-Professional Conflict: two dimensions rather than one?

This study therefore identifies separate conflicts between the GPs commercial and professional roles and between their operational and professional roles. Collectively, their commercial and operational roles represent the organisational role of the GP, encompassing both administrative and managerial tasks. Previous research (Aranya and Ferris, 1984; Shafer *et al.*, 2002; Kippist and Fitzgerald, 2009; Fitzgerald and Dadich, 2010) has addressed the concept of Organisational–Professional Conflict. This is typically regarded as an inconsistency experienced by the professional between what the organisation and profession expect of them by way of behaviour, as goals and values may not be aligned. Findings emanating from the current study suggest that Organisational-Professional Conflict can also be viewed as consisting of two separate (though related) forms of role conflict. While these organisational roles are linked, the manner in which each role conflicts with the professional role differs. In this context, the commercial role conflicts because of a different value orientation when faced with an underlying professional ethos, while the operational role is in conflict because of the actor's reluctant acceptance of the need to generally engage in dual roles with goals and expectations that are difficult to both meet together.

Thus, it is suggested in the current study that Organisational-Professional Conflict, as opposed to being viewed and measured as a single dimension (Aranya and Ferris, 1984; Shafer, 2009) might also be conceptualised and studied as consisting of Commercial-Professional Conflict and Operational-Professional Conflict as separate but related dimensions. In fact, this builds upon Gunz and Gunz's (1994; 2007) contention that the original items used by Aranya and Ferris (1984) are measuring different constructs, but are treated as a single dimension[57].

57 In Aranya and Ferris (1984: 7), the measure of Organisational-Professional Conflict is based on one item ('*The type and structure of my employment framework gives me the opportunity to fully express myself as a professional*'), with a second item used to evaluate the subject's response ('*In your organization, there is a conflict between the work standards and procedures of the organization and your own ability to act according to your professional judgement*'). Gunz and Gunz (1994; 2007) use both items and report separate results, finding them to be generally consistent with each other.

7.4.5 Overload: a lack of time to do what has to be done

This study has identified that the GP as manager has three potential work roles – commercial, operational and professional. However, actively combining these roles, and seeking to meet the expectations associated with each, can create further difficulties. One of the key challenges identified by those GPs with an involvement in management was a lack of available time for the managerial role (section 6.4.1) because of other pressures, most notably their primary clinical role. Thus, the findings (section 6.6.1.1) demonstrate that, in the work domain, GPs – particularly owners – are exposed to potential role overload as they are tasked with multiple expectations that they can struggle to achieve in a limited timeframe (Coverman, 1989; Lindberg and Wincent, 2011). Consistent with Dawson *et al.* (1995), Harrison and Miller (1999), Willcocks (2004) and Checkland *et al.* (2011), managerial and administrative responsibilities absorb time, which is already limited. This can hinder the clinician from carrying out what they regard as their primary clinical duties (Hunter, 1992) and may place a strain on the individual (Rout, 1996; Rout *et al.*, 1996).

Role theory predicts that, when faced with conflict, actors can seek to make a choice between roles (Van de Vliert, 1981). While the findings indicate that the clinical role is their overall priority, GPs acknowledge that they are typically, even reluctantly, obliged to address other expectations as well. For owners, this includes the demands of management. Enhancing role performance through training (Hall, 1972; Kippist and Fitzgerald, 2009) is a possibility, though again a lack of time appears to mitigate this as an option amongst interviewees (section 7.3.1). Instead, a compromise can be made by GPs between their roles, through prioritising and scheduling their work and different aspects of this (section 6.6.1.2; Sofer, 1970; Bergin and Savage, 2011). This highlights how avoiding one or other role completely, or inadequately attending to what is required, is not feasible when both are salient (Van de Vliert, 1981; Hales *et al.*, 2012). The findings indicate that attempts may be made to address this compromise in work (e.g. protected time, working through breaks and between consultations), but that this is not always successful. Consequently, other outlets may be necessary.

Subsequent studies (Brierley and Cowton, 2000; Shafer *et al.*, 2002; Shafer, 2009) have been known to use both items as part of a single Organisational-Professional Conflict scale.

While the tradition in general practice was of an often 24-hour role, this has changed with the advent of 'out-of-hours' services. Thus, although spill-over of work into the home was previously an almost accepted fact for many GPs (Nic Gabhainn *et al.*, 2001; O'Dowd *et al.*, 2006b), contemporary structures facilitate more regular hours (O'Dowd *et al.*, 2006a) which is an important attraction of general practice (section 6.2.2; Jones and Fisher, 2006). In spite of this, the findings suggest that owners can still appear compelled by their workload to address some aspects at home (Gilliland *et al.*, 1998), given their responsibility for both management and clinical work. Thus, the home domain is a source of potential relief for non-clinical duties (section 6.6.1.2) as demands are rescheduled and support is availed of (Bakker *et al.*, 2005). While established owners appear to be somewhat inclined to do this, the actual work performed is limited with paperwork, decision-making and some reflection on their work being the most prominent activities. Amongst newer owners, a similar approach is adopted, though they appear to be less inclined to bring work home, while non-owners take an even harder line on this, facilitated by their lack of managerial involvement. Consequently, as a source of relief for overload, stemming from responsibilities that are not directly clinical, the home domain is limited and may be declining.

Thus, as the findings indicate, attempting to meet multiple expectations within the context of limited available time proves challenging, which suggests that the potential experience of role overload is linked to the choices made by GPs in being both managers and clinicians. Amongst those without an active managerial role, time appears to be less of an issue (with administrative tasks their most notable non-clinical burden), suggesting that the absence of one or other role and associated expectations and responsibilities (e.g. through delegation) could reduce the risk of overload. Therefore, it is important to comprehend what underpins these choices, in spite of the possible adverse consequences.

7.4.6 The catalysing affect of control on role conflict

The role conflicts identified in this study are potentially manageable; if commercial and/or operational management responsibilities are passed on to others (Hall, 1972; Van de Vliert, 1981), the GP is left to focus on their clinical role. Thus, value conflicts and incompatible expectations stemming from occupying dual roles need not arise to the same extent, or in the same way, if others make the necessary choices and decisions

(Ritzer and Walczak, 1988; Gerth and Wright Mills, 1997). Although the non-owner GP may perceive some personal conflict (e.g. discomfort with a commercial decision or requirement), as this is outside of their domain of authority, there is little tangible action that they can take. Therefore, any internal sense of perceived role conflict should not have direct external consequences for the actual undertaking of their patient care role, nor increase their workload, as the professional role is their sole focus. Essentially, for the non-owner, responsibilities beyond the consulting room are mainly dealt with by someone else.

However, this is different for GP owners. When one considers how the owner's approach to management is built upon 'decisional control' (section 7.3.7), this suggests that their desire for overall control mitigates their willingness to assign these roles to others. In effect, this positively influences their experience of Organisational-Professional Conflict. Although elements of their non-clinical roles are typically assigned to supports, these represent routine or less preferred aspects (e.g. paperwork, appointments, patient payments). The GP owner remains responsible and in control, subjected to the conflict associated with filling multiple roles and meeting the associated, and at times incompatible, expectations. Role conflict is not just perceived by owners, but has tangible implications for what they do. Indeed, in the small number of interviews where owners relinquished operational control, it appears that their actual experience of Operational-Professional Conflict may have been curtailed, replaced instead by a more externalised conflict between practice members.

Control is also proposed as a factor in the GP's potential experience of role overload. By being dominant, the GP owner can ensure that commercial and professional perspectives are suitably balanced and not inappropriately dictated to by non-professionals, while also preventing issues arising between clinical and administrative staff members who may have opposing agendas or demands. Although this may be positive for other members of the role set (patients and staff), the GP owner personally faces the challenge of having to then achieve such outcomes within acknowledged time constraints. Therefore, the findings from the current study suggest that control can act as a *catalyst* that translates perceived role conflicts for owners into actual role conflicts initially, affecting the work that they do. In this regard, they are compelled to undertake and perform multiple incompatible roles by virtue of being in control and responsible.

Control can also create the potential for role overload laterally, as these multiple incompatible roles are performed by owners under time constraints (Coverman, 1989).

This perspective on control seems to differ somewhat from the predictions of the Job Demands-Resources model (Bakker *et al.*, 2005; Bakker and Demerouti, 2007), where autonomy is typically viewed as a resource that can buffer the consequences of high demands for the individual. Therefore, while possessing control can assist in resolving role conflict (Shenkar and Zeira, 1992), and is utilised by interviewees in scheduling and prioritising tasks and delegating work to supports (Schaubroeck *et al.*, 1989), this study raises the prospect that it may also contribute to the experience of role conflict and role overload. In some respects, this resonates with Bakker *et al's.* (2005) suggestion that high levels of control and associated responsibility may have strain consequences for the role occupant which resources alone cannot fully address (Parasuraman and Simmers, 2001). Consequently, owners need to find ways to remain in control, while attempting to avoid being overloaded and experiencing strain.

7.4.7 Role conflict and the implications for the GP as manager at work

A visual depiction of how role conflict affects the work activities of the GP is presented in Figure 7.2, bringing together the preceding strands of the discussion in section 7.4. As the GP addresses multiple roles, they are prone to experiencing role overload stemming from a lack of time. To some extent, the GP engages in delegation to other supports, acting as a 'release valve' for role conflict. However, as previously highlighted, this is generally limited in terms of actual management responsibility, which tends to remain under owner control. An alternative approach to addressing overload is where secondary roles are moved out of core working hours and partitioned into the home domain, thus rescheduling conflicting demands. However, this is also availed of to a limited extent, such that what is accomplished beyond the working day is relatively minor. Although GPs appear willing to make sacrifices for patients by working out-of-hours, this is not nearly as apparent when the work is non-clinical and therefore less appealing (Bergin and Savage, 2011).

As the home domain is no longer seen as a rich source for dealing with work spill-over and the delegation of managerial responsibility is limited, the potential for role overload means that GPs as managers must refine the scope and extent of their managerial

activities. This is particularly important as clinical demands on GPs are increasing (Thomas and Layte, 2009; Layte and Nolan, 2009). From the findings, the approach adopted appears to entail selectively targeting those activities that allow GPs to maintain their desired control and dominance within the context of time limitations, while ensuring that the key responsibilities attached to their commercial and operational roles are met. In this manner, they engage in both structural (reallocating activities; using supports) and personal (prioritising; partitioning; making choices; eliminating tasks) role redefinition (Hall, 1972) as they adapt the role to the situation (Rodham, 2000). Thus, while GPs may seek to address multiple roles, particularly as owners, this will not be at the cost of patient care; where compromises are required, this is in the undertaking of secondary responsibilities including management.

As section 7.3.7 highlights, the managerial role adopted concentrates efforts on a sub-set of the typical activities and functions of managers and on an approach to management that broadly achieves their aims. In this way, the managerial role is ‘pared down’ (Fitzgerald and Sturt, 1992), through delegating, scheduling and selecting appropriate tasks; indeed, the GP as manager’s ability to control the nature and timing of their work and draw upon supporting resources is important (Demerouti *et al.*, 2001; Bakker *et al.*, 2005). The approach adopted by GP owners in managing role overload effectively limits the scope of their managerial engagement while retaining responsibility, focusing attention on those elements that are viewed as essential (Figure 7.1) to achieve overall control and maintain their clinical role, within constrained time. In this regard, it may be argued that seeking to address the experience of role conflict and role overload has implications for the nature of the GP's managerial role.

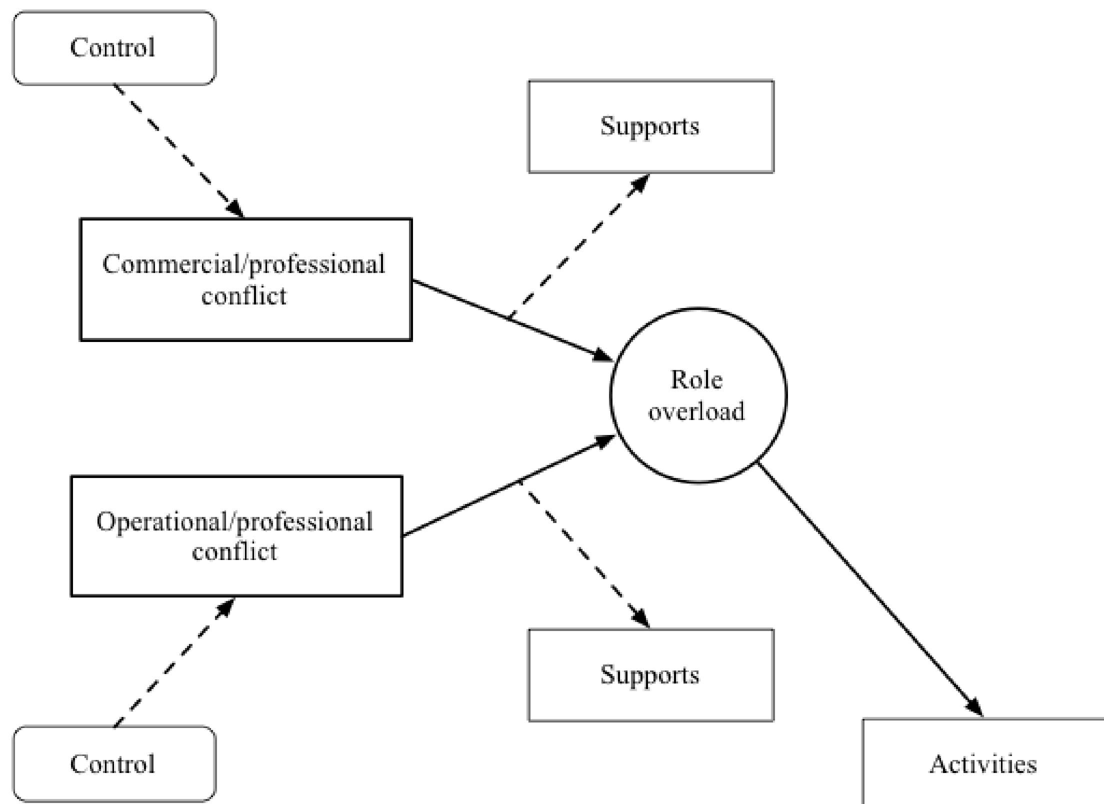

Figure 7.2 – A model of role conflict for the GP as manager

7.5 Factors influencing the GP role as manager

7.5.1 The GP's work agenda: a combination of roles

This study identifies that the work agenda of the GP (Kotter, 1982) – what they intend to do in a general sense and what they are working towards – consists of two related, broad roles; organisational (commercial/operational) and professional (clinical/care). In setting their agenda, the GP conceives the frame of the job (Mintzberg, 1994) as they consider their purpose (what they seek to do), perspective (their overall approach to this) and position (the specifics of what will be done). Thus, while the core of the agenda essentially reflects their ‘purpose’ and underlying intention or goal, their ‘perspective’ and ‘position’ determine what they will do in terms of specific actions and tasks to meet this. Given a general prioritisation of the professional role by interviewees (Gatrell and White, 1997; Fitzgerald *et al.*, 2006), the GP agenda primarily emphasises their clinical/care expectations as they seek to address the needs of patients through focusing most of their time and effort towards associated activities. Within this mostly

clinically focused and prioritised work agenda, their secondary organisational role is also located.

