THE NEW ZEALAND MEDICAL JOURNAL
Vol 115 No 1158 ISSN 1175 8716

Morale in general practice: crisis and solutions

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Abstract

Aim To place the causes and level of psychological stress among general practitioners (GPs) within the context of the overall morale in the profession and to describe solutions suggested or achieved in response.

Methods Postal survey of a random sample of GPs in New Zealand. Levels of morale and psychological distress (GHQ-12) were assessed. Respondents scored categories of workload stress and generated solutions to perceived stressors.

Results The response rate was 448/ 658 (68%). Potent causes of work stress were excessive paperwork, bureaucracy, multiple problem consultations, time pressures and combining work with family life. Overall mean 5 point Likert scale ratings for perceived stress and morale were 3.47 (SD 0.98) for morale, and 4.15 (SD 0.85) for stress. GHQ scores: of 448 respondents 143 (33%) scored 4-8, and 43 (10%) scored >8. The most commonly suggested solutions were simplifying paperwork, increasing the General Medical Subsidy, increasing locum provision and providing united professional representation.

Conclusions Potent sources of stress and low morale continue to affect New Zealand general practice, with significant numbers of GPs recording high levels of psychological distress. Morale was higher than in the UK, but lower than in Ireland. GPs have developed a range of potential solutions they would like implemented.

There is international recognition of low morale and a state of unhappiness among health professionals[1]. In New Zealand general practice difficulties in recruitment and retention particularly in rural areas[2,3], have occurred at the same time as erosion of incomes and increasing burdens of administration and paperwork. These difficulties have been recorded in surveys of stress, psychological symptoms and 'burnout'. Although GPs may remain satisfied with their jobs overall, work is perceived as affecting physical health of nearly half of GPs, over half often contemplate leaving and one third have a significant level of psychological symptoms[4].

The New Zealand situation is not unique, but the small size of the available workforce tends to magnify the impact of problems. Similar studies in the United Kingdom and Australia have also shown that stress levels amongst GPs is significant[5-7]. In an Australian study, 12.8% of respondents showed high levels of psychological symptoms and 53% had considered leaving general practice because of occupational stress[7].

Although 'stress' and 'morale' are terms that are commonly used together or even interchangeably, there are important differences in their definition and meaning. Stress has been defined as the 'perceived inability to cope with demands'. Individual stress levels are likely to vary with time and to react readily to changes in circumstances.

Morale can be defined as a 'feeling of confidence in one's situation with a positive hope for the future[5]. It is likely to be less variable, less transient, and more resistant to change than individual stress levels and is more likely to reflect the individual's perception of the future of their group or organisation. Morale has been studied in relation to the socioeconomic profile of the practice area and type of health system, and found to be associated with time pressures, small practice isolation and a lack of patient centredness[8]. In a UK setting it was also linked to the structure, management, and expectations of the NHS.[5]

While specific measurement scales and instruments have been used to measure GP stress[6,7], morale has not been evaluated to the same extent, yet is likely to have just as great an impact on health care and health professionals.

While there has been considerable detailing of the extent and causes of health professional stress, there has been little exploration of the potential and actual solutions that might be generated by those health professionals to overcome their difficulties. Despite present challenges it seemed likely there would be many individual and group initiatives to try and decrease individual stress and improve overall morale. The Royal New Zealand College of General Practitioners (RNZCGP) for example has prepared a resource for GPs regarding self-care, intended to be used as an educational and audit tool to help them to better recognise and manage their own stress levels.

This research thus aims to place individual practitioner stress and its causes, within the context of the overall morale in the profession and the solutions that practitioners suggested or had achieved as a response.

Methods

A postal survey was sent to a sample of 700 New Zealand GPs, during the year 2000, the sample being obtained from the RNZCGP database. The initial random sample was weighted to enable representative responses from both urban and rural GPs.

Non-responding doctors were sent reminder questionnaires after one and two months. The four part questionnaire assessed a priority order for previously identified stressors, levels of psychological symptoms and morale, perceived solutions to work stress and low morale, and demographic data.

A list of potential causes of work stress was collated from a RNZCGP survey and the results of previously published studies from the Departments of General Practice in Wellington and Auckland. These were grouped into six categories: non-clinical demands; representation; financial issues; personal issues; workload and consultation structure and length. A further miscellaneous category (other) was created in which respondents could specify stressors that were not listed. Respondents were invited to provide free text detail as to the impact of the sources of stress in each category.

The respondents were asked to score the causes of stress using a Likert scale. In the 'non-clinical demands' category respondents were asked to specify organisations that were considered to generate most stress. These responses were collated and ranked by the frequency to which they were referred.

