Turning the winter of doctor discontent to summer: tackling GP needs in state primary care

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Abstract

Introduction: A study on job satisfaction among state General Practitioners (GPs) in Malta addressed the problem of the inadequate number of doctors within the government GP service. It investigated the hypothesis that this is due to poor job satisfaction, and allowed GPs to suggest other reasons and propose solutions.

Method: A mixed methodology was used, with both quantitative (the Spector 'Job Satisfaction Survey') and qualitative methods (3 open questions) in a questionnaire sent to current and former government GPs, followed by focus group/elite interviews.

Results: 71 out of 136 questionnaires were returned, giving a 52% response rate.

- *Quantitative analysis:* Job dissatisfaction was confirmed among health-centre doctors during 1998-2003. Taking significance as $p<0.05$, regression analysis revealed that doctors formerly working in health centres were significantly more dissatisfied than present ones (univariate $p=0.033$), and working part-time is significantly more satisfying than working full-time (univariate $p=0.007$, multiple $p=0.039$).
- *Qualitative analysis:* 41% of GPs felt unappreciated, neglected and disrespected; 39% experienced job dissatisfaction, stress and depression; while 31% felt verbally and physically used, misused and abused. The top causes cited for the lack of government GPs were poor pay and ancillary benefits (70%), poor training prospects/ career progression (54%) and poor working conditions (46%).

Discussion: As former state GPs during 1998-2002 were significantly more dissatisfied than those in employment in 2003, this corroborates the hypothesis that job dissatisfaction is associated with the shortage of government GPs. Direct solutions (enhanced remuneration/conditions and professional development) and indirect measures (organisational, management and educational initiatives to improve working arrangements) were proposed and discussed.

Key words

Job satisfaction; general practitioners; personnel management; primary health care; Malta

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Introduction

"Now is the winter of our discontent
Made glorious summer by this son of York"
William Shakespeare, 'Richard III':I, i, 1-2.

The government general practitioner (GP) service provided by Malta's Primary Health Care Department (PHCD) forms the backbone of local state primary care. It services one-third of the population, free-of-charge at the point of use for citizens, through 9 main health centres and 45 peripheral local clinics.[1,2] However continuity of care is poor and doctor-patient relationship weak, due to absent patient registration and incomplete record-keeping. Moreover, there is a lack of GPs in permanent posts (at approximately two-thirds of the recommended complement of 110) despite adequate facilities (health centres, clinics and equipment).[3]

GPs in England intending to quit direct patient care within 5 years rose from 14% in 1998 to 22% in 2001, with a decrease in overall job satisfaction cited as the most important reason.[4] US primary care physicians dissatisfied with their jobs have been found to be more than twice as likely to leave.[5] Doctor discontent therefore merits attention in order to help increase the supply of general practitioners.[4]

Rationale & purpose of study

The lack of GPs working in state health centres in Malta has been proposed to be a result of poor job satisfaction.[3] As this situation impedes the plans of Malta's Health Division to strengthen primary health care[1], this project set out to investigate this hypothesis and recommend solutions using a "bottom-up" approach, with state GPs together sharing fresh ideas about how they work.

Methods

A mixed methodology was used, incorporating both quantitative and qualitative methods, in order to obtain triangulation of data and thus improve research validity. The primary survey instrument consisted of a questionnaire, which also served to gather the participants' professional and demographic details. This was mailed to all 84 GPs (70 in permanent posts and 14 part-timers) in the PHCD in January 2003 and to another 52 who had left the department during 1998-2002. After being completed anonymously and on an informed-approach basis, the questionnaire was to be returned by post in a pre-addressed and stamped envelope. A reminder was posted to participants after the set closing date.

The quantitative section of the questionnaire entailed the measurement and analysis of general practitioners' job satisfaction through the Spector 'Job Satisfaction Survey'[6], consisting of a 36 item, nine-facet scale to assess employee attitudes about the job and aspects of the job. The 9 facets of job satisfaction (pay, promotion, supervision, fringe benefits, contingent rewards, operating procedures, co-workers, nature of work, and communication) were measured using a 6-point Likert scale ranging from "strongly disagree" to "strongly agree". The Job Satisfaction Survey was analysed using the 'Instructions for Scoring the Job Satisfaction Survey'[7], Microsoft Excel 2000 and SPSS (V. 11) and Intercooled Stata (V. 7).