The two roles in the work agenda collectively form the overall GP role, as they interact. Individual GPs can operate somewhat differently by prioritising their own specific elements of their agenda; this affects the nature of their role. Typically for non-owners – whose focus is primarily on their professional role, with some limited administrative tasks and low-level participation in business matters – a managerial role is largely absent, creating a narrow agenda and little scope for conflict. Conversely owners, for whom both roles exist and for whom time may be limited, can have a more expansive work agenda that requires greater effort at achieving balance and utilising the support of others. The owner's emphasis on particular aspects of these roles within their agenda can be a matter of some choice, but within a broad acceptance by most that neither role is fully avoidable (Stewart, 1982). In this context, the GP owner's complex, multi-faceted and time-restricted work agenda is a factor in the role conflicts that they experience, as well as helping to shape their managerial activities (Carroll and Gillen, 1987). Consistent with section 7.4.7, these activities are refined to only those realistically needed to allow the owner to achieve organisational control as their underlying intention, while mainly focusing on their primary clinical/care role.

7.5.2 Influences on the GP work agenda: forming the managerial role

Attempting to understand why the work agenda takes this form requires consideration of the various influences on the GP role (Carroll and Gillen, 1987). While these have been discussed throughout the preceding sections, it is important to separately identify them here in the context of the work agenda. Section 7.3.7 indicates that GPs typically choose to position themselves towards the professional end of a professional-bureaucratic continuum as they seek to remain autonomous and in control in their practices, as might be traditionally expected of professionals. Indeed, for owners, it is expected by their staff that they will assume control by virtue of their status as the legitimate manager. There is also an acknowledgement amongst interviewees that the involvement of non-professionals is necessary so that the GP may meet the clinical/care expectations of patients. This entails introducing elements of a more 'enabling' bureaucratic structure and gives rise to some delegation of mostly routine aspects, with greater sharing in a small number of practices. Section 7.4.2 notes that GPs are neither entirely altruistic nor

self-interested, but seem to occupy a more middle-ground orientation as they are expected to address both patient care needs and commercial sustainability. An active GP involvement in management can help to maintain a reasonable balance within the practice between potentially opposing values, acknowledging the importance of this for the different stakeholders. Taken together, these indicate that the GP's underlying professional ethos (autonomy/altruism) and their recognition that a business focus is required (bureaucracy/self-interest) influence their work agenda in how they address and balance issues of control versus delegation and patient versus profit in managing the practice.

Other influences are also identifiable. Section 7.3.1 highlighted a lack of formal management training by GPs, with an emphasis on clinical learning. This is consistent with the nature of the GP's managerial work; the focus of the relatively limited management training that is undertaken has tended to be on more operational matters as opposed to broader issues around strategy, leadership and planning. Consequently, as an influence on their role, the general lack of management training and development beyond the practical and operational may downplay this aspect of their work and limit its scope. Section 7.3.5 identifies that the GP’s career stage is a key factor in engaging with the managerial role. Generally, unless the GP is an owner or near-owner, their involvement is minimal as the clinical role dominates, while the absence of an ownership stake also limits the interest of non-owner GPs in advance preparation for the role. Therefore, while career stage as an influence largely differentiates between the GPs involvement or not in management, a lack of management training may limit the scope and capacity of their managerial work and, in this regard, have implications for the nature of the role itself.

The study therefore identifies that the GP work agenda (or GP role) is influenced by four factors: their professional ethos, the needs of the business, their career stage and their training. These factors help us to understand *why the managerial role (as part of the wider GP role) is the way it is*. In this regard, from a managerial perspective, the work agenda can be described as being owner-dominated with support primarily in routine areas (*perspective*), engaging in mostly narrow and operationally focused tasks/activities (*position*) that facilitate overall control, while seeking to address and balance the expectations of various stakeholders (*purpose*). This is consistent with the

overall nature of the managerial role of the GP and how it is performed, and the conflicts that ensue from the interaction between the professional and organisational roles.

7.6 The GP as manager at work: an integrated model

In this chapter, the component elements of a model of the GP as manager at work were identified; these are now brought together to form an integrated model (Figure 7.3).

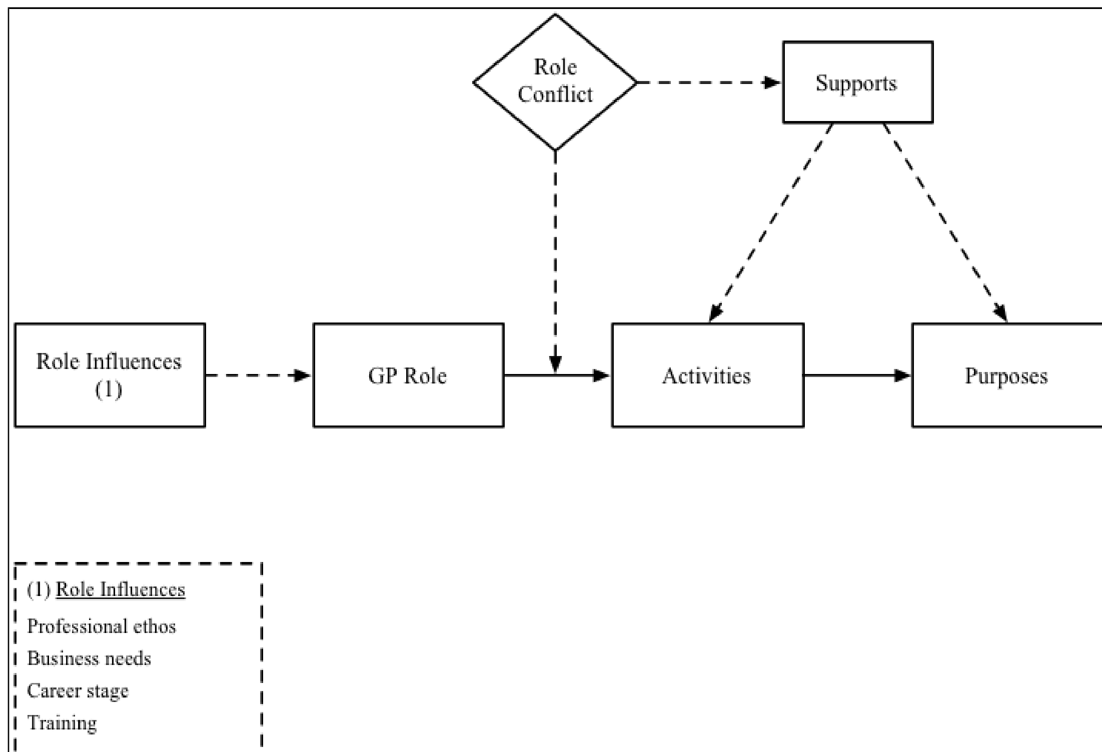

Figure 7.3 – An integrated model of the GP as manager at work

This builds upon the preliminary model (Figure 4.1, p.77), incorporating the subsequent findings from the primary research. While utilising and broadly supporting Carroll and Gillen's (1987) integrating model of the manager at work (Figure 2.1, p.24), the current study extends this. By combining three analytical lenses (management, professions, role), a wider knowledge of the managerial role of the GP as a clinical professional is developed, giving rise to an adapted model. Acknowledging the exploratory and qualitative nature of the research, this is being presented as a 'mapping' of the process of the GP as manager at work, combining empirical data and existing theory, as opposed to a causal model. Further quantitative research would be required to test the associations

suggested here amongst larger samples. Therefore, while the model represents a contribution to knowledge, it is also a starting point for future studies.

7.7 Summary

This chapter has discussed the main research findings in three key areas relevant to the overall objective of the study. The nature of the managerial role of the GP is one that is primarily focused on operational oversight and close control. Based on the core activities identified in this study and the underlying purposes of these, the GP is found to manage by maintaining tight control of the decision-making process, reflecting their autonomous nature as both professionals and, in general, as owners. A support for the GP is the practice manager, though their involvement in management can be limited and underdeveloped, reflecting the typical dominance of the GP owner. Given the GP's time poor nature, this is somewhat surprising though equally the negative outcomes highlighted of practice managers' over-involvement in management must be acknowledged.

The GP as manager can experience multiple work-based role conflicts arising from the interactions of their commercial, operational and professional roles (as elements of Organisational-Professional Conflict) and a general lack of time. However, the relevance of their participation in all three roles, in some form, is noted. The need for control appears to be a factor in these conflicts and in the potential experience of overload, suggesting that less control may have positive benefits for owners. All three forms of conflict are linked, ultimately having a negative effect on the capacity of the GP to collectively function as manager and clinician, with the managerial role appearing to be streamlined or pared down as a consequence.

The chapter also identified the work agenda of the GP and the key factors that influence and shape this; achieving the underlying intentions or goals of this agenda affects the nature of the managerial role itself and how it is performed, with implications for the GP. These three strands of the discussion are brought together as a final integrated model of the GP as manager is presented. The proceeding and final chapter presents the conclusions and contributions arising from this study, including implications for practice, and addresses the overall research objective and research questions.

Chapter Eight

Conclusion

Chapter Eight: Conclusion

8.1 Introduction

This chapter addresses the overall objective of the study, being: 'To determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role'. After briefly outlining the context for the research, the chapter revisits the research questions and addresses these. Following from this, the contributions (theoretical, empirical and practical) made by the study are explained, while a number of implications for policy and practice are identified. The limitations of the study are discussed and how the researcher sought to address these where possible. Avenues for future research are suggested, before the researcher's concluding comments.

8.2 The context for the research

From the researcher's review, this appears to be the first study in Ireland of GPs as managers, even though management in practices is identified as an area for international research (National Institute for Health Research, 2008; Hummiers-Pradier *et al.*, 2009). Given the increasing importance of the sector nationally (DOHC, 2001; DOH, 2012), particularly in light of a growing and ageing population and an insufficiency of GPs (Thomas and Layte, 2009), an understanding of their management role and its value is timely when recognising the rising clinical and commercial pressures that GPs are faced with. Thus, any means by which this role can be performed more efficiently and effectively should be welcomed at the practice level, but also in the wider national context, potentially increasing GPs availability to patients and ensuring that services are delivered in well managed and sustainable businesses. In this respect, the current study makes a contribution to an important yet underresearched group in the Irish context.

8.3 Addressing the research questions

In outlining the research gap and justification (sections 1.3.3 and 1.3.4), this dissertation has highlighted that there is limited and incomplete understanding of the managerial role of the GP in existing literature. An established management theory base is also lacking. Furthermore, the question of whether the role is valuable appears to have not yet been adequately addressed in primary care. Section 1.3.4 provided justification for

the use of a multi-theory lens in addressing the research objective, acknowledging that GPs have a key professional role (as clinician) that may be inconsistent with any managerial role they fill, with potential role conflict implications for the GP. Within this context, the overall research objective and research questions were developed (section 5.3). A short review of these research questions, along with key research outcomes, is now provided.

8.3.1 What work roles (professional and non-professional) do GPs undertake and where do their priorities lie?

The study identifies the prominence of the clinical and patient-focused professional role of the GP and this represents their broad priority and preference. A business management role, while secondary, is an important role for GP owners in particular, though one that they can tend to fill with a degree of reluctant acceptance.

8.3.2 What is the managerial role of the GP and how is this performed?

GPs manage mainly through operational oversight and close control, with a primarily internal focus and, at times, in a relatively informal manner. It appears that GPs as managers (and generally owners) concentrate on activities associated with the roles of Leader, Monitor, Resource Allocator, Disturbance Handler, Entrepreneur and Disseminator, representing *what they do in a practical sense*. The combination of these roles suggests that GPs principally manage by being central to the decision-making process. In this context, the GP as manager focuses on Command and Control functions as *the purposes of what they do*. These follow from their primary activities as GPs adopt a ‘decisional control’ approach, such that by controlling decisions they control the organisation, while availing of some mostly administrative support for routine aspects. Other functions, including planning, are found to be less prominent or relevant at present. In this way, the managerial role of the GP seems to be designed to intentionally deliver their desired outcomes of control and addressing expectations without compromising on patient care.

8.3.3 What factors influence the managerial role of the GP?

Professional Ethos

The study demonstrates that an underlying professional ethos is important. A desire for autonomy seems to encourage GP dominance over organisational affairs by way of

preserving professional priorities, while a traditional altruistic orientation appears to motivate a focus on patients' needs in practice decisions.

