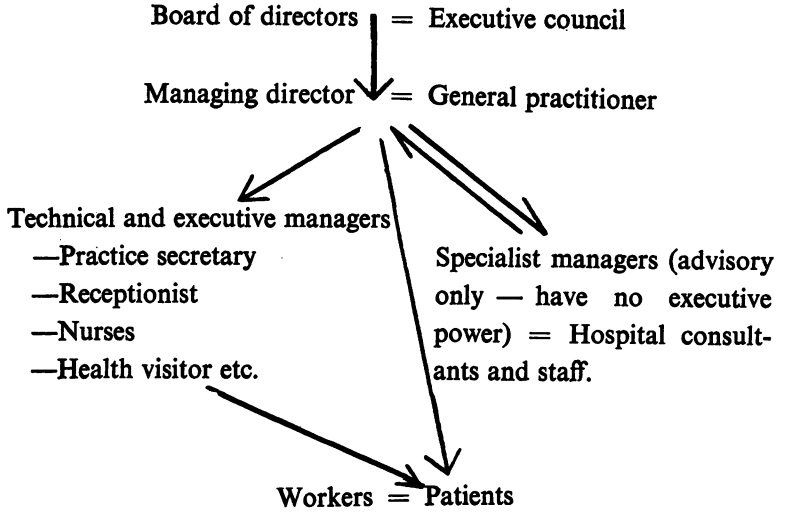
MORALE AND MANAGEMENT IN GENERAL PRACTICE*

B. L. E. REEDY, M.B., B.S., D.Obst.R.C.O.G.
Chinnor

THIS paper should really have been entitled 'Morale and *the* management'—the morale to which I refer is that of our patients and you and I are the management.

It has often seemed to me that general practice has many activities in common with business and industry. A comparison of the command or management structure of each might look like this:



A reading of the literature on industrial psychology and the science of management of industrial relations makes it obvious that there are many parallels with our own situation, that we have something to learn from the intensive study and rapid development since the war of management technique and communications theory and

*A paper read at the Thames Valley Faculty postgraduate weekend course, on 13 May 1967, at Reading.

that we appear to have woefully ignored these developments.

I cannot find any medical literature on the cultivation and maintenance of the morale of patients in general practice.

Peter Drucker in his classical monograph *The practice of management* gives these as the five basic operations for a manager:

1. Sets objectives
2. Organizes the work
3. Motivates people
4. Communicates with people
5. Measures the performance of subordinates (= patients) and develops them

We general practitioners fulfil all these criteria in relation to our practices and the last three are directly concerned with the management of people. The effectiveness of the business manager in carrying out these three functions is related to the creation in his workpeople of the condition of what is called 'morale'. This morale of an industrial or business enterprise has a great deal to do with its effectiveness and profitability in the broadest sense of the word. The object of this paper is to examine these three aspects of our managerial activities in relation to our own patients.

I propose to discuss the following:

1. That each patient on a doctor's list bears a group relationship to all the other patients of that doctor and to the doctor himself
2. That a condition of 'morale' exists in this group, the level of which affects the way in which a practice runs and its satisfaction value for the doctor and the patients
3. To define this state of morale and study the factors affecting it
4. To see if it can be measured or evaluated
5. To relate 'morale' to current and future developments in general practice

1. *Group relationship*

A 'group' as defined by social psychology consists of a number of people whose relationship to each other is formed by: ". . . mutual awareness and expectations between the individuals on the basis of a background of shared experience."

There are so called 'primary' groups which have a small number of members and are personal and intimate in their relations—for instance, the family, a games team or a committee.

Then there are so called 'secondary' groups which are much larger, in fact too large for contact to occur between all the members at one time—for instance, an orchestra, an army brigade, a general practice. They immediately imply a certain formalization of relationships and are termed 'structured' if, as in general practice, there is Authority *versus* Submission and the group depends on formal behaviour patterns for its integrity. This meeting is just such a group and its structure would dissolve if one of the audience failed to

conform to its group behaviour pattern by, for instance, persistently interrupting a speaker or by playing a portable radio.

The formation of groups depends in the first place on interpersonal relations—that is, on the 'one to one' relationship. In medical practice this is the basic doctor-patient relation and this has been explored in depth by Michael Balint and his colleagues since 1949.

By contrast with the 'one to one' relationship medical practices consist in general of 'structured secondary groups' in which the leader (the general practitioner) has a 'one to many' relation with the group and it is this 'one to many' relationship which I believe to be worth formal study.

What are the particular features of a doctor's secondary group with his patients and what exactly constitutes this group?

