Motivation amongst health secretaries at Norwegian GP clinics

A qualitative study about health secretaries’ reflections and experiences as employees at GP clinics

Marthe Helene Sandli
Supervisor: Ivan Spehar

THE UNIVERSITY OF OSLO
The Faculty of Medicine
Department of Health Management and Health Economics

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IV
Abstract

Title: Motivation amongst health secretaries at Norwegian general practitioner (GP) clinics: A qualitative study about health secretaries’ reflections and experiences as employees at GP clinics.

Project description: The study investigates what is needed in order to motivate health secretaries at Norwegian GP clinics.

Background: Previous research suggests that GPs do not know how to motivate their employees and lack formal training before taking on the responsibility of being a manager. With the possible introduction of primary health care teams, it is important to know how health secretaries view their role in the workplace. This is related to challenges within the workplace that might arise due to GPs lack of management training.

Aim: Examine what health secretaries need to feel motivated at work in Norwegian GP clinics, and look closer into how GPs can improve their understanding of what motivates their employees.

Methods: A qualitative research method was chosen, using semi-structured interviews to investigate the topic. The study performed three one-to-one interviews and one focus group interview. Systematic text consideration was used to analyse the data.

Conclusion: A combination of Deci and Ryan’s self-determination theory and Herzberg’s two-factor theory can be used to describe in what way health secretaries experience motivation and challenges within the workplace. Further management training for GPs should be offered to create better GP clinics. The study found which factors the GPs need to focus on in order to motivate their health secretaries in a better way, such as the need to be recognised and acknowledged for their work performance, and the importance of social relations within the workplace.
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1 Introduction

Primary health care covers several functions within the health care sector. Norwegian primary health care services are provided and offered in each municipality, and consists of services such as general practitioners, nursing home care, and preventive health care work for children, adolescents and those pregnant (Braut, 2015). In Norway, general practitioners (GP) work as gatekeepers into specialist health care (Frich, Iversen, & Tjerbo, 2017). Frich et al. (2017) argue that this gatekeeper function is important and makes it easier for hospitals to be ready for patients and prepare for each individual case to a larger extent. Seeing as the entire health care system depends on a well-functioning primary health care service, the role of the gatekeeper is essential. However, it should be said that in some cases, such as health care provided for patients with chronic diseases, the gatekeeper function seems to be counterproductive (Bodenheimer, Lo, & Casalino, 1999). To ease the pressure on the specialist health care system, patient groups with chronic illnesses are being targeted and focused on in a new pilot project with primary health care teams in Norway.

This study aims at clarifying how health secretaries experience their role in the work place, and how they view motivation as a contributing factor to either good or bad sides of their workday. By looking into this, GPs might be able to use the findings to create a better work environment for both their health secretaries and themselves. The thesis will go through motivational theories, results and findings from the study and contribute to increased knowledge when it comes to what motivates health secretaries.

1.1 Motivation

Through their research, Deci and Ryan (2000) developed a self-determination theory (SDT). SDT consist of three components describing basic human needs that have to be fulfilled in order to feel the motivation needed to accomplish a task. These three components are competence, autonomy, and psychological relatedness. If all these components are in place, one can truly use motivational management theory to best stimulate and encourage employees. SDT has, through research, shown to be relevant when looking at motivation as a management tool (Deci & Ryan, 2000; Reiss, 2012; Ryan & Deci, 2000). In particular, SDT focuses on autonomous motivation and controlled motivation. SDT also uses motivation to
predict both performance, relational and well-being outcomes (Deci & Ryan, 2008). By distinguishing between different types of motivation, SDT believes it is easier to determine important outcomes such as effective performance, creative problem solving, psychological health and well-being. It is argued that by looking into the quality of motivation, rather than the amount of motivation, one can truly increase the well-being and motivational level within a work place (Deci & Ryan, 2008).

This study has looked into motivational theories, and applied them to see what kind of aspects play a part in the motivation of health secretaries and how they experience their workdays. Herzberg’s two-factor theory takes recognition into account to a much larger extent than the SDT theory, and highlight this aspect as a motivational factor (Herzberg, Mausner, & Snyderman, 1993). Herzberg et al. (1993) argue that there are different factors contributing to job satisfaction and job dissatisfaction. Satisfaction is about growth, achievements, recognition and work development; and dissatisfaction deals with the challenges of salary, administrative work and equipment functioning properly. Satisfaction in this case is not the opposite of dissatisfaction, and factors contributing to job satisfaction will not necessarily remove dissatisfaction factors. The two-factor theory suggests a strong correlation between job satisfaction and one’s ability to be productive in a work setting. This study has looked closer into how the two-factor theory, combined with the SDT, can create a better understanding of how health secretaries experience motivation within the work place and what they think creates a better work environment.

In addition to Deci and Ryan’s SDT and Herzberg’s two-factor theory, this study will discuss intrinsic and extrinsic motivation to describe the results and findings, and also to get a better understanding of the theories. Intrinsic motivation largely describes, and focuses on, how inner motivation drives one to perform a certain task. Extrinsic motivation, on the other hand, focuses on reaching a goal using rewards, such as monetary incentives, or threats of sanctions (Reiss, 2012).

1.2 Previous research

Little research has been carried out when it comes to health secretaries and what motivates them as a career group. This also include what expectations they have of the job they perform. A focus group study by Spehar et al. (2017) indicate that GPs in Norway struggle to
motivate their employees. There appears to be a “cultural gap” between doctors and secretaries in which GPs have a lack of insight into the secretaries’ motivations and expectations (Spehar, Sjøvik, Karevold, Rosvold, & Frich, 2017). “Cultural gap” in this setting means the different kind of education levels between health secretaries and doctors. The expectation towards a work task might be different with the individual educational level that exists between the two work groups.

This research project and study tries to get an insight into what actually motivates health secretaries and what they expect of their employer and the work they do. Spehar et al. (2017) found that GPs had noticed how the health secretaries appeared to have a lower ambition level when it came to work assignments and had lower aspirations towards their work place than themselves. Another issue the GPs were surprised to discover was how their secretaries did not want to take on more or new responsibility when encouraged to do so. “We don’t really know what their ambitions are. Where they want to go. They may not necessarily think the same way as we do” (quote from a GP in Spehar et al., 2017). The study by Spehar et al. (2017) observed 17 participants after taking a five-day management course and analysed how they experienced their role as a leader. The study used a focus group and all participants were given a 2000-word long assignment where they discussed a challenge from primary health care or a leadership issue experienced in their own clinic. Through this, they found that the GPs’ main challenge by working as leaders were largely how they had to manage different educational backgrounds from their own medical degree. The main finding from this study suggests that GPs need more preparation and formal training to take on the task as a leader and manager due to the tension they experience between the role as a clinician and a leader (Spehar et al., 2017). By giving an insight into the role of the health secretaries, it might be easier for the GP’s to combine the role as a leader and a clinician. This understanding could be used as a supplement for GPs in formal training to become leaders with a broader management skill set.

By trying to find the key elements in how health secretaries view their workday and what motivates them as a group, it might be easier to understand their expectations towards the work place and work tasks. This study has therefore emphasised these findings and looked into how the results of the study can contribute to management training and continuous education programmes for GPs as leaders and managers.
1.3 Health secretaries and their role in the clinic

Regarding health secretaries and their role in the work place at a GP clinic, it is important to acknowledge how they are, in fact, the first employee patients interact with. As an example; health secretaries oversee answering the phone and organising all appointments with the doctors at the GP clinic. In cases where GPs find the management role challenging, it would be highly relevant to look closer into what motivates their staff and use this to become better leaders. Seeing as most GPs in Norway work at relatively small clinics (Rørtveit, 2015) and mainly interact with a few other doctors and their health secretaries, the GPs are in continuous dialogue with all their staff. This communication challenge is why this study has interviewed several health secretaries in order to expand the knowledge in the field and contribute to the research field of motivation amongst specific work groups. Health secretaries can be found on several levels within the Norwegian health care system. This study has therefore limited its research to GP clinics in order to make the findings more applicable to the GP and health secretary relationship and work setting.

1.4 Organisation of the general practitioners

In Norway GPs are organised through a Regular General Practitioner (RGP) scheme. Each individual municipality is responsible for the organisation of this scheme (Helse- og Omsorgsdepartementet, 2017a). The municipalities also have to make sure there are a sufficient amount of GPs to meet the demand within the municipality. The RGP was introduced in 2001, and the goals of this implementation were to increase access to GPs, and make primary health care services better abled to provide quality service to the population within each municipality (Helse- og Omsorgsdepartementet, 2017a; Sandvik, 2006). The RGP scheme is regulated by the “Regulations on the RGP scheme in municipalities” (Helse-og Omsorgsdepartementet, 2012). GPs sign contracts with the municipalities, entering into an agreement about providing primary health care services to the inhabitants (Helse- og Omsorgsdepartementet, 2017a). The GPs are responsible for employing their own staff, for example health secretaries, and the additional administrative work employment leads to. In this study, all participants are currently working at GP clinics where the GPs are self-employed.
1.5 The study

This study has performed both one-to-one interviews and a focus group interview in order to investigate how health secretaries experience motivation or a lack of motivation within their workplace. In chapter 2 motivational theories will be discussed, and chapter 5 will analyse to what extent existing motivational theories, such as SDT and the two-factor theory, are applicable when considering health secretaries as a work group. The reason for choosing to focus on SDT and the two-factor theory is because these are two main influential theories within the field of motivational science (Cook & Artino, 2016; Sanjeev & Surya, 2016).