Business Needs

The demands of the business are influential. Altruistic tendencies are balanced against the realities of profit and sustainability, while in the collective best interests of the business and of patient service, the GP cedes some control to non-clinicians.

Career Stage

It is apparent that career stage is important, as owners are dominant; those in early career have very limited managerial involvement, increasing somewhat as they approach ownership. However, unlike some professions, GPs as managers do not tend to step back from their core professional duty of direct service delivery.

Training

The study highlights that GPs generally have limited training in management, with much of this being informal and 'on-the-job', as their priority is clinical development. A lack of training appears to affect management capacity; with the learning focus tending to be on mainly operational aspects, this seems to be where they mostly devote their managerial efforts.

8.3.4 How do the GP's roles interact and what are the implications of this for the GP in terms of potential role conflict?

The study identifies two forms of role conflict potentially experienced by GPs as managers, particularly owners. These conflicts can arise between the commercial needs of the practice and patient interests, and because of the operational demands of managing the business while also addressing patient needs. Meeting the various expectations associated with these collective roles can give rise to role overload as available time (both in work and beyond) is limited, which may place strain on the GP. Some relief exists in the form of administrative supports; however, overall responsibility for management remains with the controlling GP owner. Therefore, the GP as manager typically prioritises their clinical role, while seeking to efficiently streamline or pare down their less preferred managerial role (section 8.3.2 above) by way of managing overload.

8.3.5 What is the value of the managerial role of the GP?

The final research question seeks to address whether GP involvement in management is of benefit to stakeholders. In a positive sense, the study finds evidence that GPs, in filling a commercial role as they engage in managing service innovation and the generation of resources, seek to establish a reasonable balance between business and patient interests. This may be partly altruistic, but also demonstrates self-interest, as both motivations co-exist. Meeting the needs of patients effectively and efficiently is essential if the business is to succeed, but without some success, patient needs cannot be well catered for. By virtue of maintaining control of commercial decisions, it may be argued that the GP is contributing value to the patient experience while also delivering value to the organisation. Therefore, the commercial involvement of the GP is a core responsibility.

Owners, by virtue of retaining responsibility for operational matters as they engage in managing service provision and the usage of resources, appear to mitigate conflict between clinicians and non-clinicians that can stem from a dominant practice manager. This was not commonplace, but created considerable tension and dissatisfaction where found. The indication is that having the owner visibly active in the management of operations would have prevented such outcomes. In this regard, by managing the clinical-managerial boundary and actively dealing with staff issues, owner involvement is valuable through maintaining harmony and ensuring that the expectations of professional colleagues and staff are being met.

A key challenge that owners face in fulfilling their clinical-managerial responsibilities (section 8.3.4) is role overload. However, the primary activities and functions of GPs as managers (section 8.3.2) are not fundamentally different to those of managers generally, being effectively a sub-set of what most managers should do. This raises the argument that an appropriately trained non-clinical manager, reporting to the owner, could carry out much of this work. By delegating, the time spent by GPs on operational management in particular may be freed up. This time could be devoted to clinical duties – relieving in part the growing strain on services – or allocated to higher-end management, where attention is currently limited. Thus, by relinquishing greater control in more operational areas, it is argued that the value of the GP as manager may potentially be improved as they widen their focus.

8.4 Contributions of the study

8.4.1 Theoretical contributions

Contribution 1

The model developed (Figure 7.3, p.212) is based on Carroll and Gillen's (1987) integrating model of the manager at work (Figure 2.1, p.24), but extends and augments the theory in a number of ways. This stems from the study's use of three analytical lenses (management, professions, role) to generate a wider understanding of the managerial role in a novel context. Firstly, the original model appears to have been developed with full-time managers in mind and thus is not fully applicable to those who are ostensibly part-time managers and full-time professionals. In this regard, the adapted model takes account of the professional role, which is prioritised in a work context (Fitzgerald *et al.*, 2006; Russell *et al.*, 2010). Therefore, certain characteristics of professionals (and clinicians in particular) – notably the desire for autonomy (Brint, 1993; Majorbanks and Lewis, 2003), their altruistic tendencies (Pellegrino, 1987; RCP, 2005), their career stage (Dalton and Thompson, 1986) and a lack of management training (Joyce, 1998; Montgomery, 2001) – are influential in shaping the secondary managerial role.

Secondly, the adapted model demonstrates how the presence of a professional role may give rise to role conflict (Kahn *et al.*, 1964; Biddle, 1986), which can have implications for performing the managerial role. Thus, rather than professionals as managers necessarily engaging in all of the same activities and performing all of the same functions as traditional managers, the adapted model identifies (Figure 7.1, p.193) how the role is tailored to a sub-set of these (Fitzgerald and Sturt, 1992) to accommodate time pressures, while allowing the professional as manager to still achieve their core objectives and intentions. In this respect, the study demonstrates how managing through 'decisional control' – being central to and dominant in decisions by way of maintaining control – can be an effective approach to meeting these needs.

Thirdly, the original model was specific to the individual manager, but did not directly include the actions of other staff members who both feed into and feed from the manager's work. While Carroll and Gillen (1987: 47) highlight 'Unique tasks and problems assigned by others' as influencing the work agenda, this study identifies a more direct involvement from practice supports (such as the practice manager;

Westland *et al.*, 1996) at the level of actual activities and functions. Therefore, supports are viewed as a core part of performing the managerial role as opposed to an influence, reflecting a two-way interaction.

The researcher suggests that the model developed in this study could have applications in contexts that are similar to general practice, such as other health care professionals in independent, professionally-owned businesses. Beyond this, the researcher believes that, with further adaptation, the basic elements of the model (influences, work agenda, role conflict, activities and purposes) could be applied to other professions as well where dual roles are present. Context-appropriate models could be constructed, using the basic model presented, to provide a greater understanding of the roles involved and as a means of considering the value of the roles themselves.

Contribution 2

Section 7.4 discussed the role theory concept of Organisational-Professional Conflict (Sorensen, 1967; Kippist and Fitzgerald, 2009; Fitzgerald and Dadich, 2010) and outlined its presence in the current study, as an inconsistency is found between the expectations of the practice (organisational) and the patient (professional) arising from differences in goals and values. However, while previous studies (Aranya and Ferris, 1984; Gunz and Gunz, 1994; 2007; Shafer, 2002; 2009) identify and measure Organisational-Professional Conflict as a single dimension, the current research challenges the theory and suggests an amendment to the concept.

In this regard, Organisational-Professional Conflict may also be viewed as consisting of two separately identifiable, though associated, forms of conflict. Commercial-Professional Conflict is found to exist when the commercial orientation of the GP as manager is, in value terms, in potential conflict with their professional orientation to the patient as clinician. On the other hand, Operational-Professional Conflict arises because the GP as manager reluctantly engages in operational tasks as this is expected of them in addressing organisational goals, while also being expected to fulfil their clinical and care responsibilities to patients. Collectively, the commercial and operational roles amount to the managerial/organisational role of the GP. Therefore, future studies addressing and measuring conflict between organisational and professional roles may need to consider using scales which treat this not as a single dimension but rather as two dimensions.

Contribution 3

The study highlights the potential influence of control on the GP's experience of role conflict, (Figure 7.2, p.209) suggesting that conflict might be reduced if either of the non-professional (commercial/operational) roles is relinquished. Evidence is available of extensive delegation of routine administrative tasks and front-office management, but it is less common that GPs appear to delegate managerial responsibility (Guthrie, 1999; Checkland, 2004). This study suggests that the GP's need for autonomy and control as a professional (Majorbanks and Lewis, 2003) and an owner (Florén, 2006) motivates them to retain commercial and operational responsibility, catalysing the associated role conflict, with implications for the work they undertake. In this vein, it is also argued that the desire for control contributes to the possible experience of role overload as a form of role conflict (Kahn *et al.*, 1964) and, thus, the need to actively address this. By taking on responsibility associated with management in addition to the more salient clinical role, the GP as manager attempts to meet multiple expectations in a time-limited context (Buchanan *et al.*, 1997; Checkland *et al.*, 2011), creating scope for overload (Coverman, 1989). Thus, control is identified as a catalyst for both role conflict and overload, which has implications for our current understanding surrounding the association between these concepts.

Previous literature (Demerouti *et al.*, 2001; Bakker *et al.*, 2005; Bakker and Demerouti, 2007), in the context of the Job Demands Resources (JD-R) model, has identified job autonomy and control (resources) as a potential means of buffering the adverse strain consequences of high workload and time pressures (demands), as the individual has greater discretion over the timing and performance of tasks. In this regard, control as a resource may assist in reducing role conflict and overload (Shenkar and Zeira, 1992). The current research concurs here, as subordinate support (delegation) and task discretion is availed of by GPs. However, the suggestion in this study that high levels of control and responsibility can also add to workload and time pressures, thus increasing demands as opposed to buffering them, appears to extend the theory. Indeed, this is consistent with Bakker *et al's*. (2005) acknowledgement that high levels of control and responsibility may have adverse consequences for an individual's experience of strain (also Parasuraman and Simmers, 2001), though this is not reflected in the JD-R model. The adaptation suggested by the current study may then be partly contextual, though not

necessarily unique to GPs, as those for whom control acts as a catalyst are typically owners; previous research on the JD-R model has focused on employees.

8.4.2 Empirical contributions

Contribution 1

This study has helped to increase our understanding of how GPs address the apparently opposing motivations stemming from being altruistic and self-interested, and the implications of this for both the patient and the GP. While altruism may traditionally underpin the behaviour of clinical professionals (Pellegrino, 1987; Cruess *et al.*, 2002; RCP, 2005), this study contends that viewing them as altruistic in isolation is unrealistic. Additionally, the notion that an emphasis on commercialism and profit might be taking over (Stone, 1997; Relman, 2007) appears excessive in this context. Instead, a blending of interests occurs (Gillon 1986a; 1986b; Maier and Shibles, 2011) with positives for both patient and practice; by pursuing reasonable self-interest, the best interests of the patient are ultimately being met (Rubin, 2009) as one complements the other.

Consequently, the study helps to bring some contextual clarity and refinement to the empirical debate (Croxson *et al.*, 2001; Spoor and Munro, 2003; Gartland and Carroll, 2004; Pockney *et al.*, 2004) surrounding the existence of altruism, arguing that GPs may be best viewed as ‘part altruistic, part self-interested’. This recognises that they are both patient and profit focused (Batson and Powell, 2003). It would appear that GPs may typically veer in the direction of patients’ interests, reflecting their strong professional ethos (Pellegrino, 1999), but that they also acknowledge the need for reasonable balance (Gillon, 1986b). Thus, GPs should not be concerned about being viewed as profitable ‘businesspeople’ as well as caring clinicians and seeking to possibly hide this duality (Descombes, 2002), but rather need to demonstrate how a successful practice is a positive for patients. In seeking to maintain their image as patient-focused, GPs should ensure that they retain essential services and expand and enhance their offering in appropriate areas; this requires profits and cash for continuity and reinvestment. Therefore, positively balancing both motivations, without excesses in either direction, would appear to be both a viable and sustainable position to adopt.

Contribution 2

As far as the researcher is aware, this is the first study to empirically examine Carroll and Gillen's (1987) integrating model of the manager at work. While the current study extends and adapts the model (see first theoretical contribution above), the findings also broadly support the original structure. Thus, the manner in which various influences can shape the work agenda, how the manager's activities can stem from this agenda, and how the functions engaged in can relate to the activities and ultimately reflect the overall purposes of management are present in Figure 7.3 (p.212). The current research is consistent with Fells (2000) and Lamond (2003; 2004) in suggesting that the seminal theories of Kotter, Mintzberg and Fayol may be related when viewed as part of an integrated process of management. Thus, this study provides some empirical evidence that helps towards demonstrating the relevance and applicability of the original model.

Contribution 3

While Organisational-Professional Conflict is an established concept in academic literature, much of the focus has been in the accounting (Shafer *et al.*, 2002) and legal (Gunz and Gunz, 1994) professions. Kippist and Fitzgerald (2009) draw attention to the lack of studies in the medical profession. The present research provides some empirical evidence of the existence of Organisational-Professional Conflict in healthcare management and, specifically, in general practice where no previous studies have been identified. While their natural affinity towards the professional role is strong (Gatrell and White, 1997), GP owners in particular demonstrate commitment to the needs of the organisation as well (Aranya and Ferris, 1984). However, by seeking to adequately address both organisational and professional expectations, conflict can arise, which has the potential to lead to stress for the role occupant (Wickham and Parker, 2007).

The study demonstrates how the GP as manager retains the overall managerial role but seeks compromise by way of dealing with possible role conflict. This is achieved by designing and paring down (Fitzgerald and Sturt, 1992) the detail within the managerial role to deliver desired objectives within available time, while maintaining a professional focus. Therefore, rather than choosing to solely engage in clinical duties and ceding control, the GP undertakes both roles (Van de Vliert, 1981) while structurally and personally redefining the management role (Hall, 1972). This entails delegating, de-prioritising and eliminating those aspects of management deemed less important. In this

respect, striking a manageable balance (Gunz and Gunz, 2006) and adapting the management role to the circumstances (Rodham, 2000) help to address role conflict.

Contribution 4

From prior literature, the researcher noted the presence of few international studies that specifically addressed the managerial work of general practitioners using empirical data (e.g. Fitzsimmons and White, 1997; Holton *et al.*, 2010). A notable feature of these studies (aside from Gatrell and White, 1997) is a lack of underpinning and supporting theory from a broader management context. Therefore, the current research appears to be a first attempt to empirically identify what GPs as managers do and the purposes of what they do, while basing this in core management theory by way of permitting comparisons to managers generally. In this regard, the findings demonstrate that GP owners are managers, addressing roles (Mintzberg, 1973) and functions (Fayol, 1988) typically associated with occupants of such positions. However, in contrast to more 'traditional' managers, GPs tend to focus attention on a sub-set of roles and functions that ensure they are central to decisions and in control of the practice.

