

Management in general practice: the challenge of the new General Medical Services contract

Kath Checkland

SUMMARY

Background: Managers in general practice perform a variety of roles, from purely administrative to higher-level strategic planning. There has been little research investigating in detail how they perform these roles and the problems that they encounter. The new General Medical Services (GMS) contract contains new management challenges and it is not clear how practices will meet these.

Aim: To improve understanding of the roles performed by managers in general practice and to consider the implications of this for the implementation of the new GMS contract.

Design of study: In-depth qualitative case studies covering the period before and immediately after the vote in favour of the new GMS contract.

Setting: Three general practices in England, chosen using purposeful sampling.

Method: Semi-structured interviews with all clinical and managerial personnel in each practice, participant and non-participant observation, and examination of documents.

Results: Understanding about what constitutes the legitimate role of managers in general practice varies both within and between practices. Those practices in the study that employed a manager to work at a strategic level with input into the direction of the organisation demonstrated significant problems with this in practice. These included lack of clarity about what the legitimate role of the manager involved, problems relating to the authority of managers in the context of a partnership, and lack of time available to them to do higher-level work. In addition, general practitioners (GPs) were not confident about their ability to manage their managers' performance.

Conclusion: The new GMS contract will place significant demands on practice management. These results suggest that it cannot be assumed that simply employing a manager with high-level skills will enable these demands to be met; there must first be clarity about what the manager should be doing, and attention must be directed at questions about the legitimacy enjoyed by such a manager, the limits of his or her authority, and the management of performance in this role.

Keywords: case studies; interviews; practice management; qualitative research; role.

Introduction

MANAGEMENT of the 'old' general practitioner (GP) contract introduced in 1990 was largely a matter of ensuring that claims were correctly filed, that systems were in place to ensure that targets were met, and that patient numbers were accurate. By contrast, the managerial demands associated with the new 2003 contract are likely to be much higher.¹ As a recent briefing paper about practice management by the NHS (National Health Service) Confederation comments somewhat tortuously:

*'Practice management is crucial to successful implementation of the new contract, which incentivises organisational achievement at the practice level.'*²

Practice management in United Kingdom (UK) general practice has evolved continuously since its introduction in the 1970s, and as a result there is diversity of provision.³ In the early days of practice management most managers were promoted from within, becoming senior receptionists and gradually taking on a more developed role.⁴ Further change occurred in the 1990s with fundholding, when many practices used the associated management allowance to employ managers from outside the NHS for the first time.^{5,6} Although there is little published evidence about the actual roles being fulfilled by managers in UK general practice, Fitzsimmons and White⁷ used data from development work in Dorset to classify the work of managers as operational, tactical or strategic (Box 1).

In a qualitative study of practice managers, Westland *et al*⁸ found that larger practices, as well as those that had previously been fundholding, were more likely to have managers working at the higher levels, while Laing *et al*⁹ found that involvement of managers in decision making about purchasing services in fundholding practices varied, with male managers and those recruited from outside the health services more likely to have a strategic role. Building on findings such as these, there have been various attempts to codify the role of practice manager, most recently by Borrie *et al*.¹⁰ Based upon this, the *Competency framework for practice management*, issued as an appendix to the new 2003 UK General Medical Services (GMS) contract¹¹ recognises the current diversity of roles occupied by managers. It provides illustrations of the expected behaviour of managers performing administrative, managerial, or strategic roles across a variety of management areas, and links this to the demands of the new contract. This article uses results from qualitative case studies in general practice to draw some conclusions about the

K Checkland, MA (ECON), MRCP, general practitioner and research training fellow, National Primary Care Research and Development Centre, University of Manchester, Manchester.

