Time Out for Respite and Recovery: A Qualitative Study of Influences on General Practitioners' Adaptation to General Practice

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BPsych(Hons)

A thesis submitted in fulfilment of the requirements for the
degree of Doctor of Philosophy

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August 2011

ABSTRACT

Previous research has highlighted general practitioners (GPs) maladaptive coping efforts, but little is known about GPs who appear to adapt positively to their inherently demanding work. This study aimed to address this knowledge gap by identifying factors that optimise GPs adaptation to working in general practice. A qualitative methodology underpinned by a constructionist epistemological stance was used. Twenty-six semi-structured individual interviews with suburban and rural GPs in the State of Victoria aged between 24 and 77 years were conducted. GPs identified work demands consistent with previous research: time pressure, long hours of work, heavy workload, and pace of work; work interfering with non-work/family, threat of malpractice litigation, and bureaucratic interference. However, the degree of concern and coping responses was varied; some GPs appraised the work demands as a threat while others considered them an opportunity. GPs adopted a range of adaptive behaviours to manage and resolve work demands that were influenced by six key elements. These were: (1) the degree of work centrality to GPs, (2) the inclination of GPs towards integration or segmentation of work and non-work/family domains, (3) situational factors in the general practice and non-work/family domains, (4) ability to psychologically detach from GP role (5) choice of respite activity, and (6) adequate recovery from work demands. An heuristic schema that brings together these six elements and their implications for GP adaptation was presented. Understanding and self-knowledge about work orientation, and preference for integrating and segmenting life domains, point to the need for tailored respite strategies that facilitate psychological detachment, recovery of resources, and successful adaptation to working in general practice and life as a GP. This knowledge may also assist medical students to prepare for meeting the challenges of their future medical careers.

DECLARATION

"I, Amanda Murfett, declare that the PhD thesis entitled *Time Out for Respite and Recovery: A Qualitative Study of Influences on General Practitioners' Adaptation to General Practice* is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work".

Signature: Date: 30/08/2011

ACKNOWLEDGEMENTS

This research was possible due to the generosity and support of many people. First, thank you to my supervisor Professor Adrian Fisher who assisted with finalising and submitting the thesis.

Thanks also to Associate Professor Denise Charman who worked with me in the early stages of the project.

A very special thank you to Dr Delwyn Goodrick. This thesis would not have been completed without her support and encouragement.

To the participants of this study I extend my sincere thanks for their generous disclosures and honesty.

To my industry partner representatives Margo Field, Jenni Parsons, and Ian Watts, thank you for making participant recruitment a smooth process.

Thank you to my friend Dr Julie Morsillo who generously assisted with reading the final draft and preparation of this document.

To my friend Dr Lyn Radford thank you for reading drafts and sharing my PhD experience.

Thanks also to friends, colleagues and staff at the School of Psychology, Victoria University, especially Dr Lesley Birch, Kim Shearson, Dr Felicity Morris, Dr Michelle Ball, Jane Trewin, Janine Jarski, and Grace Shirippa.

Last but not least, very special thanks to my partner, Vic for his unfailing support throughout the project.

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CHAPTER 1

INTRODUCTION

General Practitioners (GPs)[1] work in a changing healthcare environment. There is an unprecedented and ongoing expansion of medical knowledge and technology, and an escalation in patient expectations (Harrison & Lee, 2006; Murray, Montgomery, Chang, Rogers, Inul & Safran, 2001; Warren, Weitz, & Kulis, 1998). The social position and status of the medical profession has also changed, with evidence of increasing cynicism towards the expert knowledge of medicine (Lupton, 1997). In addition to the many changes that are taking place in medicine, GPs function in a highly demanding work environment with long work hours, high workloads, and threats of litigation (Catino & Celotti, 2009; Firth-Cozens, 1999; Makin, Rout, & Cooper, 1988; Summerton, 2000; Sutherland & Cooper, 1992; 1993).

Research into the occupational health of doctors, and the subsequent influences on their health and wellbeing, has attracted considerable attention over the past 20 years. The literature has tended to focus on negative aspects contributing to health problems, rather than positive contributions to wellbeing. Occupational health problems experienced by doctors have been associated with both workplace factors and with individual factors (Firth-Cozens, 1999). Studies of doctors' functioning have emphasised negative aspects with some studies suggesting that medical practitioners experience higher rates of suicide, especially among women doctors (Hawton, Clements, Sakarovitch, Simkim, & Deeks, 2001; Lindeman, Laara, Hakko, & Lonnqvist, 1996; Schernhammer & Colditz, 2004),

[1] GPs provide primary care medical services in Australia and in the United Kingdom. In the United States and Canada primary care providers are often known as family physicians. As well as providing medical care, GPs are traditionally the 'gate keepers' of the health care system, and as such, are responsible for referring patients to other facilities and services within the health system, especially to other medical specialists.

depression, alcohol abuse, (Firth-Cozens, 1999; Schattner, Davidson, & Serry, 2004), substance abuse and burnout (Caplan, 1994; Miller & McGowen, 2000; Sutherland & Cooper, 1992) and marital problems (Harari, 1998).

Despite this focus in the literature, it is clear that many doctors adapt well to the work demands of general practice. There is, however, limited literature relating to GPs who achieve optimal professional and personal functioning in the high demand environment of general practice. Further, there is limited literature about their experience of work and life as a GP. The current research contributes to new knowledge by shifting away from a deficit approach to an ability approach (Frydenberg, 1997).

Adaptation is a generic term for processes influencing how well the person routinely deals with the demands or requirements of living (Lazarus & Folkman 1984a). The term coping has become part of the vernacular; coping is principally a psychological concept which Lazarus and Folkman (1984a) define as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal resources of the person" (p.141).

GPs' work involves handling the physical, psychological, and social problems of others; there are pervasive and ongoing challenging demands associated with the content and context of their work. These daily hassles (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982) or chronic demands may be part of everyday life for doctors. Therefore, identifying the ways in which GPs cope with, and adapt to, the demands of general practice is important because some of these demands may be inevitable for GPs, and the medical profession more generally.

With social changes, such as an increase in women into the paid workforce and an increase in fathers' participation in family work, many doctors seek to manage their work

time so they can enjoy both their work and non-work/family lives. Schattner and Coman (1998) identified work intruding on family life was a significant stressor for GPs. The issue of work interfering with non-work life was considered in a qualitative study conducted by Tolhurst and Stewart (2004). These researchers identified a generational change in attitudes of Australian medical students toward work life balance. The medical students believed there were lessons that could be learned from previous generations of doctors who tended to put work before family and lifestyle. This younger group considered that a balance between work, family, and lifestyle an important aspect in their career decisions. While Schattner and Coman (1998), and Tolhurst and Stewart (2004) have identified work-life balance as a concern for doctors, there has been little research into the adaptive strategies adopted by doctors to achieve balance, and the factors that contribute to their perceptions of work-life balance.

This study focuses on understanding how GPs experience general practice, and how they accommodate and manage the demands of their work and non-work/family domains. Developing an understanding of the factors contributing to, and maintaining healthy adaptation will provide new information that is relevant and meaningful to practicing GPs, and medical students in training. The study findings will also have important implications for assisting with retaining GPs capable of working in demanding circumstances.

1.1 Organisation of the Thesis

The structure of this thesis is presented in a linear manner, from literature review through method, analysis of transcripts of face-to-face interviews, and presentation of findings to synthesis and discussion. The collection and analysis of existing literature, and analysis of interview data did not, however, develop in a way that this linear presentation

might suggest. Rather, an iterative process of data analysis and literature review was carried out. As relevant themes emerged during data analysis, the researcher returned to searching existing literature to assist with conceptualising the themes emerging from interviews.

Chapter 2 describes how the concept of stress evolved during the 20th century, and into the 21st century. Also presented is an overview of four occupational stress models that provided preliminary guidance for the study. However, the literature indicates that stress and anxiety may also come from other life domains. Occupational stress cannot be considered in isolation because work and non-work/family are interconnected domains. Furthermore, individual differences in work orientation may influence how stress is appraised. The chapter concludes by presenting the literature relating to adaptive coping strategies.

Chapter 3 begins with descriptions of the role and profile of Australian GPs, and the health care environment in which they work. This is followed by an overview of existing literature relating to doctors' occupational stress, and a review of the literature pertaining to doctors' occupational health, and the issues surrounding their responses to the demands of working in general practice. The chapter finishes with an explanation of the need for this research, and presents the aims that oriented the study.

In Chapter 4 the methodology and face-to-face interview approach is documented. The context and methods of the interviews are described, including the sampling, data collection and management, and analysis of interviews. Issues of trustworthiness and validity are also presented.

Chapter 5 describes the reasons provided by GP participants for choosing the profession of medicine, and work in general practice as a career. This information is presented to provide a context for the experiences shared by the interview participants.

Chapter 6 provides an overview of how GP participants managed the demands of their work. This includes the multiple roles that GP participants' engaged in during a typical work day, and how these multiple roles can, for some participants, be a source of role conflict. The second part of the chapter explains participants' perceptions of time scarcity, the value of time in general practice, and the link between time and income. This is followed by the strategies participants adopted to ease the tension between time pressures, provision of quality care, and meeting patient expectations. The chapter concludes with an illustrative case study that provides an account of how one GP in this study managed her work, and the strategies she implemented to synchronise, prioritise, and manage her time.

Chapter 7 describes the ways GPs allocate time to work and other life domains and the ways they achieve psychological detachment from work. This study has identified that GPs' life domains are interconnected, with one domain influencing choices and behaviour in the other. GPs' experiences and activities within the general practice work environment influence their life outside work. Their experiences in other non-work domains appear to influence their adaptation to the general practice work environment. The final section of the chapter presents two illustrative case studies that describe two GPs in this study and their responses to the issues highlighted in the findings.

Chapter 8 is a synthesis of the three findings chapters, and provides an overview of the similarities and differences between participants. An heuristic schema to assist GPs identifying factors that facilitate and inhibit their choice of respite activities is presented.

The final chapter, Chapter 9, discusses the findings of this study, its major contributions, and implications for practice, limitations, and directions for future research.

1.2 Conclusion

Research carried out in Australia and overseas has produced consistent findings regarding doctors' concerns about work conditions, and the healthcare systems under which they work. Findings suggest there are some aspects of working in medicine that contribute to discontent. There is, however, a lack of understanding about factors underpinning these concerns, and the strategies GPs adopt to address these concerns. The focus of this study is to identify factors influencing GPs' healthy adaptation rather than maladaptive responses to work demands.

It is important to have GPs who are functioning at optimal levels because GPs have a central role in community health care. GPs who are not highly functional may have a detrimental effect on the delivery of high quality health care in the community (Firth-Cozens, 1999; Schattner, 1998). There has been minimal research undertaken regarding the factors that influence GPs optimal functioning. This thesis will contribute to addressing this lack of knowledge by answering the question: What are the factors that promote and maintain GPs adaptation to general practice and life as a GP?

CHAPTER 2

STRESS AND COPING

The chapter begins with a description of how the concept of stress evolved during the 20th century, and an explanation of the cognitive and behavioural coping efforts used to manage perceived stressful encounters. This is followed by an overview of three occupational stress models that provided preliminary guidance for the study. However, stress and anxiety may also come from other life domains. The next section considers that occupational stress cannot be viewed in isolation because work and non-work/family are interconnected domains. Also presented is the notion that individual differences in work orientation may influence how stress is appraised. The chapter concludes with the literature relating to adaptive coping strategies.

2.1 Stress

There are many definitions of stress that vary depending on the discipline. Hans Selye (cited in Ice & James, 2007), introduced the concept of stress from physics and engineering, and described stress as a non-specific response of the body to a 'noxious' stimulus. This is a physiological reaction to physical and physiological stimuli or stressors, whereby the body responds to any external source of stress in an attempt to restore the body's internal homeostasis. The initial quick hormonal reaction is the fight or flight stress response. Selye later elaborated on this process of the body's struggle to maintain balance and developed a three stage syndrome known as General Adaptation Syndrome (GAS). The first stage of GAS is alarm reaction, whereby the body reacts to a stimulus by activating the hypothalamic pituitary adrenal (HPA) axis. The second stage is resistance, which signals successful adaptation to the stimulus. The third stage, exhaustion, occurs when there is prolonged exposure to stimuli (Ice & James, 2007).

From his experiments with rats, Selye (1946) discovered that these processes were adaptive for the organism defending against stressors. However, there is a limited supply of adaptive energy to cope with stress, and it declines with continuous exposure to stressful stimuli. If there is exposure to chronic stressors, this can suppress the immune system, and place the organism at risk of a variety of diseases (Ice & James, 2007), such as mental health problems, cardiovascular disease, and a range of unfavourable health outcomes LaMontagne, Ostry, Louie, & Keegel, (2006).

While some stress investigators were researching with animals, others were considering the influence of psychosocial stressors on humans (Ice & James, 2007). For example, in an attempt to chart psychosocial stressors, Adolf Meyer devised the life chart in the first half of the 20th century to chronologically document a person's major life events and significant illness experiences over his or her life span. Analyses of his patients' charts found that stressful major life events frequently preceded illness onsets. Stressful events were defined as occurrences that were likely to bring about readjustment requiring changes in people's usual activities, such as a change of habitat, births, and deaths (cited in Dohrenwend, 2006). Meyer's chart was later modified by Stanley Cobb, Harold G. Wolff, Stewart Wolff Jr., Lawrence E. Hinkle, Jr., and Thomas H. Holmes who often simplified the chart to focus on a single organ system (Rahe, 1990).

Following from this descriptive work by Cobb et al., the next step was the development of psychometric measures. One of the first scales was published by Holmes and Rahe (1967). *The Social Readjustment Rating Scale* measured life events such as death of a spouse, divorce, fired at work, and sex difficulties. Although these researchers were investigating humans, they were still based on a Selyen model of non-specific response to stressors, whereby the stress response did not vary by stressor (Ice & James, 2007).

Lazarus and colleagues moved beyond the simpler notion of physiological responses to non-specific stressors. They proposed that the stress process is a transaction between the person and the environment (Lazarus & Folkman, 1984b; Lazarus, 1999). According to the often cited Lazarus and Folkman (1984b) cognitive/transactional model of stress and coping, people's feelings, thoughts, and actions in stressful circumstances depend on their appraisals of the situation. Stress occurs when the situation is appraised as demanding or exceeding resources (e.g., social skills, problem-solving skills, self-efficacy, social support) and jeopardise wellbeing (Lazarus & Folkman, 1984a; Lazarus & Folkman, 1984b).

In order to emphasise the transactional nature of stress, Lazarus and Folkman (1984b) proposed a 2-stage step model of stress and appraisal. In the first step, primary appraisal ('what is at stake'), the situation is perceived as a challenge, threat or loss. In secondary appraisal ('what can be done') people evaluate what action they can enact in order to solve the problem, prevent the loss, or remove the threat based on judgment of their available resources, ability to cope, and available ways of coping. Perceptions of stress and coping ability depend on both personal and environmental factors. One environment that has received particular attention is the workplace. Job stress is a concern across employment sectors, and occupational levels, because perceived stressors emanating in the workplace have been associated with physical (Belkic, Landsbergis, Schnall, & Baker, 2004; Siegrist & Peter, 2000a;)and mental illness (Stansfield, Fuhrer, Shipley, & Marmot, 1999), and organisational outcomes, such as lost work days and turnover rates (Fletcher, 1988; LaMontagne, Olstrey & Shaw, 2006).

2.2 Coping

The ways people deal with stress, adversity, and change, the kinds of coping processes they utilize in different situations and, the benefits that accumulate from engaging in different forms of coping have produced a considerable body of empirical research (Beutler & Moos, 2003; Suls, David, & Harvey, 1996; Zeidner & Saklofske, 1996).

Coping strategies are mechanisms of adaptation (Cramer, 1998). The principal importance of appraisal and coping processes is that they influence adaptation; in particular, three major adaptational outcomes: 1) functioning in work and social living, 2) morale or life satisfaction, and 3) somatic health. These three adaptational outcomes influence overall quality of life (Lazarus & Folkman, 1984b).

As well as the wide variety of cognitive and behavioural efforts used to manage perceived stressful encounters (Lazarus & Folkman, 1984b), there are other psychological mechanisms that may be used to relieve stress, i.e., defense mechanisms. These mental mechanisms alter veridical perception in order to protect the person from too much anxiety. The source of the anxiety may be from the perception of a worrying external event or the presence of a disruptive internal psychological state such as a fear, drive, or wish (A. Freud, 1936, cited in Cramer 1998). Defense and coping are two different types of mechanisms that may both provide an adaptive function, that is, to protect people from the emotional consequences of perceived stressful events, and adversity, and may be considered to be an "adaptational process" (Cramer, 1996 p. 920).

Coping theorists mainly consider two forms of coping: coping as a style and coping as a process (Aldwin, 1994). Coping style refers to a person's stable and characteristic way of managing all stressors, regardless of their situational context, and is measured in

relation to how a person handles stressful situations in general (Carver, Scheier, & Weintraub, 1989).

In contrast, the process of coping refers to a person's varied ways of managing stressors that change in response to both person and situational variables, and is measured in relation to how a person handles a particular stressful situation (Lazarus & Folkman, 1984b). In the process of coping, people are thought to use a number of different coping strategies involving a range of behaviours, cognitions, and emotions directed at managing their experience of stressors. The widely used "Ways of Coping" questionnaire includes a number of items that reflect the defense denial, for example, "Went on as if nothing had happened" (Cramer, 1998).

Lazarus and Folkman's transactional model of coping involves the process of coping; they propose a reciprocal relationship between personality and situational variables (Lazarus & Folkman, 1984a; 1984b). Although each person has a preferred coping style, she or he uses different coping strategies for different perceived problem situations; these may change with the demands of the situation. In this model, coping strategies are neither intrinsically good nor bad (Folkman, Lazarus, Dunkel-Schetter, Delongis, & Gruen, 1986). Rather, their value can be measured in terms of their outcome in relation to managing stressors (i.e., functional/adaptive, dysfunctional/maladaptive). As described by Frydenberg (1997), "Self-evaluated outcome is the major determinant (of the success of coping actions). That is, the respondent is asked to assess, 'Did it work for me?'" (p. 52).

The outcome of a coping strategy can be assessed in relation to the distress a person experiences, the source of that distress (Lazarus & Folkman, 1984b), and alleviating one source of distress at the expense of another may not be adaptive. Furthermore, there may be multiple outcomes of people's attempts to cope; some outcomes are associated with

positive consequences and others with negative consequences (Folkman, 1992). Adaptive coping is thought to involve the contextually determined, and flexible, use of a range of coping strategies, such as problem-focused coping (e.g., planned problem solving) emotion-focused coping (e.g., distancing, applying self-control, accepting responsibility, escape-avoidance, positive reappraisal) (Lazarus & Folkman, 1984a). With problem-solving coping, people try to manage or change the situation; whereas emotion-solving coping, people try to manage or change their cognitions. These two forms of coping are not mutually exclusive, and in any given situation, people are thought to use a variety of different emotion-and problem-focused functions (Folkman & Lazarus, 1980).

Coping behaviours such as excessive alcohol consumption, or drug dependency and self-prescribing may provide temporary relief from stress, but do not deal with the problem. In the longer-term, however, these coping mechanisms may be maladaptive, and negatively affect functioning at work and social living, lower morale and/or life satisfaction, and somatic health (Lazarus & Folkman, 1984b).

In addition to coping as a style and coping as a strategy, there is a third coping strategy of seeking social support. This is usually categorised as 'instrumental' support or 'emotional' support, and can involve either problem-focused coping or emotion-focused coping (e.g., seeking emotional support or tangible support) (Folkman, Dunkel-Schetter, Delongis, & Gruen, 1986). Social support functions include encouragement, understanding, and affection (i.e., esteem or emotional support; practical assistance, and tangible resources (i.e., instrumental support; advice and information (i.e. informational support); and feelings of support and belongingness (i.e. social companionship) (Cohen & Wills, 1985; House, 1981)

Two models defining differential effects of social support are 1) the main-effect model representing the direct effects of everyday social support, and, 2) the buffering-effect representing the interactive effects of social support at times of stress (Cohen & Wills, 1985). The main or direct effect model proposes that social resources have positive effects on physiological and psychological health (Vermeulen & Mustard, 2000). The buffering effect model proposes that social support interacts with the stressful event and protects against the negative effects of the stressor because the fulfilment of social needs assists people to cope with stressful situations. Social support as a moderator of reducing the negative influence of stressors on a number of adjustment outcomes has been readily accepted, because, intuitively practical assistance and encouragement from others should relieve the effects of perceived stressful events (Jimmison, McKimmie, Hannam & Gallagher, 2010).

Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) found differences in the coping patterns of people seeking social support. Participants sought less social support in encounters that involved their self-esteem; they posited this finding may have been due to shame or embarrassment. Due to societal expectations, and the medical culture, it is possible these factors contribute to doctors' reluctance to seek help. This is discussed later in section 3.4.3.

Coping is a complex process, influenced by personality characteristics Bolger, 1990; Friedman et al., 1992; Long & Sangster, 1993), situational demands (Folkman et al., 1986; Heim, Augustiny, Schaffner, & Valach, 1993), and also the social and physical characteristics of the setting (Mechanic, 1978). The process of coping considers personal and environmental influences on coping, it is therefore compatible with studying GPs' adaptation to working in general practice.

2.3 Occupational Stress Theoretical Models

The detrimental effects of excessive workplace demands have contributed to a growth in interest in understanding the factors that moderate an individual's response to occupational stress. A range of theoretical frameworks has been identified to describe the physical (e.g., impact of noise) and psychosocial (e.g., impact of perceived time pressure) **s**tressors associated with occupational stress, and adverse health outcomes. These models are not specific to the medical profession, but were developed to illuminate responses of individuals who work across various occupational fields.

The current study was informed by four theoretical models of occupational stress: (1) The Job Demand-Control-Support Model (JDCS) (Karasek & Theorell, 1990), (2) the original Effort-Reward Imbalance Model (ERI) (Siegrist (1996), (3) the amended ERI (Siegrist, 1999), and (4) the Effort-Recovery Model (Meijman & Mulder, 1998). The following sections present an overview of these four models, and their implications for this study.

2.3.1 Job Demand Control Model

The Job Demand Control model (JDC) (see Figure 1 below), also known as the Job Strain model (Karasek, 1979), proposed that job strain will happen when high psychological and physical demands - such as pace of work, effort, and volume of work, and low levels of control over the work process are present. According to Karasek (1979), control or, more precisely, decision latitude, which is the authority to make decisions concerning the work, combined with the ability to use one's skills at work promoted both productivity and health. The combination of high job demands and low job control, that is, high-strain jobs, are believed to result in stress reactions such as high blood pressure and low job satisfaction. On the other hand, jobs characterised by low demands and high

control (low-strain jobs) will result in lower than average health complaints (Karasek, 1979; Karasek & Theorell, 1990).

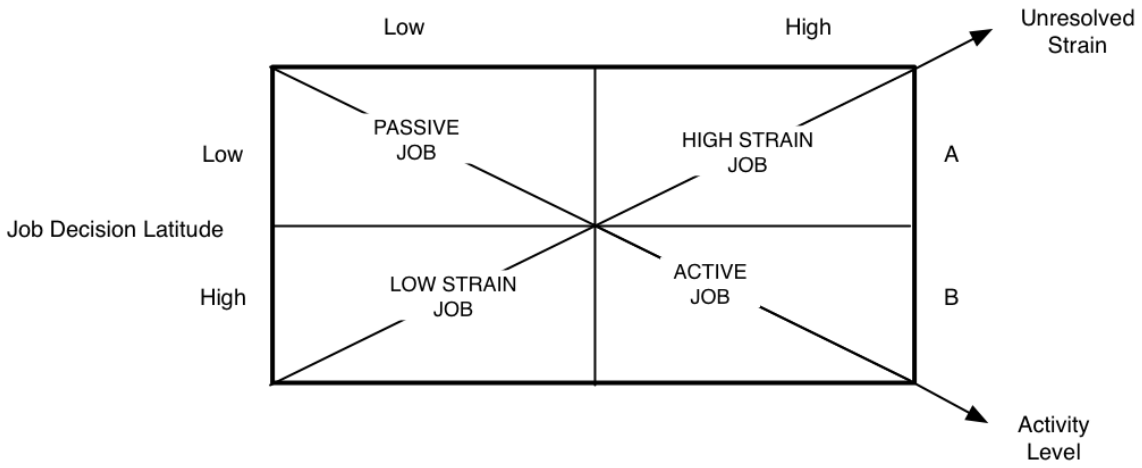

Figure 1. Job Demand Control Model (Karasek, 1979, p.288).

The JDC model classifies physicians as having high demand and high decision latitude; hence the demands of the job will not be experienced as particularly stressful because there is also autonomy in decision making (Karasek, 1979). Consistent with the propositions of the JDC model, a study by Keeton, Fenner, Johnson, and Hayward (2007) found that for doctors, the most important predictors of work-life balance were control over scheduling and work hours. However, GPs may not always perceive they have autonomy in decision making, especially with regard to workload and constant time pressure. It may, therefore, be valuable to also consider individual GP's subjective perceptions of their ability to control their workload.

The original JDC model (see Figure 1) was expanded to include social support, following studies demonstrating the moderating effects of social support on job strain (Karasek & Theorell, 1990). The Job Demand Control Support model (JDCS) proposed that job strain occurred when workers perceived that the work was of high demand, low decision latitude, and lack of available social support.

This JDCS model is one of the most well- known, often cited, and reviewed models pertaining to wellbeing and work. Underpinning this model is the proposition that work control and social support assist the individual to deal with work demands, thus influencing health, wellbeing and productivity. The psychological processes underpinning the beneficial effects and main predictions of the model have mainly been tested with statistical interactions between demands, control, and support, and it appears that the JDCS model has not been unequivocally supported.

A study by Beehr, Farmer, Glazer, Gudanowski, and Nair (2003) found that gender role status may moderate the relationship between social support and individual strains. More feminine people reacted more strongly and positively to social support than more masculine people. DeLange, Taris, Kompier, Houtman, and Bongers (2003) provided only modest support for the hypothesis that the combination of high demands and low control resulted in high job strain. As will be explained later in section 3.4.3, although doctors (male and female) are aware of the benefits of seeking help, they are often reluctant to solicit help and support from other health professionals, peers, and work colleagues. They may not, therefore, benefit from the social support available to them because they do not seek it out.

The concept of control in the JDCS model assists with understanding relationships between stressors and strain reactions. However, the interpretation of the construct of control is dependent upon the research focus and discipline (Parkes, 1989). Therefore, when considering factors associated with occupational stress in GPs, it is important to consider how individual GPs conceptualise control, and how they choose to activate the control and support available to them.

2.3.2 Effort-Reward Imbalance Model

An occupational stress model explaining the influence of work on health was developed by Siegrist in 1996. The Effort-Reward Imbalance Model (ERI) (Siegrist, 1996), see Figure 2, proposes a failed reciprocity between efforts and rewards. That is, an effort-reward-imbalance may elicit recurring negative emotions and unrelenting stress responses, which, in turn, activate subsequent adverse health outcomes, especially coronary heart disease and associated risk factors (Siegrist, 1996; 1998).

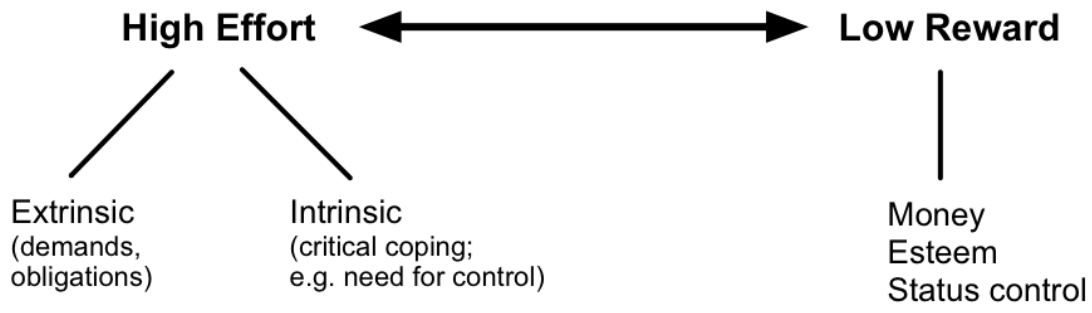

Figure 2. Original Effort-Reward Imbalance Model (Seigrist, 1996, p.30).

Generally, people do not stay in high effort/low reward imbalance situations (Vegchel, de Jonge, Bosma &Schaufeli, 2005), however, Siegrist (1996) identified three particular circumstances where this situation could prevail. These include: (1) for strategic reasons, such as the expectation of future gains, (2) no alternative employment choice, and (3) excessive work-related over commitment.

Over commitment (OC) is perceived as a personality characteristic based on the emotional, cognitive, and motivational components of Type A behaviour that indicates excessive ambition, combined with need for approval and esteem (Hanson, Schaufeli, Vrijkotte, Plomp, & Godaert, 2000; Siegrist, 1998). Workers characterised by excessive OC demonstrate difficulty in recognising the negative trade-off between high effort and

low reward. They misjudge the balance between their work demands and their own resources for coping with these demands (Siegrist, 1999; Siegrist & Peter, 2000).

Siegrist (1999) proposed the amended ERI model (see Figure 3) has three central assumptions: (1) high efforts combined with low rewards increase the risk of poor health, (2) a high level of OC may increase the risk of poor health, and (3) high efforts/low rewards combined with a high level of OC have an even higher risk of poor health.

In Figure 3 below, the amended ERI model (Siegrist, 1999) indicates over commitment as an independent concept that influences the perception of both efforts and rewards. The effort expended at work is not limited to the extrinsic demands, such as pace and volume of work, but is also connected to workers' intrinsic effort or OC.

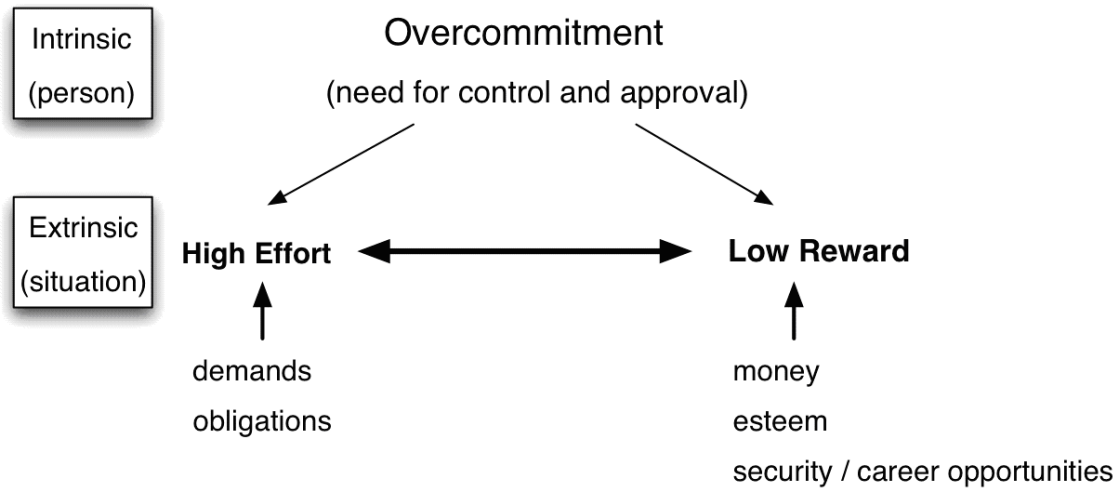

Figure 3. Amended Effort-Reward Imbalance Model (Seigrist, 1999, p.40).

This model is pertinent to the study of GPs as it connects the personality characteristic of over commitment, with the situation-specific components of efforts and rewards. Doctors generally tend to have a conscientious and compulsive personality style, and strive for perfection (Gerber, 1983; Menninger, 2003). These researchers also

identified that doctors' compulsiveness was associated with distress through an excessive sense of responsibility for things beyond individual control. Doctors may therefore be susceptible to OC. The rewards of working in general practice go beyond financial reward to include altruistic benefits such as making a contribution to people's lives. Rewards also signify opportunities for achievement, maintenance, and control of a valued occupational status, and the money and prestige that accompany that status (Siegrist, 1996).

2.3.3 Effort-Recovery Model

The high ideals of the medical profession may contribute to some GPs propensity for over commitment to their patients and their work, resulting in a depletion of their own resources and inadequate recovery from work demands. The Effort-Recovery model (E-R) (Meijman & Mulder, 1998), see Figure 4, is a conceptual framework for the psychological study of workload. It was originally based on explanations for individuals' responses to physical exercise (Meijman & Mulder, 1998).

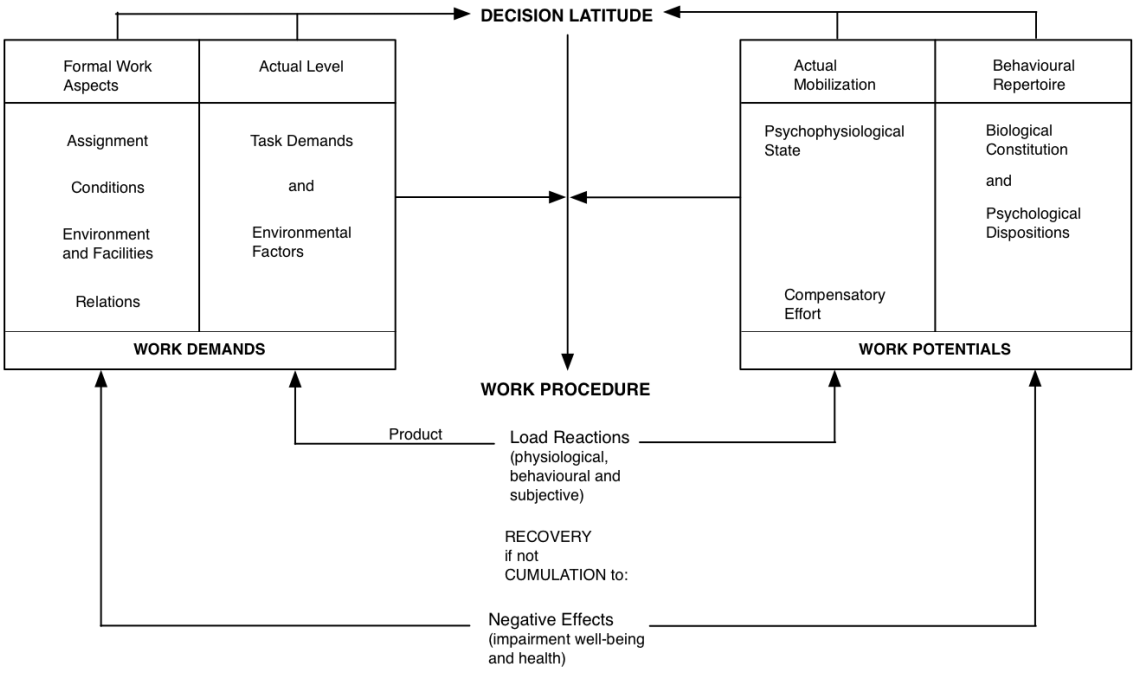

Figure 4. *The Effort-Recovery Model (Meijman & Mulder, 1998, p.9)*

The E-R model proposes that carrying out the responsibilities of life and exposure to workload requires effort (time and energy), described as the activation of personal resources to satisfy a demand. Effort expended results in the development of short-term psychological and physiological reactions such as acute fatigue and accelerated heart rate. These reactions are theoretically reversible, and, when effort is no longer needed or when the psychological and physiological reactions to effort can be eased through other means, recovery occurs (Dikkers, Guerts, Kompier, Tavis, Houtman, & van den Heuvel 2007; Guerts & Sonnentag, 2006). This process is considered adaptive because it provides the individual with information about the amount of effort required to perform the task, and reversible because when the exposure to workload ceases, the functions that were activated will recover again within a certain period of time (Guerts et al., 2006).

A principal assumption underpinning the E-R model is that responses such as chronic fatigue and strain develop when opportunities for recovery from workload are inadequate. This is particularly relevant to individuals (such as doctors) in work settings where job demands are too high, and or they are unable to adjust their work behaviour by moving to less demanding tasks in order to recuperate and recover (Geurts, Taris, Kompier, Dikkers, Van Hooff, & Kinnunen, 2005). If recovery is inhibited, vitality at work can be reduced (Schellekens, Sijtsma,Vegter, & Meijman, 2000) and mood impaired (Sluiter, Van der Beek, & Frings-Dresen, 1999

Recovery from workload can occur through various active and passive leisure activities, such as physical exercise, spending time with friends, watching television, and reading. These activities provide individuals with temporary respite and have psychological and physical benefits that facilitate recovery from daily demands (Sonnentag, 2001). When opportunities for recovery are unavailable after a perceived stressful day at work, negative reactions can build up and spill over into the non-

work/family domain (Dikkers, Guerts, Kompier, Tavis, Houtman, & van den Heuvel 2007; Guerts & Sonnentag, 2006).

The chronic high work demands that GPs experience, and the effort associated with these work demands, have been well documented (e.g., Dua, 1996; 1997; Firth-Cozens, 1999; Makin, Rout, & Cooper, 1988; Schattner 1998; Sutherland & Cooper, 1992; 1993).

Given the chronic work demands experienced by GPs, it could be that some doctors have an imbalance between effort and recovery; when this occurs, the psychological and physical effects may be detrimental to their health, wellbeing, work performance, and work-life balance. The E-R model provides a framework for shifting focus on the efforts GPs expend at work, to gaining a greater understanding of how they might recover and adapt from the demands of their work.