8.4.3 Practical contributions

Contribution 1

One of the objectives of this study was to consider the value of the GP as manager. Previous research addressing this particular topic for clinical-managers generally (Montgomery, 2001; Goodall, 2011) appears somewhat unresolved, and for GPs specifically (O'Riordan and McDermott, 2012) is lacking. This is a significant deficit, given the importance of primary care at a policy level (DOHC, 2001; DOH, 2012) and an insufficiency of GPs to cater for a rising population (Thomas and Layte, 2009). Initially, the study identified, from previous literature, three positive (organisational benefits; representing the needs of patients; resolving conflicts) and three negative (lack of time; negative motivations for assuming the role; being viewed as a 'defector' by peers) features associated with clinicians as managers. This represents a basis for considering the value of the role, in terms of whether GP involvement in management is of benefit to stakeholders.

Broadly, the empirical research conducted found evidence of all three positive reasons for GPs functioning in a management capacity. Adopting a commercial role, in conjunction with the professional role, helps to achieve a balance between

organisational and patient interests, while taking responsibility for operational management can act as a means of reducing conflict between clinicians and lay management. Indeed, by absorbing this conflict as 'boundary spanner', the GP as manager avoids being viewed as a ‘defector’ (Hallier and Forbes, 2004) by peers. No evidence was found of negative or harmful motivations for managing, possibly because of the owner-managed nature of practices, though it is acknowledged that GPs can be ‘reluctant’ (Scase and Goffee, 1989) to embrace the role.

A lack of time was a central issue in this study. The significance of this, in terms of the value of the role, is that GPs must weigh up whether time spent on management is worth sacrificing time spent on clinical responsibilities. As previously noted, GPs appear to resolve this by streamlining their managerial involvement to those roles and functions that are necessary to achieve their objectives. Therefore, the findings suggest that GPs are conscious of where they contribute value in their organisations and attempt to address this issue. However, the study also indicates that, while time spent on the commercial role can be important and beneficial for both patients and the practice, a detailed engagement in operational management tasks (e.g. staff issues, systems, non-clinical policies) may contribute little value beyond conflict avoidance. Thus, the GP as commercial manager can be valuable, though the merits of the GP as operational manager may be questioned.

Contribution 2

The study highlights the under-utilisation by GP owners of an existing support in the form of the practice manager (Laing *et al.*, 1997). In this context, the findings suggest that role incumbents may be managers in name but not necessarily in nature as their involvement can be limited, focusing mostly on front-office activities and routine support. Although consistent with prior literature (Fisher and Best, 1995; Laing *et al.*, 1998), this is significant given the time restrictions faced by owners and may become an even more acute issue if Universal Health Care increases numbers of GP consultations (Layte and Nolan, 2009). While, in some cases, the management role was shared more so with the practice manager, these were in the minority; however, owners appeared to appreciate the increased support and the fact that it importantly removed some of their burden. Thererfore, the study suggests that greater consideration could be given to expanding or enhancing the practice manager role to absorb more of the operational management tasks undertaken by GPs, helping to instil a degree of formality that can be

absent (e.g. lack of employment contracts and key HR processes). In this respect, there may be a greater need for the rarely found 'progressive' manager (Verrill, 2005) as practices become busier clinically, as well as becoming larger and more complex organisations (Greiner, 1998; Checkland and Harrison, 2010).

Contribution 3

A lack of management training has been identified as an influence on the managerial role of the GP, noting also that much of the formal training undertaken – mostly experiential – happens in early career as registrars. Previous literature is divided as to when is the optimal time to deliver such training (Hunter, 1992; Kindig, 1997), recognising that clinical development is the priority for registrars (Martins *et al.*, 2005) and the focus of their attention while, in later years, cost and time become issues for owners (Flóren, 2003). The current study suggests that early-career management training may be valuable and appropriate, but that greater opportunity to practically apply such training post-qualification is needed as an incentive to better engage. This would help towards addressing two further issues identified – (1) providing owners with an additional and up-to-date resource to whom management tasks might be delegated (Gerada, 2008); and (2) ensuring that non-owners are more experienced in the basics before they enter ownership (Sibbett *et al.*, 2003), facilitating a smoother transition than at present. For existing owners, this may also provide them with time to enhance their own managerial skills in higher-end and underdeveloped areas such as strategy, leadership and managing change. This could be facilitated through undertaking focused formal programmes for GPs, such as the ICGP/DCU 'Leadership for General Practice' course. Given the changes occurring in the primary care environment (increasing team working, Universal Health Care, issues of GP supply), these skills may become increasingly important and greater efforts to develop these may be warranted.

8.5 Implications for policy and practice

Bearing in mind the contributions identified in section 8.4, and with particular reference to those of a practical nature, this research identifies a number of implications for both policy and practice. Firstly, the study highlights that GPs may be engaging in aspects of management that do not necessarily require their active input and where they are unlikely to contribute considerable value, particularly when dealing with operational matters. In the context of increasing inter-professional working associated with membership of primary care teams (DOHC, 2001), it can be argued that there are

potentially more valuable areas where GPs could focus their attention. These might include liaising with team members, coordinating patient services and team leadership. At a practice level, the lack of significant involvement in planning and strategy development, promoting the practice, business organisation, and external monitoring was notable. Given the changing and complex primary care environment that GPs are now operating in (i.e. growth in practice sizes and the employment of practice managers; population increases; transition towards Universal Health Care; challenging economic climate), it is suggested that these are areas where GPs may need to devote greater time to if they are to avail of opportunities and protect against threats.

By means of facilitating such a change in focus, GP owners may need to be willing to cede greater control to lay managers over relevant non-clinical areas and to legitimise their authority (Raelin, 1989; Checkland, 2004), while retaining an oversight role to address issues or conflicts that may arise and review overall outputs. Consequently, the traditional practice manager role could be enhanced, moving from ‘administrator’ to ‘business manager’. Such a move could entail greater involvement in areas such as HR management and establishing internal processes, preparing and reviewing broader formal performance reports, non-clinical policy setting and some independent decision-making. This may necessitate additional training or specific recruitment to ensure that role occupants have the necessary skills for the expanded role. Where non-clinical managers are in a position to operationally manage with legitimacy, this frees up the GP as manager to focus their efforts on the clinical role and on dealing with higher-end management (Fitzsimmons and White, 1997). Indeed, by relinquishing some control, this may increase the imperative on GPs to engage in the development of more formal plans and targets as a means of directing and monitoring the work of non-clinical managers. Therefore, a greater policy emphasis on promoting the benefits of an enhanced practice manager role to GPs, accompanied by affordable, tailored and ongoing formal training specific to the needs of role occupants, may be beneficial.

While the findings affirm the relevance of developing doctors’ management skills, recognising that most registrars aim to become owners (O'Kelly *et al.*, 2012), it is beyond the scope of this study to identify what should be the specific content of management training for GPs from a policy perspective. However, it can be suggested that it might be of benefit to compliment existing largely experiential and on-the-job approaches with some management theory and contemporary thinking from the field,

highlighting the value of formal and tailored programmes (Ireri *et al.*, 2011). Furthermore, on the basis that GP registrars may engage with management training to a greater degree if they are aware that they will be using it early, some emphasis on concepts and frameworks could also be beneficial at this juncture to make the training lasting and transferable (Hadley and Forster, 1995). If non-owner GPs are to meaningfully contribute to the management of their practices as a support for owners, a key element of this will be the training they receive.

The understanding developed in this study that GPs are both altruistic and self-interested has important practical and policy implications. With free GP care for all due by 2016, it is essential that those designing the new system recognise how GPs reflect both of these motives (Batson and Powell, 2003) in their decision-making process. Payment structures will need to be cognisant of how GPs react to financial incentives in a rational manner (Walley *et al.*, 2000), but equally that their professional values must be accounted for and appropriately reflected (Young *et al.*, 2012). Both a moral and financial motivation exist, and incentives and professional values should ideally be aligned (Campbell *et al.*, 2007; McDonald and Roland, 2009); blunt instruments that seek to manipulate GPs or stifle clinical autonomy may not be effective. Therefore, the current approach of predominantly capitation payments will need to be carefully considered, as this may not adequately motivate GPs to enhance service availability (Mechanic, 1975), while a system of incentives based on achieving targeted outcomes might not be patient-centric (McDonald *et al.*, 2008). It is beyond the scope of this study to recommend one or the other, but simply to warn that careful consideration of all approaches is essential at a policy level, given the dual and complex motives of GPs.

8.6 Limitations of the study

There are a number of limitations inherent with this study that have implications for the conclusions arrived at, while also acting as a means of identifying opportunities for future research. Firstly, the methodological approach used in this dissertation must be acknowledged in terms of interpreting the findings. The nature of qualitative research requires that the researcher study at a deep level, acquiring and interpreting the perspectives of those with something interesting to say as they explore an area that is under-addressed, while avoiding being overcome by masses of data. Therefore, a relatively small number of GPs (35) were interviewed, although sample size was in line with the advice of other researchers for the purposes of seeking data saturation (Guest *et*

al., 2006; Francis *et al.*, 2010) which was achieved. While this sample was also partly self-selecting, the researcher is satisfied that interviewees come from a broad range of practice sizes and types such that findings are not narrowly focused. Collectively, the small sample size and non-probability approach to selection means that the prospect of generalising to the population is understandably limited. However, as the interviewees are reflective of the types of GPs working in Ireland and typical practice structures, it can be suggested that the conclusions reached may have relevance beyond the sample.

The rationale for using semi-structured interviews is presented in section 5.5, as well as the reasons for not adopting alternative designs (e.g. grounded theory, case studies; section 5.4.3). The limitations of this specific approach to data collection, including interviewer bias, time constraints, accessing suitable interviewees and seeking validity and reliability, are also considered in chapter five. In this regard, while the researcher accepts that it is not possible to completely eliminate these, steps have been taken to address their impact. Furthermore, the use of the telephone interview approach meant that non-verbal cues were not as available and the researcher was not in a position to engage in observation. However, as indicated in section 5.9, this did not have any significant adverse impact on the research or quality of data collected; indeed, the use of the telephone as a medium provided further benefits that were of greater overall importance.

The domain for the study (Irish GPs) is quite specific and the conclusions arising from the research must be understood in this particular context. Thus, while the researcher has identified a number of contributions to theory, the applicability of these to other contexts is necessarily unsubstantiated at present. However, the researcher has attempted to make tentative suggestions (section 8.4.1) as to how some of these contributions may be informative to, and developed in, other domains as well.

All interviewees in the study are GPs, which reflects the focus of the research. By selecting GPs at different career stages, the researcher was able to acquire different perspectives of both ‘managers’ and those who are ‘managed’. This served to both confirm and question the findings from interviews with owners in terms of some of the issues raised. However, beyond GPs, no other members of the practices were interviewed.

8.7 Avenues for future research

As highlighted in the limitations, the final model of the GP as manager is qualitatively developed from a relatively small sample of GPs. Therefore, a clear opportunity for further research is to test this model and some of the conclusions quantitatively. This would require a larger sample of GPs, a survey based upon the model and the testing of specific hypotheses. Such a study is now possible, as the researcher's exploratory design has developed a model, using theory and empirical data, to facilitate this.

The limitations also acknowledge that other practice members were not interviewed over the course of the study. In particular, the role of the practice manager requires further investigation as they are identified as a key, if underutilised, support. Therefore, future research could seek to understand how practice managers, who remain a relatively recent addition to Irish practices, approach their roles, the tasks they undertake, the training that they engage in and the extent to which they view themselves as managers. In addition, by studying practice managers directly, greater insight can be developed into how they believe that their roles can be expanded and enhanced if they are to become more 'managerial' in the future. While practice managers have been researched in the UK (Laing *et al.*, 1997; Newton and Hunt, 1997), there is a dearth of Irish literature on the role.

A lack of management training was identified as a negative influence on the GP's capacity to manage. The study recommends that further consideration be given to the content and format of such training, but has not attempted to establish what this should be at different career stages and for different practice members, clinical and non-clinical. Therefore, there is scope for future research in Ireland to consider this specifically and to develop a framework that enables those with a managerial involvement to identify training needs over their career and how best to meet these, formally and informally, as they transition through stages. In addition, such a framework would be beneficial to training bodies and organisations in designing appropriate programmes.

The overall model developed is based on the GP as manager in their practices. However, as highlighted in section 8.4.1, the researcher believes that future studies could seek to adapt and develop this model for other contexts. For the GP themselves, this might be considered in terms of their involvement with other healthcare

professionals in primary care teams. This could be particularly relevant if the GP holds a team management or leadership role that may require a different approach to that which they are accustomed to in their own practices. Other similar candidates, such as independent health professionals who run their own practices, were also suggested. Research could additionally examine how the model may be adapted more broadly in non-healthcare professions, specifically amongst those who fill the dual role of professional and manager.

8.8 Concluding comments

This study set out to determine the nature and value of the managerial role undertaken by GPs, and the potential role conflict implications for GPs when the managerial role is undertaken in conjunction with a professional role. In addressing this objective, the researcher contends that a better understanding has been achieved of how GPs manage, why they manage in this particular manner and ways in which this might be improved. Given the important contribution that primary care – and the GP as a central component – makes to the health of the nation, it is hoped that by applying some of the knowledge generated here, this contribution might be enhanced, even modestly.