Address for correspondence

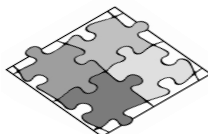
Dr Kath Checkland, National Primary Care Research and Development Centre, Fifth floor Williamson Building, University of Manchester, Oxford Road, Manchester M13 9PL.
E-mail: kath.checkland@dia1.pipex.com

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HOW THIS FITS IN*What do we know?*

The new General Medical Services contract will place considerable demands on practice management. Little is known about the exact roles currently being performed by managers in the United Kingdom and the problems they encounter.

*What does this paper add?*

This research suggests that if managers are to take on work at a strategic level to drive the implementation of the new contract, questions of legitimacy, authority and performance management must be addressed.

significant issues facing management in general practice in this new environment.

Method

These results form part of a larger study investigating the organisational impact on general practices of normative models of practice embodied in both National Service Frameworks and the clinical quality framework of the new GMS contract.

This study involved in-depth qualitative case studies in three practices in England, chosen using purposeful sampling.¹² Practices in a single primary care trust (PCT) were recruited to avoid differences arising from local activity of different PCTs, and within this, practices with a spectrum of engagement with the PCT, from current active participation to no involvement at all, were chosen. The practices all had a history of active involvement in NHS developments, to allow comparison of reaction to this new type of innovation (involving significant pressure from more senior staff on more junior staff to conform) with responses to previous changes in the NHS such as fund-holding, audit and local quality improvement schemes. The practices were all inner-city practices, covering ethnically and socially diverse populations, and were medium-sized, with patient numbers between 5000 and 6700. Data collection involved semi-structured interviews with doctors, nurses, practice managers and other staff with managerial or clinical responsibilities (for example, healthcare assistants, data recording clerks, and office managers), alongside observation of both meetings and other incidental practice activity. Box 2 lists the interviewees in each practice, and Box 3 shows the topics covered in interviews.

Questions relating to managerial roles were informed by Fitzsimmons and White's framework,⁷ dividing management work into the categories of operational, tactical and strategic (Box 1), while recognising that many managers will fall somewhere between these categories. Information gained in this way from interviews was compared with the observed roles performed by managers during meetings and other incidental activity. Documentation relating to practice organisation, audit data and papers from meetings were collected. The author undertook all of the interviews and observations, and as a fellow GP (albeit in a different area), attained a degree of 'insider' status¹³ that might not

Operational

Routine work required to keep the practice running: for example, payment of wages and salaries, setting up systems to ensure all appropriate claims are filed to maintain practice income, management of maintenance of premises

Tactical

Managing short- to medium-term objectives: for example, management of computerisation, overseeing audit work, overseeing service developments

Strategic

Contributing to the long-term development of the practice. This involves keeping abreast of NHS developments, assessing practice strengths and weaknesses, bringing ideas to team meetings and liaising with outside bodies such as health authorities (now PCTs)

Box 1. Levels of management in general practice (adapted from Fitzsimmons and White⁷).

Practice A	Practice B	Practice C
3 partners	4 partners	3 partners
1 practice manager	1 practice manager	1 practice manager
1 office manager	1 administrative manager	1 practice nurse
2 practice nurses	2 practice nurses	1 healthcare assistant
1 audit clerk	1 GP registrar	1 GP registrar

Box 2. Personnel interviewed in each practice.

The organisation

- The formal and informal roles that are being filled in this organisation ('Who does what?')
- The organisational expectations of behaviour in those roles ('What do participants think practice members should be doing?')
- The values that underpin both behaviour in roles and expectations about that behaviour. This included questions such as: 'What is the best/worst thing about your practice?' 'What is the most important part of being a GP to you?' 'What metaphor would you use to describe your practice?'