Generic models of occupational stress have offered key insights into the work relationship; however, they have also been criticised for focusing too heavily on a narrow range of generalised work characteristics, and ignoring more situation-specific variables (Sparks & Cooper, 1999). Job stressors were examined by Beehr, Jex, Stacy, and Murray (2000) in a sample of 198 door-to-door book dealers using self-report measures of job stressors, psychological strains, co-worker social support, and performance. Results indicated that the strongest predictor was a job-specific measure of chronic stressors. Job-specific stressors were more important to workers because they focused on their particular and unique work situations. The chronic aspect of these stressors caused more strain, because chronic stressors have temporal dimensions of frequency, intensity, and duration. These temporal dimensions are also present in medical general practice.

The temporality and specificity of job stressors may be especially pertinent to understanding GPs' adaptation to working in general practice, due to their chronic

workloads and distinctive work environments. GPs' work involves handling the physical, psychological, and social problems of others, as well as often running a small business and managing staff. There are pervasive and ongoing challenging demands associated with the content and context of their work.

The stress and strain associated with working in general practice has been well documented (e.g., Dua 1996; 1997; Firth-Cozens, 1997; Winefield & Anstey, 1991). However, theoretical and empirical work over several decades has demonstrated that work and non-work/family are interconnected domains (Kanter, 1977; Pleck, 1977; Voydanoff, 2005). It is also possible that doctors experience stress and strain from their other life domains.

2.3.4 Work-Non-Work/Family Conflict

Literature regarding the linkages between individuals' work and non-work spheres (e.g., Greenhaus & Beutell, 1985; Greenhaus & Parasuraman, 1986; Grzywacs, Almeida, & McDonald, 2002; Kirchmeyer & Cohen, 1999; Noor, 2004; Rice, Frone, & McFarlin, 1992) has challenged the formerly held belief that work and family/non-work are independent (Blood & Wolfe, 1960; Dubin, 1973 cited in Edwards & Rothbard, 2000), and demonstrated that work and non-work are interconnected life spheres.

For both men and women, events at work affect events at home and, vice versa (Greenhaus & Beutell, 1985). Experiences at work and at home influence personal and family wellbeing. Work and non-work/family domains can be reciprocally supportive; good experiences in the workplace provide a buffer against problems at home, and can protect health and wellbeing. Furthermore, good relations with spouses and children can protect against stress in the workplace (Barnett & Rivers, 1998). However, there can also be conflict with competing demands from work and home. Work-family conflict (WFC)

has been defined as a form of inter-role conflict, where role pressures/demands from the work and family spheres are mutually incompatible in some aspects.

Work-family conflict can be time-based, strain-based, or behaviour-based (Greenhaus & Beutell, 1985). The most common type of WFC is time-based conflict. This occurs when role pressures originating in the two different domains compete for the individual's time. Strain-based conflict occurs when the tension experienced in one domain interferes with performance in another domain. Behaviour-based conflict occurs when the behaviours associated with roles are incompatible.

A study by Greenhaus, Parasuraman, Granrose, Rabinowitz, and Beutell (1989) found that time-based and strain-based WFC was strongly related to job involvement for women, but not for men. Time-based conflict was lowest when both spouses were highly involved in their jobs. These findings suggest that WFC is lowest when both spouses work, and their work is a significant life interest.

To date, research about doctors has considered doctors' work and non-work domains as separate spheres. In Australia between 1986 and 2006, the labour force participation rate among women aged 15 years and over increased from 48% to 58% (ABS, 2008b). This increase, combined with an increase in fathers' participation in family work (Moen & Sweet, 2003; Pleck 1995), and interest in the quality of life, has seen a shift in researchers away from viewing work and home as separate domains (Burke, 2004a; Burke, 2004b). It is important that research regarding doctors' stress considers work and non-work/family as interconnected spheres as WFC research indicates.

Although there has been considerable research outside medicine into integrating work and personal life, there has been little study into how doctors manage the demands of their work and non-work/family domains and how they interact. Achieving a balance

between work and non-work/family domains is challenging, and an imbalance in the relationship between work and home can be a source of conflict resulting in adverse effects on attitudes and wellbeing (Bacharach, Bamberger, & Conley, 1991). Of particular relevance to general practice as possible sources of conflict are time pressures and the strain (from work stressors) associated with general practice. These sources of conflict may be exacerbated by specific behaviours enacted by doctors, such as restricted emotional display at work (detached concern). This lack of emotional display may be inconsistent with the level of expressed emotion expected by family members and may contribute to work family conflict (Greenhaus & Beutell 1985).

Research findings have led to advocating for a holistic view of people's lives to be adopted, but there has been little research into how GPs integrate work and personal life. Work intruding on family life has been identified as a significant concern for Australian GPs (Dua, 1997; Schattner & Coman 1998). The current generation of students, and younger generation X doctors, value time off and lifestyle as well as their work (Keeton, Fenner, Johnson, & Hayward, 2007). A qualitative study by Tolhurst and Stewart (2004) explored the attitudes of Australian medical students, and identified a generational change in attitudes toward work-life balance. The students spoke of learning from previous generations who were inclined to place work first, and considered a balance between work, family, and lifestyle an important aspect in their career decisions. While these studies have identified that managing the work and non-work/family domains, and balancing work and personal life were a concern for doctors, they did not provide information about the strategies that doctors used to manage their work and personal life.

Although balancing work and personal life have been identified as a concern for some doctors, this may not always be the case; there are individual differences that may come into play. For example, a doctor's preference for integrating or segmenting life domains,

and work orientation may influence how he or she chooses to balance their various life spheres.

2.4 Boundary Theory and Border Theory

Boundaries (or borders) demarcate the perimeter and range of a specific life domain (Ashforth, Kreiner, & Fulgate, 2000). Boundary theory (Nippert-Eng, 1996a; Nippert-Eng, 1996b; Zerubavel, 1991) and work-family border theory (Clarke, 2000), both consider how people "construct, maintain, negotiate, and cross" (Desrochers & Sargent, 2004, p.40) domain borders or boundaries. These theories are both useful for understanding how people perceive their roles and responsibilities, and move between their various life roles and domains (Sutton & Noe, 2005). Nippert-Eng (1996a) identified examples such as home, work, and church as social domains that are created by boundaries that are perceived as real by the person who created them. Boundaries (or borders) can be constructed along a continuum from strong to weak. Strong boundaries are closed to influence and segment or divide domains. Conversely, weak boundaries are open to influence and integrate or merge domains (Ashforth et al., 2000). Both these theories also consider the implications of integrating and segmenting life domains.

According to boundary theory (Nippert-Eng, 1996a; Nippert-Eng, 1996b; Zerubavel, 1991), people build and preserve boundaries in order to simplify and order their environment. These boundaries are mentally placed around similar or functionally related areas, or domains, that have meaning for the person who creates and maintains the boundaries. People psychologically move between roles, that is, role exit to role entry (Ashforth, et al., 2000). A common role transition or border crossing is leaving work and returning home to a parenting role (Sutton & Noe, 2005).

Unlike boundary theory, work-family border theory considers work and family domains only. The key interest in this theory is work-family balance which is defined as "satisfaction and good functioning at work and at home, with minimum of role conflict" (Clark, 2000, p. 751).

Although there are some differences between boundary and border theory, they share some similar propositions (Clark, 2000; Ashforth et al., 2000; Nippert-Eng, 1996b). Desrochers and Sargent (2004) identified three major similarities as: (1) integrating work and non-work/family eases domain transitions, (2) separating work and non-work/family domains assists managing borders, and (3) integrating and segmenting domains can improve the well-being of employees. There are, however, some individual and environmental characteristics that require consideration. For example, an individual's time management skills or the particular meanings they attach to work and non-work/family domains, and, the norms and policies of the workplace. These characteristics influence the fit between integrating and segmenting preferences and the social context.

A four item scale developed by Kreiner (2006) assesses segmentation preferences. Items include: *I don't like to think about work while I'm at home,* and *I prefer to keep work life at work.* Responses are based on a 6-point Likert scale ranging from strongly disagree to strongly agree. Higher scores indicate a greater need for segmentation of work from other life domains, and lower scores indicate a greater need for integrating work and non-work/family domains. People with a need for segmentation prefer to keep temporal and physical boundaries intact (Ashforth et al., 2000)

The need to keep work and other life domains segmented may be particularly pertinent for people who experience intense occupational demands, such as priests or doctors (Kreiner, Hollensbe & Sharpe, 2006). Because of the cultural expectations

associated with the medical profession, there may be lack of fit between the cultural expectations and doctors' personal preference for integrating or segmenting. Doctors may have difficulty drawing the line between work and family, because, they may choose to accept phone calls from patients at home. It is, however, possible for doctors to maintain a clear work-family boundary by referring their patients to a locum service rather than accept calls at home. Whether doctors choose to integrate or segment their work and non-work/family domains may also be influenced by their work orientation.

2.5 Work Orientation: Work Centrality and Job Involvement

Work centrality and job involvement have often been used interchangeably in the literature related to individuals' attachment to work. The work centrality (WC) construct has been conceptualised in several ways, but the present research defines WC as the beliefs that individuals have about the degree of significance that work has in their lives (Paullay, Alliger, & Stone-Romero, 1994). Individuals for whom work is a central life interest have a strong identification with work, and, they believe in the value of work; the work role is an important and central part of their lives (Brooke, Russell, & Price, 1988; Hirschfeld & Field, 2000; Kanungo, 1982; MOW International Research Team, 1987; Starcevich, 1973).

WC originated with Dubin's (1956) study of 'central life interests' (CLI); this concept was informed by Weber's (1905/1930) Protestant Work Ethic theory (cited in Paullay et al., 1994). The Dubin study (1956) proposed that people have social experiences in a number of life domains (e.g., work, family, community), but these various settings do not have equal salience for the individual. A person may prefer any one or more of several social domains for carrying out activities. This first study of CLI used the CLI questionnaire developed by Dubin. This questionnaire measured a person's CLI by

describing a behaviour and asking where the respondent would be most likely to enact the behaviour. All 32 items provide the respondent with the opportunity to identify whether they would enact a specified behaviour in a work setting, a non-work setting or a non-specific location. For example, one item asks *I would much rather be a leader: 1. in any organization, just so it's a good one; 2. in my club or church or 3. in my work*. Results of this study found that almost three out of every four industrial workers in the sample considered that work and the workplace were not central life interests. Orzack (1959) replicated the Dubin (1956) study with a sample of professional nurses. Based on the assumption that for the professional, work is a point of self-identification and is both valued and important, the study hypothesised that work was more likely to be a central life interest for professionals than for industrial workers. This hypothesis was based on the premise that the training undertaken by professionals includes technical skills, but also includes the learning of behaviours that will be appropriate in their future professional roles and work settings. Orzack (1959) found that in contrast to the industrial workers, four of every five nurses identified that work and the workplace were central life interests.

More recent empirical research using the WC construct has identified that work centrality is associated with a person's value system and self-identity (Hirschfeld & Field, 2000). The extent to which an individual derives personal meaning, and invests in non-work life roles is related to their level of the centrality of work in their life (Stephens & Feldman, 1997). Work centrality may also be associated with the allocation of time, and possibly effort among various life domains (MOW International Research Team, 1987; Wallace, 1999).

Job involvement refers to a person's cognitive state of psychological identification with the job. Kanugo (1982) defined job involvement as the psychological importance of work or the centrality of work to the individual, and the importance of work performance

to self-image. The job-involved person is significantly personally affected by the entire job situation, such as the work itself, co-workers, and the company. Conversely, for the non-job involved individual, work is not as important as non-work life. The core of this individual's self-image is not greatly affected by the kind of work s/he does or how well they perform at work (Lodahl & Kejner, 1965).

In a meta-analysis of organisational research into job involvement, Brown (1996) found that people who are prone to be highly job-involved are high in self-esteem, internally motivated, and have a protestant work ethic. Effort or working "hard" is a behavioural outcome of job involvement. The job-involved person is generally satisfied with the job, particularly the content of their work because this is intrinsically satisfying; the intrinsic need satisfaction is more important than the extrinsic need satisfaction. These individuals are, therefore, less likely than others to leave the organisation. The job-involved person requires an interesting, challenging job and this further cultivates job involvement. Overall, the job-involved person experiences few ill-effects from identifying strongly with his or her job. They do not, usually, have high levels of stress, anxiety, somatic health complaints, or work-family conflict especially when both spouses are job involved. No strong spill-over effects of job involvement was evident (Brown, 1996), but the job-involved person is not likely to demonstrate high levels of involvement in non-work domains as their major focus is their job role (Frone, Russell, & Cooper, 1992).

The consequences of high job involvement are generally positive (Probst, 2000). However, a study by Frone, Russell, and Cooper (1995), using household interviews with a randomly selected community sample of 795 employed adults, found that a job stressor that is perceived to impede successful role performance may be related to elevated alcohol use in people for whom the job is highly salient for self-evaluation of an important role-identity.

2.5.1 Measuring Work Centrality and Job Involvement

WC can be measured directly, and is assessed by asking how central and important the role of working is in one's life in *absolute* terms (Harpaz, Claes, Depolo, & Quintanilla, 1992; MOW International Research Team, 1987). WC can also be measured indirectly by comparing the *relative* importance of work and other life roles (van der Velde, Feij & van Emmerik, 1998).

The Work Centrality Measure developed by Paullay et al. (1994) taps into the centrality of work in people's lives with items such as *" I would probably keep working even if I did not need the money"* and a reverse scored item *"To me, work is only a small part of who I am"*. The Lodahl and Kenjner (1965) Job Involvement (JI) measure contains items such as *"The most important things that happen to me involve my work"* and a reverse scored item *"Most things in life are more important than work"*. In spite of concerns about deficiencies of this scale, it has frequently been used (or at least a subset of the items) and continues to be used in research (Reeve & Smith 2001).

In the current study, the term 'work centrality' is used because all participants identified a degree of importance that working has in their lives (MOW, 1987). It is relevant to consider participants' work orientation, because, the centrality of work in the lives of GPs has the potential to influence how they allocate time, and perhaps effort among their various life domains. Thus, work orientation and preference for integrating or segmenting work and non-work/family domains may also influence GPs coping strategies, and choices about taking time out from work for respite and recovery from the demands of their work. The next section considers adaptive approaches to deal with the demands of medicine and general practice.

2.6 Adaptive Coping Strategies

As mentioned earlier, stress does not always cause distress (Selye, 1975); stress can also have positive aspects. This section focuses on adaptive approaches to dealing with the demands of medicine and general practice.

The lack of empirical evidence addressing the concerns commonly raised in the literature regarding doctors' self-care and health was acknowledged by Miller and McGowan (2000). Based on stress management literature, and reflections on the issues identified in their study, they suggested that physicians needed to "practice what they preach" (p. 972) regarding caring for their own health, and engage in meaningful activities outside of work. These researchers identified several characteristics and attitudes that prevail within the profession require change: (1) developing a professional attitude of self-confidence, competence and authority without promoting a sense of invincibility; (2) recognising distress in colleagues and offering assistance and support, (3) reducing work-life conflict; and (4) removing the necessity for workaholism. These suggestions will require changes to medical culture that may be met with some resistance because they challenge long-standing attitudes and traditions within the medical profession.

An open ended two-page questionnaire was sent to 550 readers of the *Medical Encounter,* the newsletter of the Task Force on Patient and Doctor of the Society of General Internal Medicine (USA) by Quill and Williamson (1990). The readers were primary care physicians in internal medicine, with a few family physicians and doctorate-level behavioural scientists. The 10% response rate to the open-ended survey responses were organised into categories and included: "(1) self-awareness, (2) sharing of feelings and responsibilities, (3) self-care, (4) developing a personal philosophy, and (5) non-

traditional coping skills of reframing and limit setting" (p1857). The sample respondents described a variety of specific methods for enhancing adaptation. These included increasing self-awareness through religious practice, continuing education outside medicine, personal psychotherapy, meditation, yoga, stimulating book reading, and keeping a personal journal. Also identified was sharing of feelings and responsibilities that included spending time with family, friends and colleagues, storytelling, complaining, laughing over human idiosyncrasies, interests outside medicine (physical activity, clubs, teams), self-awareness groups, using multidisciplinary health care teams, and getting assistance with domestic or professional tasks. Adaptations for promoting self-care included scheduling and taking frequent vacations, limiting evening, weekend, and on call work, taking brief breaks during the day, making time for family and or friends, interests and friendships outside medicine, regular sleep, meals and time to oneself, and physical activity. The 10% response rate suggests that it is difficult to collect data from busy doctors. Another reason for the low response rate may indicate the lack of successful strategies used by the surveyed group, or that the requirement for introspection and self-revelation was a disincentive to respond. More importantly, the poor response rate casts some doubts over the conclusiveness of the findings. Further research is required to understand the adaptive strategies doctors employ to manage their work demands.

In an Australian GP study of doctors' health and wellbeing (Schattner, 1998), GPs nominated social support as the most frequently used coping strategy, consistent with other research (e.g., McCall, Maher, & Piterman, 1999; Miller & McGowan, 2000; Murfett & Charman, 2006; Rogers, 1998). The least frequently used coping strategy for occupational stress was to seek professional help. Other reported techniques included strategies thought to be less helpful such as avoidance (e.g., take time off work) and

denial (e.g., pretend nothing is the matter). However, statistically significant differences revealed that men tended to take time off work, while women talked about stressful events with family and friends.

Choosing to respond to job demands with behaviours such as physical activity, meditation, time management, and cognitive restructuring may improve physical and psychological health (Sutherland & Cooper, 1993). When people engage in these types of behaviour, they are taking time to psychologically detach from their work role by engaging in respite activities that facilitate recovery from work demands. This is especially important because it is difficult for doctors to completely leave their patients at work; they often take patients home in their thoughts (Yalof, 1988). These adaptive coping strategies do not recognise individual differences, and presume that GPs can psychologically detach from their work; however, the degree to which individual GPs can do this may be related to their work orientation.

In this chapter, the concept of stress and four models of occupational stress were presented. Also the notion that all life domains are interconnected, and stress and strain should not be considered in isolation was addressed. However, work orientation may influence both the appraisal of stress and perceptions of work and non-work/family conflict. The chapter concluded with literature related to adaptive coping strategies. The following chapter describes the role of Australian GPs, the healthcare environment, and an overview of the literature relating to doctors occupational stress.

CHAPTER 3

AUSTRALIAN GENERAL PRACTITIONERS

The first sections in this chapter provide descriptions of the role and profile of Australian GPs and the healthcare environment in which they work. The next sections review the literature pertaining to doctors' occupational health, and the issues surrounding their responses to the demands of working in general practice. These sections are followed by a review of the literature pertaining to GPs occupational stress and the personal characteristics that influence their responses to workplace stressors. The chapter concludes with a rationale for the current study and the research questions that oriented the study.

3.1 Role of GPs in Australia

In Australia general practice is a specialty that requires advanced training. GPs working in Australia diagnose and treat peoples' physical and mental disorders and injuries, and also provide preventive and health promotional services. They hold a bachelor degree or higher qualification, and one year of hospital-based training, and are registered or licensed by state or territory authorities (Australian Bureau of Statistics [ABS], 2003). GPs provide primary care medical services in Australia and in the United Kingdom. In the United States and Canada primary care providers are often known as family physicians.

In Australia, the majority of GPs work in general practice medical services. They do not only provide medical care, they are also traditionally the 'gate keepers' of the health care system, and, as such, are responsible for referring patients to other facilities and services within the health system, especially to other medical specialists. GPs also

commonly seek opinions from other specialists for diagnosis and management of their patients' illnesses (ABS, 2003).

GPs most commonly practice in a small business environment. Forty percent work in group practices of five or more GPs, and 16% work in solo practices. The majority of GPs work in private rooms (78%), with the remainder working in acute care hospitals, 24-hour clinics, and non-residential health care facilities (Australian Institute of Health and Welfare [AIHW], 2005).

3.1.1 Australian GP Profile

In 2006, there were 35,452 GPs registered in Australia. The numbers of GPs per 100,000 persons rose between 1997 and 2006. In Victoria, where the current study was based, the ratio of GPs per 100,000 persons was 181.9 compared with 178.6 for all of Australia (ABS, 2008a). In the last 20 years there has been an increase in female participation in general employment from 39% to 46%. Correspondingly, there were also increases in the proportion of female GPs from 25% in 1986 to 39% in 2006. The most significant increase, however, was that 53% of GPs under 30 years were female. GPs are on average older than the rest of the working population, and 12% were aged over 60 years.

The working hours of a GP appears to be higher than some other professions. GPs generally worked longer hours regardless of whether they were male or female, or worked in hospitals or general medical practice settings (ABS,2008a). Of those GPs working full time, 61% reported working 45 hours or more a week with 39% reporting that they worked 55 or more hours a week. The average hours worked by full-time GPs increased with geographical remoteness, with those working in very remote areas (VRAs) working

53.6 hours a week, compared to an average of 49.2 hours a week in major cities (ABS, 2008a).

There has been a steady increase in the proportion of GPs working part time, which may be attributed to GPs changing attitudes towards the role of work, older GPs working part-time, and an increased number of females in the GP workforce. In 1986, 15% worked part-time, by 2006 there were 22% part-time GPs (ABS, 2008a).

In Australia, the geographical location where GPs choose to practise is influenced by family, social and professional connections, lifestyle preferences, and market forces (AIHW, 2005). These factors have tended to attract the highest concentration of the medical workforce to the relatively wealthier, more inviting inner suburbs and capital cities. Thus, there is an unequal geographical distribution of the GP workforce across Australia. In 2006, there were 204.9 GPs per 100,000 persons in major cities, compared with 128.3 per 100,000 persons in inner regional areas and 64.5 per 100,000 persons in VRAs. Patients in suburban areas, therefore, have greater access to GP services than their rural or regional counterparts (AIHW, 2005).

Geographical areas of social disadvantage also have fewer medical practitioners. While levels of social disadvantage tend to be higher in regional and remote areas, the pattern of fewer medical practitioners in socially disadvantaged areas within major cities is also apparent. Only 5% of GPs chose to live in the most socially disadvantaged areas, but 11% worked in these areas (ABS, 2008a). There is also a lack of allied health services in these areas, so GPs provide other services (e.g., counselling). These services can be time consuming and not well remunerated for GPs.

3.1.2 General Practitioners' Remuneration

According to *Australian Doctor* (Kron, 2007), the average gross income of GPs can vary between $AU220,000 and $AU275,000 (before tax)[2] per year depending on a number of variables such as, geographical area of practice, type of work, type of billing for service, hours worked, and whether the GP is a practice principal/owner or employee. Compared to other medical specialties, this is sometimes considered to be poor remuneration, given the years of education required to achieve the qualification, and the degree of professional responsibility inherent to the role.

GPs are paid, in part, by the Australian Government through the Health Insurance Commission (HIC). When GPs submit their fees for service to patients for payment, the HIC records all GP activities. All GPs' individual data are recorded and compared to the average expected number of short or long consultations, number and type of drug prescriptions, referrals, and other types of treatment. These data enable the HIC to track GP activity; monitor levels of service delivery, and detect outliers for follow up investigation.

Medicare[3] is the Australian Government funded health insurance scheme that provides free or subsidised health care services to the Australian population. GPs can elect to bulk-bill their patients and receive payment of the scheduled fee directly from the HIC; or utilise a co-payment system whereby they charge the patient a fee above the

[2] Income is based on deduction of expenses but before tax planning for a GP working full time -- 40-50 patient contact hours a week.

[3] Medicare came into operation on 1 February 1984. It provides free hospital services for public patients in public hospitals through the Australian Health Care Agreements and the States. Medicare provides a subsidy to private patients for hospital services (75 per cent of the Schedule fee) and provides benefits for out-of-hospital medical services such as consultations with GPs or specialists (85 per cent of the Schedule fee).

Medicare scheduled fee. The patient claims their rebate from Medicare, and then pays any out-of-pocket difference (to the doctor) between the scheduled rebate fee, and the fee charged by the particular GP. The fee for service charged is at the discretion of individual GPs, who may elect to charge from between $AU5 to $AU30 or even more above the scheduled rebate. Co-payment billing is likely to provide a higher income to the GP than bulk billing Medicare for payment.

As a way of providing incentives to GPs for management of chronic health conditions, the Australian Government introduced alternative payment systems, known as blended payments, in November 2001. Payments made through the Practice Incentives Program (PIP) are in addition to other income earned by GPs and the practice, such as patient payments, and Medicare rebates. Four PIP measures deliver increased funding to GPs to provide better mental health care, improved management of diseases, such as asthma and diabetes, and increased screening for cervical cancer. GPs working in PIP practices are also eligible to receive a Service Incentive Payment (SIP) in these areas of care.

This additional payment system is controversial, as many GPs question the role of government in defining the parameters of their clinical care. The associated bureaucratic demands of additional paperwork and administration may also pose additional demands on the GP. Some GPs, therefore, choose not to participate in these additional payment programs.

3.2 Demand for GP services

It is common for Australians to consult a GP. Data from the Australian Institute of Health and Welfare (2005) indicated that approximately 85% of the population see a doctor at least once a year. In 2010-2011 people aged 15 years and over (82%) consulted

a GP at least once (ABS 2012) The high demand for GP services, combined with the trend of more GPs working part-time (Joyce, McNeil, & Stoelwinder, 2006), has a corresponding influence on the GPs workload, and the level of remuneration generated from consultations.

With an ageing population, the demand for GP services is unlikely to diminish; the number of patient presentations will remain high, and the range of patient needs will remain diverse. Patients do not present to the GP with only physical ailments or illness; many patients consult GPs as the 'first port of call' for their psychological and psychosocial needs as well. The GP requires sufficient time and breadth of knowledge to provide quality care, which influences the quantitative and qualitative aspects of GP workloads.

3.2.1 An ageing population

As a result of continued low levels of fertility (i.e., fewer children in the population) and an increasing life expectancy, Australia's population is ageing. According to the Australian Bureau of Statistics (2008b), the median age increased from 30.5 years in 1984 to 36.8 years in 2007. For the year ending 30 June 2007, the population aged 60-64 years grew by 7.6%. The population aged 85 and over was also up by 6.8% 2008 (ABS, 2008b). People who are older often have more complicated health care needs, and require ongoing support for chronic health conditions. For example, the ageing population will mean a higher proportion of patients will require longer consultations to manage complex medical conditions and/or chronic disease. Providing quality care for these patients will influence the capacity of GPs to care for as many patients in the time available, which may lead to restrictions on GP capacity to maintain their income. Furthermore, the current workload of GPs is likely to continue to expand, placing more time pressure on the GP

and their capacity to manage their work-life balance. As there tends to be lower numbers of GPs in regional areas (AIHW, 2005), the increased health demands associated with older Australians will add further stress to the limited GP resources in more remote areas.

3.2.2 Mental Health Needs

Andrews, Hall, Teesson, and Henderson (1999) conducted the first national Australian survey of mental health and found that mental disorders accounted for 20% of the Australian burden of disease. Approximately half as many Australians have a mental disorder as have a chronic physical disorder (e.g., kidney disease, chronic bronchitis). Physical disorders are more prevalent in the aged, and mental disorders are more frequent in the younger population. One in five adult people identified with significant psychological distress were receiving help from a GP, rather than a mental health professional. The demands for both physical and psychological care mean that GPs require skills in managing a diverse range of presentations that go beyond physical ailments.[4]

3.3 Workforce Shortage and Demand

The changing characteristics, and work preferences, of practising GPs will influence the balance between supply and demand for primary care services and future workforce planning (Charles, Britt, & Valentini, 2004). There has been increasing concern about workforce shortages of GPs that are related to projected characteristics of both the general practice workforce, and the ageing Australian community (LaMontagne, Ostry, Louie, & Keegel,2006). An analysis by Joyce, McNeil, and Stoelwinder (2006) predicted that the

[4] Since November 2006, GPs have the option to refer patients with diagnosed mental disorders to a range of mental health services providers, including psychologists. The Australian government introduced new mental health Medicare items through the Better Access to Mental Health Care. This initiative entitles patients to access a number of individual services and group therapy services per calendar year; the number of services available to patients is dependent on their particular circumstances.

availability of effective full-time practitioners in Australia would continue to fall. Projections of long-term shortages in the future GP workforce were modelled according to key changes in intakes of Australian GPs; attrition due to increasing retirement rates of doctors in the "baby boomer" generation, and a decline in working hours by both male and female doctors. While there are limitations to the accuracy of projective modelling, the impact of an increasingly part-time work force and rates of retirement on GP workforce shortages have also been identified by others (e.g., Charles, et al., 2004).

Workforce shortages are also influenced by the number of medical graduates electing to pursue general practice as a specialty. According to Joyce and McNeil (2006), a declining proportion of new graduates from Monash University Medical School were choosing general practice as a career. These researchers compared four cohorts (N=386) of Monash Medical School graduates who completed their degrees in 1980, 1985, 1990 and 1995. Eight years after graduation, half of those in the 1980 and 1985 cohorts were working in general practice, compared with 38% of the 1990 and 33% of the 1995 graduates. The decline in attracting graduates to general practice has been attributed to the perception that general practice is less prestigious than other specialties (Lambert, Evans, & Goldacre, 2002).

Investigating the issues that may influence the functioning, job satisfaction, and intention to stay in the GP workforce is important because the increasing demand for healthcare services will be at a rate that will challenge Australia's training and service delivery systems (Health Workforce Australia, 2012). It will, therefore, be imperative to understand the stressors and coping strategies that GPs use to enable successful adaptation to their workplaces so that GPs stay in the workforce, and, continue to care for

the future health requirements of Australians. The following section provides an overview of the literature regarding occupational stress in doctors.

3.4 Overview of the Literature on Occupational Stress in Doctors

Given the nature of GP work, and the range of patient presentations and needs, GPs may be more susceptible to occupational stress than those working in many other professions. The sources of potential stress may influence GPs' perceived job satisfaction, physical and psychological health, and decisions to continue working in general practice. The outcomes of occupational stress may, therefore, also influence workforce shortages.

Research into the sources and levels of stress in doctors, and the subsequent influences on their health and well-being has attracted considerable attention. Factors associated with stress related problems have been identified in the workplace and within the individual (Firth-Cozens, 1999). Doctors (and other health professionals) working in the UK demonstrated above threshold levels of stress that persisted at around 28% compared with 18% in the general working population (Firth-Cozens, 1999). In addition to pressures in the workplace, Dua (1996; 1997) also identified age and gender differences in GPs' reported occupational stress, with younger males reporting greater stress than females. Winefield and Anstey (1991) found younger GPs reported more emotional exhaustion and depersonalisation than older GPs.

In a survey of Australian metropolitan GPs, occupational stress was cited as a reason for them considering abandoning their profession (53%), or leaving their current workplace (50%) (Schattner 1998). Occupational stress has numerous sources, and various theories have found empirical support in the literature (Dollard & Winefield, 2002). In many of these sources, stress is considered as an individual response to a perception of excessive work demands, and is predominantly characterised as a

debilitating response. The influence of stress and ill health in doctors is cause for concern, particularly in light of the growing demands on the profession.

All people experience stress, and some stress is necessary for motivation, growth, and development. When a source of perceived demand (or stress) goes beyond a person's perceived ability to manage or cope, a state of stress is believed to be present. It is, therefore, important to distinguish between a negative form of stress or distress and positive stress, or eustress (Selye, 1975). While stress has positive elements, this section reviews the literature regarding the negative outcomes of occupational stress, and their implications for GP adaptation to the demands of general practice.

3.4.1 Doctors' Work Context and Occupational Stress

Australian research into GPs' occupational stress (e.g. Dua, 1996; 1997; Schattner 1998) has utilised surveys and quantitative analysis to identify sources of stress and identified similar findings regarding occupational stress in GPs. Schattner (1998) stated that sources of stress have included work demands, such as hours of work, time pressures, expectations that they needed to work even when they were sick, government's interference with their work, and concerns about their work disturbing their family and leisure time. In Dua's studies, rural practitioners reported extra pressure that included difficulties finding locums, increased after-hours work, and poor access to professional development.

3.4.1 .2 High Demand

A common cause of stress at work is perceived high work demand. Doctors' view their work as having ongoing demands, such as high workload, long work hours, anxiety about making mistakes, and threat of litigation. Some doctors experience work and non-work inter-role conflict, that is, a sense of incompatibility between one role and another

(Kirchmeyer, & Cohen, 1999). Research regarding doctors and occupational stress suggests that the excessive work demands experienced by doctors have the potential to cause stress. These work demands may contribute to doctors' dissatisfaction with their jobs, and, result in maladaptive strategies being adopted to deal with the demands of their work.

Occupational or job stress has been linked to a range of occupationally-related illnesses and associated organisational outcomes, such as job satisfaction, absenteeism, and turnover (LaMontagne, Olstry, & Shaw 2006). A recent review of job stress and health conducted by LaMontagne, Ostry, Louie, and Keegel, (2006), commissioned by the Victorian Health Promotion Foundation, found compelling evidence that job stress predicts mental health problems, cardiovascular disease, and a range of unfavourable health outcomes. While most studies examined in this review were cross-sectional, one longitudinal study by De Lange, Taris, Kompier, Houtman, and Bongers (2004) provided evidence of a causal link between psychosomatic complaints and psychological stress. These researchers conducted a prospective study of 668 Dutch employees using 4 waves of data collection from 1994 to 1997. Results found evidence of reciprocal causal relationships between work characteristics and mental health. Results also indicated that a 1 year time lag provided the best model fit with adverse effects on mental health occurring from 1 year of exposure.

Doctors face distinctive professional and personal demands that are potentially stressful due to regular contact with disease, pain, death, and suffering for which there is no cure (Winefield, Farmer, & Denson, 1998). GPs practising in rural, remote, and under-serviced urban regions may be confronted with additional demands as they endeavour to balance professional, community, and family commitments (Humphreys, Jones, Jones, & Mara, 2002; Schofield, Page, Lyle, & Walker, 2006).

3.4.1.3 Threat of Malpractice Litigation

The threat of malpractice litigation was another commonly cited occupational concern in the literature and source of work dissatisfaction (Arnetz, 2001; Charles, Wilbert, & Franke, 1985; Nocera & Khursandi, 1998). The actual incident or mishap that initiates a lawsuit may be acute, but the process of litigation is usually lengthy and, therefore, the distress associated with the process can become chronic and extend for a number of years (Charles, Wilbert, & Kennedy 1984).

In addition, changing social attitudes regarding the expectation of best care from those who provide care mean that patients now expect their doctor to fully inform them about their illness, their treatment options, and any associated risks. In the event of a medical mishap, patients in Australia are now more likely to seek compensation, and engage in mediation or litigation.

In Australia, Medical Defence Organisations (MDOs) are different from insurance companies in general. They have discretion whether to pay or to contest claims.[5] The Medical Indemnity Industry Association of Australia's (2007) annual indemnity report found that in the in the 10 years to 2005, there was a 37% rise in claims against non-procedural[6] GPs, and a 19% rise against procedural GPs, although there are signs claims may have plateaued in more recent years, possibly due to state tort law reforms (Mackee, 2006).

Malpractice litigation has a professional and personal impact on doctors' lives. A study of Chicago Medical Society members by Charles, Wilbert, and Franke (1985) found

[5] A not-for-profit mutual organization created and owned by medical practitioners to provide various medical indemnity services to members.

[6] The definition of procedural general practitioner adopted by the Australian Government is one who: provides non-referred services usually in a hospital theatre, maternity setting or other appropriately equipped facilities that in urban areas are typically the province of a specific referral based specialty. Most commonly this refers to the fields of surgery, anaesthetics and obstetrics.

that in response to both the threat and actuality of litigation, sued and non-sued doctors had professional reactions and symptomatic reactions. Not surprisingly, doctors who were sued reported more severe emotional disruption than non-sued doctors. Symptoms included severe depressed mood, inner tension, anger, frustration, and physical illness. As a result of litigation doctors became more concerned about maintaining meticulous records, ordering more (potentially unnecessary) diagnostic investigations, studying professional literature more thoroughly, and attending more continuing education courses. While such changes in professional practice may have been warranted, the additional demands on the GP also increase. These professional (and personal) changes may also have an impact on the delivery of quality health care. For example, increases in medical costs to the community, erosion of the doctor-patient relationship, and decline in doctors' self-confidence and job satisfaction.

While many studies (e.g., Dua, 1997: Firth-Cozens, 1999; Schattner, 1998) have found that the high demand work environment of medicine contributes to doctors' perceptions of occupational stress, perceptions of occupational stress may also be influenced by doctors' individual characteristics.

3.4.2 Doctors' Personality and Occupational Stress

The amended ERI model (1999) proposed that conditions at work and individual characteristics such as self-esteem, self-efficacy, and over commitment were associated with occupational stress. Miller and McGowan (2000) also identified that workplace stressors were related to individual characteristics such as perfectionism, competitiveness, altruism, and social conscience. Self-criticism, empathy, and early family relationships have also been associated with workplace stress (Firth-Cozens, 1999).

A longitudinal study by McManus, Keeling, and Paice (2004) surveyed UK medical students during their medical training from entry in 1991, 1992, or 1993, and followed to their final year at medical school (1995-1998). These researchers found that stress levels were related to personality differences. Doctors who were most stressed showed higher levels of neuroticism (in the present and past); those reporting the most emotional exhaustion also had higher neuroticism levels, and were also more introverted. Overall satisfaction with a medical career was related to lower levels of neuroticism. Extroverts reported more personal accomplishment and more satisfaction with medicine. Differences in approach to work, and perceptions of workload and supportiveness in the workplace were influenced by the external environment. While the study revealed relevant personality characteristics that were associated with workplace stress, it was not possible to isolate the direction of causality.

Due to the high levels of academic achievement required for entry into a medical degree, and the standards of the medical profession, doctors generally tend to have a conscientious and compulsive personality style and strive for perfection. They self-generate expectations for high performance and working hard (Gerber, 1983 Menninger, 2003). This personality pattern encourages attention to detail and thoroughness which is desirable for the delivery of quality medicine.