The future for health services in Ireland is a challenging and uncertain one. The pressures and difficulties faced by the secondary care system are well known – waiting lists, patients sleeping on trolleys, insufficient staff, over-crowded Accident and Emergency departments and quality assurance concerns are but a selection of these. In addition, continually cutting health funding on an annual basis while demand for services are rising only compounds the problem. Faced with this, the Irish health system is increasingly reliant on effective and efficient primary care and general practice sectors to relieve these pressures by keeping people out of hospitals, when it is possible, practical and safe. The emphasis in these sectors on health promotion, prevention and early intervention is ultimately more cost effective than later treatment. This can help to stem the tide of hospital admissions on a long-term basis as well as best serving the interest of patients in general. Consequently, investing in primary care capacity is in the overall national interest, and this is recognised at the health strategy level.

While this study affirms that GPs (owners principally) are managers and can identify some value in this, the research also questions whether there may be other ways to deliver the same, or even improved, value. Greater sharing of responsibility for

management and some easing of owner dominance could be of benefit to patients directly (increased GP availability) and indirectly (owner has time to enhance and develop the practice and services), with potential benefits for the overstretched secondary care system. The researcher acknowledges that GPs are also facing into a challenging and uncertain period and are likely to experience their own difficulties, which may affect the nature of their role. However, as small and nimble entities, unburdened by bureaucracy and legacy problems, their practices can be easier to change and adapt to an evolving environment. Certainly, a reshaping of the managerial role of the GP will not 'cure all ills', but may still be part of the solution to what is a 'chronic' national problem.

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Appendices

Appendix A: The context of the study: General Practice and the General Practitioner

A.1 Introduction

Appendix A addresses the context of the study. Initially, the structure of general practice in Ireland is outlined. The manner in which GPs are remunerated is then explained, as well as their working hours and the impact of out-of-hours co-operatives. Within the context of the definition of general practice, the role of the GP is outlined. The training and qualification process for GPs is also briefly reviewed. Appendix A closes by looking at some of current changes and challenges affecting the profession and its members, and the implications of these.

A.2 The structure of Irish general practice

It is estimated that there are 2,954 GPs in Ireland (Teljeur *et al.*, 2013), an increase of over 470 GPs on 2005 figures (O'Dowd *et al.*, 2006a). GPs are either owners in their practices (partners/sole practitioners) or non-owner employees (full-time/part-time/sessional/locum). Although the norm remains for GPs to function as owners, with most registrars aspiring to such a role (O'Kelly *et al.*, 2012), there is growth in the numbers of employed GPs (Competition Authority, 2010). Typically, non-owner GPs can have limited involvement in practice decision-making (Lester *et al.*, 2009), though Gerada (2008) suggests that this cohort represents an untapped source of skills and expertise that could be utilised in a management context.

Practices typically hire ancillary staff to assist the GP – the most common are practice nurses, clerical staff (secretaries/administrators) and, more recently, practice managers[58]. A notable change in general practice in recent years is the move from being single-handed[59] towards partnership/group practices and teams (Evans, 2004). This has resulted in growth in staff numbers and in the overall range of services offered (O'Dowd *et al.*, 2006a; Morgan and Beerstecher, 2009), better service delivery and an

58 In 2005, O'Dowd *et al.* (2006a) found that 30% of practices surveyed employed a practice manager, while Bourke and Bradley (2010) find that this has now grown to an estimated 54%. Although a notable increase, when compared to Grimshaw and Youngs (1994) Scottish sample where 63% of respondents had a practice manager in the early 1990's, the relative newness of this role in an Irish context is apparent.

59 'Single-handed' means only one GP operates in the practice. In 2005, 37% of surveyed practices were single-handed (O'Dowd *et al.*, 2006a); this fell to 25% in Bourke and Bradley's (2010) sample.

improved working environment for practitioners (Competition Authority, 2010). However, this also increases the complexity of practices as organisations (Checkland and Harrison, 2010), adding to the management burden.

The majority of GPs (Thomas and Layte, 2009) are members of the Irish College of General Practitioners (ICGP), which acts as a representative organisation for members as well as being the specialist training body for general practice (see section A.6). In order to become a member, an individual must have either completed specialist training in Ireland or have been equivalently trained internationally to recognised standards. Additionally, GPs must be registered with the Medical Council, which is the registration body for all doctors. The Medical Council is also responsible for overseeing that each registered practitioner achieves the required standards of competence on an ongoing basis and in dealing with public complaints against doctors. A further representative organisation for all doctors is the Irish Medical Organisation (IMO), which acts in the capacity of a union[60]. The IMO are active in negotiations concerning the conditions and remuneration of hospital doctors, GPs and registrars, dealing with State bodies such as the Health Service Executive (HSE[61]) and Department of Health[62] on these matters.

A.3 Remunerating GPs for their services

GPs operate as independent contractors and possess considerable autonomy with regard to medical practice, within the guidelines, standards and protocols issued by relevant bodies including the HSE and Medical Council. Remuneration for services comes primarily from two sources. Depending on the economic status of the presenting patient, payment is made personally by the patient per visit[63] ('private patient') or by the State ('public patient') through various schemes. Thus, the Irish system has elements of other systems (e.g. in the UK and much of Europe, GP care is free/heavily subsidised, while in the US, insurance companies are key payers along with federal funding for certain patient categories), but differs notably by adopting such a hybrid form, with a majority of patients paying full price (Smith, 2010; Nolan and Smith, 2012).

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60 In May 2013, the National Association of General Practitioners (NAGP), a smaller organisation specifically focused on representing GPs, was re-launched with a view to gaining similar negotiation rights.

61 The HSE is a State body, appointed by the Minister for Health to manage and run all public health services in Ireland.

62 This is a government department, headed by the Minister for Health along with two Ministers of State, one of whom has specific responsibility for Primary Care.

63 Depending on their health insurance, private patients may be entitled to partial reimbursement of fees paid. In addition, some tax relief is available.

The bulk of State payments are made through the General Medical Services (GMS) scheme, principally in the form of capitation payments. Approximately 40% of Irish residents are catered for through the scheme[64] (DOH, 2013). Public patients register with an individual GP, who receives an annual payment based on the number of patients registered with them, with variations for patient age and distance from the surgery. Until March 2012, only those GPs who had been granted a 'list' of specific GMS patients could be remunerated in this manner. However, in line with the requirements of the European Union/International Monetary Fund Programme of Financial Support, this has been opened up to all qualified GPs, helping to improve competition and increase/retain GP numbers.

In March 2011, the Irish Government announced that it would be introducing Universal Health Care (UHC) in general practice. This acknowledges that patients who pay directly are less likely to visit GPs (Layte and Nolan, 2009), potentially giving rise to adverse health outcomes. Consequently it is planned that, by 2016[65], all patients will be granted free GP care at the point of delivery. It is believed that GPs will be remunerated on a capitation basis by the State, encouraging greater delegation of care to others, and with an increased focus on the management of chronic diseases. In November 2012, the Department of Health (2012) launched *Future Health: A Strategic Framework for Reform of the Health Service 2012-2015*, with free GP care a central element of this. However, the final form of this new system is undetermined; a white paper from the review group set up to advise on the structure has yet to be published. Based on Buckley (2013), the fully implemented programme is expected to cost in the region of €330-€400 million annually.

64 Eligibility for this scheme (which also covers hospital care and prescription drugs) is means tested for patients/dependents. For those who do not qualify, they may be eligible for free GP visits only depending on their income levels. According to DOH (2013), 2.9% of the population hold a 'GP Visit Card'.

65 By 2013, the initial planned phases of the new scheme had not been implemented because of legal difficulties. Instead, the Government announced, in its budget for 2014, that free GP care would be introduced for all children under six years of age. The Government have also indicated that they remain committed to introducing free GP care for all by 2016.

A.4 Working hours and GP co-operatives

Full-time male GPs in the UK work an average of 50 hours per week, while female GPs work some 43 hours per week[66] (Gravelle and Hole, 2007), with employed GPs working fewer hours than owners (NHS Information Centre, 2007). During this time, GPs are engaged in consultations with patients while also undertaking associated administrative duties (e.g. letter writing, completing forms) and managerial/business related work. For an owner, non-consulting time can be significant, with the NHS Information Centre (2007) estimating an average of 36%. In addition, GPs are reported to commonly perform administrative work at home; Gilliland *et al.* (1998) noted over 55% of their sample of Irish GPs spending more than two hours at home per week on such tasks.

However, these are less hours than are normally required of non-consultant hospital doctors (NCHDs), where the IMO (2011) report that 40% work in excess of 61 hours per week with a further 30% working between 50 and 60 hours weekly. Similarly, O'Kelly *et al.* (2012) found that while 48% of GP registrars on their hospital rotation worked more than 60 hours each week, this was considerably lower at 10% when they were training in GP practices. Indeed, it appears that working hours and conditions are important factors in choosing general practice. Jones and Fisher (2006) note how 75% of males and 83% of females had changed their career preference from other medical disciplines to being a GP for this reason, while O'Kelly *et al.* (2012) found that registrars in general practices indicated improvements in their morale, lower stress levels and a better quality of life compared to those on hospital rotation.

In addition to their normal working week, the majority of GPs undertake some out-of-hours commitment (O'Dowd *et al.*, 2006a), which means being available to patients beyond normal surgery hours. Traditionally, GPs – particularly those in rural locations – were responsible for their own patients' needs, being effectively available throughout the night and at weekends. O'Dowd *et al.* (2006b) note that, before co-operatives, GPs were on-call for 46 hours per week on average. In 1999, the first GP co-operative was established which meant that individual participating GPs would operate on a rota basis to cover a range of practices from a central location at nights and weekends; thirteen co-operatives now exist nationally. These arrangements have met with favourable patient

66 Recent Irish estimates of working hours are not available, with some variation noted in the limited information published; Nic Gabhainn *et al.* (2001) report average scheduled hours per week (excluding out-of-hours) between 37 and 39, while Boerma (2003) indicates average working weeks in excess of 60 hours.

and GP satisfaction ratings (Smith *et al.*, 2001; O'Dowd *et al.*, 2006b; HSE, 2010). In particular, GPs have reduced their night and weekend hours substantially (O’Dowd *et al.*, 2006a), enhancing their own quality of life and the quality of their family/social life (O’Dowd *et al.*, 2006b).

A.5 Defining the role of the GP

The role of the GP is multi-faceted, but is primarily a clinical role which is built around delivering care to patients: “medicine is a vocation and those who enter this profession do so with the overwhelming desire to treat and cure patients” (IMO, 2007: 1). The ICGP curriculum development group have adopted the European definition of the specialty of general practice (ICGP, 2005; see Appendix A1) in developing their core curriculum (see section A.6). This expands to six core competencies: Primary care management; Person centred care; Specific problem solving skills; Comprehensive approach; Community orientation; Holistic modelling (Appendix A2 provides details of the characteristics that underpin these competencies). Mastery of these competencies means that the doctor has “the capability of managing all problems presented in general practice” (WONCA, 2011: 27). The characteristics and competencies are implemented in the areas of clinical tasks, communication with patients and management of the practice.

The caring/clinical emphasis in this definition is also clear in Gregory’s (2009) outline of the roles performed by general practices[67], where the focus is on consultation, prescribing drugs, treatment of various types of ailments, referrals to specialists, screening and immunisation, condition management and health promotion. However, the IMO (2007) widen this, with much of the above captured within the 'diagnostician' role of the GP, which is acknowledged as their most important function. In addition, the IMO outline their role as a continuous scholar, advocate, communicator (incorporating management) and teacher/mentor.

Although practice management is highlighted as an implementation area, and primary care management is a competency (though wider than business management, as Appendix A2 indicates), there is limited reference across the definitions to this specific role. Thus, an understandable emphasis appears to exist on the caring/clinical role, even

67 While based on English practices, the roles are consistent with those found in Irish practices (Nolan, 2007; Competition Authority, 2010).

though the business management elements of being a doctor/GP are acknowledged at the policy level (General Medical Council, 2006), with prior literature supporting the notion that GPs are likely to react to financial incentives (Brick *et al.*, 2012). This highlights a commercial as well as patient orientation amongst GPs, as owners/employees of small businesses. Illustrating this, Lynch (2012) quotes the CEO of the ICGP – Kieran Ryan – who notes that, in the context of services provided by rural GPs faced with cuts in their income, "(Doctors) want to provide care for their patients and endeavour to do whatever they can to do it, but are faced with the realities of running a business". Therefore, while not perhaps appearing as prominently, the business management role of the GP is important.

A.6 Qualification and training

As section A.2 indicated, GP training takes place under the auspices of the ICGP as the designated post-graduate training authority for general practice. In order to train in the traditional manner, an individual – with a recognised undergraduate degree in medicine and qualified as a Medical Practitioner – must apply to the ICGP to join one of fifteen regional training programmes. Places on these programmes are currently limited to 157 annually and are oversubscribed (Boate, 2011). Training takes a total of four years (two years in secondary care and two years in general practice). A trainer is appointed to each registrar, who formally mentors, supports and trains the individual while they work in the practice, as they see patients and engage in typical practice activities with other staff. Registrars also attend off-site training workshops.

In order to qualify as a GP, registrars must have satisfactorily completed their training, achieved the required standard in their examinations and be formally elected to the college as a member. Examinations are set and administered by the ICGP in accordance with their core curriculum. This curriculum covers a wide range of clinical and patient related areas of relevance to general practice (e.g. separate modules on Paediatrics and Dermatology), as well as one module out of thirteen devoted to practice management[68] (ICGP, 2007). Thus, consistent with policy reports on medical education in Ireland (Fottrell, 2006; Buttimer, 2006), it is recognised that trainee doctors need some

68 Examples of the 23 learning outcomes addressed in the Practice Management module include "Outline what needs to be included in a business plan to include financial management/analysis, basic information management/planning, systems organisation, etc.", "Identify the statutory framework required for HR compliance in the practice" and "Demonstrate an understanding of the structure of the healthcare system". The researcher understands that the curriculum is currently being revised.

education in management. However, O'Kelly *et al.* (2012) also note that a lack of management training is one of the key weaknesses highlighted by registrars in the current GP training system[69].