National Service Frameworks

- Attitudes to the idea of central models of service
- Attitudes to the reality of National Service Frameworks
- Activity within the practice directed towards their implementation

The new contract

- Attitudes to the new contract
- Roles in the implementation of the new contract
- Action taken so far

Box 3. Areas covered in interview questions.

have been available to a non-medically qualified researcher. The study received local research ethics committee approval. Initial fieldwork relating to National Service Frameworks took place between March 2002 and March 2003, with a further round of data collection between September and November 2003 following the vote for the new contract. In each practice at least one clinical session was undertaken as a locum. As well as recompensing the practice for the time taken in interviews, this allowed the

researcher to gain a more in-depth understanding of the practice context; for example, the way staff interacted with the doctors, the approach to record keeping, the nature of the population, and the way in which surgeries were organised.

The interviews were transcribed and analysed thematically¹⁴ using the computerised qualitative data analysis package ATLAS.ti. Initial coding was open,¹⁵ using descriptive codes to understand the range of responses represented in the interviews and to develop an understanding of the areas of agreement and disagreement between participants. This data was then further analysed alongside detailed fieldnotes from observation in the practice and any available documentation using a framework for understanding organisational behaviour derived from the organisational studies literature.¹⁶ This framework combines ideas about the roles (both formal and informal) occupied in an organisation, the underlying norms that inform the development of those roles,¹⁷ 'sensemaking' as a primary organisational activity,¹⁸ and the distribution of power between organisation members to build up a picture of how the practice works. The three case studies were then compared, and recurring themes identified. Trustworthiness was enhanced by the triangulation of data collection methods; information from observation, interviews and available documentation was compared in an attempt to generate as broad and deep an understanding of the research situation as possible.¹⁹ In addition, the main findings were discussed with the participants. This article reports results relating to the role of management within the practices.

Results

Perceptions of managerial roles

In a move that was unusual for a practice that had not been fundholding, practice A had taken the decision in the 1990s to employ a manager with experience outside the NHS. It was the expressed intention of the partners in this practice that their manager should work at what is defined above as the strategic level, with an input into shaping the future direction of the practice, as well as managing the administration, and the manager shared this vision of the role. In the context of the new contract, the doctors in this practice were very conscious of the need for a strong overall managerial hand to guide practice activity if they were to meet both the clinical and organisational quality targets successfully, as well as develop bids to set up enhanced services. Their manager welcomed the framework of competencies published with the contract, and viewed it as a template that could be used to both clarify and develop her role in the practice.

Practice B had been fundholding, and had taken on a manager from outside the health service to run this side of the practice in parallel with an administrative practice manager. At the end of fundholding, managers such as this were faced with redundancy, but the partners in this practice decided to re-deploy the fundholding manager. There was a job description that stated that the manager should have a role in shaping strategy, but there was confusion in practice between the partners and among the staff as to what this role legitimately

involved. The doctors were taking the lead role in planning for the contract, although they felt they would like their manager to be doing this. They identified a need to employ someone with an information technology (IT) background to ensure that their data collection and management was efficient.

Practice C had been part of a community fundholding scheme. Their manager had been promoted from a reception post, and performed at a purely administrative level. One doctor in this practice summed up the doctors' collective view of what managers' work should involve in this way:

'... I think it would be very difficult in a small practice to devolve that [strategic] function to a manager, because what would the manager say? "I've read the NHS plan and you should be doing this", so it wouldn't work, would it, I don't think.' (GP 2, practice C.)

In this practice, there was a practice meeting each week that was not attended by the manager. Communication between the manager and the partners involved informal meetings between one partner and the manager. When asked about involvement in wider issues, the manager commented:

'In some ways I think that's a bad thing, in some ways, only from my point of view because it means I don't get involved in things and other practice managers might talk about ... and I think, "what are they talking about?". Because it doesn't filter down, but the good thing is I'm probably not as pressurised as other people, which makes my life happier and it's that balance, isn't it? I think they like to get involved, I think in a way I mean they should do, it's their business, it's their baby really.' (Manager, practice C.)

This practice had become a Personal Medical Services (PMS) practice towards the end of the initial fieldwork. They were intending to 'shadow' the new contract, working at their own pace to meet targets, moving back to a GMS contract at some point in the future if they felt it was right. They regarded their PMS status as a protection against any instability that resulted from the transition.

