

Unfashionable tales:

narratives about what is (still) great in NHS general practice

Abstract

Background

There is clear evidence that general practice has become a less popular career choice and among GPs there are high levels of dissatisfaction and demotivation. Little empirical evidence has emerged to indicate which factors contribute intrinsic value to the working lives of GPs and sustain their ongoing commitment.

Aim

To understand which aspects of work continue to motivate and engage senior GPs by exploring their narrative accounts.

Design and setting

This was part of a qualitative study in which senior GPs and hospital specialists contributed narratives in which they reflected on their working lives.

Method

Individual, open interviews were conducted with eight GPs who had graduated in the early 1980s. Thematic analysis and situational analysis mapping were used to identify and connect related themes.

Results

During interviews in which doctors drew on a wide range of encounters and experiences, they revealed which aspects of work were associated with greater intrinsic rewards and contributed to their continuing motivation. Having chosen careers that suited their preferred settings and working practices, they recounted adjustments made in response to new challenges and confirmed experiencing greater enjoyment when performing roles affirming their sense of providing valued health care.

Conclusion

This study's findings offer an alternative angle from which to consider the current unpopularity of general practice careers. The article proposes that long-term engagement of practitioners may be achieved through provision of adequate supportive resources to allow them to enact a sense of medical identity that matches with their acquired expectations of their role in the NHS.

Keywords

general practice; job satisfaction; medical identity; professional practice; professionalism.

INTRODUCTION

Dominant messages emerging from contemporary general practice paint a bleak picture of a workforce crisis arising from unsustainable workloads, dissatisfaction, and insufficient recruitment.¹⁻³ Detailed analyses of workforce demographics and patterns of retention confirm a significant and ongoing shortfall in the number of GPs available to support delivery of accessible and high-quality primary care.⁴ An ageing population and shifting of care into community settings look set to increase GP workloads, yet survey evidence suggests that many qualified GPs are relocating internationally or opting for early retirement.⁵ A range of strategies to support and reinvigorate UK primary care have been proposed or implemented, including Royal College of General Practitioners and NHS England initiatives to promote GP careers and build an effective future workforce.^{6,7}

During the past 25 years, many aspects of general practice have changed. Successive GP contracts have reshaped services, altered priorities in primary health care, and redefined payment mechanisms. Of particular significance was the 2004 contract in which the Quality and Outcomes Framework (QOF) linked payment to targets in the management of certain chronic conditions rather than for provision of services to patients. Studies confirmed that GPs responded to achieve those targets,⁸ though possibly with relative inattention to other aspects of medical care.⁹⁻¹¹

Regulation and monitoring of primary care have increased in the form of appraisal and revalidation for all GPs, CQC inspections, clinical activity audits, and patient satisfaction surveys. Contractual changes have generated shifts in working patterns, with an increased proportion of doctors working as salaried employees, many of whom report less influence or engagement in the effective operation of the practice.^{12,13} Doctors are also engaged with commissioning health services and working together to effect improvements in how these are delivered to patients.³ Although some doctors view additional roles as welcome opportunities to enhance their effectiveness, some have claimed that these changes disrupt the 'proper' work of GPs by reducing time available for patient care.¹⁴

To understand the effects of these changes on GPs who were attracted to general practice during the mid-1980s, this article probes the biographical narratives of well-informed and reflective practitioners to identify characteristics of GP work to which they attach greatest value and to discover what motivates their continuing practice. Awareness of doctors' underlying sense of medical identity, and how this appeared to influence their reactions to shifts in expectations, adds to knowledge about how attractive, valuable, and durable roles for GPs may be re-established.