Post-qualification, GPs are required by the Medical Council to undertake a minimum of 50 hours of continuous professional development annually. To assist, programmes of training are provided by a variety of bodies including the ICGP. The majority of ICGP programmes are in clinical areas (e.g. Diabetes Care and Minor Surgery), in addition to two specific management-related courses for qualified GPs. These are the Diploma in Management in Practice and, since October 2011 in conjunction with Dublin City University, the Leadership for General Practice programme, with the latter programme recognising the increasing and more recent importance of leadership skills in this domain[70] (Clark, 2012; Willcocks *et al.*, 2013). Both programmes are part-time and run over an academic year, involving blended learning and the completion of assessments. In addition, the ICGP facilitates education through a Small Group Network of monthly meetings, reflecting a preference for this form of localised learning.

A.7 The national Primary Care Strategy and development of primary care teams

In 2001, the Department of Health and Children published Ireland's first Primary Care Strategy entitled *Primary Care: A New Direction* (DOHC, 2001). The strategy was developed with the goal of enhancing the effectiveness and capacity of primary care to deal with the vast majority of health needs, thus relieving pressure on the hospital system, improving health status and controlling costs. This recognises that an emphasis on primary care internationally has been found to positively benefit population health (Nolan and Smith, 2012), with the GP a key component (Layte and Nolan, 2009). At the core of the strategy is the development of multiple primary care teams nationally, each to offer primary care services to populations in a defined area, such that all patients would have access to a team in their locality (DOHC, 2001).

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69 The ICGP provide a further optional programme in management to registrars ('Management in Practice and the GP Registrar Course'). Approximately fourteen registrars on average undertake the programme annually.

70 The literature cited here is from the UK, where recent policy changes give rise to broader leadership roles for GPs in Clinical Commissioning Groups. While this is not currently the case in Ireland, GP involvement with primary care teams can give rise to leadership responsibilities (see section A.7), in addition to leading in their own practices.

Each inter-disciplinary team (approximately 20 members) consists of a range of primary care practitioners, including GPs, nurses, physiotherapists, counsellors and administrative staff. Members are expected to meet regularly (preferably from dedicated facilities) to discuss specific cases and can inter-refer patients as the need arises, availing of an enhanced skill mix as a means of assigning workload to where it is best suited (DOH, 2012). Teams liaise with a wider primary care network of other medical professionals and organisations, including dentists and dieticians and, beyond this, with specialist services including acute hospitals.

International experience of teams in primary care has found that GPs may adopt a leadership role (DOHC, 2001). Draft policy guidance (HSE, 2011: 11) indicates that the GP, when team leader, "takes responsibility for ensuring effective decision making and functioning of the team". This is a departure for GPs from traditional working relationships as at least some of the other team members are likely to be neither employees nor co-workers but independent professionals and peers, creating new managerial challenges where positional power is less relevant (Willcocks, 2003). In this context, the move to inter-professional teams may necessitate GPs taking on additional managerial duties (O'Riordan and McDermott, 2012) and utilising different approaches (Willcocks *et al.*, 2013).

To date, the overall strategy has met with mixed success. As of September 2012 (most recent figures), 417 primary care teams had been established, with plans to achieve 485 teams by year-end, containing 1,636 GPs and serving 3.8 million people (Reilly, 2012). However, issues have been raised with regard to the effectiveness of teams, with some held to exist in name only; almost two-thirds of GPs surveyed reported that their teams were functioning poorly (ICGP, 2011). Problems identified have included GPs not being able to attend team meetings, concerns over patient confidentiality, infrastructural issues and management problems (ICGP, 2011). However, the desire to see the strategy through has been reiterated by the Minister for Health and Children (Reilly, 2012). Consequently, for GP members, increasing levels of inter-professional working and functioning in teams, with associated leadership and managerial duties, may potentially arise as they become more effective, numerous and centrally located.

A.8 Challenges facing the profession

While GPs report increased morale and decreasing levels of stress in recent years (O'Dowd *et al.*, 2006a), the profession is facing a number of significant challenges presently. Arising from the ongoing economic recession, and the Government's efforts to reduce spending, GP incomes have decreased. However, these reductions are resisted by the IMO, who note that "General Practice is at breaking point and the imposition of further cuts … threatens to destroy the fabric of the Irish General Practice System", noting the high fixed cost base of practices (IMO, 2013: 2). Indeed, the IMO suggest that cutting GP incomes will have a negative impact on the capacity of practices to introduce UHC, contending that GPs are already using "the overall income of their practice to provide services to patients based on their medical need and without regard to the cost of providing each service" (p.4). Thus, reductions are expected to adversely affect patient services and increase pressure on secondary care (IMO, 2013), with the NAGP (2013) estimating that 8% of practices could close because of cuts.

Two frequently observed and inter-relating recent trends in general practice have been the increasing feminisation of the profession and large numbers of GPs approaching retirement (Thomas and Layte, 2009; Competition Authority, 2010). In 2005, approximately 69% of all GPs were male; this is a notable decline from 85% in 1992 (O'Dowd *et al.*, 2006a) and reflects the increasing proportions of females (70%; O'Kelly *et al.*, 2008) presently in GP training. Thus, while registrar numbers have increased, concerns have been expressed that many female graduates will choose to work part-time. In 2007, 68% of recently qualified female GPs worked on a part-time basis, compared to 33% of males (O'Kelly *et al.*, 2008)[71], while most current female registrars (61%) indicate their intention to work less than full-time in practice in the future (O'Kelly *et al.*, 2012). Consequently, although 157 training places are available, this will not give rise to 157 whole time equivalent GPs annually (O'Kelly *et al.*, 2008). In terms of retirements, research indicates that these are mostly male (reflecting the more traditional gender profile of the profession) and were working full-time (O'Kelly *et al.*, 2008). The IMO (2013) highlight that 30% of currently working GPs will have retired within fifteen years, while Bourke and Bradley (2010) note that a typical sole practitioner – still about 25% of GPs – is male and 50 years of age or older. As a

71 O'Dowd *et al.* (2006a) found that, in 2005, amongst all qualified GPs, part-time employment was considerably lower at 20% for females and 4% for males.

consequence, considerable numbers of full-time retirees will be replaced by part-time GPs[72].

Thomas and Layte (2009) consider the consequence of these trends for general practice. The authors note that GP per capita in Ireland is already below the European average, which is inconsistent with a strategy that wishes to place increased emphasis on the primary care sector. With forecasted population growth up to 2021 and greater increases in older age groups[73], the research concludes that the 150 training places initially recommended by Buttimer (2006) would not be sufficient to achieve European averages, with an additional 100 full-time equivalent training places required each year instead[74]. Therefore, without further increases in registrar numbers beyond 157 annually and schemes to recruit more GPs/delay retirements[75], GPs are facing into a period of significant over-demand for their services; between 2006 and 2021, demand for GP consultations is forecast to increase by over 48% (Thomas and Layte, 2009). Indeed, if 'free' GP care is introduced[76], this may further accentuate the challenge as research demonstrates that those who do not pay for the service tend to be greater consumers (Layte and Nolan, 2009), with consultation charges seemingly acting as a deterrent (Nolan and Smith, 2012).

These issues are recognised and solutions have been implemented or proposed, in part because of the Irish Government's commitment to eliminate the restrictions on the number of qualifying GPs. Solutions include using nurses and pharmacists for specific elements of care delivery (Thomas and Layte, 2009), an alternative route to qualification for those with extensive general practice experience but lacking some component of training[77] and 'fast track' training for doctors with hospital experience but

72 The sizable difference between full-time and part-time hours is illustrated in the NHS Information Centre (2007) report. While full-time partners worked an average of 44.4 hours per week, part-time salaried GPs worked an average of 23.8 hours per week. On this basis, replacing a full-time owner with a part-time employee is an average loss of over 20 hours per week.

73 Older age groups are typically heavier users of GP services (Thomas and Layte, 2009).

74 Thomas and Layte (2009) estimated that, in order to achieve the EU average by 2021, 3,149 GPs would be needed in total by 2013. However, as section A.2 indicated, this is currently 2,954 GPs, highlighting an undersupply already. Thus, while the authors suggest that a target of 87 GPs per 100,000 population would approach the EU average, based on Teljeur *et al.* (2013), Ireland remains considerably below this at 64.4 GPs/100,000.

75 Along with increased recruitment of GPs from abroad, encouraging GPs to delay retirement (O'Dowd *et al.*, 2006a) is specifically mentioned in the current Programme for Government as strategies to increase GP numbers. However, aside from opening up access to GMS patients for qualified GPs which may encourage international interest (see section A.3 above), no specific initiatives have been implemented to achieve these goals to date.

76 This was not considered in Thomas and Layte's (2009) study.

77 Currently in place.

who have not been through GP programmes[78] (Boate, 2011; Dáil Éireann, 2012). As many of these are recent initiatives (where implemented), their impacts are difficult to fully determine at present.

A.9 Conclusion

The GP context in Ireland is an evolving one as practice sizes increase, working hours and incomes decrease, inter-professional team working becomes more prevalent, and the gender balance changes. Some features do seem relatively constant (the primacy of the clinical role and focus on patient care, with less emphasis on management learning compared to more clinically-related training), while uncertainty surrounds other potential changes (the introduction of UHC and means to increase GP numbers/manage workflow). This is all taking place within a highly challenging environment of continued reductions in government expenditure, a rising and ageing population, and insufficient capacity within the system to meet associated demands. It is within this complex and changing context that the GP also functions as a manager, which is the focus of the current study. This appendix highlights that, although acknowledged, the managerial role is secondary and appears less clearly defined and considered in practice. In addition, this appendix raises the important question as to whether GPs have the available capacity to both manage and fulfil their primary patient care obligations, given the nature of the context and the growing challenges. Thus, GPs need to be mindful of where they are contributing value, which is a relevant issue in this study.

78 This is not currently in place.

Appendix A1: Definition of the specialty of General Practice

General Practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General Practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to the health needs and resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe health care.

Source: Definition of General Practice (ICGP, 2005)

Appendix A2: Competencies and characteristics of the discipline of General Practice

Primary Care Management

1. The ability to manage primary and continuing contact with patients adhering to the principles of confidentiality and maintaining accurate patient records.

2. (a) The ability to co-ordinate care with other professionals in primary care and specialists leading to effective and appropriate care provision, taking the advocacy position with the patient when needed. The ability to participate in teamwork and delegate tasks, where appropriate, in the general practice setting.

2. (b) The ability to manage change exploring its positive potential.

Person Centred Care

3. The ability to adopt a person centred approach, dealing with patients and problems with respect and dignity and developing a relationship of trust. Protection of marginalised patients should be a priority.

4. The ability to develop and use the general practice consultation to produce an effective doctor patient relationship. The ability to share with the patient the decision making process and responsibility for their health.

5. The ability to provide longitudinal continuity of care as determined by the needs of the patient while striving to maintain a person centred approach which may become more difficult in the context of changing practice models.

Specific Problem Solving Skills

6. The ability to utilise a specific decision making process informed by the clinical picture and the prevalence and incidence of illness in the community.

7. The ability to diagnose and manage conditions some of which may present early in an undifferentiated way, to intervene urgently when necessary, to tolerate uncertainty and unpredictable developments and to know when appropriate to cease investigation, while continuing to provide care.

Comprehensive Approach

8. The ability to manage acute, chronic and rehabilitative health problems simultaneously in the same individual. GPs while maintaining their generalist skills may also wish to develop special skills.

9. (a) The ability to promote health and well being by applying health promotion and disease prevention strategies appropriately. The ability to recognise that GPs have a responsibility not to medicalise normality.

9. (b) The ability to value the importance of their listening and supportive role.

Community Orientation

10. (a) The ability to reconcile the health needs of individual patients and the health needs of the community in which they live, balanced with available resources, recognising the responsibility to maintain their own skills.

10. (b) The ability to participate in combined care taking an appropriate part with secondary and tertiary care.

Holistic Modelling

11. (a) The ability to use a bio-psycho-social model taking into account cultural and existential dimensions. The ability to recognise the role of social, cultural, ethical, religious and family background in the determination of health.

11. (b) The ability to maintain and nurture ones own physical and mental well being which leads to better patient care (recognising limitations and professional boundaries and the need to seek help when appropriate).

Note – The characteristics have been adapted by the ICGP for the Irish context.

Source: Definition of General Practice (ICGP, 2005)

Appendix B: Fayol's (1988) functions of management

Planning:

Fayol recommends the construction of formal plans. By ensuring that plans are formulated, management bring together expertise and knowledge from all parts of the organisation, assisting in implementation, accuracy and alignment. Plans can be long, medium and short-term in nature, one feeding into another; Parker and Ritson (2005) emphasise that Fayol saw planning as both strategic and flexible in nature. The plan considers available resources, the nature of the work and future trends, while the manager determines the direction; unity, continuity, flexibility and accuracy are features of a good plan of action. Fayol notes that the absence of a plan leaves the organisation open to mistakes and deviations of a costly nature; such deviations may arise because of a reaction to a temporary change in the environment that does not warrant any amendment in the path being taken. Thus, management need to ensure that plans at all levels work together to avoid drift by putting in place appropriate systems and processes.

Organizing:

This function is primarily the organisation of people, putting in place lines of reporting and authority and ensuring that communication occurs. Fayol outlines a number of management 'duties', including the maintenance of discipline, harmonising activities, leadership, performance management, decision-making and ensuring that the plan is actioned. These are largely fulfilled through effective organisation of the business, the nature of which varies on the size and complexity of the entity. Complexity is affected by the numbers employed and the nature of their work – less supervision is needed for highly motivated professionals, flattening the structure, enhancing communications and reducing costs. In this respect, the selection process for employees is important, to whom work is delegated by the manager to assist them in specific obligations e.g. correspondence, drawing up/revising plans, information provision.