Data has been collected through one-to-one interviews and a focus group interview. The way these interviews were conducted, was by using a semi-structured interview method. For analysing the data, systematic text consideration was used. Chapter 3 will discuss the methods in greater detail and the results from this study will be presented in chapter 4. The findings in this study will be discussed in chapter 5, and also be used to suggest how further management training of GPs could improve their management skill set and make them better leaders in primary health care. The following chapter will go into the theoretical background for this study.
2 Theoretical Framework

2.1 Motivation as a concept

Deci and Ryan (2008) created a framework and foundation for the many studies performed within the field of motivation. If someone feels motivated, they are moved towards something, for example a goal, whereas a person who lacks inspiration is characterised as unmotivated (Ryan & Deci, 2000). By looking at the inherent capacity humans have to engage and feel wellness, as well as psychological growth, the theory of self-determination (SDT) examines whether biological, social, and cultural factors improve or weaken these capacities (Ryan, 2017). According to SDT, motivational factors depend upon the three components of competence, autonomy, psychological relatedness. These three factors together form the foundation from which motivation can take place. Interpersonal relationships, the ability to act competently in different situations and manage one’s thoughts, feelings and behaviours all combined could give a better sense of creativity regarding one’s life (Fiske, Gilbert, & Lindzey, 2010). Using these three factors, an individual is able to incorporate new experiences, knowledge, and information in a more flexible and, maybe most importantly, a less defensive way (Kernis & Goldman, 2006). Herzberg on the other hand views motivation slightly different and explains it with the two-factor theory. The two-factor theory suggests factors that give satisfaction at work and those creating dissatisfaction (Herzberg et al., 1993). The two-factor theory emphasises the aspect of recognition to a larger extent than SDT theory. Nonetheless, both theories shed light on important factors within motivational science.

2.2 The self-determination theory

The competence factor in SDT, being the first of the three, refers to the ability of expressing the capacities one has in a work setting, and also regarding interactions in a social environment (Deci & Ryan, 2002). Deci and Ryan (2002) suggest that the need for competence leads individuals to work on their skill set and pursue challenges that are fit for their capacity level. Following from this, one can argue that competence is less of a skill or capability, but rather a sense of confidence and the ability to influence and explore the environment an individual is in. Competence is about supporting actions that succeed in giving an individual a feeling of accomplishment (Deci & Ryan, 1985). The sense of
accomplishment will in turn lead to a form of intrinsic motivation (Deci & Ryan, 1985). Deci and Ryan (1985) argue that constructive feedback and good communication are a part of the feeling of accomplishment and of confidence in work performance.

Autonomy refers to actions decided by oneself and being in control of one’s own behaviour (Deci & Ryan, 2002). This second factor in SDT can be said to be an individual’s ability to express themselves. In a way, their behaviour is an expression of the actual self. The perceived feeling of having support in one’s actions, is an important factor when it comes to autonomy, as this leads to one’s feeling of autonomous behaviour (Deci & Ryan, 1985). Another aspect to acknowledge is that the competence factor has to include a feeling of autonomy of the task performed in order to feel intrinsic motivation (Deci & Ryan, 1985). The individual should be able to relate to and incorporate the task, and by doing so enabling autonomous actions. The autonomy aspect has several benefits to it when used correctly. For example, it is more likely that the individual shows more creativity, performs a task in a better way and ends up more satisfied and happy with the end result. The well-being of the individual is therefore enhanced, and the individual is able to improve daily task performance.

The third factor, psychological relatedness, raises the importance of being cared for and the importance of caring for others (Deci & Ryan, 2002). The crucial part here is that one belongs somewhere, in a community or in a work place in such a way that one feels connected to others (Baumeister & Leary, 1995). Psychological relatedness concerns secure relationships with others and within the work place, meaning it is important to feel accepted and integrated by colleagues (Deci & Ryan, 2002). Intrinsic motivation will work in a better way when individuals have support from colleagues and managers (Deci & Ryan, 2002).

An issue that Deci, Koestner and Ryan (1999) raises is that if individuals receive monetary incentives, it reduces the intrinsic motivational factor for wanting to perform a task. This meta-analytic review by Deci et al. (1999) discovered how monetary incentives, independent of being engagement dependent or completion dependent, undermined the self-reported interest in the tasks performed. The research indicates that receiving such a monetary reward makes individuals feel controlled to a larger extent, and therefore undermines the intrinsic motivation (Fiske et al., 2010).
As Ryan (2017) argues, SDT can be applied in multiple arenas of research. Amongst which arenas the author highlights are classrooms, families, health clinics and work places (Ryan, 2017), suggesting that different types of motivational regulations can be identified through research and assessment. What is essential to remember is how SDT assumes that all individuals inherently are curious, deeply social and psychically active beings. SDT looks into how competence, autonomy and relatedness work together by creating a framework for motivation and the theories of how employers can motivate their staff.

2.3 The two-factor theory and Maslow’s need hierarchy

In 1959, Herzberg et al. (1993) studied how motivation could increase job productivity and give better results if employees experienced feelings such as responsibility, achievement and recognition. Herzberg’s two-factor theory is based on Maslow’s hierarchy of needs theory (Herzberg et al., 1993). However, unlike Maslow, Herzberg argues that satisfaction does not necessarily remove dissatisfaction, as those two factors work somewhat independently (Herzberg et al., 1993). Maslow argued that satisfying our needs will lead to motivated employees by reaching the top of the pyramid with self-actualisation (Holzknecht, 2007). The pyramid has five levels, going from physiological needs to self-actualisation. Level one includes basic needs such as food and water, level two entails safety and security regarding health, employment and stability, whilst level three considers love and belonging, taking into account friendship, intimacy and sense of connection (Holzknecht, 2007). Level four concerns self-esteem where confidence and achievement are important, and lastly self-actualisation in which creativity and spontaneity can flourish, and acceptance and inner potential are important (Holzknecht, 2007).

Maslow’s theory has been criticised because of the fact that he suggests that if all levels of need are fulfilled, an individual will always feel motivated at their job (Kaur, 2013). Graham and Messner (1998) argue that there is limited empirical data to support Maslow’s research and conclusions. A point Graham and Messner (1998) make is that Maslow’s theory relies on every individual and employee behaving in the same way when facing a certain situation. They also argue that Maslow’s theory support theories of job satisfaction rather than motivation (Graham & Messner, 1998). Another criticism towards Maslow theory is that all situations are treated similarly and that there is only one way to meet an individual’s needs (Graham & Messner, 1998). Although criticised, Maslow’s hierarchy of need theory has
contributed massively to the field of organisational behaviour and added valuable management knowledge. The theory is still used as groundwork when researching motivation (Kaur, 2013).

Seeing as the two-factor theory is largely a continued work of Maslow’s hierarchy model, it is vital to take into account how Maslow views motivation. Regarding job satisfaction and job dissatisfaction, Herzberg argues that one cannot use semantics in order to truly understand the difference (Herzberg, 2008; Herzberg et al., 1993). The argument is that job satisfaction is not the opposite of job dissatisfaction, as the semantics of the language would imply. Here, adding a job satisfaction factor does not in fact remove a job dissatisfaction factor, meaning that factors producing satisfaction are separate and different from factors creating dissatisfaction (Herzberg, 2008). Hence, the opposite of job satisfaction is no job satisfaction, and the opposite of job dissatisfaction is no job dissatisfaction.

The two-factor theory consists of two different aspects; motivation and hygiene. The hygiene factor concerns more basic needs, like those we share with other animals and those covered by the lower levels of Maslow’s need hierarchy (Herzberg, 2008). Herzberg (1993) argues that the motivation factor is more unique to human beings, this entails the urge to experience recognition for performance, possibility for growth, and development within one’s profession. Thus, a motivator is a source for job satisfaction and a hygiene factor a source for job dissatisfaction and unhappiness in the work place (Herzberg, 2008). Herzberg (2008) further argues that fear of punishment or failure will make an individual behave in a certain manner through extrinsic factors. One the other hand, Herzberg (2008) argues that motivational factors aspire for growth through challenging and interesting work tasks for the individual.

Herzberg (2008) takes into account the importance of being recognised and appreciated for work performance. It is suggested that this direct feedback enhances the work performance experience for an individual. By adding the element of recognition into factors influencing motivational theories, the two-factor theory highlights just how important recognition is viewed by individuals. Realising the complexity of motivating humans has changed how leaders both view their employees, but also how they are best able to provide a good work environment. Herzberg argues that there is a need to enrich the work environment and use motivational factors when planning and organising a work place (Herzberg, 2008).
Hu (2017) suggests that the two-factor theory could be a way for the public sector to motivate employees. Seeing as monetary rewards are limited within the public sector, increasing job satisfaction for employees through monetary incentives is difficult (Hur, 2017). Therefore, this sector could benefit from using other incentives, such as motivation as viewed by the two-factor theory. Herzberg’s two-factor theory suggests that there are different factors creating satisfaction and dissatisfaction at work (Herzberg et al., 1993). Hence, to increase satisfaction is not to decrease dissatisfaction. Motivation is said to be a factor causing satisfaction and includes elements such as personal growth, challenging work, recognition for achievements and involvement in decision-making. Dissatisfaction is a part of the hygiene factor and focuses on more basic needs such as job security, salary, and work conditions. The possibility for growth and development within the work setting is seen as important, for examples through continued education.

It has been suggested that the two-factor theory is inadequate due to the lack of consideration of different situational variables (Heery & Noon, 2017). It is assumed that job satisfaction will lead to an increase in productivity, which might not always be the case (Heery & Noon, 2017). However this has been suggested, the theory is still widely recognised and used within the field of motivational research (Herzberg, 2008; Holmberg, Caro, & Sobis, 2018; Hur, 2017; Lynn DeVito, Brown, Bannister, Cianci, & Mujtaba, 2016).