1. A large part of every doctor's list is built up by a 'chain of recommendation' from the group to its new members.

2. Patients discuss the doctor frequently within their 'primary' groups, each of which interlinks with all the others at work, in the family, at the club. They discuss his family life, foibles, characteristics, successes and failures and thus build up a kind of 'group image' of him. It is well-known that knowledge of the individuality and personality of the group leader tends to easier identification with his objects and views by members of the group and greater loyalty to him. This makes it important that the leader allows himself to be 'known' in the fullest sense to his group and to put across his image satisfactorily.

3. One of the characteristics of groups is the creation of a 'culture pattern' of their own, to which individuals have to conform in order to belong, and this of course occurs in general practice because we ask all our patients to conform to the pattern of administrative behaviour peculiar to our own practice.

4. All the patients in a practice are linked by the background of shared experience, not the least of which is the strong and unpleasant emotion of fear. All the patients of a doctor at some time in their lives bring fear under the same roof, into the same room and before the one man.

Every secondary group consists of sub-groups (i.e. primary groups) either on a geographical basis or brought together by common interest or activity. I would guess that the 'pregnancy club' is possibly the most powerful sub-group in a practice.

2. *Group morale*

Now I am going to quote from another classic of management technique—*Managers, men and morale* by Brown and Raphael: " . . . These sub-groups are in constant and regular contact—what they think and feel constitutes the morale of the organization." It follows that a doctor who can create and maintain a high state of morale in his organization is acting as a socially cohesive force and by doing so may actually help to negative or offset the many disruptive influ nces in the contemporary life of the community he serves.

This leads inevitably to a dynamic view of the work of a general practitioner and it follows that early on in management selection for general practice in the medical schools we should try to find those undergraduates who are positively motivated towards the creation of such social groupings with a high morale and internal cohesion and with themselves at the centre performing in addition their clinical work. If a medical student is not so motivated, modern screening and selection techniques should discover this early on and guide him elsewhere than general practice.

3. *The nature of morale*

Now to examine the 'nature of morale and its effects on general practice'.

The *Oxford English Dictionary* defines 'morale' as: 'A moral condition especially as regards discipline and confidence, particularly of troops'.

Many of us will remember that a military unit's morale is measured positively by its fighting effectiveness and negatively by the number of soldiers on the daily charge sheet. Similarly, an industrial concern has as its signs of high morale a high productivity record, increasing profit and turnover, low rates of absenteeism, sickness and labour turnover and rare or absent industrial disputes.

I believe that a group of patients similarly manifests its needs, satisfactions, frustrations and aggressions in relation to its managers (that is the doctor and his staff) and that the manifestations of these are what makes a practice a more or less easy or difficult one to work in.

Now let us revert to our *O.E.D.* definition and examine the factors in general practice affecting discipline.

1. Discipline is affected by the extent to which a disciplined framework is provided so that all patients are able (if they are capable) to conform to an 'approved' behaviour or culture pattern in respect of appointments, consultations, requests for prescriptions, home visits and so on.

2. The existence of a recognizable personal discipline in the doctor himself. For the patients this means above all his degree of reliability for them and his integrity towards them.

3. The presence of a mature and stable central personality (the doctor) both geographically and socially within the community over a long period of time. My own impression and the impression of other doctors I have spoken to is that it takes between two and three years for group behaviour to become 'fixed' around a new doctor in a practice. This, I am told, is also the time, classically, which it takes for a frustrated love affair to burn itself out. Perhaps there is a parameter of human behaviour here somewhere.

4. The manner in which disciplinary action is taken by the doctor when it is needed. If the principles I am trying to formulate are correct and correctly applied, discipline should be needed less and less often as time goes on. It goes without saying that disciplinary action should be right in amount, quality,

timing and manner of taking and should never destroy the basic relationship of mutual trust between doctor and patient.

Still in pursuit of our definition of 'morale' we move on to the factors affecting confidence (that is, of the patients in the doctor).

1. Discovery by the patient of the diagnostic effectiveness of the doctor.

2. Discovery by the patient of the therapeutic effectiveness of the doctor.

3. Realization by the patient of the degree of apparent personal involvement a doctor allows himself in an illness situation. Really I suppose this means his sympathy for and humanity towards his patients.

4. Hearing other patients or other doctors express confidence in a doctor or praise him.

5. The feeling by a patient that the doctor likes him and admires his qualities in spite of his shortcomings or his feelings that he is inferior or repulsive in some way.

