

GPs working in solo practice: obstacles and motivations for working in a group?

A qualitative study

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Objective. Our aim was to analyse the obstacles and eventual motivations of solo GPs for working in group practice.

Methods. A qualitative study using 12 focus groups was carried out in primary care in French-speaking Belgium. The subjects comprised four samples of GPs: 20 GP trainers, 18 GP trainees, 25 women GPs and 25 other GPs. The focus groups were taped and transcribed. Two independent researchers carried out the analysis using the QSR NUD.IST® software.

Results. The participants (88 GPs) did not share a common definition of group practice—in particular multidisciplinary working—the need for a common pool of patients and shared premises. Their main sources of motivation for eventually setting up a group practice were better quality of life, continuity of care and sharing professional knowledge. The main obstacles were a required agreement between colleagues, the loss of a personal patient–GP relationship, budgetary constraints, and divergent views on group practice and GPs' profession (especially true for the association of GPs from different age groups).

Conclusion. The current study shows that GPs working solo have divergent views of group practice. However, they clearly perceive advantages to this type of association (e.g. better quality of life and continuity of care). This study also confirms the high level of stress and tiredness felt by GPs and especially senior practitioners.

Keywords. Continuity of patient care, family practice, focus groups, group practice, quality of life.

Introduction

No single type of practice has a monopoly on high quality care.^{1–3} However, teamwork can be a contributing factor to the continuous development of quality of care.⁴ Structural conditions of group practice can also improve quality of care, i.e.

- The setting up of systematic care systems⁵
- The organization of small, functional, structured and multidisciplinary teams⁶
- The improvement of processes through a responsible coordinator⁴

- Access to patient records for discussion amongst peers.⁷

Most GPs in Belgium work in a fee for service system. Patients are completely free to choose their doctor and to change if they feel like it. GPs are self-employed and the patients are their unique source of income. This system creates competition between GPs.

Nevertheless, a minority of them (~10%) work in partnership and approximately a sixth of these partnerships are capitation systems. In Belgium, there currently are no budgetary incentives to motivate GPs to form partnerships. However, the Belgian government is planning new laws to foster primary care partnerships.

Despite a high number of physicians (15 GPs/10 000 inhabitants), many doctors—in particular male GPs—have a heavy workload.⁸ The medical profession suffers from stress, and the French-speaking GPs describe their quality of life as moderately satisfactory or even unsatisfactory.^{9,10} However, GPs working in group practice

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have a high level of professional satisfaction.¹¹ They are greatly motivated by the exchange of experience.¹¹ Continuous medical education¹² and social support¹³ have been identified as strategies that help GPs cope with stress and attain job satisfaction.

Most Belgian GPs do not work in partnership. Group practice can improve quality of care and professional satisfaction. Therefore, what are the obstacles and motivations perceived by solo GPs with regards to partnership?

Due to the complexity of this unexplored subject, a qualitative study by focus group was carried out by the Departments of General Practice of the three French-speaking Belgian universities.

Methods

Due to the exploratory nature of the study, focus groups were used. This also allowed for the stimulation of the participants using group discussion dynamics.¹⁴

Four groups of doctors were defined: GP trainers, GP trainees, women GPs and a fourth mixed group called 'other GPs'. GP trainers and their assistants were interviewed because of their particular professional partnership; assistantship can lead to long-term association with the GP trainer. Trainees and trainers were, of course, interviewed separately to guarantee group homogeneity and freedom of speech.

The three Belgian French-speaking university centres for general practice invited and interviewed doctors from each group. A total of 12 focus groups was therefore organized. The collaboration of these three universities ensured a geographical representation of the participants and of the universities from which they graduated.

Doctors were selected on the following criteria: they worked alone and were interested in group practice, and those that the research fieldworkers knew personally were not selected. Two sources of information were used for the recruitment:

- (i) articles in medical journals: these produced a low response level (17% of the participants) and
- (ii) personal phone calls to doctors who had been randomly selected.

Participants were not informed of the financial incentive.