Problems with performing the strategic role

Although two out of three of the study practices aspired to have a strategic management function in their practice, there were considerable barriers to these aspirations being realised. Firstly, in practice B, although the manager aspired to having a strategic role, there was confusion among the other staff (including GPs) as to exactly what this role involved. These quotes illustrate that confusion:

'[The practice manager] was a business manager really, she wasn't really practice, although she had worked in a practice before she didn't really have anything to do with the actual practice stuff, it was more the financial stuff and ... umm ... that has continued really, she's responsible for the financial ... the business and financial part of the practice.' (Administration manager, practice B.)

'I think ... sort of managing the finance and advising us on ... the financial aspect of the practice management

and perhaps bringing us ... you know the sort of person who could intermediate between us and the health authority, or the PCT or whatever and sort of also be nominated to deal with the practice, sort of, bank account and things like that ... somebody like that ... and possibly... possibly have some staff ... responsibilities as well ... so I suppose... which is what she does or she's supposed to be doing.' (GP 4, practice B.)

Secondly, she felt constrained by lack of time from performing in this way:

'One of the problems I've got is, and again it's an historical thing, is that the infrastructure is not strong enough really to deal with the demands that we come [across], we have in general practice, and I thought I could cope with it myself, and really there isn't enough time now, that's what you end up ... but here I end up being the IT manager and I'm trying to spend a day a week, out of two and a half days, on IT development, it really isn't ... it just puts enormous pressure on the rest of the work that I have to do ...' (Manager, practice B.)

Thirdly, she admitted to having been demoralised by things that had happened both in the practice and outside, and this had curbed her enthusiasm for looking proactively at the wider climate of the health service. The end of the fundholding scheme had played a part in this. As well as causing personal stress about job security, the loss of funding to the practice had reduced the available funding for staff, and the loss of the flexibility associated with fundholding had reduced her personal job satisfaction. It is also likely that the end of fundholding and consequent change in her role had contributed to the confusion discussed above.

In practice A there had been problems over many years with staffing, particularly problems in filling the post of office manager. They had also recently moved into a new building, and had had a large influx of patients, resulting in a heavy workload for the existing reception and other administrative staff. As a result, the manager had been busy with the administrative work and had been unable to do the strategic work to which she aspired. She made the following comments in a discussion about what she would like her role to involve:

'I, I feel it's ... I feel [strategic management] is something I should be doing and I don't do very much of that ... because of time constraints, and I feel very disappointed about that, that I don't have a better overview of the major healthcare initiatives and ongoing, you know, think about what happens and what this means to us, what should we be doing to initiate things to, to comply or achieve or whatever, so I'm quite disappointed about that. But having said all that, it's been a very, sort of, rough time in terms of staffing, a lot of turnover, so much to do with the building, so much to do with the, sort of, pressures of work ...' (Manager, practice A.)

Performance management: the relationship between partners and managers

The doctors in practice A felt that they were not very good at managing their manager. They had no training or experience

in this, and felt that they did not know how to ensure that the manager was performing as they intended. One of the doctors expressed it thus:

'Now [the manager] has got some great strengths, but oh dear, we don't know how to manage [the manager] we always feel we can't say anything because we don't want to offend her, because we depend on her for this, and depend on her for that. But the fact is I think GPs are probably hopeless because we're never firm ... Our personality and I think as GPs, there probably are a few people out there who are good managers, but we're not.' (GP 1, practice A.)

Similarly, in practice B the doctors felt that they had failed to act to ensure that their manager was performing as they would like. In answer to a question about managing the manager, one GP said:

'... But it's having the time, the responsibility ... I think as a partnership we are guilty of this [avoiding confrontation].' (GP 3, practice B.)