Coordinating:

Effective coordination by management helps to establish harmony between the various parts of the entity. This function entails ensuring that the supply of resources is in line with what is appropriately required through careful sequencing and timing of relevant activities. Thus, all parts of the business work together in an orderly manner, each part knowing what they have to do and how they relate to the rest of the firm in order to achieve planned objectives. Schedules are established and updated as circumstances change. Fayol indicates that a key tool of coordination is the regular formal meeting, which instils a unified focus. At such meetings, management is informed about the running of the organisation and any issues arising are discussed and addressed as decisions are made.

Commanding:

Commanding[79] requires management to extract optimal returns from employees in a manner that serves the interests of the overall firm. Thus, the manager needs to have an in-depth knowledge of their staff and their abilities, as well as any agreements in place. Following from this, the manager needs to be ready to remove those who are not deemed sufficiently competent for the role, but also needs to lead equitably and by example. Periodic inspections of the organisational structure are recommended to remedy any weaknesses identified. Fayol indicates that meetings and reports are important tools of command. Meetings are opportunities for the manager to explain items, seek opinions, make decisions, ensure that instructions are understood and to clarify that everyone knows what they are to do. Reports ensure that the manager is fully and promptly informed as to what is happening. However, a manager who commands effectively will also delegate and empower appropriately, needing to avoid excessive detail as a means of preserving time for more important matters.

Controlling:

The final function described by Fayol establishes whether everything that was planned actually happens. Control involves checking and monitoring various aspects of the

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79 The negative connotations associated with 'commanding' – in the sense of being 'dictatorial' – were not Fayol's view of this function (Fells, 2000). Lamond (2003) and Parker and Ritson (2005) indicate that a more modern view of the function (though still consistent with Fayol) would encompass motivation, leadership and empowerment/participation.

organisation including quality, progress, finances and resources. When operating effectively, surprises are minimised and control is exercised in a timely manner. If the plan is not being achieved, corrective action is taken by identifying and resolving weaknesses, discrepancies or faults. In order for the control function to operate, all of the other functions should be effective – the active following of a plan is required, within an organised structure where meetings occur to coordinate actions and where command is exercised. Prompt reporting of deviations is essential in order for early action to be taken to rectify these. Whether this is carried out by the manager or by others depends on the complexity of the organisation, though Fayol warns that where the manager fills both roles, rather than focusing on the wider needs of the organisation, the firm may suffer.

Appendix C: Mintzberg's (1973) roles

Figurehead:

The manager performs certain duties that are mostly symbolic, but that ultimately derive from their position and authority such as representing the organisation; decision-making or information-processing of a material nature is not required.

Leader:

The leader role is fundamental and over-arching, and derives from the manager's formal position, involving relationships between manager and subordinate. HR activities are encompassed in this role, as the leader is involved in recruitment, selection, evaluation and reward. Motivation of others stems from this role, as the leader seeks to encourage higher performance. Mintzberg also refers to the leader 'meddling' in operations. This arises because their overall role gives them a mandate to broadly explore and probe the organisation, identifying issues and problems with the power to address. As leader, the manager brings everyone together under a common organisational goal.

Liaison:

Dealings happen with parties over whom the manager may not have control but from whom the manager needs information and assistance. Thus, the manager interacts with peers and contacts from their internal and external networks, extracting what they need while also reciprocating. In this respect, the liaison role paves the way for the informational roles of the manager by establishing the necessary relationships to facilitate information flows.

Monitor:

The monitor role entails the manager seeking out information, as well as being in a position to receive unsolicited information. As a consequence, the manager acts as a nerve centre. Various categories of information are obtained by the manager, including operational, external events, analyses and reports, ideas and trends. Not all of the information is formal as the manager also makes use of rumours, acting as a filter and an integrator. Some of this is passed on, while the manager processes other information

to identify opportunities and problems, to better understand the organisation and the environment and to develop plans.

Disseminator:
The disseminator role involves the passing of information to internal parties. This information may be facts obtained that are relevant to the work of others, or may be value-based which outlines the manager's opinions on matters where their perspective is needed. In this respect, dissemination can be associated with delegation.

Spokesman:
Where the manager transmits information externally, they are acting as spokesperson for the organisation. This may entail lobbying, informing the public, speaking as an expert or providing relevant information to external contacts as part of an 'exchange'. Such information needs to be current and accurate to ensure that the manager remains credible.

Entrepreneur:
As entrepreneur, the manager "acts as initiator and designer of much of the controlled change in his organization" (1973: 78). Having identified opportunities and threats in the environment (through the Monitor role), the manager decides what action is to be taken (initiator) and determines a response (designer). This may entail delegating specific tasks to others; in some cases, the manager has little involvement in the project, while in other situations they may choose to directly supervise.

Disturbance Handler:
When the manager is handling disturbances, they are dealing with matters and changes that are outside of their control. Thus, corrective action is taken to resolve disputes and unforeseen events and threats. Given the sudden nature of disturbances, the manager is often reactive. Mintzberg also indicates that there is a middle ground role between that of the 'entrepreneur' and the 'disturbance handler', namely that of 'problem solver'. Here, the manager is either acting early to prevent a crisis or reacting to a minor disturbance to avoid an escalation.

Resource Allocator:

The manager makes decisions as to how resources will be deployed within the organisation in seeking to achieve the strategies set and oversees how this happens. This encompasses all of the resources under the manager's control. Mintzberg identifies three elements to resource allocation – scheduling of their own time which indicates where their priorities lie; programming work by deciding who does what; and authorising and sanctioning actions. This final element gives rise to budgeting, based upon which some decisions are made, though many may be ad-hoc. Managers can also develop loose mental models and flexible plans to guide them in choices.

Negotiator:

The final managerial role involves the manager taking part in internal and external negotiations with parties. As an authority figure, the manager possesses the power to make decisions and to enter into commitments arising from this.

Appendix D: Advantages of the interview approach

Advantages of interviews	Experience in current study
Flexibility	By utilising a semi-structured approach, the researcher was able to make changes during interviews to address new information/perspectives as they arose.
High response rate	In total, 35 interviews were conducted; this represented a response rate of 78% based on those potential participants that the researcher was able to speak with (see section 5.6.1).
Easy administration	The use of telephone interviews[80] predominantly was a convenient means of data collection for interviewees as it allowed them to be interviewed at the most suitable time for them and in their preferred location (see section 5.9.1).
Opportunity to observe non-verbal behaviour	The use of telephone interviews meant that non-verbal cues were not observable. However, this was not a significant loss in the study and was compensated by attention to audible intonation and pauses (see section 5.9.2).
Demands less patience and motivation	In general, the researcher found that the active engagement of both parties in a conversation was well received and that interviewees appeared interested.
Control over the environment	The interview approach provided the researcher with scope to have some control over the environment in which the data are collected. However, as section 5.9.2 discusses, the researcher made conscious efforts to maintain some balance here.
Capacity for correcting misunderstandings by respondents	The interview allowed questions to be rephrased and/or explained where necessary.

80 The use of telephone interviews is discussed in section 5.9.

Control over the order of the questions		While the researcher had ultimate control, the conversational nature of the exchanges meant that some flexibility was both required and welcomed.
Opportunity to record spontaneous answers		The nature of the interviews encouraged instinctive responses, as opposed to planned and pre-meditated answers (interviewees did not know questions in advance). In addition, where interviewees raised interesting points after the interview had formally finished, these were noted.
Control over the identity of the respondent		Each interviewee was ultimately recruited through their membership of a professional association, thus verifying their credentials.
Completeness		All topics and questions, as appeared relevant to their circumstances, were addressed with each interviewee.
Control over the time, date and place of the interview		As noted above, all interviews were arranged based on the interviewees' requirements and schedules; this was seen as critical in gaining their participation (see section 5.9.1).
Ability to handle complexity		By virtue of being a verbal exchange, the researcher was able to frame and address complex and in-depth topics/questions, and clarify, explain or probe where appropriate.
Greater permissible length		On average, interviews lasted approximately one hour, allowing for a detailed exploration of the relevant topics.

Source: Adapted from Sarantakos (2005)

Appendix E: Interviewee details

Interviewee	Position	Gender	Total numbers of staff	Formal practice manager	Years in current practice	
				Note 1		
Established Owners (Years in Current Practice > 5 years)						
GP 1	Sole Practitioner	Male	>16	Yes	19	
GP 2	Partner	Female	>16	Yes	5.5	
GP 3	Sole Practitioner	Male	6-10	Yes	25	
GP 4	Sole Practitioner	Male	6-10	No	20	
GP 5	Sole Practitioner	Male	6-10	Yes	6	
GP 6	Partner	Female	11-15	Yes	12	
GP 7	Sole Practitioner	Male	6-10	Yes	10	
GP 8	Partner	Male	11-15	Yes	22	
GP 9	Sole Practitioner	Male	6-10	Yes	26	
GP 10	Partner	Male	>16	Yes	8	
GP 11	Sole Practitioner	Female	11-15	Yes	25	
GP 12	Sole Practitioner	Male	6-10	No	25	
GP 13	Partner	Male	>16	No	25	
GP 14	Sole Practitioner	Male	1-5	Yes	29	
GP 21	Partner	Male	11-15	Yes	6	*Note 2*
New Owners (Years in Current Practice < 5 years)						
GP 15	Partner	Male	6-10	Yes	4	
GP 16	Partner	Male	6-10	Yes	4	
GP 17	Partner	Female	1-5	No	1	
GP 18	Sole Practitioner	Male	1-5	Yes	1	
GP 19	Partner	Female	1-5	No	0	
GP 20	Sole Practitioner	Female	1-5	Yes	5	
Non-Owners						
GP 22	Assistant	Female	6-10	Yes	1	
GP 23	Assistant	Female	11-15	Yes	1	
GP 24	Assistant	Female	6-10	No	2	
GP 25	Assistant	Male	6-10	Yes	5	
GP 26	Assistant	Female	1-5	No	1	
GP 27	Assistant	Female	6-10	No	4	
GP 28	Assistant	Female	6-10	No	1	
GP 29	Assistant	Female	1-5	Yes	2	
GP 30	Sessional/Locum	Female	1-5	No	1	*Note 3*
GP 31	Sessional/Locum	Female	11-15	No	1	
GP 32	Sessional/Locum	Male	1-5	No	0	*Note 3*
GP 33	Sessional/Locum	Male	6-10	Yes	1	*Note 3*
GP 34	Sessional/Locum	Female	1-5	No	2	
GP 35	Assistant	Male	>16	Yes	2	

Note 1 - This is based on the interviewees own declaration of an official practice manager.

Note 2 - GP 21 was interviewed as part of the 'new owners' by virtue of his membership of the Network of Establishing GPs. However, based on his time in his current practice and his own acknowledgement, he more appropriately fits the definition of an 'established owner'.

Note 3 - Amongst non-owners, three of the interviewees (GP 30, 32 and 33) work in more than one practice. The information provided here, with respect to their practices, relates to the practice they spend most of their time in. However, all interviewees were encouraged to talk about past and present practices.

Appendix F: Interview protocol

In applying this protocol, the researcher seeks to adopt a reasonably conversational approach and, allow some flexibility in the order and wording of questions based on the circumstances of the interview. Additional questions will be introduced as appropriate.

Introductions

- Thank interviewee and establish initial rapport through brief chatting
- Inform interviewees of approximate length of interview
- Request permission to record and advise when starting
- Brief outline of research, interview and overall process
- Reassert re anonymising of text and availability of transcript

Interview questions

- Based on appropriate interview schedule (see Appendix F1 to F3)

Closing

- Thank interviewee for their participation
- Ask how they feel interview went and how they found the process; note any comments on this for improving future interviews
- Offer transcript and agree mode of delivery (password-protected, by email)
- Note any relevant comments/insights that arise after recording ceases

Appendix F1: Initial interview schedule for established owners

1. Can you tell me about the work that you do?

2. How has this changed since you became an owner? (Prompt: Was this what you expected?)

3. What were your reasons for going into partnership/setting up your own practice?

4. How did you prepare for that transition? (Prompt: How did you find out about what your new role would entail?)

5. What do you remember most about the period just after you were appointed a partner/went into practice on your own? (Prompt: How did you feel?)

6. Did you change personally to fit the new role or adapt the role? In what way?

7. I would like to talk about how the practice is managed (*use questions to stimulate responses, further questions and discussion*):
(a) What is the management structure?
(b) Does the practice have a formal business plan? (Prompt: How often is this reviewed?)
(c) How are key practice decisions made? (Prompt: Types of decisions? Process?)
(d) Who is involved in making decisions? (Prompt: In what ways?)
(e) Who attends meetings and how regular are they? (Prompt: Types of meetings?)
(f) What is generally discussed at these meetings?

8. (a) What managerial roles do you undertake?
(b) When does this work get done? (Prompt: In work? After work? At home?)

9. What support is in place to assist you in your managerial roles? (Prompt: Practice manager? Others? What do they do?)

10. What would you say are the greatest challenges you face in fulfilling your managerial roles?

11. (a) How would you describe your attitude <u>now</u> towards the managerial side of being a GP?
(b) Has this changed in any way from <u>before</u> you became an owner?

12. (a) In your present role, do you ever experience conflict between your clinical and managerial roles? (Prompt: In what way?)
(b)What impact does this conflict have on you, if any? (Prompt: Does it ever lead to stress?)

13. How do you deal with this conflict?

14. How have you learned the more managerial aspects of your GP role?

15. (a) Have you received formal management training at any stage in your career? (Prompt: What was this?)
(b) Did you find this formal management training relevant? (Prompt: In what way?)
(c) How did you apply this formal management training in your practice?
(d) Is there any additional training that you would have liked?