2.4 **Intrinsic and extrinsic motivation**

This study has investigated the main fields within motivational theory and also looked closer at the two factors: intrinsic and extrinsic motivation. Extrinsic motivation is based on performing a task because of external factors, such as being rewarded to reach a goal or receiving a threat of sanctions if one is unable to reach that specific goal (Reiss, 2012). On the other hand, intrinsic motivation focuses on performing or doing a task based on an inner wish or will, or purely because one is interested in the task itself (Reiss, 2012). However, Reiss (2012) suggests that this way of looking at motivation is too narrow and states that the human mind and motivation cannot simply be divided into two categories. This study takes Reiss’ suggestion about how diverse motivation can be into account. It is useful to have a category to link findings to, whilst remembering to look further during the research. Sometimes, motivational factors can be difficult to distinguish between. Motivation can be driven by both extrinsic motives, such as a steady income, and intrinsic motives that takes
into account social well-being and wanting to perform a task because of one’s own will. Factors, such as a steady income, can be taken advantage of by an employer, who has the possibility to make individuals perform in a certain manner in order to for example keep their job. This is a clear example of extrinsic motivation and the use of sanctions to reach a goal.

An example of the implications of how extrinsic and intrinsic motivation affect each other, is a study performed by Deci in 1971 (Deci, 1971). The study analysed college students working in a newspaper office over a period of 16 weeks. First, they observed the level of intrinsic motivation during the first four weeks, establishing a baseline level, without splitting the college students in groups. None of the students was aware they were being observed. One staff member split the students into an intervention group and a control group. The intervention group was rewarded with 0.5 USD for each headline they made, whilst the control group did not receive any money for headlines made (Deci, 1971). After only three weeks of rewarding the creation of headlines, they assessed both groups and discovered that the intrinsic motivation level had decreased in the intervention group. This continued even after the payments had stopped after an additional two weeks. The results were significant, as the levels of intrinsic motivation was reduced when receiving extrinsic rewards (Deci, 1971). Deci and Ryan (1985) have found that extrinsic rewards undermine an individual’s self-determination, affecting intrinsic motivation for performing a task over time. Hence, the use of rewards can be said to damage intrinsic motivation (Deci & Ryan, 1985; Notz, 1975).

2.5 Education and how the GPs are organised in Norway

In Norway, the title of “health secretary” has been a protected title since 2001 through the Health Personnel Act of 1999 (Helse- og Omsorgsdepartementet, 2012). The educational pathway for health secretaries is through an upper secondary school programme where a two-year course is given after a one-year foundation course in the field of health and social studies (Braut, 2009). In a general practitioner (GP) clinic they perform different tasks such as handling patient calls, work in the laboratory with for example blood samples and vaccines, and general paperwork, such as sending NAV (the Norwegian labour and welfare management) needed medical certificates (Braut, 2009). Health secretaries experience patient contact through lab work, phone calls and at the reception desk. As for doctors, a six-year programme at university level is required, as well as specialisation afterward (Helse- og Omsorgsdepartementet, 2014). This specialisation programme is currently being altered and a
different programme will be implemented in 2019 (Kalveland, 2017). Level one of this specialisation programme (LIS 1) will be for one and a half years (previously known as the foundation programme). Then, after the implementation, a specialisation period in a specific field, such as general medicine, (LIS 2 and 3) will contain a different set of learning goals. A supervisor has to make sure these goals are reached, and completing a certain number of surgeries or attending a number of courses will no longer be required (Kalveland, 2017). Today, all doctors need to go through a set amount of mandatory as well as optional courses and complete a number of surgeries over a time period of together at least 6,5 years before being given the title as specialist (Kalveland, 2017).

Municipalities are responsible for providing primary health care in their area. This includes, amongst other tasks, school nurses, GPs and nursing homes (Braut, 2015). In 2001, the primary health care service was reformed and the Regular General Practitioner (RGP) Scheme was introduced in Norway (Helse- og Omsorgsdepartementet, 2017a). The reason behind this implementation was primarily to increase access to GPs and the services they provide in order to create a better primary health care service for the population (Sandvik, 2006). Within the Norwegian population, only 67 % had a GP before the implementation in 2001, whilst today the Directorate of Health reports the number being 97,9 % (Gaardsrud, 2016). After the implementation of the RGP scheme within the primary health care service it seems as if access to GPs have improved and the amount of doctors have increased (Sandvik, 2006). However, several GPs, as well as the Norwegian Medical Association, argue that additional GP positions are needed to be able to keep up with the quality and accessibility level we have today (Den Norske Legeforening, 2014; Wesnes, Kristoffersen, & Burman, 2012). An increase of investments within the primary health care system is also needed in order to meet the goals of the Department of Health and Care Services (Den Norske Legeforening, 2014; Wesnes et al., 2012). A well developed and organised health care system, that is also cost-effective, is dependent on a well-functioning primary health care service (Nylenna, Gulbrandsen, Førde, & Aasland, 2005). The next chapter will go further into what kind of methods were used in this study.
3 Method

3.1 Background

The background for this thesis is to look into what motivates health secretaries in Norwegian general practitioner (GP) clinics. To investigate this, qualitative research was used. Qualitative methods, to a large extent, try to capture the essence of traits, motives, actions, experiences, expectations and thoughts (Malterud, 2002; Reeves, Albert, Kuper, & Hodges, 2008). When analysing the material through qualitative methods, the knowledge derives from experiences by understanding and organising the empirical data (Malterud, 2012b). Being able to do one-to-one interviews as well as a focus group interview made it easier to get an understanding of the background for how health secretaries felt motivated during a workday. Throughout the focus group interview, it was useful to use the previous experience, attitudes and different perspectives from the one-to-one interviews to grasp the core essence of how the participants’ workday was affected. Focus groups are, to a large extent, able to capture this essence and add useful information to the data collected (Malterud, 2002). The main focus of this thesis has been to point to how motivation displays itself, and if health secretaries are largely motivated through intrinsic or extrinsic factors.

Little research has been carried out when it comes to health secretaries and what motivates them as a career group. A focus group study by Spehar et al. (2017) indicate that GPs in Norway struggle to motivate their employees. There is a need for more knowledge on how health secretaries experience their own role, and what they see as facilitators and barriers for engaging in their role. The aim of this study is to understand how health secretaries experience their role as an employee and how they view their own role in the work place. By understanding this, GPs, as employers, might be able to perform the task as managers and leaders in a better way and improve their management skill set. In addition to this, multidisciplinary practices, consisting of nurses, physiotherapists, pharmacists, and other complementary professions are still rare in Norway and the relationship between health secretaries and doctors is therefore relevant to research (Rørtveit, 2015). Hana and Rudebeck (2011) discovered that GPs in Norway felt unprepared to take on the leadership task, prioritising clinical work and often waiting for a problem to arise before dealing with the situation. When there is little evidence and support material and no given outcome,
qualitative research can be useful to investigate the issue in question (Malterud, 2017). This is part of the reason for why qualitative research was chosen in this study. Therefore, interviews of health secretaries were performed and analysed.

### 3.2 Choice of method and interview guide

The reason behind the choice of doing one-to-one interviews is mainly because it allowed for interpretation of body language and a different understanding of the participants’ views and thoughts on any work related issues. By using interviews as a research method for this study, it allowed the strengths of qualitative research to come to light.

There are three main ways to conduct interviews within the field of qualitative research; unstructured, structured, and semi-structured interviews (Thagaard, 2013). Unstructured interviews try to avoid leading the participants in any direction and questions are not prepared beforehand. On the other hand, structured interviews have all questions prepared, for example through a set survey, and there is little room for open conversation to occur. The interview guide used in this study is a semi-structured interview design. Questions were prepared beforehand, but the chosen method allowed for follow-up questions to a greater extent, allowing different and interesting elements to be discussed more in-depth during the interviews. A semi-structured design is useful in qualitative research and can make the conversations feel freer and more open-minded (Creswell, 2017; Jamshed, 2014). The first interview guide (see appendix 1) was conducted to fit with the one-to-one interviews. The focus group interview guide (see appendix 2) was compiled based on both the first interview guide as well as the raw data from the first interviews. The two interview guides were developed using previous research on qualitative interviews and after discussions with my supervisor (Justesen & Mik-Meyer, 2012; Leech, 2002; Malterud, 2017; Reeves et al., 2008; Rubin & Rubin, 1995).

The first interview was a pilot interview, and this was used to adjust the interview guide for it to be a better fit for the situation and for the health secretaries. Although the first interview was seen as a pilot, it is still included in the study due to its rewarding character.
3.3 Data collection and recruitment

For the interviews, several GP clinics around the Oslo region were contacted, all with between two and five health secretaries employed. The recruitment process turned out to be more difficult than first anticipated, as most of the health secretaries were too busy to contribute to the study. The first three interviews were performed in a GP clinic in Oslo in February. Due to illness, the next two interviews scheduled were cancelled on the day, and unfortunately the health secretaries were not able to reschedule. The focus group interview was arranged at a GP clinic with three health secretaries in March. However, the third employee had to leave work early due to illness, but the remaining two discussed the questions asked in accordance with the focus group interview guide. Although the recruitment process turned out to be rather difficult, the health secretaries who contributed gave the study valuable data to work with and work on. The term focus group is kept, despite only two people participating in it. Originally, the interview meant to include three participants, qualifying it for the term focus group (Malterud, 2012a). Taking into account the way the focus group interview was executed, it appeared more similar to a focus group interview rather than a group interview. The term focus group is therefore used throughout the thesis to describe the interview with two participants.

During all the interviews, an audio recorder was used to be able to focus on establishing a connection between the interviewer and the health secretary. This allowed for better focus and an easier way to take notes of follow-up questions for the health secretaries. Due to the use of an audio recorder and also storage of interview data, there was a need to send an application to the Norwegian Centre for Research Data (NSD). This application was approved in early February (see appendix 4) and the data collection could then start.

3.4 Conducting the Interviews

The location for the interviews and focus group was, in both cases, at local GP clinics. This seemed both natural and was also convenient for the participants. The participants made sure there was an appropriate room available to conduct the interviews in all cases. They were able to decide both time and place for the interviews, to make sure participation was as easy as possible for the health secretaries.
Before the interviews started, I presented myself, the research topic, and its purpose, and a consent form (appendix 3). For the latter, time was given to read through thoroughly before signing, and the health secretaries were all given a copy. In addition to this, they were informed about the study when contacted the first time for participation. Consent to use an audio recorder to document the interviews was explicitly asked for, although this was also stated in the consent form. This was not an issue in any of the interviews, and the health secretaries all gave consent.