Table 1: *Demographic and professional details of questionnaire respondents*

Characteristic	*Number*	*Percent*
Gender:		
• Male	51	71.8
• Female	20	28.2
Status:		
• Married	52	73.2
• Single	15	21.1
• Separated	4	5.6
When based in health centres:		
• Presently	53	74.6
• Formerly	18	25.4
Hours of work in health centres:		
• Full hours	55	77.5
• Reduced hours	7	9.9
• Part-time	9	12.7
Private practice (after hours) while employed in the Primary Care Department:		
• Yes	43	60.6
• No	28	39.4
Housework, caring for children/elderly while employed in the Primary Care Department:		
• Yes	39	54.9
• No	32	45.1
Continuing education activities when in health centres:		
• Yes	41	57.7
• No	30	42.3

The qualitative method comprised the following 3 open questions which were put to doctors in the same questionnaire:

- How does/did it feel to be a doctor within the government GP service?
- What are the causes of the shortage of GPs in state primary health care?
- What solutions are needed to tackle this problem?

The implementation of proposed solutions was then discussed during a focus group of 6 GPs using a SWOT (strengths, weaknesses, opportunities and threats) analysis which was recorded on flip-charts and audiotape. The proposals together with the results of the SWOT analysis were subsequently discussed with policy-makers and managers/ administrators during audio-taped interviews. Qualitative analysis was performed by inputting all data into a Microsoft Word 2000 document (being translated from Maltese to English where necessary). Key data were highlighted (data reduction), after which 'data interpretation' was used to draw up themes.

Ethical considerations

Authorisation was obtained from the Director General (Health) of Malta and approval from the Board of Studies of the Institute of Health Care, University of Malta. Participants were informed that they would be part of a research study that was intended to assist the PHCD in evaluating and improving conditions of work within the GP service in Malta. Participation was entirely voluntary, and the confidentiality of participants in the survey and focus group was ensured as only the researcher analysed the data, with no reports ever identifying participants in any way.

Table 2: *Job Satisfaction Survey mean scores and interpretations (according to facet subscale and in total) for all doctors*

Facet subscale[a]	*Mean score*	*Interpretation*
Pay	8	Moderately dissatisfied
Promotion	7	Moderately dissatisfied
Supervision	15	Slightly satisfied
Fringe Benefits	8	Moderately dissatisfied
Contingent rewards	7	Moderately dissatisfied
Operating conditions	10	Slightly dissatisfied
Co-workers	14	Slightly satisfied
Nature of work	12	Slightly dissatisfied
Communication	10	Slightly dissatisfied
Total satisfaction[b]	**91**	**Slightly dissatisfied**

[a] *Interpretation of facet scores: <4: very dissatisfied; 5-8: moderately dissatisfied; 9-12: slightly dissatisfied; 13-16: slightly satisfied; 17-20: moderately satisfied; 21-24: very satisfied.*

[b] *Interpretation of total scores: <36: very dissatisfied; 37-72: moderately dissatisfied; 73-108: slightly dissatisfied; 109-144: slightly satisfied; 145-180: moderately satisfied; 181-216: very satisfied.*

Table 3: *Results of regression analysis of those individual categories that were statistically significant (p-value <0.05)*

Category	*Univariate regression analysis*			*Multiple regression analysis*		
	Coefficient	*Confidence interval 95%*	*P-value*	*Coefficient*	*Confidence interval 95%*	*P-value*
Gender:						
Male	0			0		
Female	8.56	-1.12, 18.24	N.S.	5.14	-6.24, 16.52	N.S.
In health centres:						
Presently	0			0		
Formerly	-10.8	-20.70, -0.90	<0.05	-8.06	-18.17, 2.05	N.S.
Hours of work:[a]						
Full	0			0		
Reduced	5.69	-8.65, 20.02	N.S.	-0.49	-15.77, 14.79	N.S.
Part-time	18.07	5.22, 30.91	<0.01	13.92	0.71, 27.12	<0.05
Private practice:[b]						
Yes	0			0		
No	8.04	-0.86, 16.94	N.S.	4.38	-5.70, 14.46	N.S.