16. If you could make three changes to your current role, what would they be?

Appendix F2: Initial interview schedule for new owners

1. Can you tell me about the work that you do?

2. Can you describe for me a normal working day for you?

3. What were your reasons for going into medicine initially? (Prompt: GP specifically?)

4. What were your reasons for becoming an owner? (Prompt: Has the work changed?)

5. How have you learned this role? (Prompt: In particular, the managerial side)

6. What are your goals for the practice?

7. Can you tell me a bit about how the practice is managed (*use questions to stimulate responses, further questions and discussion*):
(a) What is the management structure?
(b) Who carries out the key managerial roles in the practice? (Prompt: What are these roles?)
(c) Does the practice have a formal business plan? (Prompt: How often is this reviewed?)
(d) How are key practice decisions made? (Prompt: What is the process?)
(e) Who is involved in making decisions? (Prompt: What do they do?)
(f) Who attends meetings and how regular are they? (Prompt: Types of meetings?)
(g) What is generally discussed at these meetings?
(h) What performance measures are used in the practice? (Prompt: Controlling activities)

8. (a) What managerial roles do you undertake? (Prompt: When does this work get done?)
(b) What would you say are the most important of these roles? (Prompt: Which take most time?)
(c) How would you describe your management style?

9. (a) What supports are in place to assist you in your managerial roles? (Prompt: Practice manager/Others?)
(b) What do they do?

10. Have you received any formal management training? (Prompt: Was this relevant? Reasons for none? Need in the future?)

11. What would you say are the greatest challenges you face in fulfilling your managerial roles?

12. How do you see your role in the future? (Prompt: Is it likely to change?)

13. What would you say takes priority for you in work – your clinical role or your managerial role? (Prompt: What are your reasons for this?)

14. (a) In your present role, do you ever experience conflict between your clinical and managerial roles? (Prompt: In what way?)
(b) How do you deal with this conflict?

15. (a) Do you ever feel overloaded? (Prompt: In what way?)
(b) How do you deal with this?

16. Do these conflicts ever lead to stress? (Prompt: How do you deal with this?)

17. If you could make any key changes to your current role, what would they be?

Appendix F3: Initial interview schedule for non-owner GPs

1. Can you tell me about the work that you do?

2. Can you describe for me a normal working day for you?

3. What were your reasons for going into medicine initially? (Prompt: GP specifically?)

4. What were your reasons for going into your current role? (Prompt: Has the work changed?)

5. (a) How have you learned this role? (Prompt: In particular, the managerial side)
(b) Have you received any formal management training? (Prompt: Was this relevant? Reasons for none?)
(c) Is there any formal management training that you feel you need? (Prompt: How will you get this?)

6. Can you tell me a bit about how the practice is managed (*use questions to stimulate responses, further questions and discussion*):
(a) What is the management structure? (Prompt: What are the lines of reporting?)
(b) Who carries out the key managerial roles in the practice? (Prompt: What are these roles? What does the practice manager do? What do the owners do?)
(c) Does the practice have a formal business plan?
(d) How are key practice decisions made? (Prompt: What is the process?)
(e) Who is involved in making decisions? (Prompt: What is your role here?)
(f) Who attends meetings and how regular are they?
(g) What is generally discussed at these meetings?
(h) What performance measures are used in the practice? (Prompt: Controlling activities)

7. (a) What managerial roles do you undertake (if any)? (Prompt: When does this work get done?)
(b) What administrative roles do you undertake? (Prompt: When does this work get done?)
(c) What supports exist to help you with this type of work? (Prompt: Practice manager/others?)
(d) How would you describe your management style?
(e) How would you describe the management style of the practice manager? (Example?)
(f) How would you describe the management style of the owners? (Example?)
(g) How would you describe your attitude to management/administrative work?

8. (a) How does the practice manager impact on your work as a GP?
(b) In what ways do they support your work?
(c) Do they ever hinder your work? (Prompt: In what way?)

9. You mentioned that you do/do not want to be an owner in a practice in the future:
(a) What are your reasons for this?
(b) (If don't want to be an owner): What would need to change for you to change your mind on this?

10. What would you say are the greatest challenges you face/will face in fulfilling your managerial/administrative roles? (Prompt: How do you address these challenges?)

11. How do you see your role in the future? (Prompt: Is it likely to change?)

12. What would you say takes priority for you in work – your clinical role or your managerial/administrative role? (Prompt: What are your reasons for this?)

13. (a) In your present role, do you ever experience conflict between your clinical and managerial/administrative roles? (Prompt: Does one ever get in the way of the other? In what way?)
(b) How do you deal with this conflict?

13. (a) Do you ever feel overloaded? (Prompt: In what way?)
(b) How do you deal with this?

15. (a) Do these conflicts ever lead to stress? (Prompt: How does the stress show itself?)
(b) How do you deal with this stress?

16. If you could make any key changes to your current role, what would they be?

Appendix G: Codes and higher-level categories used

Clinical Role
Choosing medicine
Choosing general practice
Enjoying being a GP
Work a GP does
Ownership
Ownership
Choosing ownership
Memory of ownership transition
Preparing for transition to owner
Work changed
Why partnership
Partnership benefits
Management Training
Learning managerial role
Formal management training
Applying formal management training/education
Relevance of formal management training
Learning by doing
Additional training desired
Teaching trainees managerial side
Experiences of trainees in managerial teaching
Mentoring
Business/General
Choosing role
Role transition
Future role
Primary care teams
Group practice
Goals
Branding
Most important person in the practice
Management Work
Challenges in managing
Responsibility
Admin work
Management structure
Management style
Managerial roles
Formal management
Business planning
Formal business plan
Strategy
Reactive
Succession

Innovation
Controlling activities of practice
Monitor
Motivation
Networking
Organisation
Finances
Performance measures in practice
Practice meetings
Discussed at practice meetings
Regularity of practice meetings
Teamwork
Making practice decisions
Practice decision makers
Delegation
Change
Role Conflict
Attitude before ownership to managerial work
Attitude now to managerial work
Role overload
Time
Timing of managerial work
Bringing work home
Working out of hours
Co-ops
Priority – clinical/managerial
Conflict between clinical and management
Role conflict internal
Desired changes to current role
Dealing with role conflict
Supports
Practice support for managerial role
Practice manager
Supports

Note – Words in bold represent higher-level categories.

Appendix H: Extract from data analysis table

Category	Code	Memo	Within code analysis	Total	Sample interview quotes
Management Work	Challenges in managing	**EO's:**	• Finances	3	(O)ne of the biggest challenges for all GPs now is funding and it's going to get more difficult in the future.
		Management not perceived as difficult – challenge lies in not having the time and the resources. Lack of expertise – somewhat.	• Staff management	3	There can be tricky staff issues … individual staff members might have gone running to particular GPs with their problems or worries.
			• Time	9	(I)t's probably just constraints of time and just have the time to reflect and contemplate.
					Time, there's never enough.
					(H)aving the interest and having the motivation to actually devote time and effort to that.
					There are guilt issues there, because it is very satisfying to see 20 patients in a morning and go for lunch and say well I worked.
					(T)rying to keep on top of things reduces challenges.
					(I)t is getting more difficult from my point of view to get everything done.
					(W)e're also operating at two sites here in town so that also adds to the fragmentation.
					You find you spend less and less time consulting and more time managing.
					(W)hat we are best at and want to do is seeing patients and anything that distracts us from that is a distraction and some of those things, perhaps, are best farmed out.
			• Delegation	3	Delegation, the failure of delegation.
			• Expertise	2	(Y)ou're trying to keep a handle on things which you don't have great expertise in.
			• Bureaucracy	2	(D)ealing with the bureaucracy side of things and that can be quite problematic.
		NO's:			
		Tend to see it as more daunting – lack of experience/interest? (EO's have limited training)	• Staff management	6	(H)aving a responsibility to your employees and supporting and dealing with things like maternity leaves and so on.
		Staff management again the core issue – it is a people business – does this clash with their altruistic nature??	• Time	6	I would struggle with time management at the best of times because of running two sites and my significant workload.
					(J)ust getting enough time to do it and to do the patient side of things.
					My time management could be a bit more efficient and probably get distracted by the job that's in front of me.
					(J)ust accepting that there is absolutely no way that you can possibly do everything that needs to be done.
					(O)nce we realised that I was going to take over this practice, he [spouse] immediately said I'll manage the paperwork.

Appendix H: Extract from data analysis table (continued)

Category	Code	Memo	Within code analysis	Total	Sample interview quotes
					(T)rying to do all of the things you're supposed to be doing for [patients] and then you're trying to manage the business on top of that. I think time is the biggest constraint.
		Lack of time again – noticeable not a tendency to bring home (Work late??)	• Running the business	3	Sometimes it's just the lack of knowledge of where to go for the answers.
			• Systems	2	(W)e don't really know how much money comes in from each of our resources on a weekly basis.
		E'ees:	• Finances	3	(L)earning about the finances and learning that side of thing.
		Recognition of it being a business.	• Expertise	4	I wouldn't be afraid of it, but I just don't think I know enough about it.
		More limited involvement, but are staff managers by virtue of their position. Expertise and experience issues (LBD?)	• Balance	3	(Y)ou can't be a clinician and not have any money coming in the door.
		Time again, though less so	• Running the business	4	(M)aking sure that everything … will be running the place as a business.
			• Staff management	5	(T)he one thing I would absolutely dread is if someone had to be let go. I think that would be the worst, be it myself or someone else.
			• Time	3	(T)here just wouldn't be enough hours in the day beyond the clinical stuff to attack the management stuff.
					(T)ime management and I put a piece of paper down and I go where did I put it.
					I can't see that I would be able to continue what I'm doing now. The more I get involved in management, I'll have to delegate.
			• Delegation	2	I'm much younger, much less qualified and much less experienced and here I am telling [staff] how to do their job.

Appendix I: Comparison of managerial tasks identified in the findings to previous clinical-manager literature

Task performed by GPs	Previous empirical literature
Staff management	Betson and Pedroja (1989) Schneller *et al.* (1997) Gatrell and White (1997) Braithwaite (2004) Holton *et al.* (2010)
Financial management	Fisher and Best (1995) Walker and Morgan (1996) Gatrell and White (1997) Braithwaite (2004) Kippist and Fitzgerald (2009) Holton *et al.* (2010)
Review of information and monitoring activities (encompassing performance measurement)	Betson and Pedroja (1989) Fisher and Best (1995) Fitzsimmons and White (1997) Gatrell and White (1997) Holton *et al.* (2010)
System implementation/management	Betson and Pedroja (1989) Fisher and Best (1995) Fitzsimmons and White (1997) Braithwaite (2004) Holton *et al.* (2010)
Establishing policies	Betson and Pedroja (1989) Fisher and Best (1995) Holton *et al.* (2010)
Facilities management	Braithwaite (2004)
External liaison	Gatrell and White (1997) Braithwaite (2004)
Marketing	Holton *et al.* (2010)

Appendix J: Illustrations from interviews of managerial roles engaged in and the purpose(s) of these

Monitor → Resource Allocator → Entrepreneur	Purpose(s)
Initially, as a sole practitioner in private practice, for many years I didn't have a nurse. We've a lot more staff now, the place is much bigger similar to most practices really, it's expanding. The area actually changed as well, this particular area, in that there was an awful lot of development and building	Organising
I guess our initial thing was just watching the costs, we were guestimating how much the ESB was going to be, how much consumables would we need because if we were saying well, if we see four people a day, well we wont need as many couch rolls	Planning (in a narrow sense) Commanding Controlling
Monitor → Resource Allocator → Entrepreneur/Disseminator	
(W)e did a cost benefit analysis with regard to surgical instruments. [Nurse] did the necessary research and figured that, if we were actually to meet the new standards, it would cost us about eight grand and that the volume of work that we were doing didn't justify that. So, we made the decision to go to disposable equipment for most things and just to stay the way we are with regards to others, even though they don't meet the standards, they're very close to the standards, it will just have to be that way. That was the decision in terms of the monetary side	Planning (in a narrow sense) Commanding Controlling
I suppose one decision that we did make recently, we decided to close our medical card list. We are just too busy, we have too many medical card patients. We've closed it public and private	Commanding Controlling
Monitor → Disturbance Handler → Disseminator	
Since I found out [about a maintenance issue], I sent a note to the practice manager to sort it. It's just bringing it to someone else's attention and delegating	Commanding Controlling
She [practice manager] spoke to me yesterday about the visitor from the employers agency and one of the issues he had was that we don't have a clocking in system for staff and he felt that was important … we had a sort of an informal discussion about that … I would have put my views across to her and some other people put their views across as well	Commanding Controlling

Monitor → Disturbance Handler → Entrepreneur	
I heard a stunning presentation from a Professor of General Practice who ran an appointment system in R and he described how he structured it, how it could work and within 6 months, we had it running in Q and nobody could believe it. We would have been one of the first practices [in the area] to use a structured appointments system in a very deprived area and they are all doing it now During the last couple of years, we've had an employment issue with a member of staff … so there had to be disciplinary action there	Planning Organising Commanding Controlling Commanding Controlling
Monitor → Disturbance Handler → Entrepreneur/Disseminator	
(I)f I find somebody is not doing enough work then there is a consultation process. If I find people are running over, then again it's a consultation process. The reception staff will feed back to me if patients are kept too long waiting	Commanding Controlling
Monitor → Resource Allocator/Disturbance Handler → Entrepreneur	
We took on a new partner because our practice is growing and because the complexity … what we do in a consultation is changing so we needed a new partner. We planned for it financially by referring back to the books for the previous year and predicted growth	Planning Organising Commanding Controlling