Doctors' compulsiveness was identified by Gerber (1983) and Menninger (2003) as being associated with distress through an excessive sense of responsibility for things beyond individual control, unwillingness to take holidays (vacations), difficulty in allocating time to family, and trouble setting limits. These characteristics have the potential to influence the perceived balance between doctors' work and non-work/family domains.

A study by Firth-Cozens (2000) suggested that stress needs to be accepted and managed. Successful stress management is a crucial aspect of patient safety, and will positively influence the lives of doctors and their patients. Firth-Cozens (1987) also acknowledged that problems associated with stress come from both the workplace (lack of sleep, poor communication, and poor teamwork), and the individual (personality, self-critical, unsupportive early family relationships). It is clear that people do not experience the same degrees of stress, illness, health, and wellbeing at all times, these things are dynamic and change depending on many internal and external factors.

3.4.3 Negative Attitude to Help Seeking Behaviour

Doctors are reluctant to seek help when faced with challenging demands (Gerber, 1983; Menninger, 2003). Societal expectations and the medical culture contribute to, and or, reinforce doctors' low level of help seeking behaviour. Doctors are expected to support others and be strong; many believe it is unacceptable to reveal vulnerabilities and weaknesses to others (Gerber, 1983; Miller & McGowan, 2000). Doctors may have difficulty asking for help and adopting the patient role (Rogers, 1998; Thompson, Cupples, Sibbett, Skan, & Bradley, 2001).

Although doctors may have ready access to support services for psychological concerns, they avoid seeking help. The reasons identified for their reluctance to seek support include: time constraints due to work demands, a belief they can self-medicate and self-diagnose, and concerns about confidentiality (Allibone, Oakes, & Shannon, 1981; Pullen, Lonie, Lyle, Donald, & Doughty, 1995; Thompson et al., 2001).

The culture of medicine may be a barrier to doctors seeking healthcare for their own needs (Centre et al., 2003; Davidson & Schattner, 2003; Thompson et al., 2001). Medicine has typically attracted individualistic young people who value their

independence (Mechanic, 2003). Being accepted into medicine requires high academic achievement, and the capacity to withstand the high demands associated with medical training. Medical students are exposed to sickness, pain and death, surrounded by a culture where 'real or good doctors' are able to carry on without showing distress. They learn they are expected to care for others and not require care themselves. Following qualification, doctors usually work very long hours, and are expected to deal with a range of human problems, often with insufficient support from colleagues (Gerber, 1983; Smith, 1997).

Doctors often work through illness and present late when they may have more serious conditions themselves. This may, in part, be indicative of the image of invincibility and denial of vulnerability encouraged by the medical profession (Thompson et al., 2001). Although the New South Wales Doctors Mental Health Policy (1997) recommended that all doctors have their own GP, research has found that many doctors are still reluctant to seek formal care (Davidson & Schattner, 2003). Doctors may also avoid seeking mental health treatment due to fear of punitive responses and discrimination in medical licensing, hospital privileges, professional advancement, and personal insurance (Levine & Bryant, 2000).

Research findings from various occupational groups, including medical practitioners, indicate that a particular job combined with certain individual characteristics may be predictive of job dissatisfaction, mental ill health, heart disease, accident occurrence, alcohol abuse, and social and family problems; one symptom may aggravate another (Sutherland & Cooper, 1993).

While doctors are physically healthier than the average person in the community (Carpenter, Swerlow, & Fear, 1997), they are often unwilling to seek help, and tend to

self-medicate (Chambers, 1993; Davidson, & Schattner, 2003; Forsyth, Calnan, & Wall, 1999; McCall, Maher, & Pitterman, 1999; Pullen, Lonie, & Lyle, 1995). It appears that some doctors have significant psychological vulnerabilities (Vaillant, Sobawale, & McArthur, 1972), and are engaging in maladaptive behaviours in their endeavours to deal with the high demands and stress inherent in a medical career (Dua, 1996, 1997; Firth-Cozens, 1999; Schattner, 1998). Whether this is predominantly due to the demands and stress associated with the job, or to pre-existing personality traits, remains unresolved.

3.5 Psychological Health

In comparison with the general population, some studies have found that medical practitioners experience higher rates of suicide, especially among women doctors (Hawton, Clements, Sakarovitch, Simkin, & Deeks, 2001; Lindeman, Laara, Hakko, & Lonnqvist, 1996; Schernhammer, & Colditz, 2004), depression, alcohol abuse, (Firth-Cozens, 1999; Schattner, Davidson, & Serry, 2004), substance abuse and burnout (Caplan, 1994; Miller, & McGowen, 2000; Sutherland & Cooper, 1992) and marital problems (Harari, 1998). The following section outlines three psychological health issues for doctors: burnout, depression, and impairment.

3.5.1 Burnout

Burnout describes a collection of symptoms, and is generally defined as a "state of physical, emotional, and mental exhaustion that occurs as a result of intense involvement with people over long periods of time in situations that are emotionally demanding" (McCranie & Brandsma, 1988, p.30). There is also a depressive component of burnout whereby an individual experiences feelings of helplessness and hopelessness, develops a negative attitude toward work and life, and a sense of distress and failure (Pines & Aronson, 1988). Over time, doctors who experience burnout become increasingly

disillusioned, dissatisfied, and cynical about their work and other parts of their lives. Once caring doctors can become uncaring toward their patients, and dread clinical work (Guthrie & Black, 1997).

Increased burnout has been associated with greater perceived job stress rather than demographic or external work characteristics such as practice arrangements (i.e., solo, partnership, or group), hours worked or time in direct patient contact. Accordingly, subjective perceptions of work are considered more important for burnout than objective work conditions (McCranie & Brandsma, 1988). It is possible that doctors are susceptible to burnout due to the high ideals of the profession, and long work hours, combined with bureaucratic paperwork placing additional burdens to their already heavy workload; increased patient expectations, and an increase in patients making complaints against doctors (Guthrie & Black, 1997).

3.5.2 Depression and Suicide

A report by Clode (2004), *The Conspiracy of Silence: Emotional Health Among Medical Practitioners,* identified high levels of depression and psychiatric disturbance among doctors. Similar findings have been reported internationally (Hawton, Clements, Sakarovitch & Deeks, 2001; Centre et al., 2003). These statistics suggest doctors are vulnerable to the demands of dealing with caring, and the associated demands of the medical profession, and that the profession is high-risk. Conversely, other research has suggested that the lifetime frequency of self-reported depression in doctors is as common in doctors as it is in the general population – about 13% for men and 20% for women (Centre et al., 2003).

This lack of consistency in findings regarding depression in the medical profession may be because, although many studies of psychiatric disorder in doctors have used

Goldberg's General Health Questionnaire (Goldberg & Williams, 1988) to screen for psychological morbidity, different forms of the questionnaire and different cut-off points have been administered (Guthrie & Black, 1997). Comparison across these studies may, therefore, be compromised.

Suicide is an extreme response to situations appraised as stressful. A higher rate of suicide amongst doctors compared with the general population has been reported since the 1960s (a'Brook, Hailstone, & McLaughlan, 1967; Pitts, Schuller, Rich & Pitts, 1979; Rose & Rosnow, 1973). Research has considered a number of issues that may contribute to suicidality in doctors. For example, whether people who are more prone to developing psychiatric illnesses enter the medical profession, and medical knowledge facilitating successful suicide attempts. Hawton, Clements, Simkin, and Malberg, (2000) found that the greater proportion of suicide deaths in doctors were by self-poisoning. This finding may be influenced by the fact that doctors have ready access to drugs, and have knowledge of drugs and doses that are likely to cause death. It is possible that a combination of individual, organisational, and professional factors interact (Wall et al., 1997). Under-reporting may be of more concern than over-reporting (Arnetz, 1997), and the incidence may be higher in doctors who do not do not have the protective effects of being married (Stack 2004).

There is evidence indicating a rise in the incidence of depression among the general community. The depression initiative *beyondblue*[7] encourages people to seek help from their general practitioner. Encouraging people to consult their GP is likely to increase GPs already heavy workload, and given the key role of GPs play in the treatment and support

7 *beyondblue* , the national depression initiative was established in October 2000 by the Australian Government and the State of Victoria. The intention of the initiative is to make a contribution that has national and international significance in the field of depression. The focus is to create a community response to depression, moving depression away from a mental health service issue to one which is acknowledged and addressed by the wider community.

of depression in the general community, Clode (2004) suggested the need for a national strategy to support GPs with both their own emotional health issues, and those of their patients. Centre et al., (2003) emphasised the importance of maintaining doctors mental health and well-being because of the direct effect their health has on the delivery of quality patient care.

3.5.3 The Impaired Doctor

Self-regulation is a distinctive characteristic of professions, and to a large degree, doctors regulate their own practice. Self-regulation may result in doctors continuing to work when they are not fit to do so (Arnetz, 2001; Tempelaar 1997). Numerous studies have described the characteristics of impaired doctors, but doctors who become incompetent in practice, for whatever reason, often continue working. Rosenthal (1997) identified five categories of problem doctors: "1) inexperience and/or work pressure; 2) interpersonal or personality conflicts; 3) impairment, including getting old; 4) apparent lack of knowledge or skill; 5) criminal behaviour" (p. 16). Impairment can include continuing to work into old age, drug and alcohol use, and psychological problems. All these categories define the problem of impairment within the doctor.

It seems there is a reluctance to discuss problems with colleagues, resulting in tension between inter-collegial conduct and concern for the patient (Wise, 1996). Colleagues attempt to persuade the malfunctioning doctor to alter his or her behaviour. If this is unsuccessful, they adapt the work environment to reduce likelihood of adverse outcomes by reducing the number of patients or limiting the malfunctioning doctor's access only to lower risk patients. If these strategies fail, a "committee of wise men" (colleagues) (Tempelaar, 1997, p. 48) seek to find resolution of the problem. The last resort is an

attempt to persuade the malfunctioning colleague into early retirement; this also serves to protect the colleague from disciplinary proceedings (Lens & van der Wal, 1995).

Australia introduced The *Health Practitioner Regulation National Law Act 2009* which took effect on July 1st 2010. The health professions covered by the national law are chiropractors, dentists, doctors, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. This national scheme provides for mandatory reporting of a registered colleague or employee who is unwell or practising incompetently or unethically. Specific examples include practising while intoxicated by drugs or alcohol, sexual misconduct, placing the public at risk of substantial harm in their practice because they have impairment, or because of a significant departure from accepted professional standards. Failure to report such conduct can result in the registrant being liable to disciplinary action (Houston, 2010). It is, however, possible the introduction of mandatory reporting will be a disincentive for health professionals to seek help if required.

In the preface to the book *Problem Doctors* edited by Lens and van der Wal, Smith (1997) suggested that public expectations of medical care require answers and solutions, and often these expectations cannot be met. Death, sickness and pain cannot be overcome. Those within medicine know of the uncertainties and vulnerabilities of the profession. However, the public do not want to know of vulnerabilities, they want results, and doctors want to provide results but know there are limitations. Patients now actively seek out the best that is available; they demand and value choice, believe strongly in technological progress, and look for whatever seems new or better. These views affect patient behaviour and may be perceived as an additional demand in doctor-patient encounters. Doctors are now taught the importance of involving patients in decision-making about their health and interventions. For some doctors these changes are welcome, but for other doctors who are

well into their careers, and who were traditionally trained, these changes can be challenging (Mechanic, 2003) and contribute to discontent and job satisfaction.

3.6 Doctor Discontent and Job Satisfaction

Doctors who are discontent or dissatisfied complain about the medical system and its associated demands, and contemplate leaving the profession (Dowell, Hamilton, & McLeod, 2000). These doctors do not have a medical health problem, and are able to function at a reasonable level (Schattner, Davidson, & Serry, 2004).

Doctor discontent is not a new concept and has been written about for several decades (Linzer et al., 2000; Mawardi, 1979; McCranie & Brandsma 1988; McCranie, Hornsby, & Calvert, 1982), Mechanic, 1975; Mechanic 2003; Warren, Weitz, & Kulis, 1998). There appears to be general agreement about the existence of doctor discontent among the medical profession in Canada, United States of America, United Kingdom, New Zealand, and Australia. This sentiment was captured by Smith (2001), then editor of British Medical Journal, when he asserted that doctors were unhappy, and Zuger (2004) in The New England Journal of Medicine wrote of "widespread professional malaise" (p.69).

In spite of much commentary about the discontent in Western doctors, empirical studies have identified various levels of job satisfaction in doctors. Job satisfaction refers to an individual's emotional state of liking their job (Brooke, Russell, & Price, 1988). A longitudinal study by Nylenna, Gulbrandsen, Forde, and Aasland (2005) found that a representative sample of 1,174 Norwegian doctors, surveyed in 1994 and again in 2000, reported an increasing level of job and life satisfaction. This finding challenged the notion of unhappy and dissatisfied doctors practising in Western countries. The primary care doctors in the sample reported a higher level of job satisfaction than average, and the overall sample of doctors believed they had a higher level of job satisfaction than other

comparable professional groups. Using data obtained from these same samples, Gulbrandsen (2002) found that a high level of job satisfaction, and being older, positively influenced doctors' perceptions of the gatekeeper role demands. The gatekeeper role was an added demand especially for younger doctors trying to meet patient expectations. More than one third experienced stress due to patient expectations for help with non-medical reasons for presentation.

A study of 448 Portuguese family doctors (Biscaia, Ferrinho, & Colaco, 2004) found the average score on a validated job satisfaction questionnaire was neutral. Negative evaluations of job satisfaction were associated with pressure at work, poor work conditions at the practice, and the remuneration received. Positive evaluations were associated with commitment to work, feeling adequate to perform expected tasks, and relationships with work colleagues. Evaluations were also influenced by factors relating to specific work settings, such as sharing consulting rooms, the proportion of nurses to doctors, the proportion of administration staff to doctors, the proportion of patients in the practice to doctors, and the number of overtime hours worked. While this study was useful in identifying work factors that influenced job satisfaction, a limitation of this study was that the discussion was limited to specific job factors. The study neglected to consider factors related to doctors' individual characteristics, attitudes toward work, and also factors outside the practice setting, which may influence doctors' job satisfaction. It is important to consider factors, other than work factors, because for both men and women events at work affect events at home and vice versa (Greenhaus & Beutell, 1985).

Warren, Weitz, and Kulis (1998) surveyed 510 US doctors about their satisfaction with their work environment, and found that doctors were more likely to be satisfied if they were able to give orders to non-physicians in the healthcare system that were followed, were not required to subordinate their clinical judgment to that of non-

physicians, received the financial remuneration they wanted, and believed their patients had confidence in doctors. Hueston (1998) also surveyed 537 US family physicians and found that the majority of family physicians were mainly satisfied with their career, and would select family practice specialty again. A smaller majority was also satisfied with their financial reimbursement, but those in smaller group practices were less satisfied with their careers than physicians working in larger group practices (Hueston, 1998; Skolnik, Smith, & Diamond, 1993).

In a qualitative study, Reames and Dunstone (1989) interviewed 19 US doctors and found that doctors who focused on the value of their relationships with patients, and their natural interest in medicine, were more satisfied than those who valued being successful at the business of medicine. A study of career choice in Finnish doctors, (Hyppolh et al., 1998) investigated the social background of doctors, the reasons that influenced their choice of medicine as a career, and the association between those reasons and satisfaction in career choice. A questionnaire was mailed to a random sample of 2632 Finnish doctors (with a mean age 34 years) in 1988 and to 2332 doctors (with a mean age 34 years) in 1993. The majority of respondents reported that academic success, interest in people, a wide variety of job opportunities, and that medicine is a highly appreciated profession, had influenced their decision to enter medicine quite a lot or very much. More women than men were influenced by success at school, interest in people and vocation, (meaning the sense the medical profession as a calling). Vocation, interest in people, and wide range of job opportunities were significantly less likely to be mentioned as an important career choice motive by the 22% of respondents that reported they would not choose to enter medicine again. Interest in people and vocation were important to prospective doctors, while lack of vocation and slight interest in people appear to be the critical factors influencing doctors' later dissatisfaction with the profession. Doctors who

identified success at school as an important reason for choosing medicine were more likely to consider another profession if they were beginning their studies again. Social background, gender or current job was not found to affect professional dissatisfaction.

More recently, in 2008, the Physicians Foundation commissioned a survey of US primary care physicians. The Medical Practice (2008) survey was mailed to 270,000 primary care physician engaged in active medical practice in the United States. Primary care physicians were defined as family physicians, general internists, pediatricians, and obstetrician/gynecologists. Surveys were also mailed to 50,000 practising physicians in surgical and diagnostic specialists who were randomly selected through a national physician database provider. The total number of responses received was 11,950 – a response rate of approximately 4%. Over 27% of respondents were family physicians, the single largest category of respondents. With regard to how they envisioned the next three years, 51.48% were satisfied with their work, and planned to continue practising in the same way, 11% planned to retire. Approximately 13% planned to seek a job in a non-clinical healthcare setting, and 10% would seek a job unrelated to healthcare. If these physicians actually left the profession, it would exacerbate the growing shortage of primary care physicians. Only 27.69% of primary care physicians would choose to be primary care doctors, given the choice again. Over 41% would choose a surgical or diagnostic specialty rather than primary care, and 60% of physicians would not recommend medicine as a career to their children or to other young people. Given the low response rate, these findings should be interpreted with care. Also of note is that over 50% were satisfied with their work.

3.6.1 Australian Doctors' Job Satisfaction

The Australian literature regarding doctors' job satisfaction identified similar findings to the overseas literature, with the majority of doctors indicating they were satisfied with their jobs. There were also similar factors identified that contributed to doctors' job dissatisfaction, such as, high workload, bureaucratic 'red tape', less remuneration than other medical specialties, and work interfering with home/family activities. An *Australian Doctor* (McCredie, 2006) 'Why are you a GP Survey?' of 1320 GPs identified several factors that contributed to GPs' expectations being met and subsequent job satisfaction. In particular, this was evident in participants under 40 years of age who found general practice was intellectually challenging. This was consistent with survey respondents most often cited reason for becoming a GP, intellectual challenge. Overall, younger GPs were pleased with their career choice, but were frustrated that other medical specialties were held in greater esteem. Older GPs (over 40 years) were concerned about "red tape", and considered this an issue that would influence their decision to remain in the profession. These older GPs were less concerned about the lack of respect for general practice than their younger counterparts.

Another generational difference was identified with regard to perceptions of general practice as a vocation rather than a job. Older GPs considered general practice a vocation, but younger GPs considered general practice a job. Tolhurst and Stewart (2004) also found that younger doctors were less likely to perceive work as the single most important aspect of their lives. It could be that GPs, who find fulfilment in other areas of their life, as well as their work, may find it easier to achieve work-life balance.

In 2001, McGlone and Chenoweth surveyed 353 GPs in Victoria and found 50% were satisfied with their work, even though they considered their work had high demands,

and they had low control. The predictors of greater job satisfaction were: being female, job demands, and hours worked. Job control was the most powerful predictor of job satisfaction.

A mail survey was carried out by Walker and Pirotta (2007) containing items scored on a Likert-type scale and open-ended questions to GPs in Victoria, Australia. Three hundred and twenty three GPs responded (38%), and survey findings revealed that the majority of GPs were satisfied with their jobs. In response to open-ended questions, variety of work was the most frequently cited factor influencing job satisfaction for both males and females. Longitudinal care (ongoing care over a number of years) was important for more females than males. Improved remuneration was identified by females (42%) and males (25%) as being a factor that could improve GP job satisfaction. The gender difference regarding financial remuneration may be because females are inclined to work fewer hours per week than males. In addition, female GPs tend to conduct longer consultations, and see lower numbers of patients per hour than their male counterparts. Female GPs' remuneration is therefore likely to be less (Britt, Valentini, & Miller, 2002). All GPs were concerned about workload, and believed that less paperwork, increased support from administrative staff and a higher percentage of longer consultations would alleviate some workload pressures. Male GPs wanted to work less; female GPs wanted more support from practice nurses and other GPs, and alterations to time management. These issues are often identified in the literature regarding doctors' job satisfaction, and their desire to alleviate their chronic high workload.

Another important factor contributing to job satisfaction was doctors' relationships with their patients. Skolnik, Smith, and Diamond, (1993) found that being able to make a difference in a patient's life was rewarding and contributed to doctors' satisfaction with their work. Other factors contributing to job satisfaction included a sense of clinical

competence, relationships with business partners and with other specialists. Low levels of satisfaction were associated with perceptions of inadequate income, and lack of time for leisure (Skolnik et al.). If doctors are not satisfied with their work they may be more likely to under-perform, reduce their workloads, or retire from clinical work early; thus having a negative impact on the delivery of quality health care.

3.7 Summary

This chapter has described the role, profile and work context of GPs in Australia. In reviewing this literature a lack of empirical data regarding the adaptive strategies used by (Australian) GPs was identified. Little is known about GPs who achieve optimal psychological functioning, and GPs who choose effective strategies to deal with the high demand environment of general practice.

Changes to the practice of medicine have resulted in more tests being available and administered to patients, and an increase in administrative activities is also required. GPs experience conflict between time seeing patients and the constraints of administrative activities. These activities occur in an environment where there is frequently of fear of making mistakes and perceived threat of litigation, even when these concerns are not necessarily appropriate to the actual level of threat.

The ageing of the medical workforce has particular implications for the capacity of the medical system to respond to the increasing health needs of an ageing population that is likely to exacerbate the workload of GPs. Rural GPs are more likely than city GPs to cease work earlier, so the baby boomer generation retirement will influence rural areas before urban areas. Furthermore, younger rural GPs are no more likely to work long hours than their city counterparts (Schofield, Page, Lyle, & Walker, 2006). This has the potential to exacerbate rural and remote GP shortages because older GPs were prepared to

work longer hours to compensate for workforce shortages whereas younger rural and remote GPs are less likely to increase their hours.

In summary, both the ageing GP workforce and ageing Australian population are likely to result in even further workforce shortages. As retirement rates are likely to be a key determinant of workforce supply, it is necessary to assist GPs to remain active within the workforce for as long as possible. It is, therefore, important to identify the factors that influence GPs intentions to remain in the workforce, and also identify the adaptive strategies that can be adopted to assist GPs longevity in general practice.

While identifying sources of strain and stress in GPs is important, the study of positive GP functioning, and identification of the strategies used by GPs who successfully adapt in their chosen profession is also important. The knowledge gained from this study could be applied to the design of programs that encourage adjustment to complex work environments. This current study seeks to address the lack of knowledge regarding the positive adaptive strategies used by GPs. Thus the research question guiding this study is: What are the factors that promote and maintain GPs adaptation to life in their work as a GP?

3.8 Aims of the Study

GPs have a central role in community health care; it is important to understand what facilitates their optimal functioning. The emphasis of this study was to identify the factors that influence GPs optimal functioning while working in general practice, and the ways GPs adapt to life as a GP. It was not the intention to test pre-determined hypotheses, but rather to explore and detail the adaptive strategies GPs adopted in daily life while working in a demanding occupation. While the nature and rates of GPs in distress has been well researched, there is little information about the adaptive strategies used by GPs

who are successfully managing their work and non-work domains. The study therefore had three central questions: (1) What are the pathways to a medical career and general practice specialty? (2) What are the demands that GPs experience? and (3) How do GPs adapt to working as in a small business general practice environment, and their life as a GP?

A qualitative research design was considered a suitable research strategy to generate a systematic, detailed, description and explanation of the ways GPs in this study adapted to the demands intrinsic to general practice. The next chapter is the research design chapter that provides a detailed account of the methodology and methods used in this study.

CHAPTER 4

RESEARCH DESIGN

This chapter presents the methodology and methods adopted in this study. A rationale is provided for the selection of an interpretive qualitative approach. The subsequent sections outline the participants, sampling strategy, including sample characteristics. This is followed by the interview method and phases of data collection, including data preparation and data analysis processes, are presented together. The final section includes a researcher's statement and addresses issues of trustworthiness/validity for qualitative research that are relevant to the current study.

4.1 Methodology

All research approaches are underpinned by assumptions about the nature of knowledge and the most appropriate ways to attain knowledge. The epistemological position a researcher adopts tends to influence the ways a substantive research topic area is conceived, researched and reported. It is, therefore, important to outline the epistemological stance that informed the current study. There are two core epistemological stances, the objectivist and the constructionist (Jones, Torres, & Arminio, 2006). An objectivist epistemology tends to be aligned with empiricist and/or quantitative approaches to social research, and a constructionist epistemology with qualitative research approaches, although this is not always the case (Crotty, 2003).

The current study was underpinned by a constructionist epistemological stance (Crotty, 2003). The tenets of this stance include a commitment to the representation of multiple perspectives and values, rather than to ascertaining a single truth or a single model to explain complex interactions. A constructionist acknowledges the intersubjective relationship between the researcher and the participants, in that both

parties influence and shape the research exchange and interpretations about what is important (Kvale 1996). While I acknowledge myself as the interpreter of the research, I have elected to use the third person throughout this thesis to clarify my role as a researcher.

The researcher's constructionist lens entailed an awareness of social and cultural influences on the way GPs perceived their experiences. In this research, the researcher did not attempt to gain a 'fix' on GP adaptation by defining the concept *a priori*. Instead she sought to encourage GPs to share their perspectives and attempted to situate this within an appreciation of their background, the social and cultural influences on their practise, their work context and prior experiences. The researcher's role was to listen carefully to GPs' perspectives and the ways in which these perspectives were associated with each GP's context and background.

A qualitative research design was considered a suitable research strategy to generate a systematic, detailed, description and explanation of the ways GPs in this study adapted to the demands intrinsic to general practice. The emphasis of this study was to identify the factors that influence GPs' adaptation to working in general practice. The aim was not to test pre-determined hypotheses, but rather to explore and describe the adaptive strategies GPs adopted in daily life while working in a demanding occupation. While the nature and rates of GPs in distress has been well researched, there is little information about the adaptive strategies used by GPs to positively manage their work and non-work domains.

The core method adopted in this study was semi-structured interviews (Patton, 2002). Interviews were considered an appropriate data collection method as they provided an opportunity for GPs to express their perspectives, but also ensured that similar issues

were covered in each interview, which facilitated comparability of the responses during the analysis phase.

The intersubjectivity of the research process underpinning this study acknowledges that the researcher and participants co-construct the findings during interviews (Patton, 2002). Interview questions were therefore designed to be open-ended, and emerging understandings were tested and confirmed with participants during interviews.

4.2 Participants

4.2.1 Sampling Strategy

Participants were recruited from the data bases of rural and metropolitan Divisions of General Practice[8], names provided by linkage partners, and the researcher's personal professional networks. Recruiting GPs can be challenging in part because of work demands and professional commitments. The role of the linkage partners associated with the research grant was important in gaining access to potential GP research participants. They made introductions by letter and expressed support for the research project, thus enabling the researcher to gain entrée to potential participants.

The sampling strategy used was maximum variation sampling, a form of purposive sampling (Patton, 2002). Maximum variation sampling was used to obtain a diverse sample of participants. While the researcher aimed to generate a diverse sample, sampling was an evolving process that was guided by information embedded in the data and searching for key informants who could expand on, or offer variability to existing categories. The final sample included participants who differed in ethnicity, gender, age,

[8] Divisions of General Practice provide services and support to general practice at the local level. The Divisions infrastructure also provides a mechanism for informing and educating GPs and practice staff about changes to Federal Government programs, services and new initiatives for continuous quality improvement. It allows GPs a representative voice with local health services planning and other health agencies.

country of medical training, location of practice, practice size and structure, and career stage.

The nature and number of interviews undertaken with GPs was informed by theoretical saturation. In this study, the interviewing and analysis process were undertaken concurrently, until theoretical saturation of the units or categories was reached, that is, until no new units or categories were emerging from interviews with the sample. The primary purpose of this approach was not to constrain or interrupt the research process, but to ensure that the categories identified had conceptual depth and, therefore, potentially more explanatory power (Strauss, 1987).

4.2.2 Sample Characteristics

The total sample comprised 26 GPs, 15 (58%) women and 11 (42%) men, aged between 23 and 77 years. The mean age of participants was 46 years. This mean age is largely consistent with AIHW data of average age of GPs in Australia reported in the Chapter 3 literature review. The participants were recruited from 16 suburban and 10 rural practices in the state of Victoria, Australia.

Table 1

Male GP Sample Demographics (n=11)(42%)

	Characteristics					
Participant[9]	Age	Cultural Origin	Marital Status	Weekly Hours	Employment	Location
1. Robert	46	Australian	Married	65	Group principal	Metro
2. Matthew	77	Australian	Married	34	Locum	Rural
3. John	74	Australian	Widowed/Divorced	Retired	Retired	Rural
4. Luke	36	European	Married	52	Group salaried	Rural
5. David	50	Middle Eastern	Married	58	Group principal	Metro
6. Jeff	47	Australian	Married	76	Group principal	Metro
7. Rod	64	Middle Eastern	Married	40	Group salaried	Metro
8. Mark	58	European	Married	80	Solo	Metro
9. Russell	36	Australian	Single	34	Group salaried	Metro
10. Dean	54	Australian	Married	50	Group principal	Metro
11. Michael	57	Australian	Married	91	Solo	Rural

[9] In order to protect the privacy and confidentiality of the participants, pseudonyms are used throughout the thesis.

Table 2

Female GP Sample Demographics (n=15)(58%)

Participant	Age	Cultural Origin	Marital Status	Weekly Hours	Employment	Location
			Characteristics			
1. Sarah	43	Australian	Married	34	Solo	Rural
2. Jean	61	Australian	Married	20	Group salaried	Rural
3. Deborah	41	Middle Eastern	Married	69	Group salaried	Rural
4. Angela	24	Australian	Married	63	Intern	Metro
5. Alice	26	Asian	Single	50	GP registrar	Metro
6. Meg	47	Australian	Married	40	Group principal	Metro
7. Lyn	47	Australian	Married	41	Group principal	Metro
8. Natasha	31	Australian	Married	17	Group salaried	Metro
9. Elizabeth	47	European	Married	24	Group salaried	Rural
10. Kate	47	Australian	Married	50+(Obstetrics)	Sole owner group	Metro
11. Kim	50	Australian	Married	30	Group principal	Metro
12. Sue	35	Australian	Separated	26	Group salaried	Rural
13. Tanya	41	Australian	Divorced	40	Group salaried	Rural
14. Vicki	50	Asian	Married	65	Group principal	Metro
15. Jane	48	Australian	Separated	104	Group principal	Metro

Eighteen participants (69%) were born in Australia, four in Europe, two in Asia, and two in the Middle East. Twenty (77%) of the 26 participants were married with spouses/partners who included seven medical professionals, five professionals, three other, and three unknown.

The number of hours worked per week varied widely, from 17 to 104 hours. Practice principals, and those participants engaged in other medically related activities in addition to their GP work, reported the highest number of work hours. Thirteen (50%) participants worked 50 or more hours per week, but only four of these 13 said they would like to work fewer hours. One male solo practitioner and one female practice principal reported working extremely long hours, 91 and 104 hours respectively, neither of these participants wanted to work fewer hours. All other participants worked less than 50 hours per week, and were satisfied with the number of hours worked.

In order to preserve confidentiality of participants, three of the categories described above are summarised in Tables 1 and 2: (1) GPs country of origin has been broadly categorised into Asian, Australian, European, and Middle Eastern; (2) information about spouse/partner occupation; and (3) practice area. GPs level of training was omitted due to lack of relevance to the current study.

4.3 Interview Format

A *general interview guide approach* (Patton, 2002) was used to form the basis of the interview format. The parameters selected for the interviews were broadly guided by the literature specific to occupational stress in the medical profession, and information derived from key informants. Several broad questions were set for the interview content so that common information could be obtained from each GP, but the order and actual wording of the questions varied with each interview depending on the responses and the

context of the actual interviewee. The questions (see Appendix A) were designed to reflect these parameters and included intrinsic and extrinsic elements and provided some organising schemas for the interviews. Intrinsic elements included: reasons for choosing a medical career, recollections of medical training, satisfaction with work, attitudes to work and the medical profession, and future aspirations. Extrinsic elements included: content and context of work, patient presentation mix, and social support.

The interviews aimed to elicit GPs attitudes to their work and the medical profession, and to provide an opportunity to explore their aspirations, views about personal wellbeing, and the adaptive strategies they adopted in the work and non-work/family domain.

The researcher began each interview with as few preconceptions as possible about the issues that would be discussed (Glaser, 1978), a positioning that has much in common with a grounded theory approach (Glaser & Strauss, 1967). The emergent nature of qualitative research means the research questions may be refined and altered as the researcher identifies what needs to be asked and who should be asked as the study progresses (Cresswell, 2003). In this study, the interview guide was used as a consistent reference point; however, specific questions were reworded or modified depending on the GP's responses.

Demographic data was collected at the start of the interview. The demographic data form was developed in consultation with key informants from linkage partner representatives to capture important variables of interest (see Appendix B). Their contribution was specifically related to the format and wording of the document. Based on advice from industry representatives that GPs are often protective of personal

information, it was carefully sequenced and worded, in an attempt to elicit relevant information.

A 'grand tour' question (Spradley, 1979) was used to begin the interview. For example, *"Can you tell me about how you chose medicine as a career?" Probe: "What things influenced your decision to specialise in general practice?"* The use of open-ended questions also gave GP participants the opportunity to choose whether to disclose information that may be interpreted as socially undesirable. For example, one participant gave an account of her experience of being sued by a patient.

The researcher was sensitive to the possibility that GP participants may be uncomfortable in the unfamiliar role of answering rather than asking questions. Therefore, careful consideration was given to determine the most appropriate interview approach to maximise depth of responses. The first three interviews were conducted to check the tone, language, flow, and depth of information. During these interviews, the researcher adopted a conversational rather than interrogative interview style in order to minimise perceptions that the researcher was leading the interview, or controlling the nature of the information shared by the participant; this gave GPs the opportunity to expand on issues (Minichiello, Aroni, Timewell, & Alexander, 1990). Reflecting information back to the participant was used if clarification of a response was needed.

The open structure of the interviews and the conversational relaxed style adopted appeared to encourage GPs to share information. One participant expressed surprise at how much personal information he had revealed during the interview when he commented:

> *I didn't expect to talk about myself so much. I'm surprised. I'm used to asking questions, not answering them (Jeff)*

4.4 Phases of Data Collection

Interviews were conducted in two phases. The use of key informants in the design phase of qualitative research is common. Phase One included six face-to-face, open-ended interviews with key informants (Glesne & Peshkin, 1992) conducted prior to, and in the early stages of, the main phase of data collection. The key informant interviews assisted the researcher in gaining an awareness of the range of issues that might be identified. Preliminary analyses of the key informant interviews also provided an opportunity to identify, sift, and sort pertinent and irrelevant meaning of data (Strauss & Corbin, 1990). The information gained from conversations with key informants also assisted with providing contextual information of the current status of the medical environment at the time the GP interview data were being collected.

Consulting key informants, who were representatives from medical professional bodies and people familiar with the concerns and issues associated with general practice and GPs, assisted the researcher in gaining an understanding of the work undertaken by GPs, and elements of the context that influence their work practices. The knowledge gained from these key informant interviews also assisted with framing the approach and questions used for the major data collection component. For example, the interview approach was flexible and the sequence of interview questions was adjusted according to the flow of information from participants. The key informant interviews also sensitised the researcher to the key issues that may have been relevant, and provide a preliminary test of the fit of interview questions to the participant sample. Key informant interviews are often not explicitly drawn on as 'data for these reasons' (Agar, 1996; Spradley, 1979), and in this study were not formally included in the analysis. These key informants also provided a list of GPs who had expressed an interest in the study and agreed to participate.

Phase Two comprised 26 semi-structured, open ended, individual, face-to-face interviews with the GPs. As the core component of the study, Phase Two interviews formed the empirical basis of this study.

4.4.1 Setting up the Interviews

Prior to commencing data collection, ethics approval was obtained from Victoria University Human Research Ethics Committee (HREC) (Appendix C). All interview data were kept locked at the School of Psychology, Victoria University, with consent forms stored separately.

Potential participants were requested to participate in a 30 minute interview. The decision to request 30 minutes was based on advice from key informant linkage partners regarding a realistic amount of time GPs would agree to take part in the study. The researcher faxed, emailed or mailed a written explanation of the study (Appendix D) to potential participants. Included in the written explanation of the study was information indicating that the interviews would be audio taped for accuracy, and later data analysis. All participants were assured their participation was voluntary, and they could refuse to answer any question, or withdraw from the study at any time. Assurances that confidentiality would be respected and protected through the use of pseudonyms in any written product arising from the research were given. A convenient time and place for the interview with each participant was arranged by phone. On the advice of key informants, a gift voucher to the value of $75 dollars was offered to prospective participants as part reimbursement for their time and input into the study.

4.4.2 Interview Process

The interviews took place in the participants' practices, their home or in local cafes, and were audio-taped with their permission. Before commencing the interviews, written

consent was obtained and the researcher asked the participant to nominate how much time was available to conduct the interview. Most participants nominated 30 minutes, but expressed their willingness to continue the conversation beyond the nominated time. The duration of interviews ranged between 35 and 70 minutes.

4.4.3 Preparing the Data for Analysis

Immediately after each interview, the audiotape was reviewed and provisional themes were noted in a data file (Strauss & Corbin, 1990). In addition, the researcher's reflections regarding the interview as a whole were made. This included description of each participant's idiosyncratic behaviours, such as facial and body expressions, tone of voice, and general affect and attitude. These notes provided a context to assist with later, more systematic analysis of the transcribed interview data (Kvale, 1996).