When performing the interviews, the interview guide was used. However, as semi-structured interviews allow there was a natural flow in the conversation and follow-up questions were asked when needed. This allowed for a more personal connection and for valuable information to come up. Malterud (2017) suggests that the interview guide is in a way similar to a check list, and this was considered before the interviews were held. Seeing as it was important to adapt to the different participants, as none were alike and they all needed somewhat different approaches for the conversation and interview to flow naturally.

After the interviews, the transcription process began. This process ended up be quite challenging, as well as time consuming, something that is often the case (Malterud, 2017). The transcriptions were performed by the interviewer. This was found to be very helpful when going through the material, both because of how body language and cadences come across and what that has to say for the meaning of sentences. During the transcription of the interviews, I added context-based text, such as particular body language or references to places or co-workers, to better be able to analyse the data afterwards. According to Malterud (2017), this is said to be an important part of the process.

### 3.5 The moderator in the conversation

During the one to one interview, the conversation was formally lead by the moderator. As the interviews were semi-structured the discussion had a natural flow, but the interview session was still a question-answer situation. For the focus group interview on the other hand, the moderator’s role was a bit different. The purpose of the moderator is to a large extent to lead the discussion so that the themes in question are discussed (Malterud, 2012a; Wilkinson, 1998). Wilkinson (1998) suggests that the moderator’s role is important in order to keep some sort of structure in the discussion. The moderator makes sure all members of the group
are able to engage in the conversation, but does not actively contribute to the discussion (Wilkinson, 1998).

Being the moderator of a focus group was a different experience, and the question-answer role differed from the one-to-one interviews. During the focus group interview it was more important to use questions to structure direction of the interview whilst avoiding partaking in the discussion. The questions asked kept the interview on track and made it flow naturally through the different themes and questions. More of the moderator was required to stay on topic in the beginning of the focus group interview. Towards the end however, the health secretaries discussed the questions asked more thoroughly without being asked to expand on the topic by the moderator. Hence, the moderator played less of a role by the end of the focus group than in the beginning of it. In both settings, the participants would ask me, as moderator, to clarify questions if they felt them to be ambiguous. During the interviews, all participants were also asked specifically if they had understood the question if they seemed confused. This was in order to avoid misinterpretations that would affect their reply and discussions.

3.6 Data Analysis

The data was analysed using systematic text consideration (STC). STC is a pragmatic method used for analysing qualitative data (Malterud, 2017). The background for this method has derived from Giorgi’s psychological phenomenological analysis (Malterud, 2012b). Giorgi (2009) suggested that an object should be viewed based on how it is experienced, not necessarily how it is objectively seen. The STC method uses a four-step process to analyse, sort and code the data collected, and opens up for exploring different ways of interpretation throughout the process. The following is an explanation of this four-step process.

1. The overall impression – from chaos to themes
During the first stage of this process, Malterud (2017) recommends reading the material and raw data collected. All the transcribed interviews where therefore read through without adding comments or taking notes. The aim of this is merely to get an overview of the data before the actual analysis. Malterud (2017) also emphasises the usefulness of having more than one person going through the material. Therefore, my supervisor was also involved in
the process. During this stage, ten possible themes were identified, and these were used for the next stage to create meaningful units.

2. Meaningful units – from themes to codes
This is the stage in which the aim is to identify meaningful units of text within the text. It is important to always remember the research question when doing this, in order to keep track of which information is useful and on topic (Malterud, 2012b). Seeing as the themes were identified during stage one, the text could be recognised in accordance with the different themes and then be categorised as codes. During this stage, flexibility is an advantage and changing code names or shifting text between categories is a part of this dynamic process (Malterud, 2017). The content in each code was looked further into, and the different code groups changed names accordingly.

3. Condensation – from codes to meaning
During this stage it is important to be able to extract the meaningful units from the codes created in the previous steps. This stage allows for a reduced set of data, having only focused on creating themes and codes with meaningful units in them (Malterud, 2017). The units were then categorised into sub groups, creating fewer codes and making them fit the content in a better way. The aim at this stage is to be able to extract the meaningful messages and units within the text and put them in the correct group and sub groups. This way of doing it made the data more comprehensible, enabling the process to move to stage 4.

4. Synthesising – from consideration to description, concepts and results
In the final stage, it was important to try to conceptualise the data and extract the units to view the results and the empirical findings. The data, although worked with thoroughly, still has to represent the voice of the health secretaries and their thoughts and reflections. This can be difficult, but is a much needed method to stay true to Malterud’s STC (Malterud, 2017). The next chapter will present the results.
4 Results of empirical findings

4.1 Introduction

The aim of this study is to identify what motivates health secretaries. The data was collected through one to one-interviews and a focus group interview. In this chapter, the main findings are presented. By using systematic text consideration (STC) the findings were worked through systematically and according to the method, making sure what is quoted corresponds with the original content. There were several themes that appeared throughout the interviews, and the ones discussed in this chapter are the ones identified as so-called meaningful units.

The following themes were identified:

- Appointment capacity
- Patient frustration
- Communication
- Social relations
- Salary
- Competence within the health science
- Autonomy and Adaptability
- Understanding and recognition

4.2 Appointment capacity

Appointment capacity refers to the number of appointments the different doctors have throughout the day and the schedule show how many slots that are available for emergency appointments. Some slots will always be reserved for emergency appointments each day. When talking about this, the participants referred to this point on several occasions, both with regards to having a good day at work and having a bad day at work. Having appointments available was seen as a crucial element for the health secretaries in order to have a good day at work. This indicates the importance of being able to offer the service they do and illustrates how patient contact affect their workday. Appointment capacity was referred to as a tiring aspect, especially if an appointment on the day was not possible for the patient in question.
When you try to explain to the patient that it is not possible to make an appointment with the GP that day, they can be truly annoyed, upset and yell at us over the phone. But, it is you that has the appointment schedule in front of you and you know how many patients the GPs can see during a workday. (Interview object 1)

The health secretaries have to show great patience with upset patients and also make sure that the patients who really need to see the GP that day, are able to do so.

### 4.3 Patient frustration

Patient frustration refers to how the patients communicate with the health secretaries and how a patient’s mood influences them. Several participants highlighted how a patient’s mood affected them when answering phone calls or talking to them at the reception desk. It was also suggested that patients can be quite insensitive towards the health secretaries if they are unable to get what they originally called for. The same goes for delays and additional waiting time when visiting the GP clinic.

*The patients can be quite upset at the doctor for being delayed. They always tell us, but never the doctor. We are the ones getting yelled at and are handed that frustration – never the doctor.* (Focus group interview object 2)

The patients are, as it seems, unable to take their frustration out on the right party, in this case, being the GP. Instead, the health secretaries are the ones the patients take their frustration out on. This came across as one of the frustrating points of being a health secretary, being yelled at for something you are unable to do anything about.

### 4.4 Communication

The communication aspect was similar for all the individuals. Here it was discussed how issues and problems were communicated between colleagues at the work place. The GPs seemed to be helpful in cases that needed additional support, for example in discerning how urgent a patient’s needs are. The health secretaries could always reach the GPs by phone. It also came across that the communication pathway was well taken care of with weekly meetings where issues, big or small, were discussed between the GPs and the health secretaries. Although this was not always easy, the health secretaries felt they had a say and
were able to talk to their management. Communication as a theme seemed to be well taken care of, and was something that they all valued. However, there were certain issues, and one pointed to a GP’s ability to point out errors done by the health secretaries.

*We have one doctor who is pretty good at pointing out which mistakes we do. If the doctor didn’t find every single mistake, for example that we wrote an “S” wrong in a journal, it would have been easier to motivate yourself to perform better at the job.* *(Interview object 3)*

Stress was another factor playing a part when it comes to day-to-day communication. The results of the data analysis indicated that stress lead to situations where communication fails between the GP and the health secretary and could create unnecessary conflict. There seemed to be a common understanding amongst all health secretaries that they were to answer phone calls and schedule appointments for the patients, and not make professional assessments of patients.

### 4.5 Social relations

This point kept shining through throughout the interviews and focus group. Here, most participants talked about how important they thought that their management, the GPs, were present during the workday.

*The doctors always take time to visit the reception each morning to say “hi” and ask how we are doing. This is a very important part of our day, seeing as this makes us feel both listened to and seen.* *(Focus group interview object 1)*

It was also highlighted how important the health secretaries felt about being understood and seen during busy hours at the clinic. There seemed to be no need for a long talk or chat, but rather a simple “hello” in the door by the doctors made the health secretaries feel valued when working hard and working through stressful periods. It came across as motivational that the GPs, although they were busy, remembered that the health secretaries were busy as well during those times. The health secretaries felt valued and felt that their work was appreciated.
4.6 Salary
When discussing salary, most of the health secretaries agreed. They were all satisfied with their salary, especially compared to other GP clinics they knew about, but would like to be paid more. An increased salary was seen as a reward for a job well done, but they were all pleased with the current salary situation.

4.7 Competence within health sciences

4.7.1 The urgency matter
The health secretaries have to consider and assess each patient calling the GP clinic. They usually need to consider the urgency of the call and whether the patient can wait a few days or even weeks, or if the certain patient is in need of an appointment on the day. In addition to evaluating the different patient cases, they also have to argue with the said patient about the urgency matter.

*We have to consider the urgency matter for each patient calling. We have to consider if that particular patient needs an emergency appointment on the day, or if the case can wait. Not all patients understand that, and we have to argue and discuss with the patients who disagree [with our decision]. That can be truly difficult. (Interview object 1)*

If they, as health secretaries, consider that the patient is able to wait a few days, but the patient believes they need an appointment on the day, the patient will usually argue. This can be difficult for the health secretaries and lead to upset patients, yelling at them over the phone.