[a] *When in health centres*
[b] *After hours, while employed in the Primary Health Care Department*
N.S.: not significant

Results

Seventy-one questionnaires were returned out of 136 that were mailed, giving an overall response rate of 52%. The demographic and professional characteristics of the respondents are illustrated in Table 1.

There was comparability as regards gender between the participants (71.8% males and 28.2% females) and the target population (75.7% males and 24.3% females, or 103 and 33 respectively out of 136). Moreover, the correlation of 'hours worked' between GPs in state primary care during 2003 (69.0% working full hours, 14.3% on reduced hours and 16.7% as part-timers) and those of them who participated in the survey (69.8%, 13.2% and 17.0% respectively) was even closer.

Table 4: *Positive feelings about being a doctor within the government GP service*

Rank	*Positive aspects of working in state general practice*	*Percentage of respondents*
1	Job satisfaction (due to good support services, teamwork, some continuity of care, receiving feedback)	17%
2	Patient gratitude (for attention, treatment and services provided)	7%
3	The nature of the work (less tiring/stressful than hospital, interesting semi-emergency cases)	3%
4	Job security	1%
5	Pride	1%

Quantitative results

Scoring of the Job Satisfaction Survey revealed a total satisfaction mean score of 91, which confirmed slight job dissatisfaction among doctors based in health centres during 1998-2003 (Table 2). Slight satisfaction was found in only two out of the 9 facet subscales, namely 'supervision' of the doctors by superiors which scored 15, and relationship with 'co-workers' with a score of 14. When examining the mean scores for total satisfaction according to different categories, the lowest satisfaction score of 85 was found among doctors formerly working in health centres, with the highest score of 109 denoting slight satisfaction observed in doctors working on a part-time basis.

Taking significance as a p-value of less than 0.05, univariate regression analysis showed that the following individual categories had no significant relationship with the total satisfaction mean score: age, status (married, single or separated), year of graduation, years in health centres, housework & caring for children/elderly, and continuing education activities.

However, univariate regression analysis did reveal (Table 3) that doctors formerly working in health centres were significantly less satisfied than present government GPs (p=0.033), while working part-time is significantly more satisfying than working full time (p=0.007). Another two categories only approached

statistical significance: females were more satisfied than males (p=0.082), and doctors doing private practice over-and-above health centre duties were less satisfied than those who did not (p=0.076)

When the category-score relationship was analysed also by multiple regression analysis (Table 3) to compensate for other categories with at least borderline significance, 'working part-time' was the only category found to have a statistically significant relationship with total satisfaction (p=0.039).

Table 5: *Negative feelings about being a doctor within the government GP service*

Rank	*Negative feelings about working in state general practice*	*Percentage of respondents*
1	Unappreciated, neglected and disrespected: • by patients and the general public (not appreciative of heavy workload; not respectful of professional role) • by the administration (uncaring towards GPs' needs; indifferent to their opinion; lack of trust) • by colleagues (selfishness; side-kicking; making obstacles)	41%
2	Job dissatisfaction, over-worked, frustrated, demotivated / demoralized / deluded, stress and depression, due to: • the nature of the work (clerical paperwork; trivial complaints) • the conditions of work (inadequate remuneration/benefits; lack of staff with huge workload; long working hours) • due to the set-up of the system (poor continuity of care; lack of patient-appointment system)	39%
3	Used, misused & abused (re doctors and their services): • by patients and the public (trivial / silly complaints; verbal obscenities; lack of preventive rules/procedures) • by the administrative system (lack of structures & guidelines; non-involvement of GPs in decisions; inertia of authorities) • by fellow colleagues (abuse of junior doctors; abuse of sick leave)	31%

Qualitative results

Qualitative analysis revealed only a few positive feelings about being a state GP (Table 4), while the majority of respondents revealed negative feelings (Table 5). Quotations by doctors highlighting their experiences of dissatisfaction, disrespect and abuse while working in government health centres may be viewed in Table 6.

The main causes cited by participants for the lack of state GPs are listed in Table 7. Table 8 summarises the solutions to the problem proposed by questionnaire respondents and discussed during the focus groups and elite interviews.