The next stage involved full transcription of each audiotape that was undertaken within three weeks of the interview. One interview was not transcribed due to equipment difficulties; relevant data from this interview were used in analysis from field notes taken during, and after the interview. The researcher transcribed seven interviews. Two GPs had requested only the researcher have access to the audiotape, and five were transcribed by the researcher due to tape quality and language accents. Three GPs requested the tape to be turned off when they were disclosing information "off the record"; these data were used to inform the study, but not attributed to a particular GP. Transcriptions of 18 interviews were carried out by professional transcribers. Before sending the tapes to the transcribe, the audiotapes of each interview were edited, and any identifying information removed by the researcher to protect the GPs' identity.

Finally, the researcher crosschecked all transcriptions with audiotapes for accuracy, converted the files to rich text format, and entered the files into NVIVO 2.0 (2002) for data management, and to facilitate systematic analysis.

4.5 Data Analysis

In accordance with the principles of grounded theory, the constant comparative method of analysis was undertaken. This involved recursive stages of data collection and data analysis (Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Strauss & Corbin, 1990). As each interview was conducted, the researcher reflected on the interview and began a preliminary analysis of key issues emerging in the interview. These themes were then tested and refined within subsequent interviews. Data collection and analysis were, therefore, concurrent. Each strategy informed the other, and assisted with focusing attention on the data and supporting conceptual developments that were grounded in GPs' experiences of general practice.

The researcher formally analysed each transcript. The process of open coding (Glaser & Strauss, 1967) was initially used as a means of discovering, naming, and categorising themes in the data. Open coding involved the researcher making notations in the margins of interview transcripts identifying key issues or phrases that pertained to strategies they adopted for managing the demands of GP practice. At this stage of analysis, a wide variety of emergent themes for analysis were identified and either new categories were created or information was fitted into an existing category. The process then entailed comparing categories with others for overlap or duplication, and framing themes according to the level of emphasis by the GP participant.

For example, the category of *"litigation"* emerged as a frequent theme following comparisons of GPs' observations of changes within the medical profession, and patient

attitudes toward the medical profession. While litigation was a topic raised by all GPs, the level of concern could be placed on a continuum from *"I'm aware of it (litigation) all of the time"* (Michael) to *"I don't think I allow myself to get too worried about that (litigation)."* (Jean), "*I'm not troubled at all by litigation"* (Mark).

At the completion of data collection from all 26 interviews, the emergent themes and propositions were assessed in the light of the data generated, and compared within and across each interview. While comparison across themes identified some similarities, efforts were made not to force themes to fit with one another.

An influential aspect of analytic thinking took place in the writing of the findings for this thesis. Although usually considered a mode of 'telling' about social science work, writing is better conceptualised as a method of inquiry. Writing can also be construed as a way of 'knowing' - a method of analysis and discovery (Richardson, 1994). The drafting and redrafting process was analytically valuable, and encouraged further consideration of evidence for particular themes. The drafting process also assisted with identifying the usefulness of case studies to illustrate the findings in context.

Initial literature searches had included references to GPs' time related concerns and were identified as potential stressors, but there was no information about the meanings GPs attached to time. At this point the researcher began looking for verification of these elements and adopted a more deductive approach (Patton, 2002; Strauss, 1987). As the inquiry progressed with constant comparison within and between data, and back to the literature, the researcher consciously worked with separate factors (time pressure, workload, time scarcity). This included reflecting not only on the data, but the process and flow of each interview, (recorded in the researcher's reflective journal). The researcher attempted to weave these together to form a concept that was meaningfully

relevant to identifying factors influencing GPs adaptation to general practice while trying to understand nuances and idiosyncrasies in the data (Glaser & Strauss, 1967).

The interviews aimed to elicit GPs attitudes to their work and the medical profession, and to provide an opportunity to explore their aspirations, views about personal wellbeing, and the adaptive strategies they adopted in the work and non-work/family domain.

4.5.1 Social Context of the Interviews

The interviews took place in a seven-month period between September 2002 and April 2003. In order to give some insight and background to the period in which the interviews took place, a brief outline of the socio-political context of medical care is warranted. Issues that were topical at the time in the media may have shaped GPs views and focused the topics GPs raised in the interviews.

During the interview period there was considerable media coverage at the state and national level of issues pertaining to the medical profession. Specifically there was discussion of four issues relating to the work of doctors in Australia. These were:

- inconsistencies in the professional abilities of overseas trained doctors
- concerns expressed by doctors regarding litigation, cost of insurance, and disintegration of one insurance company involved with medical professional indemnity
- the perceived inadequacy of Medicare reimbursement to GPs to cover rising business costs

- the increasing number of doctors adopting a co-payment system instead of bulk billing[10] their patients.

While there is no way of determining how much influence the media played on the content of perceptions shared by GPs in this study, media coverage of these issues may have influenced some participants' responses. For example, in February 2003, there was extensive media coverage predicting the end of bulk billing by the majority of GPs. Two participants who were interviewed at that time expressed their views about the adequacy of Medicare reimbursement, and the benefits of utilising a co-payment rather than bulk billing system. This may not have been as salient in the interviews if the media had not been covering the topic. The role of the media in setting or reflecting the agenda can never be fully identified and disentangled from findings. It was therefore valuable for the researcher to understand participants' responses in light of context.

4.6 Issues of Trustworthiness and Validity in Qualitative Research

The emergent nature of a qualitative research design calls for some consideration of validity or trustworthiness during data collection, and as findings are being developed (Maxwell, 1996). Most researchers acknowledge the importance of processes and procedure to maximise the rigour of the research, and of the interpretations arising from research. However, there is some debate within the qualitative literature about the appropriateness of applying established procedures of validity to qualitative research. Lincoln and Guba (1985) provided a compelling argument for their preference for trustworthiness - a parallel term for validity. Trustworthiness encapsulates a fuller meaning than the veridical meaning of validity, and does not bring with it the same

[10] Bulk billing is a payment option under the Medicare system of health insurance in Australia. The doctor is paid directly by the Federal Government (Health Insurance Commission) by billing the patient via their Medicare card. The doctor receives 85% of the scheduled fee if they charge in this manner.

historical meanings underpinning the concept of validity. Trustworthiness represents the degree to which the research findings represent participants' realities (Morse & Field, 1995).

Five strategies were implemented to facilitate valid interpretation/s of findings, and bring rigour to the study. Firstly, in qualitative research, triangulation contributes to trustworthiness of data as it facilitates the consideration of multiple perspectives on a topic (Webb, Campbell, Schwartz, & Sechrest, 1966). Data were collected from semi-structured, face-to face, individual interviews with GPs, linkage partners, and key informants. This gave the researcher an opportunity to consider a variety of perspectives: the research participants, the RACGP and individuals who work with GPs.

Secondly, a conscious attempt to refrain from using leading questions was made by excluding questions relating to any prior knowledge about the general practice environment (Morse & Field, 1995). Interview questions were open-ended and allowed the participant to express issues outside the parameters set by the researcher. The researcher used the interview to check interpretations with participants by clarifying and summarising statements during the interviews.

Thirdly, a conscious decision to search for negative cases was also part of the analysis process used to improve trustworthiness (Glesne & Peshkin, 1992). In this study, negative cases were used to further refine the themes; the provisional categories were discussed with the researcher's supervisor, linkage partner representatives, and key informants. Consensus of coding categories and a final list of key themes was achieved through these discussions and re-reading of transcripts. For example, the statement made by one GP *"GPs want to live and work in the same area. It's good for business".* A negative case was sought and another GP gave a different perspective *"I live on the other side of town*

so I'm well away….. I tend not to see patients socially or in the street or crossing paths with them too often and I think that does help". Finally, the researcher's initial supervisor, who is an experienced researcher, evaluated data categories and acted as a 'devil's advocate', by critically questioning categories and interpretations of data identified by the researcher (Lincoln & Guba, 1985).

During the research process, a reflective journal was part of the familiarisation process and informed initial data analysis. In an attempt to follow the *"rule of epoch"* or *"to bracket"* (Spinelli, 1989, p. 17), expectations and assumptions about GPs were identified and noted in the journal. This journal was used to identify key issues and reflections emerging from the interviews. Subsequent review of the journal was used to inform analysis.

The journal was also used to record existing knowledge of health practice and was a way of acknowledging the researcher as data collection instrument (Cresswell, 2003; Miles & Huberman, 1994; Patton, 2002) and the researcher's influence on the study. Journal writing also assisted with developing insights and expanding conceptual thinking subsequently discussed with the supervisor.

4.7 Researcher's Statement

The Royal Australian College of General Practitioners (RACGP) partnered with Victoria University to investigate the health and wellbeing of Australian GPs. I was selected to conduct the research by the VU and RACGP research team.

My perceptions of general practice were shaped by my personal experiences – as I had been a dental practice manager. This meant that I interacted on a daily basis with dentists and patients; I understood the demands of operating a practice, staff, and financial issues etc. on the management side. I was also able to observe and discuss with the

dentists the influence and stress that the work had on them, personally and professionally. The medical and dental professions share similar work environments and small business structure. A typical day in both professions involves treating patients, keeping appointments, the doctor-patient relationship, and managing patient expectations. I believe this understanding of the context of general practice, may have enhanced my awareness, knowledge and sensitivity to some of the challenges and issues encountered by GPs.

In my undergraduate psychology training, I gained the necessary research skills to undertake the qualitative approach to the thesis. I also gained an appreciation of the theory base which allowed me to put into context the experiences that I had when working in the dental practice. These came together to equip me in the undertaking of the research, and to allow a certain deeper insight into the meanings of the results.

I commenced this study with the perspective that general practice is a demanding work environment, with heavy workloads, and diverse demands. Although every effort was made to ensure objectivity, my work experiences may have shaped the way I viewed and understood the data.

4.8 Summary

This chapter has described the approach to researching this topic. A constructionist epistemological stance underpinned the methodology and face-to-face interviews were used to gain multiple perspectives from participants.

Consulting key informants who were representatives from medical professional bodies, and people familiar with the concerns and issues associated with general practice and GPs assisted the researcher in gaining an understanding of the work undertaken by GPs, and elements of the context that influence their work practices. The knowledge

gained from these key informant interviews also assisted with framing the approach and questions used for the major data collection component.

A comprehensive outline of the research methodology and methods used to examine GPs adaptation to the demands of general practice has been provided. Also included has been information about the participants and sampling strategy. A thorough description of the procedures followed for analysing the data and the measures undertaken to support the trustworthiness and validity of the study were described. The next chapter will provide the reader with more information about the participants, in particular their journey into the medical profession.

CHAPTER 5

INTRODUCTION TO STUDY PARTICIPANTS

The inclusion of context is important in situating the views of the participants generated in this study. This brief chapter describes the reasons participants provided for choosing the profession of medicine, and work in general practice as a career. This information gives the reader some background information about participants.

5.1 Choosing a Medical Career

Participants described several different pathways into medicine; however, three core pathways were identified from the varying descriptions. These were: (1) high academic ability, (2) cultural and family factors, and (3) internal motivation for a medical career such as childhood dream, and/or medicine as a "calling". Some participants may have been influenced by more than one pathway, but they did not disclose this information. Only one participant expressed that in hindsight, she would not have chosen a career in medicine.

5.1.1 High Academic Ability

Entry into a medical degree in Australia is highly competitive. Students are generally required to obtain an extremely high Australian Tertiary Admission Rank (ATAR) in Australia to enter medical training. While each state within the country has specific definitions of the ATAR, this score is based on overall academic achievement in Years 11 and 12 in secondary school. These are now supplemented by a standardised selection test designed to assess the suitability of high school graduates to medical training. In more recent times, Australian universities have introduced medical degrees that accept mature aged students into graduate programs.

Twelve of the 26 participants interviewed stated they entered medicine because they "got the marks". Five of these 12 had little or no understanding of what was involved in a medical career. They did not know anyone else who was a doctor, but presumed that their marks meant this was the right occupational pathway for them. Kate, a 47 year old practice principal, had been confident of her academic ability when applying for a medical degree. She gave her perspective on the necessity of high academic achievement to be accepted into a medical degree. She said:

> *…. you have to be bright to get in so there's a bit of an elitist thing about you being bright enough to get in.*

Five other participants commented they were surprised they were able to obtain the academic achievement necessary to gain entry into a medical degree. Robert, a 46 year old, described his response at being accepted into medicine. He said:

> *Somewhat to my surprise at the end of year 12 I got accepted, and I think it was a huge shock to everyone, I not only passed but did well enough to get into medicine and that was something that I'd never contemplated because I'd never thought that I would do well enough to get into medicine. And I've really loved it ever since.*

Robert was very pleased to be given the opportunity to pursue medicine as a career. While both he and his family had not been confident in his academic ability, gaining entry into a medical degree was seen as a great personal achievement. His success in achieving the necessary entry requirements gave him the opportunity to belong to a profession that he held in high regard. After many years in general practice, Robert still enjoyed his work and found general practice an interesting and rewarding career.

5.1.2 Cultural and Family Factors

Seven participants had one or both parents who were doctors. These participants acknowledged that having parents who were doctors gave them an understanding of the

benefits and challenges of a medical career. They believed they were better able to make an informed decision about their chosen profession because they had witnessed first-hand a parent's or parents' work experiences and subsequent influences of this career on their daily lives. Most participants considered they had not been pressured in any way by their parents to pursue a career in medicine, but one participant experienced a need to satisfy parental expectations. Dean, a 54 year old, was ambivalent about a career in medicine, but bowed to family pressure. He said:

> *I wanted to do photography but my father nearly flipped at the time because you didn't do that, it wasn't the sort of thing that you do, it was a betrayal of your intelligence. If you are intelligent enough to do something more useful to mankind* (sic) *you did it. I came from a medical family; my brother did medicine as well. My Mum and Dad were both doctors, and an Uncle. In the end I put down medicine because I came from a medical family and it was probably just a cop out.*

At the time of the interview Dean was still ambivalent about his medical career describing his work as being a "two-edged sword". He considered that he became too involved with his patients when they were suffering. Dean found this level of involvement with his patients to be very emotionally demanding, but being involved with patients gave meaning to his life and he considered this was important.

The choice of medicine as a career also appeared to be influenced by culturally defined status attached to the medical profession. Kim, a 50 year old, explained:

> *My father was in a very caring profession and a certain status was particularly important for him. Growing up in that environment definitely influenced my choice of career, a certain status was paramount.*

Deborah, a 41 year old, described how the culturally embedded social status of medicine is similar across cultures. She said:

> *My background is Middle Eastern and they classify medical school as the best. This career is the best. If any family has a doctor in their family "OH*

WOW that's really good". The parents are proud of their children, because it took the highest mark to get there, like it is here in Australia with medicine.

In contrast, Alice, a 26 year old, explained how, even though medicine is held in high regard in Asian culture, she was discouraged by her father but encouraged by her mother to become a doctor. She said:

In Asian culture doctors are very respected members of the community, I think that was a big influence on my decision. But not so much for women. Basically women should be staying at home cooking and all that stuff, look after the kids that kind of thing so my Dad was very against me doing the course because he said "this way you will never get married". He said "no don't do it, don't do it" but I've always wanted to so I said "sorry I'm going to do it". My Mum was very supportive. She was the one who said "go for it". She said that if she had the opportunity she would do it as well. But she never had the opportunity. We don't have doctors in my parent's generation but in my generation there's quite a few.

Kim, Deborah and Alice were from different cultural backgrounds (Australian, Middle Eastern, and Asian). Even so, their families and culture-of-origin, just as in Australian culture, regard medicine as a high status career. In each culture, medicine was afforded privileged social status and authority in the community, and was perceived to be a profession that was highly regarded and sought after. Participants' decisions to pursue a medical career were influenced by these cultural contexts.

5.1.3 Internal Motivation for Medicine

A third influence in the choice to become a doctor seemed to be associated with an internal motivation that stemmed from early childhood dreams, and a sense that medicine was a calling. Six participants indicated that their decisions or desires to be a doctor were the primary result of feeling 'called' to a medical career. The desire had emerged during childhood, although none of the participants could give any particular reasons about how or why this desire had developed. Fortunately, their academic abilities matched this desire.

Elizabeth remained true to her childhood decision to become a doctor and carefully planned her education to facilitate entry into a medical degree. She recounted:

> *I decided when I was 7 years old that I wanted to be a doctor and I never changed my mind. I can't recall how I came to this decision to be honest, but I was always fixed in my mind about it and I never changed course. I chose all my school subjects in order to get into medical school, not according to my ability. In actual fact my ability was in languages, not sciences, so I struggled with physics and chemistry in order to get into medical school and you know it's the best thing I did, I love being a doctor, it's a great career.*

David, who was born in a Middle Eastern country, also decided when he was a young child that he wanted to be a doctor. He said:

> *I was 4 years old when I decided I wanted to be a doctor. My father (not a doctor) was in charge of the blood bank so I knew doctors and the medical environment. I decided I wanted to be a doctor and that didn't change. I love being a doctor. Especially being a GP because it's the best medicine you can get because you're involved with people over time, you're solving problems as you see them, you get to know them.*

Mark chose medicine as an alternative to becoming a priest. He found he did not have the necessary commitment to join the seminary, but considered medicine to be a calling that was the "next best" to becoming a priest. He said:

> *I considered becoming a Jesuit priest but I didn't have a vocation and I thought next best was medicine. People have notions about priests and doctors that they are not human, that they are super human, that they don't have emotions like everybody else, they're special. But I have seven children and none of them is inclined to be a doctor, you have to work too hard.*

5.2 Choosing General Practice

The choice of general practice as a speciality, rather than another area of medicine, was based on a number of reasons that were interrelated, and included lifestyle choice, characteristics and holistic nature of general practice, and availability of training places. These reasons for choosing general practice are outlined below.

Some specialties higher up the medical hierarchy, for example, surgery, are very sought after and gaining acceptance into a training program is extremely competitive. Successful completion of specialty training requires significant investment of time, energy and resources. Four participants noted the differences between GPs who are "generalists" and other "specialist" areas in medicine. Even though other specialty areas received significantly higher status and remuneration, these GP participants preferred treating the "whole body" rather than just "one part". Six other participants indicated their decision to pursue general practice was based on a desire for quality of life. They considered that general practice gave them more flexibility to pursue other roles and activities, as it was not as demanding academically as other specialities, but still provided adequate reward.

Sue, whose parents are both doctors, explained how she chose general practice. She said:

> *I just kind of fell into medicine, but it worked out because I really like it. My Mum used to be a GP but she went off and did some extra training, went into psychotherapy and my Dad did emergency medicine and he's now an emergency physician. But my parents didn't push me into it, even though they are both doctors; they didn't push me into it at all. I wanted to do either general practice, be a physician or be a paediatrician because I wanted to do something where you treat the whole body rather than one bit of it and they were the three fields. I would have had to stay for another five or six years to do paediatrics or physician training and I just didn't want to do it and I wasn't that interested in earning huge amounts of money.*

Sue was well informed about the pros and cons of a medical career, and drew on the experiences of both parents who were doctors. She identified that she wanted to work holistically with people, and made her decision based on this combined with not wanting to invest more time and energy into paediatric or physician training. The reasons the GPs in this study chose medicine as a career and a general practice specialty provide an important context to understand the way they experience general practice.

5.3 Summary

This chapter has provided a description of the three core pathways to a medical career. GP participants' choice of a medical career was influenced by high academic ability, cultural and family factors, and internal motivation that stemmed from childhood dreams and that medicine is a "calling". Although participants acknowledged that general practice did not have as high status and financial remuneration as some other medical specialties, they wanted to work with patients in a holistic way. Participants also believed that general practice afforded flexibility and adequate rewards, and this allowed them to achieve quality of life that was not possible with other specialties.

The following two chapters focus on the prominent themes emerging from analysis of the interviews and presentation of the case studies. Chapter Five considers how GPs manage their work; Chapter Six presents the ways GPs manage their work and non-work/family domains, and also considers the ways GPs take time out for respite that enables them to psychologically detach from their work.

CHAPTER 6

GPs' MANAGEMENT OF WORK DEMANDS

This chapter provides an overview of how GP participants managed the demands of their work. The first part of the chapter considers the multiple roles that GP participants' engaged in during a typical workday, and how these multiple roles can, for some participants, be a source of role conflict. The second part of the chapter explains participants' perceptions of time scarcity, the value of time in general practice, and the link between time and income. This is followed by the strategies participants adopted to ease the tension between time pressures, provision of quality care and meeting patient expectations. The chapter concludes with an illustrative case study (Stake, 1995) that provides an account of how one GP in this study managed her work, and the strategies she implemented to synchronise, prioritise, and experience some control of her time.

6.1 Managing Multiple Roles at Work

Each day, people engage in, and move between various roles at work, home, and other places (Ashforth, Kreiner, Fulgate, 2000). Participants in this study acknowledged that they were faced with an increasing number of profession-based roles (clinician, counsellor, social worker, business person, team leader) as well as the familial and social roles outside of work. Kim, a practice partner, identified the multiple roles she engaged in during a working day in general practice. She explained:

> *I think there are a number of roles. We're facilitators to help patients through the health system which can often by quite tricky. We're the gate keepers for Medicare and we are the support person for that person who is sick or in need, apart from the healing and physician aspect.*

In a typical work day Kim was transitioning between several in-work roles that were bounded by both physical location and time spent at work in the roles. Moving from one

role to another involved a series of role engagements and role disengagements, but did not cause her significant distress or intra-role conflict. Depending on the requirements of the patient she moved between roles such as counsellor, facilitator, or clinician. Although this combination of roles involved different behavioural components, the roles allowed Kim to maintain her overall GP role identity because they took place within the time and space (location) of her GP work.

6.1.1 Experiencing Role Conflict

Role conflict has been identified as a common occupational stressor, that can occur when there is a sense of incompatibility between demands within a role (intra-role conflict), or between one role and another (inter-role conflict) (Greenhaus & Beutell, 1985). The majority of participants in this study who were business principals or partners experienced intra-role conflict, to varying degrees between their clinical and business activities within the GP role. Robert, a suburban principal explained his experience of intra-role conflict between his clinician activities and his business activities. He did not perceive he had a choice about how business was structured in general practice. Robert resented the additional business demands of his practice, and did not enjoy this aspect of his work. He recounted:

> *I don't enjoy the administration part of practice, in fact I hate that, but that's an important part of the practice. It is by default a small business and I use the word by default because it's not by choice. I wouldn't be running a small business by choice; but you can't practice the sort of general practice that I want to practice without it being in a small business setting.*

Conversely, Kate, found her clinical and business activities interesting, and did not experience dissonance within her GP role. She enjoyed the business aspects of her practice as well as the clinical aspects. She explained:

> *It's important that GP practices do a good job as a well run business so that people will work there. This one's been hugely successful attracting people because there are proper procedures and contractual arrangements and well organised rosters and all the good HR practices that need to happen in any business. It's been really good fun putting all of this (business and premises) together; the financial things like the money and choosing the property and all of that, I like all that. There are not very many GPs who are entrepreneurial but there's a few.*

Only one salaried participant identified intra-role conflict within his GP clinical role. Luke, a rural salaried GP, completed his medical training in Europe. He identified a culturally different perspective regarding the clinical GP role in Australia He explained the differences, and the influence on his perceptions of what being a GP entailed:

> *Work Cover[11] patients are not my favourites. I think there is a bit of a cultural difference in the medical system that I was trained in. They (Work Cover doctors) were a separate specialty in Europe who dealt with all work related issues not the GP. You were not involved in making the decision about whether the patient should be working or not working, whereas here you are. I don't always feel that I'm able to know enough about a particular workplace to make that decision to work it all out. And sometimes if you have to disagree with the patient it can be unpleasant.*

Luke disliked the responsibility of deciding whether a patient should return to work or receive Work Cover entitlements. He considered that this type of judgement was outside the scope of his clinical role, and beyond his knowledge and expertise.

Some participants identified another source of role conflict that related to Government and administrative bureaucracy. Alice, described her frustration and lack of control over having to carry out secondary tasks such as "paperwork" and "red tape" required by the Government. This intruded on the satisfaction she gained from the primary task of face-to-face consultations and patient care. She explained:

> *We do a lot of paperwork. I feel like a secretary. Clinical decision-making and things like that are much more satisfying.*

[11] State government supported workers' compensation insurance scheme.

In summary, the two sections above have outlined the ways several participants in this study experienced conflict within their GP role. Luke, Robert, Kate and Alice experienced the multiple roles inherent in general practice in different ways. Luke and Robert disliked some aspects of their work roles, and experienced intra-role conflict whereas Kate had a positive attitude to her various GP roles. Alice believed that her job satisfaction was compromised when she was engaged in activities that were "forced" upon her due to Government requirements. She believed these administrative type activities impinged on the time available for the clinical care of her patients.

6.2 GPs' Conceptions of Time at Work

It cannot be assumed that all members of large, complex societies share the same conceptions of time, in particular, the use of economic metaphors that influence the way we experience time, that is, the notion of time as a resource. In medical practice, however, doctors (and other professionals) have a shared understanding that time is a scarce and valuable resource that is closely associated with remuneration and quality of care.

The following sections provide an analysis of time pressures for GPs in general practice, and outlines the various strategies they adopted to adapt to time demands.

6.2.1 The Value of Time: "There's not enough hours in the day"

Time prosperity, the perception there is ample time for carrying out daily activities, has been identified as a dimension of wellbeing that is more important than wealth or money (Garhammer, 2002). Time scarcity or the perception there is not enough time to do the things that need to be done, has been identified as a factor that is capable of inducing stress (Garhammer, 2002). Individuals within Western society tend to place the greatest subjective value on things that are relatively scarce (Daly, 1996). As technology

precipitates a faster pace of change and sense of being hurried, it seems that the value of time is rising (Blount & Janicik, 2001; Daly, 1996).

Evaluative meanings are attached to time such as time being 'well spent' or a 'waste of time' and these meanings are embedded in the cultural norms and expectations that people have about time. The ways GPs in this study spoke about time provided some insight into their values, commitments, and priorities; these insights were related to their choices about how much time to allocate to work and non-work/family.

The prevailing view of GP participants was that the high work demand of a GP meant time was often perceived as being scarce. Participants considered there were not enough hours in a day to see all the patients who would like to be seen, nor was there enough time to complete all their work related tasks. Although they were committed to providing quality care to their patients, this had to be balanced against their personal priority of generating an income that symbolised to them the value of their work and associated social status.

6.2.2 Time is Money: Balancing Effort and Reward

The phrase "time is money", first stated by Benjamin Franklin more than 200 years ago (cited in Stix, 2006), is often used in everyday conversation. In general practice, time *is* money because blocks of time are allocated to appointments for patient consultations and the GP receives a fee for each consultation. The association between time and money was clearly important to ten GP participants, as it was one of the topics spontaneously raised by participants. Of these 10, 6 participants stated they considered the remuneration they received was inadequate, and perceived an effort-reward imbalance; four stated they were satisfied their income was commensurate with the effort they expended at work.

Participants identified five factors that directly affected their perceptions of time pressure as well as their income. These included: (1) the duration, and sequencing of time for appointments, (2) the number of patients seen per day, (3) the complexity of patient presentations and patient characteristics, (4) whether a co-payment or bulk billing system of fee for services was used, and (5) the number of hours worked per week.

GPs in this study calculated the length of time spent per consultation and the number of patients seen per day to estimate their income. The consensus among participants was that they needed to see one patient every 10 minutes to cover the costs of running the business. In spite of this belief, some GPs chose to work with longer appointment times because they equated longer consultation times with quality health care. This created a level of tension as they were trying to balance the needs of patients, and cover the costs of their business while providing the best care possible.

Elizabeth had developed a reputation for counselling her patients and providing a "listening ear". This meant that she was often "running late" and was unable to see a sufficient number of patients per hour to ensure what she considered to be an appropriate income. Elizabeth was uncomfortable speaking about money; to her there was incongruence between caring (the GP role) and money. She believed that money was not an incentive for choosing to be a GP because the financial reward was incompatible with the effort and responsibility attached to the role. She considered that female practitioners were more likely than male practitioners to spend additional time with patients. She explained:

> *A male GP can if he's really slick and on the ball and does not offer a listening ear, he can get through 70 patients in a day. Now 70 standard consultations is one heck of an income. I don't know a female GP that sees more than 4 patients an hour, where all of my male partners saw 6. I don't know a female in this area that sees more than 4 patients an hour because we simply can't. As hard as we try to, the patients just sit in that room, you*

> *cannot get them out of the room once they are sobbing and they are into their story. They have got to finish their story and we run late because we see so many of these emotional problems in a day so consequently, a lot of girls (GPs) are cutting it back to 3 patients an hour even, you can't cover your overheads.*

Elizabeth also considered that female GPs earned less than their male counterparts because patients (usually females) were less likely to consult males for emotional problems; many of her consultations were for "smears or tears". Three other female participants shared this opinion. However, gender differences were not raised during interviews with all female participants, and there were two male participants who expressed a preference for working at a slower pace with longer consultations.

Elizabeth described how a GP's ability to generate an income was dependent on the complexity of patient presentations and their characteristics. For example, a consultation for a child's ear infection only requires a short appointment time. Conversely, a consultation for psychosocial problems usually takes a longer consultation time. Furthermore, the patient does not always understand the need to request a longer appointment time when scheduling the appointment if they wanted complex issues addressed. Consequently, the consultation may take longer than the time allocated for the appointment, which pushes the boundary of the following appointment time resulting in the GP "running late" for the next patient who is then also inconvenienced because the GP is unpunctual.

Some GPs made a decision to schedule fewer appointments, but managed to find ways to reconcile the tension between making money and patient care. Mark explained how he also saw four patients per hour, and used a combination of co-payment and bulk billing patients for his services. He conducted longer consultations because he considered this amount of time was required in order for him to deliver quality health advice, and

care to his patients. Mark did not consider that this approach was altogether satisfactory. While this approach enabled him to practice in ways that were congruent with his beliefs about how to deliver patient care, he did not believe he received adequate remuneration for his efforts. He explained:

> *I've tried to change but I can't go faster, I won't be happy because I've got a set work pace. I check their diabetes and I check their asthma and if they've had a smear test and so on, everything takes time and you have to keep a note of what you have done, you don't just ask a question and not write it down and that's twice as long. Because of my long consultations I have Medicare trouble. They (HIC) came and investigated and wanted to see my files, but it all turned out OK. On one or two occasions I've seen 50 patients and that was exhausting because those 50 all got their time.*

Participant David took a different approach. He saw many patients in a 12 or 14-hour day. He bulk billed all his patients, and electronically claimed directly to the Health Insurance Commission (HIC). Like Mark, he was also visited by the HIC, but this was due to the high number of patients he saw per day. The HIC identified that Mark was conducting more long consultations than the "average" GP while David was identified as conducting more short consultations than average and, therefore, the HIC considered them worthy of an investigation. Although David was conducting short consultations and Mark was conducting long consultations, both participants considered they were providing quality health care and advice to their patients. David was satisfied with the financial rewards he received for his effort, whereas Mark perceived an effort reward imbalance.

An effort-reward imbalance was also perceived by Kim, a suburban principal who worked 30 hours per week. She practised in a mixed socioeconomic area, and used co-payment billing for patient consultations. Kim suggested that in general GPs were poorly remunerated some more so than others. Although Kim used the co-payment billing system she stated she would like to generate a higher income. She believed the inadequate

reward for effort required of GPs was a cause of dissatisfaction with working in general practice. She stated:

> *I'd like to be paid more. I think GPs would feel so much better if they were better renumerated. I think that's the main root of dissatisfaction, why some GPs have walked away, because they are paid a pittance.*

Medicare offers taxpayer subsidised access to health care for all Australians, but it can obscure the real costs of health services. Kim went on to explain her philosophical position about bulk billing and gave an opinion about GPs who bulk billed their patients. She said:

> *They (GPs who bulk bill) must feel shocking. They must feel terrible, they must feel suicidal I guess. It must be terrible. We've never bulk billed. When Medicare came in I was philosophically opposed to bulk billing where people (patients) sign a slip and not seeing what they were charged. We always charge but we used to charge rebate if they had a health care card so it didn't cost them anything but at least they had to pay and then go and get their money back from Medicare or they would get an invoice which told them how much they were being charged. So we never did bulk bill and with time we started to charge those people with health care cards anyway because you just can't do it for the rebate amount. I just don't know how you would feel if you bulk billed everybody all day, I mean you must have to work so hard, or so sloppily I think some might be sloppy even.*

Kim was practising medicine before the introduction of Medicare [12]. She considered this system created a third party in the doctor-patient relationship that interfered with how she provided health care to her patients and operated her business. Kim was adamant in her view of the inadequacies of bulk billing, and considered that patients did not appreciate her services if there was a lack of visibility regarding the true cost of her services. She believed that patients should have a willingness to pay a nominal amount

[12] Medicare as we know it came into operation on 1 February 1984. Medicare is the Australian Government funded health insurance scheme that provides free or subsidised health care services to the Australian population. It provides free hospital services for public patients in public hospitals through the Australian Health Care Agreements and the States, subsidises private patients for hospital services (75 per cent of the Schedule fee) and provides benefits for out-of-hospital medical services such as consultations with GPs or specialists (85 per cent of the Schedule fee).

(A$5) above the Medicare rebate for her services. This exchange gave her a sense of reciprocity that helped her to balance the costs and gains of working in general practice[13].

Another perspective on Medicare and its influence on time and money in general practice was provided by Vicki. Vicki, a partner working full time, completed her medical training in an Asian country. She practised in a Melbourne suburb with a low socioeconomic status and had a different view of bulk billing. Vicki considered that her patients did not have the financial resources to pay for her services, and believed that bulk billing was the best billing system for her patients and her business. She provided an account of why she chose to continue with bulk billing at a time when many other GPs were opting out of this billing system. She explained:

> *We get a lot of new patients because lots of GPs around here have started co-payment billing. I did a lot of homework on whether to start billing or continue with bulk billing. The home visits are now in the afternoon and I think a home visit would be about $45. If I go to an elderly person and I say, "you need to pay me $65 for coming to see you at home", that would be hard for a pensioner or anybody, I'd be carrying this cash around in my pocket, so all right, and maybe I don't do house calls. I go to the nursing homes, do I say to this man, "pay me $65 or else I won't come". Can you do that? No. In the surgery we see about 90% who are health card holders. Do we say to them "pay $35 or we won't see you". If there are two children, do we say one we'll bill and the other we won't? And then to those 10% who are not healthcare card holders, who are just at the reach of a healthcare card, they are probably worse off. They are paying for their medicines; they are paying for everything which these healthcare card holders are getting for free, or practically for free. We would be punishing them for being poor if we made them pay.*

Vicki considered that general practice was not a high profit margin business, but that she and her business partner were running the business properly. The business was profitable, and they were satisfied with the level of remuneration they received.

[13] At the time of the interview there was considerable media coverage about the perceived inadequacies of HIC payment by some GPs for GP consultations. The rebate has subsequently been increased.

Vicki believed in the philosophy behind Medicare and prided herself in providing equal access and quality care to patients by bulk-billing without placing a higher financial burden on the sick and less well off. She considered this would have been the case if she opted for co-payment billing. While Kim perceived an effort-reward imbalance in particular with respect to the financial rewards she gained from work, Vicki was satisfied with the way she balanced her occupational efforts and rewards. She considered her financial rewards were adequate and she derived satisfaction by providing quality care to people in her community who were struggling financially -- the less well off in her community.

Kim and Vicki clearly do not share the same views about Medicare. Kim considered that the introduction of Medicare had negative effects on how she practised, and it was a forced occupational change. She believed this change confounded the doctor-patient relationship, and took away control about how she conducted her business and generated an income. Vicki had come to Australia in 1987, and Medicare was already in place, so she had only worked in Australia under this system. She considered the Medicare system supported her ability to work in a way that was congruent with her beliefs about delivery of health services, and the system adequately rewarded her efforts.

Another aspect of time and money associated with general practice was the number of hours worked per week. Sue, a rural GP, was separated from her husband and did not have children. Sue made a lifestyle choice to ‘work to live’ rather than ‘live to work’. She had chosen to be an employee rather than a practice partner, because she did not want the added responsibility of maintaining a business. Sue negotiated good pay and working conditions; this gave her a sense of control and enabled her to buffer the effects of her highly demanding job. The remuneration she received also gave her a sense of being valued by her employer and the community. She explained:

> *Everyone (other GPs) complains that you don't get paid, enough and it's true, and we don't get nearly as much as solicitors or dentists. I went to the dentist the other week and paid him $450 for an hour, but nevertheless it's a question of how much money you need. I bought a house in a cheap area and I drive a really basic car and I just don't spend a lot of money. It's a question of quality of life for me, it's more important to work less, because the work is so emotionally intense. It's an employees market especially for women, but for all GPs in most areas unless you want to work in Toorak or Balwyn (high status suburbs in Victoria, Australia) there's an under supply of GPs, and when you have an under supply that means you should be able to negotiate a good deal with your boss, negotiate a good pay rate, negotiate for holidays and so forth.*

Sue identified the discrepancies in remuneration between different professional groups, GPs, solicitors and dentists. She considered some other professionals received greater financial rewards than GPs. However, Sue also believed that being a doctor was a profession where you could make a real difference, and potentially, save peoples' lives. She found this aspect of her work very rewarding and this contributed significantly to her job satisfaction.

Sue was willing to trade less pay for more time she could call her own. She allocated her time according to her values, beliefs, and priorities. Sue valued her health and lifestyle over working longer hours to obtain material benefits. She had control over how she allocated her work and non-work time. Although Sue enjoyed her work and valued the rewards associated with her ability to make a difference in her patients' lives, she believed it was necessary to have a life outside work. Sue achieved a balance in her work and non-work by dividing her life domains with time and space boundaries that helped her to separate her roles with a minimum of inter-role conflict. Sue did not have children, therefore, she did not have the parenting and financial responsibilities. These life circumstances gave her more freedom her to make choices about how much she was going to work.