This, of course, is a fundamental wellspring of human relationships and it is this aspect of a doctor's work that Balint has done so much to help. It should no longer be necessary for any doctor to feel consistently aggrieved, irritated or angry with a particular patient's behaviour towards him. Balint's work has given him the means to gain insight into his attitude and to turn it round into a successful and therapeutic relationship both for himself and the patient.

You will notice that my reasoning has been illustrated by reference to the 'one-to-one' situation but the attitudes and feelings engendered in patients individually very quickly come to permeate the whole practice and contribute to the formation of a group attitude towards the doctor.

To sum up with another quotation from Brown and Raphael: "Confidence is present when the firm manufactures a socially useful product, in good premises, with good plant, under good management and organization".

What other factors contribute to the state of morale in our practices?

1. Effectiveness of communications; (Operation 4 in Peter Drucker's five operations). This refers to the basic discipline of understanding the patient and ensuring that he understands you in the interview situation. It also includes willingness to publicize to your patients changes, developments, improvements and practice statistics by all available means. I would draw to your attention the probable benefits of a regular six-monthly or annual printed bulletin about the practice with contributions by both doctors and patients. Dr Pike of Birmingham has successfully organized public meetings of his patients with lectures and discussions chaired by himself or his partners. These appear to have been enormously successful in creating primary groups of diabetics and so on.

2. Creating optimum conditions under which patients can perform; starting with the assumption that every single patient who comes into your surgery building is feeling acutely insecure no matter how benign the reason for his consultation, this includes details of furnishing, colour, heating, lighting—pos-

sibly even the provision of 'muzak'—all to contribute to his sense of ease and identification with his surroundings. If you are successful in creating this ease he will at once communicate with you more effectively.

3. Creating the 'dignity of consultation' for every patient no matter of what income or intellectual level. This only begins with an appointment and adequate time and assumes that a consultation once begun is a process of continuous 'creative communication'. This should only under exceptional circumstances be interrupted by the telephone or by the process of subsidiary consultation which uses an examination room to isolate the original one.

4. Objectivity in the attitude of the doctor to reasonable requests by patients.

5. Availability of a patient's 'own' doctor for him under ordinary circumstances. This is probably the most commonly-voiced criticism by patients of group practices with ineffective or absent appointment systems. They never know who they are going to see!

6. The creation of opportunities for patients to ventilate grievances and complaints of all kinds and for the making of suggestions about the practice.

Now I am going to list what I consider to be the manifestations in a practice of *lowered* morale.

Of course some of these can be outside a doctor's control and such factors might include a high level of group aggression in a community from pressure of political events, racial conflicts and alterations in social mores. Loss of kinship ties, genetic handicaps and loss of earning power are others. At the same time I believe that study of our situation may enable us to develop deliberate techniques by which the aggressive feelings of social groups can be diverted from their doctors and directed at other targets.

1. The most extreme forms of action against a doctor are legal action or a complaint to the executive council. These are equivalent to strike action in industry.

2. Removal of a number of patients from the doctor's list at their own or the doctor's request is hardly less serious and corresponds to giving or taking 'notice' in the commercial world.

3. Night and evening calls and late calls—at least some of these are motivated unconsciously by aggression against the doctor.

4. Other failures to conform to the 'culture pattern' of a practice—for instance telephoning out of recognized hours for a repeat prescription.

5. Requests for a second opinion—or the obtaining of one without the courtesy of asking.

6. Requests to change from being an N.H.S. patient to being a 'private' patient.

7. Failure to make concessions to the doctor's point of view.

8. Critical discussion of a doctor with other patients.

4. *The measurement of morale*

First let me say that I feel sure that the work-load figure for any practice is irrelevant to this consideration. Morale certainly affects work-load but there are many other things that do so as well and the figures are notorious for their inconsistency for this reason. In any

case morale is a quality and a rather intangible one at that and therefore not very susceptible to quantification.

However, an attempt to quantify should be made and I think that one would begin by studying a practice to find the figures for all the forms of aberrant behaviour I have outlined above.

Next, one could emulate techniques of American industry where questionnaires have been used very extensively to study morale problems. It should be possible to draw on this experience to compile such a questionnaire that the views and attitudes of a representative section of a doctor's patients could be studied in considerable detail. It would then certainly be possible to quantify these and draw valid conclusions about the level of morale in that practice.