Table 6: *Quotations from doctors highlighting their experiences of dissatisfaction, disrespect and abuse while working in government health centres*

Experiences of dissatisfaction

- "It is the "supermarket" experience. People come, get served (demand to be) and vanish. We always have to deliver – always plus "the customer is always right" (male, graduated 1988)
- "I feel like the civil servant who is expected to do an infinite amount of work, at a low wage, but with very high responsibility" (male, graduated 1989)
- "Work in a poorly structured service which gives no professional satisfaction, no "doctor-patient" relationship and (the) practising of defensive medicine" (male, graduated 1984)

Declarations regarding disrespect

- "It felt like being a denigrated, second-class medical professional. In the UK, the GP is the fulcrum of the NHS. In Malta he is merely a lame duck, a disrespected professional who is underpaid and is looked down by fellow colleagues and the administration" (male, graduated 1997)
- "'A second-rate doctor' ... not because I think I am less capable than other doctors, but because I feel that this is the way the general public, and 'hospital' doctors, often conceive us!" (female, graduated 1997)

Descriptions of abuse

- "The best way I can describe what I feel to be a doctor within the government GP service is "a paid slave" (male, graduated 1985).
- "Like a puppet with everyone trying to pull your strings in opposite directions. Pathetic and frustrating!" (male, graduated 1987).
- "Like a "bicca ta' l-art" (floor cloth)! Used and abused by the "patients" and unfortunately also by "colleagues" (male, graduated 1995).

Table 7: *Main causes cited for lack of state GPs (classified into themes)*

Rank	Causes of lack of state GPs	Percentage of respondents
1	Poor pay and ancillary benefits compared to responsibility of job, long hours and quantity of patients	70%
2	Poor training prospects and poor career progression	54%
3	Poor working conditions	46%
4	Poor administration/management and poor doctor-administrator relationship	37%
5	Poor continuity of care	32%

Discussion

Job satisfaction and the shortage of state general practitioners

The finding that doctors formerly working in health centres during 1998-2002 were significantly less satisfied than government GPs in employment in 2003 supports the hypothesis that job satisfaction is a contributing factor to the lack of medical manpower in state primary health care[3], although it does not exclude the existence of other reasons.

The category that showed the strongest statistically significant relationship with total satisfaction was that of working on a part-time basis compared to working full-time. As 67% of part-timers performed housework and cared for children and/or elderly relatives, part-time work would facilitate the combination of their professional and family commitments. This puts forward the possibility of full-time doctors working on a flexitime arrangement to mirror part-timers' more satisfying conditions of work.[8]

In the qualitative part of the questionnaire, the great majority of GPs revealed overwhelmingly negative feelings about being a doctor within the government GP service. Moreover, doctors had no doubt that job dissatisfaction is the sole cause of the shortage of GPs in state primary health care.

Direct solutions for the shortage of state general practitioners

Solutions addressing medical manpower needs in state primary health care may be classified into direct and indirect, with one direct solution being the introduction of better remuneration. This could be implemented, most probably outside the civil service structure, through the introduction of a performance-based contract incorporating allowances and such non-monetary benefits as indemnity, autonomy and flexibility. A survey of US generalists and specialists concluded that addressing relative dissatisfaction with income appears important in promoting doctor retention.[9] In 2003 British GPs overwhelmingly accepted a more lucrative contract tied to a new quality and outcomes framework, and which allowed them to control their workload better and trade leisure for income or vice versa.[10,11] More flexible patterns of working in general practice would not only allow more GPs to continue their careers[12], but also allow delivery of care in patterns that extend access for users.[13]

Another direct solution is that of an improved working environment, both physical and human. The necessary refurbishment of certain health centre premises[14] would provide a pleasant working environment, while ancillary staff should

Table 8: *Proposed direct and indirect solutions for the lack of doctors in state primary health care*

A. Direct Solutions

1. Enhance working conditions:
   - remuneration (fair salary, befitting importance and responsibility of work);
   - other benefits (indemnity, increased autonomy, flexible hours);
   - working environment (teamwork, ancillary staffing, refurbishing of centres).
2. Develop undergraduate, vocational and continuing training in family medicine, with the introduction of specialist status and career progression.

B. Indirect solutions

1. Introduce continuity of information and care (proper record-keeping, registration through appointments, less paperwork) with comprehensive computerisation.
2. Implement better management (improved communication & participation), organise service delivery (reassessment of role of village clinics), and curtail client abuse.
3. An educational campaign to optimise use of health centres by clients and to raise the status of the state GP among the general public.