One of the universities (UCL) wrote a standard interview protocol based on a literature review, expert advice in qualitative research and on a pilot focus group. A short list of five open questions was written and focused largely on the research objectives. This protocol and questions along with written explanations were presented to the researchers of the two other GP departments. This ensured identical invitations, questions and interview procedures in all 12 focus groups. The role of the moderator was clearly explained so that the groups would be largely self-managed. Researchers were not

chosen as moderators. A moderator and an observer were present in each focus group. Anonymity and confidentiality were strictly respected in the data analysis phase. Discussions were audiotaped and fully transcribed.

Each discussion group meeting lasted 60–90 min and centred on the following questions:

- (i) What is your definition of 'group practice'?
- (ii) Which advantages could you find in medical group practice regarding working conditions?
- (iii) Which advantages in group practice can you see for the patient?
- (iv) Which advantages associated with solo practice would you lose in group practice?
- (v) What are the obstacles which stop you from joining a primary care group (more so, how would you overcome them)?

Data analysis was carried out by two researchers using systematic classification.¹⁵ First, a node tree was created, modified and finalized according to the emergence of group practice-related themes, i.e. grounded theory.¹⁶ Each text was then coded and categorized. The QSR NUD.IST® software was used for the analysis.¹⁷

Four techniques were used to assess the reliability and validity of the data analysis and its interpretation.

- (i) The texts were analysed independently by two researchers.
- (ii) They drew similar conclusions and discussed differences between their findings. The finalization of the node tree was supervised by an external researcher.
- (iii) A questionnaire was handed out to the participants prior to the interviews. The participants ranked various factors that could influence their participation in group practice. The interview results were in concordance with those of the written questionnaires even though all the influential factors that appeared later in the qualitative study were not mentioned in the written questionnaire which used closed questions.
- (iv) The conclusions and interpretations of the data analysis were presented to five doctors who had taken part in the interviews. Overall, they agreed with the conclusions.

Results

The characteristics of the participants are given in Table 1. Twelve focus groups meetings were conducted with a total of 88 participants.

Definition of group practice

The participants described group practice as "working together with a few other doctors". They never mentioned collaboration with specialists. Other professionals

TABLE 1 Characteristics of the participants

	GP trainers (n = 20)	Trainees (n = 18)	Others (n = 25)	Women (n = 25)
Mean age (years)	48	27	43	45
Sex ratio (M/F)	18/2	8/10	22/3	0/25
No. of participants UCL ^a	7	6	10	11
No. of participants ULB	6	7	8	7
No. of participants ULg	7	5	7	7

^a UCL, Université Catholique de Louvain; ULB, Université Libre de Bruxelles; ULg, Université de Liège.

could sometimes be included, such as nurses, physiotherapists, psychologists, secretaries and dieticians. The concept of multidisciplinary partnership was often lacking. There was no common agreement on the sharing of patients or office space. Common medical records were seen as an interesting tool for group practice, but most GPs thought that sharing medical records was not an essential partnership characteristic.

As described previously, a wide variety of personal concepts led to a lack of a common group practice definition.

“Yes but ‘group practice’ can mean many different things, you know.”

Advantages

The main motivations for working in group practice were the harmonious combination of quality of life for the practitioner, continuity of care for the patient and exchange of experience between health workers.

- (i) Quality of life was identified as a real need for both junior and senior doctors, as well as for both men and women. This concerns professional, personal and family life. A better planned schedule, the opportunity for other professional (non-curative) activities, better management of emergency cases, and holiday replacements; all these would positively improve the GP’s quality of life.

“I think that what I will gain is better quality of life. For me, the richness of the third millennium is time itself.”

- (ii) Group practice also allows for continuous optimal care of the patients. The participants described group practice as advantageous to the patient, even if it was cited firstly as beneficial to the practitioner. Some of the advantages for the patient that were cited were access through group practice to complementary medical fields, and a

feeling of trust when a doctor has access to one’s own records.

- (iii) The exchange of practical experience and the continuous learning process are two other advantages of group practice. This exchange improves quality of care by sharing of know-how and by increased serenity in dealing with the patient’s problems. It allows for the at-home management of difficult and complex cases.