6.3 Managing Time

In Western cultures, taking control of time has traditionally been approached from the time management model. Time management is based on the assumption of the fast pace of life with multiple and often competing demands on people's time. Keeping pace with these demands is possible through being a better manager of time. Well-organised management of time means improved productivity and efficiency, and avoidance of wasting time. However, participating in many activities during a day may only outwardly give the impression of controlling time; the momentum of a busy life continues (Daly, 1996).

Strategies used to manage available time may, therefore, preserve the pace of people's lives and have little effect in slowing down the pace of life and reducing perceptions time pressure. Furthermore, greater efficiencies in time create opportunities to condense more activities into the same amount of time, resulting in additional acceleration of time. (Daly, 1996)

Participants' attention to time, and ability to adapt their own time orientation to match their workload demands depended on how highly they valued their time, and the income they wanted to generate. They had autonomy over their use of time; however, the ways they exercised their autonomy varied considerably. Practice principals, and GPs who were working for a wage, had the ability to negotiate their hours in order to meet the demands of other activities or choice of activity. While they did have the capacity to determine how much time they put into paid work, there were contextual factors such as income requirements, and family stage that influenced how they chose to spend time in their various life domains. These contextual factors will be elaborated further in the next chapter.

6.4 Time Pressure at Work

All participants were very aware of time and how they allocated, "used" or "spent" the time available to them. Their usual work day was a series of appointment times allocated for patient consultations, with the remaining time portioned out to related administrative tasks. For GPs in this study, the perception of lack of time and rushing at work in an endeavour to attend to patient and business requirements increased their sense of the value of their time; it also contributed to perceptions of time pressure. This was highlighted by Kate a suburban principal GP, who described some of the varied activities carried out in general practice. She gave an account of a typical day:

> *Some days the phone just constantly interrupts you and you've already seen 30 patients and you've got another 10 that need to be squeezed in. That's very stressful, and the other thing that is really stressful about being a GP is that there is almost no time just to sit quietly and think through what you need to do. You come to work and it's just, bang, there's two or three patients already waiting to see you and there's emails waiting for you to respond to, which is always patients wanting things, and the phone ringing and you don't have time to go to the toilet. I mean, that's not good.*

Kate owned a large practice in a reasonably affluent area in metropolitan Melbourne, Victoria. She had been practising in the area for more than 15 years, and had successfully built a practice that employed a number of other GPs. She enjoyed her work, but considered there was never enough time in the day to see all the patients who requested appointments. Kate controlled the number and sequencing of patients seen in a day by insisting the "girls" in reception did not "double book" her appointments by assigning two (or more) patients into the same appointment time and duration. As practice principal, Kate had the authority to make decisions about how her staff gave appointment times to her patients. This sense of control over patient allocation assisted her in alleviating the negative effects of workload and time pressure associated with patient, administrative, and business demands.

These workload demands were combined with challenging intellectual demands of the work. Kate used her autonomy as principal GP to balance and alleviate the pressure and strain associated with the competing demands on her time. Kate also identified that it was not only patients in face-to-face consultations that 'want' things. Technological advances allowed patients to email their GP with queries and requests, if the GP was prepared to offer this service. While Kate recognised that GPs were not required to respond to emails, this was another way for her to maintain her patient base.

Kate acknowledged that it was satisfying to have many patients; the demand for her services validated her in her GP role. She viewed demand as an indication that she was doing a good job because it implied that her patients were satisfied with her services. Having a large patient base also gave Kate a sense of security to generate income, and also affirmed her ability to successfully own and operate the business.

The work activities described by Kate highlighted the workload, pace, and variety of work that was typical of the majority of GPs in this study. Participants (and their office staff) sought to gain some level of control over their day-to-day experience of time, and the activities associated with attempts to control time formed an important part of their coping strategies.

6.5 Managing Patient Expectations: Punctuality and Waiting

Western society tends to operate with an objective concept of time known as "clock time", or "chronological time". With the advent of the industrial revolution in the nineteenth and early twentieth century, clocks and watches became increasingly common as punctuality and timekeeping became more important (Bluedorn & Denhardt, 1988).

In everyday activities in Western culture, there is a taken-for-granted expectation that people are usually punctual. Being on time is a matter of manners and courtesy. Failure to

comply with the expectation of punctuality is often deemed a matter of personal character, unless there is a sound excuse (Shaw, 1994).

Not all cultures and subcultures experience or interpret time in the same way. People and groups vary in their perspectives and value of time, and when there is interaction between people and groups with differing time perspectives, conflicts can occur (Levine, West, & Reis, 1980; Levine, 1988). In the Levine et al. (1980) study of perceptions of time and punctuality in the USA and Brazil, results indicated that high status successful Brazilian people were expected to be unpunctual. Whereas, in the USA, "powerful people, such as doctors, who keep us waiting" (McGrath, 1988, p. 49) were resented.

Six participants in this study perceived that their patients resented being kept waiting at the surgery for appointments. Jane, a practice partner, described how upsetting it was for her when patients expressed their displeasure about waiting times. This created additional pressure for her, as she considered she was trying to balance patient demands with her own available time. Jane was conscious of keeping patients waiting and became concerned when she was "running late". Jane had adopted a strategy to alleviate some of this time pressure. She educated both her patients and reception staff to make a long consultation appointment if a patient wanted a number of issues addressed in the one consultation. This enabled her to gain a sense of control over her time and reduce the likelihood of keeping patients waiting. She explained:

> *It's time pressures and people expecting half an hour or 40 minutes of work in 15 minutes. If you make a move to terminate things after 20 minutes, they can often get quite stroppy and say 'I've taken a day off work to see you' and I ask 'did you book a long consultation?' Some patients (often middle class professional women) are demanding a lot of time out of me and they only pay for a small amount and leave me exhausted and behind and copping it from the other patients about being late. So they now pay $75 for a long consultation and that's my deal and if they don't like it they can go somewhere else. The take up has been amazing, there's been no complaints, I feel better, they get a really really good go from me and I really go into*

everything and I think they've been satisfied and it's generally been good all round. But I had to get the staff to make sure they offer it (long consultation) and if patients then don't take it up, then I have grounds to say, 'well you didn't book a long consultation, you will have to come back.' And that's made me feel a lot better about the quality of the work that I'm doing.

She also believed this strategy improved the quality of care she provided, and enabled her to achieve adequate reward for her time. It also helped her manage patient expectations. Other GPs used different strategies to manage patient demands and expectations, as well as relieve their own concerns about remaining punctual with patient appointments throughout the day.

6.5.1 Managing Punctuality and Waiting: No Appointments

Vicki, a suburban partner who was born overseas, did not experience concern about "running late" for appointments. Vicki adopted a different system for managing patient appointments than Jane. She explained how she did not make appointments for patients; it was a matter of them coming in and waiting to see her. She explained:

We don't make appointments and we only bulk bill. You [the patient] come in the morning and you choose to come and you put your name down and you see how many there are or if I've got a shorter list, you can go with me or the other doctor, the same files we share, so the records are all there. Well, they get it free [bulk billed] and get seen most times the same day, it's not many that have to come on another day. The only thing is that they have to wait sometimes and I say to them 'you don't want to wait, come at 8 o'clock, I come at 8 o'clock'. My surgery starts at 8.30, you should be there before me if you want to be first. If you come at 10.30 with the rest, then you have to wait, sorry. You know, you've made breakfast, you've tidied your house, you've done the shopping and then you've turned up here. Well I'm sorry, I can't help you. Maybe you'd like to go home and come back tomorrow morning at 8.

Vicki's approach to managing consultations is unusual in Australia, and goes against the dominant medical method of managing patient flow. Her use of this system may have been influenced by cultural differences regarding time, punctuality and pace of work. Vicki completed her medical training overseas, and had been working and living in

Australia for 16 years at the time of the interview. Vicki's business partner, an Australian male, had been open to this non-traditional method of managing patient flow. He also adopted this method, and found it suited his consultation style.

Recalling past experiences helped Vicki adapt to her current work situation. She highlighted the differences in workload and the patient presentations between Australia and her country of origin. In comparison to Asia, she considered working in Australia was less demanding. When she was feeling as though her current workload was becoming too great, she reminded herself of past work experiences in her country of origin, and this helped her keep her work in perspective. She explained:

> *In [country of origin] you are born to it [workload] and it doesn't bother you. Now I look back and I think, my gosh, I quibble if I see 50 patients in a day. I would have seen 50 in the morning, so you think, I'm not doing any work at all. When I first came here [to Australi] we were discussing the caesarean statistics for the month at work and we'd done three in that month. Over there, I'd have done three overnight, so you just can't compare and it's so dramatic, the patients are so much sicker there.*

Mark, a solo practitioner, had taken another approach to dealing with punctuality and patient waiting times. He installed a camera in the waiting room and a monitor in his surgery so he could see how many patients were waiting. The camera helped him deal with patients wanting to extend their appointment beyond the allocated time. He explained:

> *I can be running (on time) very well at first, then the phone interruptions and unexpected long consultations, and then I had 6 or 7 in the waiting room that all came in together. So the late ones and the early ones came in and the whole waiting room is full. So I installed the camera monitor in the waiting room and I feel quite happy because I can deal with the pace myself, knowing that I can show the monitor to the patient in the surgery and say 'look I have 6 patients waiting, let's talk about this next time'. They say 'yes I understand, I'll come back next week or whatever'. Patients come in with first, second, third problem, 'and by the way' the fourth problem so I tell them 'we'll do it next time'.*

The use of the camera to monitor the waiting room gave Mark a tool to assist with managing his patients' consultation expectations. This helped him to control the length of the consultation. Being able to demonstrate to the patient that people were waiting gave him the opportunity to distance himself from refusing to extend the allocated appointment time, and the evidence of patients waiting legitimised his refusal.

6.5.2 Managing Patient Characteristics and Presentations

GPs made a decision about whether to strictly adhere to patients' assigned consultation times and remain punctual, or extend the allocated consultation time and risk falling behind time and keeping patients waiting was a personal choice. Dean explained how he often needed to extend the scheduled appointment time due to the nature of patient characteristics and presentations. Patients sometimes present with psychosomatic symptoms or medically unexplained, problems likely to generate longer consultations. He said:

> *My first patient was slow because he was obsessional so it was a situation where I was immediately 15 minutes behind. Then I had a whole lot of patients who were just slightly more complicated so I was running about 20 minutes to a patient and by the time it got to about 10am I was getting patients coming in complaining of having waited and waited such a long time and so I had to start the consultation by apologising for running so late, and saying I'm working as fast as I can and being apologetic for most of the day.*

Dean considered he had many patients with complex problems, and also too many patients to see in too little time. He saw no end to his constant high workload and believed the chronic time pressure he experienced would continue into the future. Unlike Mark and Jane, Dean had not implemented a strategy to deal with patient expectations, length of consultations, punctuality and patient waiting times. All these issues further exacerbated his feelings of time pressure, and influenced his ability to take brief respites during the day to recuperate from the demands.

During the working day participants had many deadlines to meet because each patient encounter had a deadline imposed by the length of the appointment time, and this tended to create a heightened awareness of time pressure. Kim, a suburban partner explained how, during the 20 years or so she had been practising, the pace of work had increased, due in part to the use of technology in general practice. She recounted:

> *The capacity that you work at is much faster and higher; computerisation allows you to do that but it doesn't allow you to think at a leisurely pace. I think it's really hard to think that fast and change your train of thought so quickly and so many times. If you see 25 odd patients in a day you've considered 25 different problems and sometimes multiple problems per patient.*

Kim believed technology had influenced expectations of time that resulted in a continual pursuit of better ways to increase efficiency at work. She considered that her pace of her work during a typical working day was incongruent with the time necessary to cognitively process the complex nature of patient presentations. The quality of patient care may suffer if the GP does not have adequate time to assess health needs.

The amount of time allocated to patients was sometimes considered inadequate to meet the expectations of the patient. Some GPs experienced frustration and anxiety over the quality of health care they provided, and their ability to be punctual. A number of temporal factors such as the experience of time pressure, rushing (pace of work) workload, running late (punctuality) were important influences on how GPs dealt with the demands of general practice. These factors highlight the situational demands of different work environments.

The previous sections have identified the influences of the context of general practice, and patient characteristics and expectations on how GPs allocate their time at work. In the following sections the influences of the content of general practice, in particular, the

relevance of time to diagnosis and prognosis of disease, fear of making mistakes and threat of litigation, and managing patient characteristics and expectations are explained.

6.6 Early Detection and Survival or Death: "She might die"

The clinical advantages and benefits of early detection of disease include increased survival, increased treatment options, and improved quality of life. Detecting disease in an earlier state combined with effective treatment/therapy may result in longer survival or cure rates.

The importance of early detection of disease was identified by Elizabeth who was receiving chemotherapy at the time of the interview. Elizabeth consciously delayed her own diagnosis in spite of knowing she was ill. She explained:

> *I think I was just bloody minded with my back pain, I had three months of back pain and my diagnosis was delayed because I was bloody minded. I knew there was something seriously wrong with me but it just didn't suit me to go ahead with investigations knowing that once I had investigations I would be obliged to have treatment, so I delayed my diagnosis and I don't know whether that would have been any different had I had a GP because I might not have gone to the GP knowing that I would have been obliged to investigate.*

Elizabeth resisted investigating her back pain although she knew there was something seriously wrong. She consciously chose not to investigate because she would then be "obliged" to have treatment. Even though Elizabeth was cognisant that early detection of disease has a better prognosis, acknowledging her illness would have been an admission of weakness that placed her on the "patient" side of the doctor-patient border.

The importance of early detection and treatment of disease to survival was also described by Sue. She recounted:

> *Missing cancer in a 33 year old for about 12 months, that's my worst mistake and she might die because of it. I've made a couple of big mistakes and I haven't been sued yet and they have been devastating even though I haven't been sued, you know, everyone makes mistakes. It was terrible, I*

had to take a week off work when I found out, I was so devastated, and that was partly her fault because she didn't come back, but it was also me, I could have picked it up, I can see it now in hindsight. I was devastated by that even though she doesn't blame me, she thanked me for diagnosing it and she said "I would have just left the symptoms I wouldn't have done anything unless you picked it up", but according to my standards I missed it too, for about 12 months. I talked to my counsellor about it and it helped a bit, but it can't undo what's been done, what's happened, you just have to accept it; so that was the worst by far.

Sue considered that by her standards she had made a "mistake" by not detecting disease in a patient. The ramifications of this delayed diagnosis meant that the patient may not survive. Sue considered this outcome could have been avoided if she had investigated more thoroughly. Sue was not involved in malpractice litigation, as a result of what she considered was a "mistake". The fate of her patient symbolised failure by her "standards" in an environment that highly values early detection of disease, and is averse to medical error.

6.7 The Cost of Making Mistakes: The Threat of Litigation

The majority of participants in this study believed that time pressure and pace of work were linked to increasing the potential of making mistakes. The possible consequences of making a mistake were undesirable, potentially fatal, outcomes for the patient and malpractice litigation for the doctor. GPs who have been sued know that the expense of litigation has a personal impact that lingers long after the court case has been closed (Mackee, 2006).

According to Tallis (2004), in response to a more litigious society, medicine in the future will be increasingly defensive. The medical maxim of first, do no harm will be replaced by first, ensure you have covered yourself, and then be concerned about harm.

Kim explained how perceived time pressure added to the risk of making a mistake and the ensuing fear of litigation. She implemented several strategies in order to minimise

the possibility of making mistakes and exposure to litigation, but this added to her already time pressured hours at work. She explained:

> *The main stress (in general practice) is fear of litigation, you think about it once or twice every day because you are constantly covering your tracks, not trying to hide things, but you are constantly justifying things. So you write down things that would indicate that you have considered a possibility in case later on it turns out they did have that and you haven't considered it, so you write everything down and you double check, if someone doesn't come back for their appointment you check should they've come back, you write a note on their file and say, contacted her twice, didn't come, you know, constantly cross checking and double checking and it's very time consuming and soul destroying sometimes.*

Kim attempted to "cover" all possible avenues to avoid litigation by keeping meticulous records, trying to decrease the risk, and reduce the uncertainty of her work. She considered that the necessity to engage in defensive practices affected how she worked, and her relationship with her patients was also more defensive than in the past. Kim believed in the clinical benefits of early detection of disease and tried not to "over-investigate" with unnecessary tests and procedures as a way of managing her fears of "missing something" and the possibility of litigation.

The perceived threat of litigation can be interpreted as a symbolic threat to the existence of the GP. Litigation publicly displays personal inadequacy and failure. Gerrity, Earp, DeVellis & Light (1992) observed that studies of medical students, doctors in residency training, and doctors in practice, revealed fear of personal inadequacy and failure. The impact of litigation on one participant clearly illustrates this concern, and the way it potentially influences future practice.

Elizabeth was sued by a patient she had been seeing for five years, and who had consulted her 78 times. Although Elizabeth wanted her Medical Defence Organisation (MDO) to settle, they wanted to contest the claim. By medico-legal standards the MDO considered her case impeccable. They chose to contest the claim because litigation was

getting out of control; hers was a case they could win. Elizabeth took being sued very personally, and still felt "victimised" by the experience. She recalled:

> *I was just not coping, five years of solicitors' letters and I was never free of it, the shame of it was huge. I should have been proud. I did everything right, but I felt ashamed because I was being sued. The case cost well over a million dollars to run and the patient was awarded $12,000. I felt that I had lost the case, the lawyers saw it that I'd still won because they settled for a small amount of money.*

Elizabeth considered that the medical profession had "let her down". Her male business partners did not offer her any instrumental or emotional support; but looked on with what Elizabeth considered was a "morbid fascination". The shame she felt prevented her from speaking with friends and peers about her experience; she did not seek help from a professional, so she "struggled alone". Elizabeth found little consolation in the fact that the litigant was vexatious, and this was her eleventh claim. She believed the patient and her lawyer brother were driven by avarice in making the claim, rather than her clinical competence.

Six years later, the experience remained an upsetting memory, and talking about it still caused Elizabeth to feel very emotional. She considered the episode to have been a "huge sadness" in her life that caused her to consider leaving the profession. As a consequence of the claim, Elizabeth now practised defensive medicine in order to try and protect herself. She referred her patients to specialists more often, and ordered more diagnostic investigations. She was saddened by the negative effect the process had on the doctor-patient relationship she valued with her patients. Elizabeth believed she now approached every patient as a potential litigant, and was not as compassionate with her patients.

The following case study provides an elaboration of the key themes presented in this chapter. It also illustrates the dynamic interplay between work and non-work/family domains.

6.8 Case Study: Lyn

Lyn, a 47-year old GP, was married to a medical professional (not a doctor); they have two daughters. She had been a suburban practice owner for 11 years, and for the first three years worked solo, and then employed another female GP. Although Lyn did not enjoy the business aspects of owning a practice, she highly valued the autonomy and flexibility that being a practice owner provided. Lyn considered that the autonomy gave her the decision latitude to take control of her work hours, workload, and how she conducted her business. In particular, she valued being able to adjust her work hours so that she could be at home with her daughters after school.

Lyn was committed to her patients and knew them all by name. She felt honoured to share in her patients' lives, and provide them with care over many years. She contrasted her capacity to know her patients with the larger clinics where people may not have a regular GP. She preferred a smaller practice because this allowed her to practise in a way that was congruent with how she perceived the role of GP. She was concerned the continuous changes and increasing pressures in general practice caused different working patterns resulting in a loss of continuity of care. She saw the outcome of these changes as a decrease in ownership of the responsibility that co exists with being a person's GP, and fragmentation of care. She considered the continuity of care particularly important for managing complexity, co-morbidity, and multiple pathologies in patients.

Lyn liked most of her patients, but believed a few patients did not value the level of care she provided, and the effort this entailed. She decided she was not going to spend her

time with patients who did not respect the service she gave, and dealt with these patients by writing to them suggesting they seek another GP to provide for their health care. This strategy had the added benefit of reducing the number of patients and, therefore, her workload.

Lyn intended to work until her daughters were finished their education. She was the only participant who stated she no longer gained satisfaction from her work. Even though she felt highly skilled and highly qualified in a job with social status, she had begun to question whether her job gave her a happy life. She often thought that, in hindsight, she should have been a teacher so she could spend school holidays with her daughters. She also wondered if, in fact, her daughters would have been happier if she had been a teacher rather than a GP, because being a teacher was, in her opinion, less demanding than being a GP. Lyn believed she was 'too old' (at 47 years) to leave medicine and pursue a teaching career. She was not prepared to forfeit the financial and emotional investment she had in her medical career, or to devote effort to obtaining teaching qualifications.

Lyn perceived the high demands of general practice were insufficiently financially remunerated. She addressed this imbalance by moving from bulk billing her patients to a co-payment system, which gave her higher financial remuneration. This allowed her to feel more adequately rewarded for her efforts. However, she had not been able to address the lack of intrinsic rewards that had diminished during the years she had been in practice; this contributed to her dissatisfaction with her work. She explained:

> *The buzz has gone. I had a lady in the other day with an infarct; got an ambulance, gave her aspirin and knew she got in and was stented, and she's alive. 5-10 years ago I'd say 'oh yes! yes! I saved a life', now I think my God, will the ambulance just come. I've got to go home and cook tea, and then I've got to go to a school meeting.*

Prior to becoming a parent, work had been Lyn's primary life interest. She struggled with the transition to parenthood at a time when she had just begun in her own business; trying to meet the demands of these two domains had been challenging. She said:

> *The most demanding part of the job for me was to find a way to be a mother and to do the job - that was incredibly difficult. I went back to work when my second child was 3 weeks old, and because I had a practice that was close to home, Mum would look after her and I would go home and breastfeed her. If you've actually got autonomy over your own hours you can do it. I've been able to be there for my kids as well as work. But it's taken a lot out of me.*

Lyn had chosen to work and live in the same geographical area. She was well known in the community as the local GP. Although this had benefits, such as a short commute time, and being able to conduct home visits on the way to the surgery, it did not help her to place boundaries and separate her work and non-work/family domains. She accepted phone calls from patients during non-work hours, and had difficulty leaving thoughts about her patients at work.

In order to alleviate frustrations associated with the changes to medicine and the healthcare system, Lyn acknowledged that it was important to identify the things that you can and cannot control. She put strategies in place that helped her adapt to change and took regular breaks to detach from work and replenish her resources.

This case study has illustrated the importance of time in general practice and the strategies adopted to deal with organisation and management of time. Several issues were identified and included: the relevance of time to the business of general practice, the significance of time to health and disease, especially the continuum of care that has been traditionally associated with general practice. Also demonstrated has been the importance of the meaning of time and money to GP participants, and how this is linked to effort and reward at work. The ability of participants to obtain a balance between effort and reward,

as well as their perception of achieving balance between work and life domains influenced their satisfaction with their work.

6.9 Summary and Conclusions

As highlighted in the literature review, many studies have identified the work conditions that doctors perceive as demanding. GPs in this study noted many of the same work concerns, although their degree of concern and how they dealt with these concerns varied. In the context of general practice, chronic high workloads and associated time pressures were major concerns. Related to these concerns were participants' perceptions of time scarcity, the value of time in general practice, and the link between time and income. Also related to time based concerns was the fear of doing harm to patients and the threat of litigation. Concerns about the content of general practice were identified, and included patient expectations and characteristics, and how the multiple roles participants' engaged in during a typical day could be a source of role conflict. Participants implemented a range of strategies to ease the tension between time related concerns, provision of quality care, and meeting patient expectations. The case study for Lyn provided insight into how one participant managed her work. She used her autonomy to take control over the hours she worked, and used a co-payment system that assisted to ease her perceived financial imbalance between effort and reward.

The demands associated with time in general practice are likely to become more challenging in the future. The forecast changes to the characteristics of Australia's population over the next 20 years, discussed in Chapter 3, section 3.2 will have a significant influence on general practice. With the ageing baby boomers there will be increasing demands on GPs to manage the chronic diseases that are the leading causes of death in developed countries (WHO,2008). The increase in the expected average life of

Australians and the lengthy end stages of chronic disease will have to be managed by GPs.

Patients who have complex medical conditions will require longer consultation times, and this will influence how GPs use and manage their time in order to meet the demands of the patient. One of the challenges for GPs is to develop appropriate strategies to balance patient demands with financial remuneration and lifestyle.

CHAPTER 7

TIME OUT FOR RESPITE AND RECOVERY

This chapter describes the ways GPs allocate time to work and other life domains, and the ways they achieve psychological detachment from work. The more time spent in the work domain, the less time is spent in the non-work domain, which has implications for the capacity of the GPs to adequately recover from work demands. This study has identified that GPs' life domains are interconnected, with one domain influencing choices and behaviours in the others. Regardless of whether GPs chose to integrate or to segment their work/non-work/family domains (Nippert-Eng, 1996a) their experiences and activities within the general practice work environment influence their life outside work. Their experiences in other non-work domains appear to influence their adaptation to the general practice work environment.

The first section of this chapter provides an overview of contemporary households and the subsequent influence on managing work and non-work demands. Findings from this study about how GPs manage their life domains are presented in the next section, along with the various ways that GPs engage in respite activities that facilitate their psychological detachment from their work. The final section of the chapter presents two illustrative case studies that describe two GPs work orientation, preference for integrating or separating their work and non-work/family domains, and their choice of respite activities. The chapter concludes with a description of how two participants had, in the past struggled with work and life demands and engaged in negative coping behaviours.

7.1 Contemporary Households in the Workforce

Over the past few decades research efforts about work and non-work domains have been informed by assumptions and characteristics that exist in contemporary Western

society (Burke 2004b). The single earner household that was dominant until the latter part of the twentieth century, where a worker's full time homemaker/spouse managed the non-work aspects of work lives, has largely been superseded by an increase in the number of dual earner households (Moen & Sweet, 2003). The resulting influx of women in the work force, especially women who are also raising young children, has seen changes to family arrangements that deviate from traditional gender-based roles and parenting arrangements (Edwards & Rothbard, 2000). Shared parenting responsibilities have been linked to increased role demands on both men and women (Bolger, DeLongis, Kessler, & Wethington, 1989; Greenhaus & Beutell, 1985), and these demands influence how people allocate time to work and non-work domains.

7.2 Allocating Time to Work and Non-Work Domains

During a typical workday, people move between domains where they occupy a variety of life roles. For example, doctor (work) mother or father (family), and church member (religious organisation) (Ashforth, Kreiner, & Fulgate, 2000; Ashforth, 2001); they invest time in each domain in order to meet the demands associated with each role.

Meeting the real and perceived personal and work demands and obligations associated with work and non-work domains, was sometimes challenging for participants in this study. The ways they allocated their time were influenced by their personal preferences for where they chose to spend time and effort. This choice was influenced by the degree to which each life domain was a central life interest.

7.3 Centrality of Work and Non-Work Domains

People have social experiences in a number of life domains, but these various settings do not necessarily have equal importance for the individual. A person may favour any one or more social domains for carrying out activities. The extent to which people derive

personal meaning from, and invest in, non-work roles is related to the level of work centrality in their life.

Work centrality is defined as a general belief about the value of working (Harpaz, Claes, Depolo, & Quintanilla, 1992; MOW International Research Team, 1987). It can be assessed directly by identifying how central and important the role of working is in absolute terms (MOW International Research Team, 1987). Work centrality can also be assessed indirectly by comparing the relative importance of the work role with other life roles (van der Velde, Feij, & van Emmerik, 1998). Work centrality is related to an individual's value system and self-identity (Hirschfeld & Field 2000). The degree to which an individual derives personal meaning and invests in non-work life roles is related to their level of the centrality of work in their life (Stephens & Feldman, 1997).

An individuals' work orientation can be measured by the amount of time spent working. The amount of time allocated to domains is highly variable according to individual preferences (e.g., work orientation) and needs (e.g., financial). This was highlighted by participants in this study. Michael, a rural GP, gave his views about how much time GPs can spend in activities related to medicine. He stated:

> *There is so much you can do, you could be working in medicine all of your waking hours if you wanted to be.*

Michael went on to explain how he was not "married to medicine" although he said he worked 90 hours a week in medically related activities. He believed that the individual GP may not be a good judge about whether they were spending too much time in work related activities. Michael relied on his wife to give him a "kick in the pants" if he was spending all his available time on work related matters, and not taking time to engage in respite activities that enabled him to recover from the demands of his work.

The amount of time participants chose to invest in work or non-work/family activities was varied and dynamic, depending on the degree of work centrality in their lives. For some participants, work was an absolute central life interest; for others, work was a relative central life interest that was influenced by contextual factors such as life stage, family stage, and career stage. Vicki recounted how she has managed work and family over the years. She explained:

> *I worked for a while in an outer suburb of Melbourne and when my children were small, I worked 9 to 12, I couldn't cope with being home all the time. I had studied really hard; I wanted to be in the workforce. So I worked 9 to 12 until the children became older and they went to school, and then I worked 9 to 3. Then my children went to senior school, and now are finished school, they come and go on their own. But while I was working 9 to 3, they (children) never missed me; I was there cooking dinner or reading them books.*

Vicki did not perceive her work and family domains as being inherently competitive. The interest she had in each domain seemed compatible, and she adapted her behaviours to meet the changing demands associated with each domain. She was able to function in, and gain satisfaction from, both her work and non-work activities and adjusted the amount of time and degree of centrality of interest in each domain. For Vicki, the centrality of work was relative and, over time changed to accommodate the demands of her non-work domain. In contrast, she compared how her male business partner maintained work as an absolute life interest that took precedence over his family.

> *I think this is a decent job, but don't overdo it. My business partner sometimes over-does things. He missed his daughter's birthday party and that is inexcusable. I changed how I worked after we had children, whereas he has not changed. Before he had children he worked like this and after he had children he worked like this. He doesn't go home early, he goes home after me, when his children are ready for bed or he'll say "so and so needs a house call", he doesn't say "no, it's 8pm". So I think you have to be assertive to say, this much I'm allowing for work and this much of me belongs to home.*

Vicki chose to move back and forth between domains, whereas in her opinion, for her business partner, clinical GP work predominated. He appeared to be single-mindedly focused on work to the point that he was seemingly overlooked his relationships with his family. Unlike Vicki, he had not adjusted his work orientation when he became a parent; work remained absolutely central. Furthermore, spending long hours at work reduced his opportunity to disengage from his work, and take time out to unwind from the demands of his work as a GP.

The degree of work centrality influenced whether participants in this study chose to either integrate or segment their work and non-work domains. The more participants integrated, the less mutually exclusive were their various life domains. The more participants segmented the more each domain had unique elements; separating one realm to another helped to achieve mental distance (Nippert-Eng, 1996a; Nippert-Eng, 1996b), and disengage from their work.

7.4 Managing Life Domains

Participants chose to manage their life domains in a variety of ways. Kate was one half of a dual-career couple, and, because of her preference for work related activities, she used her income to purchase services that she considered were time-consuming and uninteresting, such as cleaning, gardening, and laundry. She was aware of the advantages of outsourcing or purchasing services to reduce her need to do domestic chores. Kate valued mental labour above physical labour, and had no desire to be involved in what she referred to as “grungy” household chores. She employed a full-time Nanny (in-home care) to care for her three children, and found this was the most appropriate and convenient option for both her children and herself because it allowed her to balance her work and non-work commitments.

Kate suggested that the rewards and costs of being a GP differed because of contextual factors such as career stage, family structure, and income. She acknowledged that her strategy to outsource domestic tasks was not an option for all GPs, and highlighted the need for available financial resources to make this a viable option. She explained:

> *Because I own this business I earn more money then most GPs. I can afford to have the help. I don't need to do grungy stuff like cleaning the house so I think I'm doing it a bit better. Some of my other colleagues are definitely working longer hours than me and they feel like they are swimming behind, especially the males who have these enormous income needs because their wives don't work and they have the big mortgages and two expensive cars and kids all at private schools and so they just struggle with this huge lifestyle they try and maintain and they are working really hard. They work 12 – 15 hour days every day. It's ridiculous.*

As mentioned in chapter 6, section 6.2.2, there is a direct relationship between the number of patient consultations and income. Kate believed that meeting the high demand for GP services, and the financial rewards received for services over a period of time, could set some GPs on a treadmill of working long hours, in the pursuit of a lifestyle they considered appropriate to their social status. She considered this was exacerbated when there was one GP contributing to the household income rather than a dual-career family where both partners contributed to the household income and expenses.

Kate described herself as "entrepreneurial". She was able to successfully combine her clinical and business roles as she highly valued both these aspects of her work. Kate enjoyed meeting the demands of her work, and did not experience intra-role conflict. She appreciated the financial rewards of owning the business as this allowed her freedom to participate in her preferred activities. She incorporated an effective strategy to manage her non-work/family demands with the financial resources generated from her business.

Another participant, Kim, managed her work and non-work/family domains in another way. Kim's original decision to become a GP, 25 years ago, was one that she considered successful because general practice allowed her to effectively manage her work and family domains. As a practice partner she had the ability to control the number of hours she worked in order to be at home after school with her four children. She said:

> *This is a great job for combining parenthood and to be able to be home. I only work school hours so at least four nights a week I'm home after school and there aren't many jobs in medicine where you can do that, so that's the biggest thing for me. It's a very interesting and rewarding job too but it's great to combine it with motherhood.*

Kate and Kim provided examples of how they differed in their preferences for managing their work and non-work/family domains. Although their approaches differed, these two participants did not experience tension or conflict in managing the demands associated with the different areas of their lives. The following section describes how conflict can occur between various social roles, commonly referred to as inter-role conflict.

7.5 Tensions between Work and Non-work

There is a potential for conflict between the role expectations associated with work and non-work domains/family, which can influence personal and family wellbeing (Pleck, 1995). Individuals experience inter-role conflict when demands associated with the role in one domain are incompatible with demands and norms associated with a role in another domain (Greenhaus & Beutell, 1985). Not all roles have the same degree of incompatibility; each role can be placed on a continuum from low to high degree of interference and conflict with one another (Pleck, 1977); inter-role conflict occurs when participating in one role makes it difficult to participate in another.

Much of the work/non-work research has centred on work and its influence on the family (Burke, 2004a; Burke, 2004b). The work/non-work research initially focused on conflict, and scrutinised both work-to-family and family-to-work. The research focus has now moved to work-family balance, work-life balance, and, more recently on integration (Rapoport, Bailyn, Fletcher, & Pruitt 2002).

The use of the term *work-personal life integration* was introduced by Rapoport et al. (2002). This term implies that people can participate and gain satisfaction in both work and personal life, regardless of how much time they invest in each domain. Conversely, the term work-family balance implies a 50-50 division, but people do not always choose to weight each domain equally. The ways participants in the current research weighted their domains was influenced by their perceived degree of work centrality (absolute or relative), and this, in turn, influenced how much time they chose to spend in each domain. The concept of work-personal life integration, therefore, reflected the meanings of participants more closely, because participants gained satisfaction from both work and personal life without necessarily dividing their time equally between domains. The current study, however, used the term work-life balance because this was the term that participants used.

In an examination of the literature on conflict between work and non-work (including family), Greenhaus and Beutell (1985) found three issues associated with work-family conflict (WFC): (1) time dedicated to the requirements of one role make it difficult to find enough time to fulfill the requirements of another; (2) strain from participation in one role may spill over into another role; and (3) specific behaviours required in one role may be inappropriate in another (Burke, 1996a; Burke, 1996b; Greenhaus & Beutell (1985). These three issues were identified by GPs in this study. Participants expressed concerns regarding time pressure and workload, the stress and strain associated with the demands

of general practice, and the expected behaviours associated with the GP being a "real doctor."

Sarah considered she was "always a doctor". She had difficulty participating in activities other than her GP work, and did not feel as though she was able to achieve work-life balance. She explained:

> *I think doing medicine is the best thing. I feel very privileged to be able to share quite a lot of personal things with people and intimacies and joys and downsides. There's a lot of privilege in delivering someone's babies or being involved with their thoughts as they die. But I'm always thinking of giving up medicine, as much as I love it, because it's just too much and I don't get to do anything else.*

Sarah valued being a doctor, and the relationships she had with her patients. However, she believed that the demands associated with being a GP were so great that this role generated a high degree of interference with her personal life. Sarah attributed this interference to the nature of medicine, and her level of job involvement. This made it very difficult to "switch off" from the responsibilities and obligations associated with being a GP. Sarah considered being a GP was incompatible with having a "life outside of medicine" because of the demands and strain associated with her work. Sarah also acknowledged that her inability to disengage from being a doctor might have been influenced by her personality. She explained:

> *It might be my personality type. I don't switch off, you're always a doctor. But that may be more so in a small town. And fitting in other things is often very difficult. My relationship broke down, not long after we got here and it was very hard on my own.*

Sarah acknowledged she had difficulty maintaining boundaries and adopting other non-work related activities and identities. She attempted to reinforce her other identities by placing objects related to these identities around the surgery. She said:

> *There are little bits of me all around the surgery and I think that's really important so that you keep your identity that's not just being the doctor. See I've got all little things everywhere and you know that's really good too, not keeping it so clinical. People should keep their own identity within their work so that it's not that they're losing who they are in the doctor role.*

Although Sarah enjoyed her work, she was conflicted about the level of responsibility and engagement in her GP work. She resented that she had to struggle to maintain her non-work identity, and made significant efforts to identify with other roles. These issues appeared to compromise Sarah's positive adaptation to general practice and left her ambivalent about her work.

Another participant, Meg wanted to "leave work at work", but also found it difficult to separate her work and non-work/family domains. She said:

> *The fear of doing something wrong, the fear of doing harm; you take the worry home with you.*

A blurring of work and non-work boundaries and activities occurred for both Sarah and Meg. Both had difficulty "switching off" and were unable to leave work at work. They took worry about patients home, but it was not by choice; they were unable to psychologically detach from concerns about work in the evening hours even though they had physically made the transition to their homes.