Table 9: *Recommended human resource management policies for improving GP satisfaction and tackling medical manpower needs in state primary care*

A. Improving and maintaining the supply of GPs	*B. Reducing demand on GPs through job facilitation*
1. Appropriate remuneration: • according to level of work and responsibility; • on performance-related contract; • with appropriate allowances; and • professional autonomy & indemnity. 2. Training in family medicine: • undergraduate; • vocational/specialist; and • continuing/postgraduate. 3. Career progression to specialist posts.	1. Improving working arrangements and conditions through: • flexible working patterns; • interdisciplinary teamwork; • continuity of care through information technology; • reassessment of role of village clinics; • development of ancillary staffing; and • refurbishment of premises. 2. Educational campaigns to: • combat client abuse; and • raise the profile of the state GP. 3. Health centre management boards with: • multidisciplinary representation; and • authority to make changes as needed.

provide more competent support. Moreover, doctors need to share patient care with other healthcare professionals through interdisciplinary teamwork.[15] This would provide GPs with more time to develop the doctor-patient relationship[9] and to improve and extend their care of clients through the provision of special services.

Other direct recommendations proposed were the development of training in family medicine for medical students (launched in 2001) and newly qualified doctors (planned for 2007), together with the provision of continuing medical education and post-graduate courses.[16] These help to raise the practice of family medicine to specialist status (which in fact was introduced following Malta's accession to the European Union in 2004), and also facilitate the introduction of career progression for family doctors. Thus, while students and new doctors would be attracted to specialise in family medicine[17], GPs already in practice might be tempted by the improved career opportunity[18] of a registrar or consultant post to stay in state primary health care instead of turning to more profitable private practice.

Indirect solutions for the shortage of state general practitioners

The introduction of continuity of information and care is one indirect solution proposed to tackle the lack of government GPs. A system with good communication and continuity enjoys such strengths as patient registration, the keeping of proper medical records, and an appointment system, all facilitated through information technology (IT).[14,19] If initial threats to the introduction of IT (due to difficulties in implementation and lack of funding) are overcome, continuity of information would streamline GPs' duties through curtailing repeat prescriptions and eliminating excess paperwork. This would in turn provide GPs with the opportunity to enhance continuity of care by developing the doctor-patient relationship, improving cooperation with colleagues in primary and secondary care, following guidelines and protocols, and performing research and audit.

Other indirect solutions recommended include the implementation of better management through communication, consultation, support and appreciation. Another proposal was for the re-organisation of poor service delivery present in the village clinics (where a doctor is "wasted" in issuing repeat prescriptions for chronic conditions), concurring with a report by Malta's Auditor General regarding their inefficiency[14]. The same report[14] also confirmed abuse of health centre services; this could be tackled by client education in their proper use, together with the curtailment of service availability through continuity of care, appointment systems and limited opening times. If the information campaign was extended to highlight the strengths of government GPs and the services they provide, this would also tackle rising GP dissatisfaction with lack of recognition for good work.[20]

Limitations of study methods

The reactivity of participants may have been a limitation, in that the person filling the questionnaire would have wanted to give the researcher a reply to please the latter (the 'halo effect'). This effect was diluted during the focus group interview where, in the presence of other colleagues, participants were quite straightforward in their comments.

A bias may have been introduced in a number of ways. A possible non-response bias by disinterested doctors could have been tackled if a mini-sample of the non-respondents was taken and these were contacted directly to inquire as to the reason for their non-response. A recollection bias was limited by restricting former employees included in the survey to those who had left within the past five years. The latter step inevitably resulted in another bias regarding the composition of the study population (84 doctors working in health centres

in 2003 versus just 52 doctors who had resigned during 1998-2002), with consequently more replies being received from doctors still in employment than from those formerly employed (53 versus 18 respectively).

An interpretation bias on the part of the researcher could have been avoided through the use of a research assistant or a second opinion for the interpretation of the results. This was precluded as the study was a dissertation in part-fulfilment for a university master's degree and, as such, the researcher had to be solely responsible for the work presented. However, the researcher had already undertaken a previous research project evaluating a health service in which he was personally involved, and he was successful in not allowing the less-then-optimal results to affect the interpretation together with the subsequent conclusions and recommendations.[21]

Conclusion & recommendations

Poor job satisfaction was confirmed among state GPs, where the only category scoring some satisfaction was working part-time compared to full-time. The fact that doctors formerly working in health centres during 1998-2002 were significantly more disssatisfied than those in employment in 2003 confirms the hypothesis that job dissatisfaction is associated with the lack of government GPs. Doctors themselves were sure that job dissatisfaction is the cause of their lack in numbers.