“On a professional note, I think that what I miss the most are the exchanges. Discussion somehow forces me to reconsider my position on some scientific aspects . . . but the lack of dialogue mostly arises from a lack of time.”

In addition to these three main motivations, other advantages could be found, such as shared expenses and shared administrative workload. Nevertheless, the participants never expressed their will to form a partnership in order to increase their financial gains. A group practice requires new investments, and few incentives are available currently in Belgium. Moreover, sharing patients might decrease their income. Finally, management and meetings are time consuming.

Obstacles

Four main obstacles to joining a group practice were identified.

- (i) Relationship agreement and shared professional philosophy: these points were often cited as prerequisites for a partnership. The fear of not finding the right colleague was also expressed; it should be someone with whom the practitioner would get along and who would share the same caregiving views. Of course this fear was linked to the fear of conflicts. There was little talk within the groups on the organizational aspects (communication, objectives, leadership). The discussions focused more on the changing and humane characteristics of personal relationships.

“I worked with a GP trainer and thought he was perfect because he practised the kind of medicine that I would have liked to practise. It can be said that I might have been able to share a practice with him.” (a trainee)

- (ii) Patient relationship and loss of income: Belgian GPs and their patients feel close to each other, both emotionally and financially. The practitioners fear losing the personal relationship with the patient. The ‘one patient one doctor’ policy is well established and appreciated by both parties.

“If you were to ask my patients what they thought of me joining a group practice, they would answer that

it would be all right as long as it remained in the waiting room.”

Sharing patients is therefore quite difficult, more so if we consider the doctors' complaints about the gloomy economic climate.

- (iii) **Generation gap:** one logical solution stood out in the debate over the uneven sharing of the workload, i.e. young and old GPs should work in partnership. The problem resides in the different concepts of working conditions, mostly to do with working hours and availability. The senior practitioners make themselves available according to the patient's needs. The junior doctors are more attracted by fixed income and time schedule.

“The problem is that the younger generation wants to work from 8 am until 6 pm and want to live in peace after hours. They do not want to hear about on-call services.”

- (iv) **State of inertia:** losing one's independence and the fear of changes are other difficulties that have to be dealt with. For example, this includes the need to plan family holidays according to the practice's workload. An essential element that requires review is the specific objectives for group practice. Problems could arise if these objectives were not clearly defined.

“There are people who are in the habit of living alone, of working alone, and who aren't ready to reconsider their practitioner's habits.”

Specific answers from the four subgroups of respondents GP trainees. Group practice in a fee for service system can be an easier career start for young GPs as there is no waiting for patients. It is the only example where group practice would mean higher income. However, the main incentives are better quality of life and, more particularly, planning family life.

Some young GPs mentioned a possible future partnership with the GP trainer if the training period went well. Other individuals feared that in such a situation the established hierarchy would be maintained between trainer and trainee after the training period had ended.

GP trainers. This group of doctors showed signs of professional exhaustion, weariness and even burnout. They found it difficult to deal with extra work, with the administrative burden, with the stress caused by overcrowded waiting rooms and emergencies. Many amongst them wished to rethink their priorities in life.

“We live medicine, we sleep medicine and we eat medicine. I would like to do something else.”

They were looking for a new surge of energy from their trainees, an opportunity for shared continuous learning and long-term companionship. However, at times, GP trainers painted a discouraging picture of their young colleagues: the trainees do not want to work as the trainers did in the past and they limit their availability to patients (women in particular).

“When you work part-time (one sixth or one quarter) in general practice, you should have sufficient experience or you could become dangerous.”

The personal relationship between the patient and the practitioner was greatly debated by the GP trainers group. They questioned the legitimacy of a unique relationship between a patient and a GP. Does this desire come from the patient or from the GP who wants to be considered by his patient as the best and unique doctor? These signs of depersonalization are well known as a typical feature of professional burnout.¹⁸

Women GPs. Compared with other groups, women's openness to multidisciplinary partnership stood out. They favoured the inclusion in the practice of other care givers, such as nurses, physiotherapists, psychologists and dieticians. This would notably allow the sharing and enrichment of knowledge but would also improve the management of complex cases.