4.7.2 Challenges at work
Showing health science competence is an essential part of the day as a health secretary, having to discern each patient’s call. Another point of view they emphasised was not having sufficient challenges at work. Some felt they wanted to learn more and execute more practical tasks whilst at work, doing more than answering calls and drawing blood samples. A further issue was that it was difficult to stay updated on the profession of health secretaries, such as updates on laws, regulations and new research in health sciences applicable to a GP clinic.
Although some of them had the ability to attend two courses a year in their employee contract, they still felt that it was difficult to stay updated on the latest research or law changes. The importance of this was mainly due to patient contact and the competence aspect of their job.

*It can be difficult to keep yourself updated professionally. Even though we are a part of the health secretary union, there’s only social gatherings and no academic course. If I am not updated on current information, I might end up giving incorrect information to a patient about for example laws and regulations.* (Interview object 1)

### 4.8 Autonomy and adaptability

The autonomy aspect came to light while discussing what sort of freedom the health secretaries had and felt they had. The laboratory was one arena the health secretaries were in charge of, and they decided at what times different kind of samples had to be turned in by either the patient or the doctor, and also the latest a vaccine shot could be performed. This point could lead to communication errors, but the health secretaries were clear on discussing this and sorting it out with the doctor in question after an issue arose. This ensured that the issue was resolved quickly.

*I believe we have a certain amount of freedom. But this kind of freedom also develops over time, when we familiarise ourselves with how the different doctors want issues solved. Although, we do joke about how it’s easier to ask for forgiveness than get permission.* (Focus group interview object 2)

The health secretaries were also clear when discussing who was in charge and who had the final say. The GPs could tell them that they should have talked to them before deciding and telling a patient. That the GP would always have the final say in patient cases was a common understanding and none of them stressed this as an issue or communication challenge.

The health secretaries emphasised how it is important for them to adapt to each individual GP. They discuss and mention how all GPs are different and how they all want issues resolved in their own way. An important trait for the health secretary was being able to adapt to each GP and perform the job as per the GP’s liking. This could lead to issues every now
and then, sometimes due to the health secretaries forgetting who wanted what, and sometimes because the health secretaries got new insight into other personality traits when getting to know the GPs better. It turned out to be an advantage to know the different traits when performing the job.

4.9 Understanding and recognition

During the different interviews the health secretaries were mixed on how they felt about being given recognition for the job they performed. Some emphasised that they felt the management lacked understanding for the work they did and showed little appreciation for tasks completed. Another point that came across was how the GPs sometimes seemed to forget to emphasise on what the health secretaries did well and only focused on the tasks they did not perform in a satisfying manner. This seemed to lead to demotivation for the individuals in question. On the other hand, in the focus group, the GPs in management were praised for both their recognition and understanding of their staff.

*The management are very good at understanding us as health secretaries and appreciate the work we do. The tolerance is high for all of us. We can tell the doctors if we feel misunderstood or misinterpreted and the doctors can tell us if they thought we should have discussed an issue with them first. The doctors see us and listen to what we say. (Focus group interview object 1)*

The focus group also discussed how a higher tolerance level towards each other made the day at work easier, especially when experiencing a stressful and demanding day at work. These results will be discussed further in the next chapter.
5 Discussion

5.1 Introduction

When discussing motivation, the health secretaries were split on how to think about this factor. It was often talked about in relation to other aspects, such as having the capacity to take on additional patients or being recognised for the job they did. The health secretaries talked about autonomy and how it was reduced when general practitioners (GP) pointed out what they themselves deemed to be irrelevant mistakes. This made the health secretaries feel demotivated. Several participants also highlighted how the patients aimed their frustration towards them rather than their doctor, when having to wait longer than expected or not getting an appointment. It seemed as if the health secretaries worked as buffer between the patients and the GPs. For the GPs, it might be important to be aware of this as an issue and recognise the health secretaries for this job as well.

5.2 Theory vs empirical findings

By looking into two main motivational theories, the self-determination theory (SDT) and the two-factor theory, the results from this study can be said to point in both directions. It can be argued that neither SDT nor the two-factor model covers all the motivational factors shown in the data collected from this study, but rather that they should be combined to get the best understanding of the results.

5.2.1 Self-determination theory (SDT)

SDT has three components it mainly focuses on; the competence aspect, the autonomy aspect and the need for psychological relatedness. The results suggest that all these three components are important, and also needed, to experience a good day at work. The competence factor turned out to be important in several work related tasks. When answering the phone, the secretaries need to be able to determine which cases are urgent and which cases can wait a day or two. This is vital to get the patients who need to see the GP right away access to the service. The competence matter therefore seemed to be important and the GPs rely on this as well. Some of the health secretaries knew this took time and that they had to get to know both the patient mass and the GPs to be able to make important decisions.
White (1959) argued that humans have an inherent need to be able to produce a desired outcome, and the SDT plays a part here. The results suggested that the health secretaries relied heavily on their competence within the health sciences and on the capability of adapting to each individual GP. The desired outcome might be to perform the job in such way that the individual GPs are happy with the results and know they can rely on the health secretaries’ competence. The results from the analysis emphasises this as a big part of each health secretaries’ day. It is important that the health secretaries and the GPs know each other and are aware of their individual competence levels and know who decides what. If this is the case, the results suggest that the GPs trust their health secretaries when it comes to the urgency matter of patient calls.

Another factor that came up during the different interviews was that some of the participants wanted to increase their competence level within the field of the health sciences. Offering greater challenges at work can create opportunities for feeling competent within the work place (Gagné, 2014). The health secretaries also found it difficult to stay updated on newer research, making it more difficult to experience the feeling of competence. Seeing as the research suggests that competence and the experience of it is central when it comes to feeling motivated (Deci & Ryan, 2002; Gagné, 2014; Ryan, 2017; White, 1959), it might be important to be aware of this as a leader and manager at a GP clinic.

Autonomy was seen to be influenced by one doctors need to correct what was deemed irrelevant errors by the health secretaries. By doing this, autonomy is in a way removed. Fiske et al. (2010) argue that an individual will show decreased performance, show less creativity, and will be less happy with the end result when autonomy is reduced or removed completely. It can then be argued that some mistakes, like irrelevant spelling errors, might be better ignored and instead let go in order to create a more creative work environment and improve communication. Seeing as this level of detailed error correcting might remove the aspects of autonomy, the results from the study also show how this demotivated the health secretaries. In a way, pointing out irrelevant mistakes undermines the competence aspect as well, demotivating the health secretaries and decreasing their feeling of autonomy.

Fiske et al. (2010) further emphasise the importance of autonomy and recognising this as a management tool within the field of motivational leadership. Although some of the autonomy seemed to be removed in one part of the job, the health secretaries were in charge of the
laboratories’ opening hours and when patients could be sure to reach someone in the facilities. One of the interviewed health secretaries talked about how the GP had the final say, but that this should never be discussed in front of a patient. If a health secretary has stated one thing, for example that it is too late to draw blood on a patient, it was important for them that the GP talked to them first before promising the patient the opposite. The health secretaries wanted the GP to ask them, not the patient, first if it was OK that the patient took the blood test, even though it was too late according to the health secretaries. There was a common understanding that the GP always had this final say, and they all agreed upon this element. By removing this autonomy aspect of motivational theory from a management point of view, Deci and Ryan (1985) argue that it might lead to less productive employees.

When it comes to social relations and psychological relatedness, all the health secretaries agreed upon the importance of having colleagues. Developing a good relationship to both fellow health secretaries and the doctors were seen as key. SDT emphasises how secure social relations are important in order to feel accepted and also integrated within the work place. Several of the interviewed health secretaries highlighted secure relations as important. They expressed how crucial it was that they had time to both talk to each other in the morning and during the day, with both their fellow health secretaries and the GPs. That social relations are secure was discussed through how they felt they could trust their co-workers not to talk to others about problems or issues they had themselves. It became quite clear that the presents of social bonds and secure relations was needed in all aspects of their work environment. In this sense, SDT should be recognised as including an important aspect of everyday work life and making sure certain needs are being met. Within the field of social relations, it seems to be essential for the health secretaries to have leaders who give them recognition. The interviews and focus group both highlighted being seen and listened to by their managers throughout the day as important. Only a quick “hello” represented a feeling like one belonged at work and that someone appreciated the work performed.

It is also quite interesting to see how long it took for the participants to actually touch upon the subject of salary before the moderator brought it to their attention through questions. This might indicate how salary is not a big part of everyday conversation. The health secretaries said they were pleased with the salary level, but all of them stated that they would like a higher salary. Some of them even argued that better pay would be a sort of reward for a job well done. The research on this, especially in SDT, argues that rewards, such as monetary
incentives, can have the opposite effect and actually be damaging towards the motivation of employees (Deci & Ryan, 1985). Although, it must be said that this requires that the individuals actually get paid and that the pay is fair and equal. However, it is still essential to acknowledge how intrinsic and extrinsic motivation affect each another. Getting rewards might make the individuals feel controlled and have less autonomy, as well as feeling some sense of incompetence (Deci & Ryan, 1985). The research highlights recognition to be far more important than rewards (Deci & Ryan, 1985; Ryan, 2017). The results from this study show that recognition seems to be more important than salary and that recognition is longed for to a larger extent amongst health secretaries.

**5.2.2 Two-factor theory**

The two-factor theory takes recognition into account to a larger extent than SDT, seeing as this is one of the explicit motivation factors displayed in Herzberg’s model (Herzberg et al., 1993). Figure 1 is an illustration of the two-factor theory adjusted in accordance with this study.

