How well do general practitioners and hospital consultants work together? A qualitative study of cooperation and conflict within the medical profession

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SUMMARY

Background. *The professional relationship between general practitioners (GPs) and hospital consultants (sometimes referred to as 'specialists') is important in a health care system based upon the generalist as the first point of contact for patients and the gatekeeper for hospital services. This relationship has been the subject of considerable interest over the years, but little empirical research has been carried out.*

Aim. *To investigate the professional relationship in terms of the balance between cooperation and conflict between GPs and specialists in clinical contact.*

Method. *A qualitative study using 24 semistructured interviews and four focus group interviews with a purposeful sample of clinicians working in the south-west of England. A content analysis of the data was performed.*

Results. *There is a high level of mutual respect and cooperation between the two branches of the profession and a strong desire to build a personal relationship over a long period of time. There are few areas of significant disagreement; indeed, most members of both branches of the profession try hard to deal with, or avoid, potential conflict.*

Conclusion. *The professional relationship between GPs and specialists is better than the literature and anecdotal stories might suggest.*

Keywords: general practitioner; specialist; professional relationship.

Introduction

THE way in which general practitioners (GPs) and hospital consultants interact has important implications for any health care system in which the generalist is the first contact for patients and the point of access to relatively scarce and expensive specialist services.[1] For this reason, the relationship between the two main branches of the medical profession has received a considerable amount of interest,[2–6] although it has only rarely been systematically researched.

The traditional perceptions of the two branches of the profession were summarized by Horder[4] 20 years ago. He described GPs as being jealous of the status, facilities, and income of their specialist colleagues and resentful that, at the time, there was no special training for their role. He describes the specialists' perception of GPs as dealing with minor problems, mostly of a psychological or social nature, and rarely used or needed their medical knowledge. He claims that many specialists saw a GP's main task as to sort out what was minor from what was major and to refer the latter to the hospital.

While this description might have been exaggerated, detailed studies of the profession in the 1960s and 1970s highlighted major problems in the relationship.[3,6] More recent research suggests that there might still be problems with mutual understanding and communication. Specialists complain about inadequate information[7] and unnecessary referrals,[1,8–10] while GPs have expressed dissatisfaction with lack of information,[11–13] failure to take account of important psychosocial information,[9] and delays in communication.[14] Others have suggested that the two branches of the profession have such different core values that lack of understanding is inevitable.[13,15,16]

In the last two decades, several factors have changed the relationship between the two main branches of the profession. Specialists are undoubtedly less autonomous and less powerful within the hospital environment than they have been in the past, as a result of increasing management control of their activities.[17] In general practice, the quality of training has improved, as have the practice premises, available services, and skills within the primary health care team. The GP's key role as the patient's advocate has been enshrined in legislation, and the influence that they have as purchasers of hospital services has been said to result in a power shift within the profession.[19]

This paper is one part of a mainly qualitative, three-year study of the professional relationship in the south-west of England. Identified themes from this study were broadly classified into groups, which included career choice, relative roles in patient care, educational interactions, and future models of working together. Spanning these groups were themes that may be described as relating to the 'process' of interaction. This paper highlights cooperation and conflict within the profession, a process theme that was a major focus for the study participants.

Method

The study was conducted in the south and west region of the United Kingdom (UK) between February 1995 and April 1996. In total, there were 3900 GP principals and 2470 hospital consultants working in the region. Specialists with minimal daily contact with GPs, such as anaesthetists, were excluded from the study population. Data were collected using two types of qualitative interview; all the interviews were conducted by the author and were audiotaped and supplemented with field notes.

Semi-structured interviews

Semi-structured interviews were conducted at the participant's place of work with a purposeful sample[21] of clinicians from across the region. Subjects were selected using a qualitative sampling frame[21] to ensure a broad spectrum of demographic and professional characteristics and were identified by snowball sampling techniques.[22] The data were analysed as they were collected, and sampling ceased when categorical and theoretical satura-

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tion was achieved.[22] In total, 12 GPs and 12 specialists were interviewed. The interview schedule was designed during an earlier part of the study[23] and was applied to ensure flexibility suitable to the interviewees.[24]

Focus groups

Four focus groups, each with four GPs and four specialists from a single locality, were conducted at the local postgraduate medical centre. Participants were selected using similar criteria to the semistructured interviews. The membership of the groups was carefully balanced using advice from an expert in group dynamics, in order to ensure maximum productivity. The process was facilitated by the author, but the groups were largely 'self-managed'.[25]

Transcript analysis and interpretation

The tapes were fully transcribed, and these transcripts, together with the field notes and reflective comments, formed the raw data for further analysis. The processes of sampling, data collection, and data analysis were continuous and iterative. A content analysis[22,26] was conducted using the computer program ATLAS-TI (Thomas Muhr, Berlin, Germany, 1994). Once the data had been fully coded, annotated, and categorized, network and matrix visual displays were used to aid interpretation and develop theoretical models.[22] Such displays are easily created and modified using ATLAS-TI.