The demands of work dominated the lives of many of the GPs in this study. These work demands meant that much of their time was allocated to activities associated with work. This was a source of time conflict for Meg, she explained:

> *I'm pretty happy, I'm not financially stressed, I've got two great kids, I enjoy my work, I find it very satisfying but I'm doing far too much, I'm working 6 days a week, and I'm running the practice ….so I do 40 clinical hours but I do more in terms of looking after the place, I really only have Sunday's off, I'd like to have more time off, because I've got kids.*

Because Meg had the added burden of being a practice owner, she had a business role at work as well as her GP role. Although Meg found satisfaction in her work, and, valued the rewards she obtained from her work, she considered the number of hours she worked per week was undesirable. She expressed a wish to have more time to be with her two children. However, she was accepting of the situation because she anticipated reducing her work hours in the "not too distant" future; this enabled her to deal with the competing demands in the short term.

Another perspective of the influence of being a GP on the non-work/family domain was provided by Matthew, a 77 year old rural GP, who had been a locum for a couple of years. His reflections on work were retrospective, and referred to a time when he worked as a full-time GP. He began working as a solo practitioner in the 1950s, and built a group practice as the workload demand increased. He explained his investment and expectations associated with being a country GP. He said:

> *I think we're expected to be on call all the time if you're a country doctor and I just took it as part of the job. It never worried me to be on call. It probably gave me a sense of importance that somebody wanted you and that helps to carry you through.*

Matthew did not express feelings of conflict between domains. His work was an absolute central life interest, and his GP role identity was more salient than his other life roles. He acknowledged how his work provided a sense of self-esteem and identity affirmation that he found protective to the demands of his work. However, he considered his family were negatively affected by the amount of time he chose to allocate to his work. He went on to explain how being so involved in his GP work influenced his wife and children. He said:

> *My wife hated the interruptions particularly when they were things involving the children. I'd dash off in the middle of something get called away in the afternoon when we were having some sort of family function.*

> *How much the children suffered I'm not sure. We sent them away to boarding school for secondary schooling because there was nothing available. I guess in some ways they suffered. Looking back later I thought that I should have made bigger efforts to be involved in their activities but by that time they were all grown up. It is easy to look back and make decisions. To have more specific time for family and home life could have been done better.*

Matthew acknowledged that social changes had occurred over the past 50 years. He stated that with the benefit of hindsight, if he had his time over he would have participated more extensively in parenting and spent more time with his children. However, he was accepting of the demands and expectations of being a GP in the past, and gave an example of how his personal life was secondary to his GP work. He recalled:

> *I took up lawn bowls for a while, took up golf and I kept getting called away and Saturday afternoon someone would come down chasing you, four o'clock, half way through a bowls match and things like that and you leave and I gave that up after a while…I think that was just what I expected so it wasn't a big strain.*

Since Matthew began practising medicine some GPs, particularly 'Generations X and Y', appear to be more likely to perceive work as a relative central life interest (Tolhurst & Stewart, 2004). They are no longer prepared to invest the same amount of time, and or, psychological commitment to their GP work as were older GPs. These generational changes were highlighted by Natasha, a 31-year old suburban employee. She said:

> *Really you need to put yourself and your family first before your job. Because I think a lot of doctors who put their job first, they don't function well, they can't relate to other people well, because if you are too highly stressed you can't concentrate, you can't function properly and you need to prioritise things, not try and do everything. If you're happy in your personal life you are going to be happier and better in your professional life.*

Natasha believed that all roles and domains act in concert to influence each other, but her 'job' was secondary to her personal life. She had come to this realisation when she

was a medical student. At that time, she had much of her identity and self-worth invested in her role as a medical student. She recalled:

> *As a med student I wasn't happy because I was so worried and stressed about exams and doing well and that sort of thing. So I took the year off and I realised there's more to life than worrying, if I don't get through, we're all still going to be here tomorrow and I guess with that attitude I've just been relaxed really about things, it helps, life still goes on if you can't do medicine. And I love doing medicine but I also thought well I've just got to relax about this and enjoy it rather than be stressed about it all. Life doesn't end if you're not a doctor.*

By taking some time out from her role of medical student, Natasha realised that there was more to her identity than that of a medical student and doctor. She realised that "life did not end" when she took time away from medical training, and this realisation enabled her to relax and enjoy her study when she returned. Now that she was a practising GP, this awareness helped her deal with the demands of her job. For Natasha having multiple role involvement was protective, and part of her adaptive strategy to adjust to her GP work. She was able to draw on a variety of roles as sources for stimulation and social validation. Participating in multiple roles helped Natasha balance the costs and benefits associated with the privileges and obligations, and the rewards and concerns of being a GP.

7.5.1 Managing Separation of Work and Non-Work

Although older, Michael, a rural solo GP had a similar perspective to Natasha. He gave his views on the importance of having a life outside medicine. Michael acknowledged the value of placing impermeable boundaries around his work and non-work/family domains. This allowed him to psychologically and physically detach from his GP work. He explained:

> *You have to have an interest outside of medicine. Spend time with your partner, and include your partner in the things you are doing. It's essential*

to have time for children and time for yourself. You've got to have a strict standard, if you're off work, and not on call then you shouldn't be working.

Michael considered that multiple domain involvement was beneficial, but that quality of his experience in each domain was also important. However, he also considered that separating his work and non-work activities prevented work from spilling over into non-work domains. Michael recognised that it took significant psychological effort to separate his work and non-work domains, but considered the effort worthwhile, as it gave him the opportunity to take time for his family and himself.

Tanya believed that participating in multiple life domains provided more balance in her life, and helped to maintain her physical and psychological health. However, this may not be beneficial if things are simultaneously going awry in both domains. She talked about a time when she had a number of personal issues in her home environment that distracted her at work. In addition, she experienced a "couple of traumatic things at work" related to the deaths of several patients, which compounded the stress in both domains. She explained:

So the consequence of all those traumas and things not going very well is my married life, I developed what I now realise was pretty severe depression, which is not surprising. I was feeling like the world would be a better place if I didn't exist and I kept working through all of that, I just can't believe it now.

Tanya had ongoing physical ill health, but her depression had been controlled with counselling and medication. She reached the point where she realised a need to reconsider how she managed her work and non-work/family domains. She reduced the number of clinical hours by working half the week as a GP, and the other half of the week in a medically related area.

In summary, the sections above have illustrated the different ways GPs manage the demands of their work and non-work/family domains. The amount of time some

participants dedicated to their GP work made it difficult to find enough time to carry out the requirements of their non-work/family domains. Sometimes participants integrated their various life spheres by voluntarily and involuntarily allowing work activities to cross the boundary into the time and space of personal life. Conversely, other participants clearly segmented their work and non-work domains with impermeable boundaries and had a preference for separating work and non-work activities.

The following sections describe the concept of psychological detachment and provide examples of the various strategies used by four participants in this study to take "time out" to "switch off" and psychologically detach from their GP work. Taking "time out" from work to engage in respite activities of various types and duration provided opportunities for rest and recovery from the demands of general practice.

7.6 Time Out: Psychological Detachment

Psychological detachment involves disengagement from work routines. It is more than being physically away from the workplace, and it requires the individual to stop ruminating or thinking about work related issues. It also involves not carrying out work-related activities such as taking phone calls or scheduling appointments. Psychological detachment from work has been shown to assist in recovering from work demands and to positively influence wellbeing (Etzion, Eden, & Lapidot, 1998; Sonnentag & Kruel, 2006). Psychological detachment from work during leisure activities has been found to improve mood and reduce fatigue at bedtime, resulting in improved ability to sleep (Sonnentag & Bayer, 2005). Etzion et al. (1998) reported that male engineers and technicians who spent time away from their usual job and engaged in military service showed decreased burnout, especially those who experienced high psychological detachment from the usual jobs. This finding suggests that recovery can occur from

participating in a variety of activities, and not necessarily only pleasant activities such as those pursued in leisure or holiday (vacation) time.

Psychological detachment is strongly related to individual and job-related factors (Sonnentag & Kruel, 2006). Having the capacity to psychologically detach from work has been found to be more challenging in professions and work environments where the individual has a high workload and accompanying time pressure. Workload contributes to people having difficulty "switching off" from work because people who have ongoing high workloads may take work home in order to complete the days tasks knowing they will not have time available the following day to catch up. In addition, they may continue to ruminate about unfinished tasks and anticipate ongoing high workload in the future (Sonnentag & Bayer, 2005; Sonnentag & Kruel, 2006). Completing all work related tasks before leaving work was part of Michael's strategy to facilitate psychological detachment. He described his workload as "mountains of patients". He said:

> *I think that it's better to complete what you have to have done in a day than to take it home.*

Michael considered that it was advisable to try to get all work related activities completed during work hours and not take work home. By not engaging in work related activities in non-work time, he was able to pursue respite activities that assisted his ability to psychologically detach and recover from work demands.

The majority of GPs in this study perceived they worked with a continually high workload. Eight participants identified their difficulty with stopping thinking about work in the evenings. Of these eight, two stated their personality type may have contributed to their inability to "switch off" from work. This feature has also been found in other health professionals, (e.g., Charman, 2004). All participants recognised that not taking respite from their work would negatively affect their physical and psychological health.

Therefore, they had developed strategies to enable them to psychologically detach from their work. All participants incorporated a number of different respite activities to facilitate their disengagement from work outside of work hours.

Overall, participants were enthusiastic workers who truly enjoyed their jobs and either had no concerns about working long hours or had adopted strategies to manage the number of working hours to their satisfaction. They did not perceive that working long hours in a job they enjoyed was such a bad thing so long as they took time for recovery from the demands of their work. The following sections present the individual strategies used by four participants to take time out and psychologically detach from their work.

7.6.1 Kate

Kate was aware of the interconnectedness of her work and non-work/family domains. This was intensified because she was on call for her obstetric patients. While there was the potential for work-family conflict, this was not evident because her family supported her career aspirations and concurred that doctoring was a worthwhile career. Kate used regular physical exercise and two week holidays three times a year to aid her psychological detachment from work. She explained:

> *I do other things that have nothing to do with medicine. I think my health is excellent because I'm almost never sick and have very high energy levels, I'm a bit overweight but I love eating things, and I do a lot of exercise, I don't drink or smoke. I keep myself varied and take time off too. I have a massage every week and I do yoga three times a week and I walk three times a week and I have at least six weeks a year holiday; three lots of two weeks. I have good relationships with my kids, and I'm very lucky that I have a wonderful partner, so having someone that I can share every single thing with is hugely valuable so it's getting back to doctors looking after their own relationships and having that love and support.*

Kate also referred to the emotional support she received from her husband. She considered the support to be particularly important because she worked long hours due to

her involvement with general practice activities, and also obstetrics, which she found particularly challenging. The emotional support she received from family, and the instrumental support she received from outsourcing domestic chores helped buffer the negative effects of, sometimes excessive, work demands.

Kate considered relationships with family important in helping her to manage the stress of being a GP, but she also attributed importance to her relationships with patients. She believed the doctor patient relationships she shared with her patients contributed to the satisfaction and enjoyment she gained from her work.

Kate believed in the positive benefits of leading a healthy lifestyle that incorporated physical and relaxation activities, and affirming relationships with her family. Kate continued to look for new challenges and goals to prevent her from becoming "bored". The variety of strategies she adopted maintained her vitality, and her good health and wellbeing, which in turn, helped her meet challenges and achieve her goals in both her work and non-work/family realms.

7.6.2 Mark

Another tactic to achieve psychological detachment, not mentioned by Kate, was used by Mark, a solo practitioner. Mark's religious beliefs and activities, and his association with the church aided his ability to psychologically detach from his work. He explained:

> *The first thing I do in the morning is go to Mass. 7.00am and then I start my home visits at 7.30am every day. It's very important to me. I think I would be a very depressed, unhappy, frustrated person without it. Because I feel that I have spiritual food inside, and I receive communion every morning I do the communion in church and also I stay in touch with the bible and scriptures every day and of course on Sundays, I go to church Saturday and Sunday, not just Saturday or Sunday as some people choose to do, so that means that I hear the explanation of the gospel twice.*
>
> *I don't have much time for my hobbies but I like computers, astronomy and science fiction and I have an amateur radio licence. I've kept up my singing*

in church and I've kept up swimming sometimes, but I wish I could do more, I wish I had more free time. I have seven children and I haven't spent much time with them because I've been too absorbed in my work, that's one of my regrets.

Religious commitment was very important for Mark. He regularly participated in religious activities; considered himself religious, and actively participated in public worship. Indeed he attributed his psychological health to his religious beliefs and activities, and he viewed religion as integral to his identity. His attitude toward his work as a GP was that of a calling rather than a career or a job. He chose to become a doctor because he considered medicine the next best alternative to being a priest. Although he had worked in other professions due to necessity associated with his migration to Australia, his lifelong work had been that of doctor; he considered his work important and valuable to his community.

7.6.3 Meg

Meg had a strong sense of self-efficacy and belief in her ability to achieve her goals. Like several other participants she also identified the importance of physical activity as an aid to recovery from work demands. She explained:

Most things can be achieved with determination and perseverance, lack of belief in yourself is the most undermining thing. It's been a great job for me. I just find that it suits me. I would like more relaxation time. I used to do a lot of rock climbing and hiking, I'm still physically active, and I still do some yoga. I squeeze in a swim most days. Physical activity is really important to me

Meg expressed satisfaction and enjoyment in both her work and non-work domains. Meg was highly involved with her job and committed to building her practice. She was pragmatic about working long hours in order to achieve her goal of having a successful practice. Although she expressed a desire to spend more time with her family, and be involved in physical activity, Meg was not overly concerned because she believed the

work pressure and workload was only for a finite period. Meg was confident that some time in the not too distant future she would be able to attain "balance" in her life. In other words, her work was a relative central life interest. She envisaged that she would spend less time involved in work related activities and more time with her family.

As mentioned earlier, in section 7.5, Meg found the most demanding aspect of general practice was the fear of harming or doing something wrong for a patient; this fear was something that she took home with her from work. She expressed her appreciation for the emotional and instrumental support provided by her husband who was a doctor at a major hospital.

To alleviate the worry of doing harm, I talk to my husband, he's a doctor.

Because they shared medical knowledge and expertise, Meg was able to consult with him about her clinical concerns, and engage with him in diagnostic and problem solving activities. Talking about her fears provided her with relief and enabled her to work through issues with her husband rather than get caught up in self-focused rumination. Although discussing issues with her husband provided an adaptive way of coping with her fears, talking limited her ability to psychologically detach from her work.

7.6.4 Dean

Dean was very committed to his patients, and had difficulty psychologically detaching from his work. He described some work days as feeling like "climbing Mt Everest" and, as mentioned in section 6.5.2, had difficulty managing patient expectations and keeping consultations to the "15 minute framework"; he was therefore usually "running late" and unable to take brief respites during the day. He said:

> *I think there is this thing in me where I'm trying to do my endth for the person that I'm with and I think I get too involved. But the crazy thing about it is that if I didn't get involved I wouldn't find it worthwhile and I wouldn't*

do it, so it's this two-edged sword, you know that one of the things that I think is really important is to have meaning in your life and one of the things that gives me meaning is actually being with people at times when they are suffering most.

The majority of research has centred on the influence of long holidays on respite and recovery. But time away from work for respite can be a few days, a week, several weeks, or even longer (Westman & Etzion 2001).

Dean highlighted the positive effects of both long and short respite periods away from work. He described how he felt during the first few days of his two week holiday, and how reducing the number of days he worked each week aided his recovery from the demands of this work. He said:

When I go on holidays after three or four days I begin to feel like a different person and I start to feel wonderful and I guess maybe there is something about working really hard that crushes you a little bit. I'm certainly a lot better on Fridays after I've had the Thursday off each week, I like having the Thursdays off.

Dean also incorporated a number of other brief respite activities into his weekly routine. He reduced the number of working hours to a four day week, and regularly wrote in a journal. He derived much pleasure from running until he reached a meditative state, and he considered this was an important regular respite where he "switched off" and this helped him to deal with the demands of general practice.

These four participants provided examples of individual strategies use to take time out and psychologically detach from their work. These strategies are summarised in table 3 below, and highlight the variety of respite activities used by participants.

Table 3

Summary of Time Out Strategies

GP Participant	Strategies	Key Quotes
Kate	Regular physical exercise and two week holidays three times a year	*I do other things that have nothing to do with medicine*
Mark	Religious beliefs and related church activities	*The first thing I do in the morning is go to Mass*
Meg	Discussing work related concerns with her doctor husband	*To alleviate the worry of doing harm, I talk to my husband, he's a doctor*
Dean	Reduced work from five days to four and spends his day off in respite activities such as running and journal writing.	*I'm certainly a lot better on Fridays after I've had the Thursday off each week*

The following sections include two case studies, Robert and Kim. Each case study illustrates differences between GP participants' work orientation, preferences for integrating or separating their work and non-work/family domains, and their preferences of respite activities.

7.7 Case Study: Robert

Robert, a suburban practice principal, enjoyed his work and had no thoughts of retirement; work was an absolute central life interest, and he would continue to work even if he did not need the money. He expressed some vague plans that he and his wife, a nurse, would like to travel to regional areas of Australia doing locum work in the future. He explained:

> *I want to keep working as long as I can, I don't necessarily have a huge desire to retire at 55 years and one day. One of my (business) partners, actually quite staggered me the other day at a meeting when he said that if he won Tattslotto tomorrow he wouldn't be in to work the next day and I turned around and said "why wouldn't you want to come to work the next day?" and it never actually occurred to me that someone would actually not enjoy their job enough to not want to go to work.*

Robert's wife organised their holidays, as without a break from his work routine he became "really tired and cranky and irritable". They took a holiday break away from Melbourne several times a year, typically at four month intervals. Robert considered it necessary to take holidays in places with geographical distance from work and home, because he integrated his work and home spheres and needed to "get away". The geographical distance from work and home facilitated his psychological detachment from work, and this complemented the recovery of resources gained during his holidays.

Robert also allocated time during the week for brief respites. He played tennis one evening a week, and this was a priority activity for him. He was also a football enthusiast, and liked to go to matches with his wife. He used these activities as brief respites that allowed him to temporarily take time out from the demands of general practice.

Robert's respite activities appeared to be successful. He acknowledged there were some aspects of general practice where he experienced a little dissatisfaction and frustration, for example, the business side of general practice. However, he considered the majority of his job experiences were intrinsically fulfilling, and he derived satisfaction and rewards from his work. Robert received satisfaction and enjoyment from the longitudinal relationships he had with his patients. He found the content of his work challenging, and this gave him the opportunity to use his GP skills.

Money was important to Robert to ensure he could educate his children, and meet his family and lifestyle needs and wants. He did not directly complain about lack of financial reward, but did suggest that the number of hours he worked in order to generate his income was excessive.

Robert enjoyed being a doctor. He was committed and involved in being a GP. This was demonstrated by his availability to his patients, and the variety of activities he was

involved in that were associated with medicine, and contributed to his ongoing professional development.

Robert did not maintain boundaries between work and non-work/family spheres. He spent 65 hours per week on work related activities, and chose to integrate the spheres of his life. Robert conducted business related activities at home; his home phone number was listed in the telephone book, and patients often phoned him at home. He explained:

> *I've worked the last six days. Today (Sunday) I've got a day off. I've had a couple of phone calls (from patients) this morning, that's not a problem but they're not really days off. I'd like to be able to have an afternoon off. I think the hours that I work are probably ridiculous.*

The way Robert integrated his work into his time at home was similar to the stereotypical image of the family doctor from the past. This image is a culturally conditioned normative belief about the role of a general practitioner that is changing for some younger GPs, as identified by Natasha, in section 6.5. In the past, GPs expected to be on call 24 hours; often the doctor's residence and practice were combined in the same premises, so there were no geographical boundaries between his work and non-work domains. Although Robert lived in a different suburb from his practice, by providing his home telephone number, and being available to his patients in non-work time, he was adopting a modern day approach to not having geographical boundaries between domains. He did not consider this to be an unreasonable intrusion into his home/non-work domain. Robert's wife however, resented the intrusion, and his lack of accessibility, and participation in family activities. Robert minimised his family obligations and this provided him with sufficient time, and opportunities, to engage in respite activities that allowed him to recover from his work efforts. The ongoing emphasis on work at the expense of minimal family participation had potential to ultimately negatively affect the family.

7.8 Case Study: Kim

Another perspective was provided by Kim, a suburban GP with four children, and married to a non-medical professional. She considered being a GP was hard, and general practice challenging, and this left her feeling mentally exhausted at the end of the day. On the other hand, Kim considered general practice was a good area of medicine to combine with parenthood. She said:

> *It's a totally different life at home with the family. I'm glad I've got two different personas, that's the only way I can do general practice. You need to be able to have something completely different, so you can switch off. It brings you down to earth if you've just got to help someone with their spelling it's so good after talking to someone who's depressed or whatever, it's just a totally different life. Time out is the key, for women that's easier because many women have families and still have to cook dinner or do washing, a bit of manual labour is great if you've had a really bad day. I think it might be harder for men. They don't have such a designated parenting role and they tend to work more hours, most women do part time general practice; some of us do quite a lot.*

Kim liked her patients, but considered her workload was heavy, and patients usually presented with complex issues to be addressed. However, she believed time out from work was the key mechanism for dealing with the demands of general practice. Her strategy for psychologically detaching from work included a variety of activities. Kim enjoyed music, but her "main time out is to spend time with the family". She also highly valued holidays each year at Christmas time. Kim chose to live and work in different geographical locations. She explained:

> *I'm really glad that I don't live around here because I just hate seeing patients in the supermarket. I just like the anonymity of another name at home, nobody knows who I am or what I am or where I live. I just really like that to be able to step away. I don't know how they do it in the country, having your kids at the same school as your patients, I couldn't bear it. But it's good business, drumming up business. I know I must be very antisocial. You can put on a mask and go home without it. That's the only way I survive. This is a really stressful job and you see some really sad things, it's really good to be able to get in the car and drive for half an hour and be someone else when you get out of the car.*

Kim used her time commuting between work and home to change her "persona". The physical movement of travelling in her car at particular times of the day provided the impetus for the mental transition from home to work and vice versa. The journey was a transformational period (Nippert-Eng, 1996b) whereby Kim changed "masks" and took the opportunity to make both the psychological and physical transition between domains. Kim chose not to live and work in the same suburb, and this facilitated her ability to use time and space to separate her work and non-work/family realms.

An important component of Kim's adaptive strategy included maintaining the integrity of the boundaries of the work and non-work/family spheres of her life. In order to segment her work-home domains Kim placed definite boundaries around her work and home domains (Nippert-Eng, 1996a; Nippert-Eng,1996b). She considered this contributed positively to both her mental and physical health.

These two case studies illustrated two different perspectives of the degree of centrality of work, management of life domains and choice of respite activities. Robert integrated his work time while at home, whereas Kim clearly segmented her work and non-work/family domains. Robert accepted phone calls from his patients at any time of the day or night, and did not find this bothersome. On the other hand, when she arrived home, Kim wanted to forget about her work and enjoy family time. While there are clearly differences between these two GPs, they both appeared to have successfully developed strategies to deal with the demands of their work. Kim and Robert said they were satisfied and functioned well at work and at home; each perceived they had achieved work-life balance.

7.9 Negative Cases

At the time of the interviews, participants reported that overall, they were coping well with work and life demands. This however, was not always the case for two participants.[14] Although coping well at the time of the interview, participant A had struggled with drug and alcohol abuse for many years, but at the time of the interview had no recurring issues for a number of years. During the interview, the participant recalled that at the *"first taste of alcohol at 17 or18 years of age",* alcohol was a problem. Following this first experience, the purpose of drinking was always *"to get drunk"*. The participant speculated that, in hindsight, the choice of a medical career may have been influenced by access to drugs. There was however, no definitive answer to this conjecture.

During the interview with participant B, a detailed account of planning suicide was described. A cluster of negative events, outside work precipitated this situation, and, the plan was abandoned before any attempt was carried out. The participant sought professional help, medication, and reduced the number of clinical hours. Although work was not the primary issue, this participant believed that after a considerable number of years practising, it was time to make a change, and pursue other medically related activities as well as clinical work. At the time of the interview, this participant was no longer taking medication, and believed the balance of various work activities was good for mental and physical health.

[14] Due to the nature of disclosures, these two participants have been de-identified.

7.10 Summary

This chapter has identified that contemporary work, and the rise of dual earner households has influenced the ways that people manage and allocate time to their work and non-work/family domains. Participants identified that at times there was tension arising from competing demands of their life domains. How they managed the demands associated with each life domain was influenced by the degree of centrality of work in their lives, and also, whether they integrated their work and non-work domains. Some participants voluntarily and/or involuntarily allowed work activities to cross the boundary into the time and space of personal life. Conversely, other participants clearly segmented their work and non-work domains with impermeable boundaries, and preferred separating work and non-work activities. The more time participants spent in the work domain the less time they spent in the non-work domain, which has implications for their capacity to psychologically detach and adequately recover from work demands.

GPs' life domains are interconnected, with one domain influencing choices and behaviour in the other. Participants' experiences and activities within the general practice work environment influenced their life outside work. Their experiences in other non-work domains appear to influence their adaptation to the general practice work environment because this is when they engage in respite activities that facilitate their psychological detachment from their work. Participants used the variety of ways to achieve "time out" and psychologically detach through respite activities. On a day-to-day basis, participants' strategies included brief respites from work for activities such as time with the family, physical exercise, spectator sport, meditation, religion, journal writing, and hobbies. Longer duration respites comprised several weeks for holidays, usually spaced at intervals throughout the year. During holidays (vacations) GPs in this study engaged in activities they enjoyed and took their mind off work, thus enabling psychological detachment and

improved recovery from the demands of their work. These various strategies seemed important in their adaptation to the demands of general practice.

The following chapter provides a synthesis of the three findings chapters and highlights insights arising from data analysis

CHAPTER 8

SYNTHESIS

This chapter presents a synthesis of the findings and proposes a framework for understanding GP adaptation to general practice. The findings identified GPs' pathways to general practice, demonstrated the different ways that GPs in this study managed their work and non-work/family domains, and pointed to individual and environmental characteristics that influenced their adaptation to life as a GP. Six key elements influencing GPs' adaptation to general practice were identified. These were: (1) the degree of work centrality to GPs, (2) the inclination of GPs towards integration or segmentation of work and non-work/family domains, (3) situational factors in the general practice and non-work/family domains, (4) ability to psychologically detach from GP role (5) choice of respite activity, and (6) adequate recovery from work demands.

An heuristic schema that brings together these six elements and their implications for GP adaptation is presented. The chapter ends with a case study that illustrates some of the main themes that emerged from the interview data and provides an example of how the elements of the adaptation schema may be applied to GPs' choices of respite activity

8.1 Summary of Key Findings

In the first section of the findings chapter, GP participants described their pathways into medicine. Pathways included: (1) high academic ability, (2) cultural and family factors, and (3) internal motivation for medicine, such as, childhood dream, and medicine as a "calling". Clearly some participants may have been influenced by more than one pathway, but GPs only spoke of their core path into medicine. It was important to gain an understanding of the participants' pathways because there may have been a connection

between why they chose medicine as a career, and their subsequent adaptation to general practice work.

Participants believed that general practice provided adequate rewards, and flexible working conditions that allowed them to achieve quality of life that was not possible with other medical specialties. Although participants acknowledged that general practice did not have as high a status and financial remuneration as some other medical specialties, they wanted to work with patients in a holistic way.

The second findings chapter explained how GP participants managed the demands of their work. The multiple roles that GP participants engaged in during a typical work day were identified, and, for some participants, multiple roles were a source of role conflict. For example, the small business requirements of general practice conflicted with their clinical role. Some participants considered the financial rewards they received for their work efforts was balanced, whereas others believed the remuneration was not commensurate with their work efforts. Five of the 26 participants struggled with reconciling the time pressures and patient demands of their work with 'good medicine' and 'good business' Other participants eased the tension between time pressures, provision of quality care, meeting patient expectations and income through prioritising their daily work activities, conducting longer consultations, and co-payment billing.

The third findings chapter described the ways GPs allocated time to work and other life domains. Life domains were interconnected with one domain influencing choices and behaviour in the other; their experiences and activities, within the general practice work environment combined with their work orientation influenced their life outside work.

The following diagram (see Figure 5) provides a simple representation of the findings related to participants' experience of life as a GP.

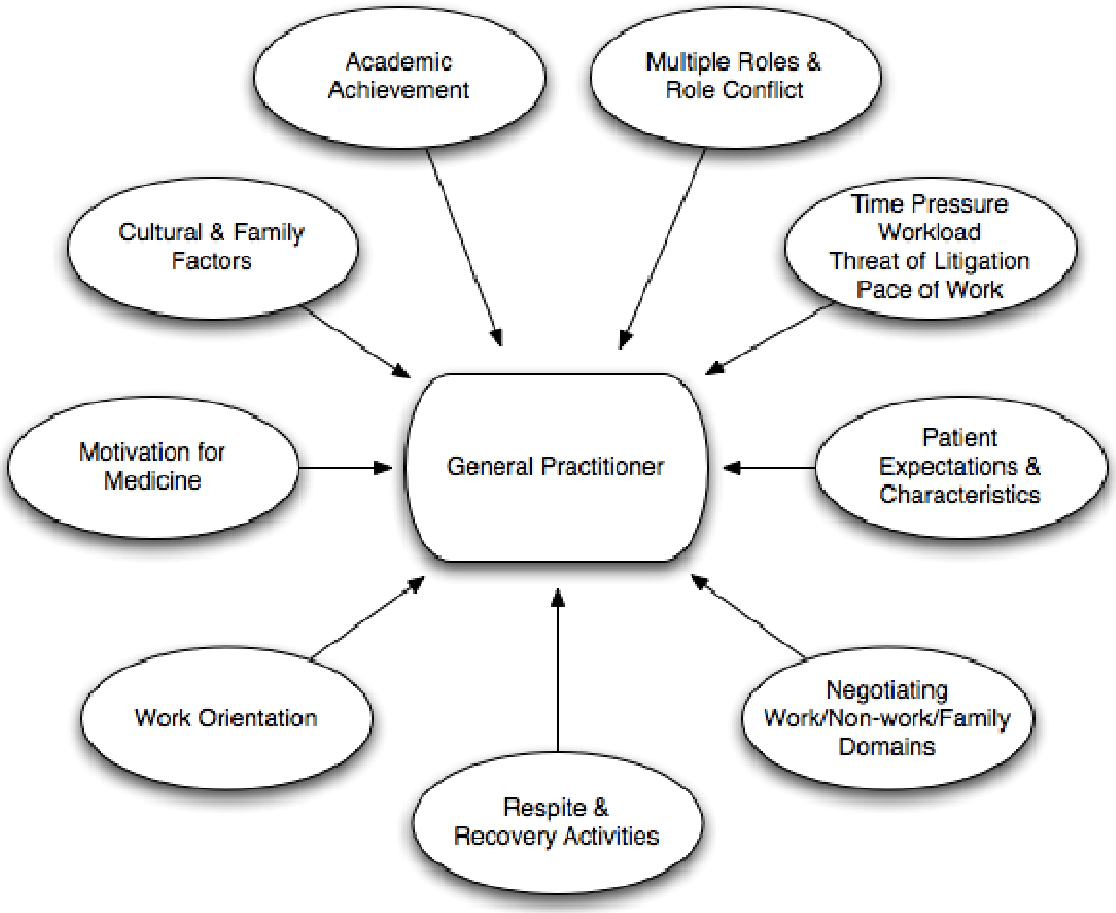

Figure 5. Summary of findings.

8.2 Work Centrality

Work, like other aspects of life, can have varied meanings to different individuals. At one extreme are individuals who regard work as the centre of their life. For these individuals work is very important, and may provide meaning and purpose. At the other extreme there are individuals who regard work as important, but other areas of life are also important. Centrality of work to an individual can be placed on a continuum divided into two sub categories, absolute centrality and relative centrality. In absolute centrality

the individual perceives work as the most important aspect of their life. In relative centrality, the individual can adapt the level of involvement in work according to circumstance or situation, such as during periods of child rearing, or shift in involvement in leisure activity (Harpaz, Claes, Depolo, & Quintello, 1992; MOW International Research Team, 1987). The findings in the current study indicated that participants could be placed on a continuum between absolute and relative work centrality. Furthermore, as the case study of Jeff that follows in section 8.9 illustrates, it is also possible that the degree of work centrality can shift over time.

When work has a high degree of centrality individuals will tend to immerse themselves in work, and spend more time in work roles. Work provides an opportunity to perform activities that provide the strongest affective self investment (Dubin & Goldman 1972). Traditionally medicine has been characterised by a high level of work centrality. The doctor was perceived as inseparable from his or her occupational role, and always supposed to be 'on the job' (Zerubavel, 1979). Medicine was viewed as a vocation or life calling, which implies a commitment to this life domain above all else. The intrinsic and extrinsic rewards gained from being a doctor, that is social status, financial remuneration, and a personal sense of meaning makes it likely that work will be highly regarded and a central interest in one's life.

Although some research (e.g., Lupton, 1997) suggests the status of 'doctor' in society has declined, a doctor is still generally regarded as having high social status, and is a highly regarded professional, which reinforces the meaning and salience of work to the individual. Several over 40 year old participants mentioned they no longer received the same degree of deference from their patients. For example, in the past, patients would not question the diagnosis and or recommended treatment. Participants commented that with information now being readily available on the internet, patients were less inclined to

accept the GPs' recommendation without question, and were more inclined to seek a second opinion. One participant also mentioned that patients would accept mobile phone calls during their consultation. This caused her irritation, and she considered this was an example of how in particular 'educated women' did not show respect. While some participants noticed a change in how patients related to them, the majority of participants still believed their work was important, and that being a doctor was the best job because you could "make a real difference in people's lives" and it was the "next best job to being a priest".

In this study, participants who reported that work occupied a highly central role in their life strongly identified with their work as a GP. They stated their work came first, and put their work before all else, with work taking precedence over other life domains. Conversely, other participants stated that while work was important, other aspects of their lives, such as family and religion, were also important.

Participants whose work was an absolute central life interest spent more time and energy at work, and tended to integrate their work and non-work domains by bringing work into their home. It may be that this tendency for absolute work centrality and bringing work into non-work/family domains is a characteristic of the medical profession that is shifting with the changing work expectations of younger generations of GPs (Tolhurst & Stewart, 2004). In a study of hospital doctors and nurses 23 years ago, Yalof (1988) found that it was not possible for individuals in these job roles to completely leave their patients at work; they always take home in their thoughts, the issues experienced by their patients. In the current study, some participants were successful in their ability to leave work at work because they consciously adopted ways of 'switching off' during their non-work time. However, some participants were better able to segment work from non-

work domains, remaining involved in both work and non-work roles, but maintaining a strong boundary between domains.

The degree of work centrality influenced GP preferences for allocating time to competing roles and life domains, and also appeared to be associated with preferences for integration or segmentation of work. Participants either allowed or restricted work demands to intrude on non-work/family time and circumstances. Participants with absolute work centrality stated their work was an important aspect of their lives; they were happy to accept calls from patients at home and engage in work related activities outside their usual business hours. They also stated they had no intention of retiring. Participants with relative work centrality commented that there was "life outside medicine" and that "time out (from work) was the key" to dealing with the demands of general practice.

8.3 Integration and Segmentation of Work

In this study integrators were defined as individuals who chose to blur the boundaries between their work and non-work/family domains. Segmentors elected to compartmentalise their work and non-work/family domains (Nippert-Eng, 1996a; Nippert-Eng, 1996b). Participants' capacity to achieve psychological detachment was influenced by the perceived centrality of work as a GP, and their preference for integrating work and non-work/family or segmenting work and non-work/family spheres. GPs for whom work was absolutely central, and who chose to integrate their work and non-work/home domains, required engagement in an activity or holiday away from home in order to achieve psychological detachment from their work. This was because they preferred to engage in work related activities, and also, because there was no boundary between work and non-work/family domains. They brought their work home, therefore,

home was not a ‘non-work’ environment. It was important for them to take holidays that were geographically distant from both home and work so that they could psychologically detach from the GP role. For those participants for whom work was relatively central, and who segmented their domains, being involved with family was sufficient to psychologically detach because they placed a secure boundary between domains and did not allow work to intrude on non-work/family time.

The majority of participants appeared to be better able to create boundaries between work and non-work. When asked to comment on how they maintained their health and wellbeing, they reported that it was helpful to close the door and “leave work at work”. Leaving their work at work allowed them to take time out from their work role and to unwind. Conversely, a smaller number of participants appeared to blur work and non-work roles, and they experienced difficulty distancing themselves from work demands. They also had difficulty psychologically detaching from their work role.

With regard to participants’ recovery of resources and overall adaptation to general practice, the segmenting participants were able to regularly take respite for recovery of resources by being away from work and work related activities. On the other hand, the integrating participants required more deliberate time away from both work and non-work/family domains in order to psychologically detach and engage in activities that allowed recovery of resources.

The two case studies presented in the previous chapter illustrated the differences in the way participants managed the integration or segmentation of their work and non-work domains. Summaries of Robert and Kim’s case studies are presented here in order to highlight the differences between participants who integrated, and those participants who segmented their work and non-work/family domains.

8.3.1 Integration of work and non-work/family domains

Robert is a 46 year old male who studied medicine because he "got the marks" He is married to a nurse and has 3 teenage children. He is a principal partner in a suburban group practice and chooses to work 65 hours per week. Robert is an individual who stated that he "loved being a doctor" and integrated work into his non-work/family domains. Robert's work was absolutely a central life interest, consuming most of his awake hours. He regularly took work home, was available to his patients on call at all times, and would forego family activities in preference for work related activities. Robert remarked that he would continue to work even if he did not need the money, and he had no plans to retire. Robert took time out from his core GP work, to work in a related medical area because he found it stimulating. Although he acknowledged that he needed holidays (vacations) for recovery from work demands, he relied on his wife to schedule holidays into his appointment book. Because Robert integrated his work and non-work/family domains, he needed to be away from both these domains in order to switch off from work. He, therefore, took holidays in a geographical location removed from both work and home.