<table>
<thead>
<tr>
<th>Motivation</th>
<th>Hygiene</th>
</tr>
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<tbody>
<tr>
<td>• Work development</td>
<td>• Salary</td>
</tr>
<tr>
<td>• Recognition for achievements</td>
<td>• Equipment functioning</td>
</tr>
<tr>
<td>• Continuing education</td>
<td>• Appointment capacity</td>
</tr>
<tr>
<td>• Appreciation</td>
<td></td>
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</tbody>
</table>

*Figure 1. Herzberg’s two-factor theory adjusted for the health secretary interviews and focus group results.*

The results from this study show how understanding and being recognised for the work performed is an essential part of the workday. It was also emphasised how the health secretaries wanted the GPs to know what they actually did during a workday and not only point out errors. This goes within the category of motivation in the two-factor model. It seemed to be important to be appreciated when at work. During the discussions of recognition, tolerance level was also mentioned. Having high levels of tolerance when talking to each other made a workday more pleasant and this was important in order to get through demanding or stressful days.
Job satisfaction is an important aspect of the two-factor theory. Which elements create a satisfying environment, and which creates dissatisfaction are crucial topics to address when managing employees. The results from the study suggest that recognition, when present, lead to the health secretaries feeling more motivated, whilst demotivation occurred when this form of recognition was absent. This relates to the two-factor theory, and it can be argued that demotivation amongst the health secretaries did not lead to dissatisfaction, but rather to no job satisfaction. Being understood, recognised, and listened to were repeated topics amongst all the health secretaries throughout the interviews and focus group. This displayed how they found it essential to experience understanding and recognition in order to have a good day at work. The feeling of recognition and having the GPs aware of their work tasks and challenges was considered important due to its motivational character when present. These motivational factors can be linked to the two-factor theory.

The results concerning salary differed from the motivational results. The health secretaries all wanted higher pay, although they were satisfied with their current salary. Some meant that salary should be used as a motivational tool, giving high pay as a reward for performance, although as Deci and Ryan (1985) argue, this might not be the best way to reward employees. In the two-factor theory, salary is considered to be a hygiene factor. The theory argues that a higher salary does not necessarily create more satisfaction or better motivation to perform work tasks but is rather a dissatisfaction factor (Herzberg et al., 1993). Herzberg argues that salary can also be viewed as a motivation factor, but as this is a motivation factor with short term effects, it is still seen as a hygiene factor (Herzberg et al., 1993). The results from this study indicates that the health secretaries feel their salary is adequate and gives them a feeling of safety, knowing their income is stable. This could be the reason they all stated they were pleased with the pay they got. It seemed as if salary was seen as a hygiene factor and not a motivation factor amongst the health secretaries, when comparing the results to the two-factor model.

Another aspect worth mentioning from the results is how equipment function and appointment capacity played a central role in determining whether the health secretaries experienced a good day at work or not. Herzberg would recognise these two factors as hygiene factors, leading to dissatisfaction when there are problems related to them. Not being able to give patients an appointment when the patient had time and wanted to see their doctor, was a factor that made the health secretaries’ day less pleasant and led to patients feeling
frustrated towards them. The same can be said about how different equipment worked and could be relied on when needed. This seemed to be an aspect that could create job dissatisfaction, rather than the feel of demotivation. What is also important to remember, is how the two-factor theory, based upon Maslow’s ideas, assumes that for motivation to take place, some basic needs, such as salary, equipment function, job security, have to be in place and fulfilled in order for one to experience job satisfaction.

SDT seems to lack the recognition aspect as a motivational factor, so Herzberg’s two-factor theory can complement SDT. Recognition gives rise to several aspects of motivational management and task performance that are worth looking into. As a leader and manager, it might be essential to see just how important the health secretaries view being given recognition for their work, as this study argues. For a GP, this could be a key factor to take into account when planning and implementing a strategy of leadership within the GP clinic.

5.3 Practical implications

The results from this study suggests that recognition could be used as a tool for motivating employees, and consequently create a better GP clinic. If the GPs are able to view how their management style affect their employees, they might get a better understanding for this and find their role as a leader more rewarding. When looking into the results from the study, it seems like recognition and being appreciated was a big part of what made a day at work a good one. GPs need to take this into account and investigate further how their actions affect their employees.

Some of the health secretaries wanted more challenging tasks when asked about what GPs could do to motivate them in a better way. Although additional tasks during the day were asked for, this might not be the same as getting more responsibility. Seeing as Spehar et al. (2017) discovered that GPs found it difficult to motivate their staff, and that added responsibilities were not appreciated amongst health secretaries, it could be that recognition is more important than added responsibilities. Being recognised for the job performed seems to be more essential to health secretaries than being rewarded with more responsibility. This study has highlighted the key role recognition plays, and also how GPs and health secretaries are different when it comes to what motivates them based on the findings from Spehar et al. (2017).
Another issue to consider is how GPs do not have any formal training in leadership before having the responsibility of managing others. It is quite a big task to take on, especially when their education fails to address this part of the job. Although most medical students will start working at hospitals or larger institutions, there are still quite a few that will either be a GP or a leader of a clinic with time (Ham, Clark, Spurgeon, Dickinson, & Armit, 2011). Ham et al. (2011) researched 22 medical chief executives in the national health service (NHS) in England and discovered that most were self-taught within the field of management. The lack of management training was also evident in a study of clinical managers in Norwegian hospitals (Spehar, Frich, & Kjekshus, 2012). This highlights the need for a better structured career path for health care professionals going into management. What should be recognised is how their role turns into a hybrid; where they must work as both a doctor and a leader. For GP clinics this might happen to a smaller extent having fewer employees, but is still relevant when discussing how health secretaries experience their workday. The GPs should pay closer attention to how they act as leaders, how they relate to their staff members and how the staff members view their relations. For the health secretaries, being seen and recognised for their competence was important and having the GPs view them as colleagues as well as employees. This could be important to create the relationship needed to be able to better motivate your employees. Creating a good work atmosphere could then lead to better relations and more productive staff, because of improved communication.

This study highlights the importance of how GPs communicate as both colleagues and leaders simultaneously. The results showed how essential the health secretaries found having time to talk and communicate throughout the day, not only about patient related issues, but also when having a stressful day. Communication from the management was therefore seen as important for having a good relationship with your co-workers. The results show that all the health secretaries were pleased with having a weekly personnel meeting with all staff, both health secretaries and doctors. This was viewed as essential in order to solve issues, take a closer look at challenges, and being able to have an open dialog about concerns or other matters they might need to work on. In addition to these weekly meetings, the health secretaries all had appraisal interviews with their manager once a year. This contributed to the health secretaries feeling both heard and seen, being recognised for their job performance and being able to discuss any issue. Regarding communication, the health secretaries were clear on how they wanted the everyday small talk to a larger extent in order to get that recognition and appreciation for the job they do. Seeing as the GP must perform both the role
as a GP, but also the role as manager, this point should be stressed more during management training of doctors.

Ham et al. (2011) argue that doctors need more structured support in order to develop into skilled professionals. The Norwegian Medical Association and the University of Oslo have cooperated and together created the “health care leadership programme” (Helselederskolen). This leadership course will offer management and leadership training for doctors within all disciplines of medicine and will be starting in autumn 2018 (Celius, 2018). This could be an essential part of creating better managed GP clinics, where the GPs have the right tools to be both a skilled doctor as well as a skilled leader and manager. In addition to this more comprehensive leadership programme, the University of Oslo already offer courses aimed specifically at GPs, targeting the primary health care system. The three main topics in these courses are health law and how to handle conflict, cooperation and quality, and management and leadership within the primary health care system.

5.4 Primary health care teams

The way the primary health care service is organised in Norway is currently under revision. A new pilot project within the field will try to shed light on the strength and weaknesses within primary health care teams in Norwegian GP clinics. The main difference between a primary health care team and the way a GP clinic is usually organised will be the presence of a nurse within the GP clinics. A primary health care team will, in Norway, consist of doctors, nurses and health secretaries (Helse- og Omsorgsdepartementet, 2017b). The different teams will all be led by a doctor, who will also be in charge of planning and organisation (Helse- og Omsorgsdepartementet, 2017b). Although, working in teams is common in hospitals and within specialist health care institutions, there are still quite few teams within the primary health care system (Dieleman et al., 2004). Dieleman et al. (2004) suggest that most team members found it helpful to work as a team when treating high-risk patient groups. The Ministry of Health and Care Services (2017) aim is that the new primary health care teams mainly focus on patient groups with compound needs. Compound needs are understood as patients with chronic illnesses, those with psychological health challenges, frail elderly individuals, patients struggling with substance abuse, and patients with handicaps and disabilities. These patients will be the main focus of the primary health care teams. Creating a
team might make it possible to maintain a better dialogue with the patient and coordinate services to fit the patient’s needs to a greater extent.

Looman et al. (2016) conducted research and performed a cost-effectiveness analysis on a project with primary health care teams that was aimed at frail elderly patients in the Netherlands. Their study found that the intervention group did not have an increase in quality of life, and the costs were actually higher compared to the control group, meaning that the cost per quality adjusted life year is higher than usual (Looman, Huijsman, Bouwmans-Frijters, Stolk, & Fabbricotti, 2016). Hoogendijk (2016) also researched this topic and reviewed three papers. The research discovered that improving health care outcomes for frail elderly, being one of the goals of the pilot project, is problematic and difficult to do (Hoogendijk, 2016).

There are several studies which consider the rising challenges of an aging population and patients with chronic illnesses and compound needs (Grumbach & Bodenheimer, 2004; Paquette-Warren et al., 2014). These studies emphasise the importance of well-coordinated teams working efficiently together and building upon the strength of each team member. In this sense, primary health care teams could be important when it comes to patients with complex diseases and compound needs. The Directorate of Health is interested in evaluating the effect of this type of system from a patient perspective (Helse- og Omsorgsdepartementet, 2017b). Considering this, a well-coordinated team might be essential to improve primary health care services in Norway. Improving the interaction between primary and specialist health care services is important with regards to improving general population health. The Directorate of Health and Care Services are interested in improving primary health care services through primary health care teams (Helse- og Omsorgsdepartementet, 2017b).