Both the managers in practice A and practice B commented on the difficulties associated with providing strategic management as an employee of a partnership. Ultimately, responsibility rests with the partners, and both managers felt that they were unsure how far their higher-level input could go. The manager in practice A commented that:

'Sometimes they want me to be strategic and sometimes they don't.' (Manager, practice A.)

The manager in practice B had similar concerns:

'We had a real problem when I first came here with our smears, we were always on about 78% [of our cervical smear targets] and increasing, but we're now on about 83, 84% and we've been like that for 2 years. So the thing is sometimes I can't get them to change, I bring them up on the agenda, we discuss it, we all basically say "we don't know what we can do", we give up ...' (Manager, practice B.)

Clinical versus managerial spheres

It was clear in all three practices that there was a division between those areas that were regarded as legitimately belonging to the manager, and those that were clinical and therefore could only be addressed by the partners. Therefore, in both practice A and practice B there was a separation between managerial and clinical meetings, and the managers in both practices did not attend the clinical meetings. One of the nurses in practice B summed this up:

'Whereas the, the practice manager it's more like, you know, financial side of things that you're actually dealing with as opposed to like the clinical side ...' (Practice nurse, practice B.)

In practice A this division was also manifest in the management of the nurses. The practice manager had line

management responsibility for the nurses in some areas, but commented that, for clinical issues:

'Yes, I'm the manager, there's obviously a direct line that doesn't go through me regarding clinical issues. So on a day-to-day basis, things to do with patients go to the GP.' (Manager, practice A.)

This same manager commented on the different viewpoints that managers and clinicians bring to the practice:

'I'm just thinking how you do look at things from a different perspective, the clinicians have got their view, managers would have their view. But you could find it quite uncomfortable in that if you've got a bunch — even if, say, you were an equal partner — the bunch of clinicians, doctors, medics, would all have their sort of starting point being in a similar area possibly, you might find on a number of issues you were always in a minority because you are looking at things from a different point of view and that could perhaps be frustrating if you're trying to move the organisation in a direction that medics didn't think you should go.' (Manager, practice A.)

All of these findings are summarised in Box 4.

Discussion

Summary of main findings

The evidence from this fieldwork shows that, although the framework for competencies in practice management offers a good theoretical template against which practices can gauge their current skill base and plan for their future needs, in practice the issues are often more complicated than they would appear. From the results presented here it would seem that even in practices that aspire to employ a manager capable of working at a strategic level as defined in the framework, there is confusion about exactly what this role should be, and how much legitimacy such a manager has. Some doctors feel unsure about their capacity to manage a manager working at this level, and there are significant constraints in terms of time and the volume of administrative work on the ability of managers to be truly strategic. Even if all other constraints are removed, managers commented on the specific challenges of managing a group of GPs who retain ultimate authority. Finally, there are still some practices in which it is felt that management remains an activity that should be the province of the doctors. Not only did the doctors in practice C not want to devolve this function, but one doctor commented firmly that 'it wouldn't work'. The current study has echoed that of Laing *et al*⁹ in finding clear distinctions made between work that was regarded as clinical, and therefore only the province of the doctors, and work that was regarded as managerial.

Strengths and limitations of the study

By taking a case study approach, detailed information has been collected not only about the formal, public roles being performed, but also about the more informal and problematical aspects of these roles. Interviewing all those

- Confusion over the legitimate role of managers, even in the presence of explicit job description
- Poor morale, partly due to rapid NHS change and uncertainty about role
- Time constraints — too many administrative tasks, a need for a different skill-mix
- Failure of GPs to actively manage performance in the managerial role
- Problems of authority — how far can managers legitimately go in providing strategic direction?
- Division between managerial and clinical work — what are the limits of managers' roles?
- Normative beliefs that all 'management' responsibility lies with GPs

Box 4. Factors preventing managers acting in a strategic role in the study.

clinical and managerial staff working in each practice allows comparison of the different accounts given by different staff, broadening the findings beyond a simple account of what managers say they do,²⁰ and the collection of observational data provides further evidence about actual behaviour.²¹