8.3.2 Segmentation of work and non-work/family domains

Kim is a 50 year old who also studied medicine because she "got the marks". She is married to a professional and has 4 teenage children. Kim believed that her father expected her to pursue a career that provided people with care, and this influenced her career choice. She is a principle partner in a suburban group practice, and chooses to work 30 hours a week. Kim was an individual for whom work was a relative central life interest; work was one part of her life, and she considered other life interests such as family were also important. She sought to detach work from other life domains, and used the commute time between work and home as an opportunity to wind down and switch

off from her work role. She did not take work home, and maintained a strong boundary between her work life and home life. Kim considered it vital to take time out for respite and recovery. She believed that compartmentalising her work and non-work/family domains, and taking time out were key elements to her healthy adaptation to working in a highly demanding job and work environment. This explicit delineation between work and non-work/family domains allowed her to recuperate and revitalise her energy levels to face the challenges of her heavy work load. Kim was also aware that by engaging in regular respite and recovery activity she was preventing the accumulation of fatigue and maintaining her health and wellbeing.

There were several similarities between Robert and Kim; both were group practices working in similar geographical areas, and studied medicine because they "got the marks". They were also both married with children, and about the same age. In spite of these similarities, Robert and Kim were very different regarding degree of work centrality and propensity to integrate or segment their work from their other life domains. These individual differences influenced their ability or willingness to psychologically detach from their work; the type, duration, and frequency of respite activity, and their subsequent recovery of resources.

Although their strategies were different, both believed they were successful in their adaptation to general practice. As part of their adaptive strategies they took a proactive stance, and took the initiative to improve aspects of their work they found unacceptable. Both were satisfied with their work, successfully managed job demands, and were able to engage in respite activities that afforded psychological detachment and replenished resources. Clearly, Robert and Kim's perceptions of work-life balance were not based on equal amounts of time and energy allocated to work and life domains. Rather, their

perceptions of balance were based on whether they believed they were able to meet the demands of each domain, and this was a strong contributor to their healthy adaptation.

Tables 4 and 5 below summarise the classification of GPs as either primarily an integrator or segmentor. While an unqualified classification is not possible or desirable, tendencies toward integration and segmentation were associated closely with GPs commentary on the ways they chose to manage the demands of general practice. Seven participants were identified as integrators and thirteen identified as segmentors. It was not possible to classify the remaining six participants, as their interview data did not contain enough information regarding integration or segmentation of work and non-work/family domains.[15]

Participants in this study who were integrators also tended toward absolute work centrality, while segmentors tended toward relative work centrality. This intuitively makes sense, because if work is absolutely central, the individual will choose to engage in work related activities regardless of whether they are at work or at home. Whereas if work is relatively central, the individual will choose to engage in other life interests that are also considered important, for example, family.

[15] When asked about the most demanding aspects of their work, Angela the intern and Alice the GP Registrar identified other issues such as the demands of a medical degree, communicating with hospital staff and patient's relatives, and long hours working in the hospital. They were focussed on obtaining their qualifications and expected to spend their time on medically related activities. They anticipated their concerns would change once they were fully qualified and no longer working in the hospital system. Deborah had recently arrived in Australia and was concerned with settling her family and finding her husband a job. With regard to the demands of general practice, she stated that communicating with fellow workers and patients challenging due to language and cultural differences. At the time of the interview, John was concerned about his advancing age and living alone. Like the other older participant, Matthew, John had enjoyed his career as a rural GP. He identified his main concern in general practice had been difficulties obtaining a locum so he could take a holiday. Russell had recently returned from working as a volunteer overseas. He related the difficulty he had experienced in finding a full-time permanent position at a practice that was philosophically aligned with his beliefs that general practice should have a biopsychosocial focus.

Table 4

Integrator Cross-Participant Summary (n= 8)

Integrator Participant	Allocating Time to Work/Non-Work	Psychological Detachment
Robert: Age 46	Peripheral participation at home. Identified closely with doctor roles & affiliation with medical profession culture & values	Rarely detached from GP work role & other medically related work. Rarely participated in family activities.
Sarah: Age 43	Appreciated status & prestige associated with doctor role, especially in a rural setting.	Rarely detached from GP work role. Participated in non-work activities to gain a sense of self other than "doctor" & detach
Matthew: Age 77	Competence & affiliation with medicine & internalisation of medical culture & values.	Rarely detached from GP work when he was a full time GP. Rarely participated in non-work & family activities.
Lyn: Age 47	Experienced time based inter-role conflict.	Rarely detached from GP work role. Participated in non-work/family roles to take respite from GP role but had difficulty psychologically detaching.
Kate: Age 47	Acknowledge importance of family, but work was priority	Rarely detached from doctor work role and worked long hours due to obstetrics
Mark: Age 58	Peripheral participation at home. Competence & affiliation in medicine and internalisation of medical culture & values.	Rarely detached from GP work role. Participated in religious non-work activities to gain a sense of self other than "doctor".
Dean: Age 54	Peripheral participation at home.	Rarely detached from doctor work role. Participated in physical activities to enable psychological detachment.
Michael: Age 57	Peripheral participation at home.	

Table 5

Segmentor Cross-Participant Summary (n=12)

Segmentor Participant	Allocating Time to Work/Non-Work	Psychological Detachment
Meg: Age 47	Experienced time based inter-role conflict. Allocated more time to the domain with the highest demand at the time (dependent on family & life stages).	Detached from doctor work role, in order to fulfill family commitments and non-work activities. Had difficulty psychologically detaching from work because she was concerned about doing harm to patients.
Luke: Age 36	Identified with both domains, but more time given to work.	Detached from doctor work role to participate in family roles. Had difficulty psychologically detaching from work because he lived and worked in the same geographical location.
David: Age 50	Identified with both domains, but more time given to work.	Detached from doctor work role through daily meditation. Regularly engaged in non-work & family roles.
Natasha: Age 31	Work was relative central life interest Identified with both domains, but family time was priority.	Detached from doctor work role to engage with young child & family.
Elizabeth: Age 47	Identified with both domains, but tried to give time to both domains.	Detached from doctor work role with weekends at family rural holiday home.
Jeff: Age 47	Identified with both domains but tried to give time to both domains.	Detached from doctor work role to engage in non-work family roles and spend time with sons.
Kim: Age 50	Identified with both domains, but family was priority.	Detached from doctor work role during commute time from work. Enjoyed non-work and family roles
Sue: Age 35	Identified with both domains, gave time to both domains.	Detached from doctor work role to engage in non-work roles
Tanya: Age 41	Identified with both domains. Tried to give equal priority to both domains.	Detached from doctor work role to engage in other medically related work roles & non-work family roles
Vicki : Age 50	Identified with both domains. Gave priority to the domain with the highest demand at the time. (dependent on family and life stages)	Detached from doctor work role to engage in non-work and family roles
Jane: Age 48	Identified with both domains. Work was priority.	Detached from doctor work role to engage in non-work roles but also engaged in medically related work.
Jean: Age 61	Gave priority to the domain with the highest demand at the time. (dependent on family and life stages)	Detached from doctor work role to engage in non-work roles

It is, however, feasible these tendencies are dynamic and dependent on individual circumstances as identified by participant Jeff. Prior to having children, Jeff's work was absolutely central; he integrated his work and non-work/family domains. After having children, however, he realised there was more to life than work, and, that his inability to psychologically detach from work resulted in him bringing his work concerns home. He considered this was detrimental to his family, especially his children. Jeff attributed his successful adaptation to general practice to his ability to leave work at work, and believed he had achieved a good balance between work and non-work/family spheres. A case study for Jeff that illustrates this change is presented later in this chapter in section 8.9.

The degree of work centrality and preference for integrating or segmenting work and non-work/ family domains has implications for GPs adaptation because these factors influence GPs choice of respite activity and ability to psychologically detach from work. If a GP is primarily an integrator, he or she will tend to view general practice work as a central life interest. While the need for respite and time out may be acknowledged, the activities in which they engage to attain respite from general practice may be in a medically related area. For example, a GP may do work in a specific area of medicine outside standard GP practice, such as emergency. The risk of positioning as an integrator for adaptation is that they may ignore early warning signs of fatigue, and become involved in the high demand, high effort and high reward treadmill. While they may be engaged in activities that provide psychological detachment from general practice, they may not schedule opportunities for respite activities that enable them to recover their resources. Recovery of resources is important for healthy adaptation because without adequate recovery, the ongoing demands of general practice may ultimately lead to health issues and or premature retirement from the profession.

If a GP is a primarily a segmentor, he or she will more readily psychologically detach from work, and have an understanding that separating work and non-work domains tends to facilitate psychological detachment and subsequent demand recovery. The segmenting GP will place strong boundaries around their work and adopt strategies such as using commute time to psychologically detach from their work, and seek involvement in non-medically related activities in their non-work/family domains.

Segmentors consider that defining and maintaining the boundary around each domain facilitates optimal functioning in all life domains. The risk of positioning as a segmentor for adaptation is they may perceive inter-role conflict as the changing demands of each role create tension about where effort should be focused. However, compartmentalising roles in each domain may prevent loss of resources rather than permit one domain to drain the other. For example, parenting activities may provide respite, psychological detachment and recovery from general practice demands. In this way, separating work and non-work/family domains may serve an adaptive function.

Participants' preferences for integrating or segmenting their work from non-work/family domains combined with their preference for absolute or relative work centrality (see Table 6 below) appeared to influence their choice of respite activity to relieve demands, and their perceptions of work-life balance. This typology represents examples on the integrator-segmentor continuum (Nippert-Eng, 1996a; Nippert-Eng, b) and absolute or relative work centrality, and the potential strengths and threats of this positioning.

Table 6

Integrator-segmentor typology and examples

TYPOLOGY	EXAMPLES	STRENGTHS	THREATS
Integrator Absolute work centrality	Always a doctor, always available (Sarah) Intrusion of work into family life (Matthew) Would continue working if he won the lottery (Robert)	Enjoys work Longevity of work life Low inter-role conflict	Risk to family and other relationships Risk to health if no respite taken for recovery Difficult to psychologically detach from work Difficult to achieve work-life balance
Segmentor Relative work centrality	I love my work but I also love my family (Natasha) I have two personas (Kim) Leave work at work (David)	Easier to maintain work/non-work boundaries Easier to psychologically detach from work May prevent loss of personal resources – energy, health Easier to achieve work-life balance	Risk if living and working in the same geographical location Effort required for transitions between domains because each domain has a separate persona

8.4 Work – Life Balance

Participants did not give equal weight to work and personal life, and they perceived work-life balance as dynamic rather than static. That is, at various times in their lives, their perception of balance changed depending on the circumstances. Rapaport, Bailyn, Fletcher, and Pruitt (2002) questioned the relevance of the term "balance" given that this implies a 50/50 split, when this is not necessarily the case. At the time of the interviews, only four GPs expressed concern regarding their work-life balance, while 16 were

unconcerned about the balance of work and non-work/family domains. GPs' perceptions of work-life balance were not based on equal amounts of time and energy allocated to work and life domains. Rather, their perceptions of balance were based on whether they believed they were able to meet the demands of each domain without expeiencing inter-role conflict.

Changes in the balance of GPs' work and life domains were dependent on circumstances surrounding situational and individual factors. All participants were optimistic they could manage to alter their work-life balance, but were aware that this was at times constrained by their career stage, and or, life stage. For example, building the business or having a young family required devoting more time and energy to the domain where the demand was higher at the time. However, these demands were regarded as temporary, and participants believed that balance could be restored when circumstances changed.

Some female participants identified that, at times during their careers, they had spent more time in their non-work/family spheres so they could be at home to care for young children. Several male and female participants adjusted their work hours in order to spend time with their children. Female participants changed work hours so they could be home with children after school, and males began work later so they could drive children to school the morning. As their children became older and more independent, their time at home decreased and their time at work increased. In other words, they adapted and spent more time in the domain where they perceived the demand was highest at that particular time.

GPs reported there had been times when achieving work-life balance had been a challenge, and they shared the strategies they used to achieve a level of work-life balance

that was acceptable to them. As their circumstances changed, they altered their work schedules and work hours; although they did not tend to reduce the total number of hours they worked. Neither male nor female participants mentioned non-work/family distractions at work, but several participants mentioned work interruptions at home. It could be that office staff handled non-work/family distractions at work. In some instances, office staff act as personal assistants in addition to their medically related work activities.

8.4.1 Job Satisfaction and Work – Life Balance

All but one participant (Lyn) indicated they were satisfied with their work as a GP on a day to day basis. An interpretation of the level of job satisfaction experienced by participants was based on participants' descriptions of their enjoyment of the work content, their expressed feelings of happiness in the GP role, and their views of the derived sense of meaning and contribution they attained from their work. Their sense of job satisfaction contributed to their perception of work-life balance.

Lyn was the only participant who stated that if she were beginning her studies again, she would have chosen to be a teacher because the work hours are more compatible with having a family. Paradoxically, this participant had adopted a number of successful strategies to address these concerns, but she remained dissatisfied with her work. It could be that her degree of work centrality and her preference for integrating her work and non-work/family domains compromised her ability to engage in respite activities that facilitated psychological detachment and recovery of resources. Although she had adapted the way she organised her work hours to fit with her parenting role, she had not been able to change her perception that a 'real' GP was professionally obliged to be continuously available to patients. In this sense she may be overcommitted to her patients.

8.4.2 Life stage and work-life balance

A number of researchers and social commentators have highlighted the differences in attitudes toward work within the current Australian workforce generations. Consistent with Keeton, Fenner, Johnson, and Hayward (2007), the younger participants in this study (under 40 years of age) valued time-off and lifestyle more than the older 'baby boomer' participants who tended to place work first. While older participants acknowledged it would be a good idea for them to work less and spend more time in other non-work activities, they chose to continue with the working style and habits they had formed over their years in practice. This was especially evident for those participants for whom work was an absolute central life interest. These individuals identified with their work and work was central to their self-image. Their work sphere was the most preferred, and they had established affective and behavioural attachment to their jobs and their work environment. Younger participants believed they could learn from the attitudes and behaviour of older GPs and achieve a more balanced approach to their work.

While the new generation of GPs may prioritise other elements of their life over full time work (Tolhurst & Stewart, 2004), there is evidence that individuals can shift an emphasis from one domain to another in response to life circumstances or critical events. Some of the older participants in this study reported that they had revised their working style and habits. They chose to change and adapt as their family circumstances changed. For example, Jeff's preferred life domain had been work prior to becoming a parent. Jeff's sense of self and self-identification with working as a doctor and the medical profession was strong. He considered his work the "be all and end all" in his life. After becoming a parent and as his children had grown, he began to become more involved with his family and identify with his role as parent. Work became a relative central interest and a shared position with his non-work/family interests. Jeff also believed that

over time, he developed clinical knowledge and experience which engendered feelings of ability to make the most appropriate responses to the patient, that is, his sense of competence increased. It is possible that a person's sense of competence significantly moderates the problematic effects of personal and professional life (Bhagat & Allie, 1989).

8.5 Situational Factors

A third influence on GPs choice of respite, and its duration and form, was associated with situational factors within the GP practice as well as factors such as family stage and age of children. The GPs work location, the type of practice and structure, and the content and demands of the work appeared to influence the GPs willingness and ability to take time out and psychologically detach from work.

8.5.1 Practice Location and Structure

The location and structure of the practice may influence the GP's perception of choices about respite. A GP who practises in a rural setting may find it extremely difficult to effectively psychologically detach from the GP role. This type of practice location may be particularly problematic for the GP who prefers to separate non-work/family from the work setting. For this individual, geographical distance between place of work and home facilitates leaving work at work. For a GP who has a preference for integration, geographical distance is irrelevant as they tend to stay accessible to patients, and bring work into their home rather than leave their work at work.

8.5.2 Work Content and Demand

A work role that has chronic high demand in terms of presenting patients places a burden on the GP to respond. While they achieve financial rewards for treating a large number of patients, there is a consequent demand on the availability of time for other

activities. Furthermore, there is increased potential to make mistakes or miss early detection of disease. GPs make a choice to consult more, and earn more, or they put parameters around the number of work hours and patients they will treat in a typical week.

All participants considered that being a GP was a demanding job, and that general practice was a demanding work environment. Sources of chronic high demand included constant high workload and time pressure, complex tasks, patient expectations, and bureaucratic compliance. The work practice issues raised by GPs in this study were consistent with previous research (e.g. Dua, 1996; Dua, 1997; Firth-Cozens, 1999; Shattner & Coman, 1998) that identified these issues as concerns for doctors.

8.5.3 Acute Incidents (mistakes) and Litigation

Participants also identified acute job demands, such as medical errors and the threat of litigation. While the chronic demands participants identified could be conceptualised in the same way for a number of jobs, acute incidents were inclined to be more job-specific. This is the case with errors in medicine. While the incident may be of short duration, and more time-limited than chronic demands, the occurrence of acute incidents in the GP's medical environment and the associated strains last longer (Beehr, Jex, Stacy & Murray, 2000). For example, a medical error can occur in a short time, but as Elizabeth explained, the consequences of the error may last for many years, for both the patient and the doctor. Furthermore, if there is a malpractice litigation suit to follow, this can take many years to be resolved. Doctors often carry the consequences of their clinical judgments with them for long periods of time.

Situational factors may influence GPs' choice of respite activities, ability and willingness to psychologically detach, and subsequent recovery of resources, without

which, their adaptation and perception of work-life balance may be compromised. For example, the GP who works in a rural practice may not be able to obtain a locum at the time they perceive they need to take respite. They therefore may not be able to coordinate the optimal duration, sequence and type of respite activities, thus leaving themselves with depleted resources and perceived work-life imbalance. Another example is the suburban GP who is on the high demand, high effort, and high financial reward treadmill. They may be privately educating several children, and their lifestyle is such that they perceive they must keep working rather than engage in respite activities and psychologically detach from their GP role. Consequently they have insufficient recovery from work demands and perceive a work-life imbalance. Individual participants identified the type, duration and sequence of respite activities that facilitated their psychological detachment, and were sufficient for recovery of resources from work demands. GPs with the ability to psychologically detach and have adequate recovery from work demands adapted to the challenges of general practice and perceived they had work-life balance.

8.6 Recovery of Resources

As identified in the current study (and other studies e.g., Firth-Cozens, 1999; Makin, Rout, & Cooper, 1988; Sutherland & Cooper, 1992; 1993), general practice is a high demand occupation. GPs generally work long hours and have a chronically high workload where patients present with complex and diverse health needs. All participants acknowledged that taking time out from work was important in maintaining their psychological and physical wellbeing. They incorporated a number of different respite activities to assist them in detaching from their GP work, but some reported more success than others in their ability to psychologically detach from work. Participants' ability to psychologically detach from work routines and refrain from ruminating or thinking about

work related issues depended on whether they preferred to integrate or segment their work and non-work/family domains.

Recovery is a process whereby an individual's functioning returns to an acceptable level after expending effort responding to the demands of work. This is achieved because the effort and strain associated with work demands are eliminated or at least improved (Meijman & Mulder, 1998; Sonnentag & Natter, 2004). Recovery is assessed as being successful when wellbeing improves, and resources used during demanding work are re-established and performance at work restored to optimal functioning (Sonnentag & Natter, 2004). In this study, GPs who successfully recovered from the demands of general practice through psychological detachment and respite activities believed this was key to their adaptation and perceived work-life balance.

According to Hobfoll (1989) resources are considered to be personal characteristics (e.g., self-esteem), energies (e.g., time, money, and knowledge), conditions (e.g., job status), and objects (e.g., house) that are directly or indirectly valued for survival, or are a way of attaining these resources. If an individual's resources are lost or threatened, or when resources are not replenished after they have been spent, he or she may be negatively affected (Sonnentag & Natter, 2004)

Resources can be renewed through a variety of respite activities (Etzion, Eden, & Lapidot, 1998; Spickard, Gabbe, & Christensen, 2001). Participants in this study identified that even short breaks could provide respite and opportunities for psychological detachment from work demands. All participants in this study took regular holidays (vacations) away from work for respite and recovery of resources. However, the degree to which they were able to psychologically detach from their GP work differed. Ability to

psychologically detach is particularly important for those in high demand occupations (Sonnentag & Bayer, 2005; Sonnentag & Kruel, 2006).

8.7 Respite and Psychological Detachment

Long work hours increase the need for recovery after work (Sluiter, Van der Beek, & Frings-Dresen, 1999). The majority of GPs in this study perceived they worked long hours with an ongoing heavy workload. Although research has identified that high workload inhibits psychological detachment (Sonnentag & Bayer, 2005), most participants had found respite activities that could counteract the negative influence of high workload on their ability to detach. The respite activities they found conducive to recovery were sometimes simply rest or a change of activity. For example, physical activity such as running, yoga, swimming, meditation, and holidays (vacations); household activities, especially caring for children were helpful for recovery from the daily demands of work (Rook & Ziljstra, 2006). The most salient factor facilitating participants' psychological detachment was their engagement in activities that were conceptually different from their daily GP work tasks.

8.7.1 Type of Respite Activities and Recovery

Time spent engaged in physical activities, has been shown to increase recovery levels (Rook & Ziljstra, 2006). The majority of participants in the current study engaged in physical activity because they considered this assisted recovery from work demands. All participants recognised the importance of physical activity for their physical and mental health, and many used this form of respite activity to facilitate psychological detachment. However, the type, duration and intensity varied considerably, depending upon the individual GPs attitude toward exercise and the amount of time they chose to allocate to

physical activity (e.g., walking, swimming, yoga, running, tennis, cycling), or, other leisure activities (e.g., music), and individual preferences and characteristics.

Participants did not always find it necessary to engage in leisure type of activities in order to take respite from work demands. For example, Robert worked in an emergency department of a hospital one day per month and found this provided respite from his GP role. In the emergency department, Robert was able to utilise the medical skills he had learned during medical training that he no longer used as a GP. He perceived this work as a positive experience that strengthened his feelings of competence, and gave him the opportunity to 'get away' from the daily demands of general practice. Although the emergency department may be considered a stressful environment, there was opportunity for Robert to experience a change of work context that provided 'time out' from his usual work duties. It is possible Robert's change of work context is comparable to the Etzion et al. (1994) study regarding recovery of resources through military service. Although clearly not leisure activities, active military service and the emergency department provided opportunities to be geographically removed from the usual workplace and engage in activities outside their 'usual' work activities. This change of work context may assist psychological detachment and respite effect, that is, recovery of resources.

8.7.2 Type of Respite Activity and Psychological Detachment

Participants used a variety of respite activities with differing duration and frequency. The type, duration, and frequency of respites also changed dependent on the level of demands at the time. Short respites comprised regular physical activity, meditation, massage, and hobbies were combined with longer respites in the form of holidays (vacations), usually in two week periods three times a year. Participants considered that the type of respite was important because the respite activity had to facilitate

psychological detachment. For some participants in particular, simply being physically away from the practice did not necessarily mean they were leaving their 'work at work', they required activities that distracted them thinking about work. The majority of participants worked for at least part of the day on Saturday and or Sunday; this precluded their use of the traditional two-day weekend respite whereby a significant amount of recovery occurs. The positive effects of a two-day period of time off from work without the pressures of work being present allow people to recover from work demands (Strauss-Blasche, Reithofer, Schobersberger, Ekmekcioglu, & Marktl 2005). This level of recovery does not seem possible during the working week. However, several participants in this study took a day off during the week, and reported finding this extremely beneficial in terms of psychological detachment and recovery from their daily GP work demands. This was consistent with the findings of Strauss-Blasche, Reithofer, Schobersberger, Ekmekcioglu, and Marktl (2005) who found that short breaks could facilitate recovery.

There may not be an 'optimal' respite length, because it may be that people require individually tailored respites or combination of respites to derive maximum relief and recovery. Although all participants acknowledged the importance of taking holidays, short breaks more regularly may be an additional benefit for GPs. As Westman and Eden (1997) identified, the relief from job stress and burnout provided by a holiday respite gradually faded. It may, therefore, be important for GPs to engage in brief respites on a regular basis in order to reduce the fade-out that occurs following return to work after taking a holiday (vacation).

Most participants' perceived constraints associated with time pressure and workload that prevented them from engaging in informal activity, in the form of brief respites, during the day for lunch or a coffee break (or even taking the time to go to the bathroom). These constraints appeared, to a large extent, to be self-imposed. Rather than insisting

that office staff allowed time in their schedule for a lunch break or short breaks during the work day, they allowed these opportunities for brief respites to be filled with extra patients, phone calls, and paperwork. All participants, whether employers or employees, had the decision latitude to control and regulate their work pace; but despite their high level of professional autonomy, some participants did not perceive they had control over their workload and work flow, and, were not taking the opportunity to engage in brief respites during the day.

The sections above have identified that degree of work centrality, preference for integrating or segmenting work, and non-work/family domains, and general practice situational factors influence individual GP participants choice of respite activity and ability to psychologically detach. The link between these factors and whether or not participants obtained sufficient recovery to facilitate adaptation and perceived work-life balance was also identified.

8.8 GP Adaptation Schema

The heuristic schema displayed in Figure 4 below was generated from interview data findings and informed by the occupational stress literature (e.g. Karasek, 1979; Meijman & Mulder, 1998; Siegrist, 1998). The schema demonstrates the multifaceted nature of GP adaptation to general practice. While it is difficult to isolate any of these factors as a singular explanation of a GPs adaptation, it may be useful to consider how, in combination, these elements influence adaptation to general practice and life as a GP.

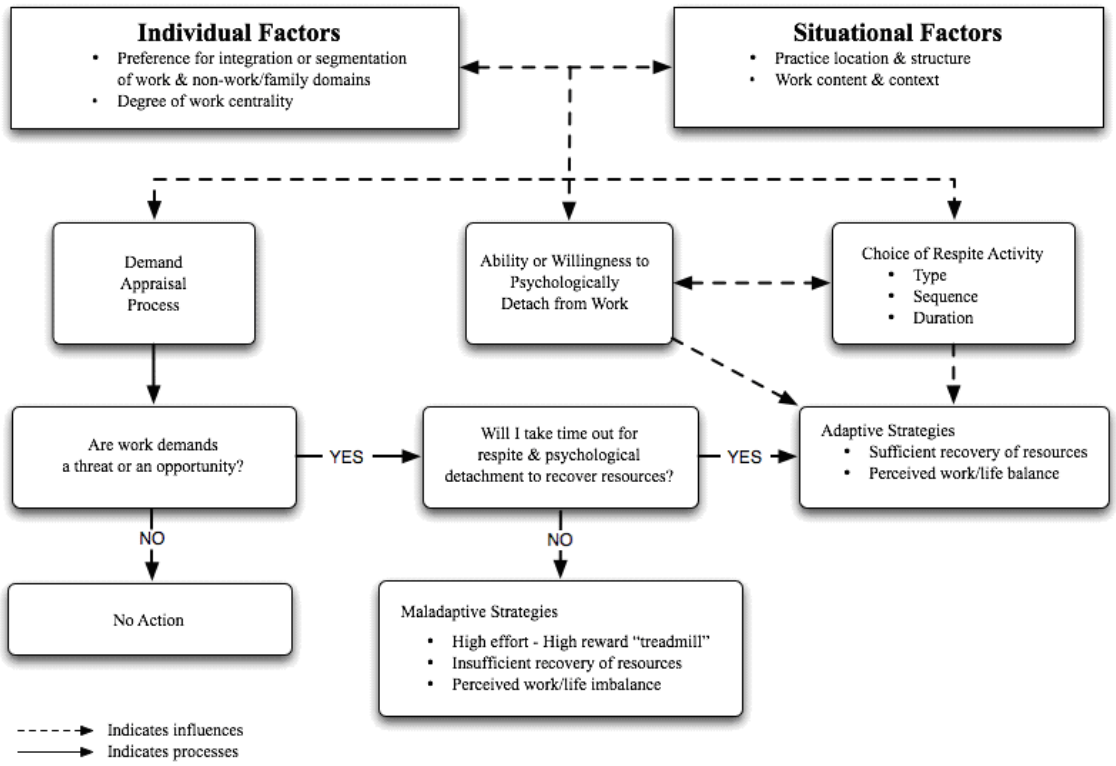

Figure 6. GP Adaptation Heuristic Schema

The diagram should be read from the top to the bottom. At the top of the diagram there are two elements that include individual and situational factors. Individual factors include preference for integration and segmentation of work and absolute or relative work centrality. Situational factors include work content and context, and practice structure and location. These two elements influence how the GP appraises or processes demands from their work environment. The demands that already have coping efforts working effectively require no further attention, nor do demands that are appraised as immaterial.

If demands are appraised as being a threat or a loss, and respite activity and psychological detachment is required, it is proposed that ability or willingness to psychologically detach influence the sequence, duration and type of respite activities that GPs choose, and their ability to psychologically detach from the work role.

Psychological detachment facilitates recovery from work demands, and sufficient recovery contributes to GPs healthy adaptation and perceived work-life balance. For example, a GP with a preference for segmenting work and non-work/family domains and relative work centrality will compartmentalise work and non-work/family domains with strong boundaries around each domain, and seek respite activities that are unrelated to work. Conversely, if a GP has a preference for integrating their work and non-work/family domains, and work is an absolute central life interest, he or she may select respite activities that allow them to remain engaged in medically related work; but this type of respite may or may not be sufficient for them to achieve psychological detachment and subsequent recovery from work demands. They may find themselves on the high demand, high effort, and high reward "treadmill" with little time to engage in non-work respite activities, thus reducing their chances for sufficient recovery. If the GP has insufficient recovery from the demands of the work, this may result in poor adaptation, vital exhaustion, (excessive fatigue, lack of energy, demoralisation, increased irritability) (Appels, 1990; 1997), and at the extreme burnout. On the other hand, sufficient recovery through psychological detachment and respite activities that are pertinent to an individual GPs needs may result in adaptation and perceived work-life balance.

Situational factors may also come into play in selection of respite activity. For example, a solo GP may find it challenging to arrange respite activities of optimal type, duration, and sequence that facilitate their psychological detachment from their GP role. It may be difficult for these individuals because high work demands and problems obtaining a locum may make it difficult to take holidays (respite activity) that are of optimal sequence, duration and type for adequate respite and sufficient recovery from work demands to occur. Furthermore, working and living in the same geographical

location, (especially small rural towns), may inhibit their ability to psychologically detach because adopting another social role in their community may be difficult. Therefore, living and working in the same geographical location is likely to be more problematic for the GP who prefers segmenting work and non-work/family domains than for the GP who prefers integrating work and non-work/family.

It has been argued that GPs' adaptation is influenced by their capacity to choose respite activities that enable them to take "time out" and psychologically detach from the role of GP; psychological detachment and respite activities facilitates recovery from the demands of general practice. GPs who are able to sufficiently recover from the demands of their work are likely to adapt and perceive work-life balance. The following case study illustrates how the schema can be applied to one GP in this study.

8.9 Case Study: Jeff

Jeff was happy with his life and "wouldn't change anything". At 47 years of age, he considered his physical health was good; he was fit enough to kick the football with his children. He planned to reduce his work hours after 55 years of age, but had no plans to retire.

Jeff had practised at the same surgery in a lower socio-economic suburb for 17 years. The first six years he worked as an employee, and since then as a practice partner. He liked the suburb where he practised, and after 17 years had formed meaningful attachments to his patients. He was married to a nurse who worked part time, and they had three dependent (under 18 years) sons. They lived in an affluent bayside suburb situated about 30 minutes drive from the practice.

For as long as he could remember Jeff wanted to be a GP, and as a child enjoyed reading about medical topics. His childhood wish became a reality, and his perceptions of

the role of a GP were informed by the GP who attended him and his family when he was growing up. He said:

> *…the doctor I attended was someone who had looked after my parents and looked after my grandparents and was very involved with family, visited my great grandmother who was being nursed at home in those days and so it was someone I knew pretty well. I think he left a major impression. He seemed to be very involved; he always seemed to be there. He was someone you could always depend on.*

It was not, however, until he was in his third year of medical training that he gained an informed understanding of what his life would be like as a practising GP. Jeff commented:

> *Until 3rd year we had no contact at all with GPs or any concept of what being a general practitioner involved and I remember going across to the newly opened Faculty of General Practice and the first thing they said was 50% of people you see will have nothing (physically) wrong with them. I was floored but I remember that vividly, it was one of those things that I remember and I've never forgotten and I obviously didn't believe at the time but I've come to realise it was probably an underestimate.*

Jeff enjoyed being connected to his patients and found this aspect of his work rewarding. He liked to have a "feel for what they (patients) and their entire family unit are doing in their lives". However, Jeff found the demands of "heart sink"[16] patients were especially challenging and unrewarding, because he felt less capable of affecting change, and making a difference for these patients.

8.9.1 Work Concerns

Jeff appraised the biggest work concern as the threat of litigation. He declared he had "a phobia of being sued or having a problem that would lead to ending up to court". Like some other participants, Jeff believed litigation was something he could not control, and

[16] The term "heart sink" refers to patients who present frequently and consequently make the doctor's heart sink. Essentially they are those patients who leave doctors with negative feelings (anger, frustration, inadequacy) on completion of the consultation.

had little to do with his professional abilities and behaviour. Although Jeff loved reading, he had stopped reading medical papers and magazines because it was beginning to negatively affect his psychological health and escalate his fear of litigation. He explained:

> *I was just becoming depressed and confused after reading them, you'd read about these stories where doctors who had done exactly the same thing that I'd done a hundred times were being sued or ended up in court over something I couldn't see a problem with. I try to consciously not over investigate, but sometimes you just feel you can't avoid it, you've got a patient who is just so persistent about his problem as a problem, your gut instinct tells you there is no problem, I've done everything I need to do to exclude anything. So you send them off for another blood test or a CAT scan or something.*

Jeff's professional competence helped him to manage his fear of litigation, but he was unable to completely control the fear. He was conscious of the potential to over investigate in response, particularly in patients who were persistent. Jeff resented the influence of the threat of litigation, and the negative effect it had on his enjoyment of work.

8.9.2 Work Orientation: Relative Centrality of Work

Jeff came to the realisation that his work and non-work domains were both important. For Jeff, fatherhood was a transforming event in his life. Prior to parenthood his identity and sense of self-worth were strongly linked to his work as a GP. He explained:

> *Over the years I've changed my expectations of work. There was a time when, work was the be all, it was much more important than it is now. I felt like it gave me all my worth to be a doctor and that was my purpose in life. Since I've had kids, I have 3 young children and I think it's really changed my view of what I can and can't do. I'm much better at leaving work at work now and going home and my life outside of work is quite separate and I try and keep things very separate.*

Jeff acknowledged that prior to having children he had expected his wife (a nurse) to accept his behaviour and listen to him "carry on and complain and tear my hair out", but he believed that it was not acceptable for his children to have to deal with this behaviour.

Parenthood provided the impetus for Jeff to reflect on how his attitude toward his work was influencing his family, especially his children. He was not sure if there was a critical incident or defining moment about realising how the work concerns he was taking home was negatively spilling over into his family life; but attributed his change in behaviour to personal and professional maturity. Jeff considered that awareness and realisation that *"you're not God, and you can't change the world"* helped him adapt and psychologically detach so he could "leave work behind".

8.9.3 Managing Work and Non-Work Domains

Jeff spent a considerable amount of time and energy (76 hours per week) on work related activities, he enjoyed being with his family, and was emotionally connected and involved in his children's lives. He did not consider his family interfered with his work. Jeff enjoyed being connected to his patients and the people he worked with, but he also liked to get away from work and keep his work and home domains separate.

> *I think it helps not to live and work in the same suburb very, very much. I live on the other side of town so I'm well away and I tend not to see patients socially or in the street or crossing paths with them too often and I think that does help. I think it would be very difficult if you were living close by or particularly if you were actually living in the surgery that would be very difficult. I think that separation of the distance makes it easier, plus it's 30 minutes or 40 minutes to get home, so you walk out the door here, you wind down, you drive home and by the time I get home I've switched off.*
>
> *I think the ability to switch of is just experience. I don't know if you can teach people how to do that, I think it's just taken me a long time to realise how important that is and that has made a difference. I feel a lot more relaxed in my off time now.*

Jeff had developed a strategy that enabled him to leave his work at work and not take home 'baggage'. Jeff managed his work non-work domains by using time travelling from work to make the physical and mental transition between domains. He "switched off" his

work by the time he arrived home, and therefore did not experience negative spill over from work to his home.

8.9.4 Respite Activities: Facilitating Psychological Detachment

In order to manage work challenges, Jeff was involved in a number of non-work related activities that helped him detach from work. These respite activities reinforced his overarching and most important strategy for adaptation; keeping his work and non-work/family domains separate enabled him to psychologically detach from his work role.

> *I've got my friends outside medicine who I prefer to mix with, I've got my family I love to spend time with, I've got things that I'd like to do by myself. I'd rather sit home a read a book or watch a movie on TV, than go to a drug launch especially at night.*

With length of time in practice and associated professional maturity, Jeff changed from perceiving work as an absolute central life interest, to perceiving work as a relative central life interest. After becoming a parent he recognised that he could no longer bring his work home, and he consciously decided to keep his work and non-work/family domains separate. Unlike other GP participants, Jeff made no references to time scarcity, workload, time pressure, punctuality, or time and money. Jeff did not believe GPs received inadequate incomes, but "wouldn't say that in front of any of my colleagues".