“For me group practice means more than two individuals. So not just two doctors sharing a practice but working together with other care-givers.”

They were also motivated by a better quality of life but were more pragmatic and down to earth. More particularly, the integration of their medical office in their home allowed them to combine both professional and domestic activities with more free time.

“As a woman, I find that group practice is a really good way to practise medicine. You cannot do everything perfectly.”

Other GPs. For this group, the first source of motivation for working in partnership was the exchange of knowledge between peers to perpetuate continuous medical education and provide quality of care. They considered group practice as a tool to increase the success of a medical practice.

This group also raised the issue of an unique GP-patient relationship just as the GP trainers did. However, in contradiction to the trainers, they found this relationship to be important, both gratifying to the GP and reassuring to the patient.

Discussion

In this study, many solo working GPs were highly motivated to work together. However, a common

definition of group practice was lacking. The large number of definitions found for medical partnership might be explained by the lack of an official framework for group practice in Belgium. The minority (~10%) of GPs who currently are working in group practice are completely free to do so and do not receive any financial incentive. This absence of an official framework also explains the wide variety of existing GP partnerships.

Nevertheless, participants were strongly motivated by group practice and saw it as a way to enhance their quality of life and the continuity of care for their patients, and to favour the exchange of experience between health workers. Breaking away from job constraints (heavy workload, out of hours calls, emergencies, administrative burden, loneliness) was even described as an urgent need for some GPs (especially GP trainers). In Europe, the gloomy context of job satisfaction among GPs is well known.^{10,12,13} Group practice can provide for such needs; the patients benefit from continuous care and this type of practice can improve the quality of care through the proposed structural measures.⁴⁻⁷

On the other hand, the obstacles to the establishment of partnerships are partly linked to the health care system (competition between care givers), i.e. to the fear that working in a group can mean losing patients. Moreover, losing patients also means losing the exclusive and gratifying patient–GP relationship.

However, these barriers are above all linked to relationships between workers. The participants had no experience of team management (communication between individuals, group organization, leadership, converging objectives), and these topics were scarcely mentioned. Nevertheless, they felt that within a partnership, relationship agreement is a key point for a successful association. The agreement depends largely on a shared vision of medicine and on dialogue between generations concerning work conditions and schedules. This correlates with a recent study that explored the relationships between partnership arrangements and workload.¹⁹ Key elements which make up partnerships and help cope with the increasing demands in primary care work were identified. These features were respect for difference, flexibility to accommodate it and willingness to communicate at a personal level.

Moreover, the financial investment needed to start such a venture has to be considered more particularly in the absence of financial incentives and with time used up in meetings and team management.

Obstacles and motivations to group practice identified by this study are mutually balancing, which explains why in any health care system, advocates for both single-handed practices and group practices can be found.

Quality of care cannot be improved solely by stimulating group practice.¹⁻³ Health service planners should better foster quality activities facilitated by group practice. Therefore, they have to take into account the opinions and potential advantages perceived by the

solo working GPs when they promote this type of practice.

Limitations of the study

The size ($n = 88$) and representativity of the sample, the pilot test and the participating GPs' interpretation of the results confirm the validity of the study.²⁰

No similar study was found in the literature. Even though it was carried out within a particular health care context (fee for service system and mostly solo working GPs), the general trends observed here are of the utmost importance to European general practice. As a matter of fact, the obstacles and motivations highlighted here are independent of the context (relationship aspects, quality of life, quality of care). Therefore, these could be adapted for GPs working in other European health care systems.

Listening to the comments made by GPs provides scope for further reflection:

- The lack of openness towards multidisciplinary partnership has identified a need for information on this important aspect of their work.
- The differences in perception according to age group indicate a need for dialogue. Both young and older GPs seek a better quality of life, but senior practitioners also expect the younger ones to adopt the same working mode that drove them to exhaustion.
- The personal patient–GP relationship is highly rated by GPs. Many of them feared the loss of this relationship through group practice. However, group practice is not incompatible with personal GP–patient relationship if the patient's freedom is respected.
- It would be of interest to compare the advantages of group practice expressed by the GPs with those perceived by the patients.

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