Primary care practice à la carte among GPs: using organizational diversity to increase job satisfaction

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Background. Primary care revival in Canada and elsewhere is viewed by many as conditional to the introduction of new organizational models. Endorsement by GPs is a key factor in the success of these models, and increasing GPs’ job satisfaction is often one of the desired outcomes of the reforms currently underway.

Objectives. The phenomenon of work satisfaction from the GP’s perspective is not yet fully understood. The objectives of this study were to elicit its different facets and to understand better how organizational factors affect it.

Methods. This is a case study carried out in the province of Quebec (Canada). We conducted semi-structured interviews with 28 GPs working in private clinics and community health centres (Centre local de services communautaires).

Results. The main themes uncovered are related to the relationship between time management and quality of care, variation in work, autonomy in day-to-day practice, team ‘orientedness’ and social rewards. We also found that some GPs prefer to combine work in different organizations and models in order to increase their job satisfaction and to better cope with an increasingly complex task environment.

Conclusion. Our study provides a comprehensive view of the various dimensions that GPs consider important in their professional life. Our findings suggest that, for many GPs, the perfect practice is tailor made and implies a combination of organizational models in order to fulfil their multiple professional goals. This has important implications for decision makers who are promoting new primary care models.

Keywords. GPs, job satisfaction, organizational models, primary care.

Background

The literature suggests that GPs are growing increasingly dissatisfied with their work.1–3 This decline in job satisfaction among GPs is thought to be the result of a web of factors, including an increasing workload, time pressure, changing attitudes towards physicians on the part of patients and the erosion of professional autonomy.4,5 Several organizational factors can contribute to diminish the quality of work life.6,7 In Canada, studies on job satisfaction among doctors show a similar trend.8–10 and many family doctors also feel that it is increasingly difficult to maintain fundamental professional principles.11 Few qualitative studies have explored the phenomenon of job satisfaction among GPs. Existing studies have looked at how GPs, especially women, often struggle to balance professional and non-professional life and how this can cause significant amounts of stress.12 From an organizational perspective, studies have also explored how GPs’ job satisfaction can be affected by different stressors related to out-of-hours care and new contract arrangements.13,14 Overall, coping with time pressure, control over one’s professional life and relationship with other doctors were recurrent themes in qualitative studies on GPs’ job satisfaction.
Job satisfaction among GPs has important implications for the sustainability and efficiency of health care systems. Indeed, job satisfaction has been identified as an important determinant of physician retention and turnover, as well as a factor that can affect performance.\(^{15,16}\) It is being suggested in Canada and elsewhere that a decline in job satisfaction among current family doctors is partly responsible for the steadily decreasing number of residency applicants each year in the field of family medicine.\(^{17–19}\) While decision makers invest in primary care renewal, many aspiring doctors do not consider general practice and family medicine as attractive career choices. This largely explains why professional colleges and associations call for assessments of changes in job satisfaction among GPs before and after primary care reforms.\(^{20}\) Given the current ‘red flags’ concerning GPs’ job satisfaction in Canada and elsewhere, we feel that it is crucial to comprehensively document what makes primary care doctors (dis)satisfied. Our objectives in this paper are to elicit the different facets of job satisfaction among GPs and to better understand how organizational factors may affect them. In order to meet both objectives, we compare and contrast the views of Quebec (Canada) GPs who practice in contrasting organizational models.

**Methods**

We conducted a collective case study\(^{21}\) in 2001–2002 to understand better how organizational factors influence the work of GPs in the province of Quebec (results forthcoming). We report here on job satisfaction, one of several work-related dimensions under study.

**Selection of organizations and GPs**

We used a stratified purposeful sampling strategy\(^{22}\) to select eight primary care organizations as our main units of analysis. We selected four private clinics and four Centre local de services communautaires (CLSCs); two organizations from each model in urban areas and two organizations from each model in rural areas. The rationale was to select settings offering contrasting practice environments to GPs. Our sampling criteria were chosen based on empirical studies showing that both organizational and contextual factors can influence GPs.\(^{23}\) This is consistent with the theoretical literature considering that the environment surrounding and permeating organizations can significantly impact on organizational structure and individual behaviours.\(^{24}\) The environment was considered in our study as an effect modifier of the relationships between organizational factors and professional practices. At the time of the study, approximately 70% of GPs in Quebec were working exclusively in a private clinic, another 5% were based in a CLSC and 25% had a mixed private clinic–CLSC practice.\(^{25}\) The models are presented in Table 1.