This approach means that data can only be collected in a limited number of sites, raising questions about generalisability. However, it can be argued that the wider themes that have arisen here — touching upon issues of managerial legitimacy, authority within practices, and the management of managers' performances — are ones that have resonance across the whole of the health service. The status of the researcher as a fellow GP, although being useful in encouraging openness in interviews with doctors, as well as aiding access, will have coloured the information received; for example, managers might have raised different issues in conversation with a fellow manager. The claims to trustworthiness of this research rest upon the use of observation, documents, and interview data as well as the discussion of findings with the participants, and the use of an explicit methodological framework¹⁶ within which to translate data from observation and interviews into meaningful information.^{14,22}

Existing literature

As discussed earlier, there is little existing literature that investigates in detail the work done by practice managers and the problems that they face. The most comprehensive study is that of Westland *et al*,⁸ based upon qualitative interviews in general practice in Scotland in 1993. They found that larger practices, with five or more partners, were more likely to have what are defined here as strategic managers. By contrast, in the current study two out of three of what Westland *et al* would define as medium-sized practices aspired to employ a manager who worked at a strategic level; this may be a reflection of a pattern of change in the role of managers occurring first in large practices and later spreading to smaller ones. The Scottish study also identified ambiguity of roles as a problem for managers, a finding that is unchanged 10 years later.

Laing *et al*⁴ identified the relationship between partners

and managers as crucial to the actual performance in the role of manager in a practice, and commented that the interaction between the expectations of the two groups is an important determining factor. This finding was echoed in the current study; even when both managers and partners were clear that input at a strategic level was desirable, confusion over how far this could legitimately go was a significant factor preventing such input occurring successfully.

Implications for future work

This study does not address the question of whether or not the future of practice management lies in a greater strategic input from non-medical staff. It can be argued that the new contract represents a narrowing of the strategic options available to practices, with more central direction of activity. However, it would seem that those responsible on the government side for negotiating the contract think that practice level strategic activity by managers is necessary, with the NHS Confederation briefing² suggesting that smaller practices that are unable to afford to employ higher-level managers should look at sharing such expertise or asking the PCT to provide it. Assuming these ideas to be practically possible, the issues raised here of legitimacy, authority and performance management of personnel not directly employed by the practice become even more important. As the new contract is implemented in practice, the impact of the new demands on practice organisation needs to be studied carefully alongside the impact on clinical care.

This study has shown that even when partners and managers were agreed that high-level strategic input was required, significant barriers existed. For example, failure to explicitly manage performance by managers, or to address directly the difficult question of how much authority managers have over partners, was an important barrier. Further work to investigate whether or not such explicit performance management is possible would be valuable. In an era in which doctors themselves face appraisal, revalidation and performance management by targets, performance management of managers would seem an obvious step, but it is one that this study suggests doctors might find difficult.

The new contract will impose a wholly new set of pressures upon practices, and this study suggests that considerable planning is needed to meet these challenges. The framework of competencies will provide a useful starting point, but these results suggest that developing effective management in the new environment is not only about skills or written job descriptions. Time to perform strategic work must be provided, and this may mean employing a wider range of administrative staff. If doctors decide that they wish to manage the overall implementation of the contract themselves without higher-level managerial input, how will time away from patient contact be provided to allow this to happen? If they do this, who will then see the patients? If managers manage the contract, how will the overlap of clinical and managerial issues that comes with payment according to clinical behaviour be dealt with?

The new GMS contract represents one of the biggest organisational changes that GPs have ever faced. This study suggests that there is an urgent need to look not only at the most

basic issues, such as how ischaemic heart disease is recorded on the practice computer, but also at the much wider organisational issues such as who is best placed to perform which roles, where legitimacy and authority lie, and how performance (of both doctors and managers) will be managed.

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