There have been concerns raised regarding the implementation of these teams in Norway. The Norwegian Medical Association has expressed concern regarding this implementation, and believes that several components are missing in order for the pilot project to work (Riise, Duvaland, & Haffield, 2018). As the Norwegian Medical Association points to, this will do little to improve the severe challenges within today’s primary health care system, such as easing the pressure on GPs.
In addition to challenges seen from the GPs point of view, it might be important to look closer into other issues as well. When implementing a health care team within the GP clinic, the doctors will be in charge of more people and will have to manage additional employees. This might create bigger cultural gaps between the different professions working at the GP clinic, and the need for management and leadership training could be more pressing. Boge (2017) researched how GPs view the implementation of primary health care teams and found that they are disinterested in an increased management position and responsibility. They fear more administrative work, that this will take time away from patient contact and lead to an additional work load. It was also emphasised how the GPs, if having an increased management position, will need additional leadership and management training (Boge, 2017). Another consideration worth mentioning is how management challenges for the GPs will be even greater when leading additional staff members. It will be key to investigate whether health secretaries and nurses might experience the same difficulties regarding communication and would need the same form of recognition by the GPs. The topics I discovered in my study could be relevant for management training and leadership courses, in addition to looking into how nurses and health secretaries cooperate in a new setting with a GP as a manager.

An aspect which might be interesting to look into is how primary health care teams will affect the health secretaries and their position within the GP clinic. As of now, health secretaries work in the laboratory, performing blood tests and testing different samples from patients. When introducing a new member to their team, a nurse, these tasks might change. The results from the study shows how some of the health secretaries want to take on new challenges, and having a nurse entering a new team set-up might make this difficult. How primary health care teams will influence the health secretaries will need to be researched further when the pilot project has been tested. There is a possibility that the new teams will lead to more administrative work for the health secretaries, compromising the important feeling of competence within the health science.

If the pilot project shows results leading to implementation of these teams into the primary health care service, it is possibly even more important that doctors have management training. The teams will be bigger, and also add another layer into this cultural gap that the doctors experienced in Spehar et al.’s study (2017). Having the necessary training in order to perform skilled leadership could be important, especially seeing as this study shows that
health secretaries believe there are other ways to motivate them as employers such as recognition for their work.

5.5 Discussing the method

When choosing a research method, it is important to understand both strengths and weaknesses. Malterud (2017) emphasises how, when conducting any form of research project, that one will never be able to grasp the true nature and reality. The results will, in some form or another, be influenced by the researcher, creating an observer bias. This is essential to be aware of especially when using qualitative research where the researcher is present with the research subject to a much larger degree than in quantitative research. It is important to be aware of and also discuss what kind of implications a researcher presence gives the results of the study. The following sub-chapter will address how this study considers the scientific knowledge of reflexivity, relevance, and validity.

5.5.1 Reflexivity

Using qualitative research methods, there are quite a few different aspects the moderator and researcher has to consider. It is important to be both open and conscious about one’s thoughts, reflections, and possible bias that might affect the research (Malterud, 2017). Having little experience within the field of health secretaries and GP clinics, can be viewed as both a strength and a weakness. This might have given me an advantage when reflecting upon the results, being able to always ask questions about the results and having a critical view towards the field. It might have given me the necessary distance to encounter new knowledge and different reflections. On the other hand, having insight into the field one researches, such as having worked as a health secretary, could have made the interview questions more relevant and given another form of connection between the moderator and the interview subjects. Looking at how the study was executed, I tried to reflect upon the data between the interviews in order to have an open mind going into the next one. I used semi-structured interviews so that the health secretaries could speak more freely, and so that I could avoid leading questions. This gave the participants the possibility to discuss and reflect upon questions that might not have been asked directly.

After the pilot interview, I altered the interview guide to better fit the next interviews. I believe that this turned out to be a strength and made me aware of what kind of focus the
interview guide gave. Although the interview guide was altered, the changes were minor, so I believe this still made the pilot interview valid for interpretations alongside the rest of the interviews and focus group interview. The questions were discussed with my supervisor to avoid them being leading. I thought that this was important since I have previously not performed neither one to one-interviews nor focus group interviews. It has been important to reflect upon my own bias towards other professions. Having been aware of this, I believe this made it easier to avoid certain behaviours within the interview situations, and it might have made me better at reflection afterwards and entering the situation without preconceived opinions.

What is also important to shed light on, is how the health secretaries might have had bias towards me as a researcher and student in higher education. I therefore made sure I was clear about my motives, my reasons for choosing this topic and why this particular work group was selected. It was also important to me that they knew that their views and opinions were not shared with their managers or co-workers, so this was stressed when introducing the study before the interview started. When selecting participants, I found it important that we had no previous relationship, as this could have affected the results. I believe that this added a positive note and created a safer space for the participants to discuss their work more freely and openly.

5.5.2 Validity

To get a better understanding of the implications of validity, I want to discuss what Malterud refers to as internal validity (Malterud, 2017). This term concerns whether or not the chosen method makes it possible to actually answer the research question. In order to answer my research question, I believed that qualitative research was most appropriate, seeing as quantitative research focuses on objective measurements and gathering numerical data (Babbie, 2010), making it unfit to answer my research question. Seeing as I wanted to investigate more in-depth, the choice of method was clear to me. Semi-structured interviews were chosen as the research method for this study, both for the one-to-one-interviews and the focus group interview. This choice of method turned out to be useful, and I believe the reflections and experiences of the participants could be discussed in a more open way. The structure of the interviews also gave me valuable information that might not have been discussed if I had chosen a structured interview method.
Malterud (2017) discusses how systematic text consideration (STC) is a useful tool for a researcher with little past experience, giving them a simple and thorough introduction on how to conduct the analytical process in a systematic manner. I found STC to be very useful as an inexperienced researcher, and the directions of the method helped me to analyse the data systematically. In chapter 3, all the steps taken in the STC are explained so that one is aware of how the data was collected and analysed before one reads the results of the study. The quotes used under each category in the result chapter are there to show the relevance to the categories and enables the reader to review the validity. During the analysis it was important for me to review the results with my supervisor. Discussing the results with my supervisor was useful as an inexperienced researcher and created a greater sense of reliability within my findings.

With regards to flexibility in the study, the interview guide was adapted to some degree after the first interview. It was then reviewed once more in cooperation with my supervisor before the focus group interview. By doing this, I might have been able to obtain more valid reflections, but the results might also be slightly different because of the altered questions in the focus group interview.

Concerning sample size, a total of five health secretaries were interviewed and included in the study. A larger sample might have made the results more valid, seeing as a great variation of both age and gender could have been displayed. All participants in the study are women aged 30 to 62. Being able to interview both men and women might have given different results, but seeing as only 0.7% of all educated health secretaries in Norway are men, participants would have been difficult to locate and their reflections might not have been as applicable to most GP clinics (SSB, 2017). Hence, investigating possible differences between gender’s responses has not been possible.

The analysing process of the raw data was started after each interview. The transcription was performed by me, as the moderator, and I found this to be useful, having taken notes during the interviews of body language and the manner in which things were said. Malterud (2017) believes this to be a strength when transcribing, as the moderator will pick up on body language, and know what the interviewer talked about at any given point without explicitly saying it. When transcribing, I made additional notes within the text so that my supervisor
could see what the participants were talking about when saying for example “here” meaning either the specific GP clinic or a place within the clinic. The work experience amongst the participants was different, ranging from five to 15 years as a health secretary at a GP clinic. This showed in the participant’s reflections over their job and how confident they felt within their field. The participants also had different experience within the health care system, and outside of the health care system, having worked in other places before becoming a health secretary.

The use of an audio recorder made the transcription process easier and also more valid seeing as all material could be transcribed and written as expressed during the interviews. During the interviews, follow up questions were asked in order to properly grasp what the participants felt and in order to get the true meaning of what was said. I could probably have been better at asking clarifying questions, but this did not feel needed when conducting the interviews. All the participants chose both the time and place for the interviews, making it easier for them to stay in a safe environment and allowing enough time to take part in the interview. What might have affected the results is the location of the interviews. All of the interviews took place in the common lunch room at the GP clinics, resulting in other individuals walking in on three occasions. The interviews were then paused until the individuals left. This might have affected the results if for example the participants felt rushed, less able to speak openly or felt disturbed by the interruption. However, it should be said that the participants seemed little affected by this and the interview process proceeded smoothly.

5.5.3 Relevance

The relevance of this study depends upon the ability of the results to be transferred to other situations. This transferability refers to the study’s applicability to other fields and conditions (Malterud, 2017). Although the results of the study might be transferable is some cases, transferability is additionally about being able to discover new knowledge that can be used within other relevant fields (Johnson, 1997; Malterud, 2017).

Little research has been carried out when it comes to health secretaries and what motivates them as a career group. This study contributes to the field and gives GPs the opportunity to look into the field of management theory and motivational theory relevant to this specific career group. This study also believes that management training could be useful for doctors,
and maybe especially GPs, in order to be better prepared for the task as a manager. It will not be possible to replicate this study the exact same way, seeing as other researchers might have weighted the answers and results differently than I have. With regards to replication of this study, both method and results are described thoroughly and have been gone through as methodically as I found possible.

The number of participants in this study might be viewed as low. The reason behind a small sample size were both recruitment challenges and illness occurring with short notice. I believe that the findings could have had greater transferability with more participants, so maybe further research should look into this as well. Even though the study has a small sample size, the reflections and thoughts on the subject in discussion during the interviews showed that many highlighted the same challenges and issues. In addition to this, the short time period to work on this thesis made it difficult to recruit more participants when short notice illness occurred. However, the interviews might have been performed more in-depth, seeing as I have had more time on my hands to concentrate on fewer participants.

