cognize this dilemma might encourage them to develop functional teams. Individual neurologists and geriatricians could continue to diagnose routine neurological problems referred to them. In addition, they could subspecialize so that each might have a specific input in a multidisciplinary team which focused, for example, on the diagnosis and continuing care of the big three: stroke, the epilepsies, and the degenerative disorders, which include alzheimers disease, parkinsons disease and motor neurone disease.With district teams like this, specialists would not need to fear professional isolation, and patients with neurological disorders would be more likely to receive the seamless service they need.

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General practitioners' low morale: reasons and solutions

'I just feel I am not valued any longer.'

'I feel that patients no longer value the service I give them.'

'It appears that the family health services authority no longer has the same relationship [with general practitioners], and the government doesn't value the services we give.'

'I just feel devalued.'

RECEIVING comments like these from keen general practitioners attending its seminars, the Royal College of General Practitioners has decided to take action.

There is good evidence of declining recruitment in vocational training. The number in vocational training posts fell by 17% in 1991, and in 1990 there was a decrease for the first time in the number of certificates issued by the Joint Committee on Postgraduate Training for General Practice (*Doctors in general practice 1979–91*, NHS statistical bulletin). It therefore appears that general practice is losing its ability to attract its share of the best graduates from medical schools, notwithstanding increased investment in staff and curricular time for general practice. General practitioners are also retiring at an earlier age and the Medical Practices Committee noted that the number of doctors over the age of 60 years had halved in the 10 years between 1982 and 1992 (Medical Practices Committee, *Chairman's report*, 1993). At the same time there is strong anecdotal evidence of low morale among established general practitioners, and although this is not universal it is prevalent enough to cause the RCGP, as the academic body of the discipline, considerable concern.

At present all countries are facing similar problems of meeting the demands of providing comprehensive health care and social care.[1] Increased expectations of populations who are living longer and surviving because of expensive medical technology, with its general inflationary costs, are bringing about many changes in the delivery of health care. Some general practitioners, however, see the changes as a chance to flourish, and not since the post-charter days of the late 1960s has general practice had such an opportunity to become the major clinical force in British medicine.[2]

In 1992 the council of the RCGP undertook a survey of a 15% random sample of principals aged from 25 to 30 years (joint RCGP/Medical Women's Federation initiative). This survey used a Delphi technique to identify the most common problems (for example, with career structure, career fulfilment and education) and trends, that would form the basis for discussion groups. The negative feeling identified was centred on lack of career trajectories (for example, views that unlike one's equally intelligent and qualified contemporaries in other walks of life, once a principal there is nothing else to aim for). Negative feeling was also based on predictable factors such as antisocial hours, difficulties in defending family time, unfair distribution of workload within the practice partnership, and opportunistic costs to good patient care of the bureaucratic load imposed by the 1990 contract for general practitioners.

In order to find out whether these concerns were confined to relatively junior principals, or were more pervasive, the survey was repeated with principals aged from 30 to 45 years, and found the same problems, together with increasing discontent with financial and workload arrangements within practice partnerships. Behind these immediate concerns loomed uncertainty about the future of general practice and about the evolution of the National Health Service reforms and their long-term outcomes.[3]

Out-of-hours calls have increased and accelerated since 1990, which might reflect general practitioners' willingness to visit or

increasing consumer demand.[4] The RCGP, as it considers support of its members as a top priority, recommended that patients should have appropriate access to a service of high quality at all times, but that this should not be at the expense of doctors' health and welfare.[5]

As patients become more knowledgeable about their health, their expectations of the general practitioner as a health educator increase.[6] A survey by the Office of Health Economics showed that a quarter of women in the age range 25 to 40 years do not believe that their general practitioner has listened to their problems.[7] This confirms the findings of previous studies that patients expressed more dissatisfaction with the information given to them than with any other aspect of medical care.[8] Although 80% of respondents in this study expressed satisfaction with the treatment or advice that their general practitioner had provided,[7] this had fallen by 10% in the last decade.[8] Complaints received by the General Medical Council have shown a general trend over the years towards an increase in the number received and a corresponding increase in the number of cases in which the General Medical Council has acted. Notably, complaints rose by approximately 20% in the year from 1991 to 1992, and by a further 24% in the year from 1992 to 1993.[9]

Research has demonstrated the importance of bureaucracy as a cause of stress at work, and competency and performance deteriorate as stress increases.[10,11] Doctors, because of their stoicism, which appears to be a learned variable during the education process, show a lack of insight into and a denial of personal illness.[12] Those doctors who are drug and alcohol misusers can display behavioural problems, which can affect patient care, professional relationships and teamwork. They can also be subjected to stigmatized and hostile attitudes from their colleagues.[13,14] Higher mortality from suicide, poisoning and cirrhosis of the liver is found among doctors than among other occupations.[15]

Importantly, a demotivated profession cannot deliver the effective service that patients expect. In January 1994 the RCGP established a revaluing general practice core group to draw up proposals to improve morale. In conversations with principals at meetings nationwide and from evidence received by this core group it has become apparent that feelings of being devalued relate to three sets of factors: educational, structural and administrative.