Quality assurance of the data analysis and interpretation

The trustworthiness of data analysis and interpretation was assessed using three recognized techniques. First, external validation (also known as inter-rater coding) of all stages of coding and interpretation of five randomly selected semistructured interview transcripts and two focus group transcripts was performed independently by three experienced qualitative researchers. The results were compared and there were no significant inconsistencies. Any differences of opinion were discussed and a consensus was reached. Secondly, the interpretation of the data was discussed personally with four randomly selected semistructured interviewees and one member of each of the focus groups in order to compare my perspective with that of the subjects. This process of responder validation again revealed no significant criticisms of my interpretation. Thirdly, the results were triangulated with different data sources within the study, with other data collecting methods used in the larger project (including key informant interviews[23] and a Likert survey), with the available literature, and, finally, with data collected incidentally outside the formal interviews. Results that were consistent between data sources and data collection methods were given most significance during interpretation.

Results

The interview transcripts were analysed in detail to identify both explicit and implicit references to cooperation and conflict in the professional relationship. The subtheme of mutual support and cooperation was represented far more strongly than that of conflict. The possibility that this was simply a reflection of an acceptable public face of the profession or a desire not to expose weaknesses was given considerable attention during the analysis and validation of the data.

The main motivation for individuals to cooperate and support each other, apart from traditional professional etiquette, was a desire to preserve a potentially long relationship, lasting the professional lifetime of the practitioners, and the perceived benefits for the patient of a relationship based on trust and mutual respect:

> 'Many GPs have a generous and supportive attitude [to specialist colleagues] and the patient comes clearly expecting a good opinion and they are immediately prepared to trust what the specialist is saying.' (ID 1.8)

Concern was expressed about the negative effect that open disagreement can have on patient care, on the professional image, and on the ability of doctors to work together in the future. Others were concerned that patient litigation would be facilitated by open conflict, and a small number of participants seemed to be motivated by a desire for an easy life.

This positive portrayal of the relationship does not represent an uncritical attitude on the part of the participants to what they expect of each other. Both specialists and GPs expressed clear statements about what they wanted in an 'ideal' professional colleague. Specialists respected GPs who were committed and willing to fight for their patients and understood their patient's background. They praised GPs' clinical skills but understood that some were stronger in certain clinical areas than in others and were willing to support their colleagues, by accepting 'inappropriate' referrals, in the weaker areas. GPs valued easy and effective access to specialists and a rapid response to requests. They expected to be treated as equal professional colleagues and to be respected for what they perceived to be their unique perspective and role.

Specialists criticized GPs for not understanding the stresses under which they now worked in hospitals, for sometimes being preoccupied with management and financial issues at the expense of clinical care, and for being overprotective of themselves in terms of half-days and holidays. There were, however, very few references to poor quality referrals and many insightful and supportive comments about the pressures under which GPs work. In general, it would appear that specialists are perhaps more understanding of the pressures on GPs than vice versa. GPs criticized some specialists for being resistant to change and for poor communication with patients, but very few references were made to arrogance or rudeness on the part of specialists to their GP colleagues.

Perhaps surprisingly, fundholding was not a major bone of contention in this study. Most participants considered that, after an initial period of posturing, the fundamental way in which specialists and GPs relate to each other as professionals has been largely uninfluenced by what they believe to be politically motivated restructuring. At a more superficial level, there was a feeling that the working relationship has, if anything, been improved as a result of greater dialogue. Private practice was considered to have a greater influence on the relationship; some specialists felt that their colleagues would 'curry favour' with GPs to attract private referrals, and there was a clear indication that GPs used private referrals to 'reward' those specialists who they perceived to provide a good NHS service.

The perceived benefits of a personal relationship between individual specialists and GPs was a recurring and strong subtheme in both the in-depth and focus group interviews. Both branches of the profession spoke of how the personal relationship builds up and improves over the years spent working together, although one GP felt that even a single meeting or telephone call could lay the foundations for a close personal relationship in the future. The development of the relationship was considered in detail, with some GPs working as junior doctors to the consultants during their training (the potential effect of this teacher–pupil hierarchy on the future relationship did not seem to be an issue), and one GP described how he 'tested out' new consultants with referrals by 'sending something simple first' (FG 4.34).