8.10 Summary and Conclusions

This chapter has presented an heuristic schema that brings together six elements and their implications for GP adaptation to general practice. The six key elements were: (1) the degree of work centrality to GPs, (2) the inclination of GPs towards integration or segmentation of work and non-work/family domains, (3) situational factors in the general practice and non-work/family domains, (4) ability to psychologically detach from GP role (5) choice of respite activity, and (6) adequate recovery from work demands.

The individual factors of preference for integration or segmentation of work and non-work/family domains; absolute or relative centrality of work, and situational factors such as practice location and structure, work content and demand, interact to influence individual GPs choice of respite activity and ability to psychologically detach from their GP role. Adequate respite activity (sequence, duration, and type) facilitates sufficient recovery from work demands and this influences perceived work-life balance and adaptation. Alternatively the GP may choose the high demand, high effort, and high reward treadmill and find they have inadequate respite activity and psychological detachment from their GP role. This may result in insufficient recovery from work demands, and thus perceived work-life imbalance and maladaption.

All participants considered that general practice was a demanding work environment. However, degree of concern about the work environment and the responses to these work demands were highly individual. Participants chose a variety of ways to adapt and achieve perceived work-life balance that was appropriate for them as individuals.

Clearly individual GP participants recognised the need to "tailor" their respite activities depending on their particular circumstances. Personalising respite activities also facilitated their psychological detachment from their GP role and replenished their resources. This was a preventative measure that enabled them to sustain the work effort required without becoming overwhelmed, experiencing deleterious health issues, or succumbing to maladaptive strategies to deal with their work demands.

The chapter concluded with a case study that illustrated some of the main themes that emerged from the interview data, and also provided an example of how the elements of the adaptation schema applied to this particular GP participant's choice of respite activity, perceived work-life balance and adaptation to general practice.

There are many factors that contribute to GPs adaptation to general practice; each individual is confronted with circumstances that can contribute to how they adapt. It is too simplistic to attribute GPs adaptation to work demands or situational factors alone. It is similarly inadequate to attribute their adaptation to individual factors only. Both work characteristics and individual characteristics are contributors to GPs' adaptation to general practice. An awareness of the dynamic interplay of these situational and individual factors is important in understanding the different ways that GPs manage and adapt to the demands of general practice and life as a GP.

CHAPTER 9

DISCUSSION

Research conducted over the past two decades into doctors' functioning has emphasised impairment, substance misuse (Caplan, 1994; Firth-Cozens, 1999; Miller & McGowen, 2000; Schattner, Davidson, & Serry, 2004; Vaillant, Sobawale & McArthur, 1972), suicide (Hawton, Clements, Simkin & Malberg, 2000; Hawton, Clements, Sakarovitch, Simkim, & Deeks, 2006; Lindeman, Laara, Hakko, & Lonnqvist, 1996; Schernhammer & Colditz, 2004), depression, alcohol abuse, (Firth-Cozens, 1999; Schattner, Davidson, & Serry, 2004), substance abuse and burnout (Caplan, 1994; Miller & McGowen, 2000; Sutherland & Cooper, 1992) and marital problems (Harari, 1998). It is also acknowledged doctors make difficult patients who are reluctant to seek medical advice from others (Gerber, 1983; Schattner, 1999).

GPs have a central role in community health care; it is important to understand what facilitates their optimal functioning. The emphasis of this study was to identify the factors that influence GPs' adaptation while working in general practice, and explore and detail the adaptive strategies GPs adopted in daily life while working in a demanding occupation.

While the nature and rates of GPs in distress has been well researched, there is little information about the adaptive strategies used by GPs who are successfully managing their work and non-work domains. The study, therefore, addressed three central questions: (1) What are the pathways to a medical career and general practice specialty? (2) What are the work and role demands that GPs experience? and (3) How do GPs adapt to working as in a small business general practice environment and their life as a GP?

9.1 Pathways to a Medical Career and General Practice

Three core pathways to a medical career ad general practice specialty were identified by participants. These were: (1) high academic ability, (2) cultural and family factors, and (3) internal motivation for medicine such as childhood dream, and medicine as a "calling". Asking participants about their career choices as a 'grand tour' question (Spradley, 1979) provided participants with a non-threatening entree into the interview, and an atmosphere that encouraged participants to share their experiences and concerns about working in general practice and life as a GP.

While questions about participants' pathways into medicine were sought to provide background information for the study, there was also an informal hypothesis that pathway to a medical career may influence participants' subsequent adaptation to the high demands of general practice. The researcher considered there could have been a link between the reasons participants chose a medical career and their adaptation to their chosen career. Specifically, that participants who were aware of the reality of working in general practice through having a parent who was a GP would know what to expect and, therefore, adapt well. Conversely, those who chose a medical career because they were academically capable of meeting the demands of a medical degree, but little understanding of the practise of medicine, may have found the demands of general practice greater than anticipated. On analysis of the findings, this conceptualisation is simplistic. The selection of career pathway into medicine intersects with a range of other factors, and experiences of working in general practice that may serve to either reinforce or negate this original motivation.

The researcher expected there would be more participants who selected medicine as a career because they perceived medicine as a calling, rather than a job, due to the high

demands of the profession. Participants shared that they believed being a doctor was a job with potential to make a difference in people's lives. In this sense, perhaps, medicine becomes a calling when the original reason for choosing medicine was of social expectation from parents and teachers that medicine was an appropriate profession for those with high academic ability. While the Hyppolh et al., (1998) study of career choice in Finnish doctors found that doctors who identified success at school as an important reason for choosing medicine were more likely to consider another profession if they were beginning their studies again, this was not evident amongst the participants in the current study.

If participants believed they had a calling, they may be more likely to adapt to work demands, but it may work in reverse if they become overly involved with their patients to the detriment to their ability to psychologically detach from their work role. Having this much investment in work may mitigate perceived work-life balance.

It could be that during their medical training students become socialised into a professional culture that generates an expectation they will remain stoic under considerable pressure derived from patient expectations, threat of litigation, and making life and death decisions.

9.2 Situational Factors: Features of General Practice or General Practice Demands

A considerable body of research has identified the features of general practice that are demanding for GPs. Common demands and issues identified by participants in this study, were consistent with previous research, such as time pressure, pace of work, workload, patient characteristics and presentations, perceived threat of litigation, and work interfering with non-work activities (Arnetz, 2001; Charles, Wilbert, & Franke 1985;

Firth-Cozens, 1999; Nocera & Khursandi, 1998; Rout, 1996; Schattner & Coman 1998). The current research contributes to the existing research regarding demands for GPs because it provides linkages between the concerns rather than identifying disconnected issues and problems. For example, patient characteristics and unscheduled complex presentations can require the GP to increase their pace of work; this creates additional pressure to perform, and an increased possibility of missing an early diagnosis. The concern about pace of work and possibility of missing an early diagnosis then exacerbates the GPs' perceived threat of litigation.

Participants identified demands that mainly revolved around time pressure and pace of work that resulted in them perceiving their workload as being chronically excessive. However, issues that were considered demanding for one GP were just as easily appraised as a source of satisfaction for another. This study, therefore, further contributed to existing research by not only identifying linkages between demands, but also identifying qualitative differences in perceptions of work demands. Although participants agreed on the types of demands, how they experienced demands, and their coping efforts in response to these demands varied. For example, workload was appraised by some participants as a constant challenge that required juggling patient demands with time pressure to remain punctual. On the other hand, some participants viewed heavy workload as an opportunity to generate income because more patient consultations equated to a higher income. This is consistent with the Folkman and Lazarus (1984a; 1984b) model of stress and appraisal; some participants appraised the situation as a challenge, while others appraised the same situation as a threat or loss.

In addition, participants identified that it was important not to acquiesce to the expectations and demands of patients, but rather take control of their work schedules, work hours, and pace of work. Most participants took control of these timing issues and

worked in a way that was congruent with their beliefs, values, and other non-work role demands. For example, one participant (Lyn) believed “the autonomy is there if you have the courage to take it”. She adjusted her surgery hours so that she could be at home with her children after school, and when her husband came home from work, she returned to the surgery for two hours of consulting. Friends and colleagues advised her that her patients “wouldn’t stand for it”, but this strategy proved to be acceptable to her patients, and also allowed her to be with her children when they returned from school.

Although Lyn enjoyed the autonomy of being a self-employed GP, she perceived an effort reward imbalance. As the amended ERI model (Siegrist, 1999) indicates, it is not only the extrinsic demands such as pace and volume of work; effort - reward imbalance is also connected to workers’ intrinsic effort or over commitment (OC), and tendency to be an integrator. It could be that the effort - reward imbalance that Lyn perceived was more to do with her conscientious attitude toward her patients care.

All but one participant stated they enjoyed the clinical aspects of their work, but not all participants who were practice principals or partners, found running a small business satisfying. Only one participant stated she was entrepreneurial and found the business of general practice rewarding. Those participants who were employees did not have the added pressure of running a business, but they were cognisant their employers expected them to generate sufficient fees to cover their salary and contribute to the overheads of operating the business. All participants complained that meeting bureaucratic ‘red tape’ requirements interfered with the real work of being a doctor. This is consistent with Sexton (2005) who proposed that when people spend more time doing the primary tasks associated with their work, in this instance clinical practice, rather than secondary tasks such as running a small business, they feel more satisfied and engaged regardless of whether their jobs are demanding and complex. This is not, however, a simple linear

relationship as there remains a tension between providing quality clinical care and running a profitable business.

Participants did not mention the content of their work, except in the circumstances of missing an early diagnosis and the threat of litigation, and *heart sink* patients. Yet, the content of their work is demanding because they are dealing with illness, and making decisions that could mean pain and suffering, life or death for their patients. A review of the findings highlights three possible explanations as to why participants did not express particular concern about the content of their work. First, it may be that participants did not consider the researcher was knowledgeable about aspects of medical care, and, therefore, chose not to explore these dimensions in the interview. Second, participants were unlikely to reveal they had any professional vulnerability in relation to their ability as a clinician. Third, as stated by several participants, over the years they had been practising, they became more confident in their professional ability, and did not perceive the need to discuss content issues. Overall, the participants emphasized the process of general practice rather than the content.

9.3. Practice Location and Structure

In addition to pressures in the workplace, the perceived demands of the general practice environment were also influenced by structure and location of the practice. For example, as identified by Dua (1996; 1997) rural participants in this study reported added pressures such as, increased after-hours work, poor access to professional development, and difficulty in finding a locum.

Practice structure, whether suburban or rural, was also identified as an influence on choice of respite activity. Working in a group practice gave participants more flexibility to schedule respite activities because co-workers can see their patients while they are

away from work. Whereas, solo participants working in suburban practices can experience difficulty in finding a suitable locum to work for them while they take holidays. If a locum is not available, the preferred duration, sequence, and type of respite activity for an individual GP could be compromised. Rural and solo GPs tended to engage in regular brief respite activities such as physical activity, and take a longer break once a year; however this was not necessarily their preferred option. The choices available to their group practice suburban counterparts regarding the type, duration, and sequence of their respite activities were greater. Suburban group practice GPs tended to take three two week breaks per year, and believed this timing was optimal because they could take time out in the form of longer breaks from general practice more frequently, and, still be able to enjoy brief respites if they chose. In order for participants to freely choose to take time away from work they acknowledged it was necessary to come to the realisation that being unavailable to patients at times was not a failure to fulfil their GP role, but rather a necessity so they could recover the resources needed to meet patient expectations, and sustain their enthusiasm for general practice.

Another issue identified by rural GPs was the challenge to switch off or psychologically detach from their doctor role because when living and working in the same geographical location, it was difficult to place boundaries around work and non-work/family domains. This was particularly problematic for participants who preferred to segment their life domains, but not so for integrators who were happy to blur the boundaries between work and non-work/family spheres.

9.4 Adapting to General Practice and Life as a GP

For many years now, the literature has depicted GPs as an unhappy and dissatisfied group of professionals, and implied that these characteristics affect doctors' psychological

health. Doctors have been portrayed with a number of personal inadequacies, and emotional problems, that suggest some medical practitioners experience higher rates of suicide, especially among women doctors (Hawton, Clements, Sakarovitch, Simkim, & Deeks, 2006; Lindeman, Laara, Hakko, & Lonnqvist, 1996; Schernhammer & Colditz, 2004), depression, alcohol abuse, (Firth-Cozens, 1999; Schattner, Davidson, & Serry, 2004), substance abuse and burnout (Caplan, 1994; Miller, & McGowen, 2000; Sutherland & Cooper, 1992; Vaillant, Sobowale, & McArthur, 1972) and marital problems (Harari, 1998).

These pessimistic conclusions have been challenged with methodologically sound studies, across a variety of cultural settings, that have identified doctors as being generally satisfied with their job and life (e.g., McGlone & Chenoweth 2001; Nylenna, Gulbrandsen, Forde, & Aasland; 2005), and, who have no more trouble with marriage and family that non-medical professional marriages (Harari, 1998). The findings in these studies are consistent with the findings in the current study.

In this study, adaptation was defined as a generic term for processes influencing how well the person routinely deals with the demands or requirements of living (Lazarus & Folkman 1984a). Participants' adaptation was determined by their assertions they were satisfied with their career choice, and successfully managed job demands; were able to engage in respite activities that afforded psychological detachment and replenished resources, and perceived work-life balance.

Adaptation cannot be construed as a stable property in the medical profession, rather a balance between individual GPs shifting expectations, and a changing healthcare environment (Murray, Montgomery, Chang, Rogers, Inul, & Safran, 2001). Indeed, participants identified there had been challenging times during their career that required

changes to the ways they carried out their job and family responsibilities. They made changes that enabled them to successfully meet the day to day challenges of general practice by implementing coping strategies that included: controlling the number of hours they worked, their workload, and their remuneration. They enjoyed effective relationships with patients and colleagues, and this contributed to their overall satisfaction with general practice.

Although the social position of some individual GP participants may have changed, (Lupton, 1997) and, their authority questioned and autonomy threatened, this was a source of irritation rather than a perceived stressor, and did not appear to influence their overall adaptation.

Participants in the current study were generally satisfied with their job and life; none of the risks identified in previous research were apparent at the time of the interviews. These findings may, however, have been influenced by the methodology used, and this is discussed later in section 9.10.

9.5 Perceived Work/Life Balance

Work and family represent two of the most fundamental domains of adult life, and the desire to achieve perceived work/life balance was reflected in the interview data. GPs' perceptions of work-life balance were not based on equal amounts of time and energy allocated to work and non-work/family domains. A noteworthy feature of participants' perceived work/life balance was that long working hours did not necessarily equate to a perceived work/life imbalance, and participants did not necessarily find working long hours exhausting. Rather, their perceptions of balance were based on whether they believed they were able to meet the demands of each domain. Participants also acknowledged the dynamic nature of perceived work-life balance. At different life stages,

such as rearing young children or building a practice, it was difficult to achieve balance; however, participants tolerated the tension associated with perceived imbalance because they were confident that as their circumstances changed with time, they would be able to regain perceived work/life balance.

In this study, several participants, both male and female, had experienced tension associated with meeting the competing demands of work and non-work/family domains. Recognising this tension, they adopted strategies to relieve the tension between domain demands. While some female participants reduced the number of hours worked, other male and female participants altered their work hours rather than forgo spending time with family. Conversely, one female participant chose to outsource her domestic chores and hire a nanny rather than reduce or alter her work hours. These findings were partially consistent with the findings of Keeton, Fenner, Johnson, and Hayward (2007) that women purposely reduced the number of hours worked to relieve tension between work and home life.

Historically, there has been a tendency for early research on work-related stress to focus on males and, therefore, the workplace has been cited as a primary stressor. Conversely, the home has been seen as a haven to take respite and recuperate from the demands of work (Baruch, Biener, & Barnett, 1987). Twenty-five years later, advances in technology provide the opportunity for workers to bring work into their home. However, whether participants in this study chose to work at home or take respite from their work at home was influenced by two individual factors, degree of work centrality, and preference for integrating or segmenting life domains.

9.6 Coping with the everyday demands of general practice

Coping and adaptation are differentiated by whether the individual is responding to a specific situation or adjusting to demands over time. On a day to day basis, participants engaged in coping activities that included: social support, time management, and taking control over the number of hours worked, and work schedules; these coping efforts assisted in dealing with time pressure, pace of work, workload, patient characteristics and presentations, perceived threat of litigation, and work interfering with non-work activities

While some GP participants appeared to value social support, others did not mention social support as being part of their coping repertoire for dealing with work demands. Although not mentioning this does not necessarily mean this is so. Social support was received from co-workers and spouses. Co-workers provided instrumental support by regulating workflow through appropriate appointment times for patients. Spouses provided emotional support by empathising with the demands of general practice, and offering support and concern. Spouses also provided participants with support for their career acknowledging both the potential for stress it may incur, and the tangible and intangible rewards their career offers.

Participants have the ability to exert control over the time demands of their jobs. They have flexibility and discretion over the hours they work, and can structure their work days to suit competing role demands, and reduce or buffer the impact of work demands. While these coping efforts assisted participants, there was still the cumulative drain on participants' resources because the job demands of working as a GP require considerable time and energy. Participants stated it was, therefore, important to participate in family, leisure, and community activities, because these activities were unrelated to work and could therefore buffer work strains (Kirchmeyer, 1992).

For day to day demands that required attention, participants adopted problem-focused coping efforts, such as time management, adjustment to work hours, and delegating work to others. However, they also appreciated that while they could cope with these daily demands, they needed to "switch off" from their work role, and engage in respite activities that facilitated recovery from work demands. Each individual participant had identified the type, duration, and sequence of respite activity that most effectively assisted with psychological detachment and recovery of resources. Two participants stated their professional functioning had become compromised to the point of burnout prior to recognising the need to take action; they made changes to their work conditions in order to restore their health, and continue to work as a GP. They had been on the high demand, high effort, high reward treadmill that had ultimately depleted their resources because they did not take sufficient respite. Participants believed that being on this treadmill led to compromised health, lack of job satisfaction, and a perceived lack of work-life balance.

The day to day coping efforts enacted by the majority of participants contributed to their overall adaptation, and perception of work-life balance. Some participants, however, chose not to exercise control over work demands, and yet they expressed dissatisfaction with their work conditions, and continued to practise in the same way rather than make changes to remedy the complaint.

The JDC model (Karasek, 1979) proposes that physicians have high demand and high control or decision latitude. It is possible, however, that individual GPs subjective perceptions of their ability to control their workload is influenced by the personality characteristic of over commitment identified in the amended ERI model (Siegrist, 1999). Some GPs may misjudge the balance between their work demands and the needs of their patients', and their own resources for coping with these demands. Their sense of

commitment to patients may prevail over their perceived ability to choose to take control of their workload.

9.7 Implications for Practice

The heuristic schema developed from the interview data could be used to underpin proactive, systematic, and coordinated approaches toward programs that promote optimal functioning in GPs. This study has identified both situational and individual factors that influence the dynamic processes involved in GPs adaptation to general practice and life as a GP. This information could also be used to assist with addressing the predicted GP shortages and contribute to GP workforce retention, especially in Australian rural and remote areas.

The heuristic schema highlights understandings of individual GP's work orientation and their preference for integrating or segmenting their life domains. Understanding these individual differences would contribute to better matching of GPs to location of practice. If a GP is an extreme segmentor, working in a rural community may create challenges for effective psychological detachment and choice of respite activity. However, the GP who is an extreme integrator is likely to be at ease with this environment because he or she is comfortable staying in their GP role. For individual GPs somewhere in between on the integrator-segmentor continuum, understanding the situational and individual factors identified in the schema may help GPs appreciate the issues they may encounter in rural practice, and the constraints they may experience in tailoring their respite activities and psychological detachment.

Participants identified that "time out" from their work was "key" to their adaptation and longevity in general practice. Taking time out from work to engage in activities that allowed them to recover lost resources contributed to their overall adaptation to general

practice and life as a GP. The major factors identified to facilitate adaptation revolved around psychological detachment, respite, and recovery. Three participants mentioned that at times they had struggled with the competing demands of work and non-work/family. But they managed to remain satisfied with their work, and, find a perceived work-life balance by ensuring they regularly took breaks from work to psychologically detach from their work role, and engage in respite activities that allowed them to recover resources.

While many GPs in this study took a two week holiday three times a year, holiday time is limited. GPs also identified the need for brief respites from work. They found time and energy beyond meeting the demands of work and family to engage in physical activity, meditation, religious activities, and hobbies. These brief frequent respites were practical ways of gaining relief from work demands. Not taking time out to replenish physical and psychological resources resulted in participants acknowledging they were more likely to experience decreased efficiency and productivity, and increased physical and emotional exhaustion.

The ageing GP workforce, and the ageing Australian population, is likely to result in even further workforce shortages. As retirement rates are likely to be a key determinant of workforce supply, it will be necessary to assist GPs to remain active within the workforce for as long as possible. It is therefore important to identify the factors that influence GPs intentions to remain in the workforce, and also identify the adaptive strategies that can be adopted to assist GPs longevity in general practice.

After working as a GP for 20-30 years the satisfaction originally gained from general practice may have waned (and the changes to the profession and healthcare environment over time) once satisfying but are now jaded. Achievement strivings may no longer give

meaning, and new source of meaning in life may be sought. Goals met may leave them still looking for another kind of life. Examining priorities may lead to reassessing how they want to spend their time (Corey & Corey, 2002).

Encouraging GPs who are considering leaving the profession to examine their motives may help them find another way of remaining in the profession. For example, several participants stated their intentions to take leave from their practices when they were older and travel around Australia doing locum work in rural and remote areas.

9.8. Comparison with other occupational stress models

Findings in this study identified consistencies with some elements of the four theoretical models of occupational stress: (1) The Job Demand-Control-Support Model (JDCS) (Karasek & Theorell, 1990), (2) the original Effort-Reward Imbalance Model (ERI) (Siegrist, 1996), (3) the amended Effort-Reward Imbalance Model (ERI) (Siegrist, 1999), and (4) the Effort-Recovery Model (Meijman & Mulder, 1998). With regard to the Job Demand-Control-Support Model (JDCS) (Karasek & Theorell, 1990), not all participants perceived they had autonomy in decision making by taking control over their work schedules. Nor did they seek to utilize the social support available to them from administrative staff to assist with time management. These findings support findings of previous research (e.g., Gerber, 1983; Menninger, 2003; Miller & McGowan, 2000) that doctors are reluctant to seek help, and they accept their heavy work schedules because they believe 'real or good doctors' are able to carry on without showing distress regardless of the circumstances. While participants acknowledged the altruistic rewards (e.g., contribution to people's lives) associated with general practice, some participants perceived an imbalance between effort and financial reward.

Consistent with the research of Keeton, Fenner, Johnson, and Hayward (2007) the majority of GPs in this study were highly satisfied with their work. During their medical careers, there had been times when they had struggled with work-life balance, mainly due to time pressure and work hours, but their enjoyment and satisfaction with their jobs had consistently been present. Participants recognised when they were struggling with work and life demands, and adopted strategies that enabled them to take control of their work schedules and work hours in order to adapt and regain work-life balance. Only one participant indicated intention to leave the profession within the next five years. The remaining participants did not intend to leave the profession any time soon.

It could be that participants' intention to continue working was influenced by their being satisfied and involved in their jobs. Over the years, participants in this study had invested in many years of study, gained non-transferable and transferable skills, were familiar with their patients and practice, lived in a convenient location with suitable travel arrangements, and had formed friendships and collegial relationships at work and within the medical profession. They had become highly job involved, and people who are highly job involved have much to lose by abandoning their jobs (Rusbalt, Farrell, Rogers, & Mainous, 1988).

The role of 'full-time' work in GPs' lives has, in the past, been perceived as the major way in which they made a contribution to society, and also provide for their private needs. However, now an increasing number of GPs are questioning the validity of this perception and are making changes. They acknowledge there are many ways to make a contribution to society other than through their doctor role, and may then choose to make changes to their work hours in order to participate in other life roles and more flexible patterns of working in general practice.

It is important that GPs pursue the type of activities that provide opportunities to recover from the demands of their work. Self-reflection by individual GPs to identify the activities most beneficial to them would assist in making the most of their respite activities given the amount of time available to them is limited. However, this may need to be a facilitated approach through institutions such as Universities, the RACGP, Divisions of General Practice and professional development activities.

9.9. Implications for Theory

GPs' self-awareness of how they appraise demands in their environment, their degree of work centrality and preference for integrating or segmenting their life domains was a first step in generating effective adaptive strategies. Self-awareness of how these personal characteristics influence ability to psychologically detach, choice of respite activities, and perceived work/life balance have implications for generating theory that is relevant to the training, professional development, and ongoing self-maintenance of GPs. This would require a deeper understanding of the interplay of motives to study and practise medicine, the nature of the general practice workplace, and considerable personality study. What may be more important and timely is the use of such theory in the selection and preparation of medical students. This would be a change away from simply "got the marks" to more complex procedures.

One area requiring change in the training of doctors is a shift away from some of the more punitive aspects of their internships. In particular, a key change would be the move away from gruelling duty schedules that have traditionally been viewed as part of the rites of passage into the medical profession. Working long hours, and sleep deprivation have been a feature of training for many decades (Firth-Cozens, 1987; Holmes, 1998; Nocera

& Khursandi, 1998). Complaint or refusal to accept work overloads could potentially lead to a perceived lack of commitment and subsequent effect on reputation (ACTU, 2000).

Working excessively long hours can impair doctors' judgement and capability, and may result in harm to both patients and doctors (AMA, 2011). Avoidable errors resulting from fatigue may lead to patient mishap, which may in turn lead to litigation. The impact of litigation on individual doctors is extremely stressful (Nocera & Khursandi, 1998).

For GPs, training needs to incorporate on the job mentoring with successful practitioners. It should also draw on other areas of professional training such as psychology and social work in which the professional aspects are balanced with strong emphases on self-monitoring and positive maintenance strategies. In this way, the practitioner would be able to build a stronger sense of their own needs in order to determine that taking breaks, and limiting hours and patients seen, are actually adaptive functions that will allow them to perform at a higher level and better serve their patients.

The young GPs also need to have training in the operation of the practice as a small business. While many have the ideal of the calling, the practice is a business like any other. It has income demands, staffing demands, rent, taxes and other outgoings. They need to be armed with the knowledge of such a situation, and either how to manage the practice or how to employ a practice manager to take care of the administrative factors.

The questions in table 7 that follows are drawn from GP participant’s interview data and the literature. They are not a tool that should be used in isolation, although these questions may be helpful to enhance GPs self-awareness and understanding their preferences in work orientation, and preference for integrating or segmenting their work and non-work/family domains.

Table 7

Questions to Assist Placement on the Integrator-Segmentor Continuum and Work Centrality

Integrator	• I accept phone calls from patients in non-work hours • I engage in work-related activities at home • I am 'always' a doctor • I discuss work related topics when not at work
Segmentor	• I leave work at work • I adopt another persona when not at work • I compartmentalise my work and non-work/family domains • I rarely think about patients after leaving work
Degree of Work Centrality	• I put family and other life interests before work • I have little interest in non-work activities • I make time for participating in respite activities • I regularly socialise with friends outside of medicine

9.10. Contribution to research

To date there has been very little research using face-to-face interviews with GPs, although, they are often surveyed regarding a variety of topics. It is difficult to gain access to doctors; they are very busy, and many are reluctant to give up their time and energy to this type of activity. Offering the gift voucher incentives acknowledged that their time and input was valuable and appreciated. This was a successful strategy to assist with gaining access to participants in addition to having the support of an industry

partner, the RACGP. Having an industry partner did not influence the research process or findings. There were no directives or expectations provided at any time during the research.

This study has confirmed and expanded upon previous research. These findings support the use of qualitative methods in a study where there is a gap in existing empirical research because context, similarities, and differences tend to be obscured in survey/questionnaire studies that follow a more singular view of the research topic. Qualitative methods used in this study highlighted the differences and similarities between GP participants. It allowed a deeper understanding and appreciation of their individual and particular experiences of the demands of general practice and life as a GP and also provided the basis for developing the heuristic schema.

This research contributes to knowledge regarding the adaptation strategies GPs implemented to deal with the demands of working in general practice and life as a GP. Although considerable research has been undertaken to identify the nature and rates of GP distress, little is known about the strategies used by GPs who adapt well to the demands of general practice. This study has provided some examples of tangible and practical strategies used by participants that can be utilised more broadly by the medical profession to assist with perceived work-life balance and overall adaptation.

9.11 Limitations

Although this research makes a contribution to the understanding of GPs' adaptation to general practice, a number of limitations may be identified. First, the study was limited by exclusion of the experiences and perspectives of GPs working in remote areas of Australia who may face different challenges than suburban and rural GPs. Second, it is unknown if GPs who considered themselves "too busy" declined to be interviewed as it

would have been yet another demand on their time. Furthermore, participants were self-selectors and GPs who were struggling may not have been attracted to participate in the study.

Third, the study was limited to a small sample of GPs practicing in Victoria. The purpose of the interviews was not to generalise the findings to the wider population of GPs. However, transferability of the information beyond the case or naturalistic generalization (Stake, 1995) is supported by the rich descriptions of experience noted in the interviews. The findings provide practical and functional in-depth information that has important implications for medical students, practising GPs and their families.

Fourth, it could be argued that this study found mainly positive accounts of working in general practice, because only GPs who were successfully adapting to their work environment volunteered to be interviewed. Some participants did, however, report they had struggled to cope in the past. At the time of the interview, they were coping well, but this may or may not be so now.

A considerable body of literature gathered over the past twenty years already exists regarding doctors who have negative outcomes associated with the demands of their work. The focus of this study was on the adaptive strategies used by GPs, and, the participants were able to contribute to this knowledge.

Finally, medicine is a high status profession; doctors have been socialised to maintain a high level of control about how they present to the public. The researcher was not part of the medical profession, and this was made clear to participants on enrolment into the study. It is possible that participants emphasised issues more relevant to the profession as opposed to issues more personally connected to their experience. There was evidence that some of the GPs shared very personal stories however the degree to which these stories

reflect real practice issues is unknown. The constructionist epistemology that underpins this research recognises this is no cause for concern, as the emphasis is on identifying and understanding people's experience as reported to the researcher not their veracity. The insights gained in this study have built upon and enriched knowledge about the experiences and perceptions of working in general practice and GPs lives.

9.12 Directions for Future Research

There are a number of other possible research directions suggested by the findings in this study relating to GPs' adaptation. The current study has demonstrated that work and non-work/family domains are inextricably linked. What happens at work influences what happens outside of work and vice versa. Research that jointly considers GPs work and non-work domains is warranted, in particular the realms of work and the family unit. Relatively little is known about how working in general practice or as a doctor, more broadly affects other members of the household, especially children.

Some doctors say they intend to leave the profession due to excessive work demands and occupational stress (Schattner, 1998). It would be valuable to study doctors who have actually left the medical profession altogether, and ascertain the influences on their decision to leave the medical profession.

This research has provided a platform for future research to continue examining the positive aspects of GP coping and adaptation. The knowledge generated may also be used to develop and refine interventions to assist current and future GPs (and other health professionals) to successfully adapt in demanding work environments.

9.13 Conclusions

Exploring how GPs adapt is important in developing policies and practices that are meaningful and relevant to GPs. It is necessary to move beyond stereotypical views of the role of GP, and for individual GPs to consider their participation in both their work and non-work/family domains.

This study extends understanding of the complexities associated with adapting to working in a general practice environment, and life as a GP. To recapitulate, this study has identified that GP participants have a variety of perceptions and responses to the demands of their work, and the content and context of their work. Overall, participants agreed that general practice was a high demand environment, and identified common sources of demands. However, the degree of expressed concern about their environment, and sources of demand differed between participants. Furthermore, individual participants differed in their degree of reactivity to these perceived demands. Perceived demands were dynamic, and participants appraised demands as either overwhelming or as exciting challenges depending upon situational and individual factors at a particular time and space.

The participants' goals were to achieve perceived work-life balance, and also to gain satisfaction from their work. In order to successfully achieve these goals, participants identified that their most important adaptive strategy was to take "time out" to engage in respite activities of a sequence, duration, and type that enabled them to psychologically detach from work, and recover expended resources.

Now, and particularly in the future, Australia will need a highly functioning GP workforce in order to deal with a growing demand for general practice services associated with our ageing population and chronic illnesses. Furthermore, environmental and socio-

technological changes may influence people's health, and their need to seek medical intervention, which may also add to the workload burden of general practice. It is timely, that as the general practice setting is faced with an increasingly demanding and uncertain environment this study has identified there are GPs that have the adaptability to meet future challenges with success. The lessons learned from the GPs in this study have implications for preparing medical students for their future medical careers. Understanding and self-knowledge about work orientation, and preference for integrating and segmenting life domains, point to the need for tailored respite strategies that facilitate psychological detachment, recovery of resources, and successful adaptation to working in general practice and life as a GP.

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APPENDIX A
INTERVIEW QUESTIONS

1. Could you tell me how you came to choose medicine as a career?
   Probes: Any critical incident? Would you make the same choices again?
   Why this location?
2. What do you remember about your training?
   Probe: Were there any incidents that were significant or particularly memorable?
3. What does the word well-being mean to you?
4. What advice would you give to young GPs about how to maintain their health and well-being?
5. When you think back over your medical career, what have been the highs and lows?
   Probes: Can you give me some specific examples? Any regrets?
6. What does being a GP mean to you?
7. How would you describe the role of a GP? Is this what you do?
8. What do you consider is the most important aspect of a GPs work?
   Probe: Is this how you thought it would be when you first began practising?
9. All professions have demanding aspects, where do you think medicine is demanding? Probe: What advice would you give for dealing with these demands?
10. Is there anything about being a GP that makes you different to other health professionals?
11. Are there changes in the profession and with patients' expectations that have made a difference to how you practice medicine?
12. Do the characteristics of your patients influence your assessment of whether your day has been enjoyable or not? (e.g., complex cases or "heart sink")
13. When you look ahead into the future, what do you see?
14. Do you have beliefs that give life meaning?
15. If you were able to (wave a magic wand) make any changes in your life, what would they be?

APPENDIX B

DEMOGRAPHIC DATA FORM

1. First Name: _____Last Name: _____

Year of Birth:_____Email or Phone:_____

Practice Post Code: _____

2. Are you a (tick more than one if applicable):

General Practitioner	Employment Type
Solo	Partner
Group	Salaried
Locum	Other

3. How many hours on average are you working each week?
_____ per week - Clinical Hours (excluding on call hours)
_____ per week - On Call Hours
_____ per week - Other hours: (Please specify the type of work during your other hours)_____

4. How would you describe your working hours?
Would prefer to work fewer hours
Satisfied with working current hours
Would prefer to work more hours

5. Are you (tick more than one if applicable):
Fellowship trained
Studying for fellowship
Overseas trained
Vocationally Registered
Other - *Please specify:* _____

6. What year did you graduate? _____

7. What language do you speak at home, if other than English? _____

8. In what country were you born? _____
In what country were your parents born?
Mother _____ Father _____

9. Marital Status:
Single
Separated/Divorced/Widowed
Married/De Facto
Partner's Occupation: _____

10. Do you have any children? Yes No Ages: _____

APPENDIX C

ETHIC APPROVAL

Victoria University of Technology **St Albans Campus**

Memorandum

VICTORIA UNIVERSITY OF TECHNOLOGY

REF:	ETH0319
TO:	Dr Denise Charman Dept of Psychology
FROM	A/Professor Ross Williams Chair, Faculty of Arts Human Research Ethics committee
DATE:	19 June 2002
SUBJECT:	***HRETH.FOA.0015/02 involving human subjects***

The Faculty of Arts Human Research Ethics Committee at its meeting on 14 June 2002 considered application for project:

Exploring General Practitioners' Health and Well-Being: A Positive Approach

It was resolved to approve application HRETH.FOA.0015/02 from 15 July 2002 to 15 July 2004.

A/Professor Ross Williams

APPENDIX D

EXPLANATION OF STUDY

PO Box 14428
Melbourne City
MC8001
Australia

Telephone:
61 3 9688 4000
Facsimile:
61 3 96894069

EXPLORING GENERAL PRACTITIONERS' HEALTH AND WELL-BEING: A POSITIVE APPROACH

This project is an Australian Research Council funded study, and PhD being undertaken by Ms Amanda Murfett. Dr Denise Charman, Department of Psychology, Victoria University, St Albans Campus is the chief investigator of the project.

Victoria University Wellness Promotion Unit, the Royal Australian College of General Practitioners (RACGP), and Central Highlands General Practice Division, are working collaboratively to investigate General Practitioners' health and well-being. The purpose of the project is to explore factors that foster and threaten GP's health and well-being.

To be part of the project we invite you to participate in a one-to-one consultative interview of approximately 20 minutes, and complete a brief demographic information form. We appreciate you have many demands on your time, and value your contribution to the study, so you will be reimbursed for the consultation with a gift voucher of your choice (e.g., David Jones, or Gold Pass movie tickets) to the value of $75.00. The interview will be audio taped, with your consent, and conducted at a convenient venue and time for you. All responses will be kept completely confidential, a pseudonym will be used on the tape and any written or computer records of the study. During the study and after completion of the project, the data obtained from the tape recordings and questionnaires will be safely stored in a locked filing cabinet at Victoria University, and all identifying information will be deleted.

Your participation in this project is voluntary. If you decide to take part but later change your mind, you are free to withdraw at any time. Debriefing, if required, could be provided by the RACGP, your General Practice Division, or Dr Charman.

If you would like more information about the project, or if there is any matter about it that concerns you, either now or in the future, do not hesitate to ask one of the investigators. Dr Charman may be contacted at the Psychology Department, Victoria University, phone (03) 9365 2536, or Ms Amanda Murfett 0407 331037.

If you have any queries or concerns that the investigators have been unable to answer, you may contact the Victoria University Human Research Ethics Committee (03) 9688 4710.

Thank you in anticipation of your assistance,

DENISE CHARMAN AMANDA MURFETT