We sent recruitment letters by mail to a small number of private clinics and CLSCs in Quebec. In order to study themes like organizational culture and professional collaboration, we excluded solo practitioners. We interviewed a total of 28 GPs (17 men and 11 women); 23 GPs across the eight case study sites and we added five interviews with GPs from different settings (four CLSC and one private clinic) in order to reach data saturation (see Table 2).

**Data collection and analysis**

We chose the semi-structured interview format (average duration 120 minutes) to explore with the 28 GPs the influence of organizational factors on professional life. The respondents were asked to freely elaborate on the different factors affecting their work (models, environment or organization specific). The interviews were tape-recorded and transcribed verbatim. The transcripts were then coded and analysed with the support of N6 software.\(^{26}\)

Our coding scheme was developed gradually. We had a start-up list of codes inspired by the literature on primary care organizations and physicians’ behaviours

| **Table 1** The CLSC and private clinic models |
|-----------------|------------------|
| **Private clinic** | **CLSC** |
| **Profile** | Oldest and predominant primary care delivery model in the province of Quebec (and in Canada); physicians in Quebec are reimbursed by the Quebec Health Insurance Board—a public body established by the provincial government and reporting to the Minister of Health and Social Services | Defined as a community and collaborative primary care delivery model; CLSCs were introduced in the early 70s and receive their funding from the provincial government |
| **Physician remuneration** | FFS | Salary |
| **Team composition** | Physician based; solo but predominantly group practice | Multidisciplinary; physicians are employees |
| **Responsibility** | Patients | Population in a specific geographical catchment area |
and the transcript analysis also involved using an open-coding strategy to develop new categories of information or to refine existing ones (Day, 2004; Strauss). Ideas and categories generated after performing line-by-line analysis were tested and further explored in subsequent interviews until saturation was reached. A final round of axial and selected coding was performed to add a conceptual layer to existing categories and subcategories in order to explore how they are interconnected.27,28 The phenomenon of job satisfaction was a recurrent theme connected to several organizational dimensions. After compiling a list of meaning statements related to job satisfaction, we looked for emerging clusters of meaning units. We then compared these units to look for commonalities and differences in the way GPs in different organizational and environmental settings experience job satisfaction.

Results

The qualitative analysis brought forward the following five key dimensions: the relationship between time management and quality of care, variation in work, autonomy in day-to-day practice, team orientedness and social rewards (see Table 3). Organizational factors and models constitute transversal themes, given, according to GPs, their profound influence on job satisfaction. For each dimension, we will systematically present the views of CLSC GPs followed by the views of GPs working in private clinics. The last section presents the reasons why some GPs prefer to be affiliated with both models on a part-time basis. Table 2 summarizes the main dimensions of job (dis)satisfaction in relation to organizational models.

<table>
<thead>
<tr>
<th>Sites</th>
<th>Respondents</th>
<th>Mixed private clinic</th>
<th>Experienced the other model at one point during career</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLSC urban (2)</td>
<td>6</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>CLSC rural (2)</td>
<td>6</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Private clinic urban (2)</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Private clinic rural (2)</td>
<td>6</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Additional interviews</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Private clinic urban</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>7</td>
<td>20</td>
</tr>
</tbody>
</table>

*We learnt during the course of the interviews that these GPs had a parallel practice in a private clinic or a CLSC. None of these settings were one of the eight case study sites.

physicians (CLSCs) were appreciative of the fact that they can focus on patients’ needs without worrying about their income. This usually leads to consultations in the (reported) 20- to 30-minute range for regular appointments. From their perspective, family medicine calls for a holistic approach, and the less time one spends with each patient, the more anxious and insecure one gets as a clinician. Several GPs chose the CLSC model of care because they see it as the most suitable to establish continuity of care and nurture the patient–provider relationship through better communication. By spending more time with patients, one ‘gives them a chance to talk’ and therefore they ‘leave your office more satisfied’. According to one doctor, spending a minimum of 20 minutes is also associated with better quality of care: ‘that’s medicine; not a lot of problems can be dealt with in 10 minutes’. For the CLSC respondents, taking the time they feel is needed is key to their job satisfaction:

If full-time in a fee-for-service setting, I would be either very unhappy or very poor. (CLSC GP)

I could go faster, but I would be unhappy; my priority is to practise a type of medicine in which I believe. (CLSC GP)

While physicians working in private clinics are often annoyed by billing codes and office expenses, many could not envision working full time on salary. They mentioned that fee-for-service (FFS) provides an incentive for work and performance and that they would simply get bored at a pace of two to three patients per hour. Some GPs thrive on volume and claim that it sharpens their mind and their clinical and mental abilities. Some of the FFS respondents admitted that many patients would appreciate longer consultations but that, from their point of view, the technical quality of care is not affected: ‘I’m working faster than a CLSC physician but I don’t have the feeling that I’m missing something.’

Variation in work
Another key dimension of job satisfaction according to the GPs is the scope of health problems they deal with on a daily basis. Some physicians choose their practice location and setting based on the types of patients they are more likely to see. For example, in many CLSCs, physicians have the opportunity to work with specific clienteles:

During my various working stints while training, I worked with teenagers and it was love at first sight. I came to this CLSC because they were looking for a physician for their Youth Program. (CLSC GP)

Physicians may also select their practice setting and location because they know they will be exposed to
Autonomy in day-to-day practice
When physicians are ‘employees’ (CLSC), they often dislike depending on managers who, in their view, are disconnected from the reality and challenges of practising medicine. In our study, seven GPs who once worked full time in a CLSC ended up switching entirely to the private clinic model or working in both models:

> I preferred the payment system of the CLSC. I thought it was less trouble than always calculating everything. But I left because I couldn’t practise medicine anymore—there was too much interference and too many frustrations. (CLSC GP)

The less ‘control’ the better. The private clinic model attracts physicians who want the freedom to shape and define the characteristics of their practice. In private clinics, GPs have more autonomy: ‘you work for yourself, it’s your business’. With more autonomy, physicians therefore have more control over whom they hire for clerical duties. In private clinics, secretaries take on more responsibilities, allowing GPs to do more of what they like: ‘treating patients’.

Team orientedness
This dimension is intrinsically linked to the daily life of GPs and the atmosphere of the work setting. For some GPs, it is the main selection criterion in choosing a practice setting. CLSC physicians find it rewarding to work with other professionals and to support them with their clinical expertise (#16). The CLSC model is described as fostering collaboration:

> When I joined the CLSC I felt at home. There was a feeling of being a full member of a medical team and I valued that. A lot of mutual support. I had the chance to work as well in a private clinic … but there was a coldness there, a sort of stiffness, it’s difficult to explain. I found the physicians in CLSCs to be more satisfied, more complete. (CLSC GP)

Most of the respondents believed that the private clinic model does not promote communication and collaboration among colleagues:

> It was a solo practice within a group … I found it awful. I had a lot of trouble coping with that. It wasn’t at all the way I wanted to practise, no way, not at all. (Private clinic GP)

GPs working full time in private clinics were unanimous in mentioning that professional isolation is the main disadvantage of this type of practice.

Social rewards
The CLSC and private clinic models bring a different inventory of rewards but all responding physicians reported greatly valuing their contribution to the health care system and how their work is perceived by their peers and in the public sphere.

Physicians working in CLSCs take pride in the fact that their case mix is composed largely of very sick and elderly patients: ‘it’s important to meet the needs of a wide repertoire of health problems and clients. Many GPs working in rural areas take pride in the fact that their practice is very diversified and true to the traditional definition and scope of family medicine. Several of our FFS respondents stated that the scope of practice in CLSCs is not gratifying because treating mainly patients with complex health and social problems means that positive outcomes are sometimes few and far between.