METHOD

Context, participants, and data generation

The biographical narrative accounts behind

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How this fits in

Recent patterns of recruitment and retention in the UK have resulted in a reduced workforce whose work is increasingly monitored, incentivised, and regulated. Dominant discourses about contemporary careers in general practice tend to focus on aspects that are perceived negatively. Narratives from this group of experienced GPs included many reflections on fulfilment, motivation, and enjoyment during their GP careers. Their accounts confirm that their job satisfaction is greater when they believe they can help achieve positive outcomes for patients and are able to engage in tasks that are well aligned with what they perceive to be good doctoring.

this article arose from an investigation into how NHS work had been experienced by a group of doctors who responded positively to an invitation mailed to an entire 1980s UK medical school cohort. They were chosen because of their ability to reflect on a 25-year period during which they progressed from a shared medical school background through postgraduate training, to career development and personal maturity. This occurred against a background of continuing changes in NHS organisation, shifting policy priorities, advances in medical knowledge, and changing societal attitudes.¹⁵

Individual, open interviews were arranged and conducted by the author (also a GP) in 2009–2010. In response to a general request to talk about their experiences of work, GPs generated narratives about experiences that seemed most significant in their careers. Recorded and transcribed interviews typically continued for 90–120 minutes with growing confidence allowing them to reveal less-than-ideal versions of their storied lives as their accounts progressed.¹⁶ Doctors usually focused first on experiences of working as newly-qualified junior doctors in acute hospital units before explaining their unfolding careers. Each co-constructed narration was unique, and variation in tone or presentation suggested sharing of both rehearsed stories and less-accessed memories of events. Interviewing stopped when preliminary analysis of eight richly detailed anonymised accounts from GPs demonstrated a combination of repetitive themes and a progressive reduction in emergence of new information.

Analysis

In-depth analysis of these reflective career narratives employed line-by-line extraction

of themes and benefited from peer discussion. Resonant but individually varied portrayals of GPs' experiences of work were subjected to situational analysis mapping techniques. Here, categories appropriate to organisational (macro) structures, social world (meso) relations, and personal positioning (micro) levels of socially constructed lives,¹⁷ demonstrated explicit and latent connections within and across mapping areas. Prominent links between their developed medical identity and responses to colleagues and organisational change prompted secondary analysis to examine this in greater depth.

As an alternative to presentation of extensive quotes or overuse of ellipses, poetic representation was applied to sociologically informative sections to transform quotes into short poems. Built on extended interpretive engagement with transcribed data, this technique utilised words in the order spoken by interviewees, and, having omitted those words believed unnecessary to convey the intended meaning, sought to maintain an authentic re-presentation of sense, feeling, or message.¹⁸ In the resulting condensed volume of data, the author therefore aimed to include only what was needed to encapsulate context and substance in the doctors' stories, allowing the space of poetic forms to carry greater expressive sense of lived experiences. Additional interpretive work and context-centred revision of poetic extracts were undertaken to achieve poems in which participants could recognise themselves. The acceptability and effectiveness of this process was confirmed by sharing some poems with participants and presentations to several audiences. Pseudonyms have been applied to all quotes, and poems are included in order to enhance readers' engagement with doctors' first-hand experiences.^{19,20}

RESULTS

Entrants to general practice in the 1980s spoke of joining a forward-looking professional group building on improved professional status, investment in primary care, optimism about preventive medicine, and a trend towards holistic practice.²¹ Training was achieved through formal programmes or via self-selected approved posts, and entry to GP partnerships was often highly competitive.

On developing and enacting their preferred medical identity

Most doctors began by recalling mixed experiences of early work in hospital

Box 1. The meaning of work

What does work mean?

'It's probably what defines me I live to work; would fear for how I would be if you took that from me in the wound down, highly deprived, high unemployment town

I wouldn't like to be sitting in an academic practice pulling my hair out if folk came in with printouts from the internet.

Give me your ordinary, down-to-earth person any day. I have got a job to do here; to support people through difficult times, challenging events in their life, to be there for them whatever they need from me.

My job is not to sit here in judgement it's to journey with them. 'If I can do that, it's a job well done.'

[Alice]

Box 2. Listening to patients

Really listen

'I really like looking after older people; I like the relationships

Older people have such a wealth of experience and complex therapeutic problems — it's medical multitasking

It's a great challenge to try and get at a level between treating conditions and quality of life and trying to guide people through those difficult decisions

I get a lot of positive feedback People say that they like having me as their doctor Perhaps I am a better GP than I used to be a bit older and wiser

I really listen Sometimes that's all I do Just listen and make them feel like they are not on their own.'