Psychological well being was assessed using the 12-item general health questionnaire (GHQ-12).[9] Individual scores ranged from 0 to 12. A cut-off of 4 or greater was used to indicate the probable presence of psychological disturbance, while a score greater than 8 indicated the probable presence of more significant psychological symptoms.[4,10] Self report levels of perceived stress and morale were measured using a Likert scale previously validated in international settings.[5]

As well as identifying sources of stress, respondents were asked to provide solutions to the problem of stress and low morale. Respondents were invited to describe solutions for any measures that would lead to decreased stress and increased morale for general practice using the same six categories as in the stress prioritisation question.

Free text responses were analysed for themes connected with particular solutions within each category. The frequency of each solution theme was recorded. Demographic data regarding personal and practice details were recorded.

Results

Of 700 questionnaires sent, 42 were returned indicating the GP was not eligible for entry into the study due to retirement or locum status. The response rate for completed questionnaires was 448 from 658 eligible (68%). The sample comprised 65% male and 35% female practitioners with a mean age of 43.7 years. The mean length of time in practice was 14.6 years. Ninety-nine (22.7%) of the sample worked in solo practice with 219 (50%) being in practices with 3 or more partners. Four hundred and one (90.9%) doctors worked more than 6 sessions a week in general practice. The length of appointment offered by the doctors varied from 5-10 minutes (17%) to more than 15 minutes (13.6%). Nearly 70% offered appointment times of between 11 and 15 minutes.

Table 1. Sources of work stress (n = 448). (Maximum on Likert scale of 5 means high stress).

Source of work stress	Mean(x/5)	SD
Excessive paperwork	4.27	0.85
Bureaucracy	4.21	1.67
Multiple problems raised per consultation	4.06	1.02
Pressure to keep to time	3.84	1.05
Combining work with family life	3.70	1.14
Longer consultation times	3.50	1.08
Inappropriate patient demands	3.50	1.07
High cost of care to patients	3.46	1.13
Fear of litigation	3.45	1.16
College	3.33	0.98
Locum Shortage	3.25	1.38
Political representation	3.20	1.29
Long hours/ on call	3.19	1.37
Media representation	3.16	1.22
CME	2.98	1.01
Technology	2.95	1.15
Poor remuneration	2.93	1.23
Public image	2.79	1.16
IPA	2.66	1.12
Competition with other PHC providers	2.54	1.22
Coping skills	2.35	1.00
Student loan debt	1.25	0.84

Sources of stress. The most potent sources of job stress are provided in Table 1. Excessive paperwork had the highest mean score (4.27) on the 5 point Likert scale, followed by bureaucracy (4.21), the difficulties caused by multiple problems in the consultation (4.06), time pressures (3.84) and combining work with family life (3.7).

Major themes identified from respondent comments portrayed a profession that felt undervalued, at the receiving end of both patient and organisational pressure, and finding difficulty in coping with the demands of family and professional life.

The respondents were asked to identify specific organisations that acted as stressors. The most frequently named organisations were ACC (34% respondents), Pharmac (12.7%) and the insurance companies (12.7%).

GHQ scores. Of 448 respondents 294 (67%) scored < 4, 143 (33%) scored between 4 and 8, and 43 (10%) scored greater than 8.

Perceived stress and morale. Overall mean ratings were 3.47 (SD 0.98) for morale, and 4.15 (SD 0.85) for stress, recorded on a 5 point Likert scale. Levels of stress and morale are recorded in Table 2, with comparison to published Irish and UK (Northern Ireland) rates.

Table 2. Perceived stress and morale among New Zealand general practitioners, compared to those in Ireland and United Kingdom (Northern Ireland).

	New Zealand		UK (Northern Ireland)		Republic of Ireland	
	n = 449		n = 905		n = 703	
Variable	%	(n)	%	(n)	%	(n)
How would you rate your morale?:						
Very poor/poor	26.7	(120)	29.4	(266)	11.4	(80)
Average	33.4	(150)	41.7	(377)	32.4	(228)
Good/very good	39.9	(179)	29.0	(262)	56.0	(394)
Not classified		-		-	0.1	(1)
How would you rate your present level of stress?:						
Very high/high	54.8	(246)	49.5	(448)	35.7	(251)
Average	33.6	(51)	43.8	(396)	49.5	(348)
Low/very low	11.6	52)	6.7	(61)	14.1	(99)
Not classified		-		-	0.7	(5)

Solutions to stress and low morale. The number of respondents who felt that solutions were required for each category of stressor is given in Table 3 together with the total number of solutions suggested for each category. In some categories more than one solution was suggested by some GPs. The non-clinical demands category was perceived to require solution by most GPs and produced the greatest number of suggested solutions. Table 4 shows the most frequently suggested solutions across all categories. Free text solution suggestions collated into common theme categories are shown. The most commonly suggested solutions were directed at streamlining and simplifying paperwork. Examples of suggestions included removing the detail required on special authority documentation for prescriptions, and an additional grant as recompense for excessive government driven paperwork.