<table>
<thead>
<tr>
<th>Key dimensions</th>
<th>Private clinic</th>
<th>CLSC</th>
<th>Combining private clinic/CLSC</th>
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<tbody>
<tr>
<td>Relationship between time management and quality of care</td>
<td>Satisfaction from being ‘efficient’ and ‘sharp’—achieving good technical quality of care while coping with time pressure.</td>
<td>Satisfaction from longer consultations because (i) allows for a holistic approach; and (ii) patients prefer more time.</td>
<td>Satisfaction from having the proper alignment between the payment method and the patients’ needs—feeling of appropriateness.</td>
</tr>
<tr>
<td>Variation in work</td>
<td>Satisfaction from treating a wide variety of health problems—high cure rate for routine health issues.</td>
<td>Satisfaction from treating the very sick—can turn to dissatisfaction when done full time over a long period of time.</td>
<td>Combining models as a strategy to avoid the feeling of having insufficient control over professional life.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Satisfaction from having control over one’s professional life.</td>
<td>Dissatisfaction with bureaucratic slowness—having less control over the practice environment.</td>
<td>Combining models as a strategy to avoid professional isolation.</td>
</tr>
<tr>
<td>Team orientedness</td>
<td>Feeling of professional isolation even in group practices.</td>
<td>Favourable context for (more) informal and formal interactions with other doctors and other professionals.</td>
<td>Combining models as a strategy to meet competing demands at society level—treating both patients with access barriers and the general population.</td>
</tr>
<tr>
<td>Social rewards</td>
<td>Satisfaction from being a ‘traditional family doctor’—high social status.</td>
<td>Satisfaction from helping the sickest and taking a large proportion of complex patients. Dissatisfaction stemming from low level of recognition from peers.</td>
<td>Combining models as a strategy to avoid professional isolation.</td>
</tr>
</tbody>
</table>
our increasingly older population in Quebec’. The willingness to take on a social mission is illustrated by a greater involvement in home and nursing home care: ‘there are glaring needs in those areas so I feel like I’m contributing, I’m taking my share of the tough work’.

Overall, they reported feeling that they are making a greater contribution to society than they would if they were serving primarily ‘healthier’ patients.

However, several CLSC physicians stated that they are troubled by the fact that working on a salary basis is viewed pejoratively by their private clinic colleagues and that they are perceived as ‘lazy’ and not ‘real’ physicians. These perceptions can be strong enough to dissuade young physicians from considering working in a CLSC:

I think that all physicians have a strong need for peer approval. It’s enormous. We have been trained this way and it’s really difficult to go against this need. (GP combining CLSC/private clinic)

Among private clinic GPs, the volume of patients is seen as a measure of performance and as one of the key differences between the two organizational models in Quebec: ‘if we all went at the CLSC pace, it would be the end of our health care system’. Most of the respondents who had experienced both models felt that FFS remuneration leads to more recognition from the public and is more likely to allow instant gratification:

It’s really a more general practice, really more satisfying. I treat more people and I have the feeling of practising medicine according to the tradition, the way I was taught to practise in school. I treat problems and I have quick results. (Private clinic GP)

When working on a walk-in basis in a private clinic, we offer tangible services, real services to the population. (Private clinic GP)

By spending a significant proportion of their time ensuring quick access to services, which often means shorter consultations, several of the private clinic respondents considered that they meet the demands of the population asking for 24/7 access: ‘it’s certainly not all my patients who wish to spend half an hour in my office’.

Finally, the interviewees from both models did consider the level of financial remuneration as a factor influencing job satisfaction. However, income was discussed mainly as a marker of social status. CLSC GPs have a lower income, and both respondents from both models feel underpaid given the length of training in medicine and the level of responsibilities.

**Organizational diversity and job satisfaction**

According to the respondents, none of the two existing models is perfect. Therefore, for some GPs, the best solution is to build a primary care practice à la carte, either by working part-time in both models or by switching from one to the other as career objectives and interests evolve. Whether related to the pace of work, to the degree of professional autonomy or to finding the right mix of patients, clinical challenges and social rewards, the physicians felt that experiencing both models of care may be good not only for them but also for their patients.