Human resource management policies (Table 9), comprising appropriate remuneration, professional development schemes and improved working arrangements and conditions, have the potential to enhance job satisfaction, reduce turnover and improve the care that state general practitioners provide to patients.

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References

1. Azzopardi Muscat N. Health Care Systems in Transition – Malta. Copenhagen: World Health Organisation, 1999.
2. Dipartiment tal-Kura Primarja. Servizzi mic-Centri tas-Sahha. Malta: Ministeru tas-Sahha, Kura tal-Anzjani u Affarijiet tal-Familja, 1997.
3. Sammut MR. Primary Health Care Services in Malta: Provision, Utilisation and Reform. The Family Physician/It-Tabib tal-Familja - Journal of the Malta College of Family Doctors 2000;19:4-11.
4. Sibbald B, Bojke C, Gravelle H. National survey of job satisfaction and retirement intentions among general practitioners in England. BMJ 2003;326:22-5.
5. Buchbinder SB, Wilson M, Melick CF, Powe NR. Primary care physician job satisfaction and turnover. Am J Manag Care 2001;7:701-13.
6. Spector PE. Job Satisfaction Survey. Department of Psychology, University of South Florida, 1994. Retrieved August 18, 2003 from University of South Florida, Department of Psychology website: http://chuma.cas.usf.edu/~spector/scales/jssnice.doc
7. Spector PE. Instructions for Scoring the Job Satisfaction Survey, JSS. Department of Psychology, University of South Florida, 1999. Retrieved August 18, 2003 from University of South Florida, Department of Psychology website: http://chuma.cas.usf.edu/~spector/scales/jssscore.html
8. French F, Andrew J, Awramenko M, Coutts H, Leighton-Beck L, Mollison J, *et al*. General practitioner non-principals benefit from flexible working. J Health Organ Manag 2005;19:5-15.
9. Pathman DE, Konrad TR, Williams ES,Scheckler WE, Linzer M, Douglas J, *et al*. Physician job satisfaction, dissatisfaction, and turnover. J Fam Pract 2002;51:593.
10. Kmietowicz Z. GPs accept contract, but consultants ask for ballot on industrial action. BMJ 2003;326:1415.
11. Lewis R, Gillam S. A fresh new contract for general practitioners. Complex, with risks attached, but addresses many of the profession's concerns. BMJ 2002;324:1048-9.
12. Baker M, Williams J, Petchley R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. BMJ 1995;310:1301-4.
13. Department of Health. Working Lives: Programmes for Change. Overview. UK: Department of Health, 1997. Retrieved July 14, 2002 from: http://www.doh.gov.uk/iwl/overview.pdf
14. Auditor General. Performance Audit. Primary Health Care – The General Practitioners' Function within Health Centres. Malta: National Audit Office, 2001.
15. Mathie T. The primary care workforce crisis: a time for decisive action. Br J Gen Pract 1997;47:3-4
16. Sammut MR. Activities and Achievements of the Malta College of Family Doctors 1989-2003. The Family Physician/It-Tabib tal-Familja-Journal of the Malta College of Family Doctors 2003;24:2-7.
17. Evans J, Lambert T, Goldacre M. GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice. Occasional Paper 83. London, UK: Royal College of General Practitioners, 2002.
18. Gruen R, Anwar R, Begum T, Killingsworth JR, Normand C. Dual job holding practitioners in Bangladesh: an exploration. Soc Sci Med 2002;54:267-79.
19. Hippisley-Cox J, Pringle M, Cater R, et al. The electronic patient record in primary care – regression or progression? A cross sectional study. BMJ 2003;326:1439-43.
20. Sibbald B, Enzer I, Cooper C, Rout U, Sutherland V. GP job satisfaction in 1987, 1990 and 1998: lessons for the future? Family Practice 2000;17(5):364-71.
21. Sammut MR. Are Stop Smoking Services Successful? An Evaluation of Smoking Cessation Clinics in Malta. Malta Medical Journal 2003;15:26-31.