Educational factors reflect current problems in undergraduate education, in which the balance between attaining and developing knowledge, skills and attitudes had been lost, and which has become increasingly disease-centred rather than patient-centred. If 'good medicine' is regarded and lauded as that which makes clever diagnoses of conditions that are rare in general practice and mobilizes technologically sophisticated treatment of such conditions, then the newly qualified practitioner, deprived of approbation for such coups, misses the real value of good medicine in general practice; this is to use acute clinical skills reliably to exclude such illnesses. If general practitioners do not value this crucial skill, then the peripheral joys of general practice, the intimacy with and trust of patients, the informality and continuity are also not valued. Nothing is more morale-sapping than lack of self-value. It is doubtful whether vocational training, much of which is already remedial in subjects such as clinical logic, has taken this on board.

Structural factors fall into two categories: career and practice partnerships. The lack of career trajectories, with their implicit characteristics of targets, achievements and moves, means that many young principals, despite having tremendous potential, see their career development completed at about the age of 27 years, with about another 38 years ahead in the same situation and surroundings. With no target there is no motivation to learn, to grow, or to change. Any hint of less than a life-time's commitment to the practice, and the offer of a partnership will be withdrawn. Those who do 'branch out' (usually about the age of 40 years), whether into undergraduate or postgraduate academia, occupational health, or medical politics, invariably face the canards of their colleagues accusing them of soft options, work shyness, or even betrayal.

What holds a practice partnership together is the equitable division of both the workload and the rewards. However, there may be only lip service to 'democracy'; senior members' votes often seem to outweigh those of the juniors, despite their equality in the eyes of the family health services authority. Dissolutions of practice partnerships continue to increase and, like divorces, vary from a relatively amicable parting of the ways to a lawyer-infested battle. Even in partnerships that do not dissolve, festering resentment and suppressed anger often remain.[16]

Administrative factors seem to reflect a lack of understanding among family health services authority managers, their public health advisers, the National Health Service Executive and politicians about the real value of good general practice as it relates to patients. Often managers are under pressure to meet targets and budgets and senior civil servants may appear overzealous in the pursuit of change.

The RCGP is aware of and responding to many of the messages. There are many suggestions and exhortations for urgent, positive and concerted actions from medical schools, royal colleges and the British Medical Association.[17] There is also a call for medical education that will enable tomorrow's doctors to learn cooperatively from the start of their training to value themselves, their colleagues and their patients.[18]

The revaluing core group set up by the RCGP to identify these problems and to advise its networks on possible actions presented its report to the council of the RCGP in September 1994. In the educational arena it is entering into dialogue not only with professors of general practice, but with deans and the education committee of the General Medical Council to find out what can be done to re-tool undergraduate education, so as to better equip graduates for clinical practice. The General Medical Council's proposals for the undergraduate curriculum are designed to limit the knowledge overload that has hitherto been a characteristic of the undergraduate years. The recommendations are for there to be a core component to the curriculum with additional elements that medical students themselves would choose.[19]

The core group of the RCGP is discussing with regional advisers ways in which problems with career developments and practice partnership functions can be addressed. In the structural arena it will need to reach out to established practices to influence them in the direction of short-term commitments, part-time and job-share positions and task rotation. In every region there should be skilled mentors/careers counsellors to support and advise doctors at every stage of their career. The masters degree courses that are now becoming more widely available should be seen as ways to train and qualify people for career mobility, not only between appointments such as trainer, course organizer, lecturer and regional adviser, but between these posts and medical advisers or other posts in purchasing consortia.

In the administrative arena the core group of the RCGP has already collected and promulgated examples of good practice in which family health services authorities and their general practitioners have found new ways to mutual understanding, trust and approbation.[20]

Since the primary need is for better information and understanding, the major strategy for the RCGP must be educational, with clear objectives for each area. Nevertheless, to understand why negative attitudes have come about, so that they can be cor-

rected and even more importantly prevented in the future, requires the formulation of research questions and the prosecution of projects to answer them. These are fields of activity entirely proper to the RCGP as the academic body of general practice, and can and should be undertaken independently from other bodies.

With the General Medical Services Committee the RCGP should explore ways of modifying the general practitioner contract to relieve general practitioners of scientifically unproven chores, and of endless data collection designed only to fulfil managers' performance markers.

The foundation of our economical, equitable and effective NHS depends on highly skilled and well-motivated general practitioners. In the face of growing evidence of loss of motivation, the RCGP must bring home to its members, the family health services authorities and the government the message that the time for action has come.

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