On a personal level, physicians described the choice of combining work settings as a balancing act: ‘that’s how I meet my needs. When I work in one model I dream of the other’. Over the course of their career, the preferences of GPs may change, and the presence of contrasting organizational models within the health care system makes it possible to make the desired adjustments. For example, many GPs believe that salary remuneration is preferable for older physicians who wish to slow down instead of retiring and for young physicians starting their career:

It’s interesting for young physicians to work in a CLSC because there you don’t feel the pressure to make money. It’s stressful, starting a practice, when you start seeing patients alone for the first time. (GP combining CLSC/private clinic)

The same logic about combining models applies when considering different dimensions of primary care service delivery. Some GPs perceive the CLSC model as favouring continuity and comprehensiveness of care, while the private clinic model has been identified as favouring accessibility. For example, one respondent explained how he refers some of his patients from his CLSC office to his private practice and vice versa depending on their needs:

The ideal formula for me is when I have the freedom to deal with my patient with a remuneration that is adapted to his or her needs .... The ideal scenario is to be doing the more specialized and in-depth work at the CLSC and the more ‘routine’ work at my private practice. (GP combining CLSC/private clinic)

It is challenging to perform well on all primary care functions, and many of the respondents felt that one model’s strengths are the other model’s weaknesses. By combining two models, some GPs feel that they are merging two ‘kinds’ of medicine and moving closer to fulfilling the promises of primary care.

**Discussion**

Our study shows that GPs experience job satisfaction differently at different times during their career and that organizational factors and models can be important catalysts. Other studies have also shown that job satisfaction among GPs is influenced by financial issues, workload, social status, variation in work, cooperation with colleagues and the freedom to choose
one’s own method of working. Our study brings in a socio-organizational perspective illustrating how GPs are actively looking for strategies to maximize their job satisfaction. Individuals are known to perform better in organizational settings that best fit their personality and preferences. The concept of a ‘person–organization fit’ can also take the form, in family medicine, of a ‘physician–primary care model fit’. Personal and professional interests and preferences are, however, a moving target and are constantly evolving. This partly explains, we believe, the high turnover among GPs in some organizational settings and models as well as our own findings about primary care model combinations in Quebec.

In addition, we believe that the phenomena of combining work settings and GPs’ turnover must be put into the context of larger social movements. In particular, the ‘individualization’ thesis provides some interesting paths of thinking. According to this thesis, individuals are more and more inclined to trust and choose their own solutions in the face of our increasingly complex and uncertain contemporary societies. The phenomenon is also tied to the notion of ‘do-it-yourself biography’, where individuals choose their goals as they go along and entertain the never-dying hope that the next place will be better than the previous one. This translates into a higher willingness to move, both personally and professionally, and the desire to live a ‘life of one’s own’. We argue that this viewpoint is helpful in explaining the fact that GPs’ professional trajectories appear to be increasingly changing and that GPs are more active in constructing their own career path. At least in Quebec, more and more GPs are wedded to several workplaces at once and are experiencing organizational model ‘polygamy’. From that angle, job satisfaction is on standby, always ‘until further notice.’ GPs’ aspiration to control their career and to address their multiple interests and preferences by moving in and out of organizations and models does not mean that they are unconnected to the health care system. As an example, our data show that by combining models, GPs actually try to adequately balance different dimensions of health care service delivery, such as accessibility and continuity of care.

The fact that job satisfaction was not the only phenomenon investigated in our study can be regarded as a limitation. However, we feel that by exploring the different factors influencing the work of GPs in different models and environments, we were able to adequately capture the complexity of intervening conditions influencing job satisfaction.

Conclusion

Our results are challenging for decision makers, who, following a prescriptive approach, often wish to identify and implement the ‘best’ primary care model. Different GPs have different personal values, and they tend to perform better in professional situations that are compatible with their identity and sense of self at a given time. Therefore, it appears unlikely, at least from the angle of job satisfaction, that a ‘one-model-fits-all’ approach would be successful. From that perspective, it becomes more difficult to only shed a negative light on the phenomenon of high physician turnover, as it may also reflect the ability of GPs to effectively mobilize the structures and existing resources in their environment.

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Conflicts of interest: None.

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24 N6 (Non-numerical Unstructured Data Indexing Searching & The- orizing) qualitative data analysis program; QSR International Pty Ltd. Version 6, 2002.