[Helen]

settings where they were able to test their own compatibility with multiple career options. Although many found junior posts exhausting, others began developing attitudes and consulting skills that would later characterise their approach in general practice and sustain an ongoing 'passion' for direct patient care and for achieving a positive outcome:

'Day-to-day patient contact, and actually building up relationships with patients, you know looking after them, either to well or to death ... that sort of relationship that you build up with people when you were looking after the ward, going back and seeing them.' [Jennie]

'It's just getting the patients to ... feel better ... seeing and understanding the illness and I think, yes, I know what is up with that patient and I know what is bothering them, and this is the treatment, and ... if not completely solved at least you know where you are going with it. And yes I like doing that.' [Richard]

Some responded to a sense of having to prove themselves as a 'proper' doctor by first achieving specialist qualifications while others pursued a specialism before realising that their preferred ways of working with patients were fundamentally different from those of specialist colleagues. Many recognised general practice as a more comfortable place to work, with greater flexibility and a more appealing lifestyle, an escape from the demands and discomforts of hospital on-call work where, as junior doctors, they could feel like 'just a tool in a machine' and caught in a competitive environment with 'challenging, hierarchical people'.

Personal stability was reported as a vital background for approaching patients' problems in a 'rational' and 'untainted' way, and flexible working hours could be adjusted to suit family circumstances. Satisfying work included the challenge of being the first doctor to assess a new problem, with an additional boost felt on confirmation of a suspected diagnosis:

'I send somebody to hospital and I phone up and I want to know how they are getting on, that kind of adrenaline rush of YES; I got that diagnosis right.' [Alice]

Each doctor constructed a coherent and positive GP identity and, although they demonstrated a range of different preferences and motivational drivers, each

reflected on achievement of many important career goals and personal fulfilment (Box 1):

On the importance of interacting with patients

Long-term engagement with patients was highly valued. Because most of these GPs had worked in the same practice for most of their career, they had acquired detailed knowledge of the personal histories of many returning patients and were cognizant of the impact of family relationships and social backgrounds:

'It's almost like old-fashioned general practice ... if they have got difficulty remembering where their roots are, I can usually fill the gaps in for them. And that's, that's a nice feeling.' [Alice]

Beyond simple factual knowledge, they spoke of relationships with patients as they negotiated life-altering illnesses together, picking up on previous encounters and continuing to support ill-defined difficulties:

'I saw a patient today who ... was already struggling as a teenager when I first met her 22 years ago ... psychiatry has bounced around saying she is just personality disorder and so ... impossible to treat, and I have seen her through my whole career ... she comes back time and time and time and time again. It's got to be a privilege hasn't it because you know that's something that no one else will have with that person, and she obviously respects me.' [George]

Facilitating the involvement of patients in their own care was a particular goal for one GP who enthused about utilising self-management and clinical decision tools, and making his personal evaluation of their effectiveness:

'I have done a little protocol for home blood pressure monitoring for people ... it's really empowered people. I have also done a new thing around a self-management plan for people with comorbidity. I have shown ... how that has changed people's health-seeking behaviour.' [Mark]

GPs spoke of dealing honestly with patients, talking through the detail of their presenting problems and what could be done to resolve them:

'I still think that ... doing a bit more for patients rather than just ticking the box and sending a bottle off, that's still quite interesting ... working out things with your

patient ... getting things organised, and knowing that, you know, they came in with a problem and ... if not completely solved at least you know where you are going with it. [Richard]

Positive feedback from patients was a frequently mentioned confirmation that doctors' efforts had been appreciated, with one defining his job as a 'privilege' and another observing that for some patients he could be 'the second most important person in their life'. Some related incidents when they had been active advocates for particular patients for whom they felt the NHS had failed to provide adequate care.

In a practice with a high proportion of older patients, a GP's investment of time to 'really listen' allowed her to better understand how to juggle conflicting treatment plans (Box 2).

Talking of teams

All doctors in this study were based in practices managed by GP partners; the sole salaried doctor had previous experience as a GP partner but chose her current position because it allowed her to balance clinical work with plans to support doctors requiring help with revalidation, and to maintain a work-life balance compatible with her own wellbeing.