In other categories there was strong support for increasing the General Medical Subsidy (GMS), increasing locum provision and providing a united and realistic representation for the profession.

Table 3. Frequency of perceived need for solutions in each stress category n = 448.

Stress category	No of GPs perceiving need	%	No of solutions suggested
Non clinical demands	373	83%	536
Representation	245	55%	346
Financial demands	272	61%	254
Personal	205	46%	52
Workload	253	56%	316
Consultation	254	57%	210
Other	56	13%	

Table 4. Most frequently suggested solutions to problem of stress and low morale.

Solution	Frequency n=448
Streamline/simplify paperwork	171
Higher GMS	153
Locum Recruitment	119
United strong realistic representation	108
Public education about realities of general practice	77
Consultation with real GPs before changing/creating paperwork	77
Media image/Adverts like pharmacies	62
Payment for paperwork	52
Increased GMS for long/complex cases	52
College requirements/Videoing for college to change/cease	50

Discussion

This study builds on previous local and international surveys of stress and unease in health professionals. It suggests that potent sources of stress and low morale continue to affect New Zealand general practice, and that GPs have developed a range of potential solutions they would like to see implemented.

Given the response rate of 68% and the national sampling frame, these results are representative of general practice at the time the survey was undertaken. The distribution of male to female general practitioners is consistent with the findings of the Medical Council of New Zealand annual workforce survey. The results of individual psychological symptom scores interpreted through the GHQ are comparable with previously published New Zealand work and are of continuing concern. This is the first New Zealand work in which levels of stress have also been compared with morale. It demonstrates high levels of psychological symptoms, self-reported high stress levels of over 50%, and over a quarter of respondents reporting morale to be very poor or poor. This is a challenging matrix and one that provides further evidence of the crisis present in primary health care in New Zealand. The levels of morale are somewhat better than Northern Ireland, which operates under the National Health Service 'free to patients' funding system, but worse than Ireland, another OECD country with a partial fee for service system.[5] We believe that the relationship between individual work stress, psychological disorder, low morale and the 'unhappiness among doctors' that received widespread international comment[1] deserves further local debate.

Despite the difficulties described by the respondents and the identification of persistent stressors there is evidence of considerable energy and innovation in defining and promoting solutions. This is the first recorded survey that has collated the suggestions of a health workforce in this way. We could only find evidence of one study that has previously asked GPs for solutions to workload stress. A questionnaire based study in England concerning the need for a stress support service for GPs showed that 78.8% of GPs asked were in favour of such a service especially one with "independently accessed counsellors and stress management groups".[11]

We believe that the wide range of solutions generated in this study goes beyond a wish list and should form the basis for continuing discussion with health-related organisations and government. Raising the GMS and reducing the difficulties

associated with excessive paperwork and bureaucracy are the two responses that doctors feel would provide the greatest boost to morale. There is a creditable realism to many of the responses and recognition that some paperwork is necessary in modern medicine. The plea for streamlining bureaucratic processes and reducing the overall administrative burden should not go unheard.

It should be noted that in the last year there has been progress in some of these challenging areas. In an attempt to meet rural workforce needs there have been a number of innovative funding schemes and incentives. If these kind of initiatives are sustained and linked to long term recruitment strategies it may alleviate the present rural workforce crisis. A further request from GPs was for united representation. In the last two years there has been a greater level of collaboration between the RNZCGP, NZMA, IPA and non IPA groupings and university departments of general practice to establish common ground and advocacy for the profession. The three year additional funding for primary care also has the potential to address some of the issues raised by doctors in this survey.

While these initiatives are welcome, more is required. Support for both rural and urban doctors is not solely defined in financial terms. Many of the doctors felt undervalued and under pressure from both the public, government and government organisations. New Zealand has a high quality system of general practice and primary care that should be recognised and celebrated. That public and political recognition would not cost much in financial terms but would mean a great deal to the morale of the respondents of this survey.

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Acknowledgements: The authors acknowledge the general practitioners who completed the questionnaire. Charlotte Maffey was funded with a summer studentship from the Auckland Faculty of the RNZCGP.

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