Further research should be conducted, looking closer at job satisfaction factors and not only motivational factors as this study to a large extent did. Another factor that should be further investigated is if the cultural gap between the health secretaries and the GPs leads to more work related sick leave. It would be interesting to see if this research can contribute to a better work environment for health secretaries. Maybe a better work environment could decrease work related sick leaves and create a better GP clinic for both health secretaries and GPs. Furthermore, it would be interesting to see whether improved communication and better understanding between the two work groups would be a step in the direction of enhanced relationships in the work environment.
6 Conclusion

When considering motivation and how to motivate employees, the medical profession has lacked an option for further education or education throughout medical school in leadership and management skills. By offering a leadership course, tailored to fit medical doctors, it might be easier for general practitioners (GP) to manage a GP clinic equipped with the right tools to do so. Seeing as the study found that motivational theories were fit to use when creating a better work environment, the results could be used when developing leadership training programmes. The results emphasise how recognition for achievements and work performed are important. This could indicate how GPs have limited leadership training before taking on the administrative and personnel tasks involved with running a GP clinic. It is important that this is recognised as an issue, and this study shows what can be done to avoid certain work issues and improve the atmosphere at work by for example giving more recognition throughout a workday.

Regarding primary health care teams, it will be interesting to see how the pilot project develops. What is important here is having a clear goal of the project. If primary health care teams are to be a part of the service within primary health care, it is highly relevant to prepare the GPs for this additional task. New challenges might arise when GPs have the responsibility of both nurses and health secretaries working so close together and further research needs to look into this potential challenge.

Further research should also look into how health secretaries spend their day, observing their full workday. It would be very interesting to research how interaction and communication are experienced by both parties; the health secretaries and the GPs. It could be beneficial for GPs, both as managers and leaders, to know how they can motivate their health secretaries. This is important because it can help avoid conflict and longer sick leave and create a better work environment and atmosphere within the work place. There are several factors that could be important to highlight in GP clinics, and this study is a start when it comes to investigating the interaction between health secretaries and GPs. Nurses will be an added component to study if primary health care teams are implemented.
The results of this study indicate that existing motivational theories are applicable, but need to be combined in different ways to meet the expectations of health secretaries. This study shows the importance of acknowledging all employees. As the results show, health secretaries want to be recognised for their work, listened to and seen as a colleague, not just an employee. It seems as if GPs might be in need of additional training before taking on the task as leaders and managers. As such, the thought of the health secretaries in this study can be used as a supplement in formal management training of GPs. However, additional research should be performed in order to be able to generalise the findings to health secretaries in other settings, such as hospitals.
References


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Forskrift om fastlegeordning i kommunene.

https://www.regjeringen.no/no/tema/helse-og-omsorg/helse--og-omsorgstjenester-i-kommunene/innsikt/fastlegeordningen/id115301/: Regjeringen.no.


Appendix

Appendix I: Interview guide for one-to-one interviews (in Norwegian)
Appendix II: Interview guide for focus group interviews (in Norwegian)
Appendix III: Consent form (in Norwegian)
Appendix IV: NSD approval (in Norwegian)
Appendix I: Interview guide (one-to-one)


Bakgrunnsspørsmål

1. Kan du fortelle litt om din bakgrunn? (Alder, bakgrunn, erfaring)
2. Kan du beskrive karriereveien din? Hvordan ble det til at du søkte akkurat denne jobben?
3. Hva er dine typiske arbeidsoppgaver i løpet av en dag på jobb?

Motivasjonsspørsmålene

4. Kan du beskrive hva som er en god dag på jobben for deg?
   a. Mulig oppfølgingsspørsmål: hvordan føler du deg da?
5. Kan du beskrive hva som er en dårlig dag på jobben for deg?
   a. Mulig oppfølgingsspørsmål: hvordan føler du dette påvirker deg?
   a. Hvordan vil du beskrive det sosiale samværet?
      i. Hva tenker du om legene?
      ii. Hva tenker du om kollegaene dine?
7. Hvordan er holdningene hos dine kollegaer til jobben?
8. Er det noe legene kunne gjort annerledes for å motivere deg bedre?
9. Hva tenker du om lønn?

Til slutt

10. Er det noe mer du ønsket jeg hadde spurt om/noe som mangler?
Appendix II: Interview guide (focus group)


Bakgrunnsspørsmål

11. Kan dere fortelle litt om deres bakgrunn?
   a. Gjelder alder, bakgrunn, og erfaring

Motivasjonsspørsmålene

12. Hva tenker dere er en god dag på jobb? Hva ville dere beskrevet da?
   a. Mulig oppfølgingsspørsmål: hvordan føler du deg da?
13. Kan du beskrev hva som er en dårlig dag/mindre god dag på jobben for deg?
   a. Mulig oppfølgingsspørsmål: hvordan føler du dette påvirker deg?
14. Hva tenker dere om kommunikasjonen på arbeidsplassen, og mellom kollegaer og sjefer?
15. Kan dere si noe om hvordan du føler samarbeidet og kommunikasjonen er på arbeidsplassen? Kan dere beskrive og diskutere hvordan kommunikasjonen foregår?
   a. Hvordan vil dere beskrive det sosiale samværet, både mtp på kollegaer og sjefer?
16. Er det noe legene kunne gjort annerledes for å motivere dere bedre?
17. Hva tenker dere om lønn?

Til slutt

18. Er det noe mer dere ønsket jeg hadde spurt om eller noe dere føler som mangler?
Appendix III: Consent form

Oslo 22.12.2017

Samtykke om å delta i mastergradsprosjekt ”Motivasjon blant helsesekretærer på norske fastlegekontorer”

Som mastergradsstudent ved Avdeling for helseledelse og helseøkonomi skal jeg gjennomføre et prosjekt med mål om å beskrive hva som motiverer helsesekretærer på norske fastlegekontorer. Prosjektet blir veiledet av Ivan Spehar, førsteamanuensis ved Avdeling for helseledelse og helseøkonomi. Prosjektet er godkjent av Personvernombudet ved NSD.


Det er helt frivillig å delta i prosjektet. Du kan på hvilket som helst tidspunkt trekke deg uten å måte begrunne beslutningen nærmere.

Er det spørsmål i forbindelse med denne henvendelsen, eller ønskes det informasjon om resultatene når de foreligger, kan undertegnende kontakte.

Med vennlig hilsen

Marthe Helene Sandli
Mastergradsstudent MHA
Institutt for helseledelse og helseøkonomi
Universitetet i Oslo
Tlf: 980 78 675
E-post: m.h.sandli@studmed.uio.no / marthe.sandli@gmail.com

Samtykkeerklæring

Jeg har mottatt informasjon om mastergradsprosjektet ”Motivasjon blant helsesekretærer på norske fastlegekontorer” og er villig til å delta i prosjektet.

Dato:…………………………………….

Signatur:…………………………………    Telefonnummer: ……………………………
Appendix IV: NSD Approval

Ivan Spehar
Postboks 1130 Blindern
0318 OSLO

Vår dato: 02.02.2018
Vår ref: 58017 / 3 / BGH
Deres dato: 
Deres ref: 

Forenklet vurdering fra NSD Personvernombudet for forskning

Meldingen gelder prosjektet:

58017
Behandlingsansvarlig
Motivasjon blant helsesekretærer på norske fastlegekontorer.
Universitetet i Oslo, ved institusjonens øverste leder
Ivan Spehar
Marthe Helene Sandli

Vurdering

Etter gjennomgang av opplysningene i meldeklarett med vedlegg, vurderer vi at prosjektet er omfattet av personopplysningsloven §31. Personopplysningene som blir samlet inn er ikke sensittive, prosjektet er samtykkebasert og har lav personvernulsempe. Prosjektet har derfor fått en forenklet vurdering. Du kan gå i gang med prosjektet. Du har selvstendig ansvar for å følge vilkårene under og sørge deg inn i veiledningen i dette brevet.

Vilkår for vår vurdering

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeklarett
- krav til informert samtykke
- at du ikke innhenter sensittive opplysninger
- veiledning i dette brevet
- Universitetet i Oslo sine retningslinjer for data sikkerhet

Veiledning

Krav til informert samtykke

Utvalget skal få skriftlig og/eller muntlig informasjon om prosjektet og samtykke til deltakelse. Informasjon må minst omfatte:

- at Universitetet i Oslo er behandlingsansvarlig institusjon for prosjektet
- daglig ansvarlig (eventuelt student og veileder) sine kontaktopplysninger
- prosjektets formål og hva opplysningene skal brukes til
- hvilke opplysninger som skal innhentes og hvordan opplysningene innhentes

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.
• når prosjektet skal avsluttes og når personopplysningene skal anonymiseres/slettes

På nettsidene våre finner du mer informasjon og en veiledende mal for informasjonskriv.

**Forskningsetiske retningslinjer**

Sett deg inn i forskningsetiske retningslinjer.

**Meld fra hvis du gjør vesentlige endringer i prosjektet**

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

**Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet**

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

**VI tar kontakt om status for behandling av personopplysninger ved prosjektslutt**

Ved prosjektslutt 01.06.2017 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

**Gjelder dette ditt prosjekt?**

**Dersom du skal bruke databehandler**

Dersom du skal bruke databehandler (ekstern transkriberingsassistent/spørreskjemaoverøver) må du innå en databehandleravtale, vedkommende. For råd om hva databehandleravtalen bør inneholde, se [Datatilsynets veiledere](https://www.datatilsynet.no/).

**Hvis utvalget har taushetsplikt**

Vi minner om at noen grupper (f.eks. opplærings- og helsepersonell/forvaltningsansatte) har taushetsplikt. De kan derfor ikke gi deg identifiserende opplysninger om andre, med mindre de får samtykke fra den det gjelder.

**Dersom du forsker på egen arbeidsplass**

Vi minner om at når du forsker på egen arbeidsplass må du være bevisst din dobbeltrolle som både forsker og ansatt. Ved rekruttering er det spesielt viktig å forespørsel rettes på en slik måte at frivilligheten ved deltakelse ivaretas.

Søvåre nettsider eller ta kontakt med oss dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Vennlig hilsen

Dag Kiberg

Belinda Gloppen Helle

Kontaktperson: Belinda Gloppen Helle tlf: 55 58 28 74 / belinda.helle@nsd.no