Those who had experience of a few different teams were particularly vocal on topics related to leadership and team cohesion. Team building through finding time for interpersonal communication was highly valued:

'We always stop for coffee which is one of those things that actually I haven't compromised on.' [Mary]

Making sure that all GPs shared a coffee break provided 'very supportive' opportunities to allocate tasks, discuss any problems, and efficiently decide on any necessary action. They could also pass on information, talk through complex cases, or simply consolidate a sense of working together. Purposeful teamwork did not happen by accident: maintaining a 'good secretarial team', 'a very strong nursing team ... three nursing prescribers and one nurse who does minor surgery' was built on more than regular coffee meetings:

'Our practice is quite well known locally for ... lots of team-building things with the staff.' [Stewart]

In addition to teams within their

practices, GPs were members of other teams, networks, and forums through involvement with undergraduate education and postgraduate training roles. These could be particularly stimulating:

'The teaching gives me a high, it's just being with young students and going back to basics again ... teaching examination, looking at interesting patients, so it's exactly back to basic clinical skills.' [Jennie]

'I would really like to always be involved in teaching other doctors ... or students, juniors, whatever. As to why? ... it's difficult to say really, just like it gives me a buzz, makes me feel ... like a real doctor I suppose, like a real doctor, a real useful person for others, a useful resource, somebody with knowledge, somebody that can help, the helpful guide sort of thing. And, an affirmation of my abilities ... still love it.' [Helen]

The importance of leadership was emphasised in another GP's reflection on quality achieved through a patient-centred team culture (Box 3).

Working within a wider organisation

Faced with rapid and continuing organisational changes that have accompanied their careers, GPs contributing to this study adapted to new processes, policies, and expectations. Working as everyday doctors (rather than shapers of NHS services) they and their workplaces have survived only by successful transitions in response to altered conditions within the NHS.

Of particular importance in these narratives was the 2004 GP Contract, under which a significant proportion (circa 25%) of funding available for providing GP services was linked to achievement of a range of clinical, administrative, and educational targets (QOF). Most GPs responded positively to QOF payments for performance, by a combination of ensuring good control and careful recording of data, and by employing staff to check that performance on these quality indicators was properly recorded and at optimum levels. Because this contract differed fundamentally from previous contracts, its introduction proved a convenient point for one doctor to progress into a managerial position. He perceived his status in relation to his GP partners as disadvantaged, an unsatisfactory situation that resolved when, with the introduction of a new contract, he was suddenly able to move into an empowered position with better understanding, greater control, and higher income (Box 4).

Box 3. A culture for quality

Shaping the culture for the team

*'We have the staff we need,
we have the equipment,
we have nice colour carpets,
nice wall art,
premises that we own.'*

*'Everybody knows the number one priority
is quality.'*

*'We are on the side of patients,
we set the direction,
and have flexibility.'*

*'We manage a small general practice,
independent contractor status allows that.'*

*'Leadership from doctors,
because if they set the right culture then
everyone follows.'*

*'We hand pick the staff,
turnover is extremely low.
Everybody knows that
I trust them and say,
Just make the best decision
that will support patients.'*

*'So we will see people,
we will go the extra mile,
we will coordinate care,
we will chase things up,
it's the classic general practice function.'*

[Mark]

Box 4. New contract, new opportunities

The other thing the contract did for me and my career

*'We had a mysterious red book
my senior partner
my chaotic practice manager
used to cook up this red book.
We never knew where we were with money.
He and she ran the practice
out of this red book.*

*A classic case of
'We have always done it like this.'
A classic case of
a nightmare
and very poorly run.*

*Everything happened at once;
the contract came,
a new, efficient young practice manager
I said
'It's my time to do it'.*

*So
the contract
with all that QOF stuff,
was so clear about how you earned your
money
and what you did it for'.*

[George]

More subtle strategic adaptations could be made to minimise additional effort; for example, to simply record an inter-professional discussion of significant (adverse) events:

'In the old days ... you wouldn't really have made anything of it, probably talk about it over coffee, which is what we do actually; we talk over coffee now and then write down our coffee talk as a significant event.' [Mary]

In response to initiatives to reduce prescribing costs and informed by regular monitoring updates, GPs spoke of achieving satisfaction by successfully maintaining a good budgetary position when compared with neighbouring practices. Although Clinical Commissioning Groups and provider networks were not then in place, there were opportunities for GPs to tender for new services, which could demonstrate their ability to be innovative and to improve patient services.