The participants felt that there were advantages for both the patients and the doctors in developing a close personal relation-

ship. The GPs felt that, if they knew and respected the consultant to whom they were referring, then they could 'build up' the referral in the patient's eyes, and this confidence, on both the patient's and the doctor's part, improved the outcome of the interaction:

> 'Certainly it is in the patient's best interest that we have a good relationship with consultants. I can think of occasions, when, because I have known a consultant, it is easier to expose one's uncertainty or weakness that you know and so you can ask the question that you want to ask plainly. I think it is not just to make us feel good and, you know, to make life more chummy.' (FG 4.13)

There was also a feeling that patients were less likely to be dissatisfied with an opinion if they felt that their GP and the specialist were working closely together and that it was easier to be constructively critical of someone with whom one had a close relationship.

There is other evidence that personal knowledge between referring doctors influences the process of the interaction and the service that the patient receives. One participant referred to this as 'matching', and there is evidence of matching between GPs, specialists, and patients. The most frequently discussed matching was of patient characteristics to specialist characteristics by the GP:

> 'The more I get to know my patients, the more I think that certain consultants would be more appropriate to refer them to. Not because I think they are better doctors but because I think the personality will suit, because I think that unless you can empathize with your consultant, or they with you, the message won't get across.' (ID2.11)

Most specialists recognized this; indeed, one surgeon positively enjoyed his reputation:

> 'I recognize that they perceive me as a certain kind of surgeon to send certain kinds of patients to, as opposed to diseases, you know what I mean. Yes, they'll send me breast patients because I am known as a conservative kind of person, they will send me the sort of person who is better to talk to than have it off next week. This pleases me.' (ID 9.23)

There is also evidence that specialists match their opinion and management input according to what they perceive the GP wants or is able to contribute. This could be either in a positive fashion, matching their skills to the skills of the GP, working as a team, or in a more negative fashion, such as the surgeon who claimed he usually reversed the urgency rating of the referrals from one particular GP.

Identification of this matching process suggests that the relationship between specialists and GPs is more than a simple mechanical process; it can be a sophisticated interaction built up over years of working together.

Discussion

The results of this study contrast with most previous investigations of the medical professional by painting an essentially positive picture of the relationship between GPs and specialists. The absence of significant conflict might come as a surprise to some observers, and I approached the investigation expecting to find more problems than were apparent. The long duration of the study, use of more than one method of data collection, and rigorous attention to assessment of the trustworthiness of the data analysis and interpretation all suggest that this study is an accurate description of the current relationship in the south-west of England. The personal characteristics, professional interaction, and health care systems might be different from other parts of the UK. It is quite likely that the relationship between inner-city GPs and traditional teaching hospital consultants is not as good.

The application of qualitative research methods, in place of a structured survey that has been used in other studies,[1,27,28] was justified by the depth and breadth of the data obtained. The opportunity to explore sensitive, complex, interpersonal issues and get behind the 'public face' shown by members of a profession outweighed the significant time and expense of this type of investigation. The main criticism was that the researcher was himself a GP. Every attempt was made to ensure that the potential effect that this might have on the interview process and the interpretation of the results was either acknowledged or minimized, as appropriate. This was addressed by the use of a personal learning diary kept throughout the study, by being explicit about my conceptual framework before designing the project, and by discussing my analysis with a broad range of people from inside and outside the profession. On balance, the benefits of the interviewer being a fellow professional, in terms of access, understanding, and ability to challenge the participants, were felt to outweigh the disadvantages.[29]

This study suggests that there is a good level of understanding and mutual respect between GPs and specialists and that individuals give a high priority to a personal relationship, established over years of working together. There are several factors that could damage the development of this relationship in the future. These include the increase in workload for all doctors, which might result in a reduction in opportunities for personal contact, and the increasing trend to impersonal referrals (a return to the 'Dear Doctor' letters of the past), resulting from the introduction of the internal market.

General practitioners and specialists in the south and west region have demonstrated a desire and enthusiasm to work together. This study provides insight and direction for doctors and others who work with the profession to build upon this goodwill.

Identification of quotations

'ID' and 'FG' identifies the quotations as originating from the in-depth/semi-structured interviews or the focus group interviews. The first number identifies the particular interview and the second number identifies the quotation within that interview.

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