A technique which has been developed in British industry is that of the 'attitude survey' in which an independent outsider, usually a psychologist with good interviewing ability is suitably introduced to the employees. At a series of confidential interviews with them individually their views on every aspect of their life with the firm are sought and suggestions encouraged. The two most practical results of such a survey are that grievances are aired which have sometimes been smouldering for years and a sort of mass catharsis is elicited with the release of emotional tensions. There also results a series of suggestions about all aspects of a firm's management, many of which are found to be both useful and original. In the long term these surveys have been shown to lead to improved productivity and reduced labour wastage and absenteeism in firms subjected to them, the effects sometimes lasting for years.

I am suggesting that attitude surveys may eventually have their place in our industry too and that the volume of useful material produced by our patients in the way of suggestions will be staggering. I am also suggesting the necessity for consumer research in general practice on a broader scale than that of the attitude survey which is mainly intended to be therapeutic for one particular organization at a time.

So many alternatives and changes are facing us that we can no longer afford to risk creating an effete practice structure because we failed to make use of the techniques of consumer sampling and in my view a body should be created to do this for us in our practices. From a morale point of view, it is a principle of good management that the doctor presented with viable suggestions about the practice by his patients must acknowledge them and then act on them or else explain why he cannot implement them for the time being.

You will now ask me, 'Why is all this necessary when we have

managed to run our practices quite successfully in the past?'

My answer is that various increasing pressures on us make it vital to organize our management technique (having realized that such a discipline does exist in our sphere) so as to retain the central and vital feature of general practice—the individuality of the personal doctor-patient relationship that should exist between ourselves and each one of our patients.

These pressures might be listed as follows:

1. Scientific progress—in particular the new clinical, administrative, communication and information storage techniques soon to come into general practice.

2. The need to manage larger groups effectively with fewer doctors.

3. The need for general practice to find a new 'image' for itself.

4. The existence of unprecedented social pressures on us. This refers to the universal expectation by our patients of a much higher degree of rapport with us, of explanation, thoroughness and greater technical skill and last but not least the expectation of greatly improved surroundings in an aesthetic sense for these activities; all within the framework of the N.H.S. which by statute we cannot escape.

5. The break-up of traditional mores in our society, and the creation of increasing insecurity and demand by modern mass communication techniques.

6. The revolt against authoritarianism which is clearly evident in our culture. The doctor has always been identified as the figure of authority, parenthood, orthodoxy and discipline. In addition the fear which our patients feel in our presence can easily become dislike if handled badly. We have to exploit means like those I have outlined to create a new archetype of ourselves and seek to divert the aggressive feelings, both group and individual, which are potentially and sometimes actually present between our patients and ourselves.

It remains to say that all the advances in general practice are tending to depersonalize our medicine. So far, Balint's work is the only factor tending to reverse this. There is a growing need to study the management of group relations between a therapeutically orientated doctor in general practice and manageable groups and to evolve means by which this relationship can be manipulated to everyone's best advantage.

In conclusion I quote again from Brown and Raphael:

Neither improvements in technology nor improvements in structure will achieve their ends unless accompanied by an improvement in the standard of management. Management is a problem of human relations. By definition a manager attains his objective through the government of others. His principal task is therefore that of establishing good relations with those others. If management is to be scientific it must call upon the knowledge and experience of those who are expert in group relations.

We as general practitioners are increasingly filling the role of managers in the health services of the country and we can surely afford to embody some of these principles of management into our

thinking, knowing that they have been formulated from the sometimes bitter experience of another profession.

REFERENCES

Lord Robens (1927). Opening address to British Medical Association. Londonderry. *Brit. med. J.* **1**, 230.

Management functions of hospital doctors (1966). Her Majesty's Stationery Office for Ministry of Health.

Drucker, P. F. (1961). *The practice of management*. London. Mercury Books (Heinemann).

Brown, W. B. D. and Raphael, W. (1948). *Managers, men and morale*. London. Macdonald & Evans.

Balint, M. (1968). *The doctor, his patient and the illness*. Second edition. London. Pitman.

Fraser, J. M. (1962). *Industrial psychology*. London. Pergamon Press.

Pike, L. A. (1965). Group health education in a general practice. *J. Coll. gen. Practit.* **10**, 317.

COLLEGE APPEAL

The following items, are offered for sale in aid of the College appeal fund:

		Price per item s. d.
Ties	100 per cent silk, black or green with College crest	25 0
	Plus postage and packing	6
Cuff-links	Enamelled with College crest	25 0
	Plus postage and packing	6
Ashtrays	Blue glass with College Coat-of-Arms in gold ..	4 0
	Plus postage and packing	6

Postage rates apply to British Isles only

Collecting boxes

May we draw members attention to collecting boxes which are available for use in doctors' surgeries in aid of the College Appeal. Please apply to the **Appeal Secretary, College Headquarters.**