'The new service is a lot of the old stuff with a nicer feel ... brought in all the other services for patients ... it's amazing the amount of IT we have introduced and yet retained that small flavour of the surgery as well still, so that's good.' [Jennie]

'We are involved with this social medical corporation model ... which has expanded quite a lot.' [Stewart]

DISCUSSION

Summary

These stories are selected from recent biographical narrative accounts in which doctors recounted both positive and negative aspects of their experiences during 25 years of NHS employment. In isolation they do not convey complete representations of their careers, but, as integral components of the stories they chose to tell, they encapsulate some of the reasons that GPs continue to work with and for patients. They are intended to add a counter-perspective to many articles, papers, and reports that focus on negative aspects in order to stimulate debate about the reasons behind current discontents and to contribute ideas about how these may be resolved.

Development of medical identity including concepts about how doctors ought to work with patients, vocational commitment to provide high-quality services, and a sense of being part of a great profession, were important back-story elements in these accounts. As front-line clinicians, GPs

reported fulfilment, excitement, and a sense of purpose, achieved through responding to patients' needs and offering long-term support. As teachers, they reported great pride in shaping the clinical skills and professional development of medical students and junior colleagues, hoping they would step forwards as future professional leaders. As senior GPs they would expertly negotiate around obstacles and devise new ways of working. They proved capable of adapting to new regulatory mechanisms and of surviving unanticipated expectations. Although neither they nor the conditions in which they worked were perfect, it was still the case that professional pride, ability to make things happen for patients, listening skills, and supportive action were not simply trite and aspirational statements but also remained vital contributors to personal and professional fulfilment.

Strengths and limitations

It must be acknowledged that a limited study such as this cannot encompass all opinions or convey how widely held each position may be across this or another group of GPs. Further, since all had continued in practice for 25 years after graduation they had, by definition, achieved some success in negotiating workplace changes. However, presentation of data from this study to a variety of audiences has confirmed that these findings resonate with the experience of many doctors and this lends greater significance to their utility as indicators of working practices that are valued by GPs.

Comparison with existing literature

Amid great concern for the future of primary care, as emphasised in multiple comprehensive reports,^{4,6,7} the recently published Primary Care Workforce Commission report envisages extended multidisciplinary teams as a means to manage delivery of high-quality primary health care.²² Further, it proposes measures to enhance 'care of the provider' inadequately resourced and integrated teams, with a view to supporting 'challenging and satisfying careers'; which would in turn boost GP recruitment. However, the stratified working patterns and multiple supervisory roles described in the report may generate working conditions that are not well aligned with aspects of general practice valued by doctors interviewed in this study. Although not presuming that doctors' views of what constitutes good general practice should go unchallenged, clinicians' responses to emerging forms of general practice require further interpretive investigation because

they represent an essential component in their future engagement.²³ Given a lack of recent published evidence about factors contributing to low GP recruitment and retention, further evaluation of urgently-needed strategies to resolve this would benefit from similar in-depth evaluations as they are implemented.⁷

Implications for research and practice

The purpose of this article is to add evidence of what constitutes valued work and recognise latent rewards that are widely recognised in NHS general practice but often obscured by the primacy granted to counterbalancing perspectives. Publication of these stories for audiences beyond the confines of general practice demonstrates that, despite fundamental shifts in medical settings, professional expectations, and an altered compact between GPs and their patients, employers, regulators, and public, it remains possible for GPs to construct narratives that affirm professional pride.

Provision of high-quality care depends on motivated, engaged, and supported professionals.^{24,25} To attract and retain motivated GPs, it seems useful to consider the extent to which working in general practice corresponds with doctors' enactment of their professional identities and how they judge what is valuable for patients. Likewise, selection and training should prepare practitioners with skills to adapt to changing expectations. Adequate resources and support that facilitates professional development would assist in dealing with multimorbidity and complex case management, and allow time to include patients in decision making. Structures that enhance team cohesion and shared objectives may prove more effective in preventing low morale and declining performance than is possible through financial rewards.

The nuanced narratives of these GPs provide evidence to confirm that, however unfashionable it is to say so, general practice can still be a great place to work.

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Competing interests

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