POST VIVA RESUBMISSION

DOCTORAL THESIS D10D ELG

# A Systems-Psychodynamic Exploration into GP Experiences of Current Changes in Healthcare Delivery

Liz Greenway

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Consultation and the Organisation

(Resubmitted 19th August 2021)

## Abstract

My research uses a psychosocial approach to undertake an exploration into general practitioners' (GPs) experiences of current changes in healthcare delivery. Under the impact of the neoliberal paradigm and the challenges of running a general practice, GPs appear to have been retiring early, and it has been hard to recruit GPs for some years. At this time, when we are seeing an ageing population, increasing incidence of chronic comorbidities, and the development of clinical technologies, the biopsychosocial model of medicine has to contend with much complexity. Moreover, the nature of primary care is such that the business of general practice is also being challenged by the processes of commissioning, bidding and contracting required to sustain income and viability, with some practices joining together to form primary care networks in order to survive. All of these varying elements beg the question: what defines GPs' primary tasks, roles and systems, and how might their motivation and identity be affected by this situation of clinical complexity and financial challenge in the healthcare context? Bringing in concepts from systems psychodynamics and organisational consultancy, this thesis considers both the doctor- and organisation-in-the-mind. Using a qualitative approach to explore these dynamics, semi-structured interviews were undertaken with 12 GPs at different stages of their career, with different interests and responsibilities. Ten themes were identified as pertinent to the sample, to varying degrees: 1) the long-term patient relationships – dependency and intimacy; 2) identification with the role, and the GP surgery as a second home; 3) underpinning ethical value systems; 4) satisfaction in one's role as a clinical GP; 5) the systemic leadership role; 6) being overwhelmed by the context; 7) a business-minded approach to the financial state of the surgery and context; 8) determining one's own timetable; 9) one's own family or illness as a motivator; 10) family aspiration as a motivator. Three major clusters of responses were identified, revealing three GP types with varying social defences and valencies for individual and group functioning.

The neoliberal paradigm, together with managerialism, changes in funding methodology, the erosion of social support systems, an ageing population, advanced medical technologies and other issues, appear to have disrupted GPs status as the family-doctor-in-the-mind committed to caring for patients from cradle to grave. An increasing ambivalence about meeting the demands of patient dependency, and a turning away from the responsibilities of full-time partnerships in general practice, is an identifiable trend. In addition, my research identifies the alternative allure of entrepreneurial activity and engagement with both organisational demands and novel clinical pathways in the wider system of healthcare. Through the application of the metaphor of the periodic table, a hypothetical model is tentatively offered comprising the three GP types in order to consider not only the effect on individual GPs but also the possible impact on general practice as an institution.

**Keywords:** valencies, general practitioner, systems psychodynamics, psychosocial, social defences, general practice, organisation-in-the-mind

**Table of Contents**


List of Tables vii

List of Figures vii

Abbreviations viii

Acknowledgements ix

Prologue 1

Chapter 1. Introduction 3
1.1 Origins of the Research Project 7
1.2 Development of the Research Questions 12

Chapter 2. Literature Review 14
2.1 Introduction 14
2.2 The Context at the Time 16
2.3 Neoliberalism 19
2.4 Status, Well-Being and Work of GPs and Primary Care 25
2.5 Doctors' Narratives: Autobiographies, Biographies and Novels 28
2.6 Doctors' Narratives: Recent Qualitative Research by GPs 32
2.7 Consultations to GPs 34
2.8 Vulnerability and Splitting 37
2.9 Systems Psychodynamics 39

Chapter 3. Methodology 56
3.1 Critical Realist Position 56
3.2 Rationale for the Research Method 58
3.3 Interview Sample 58
3.4 Research Study with a Sample of GPs:
Free Association Narrative Interviewing 61
3.5 Developing the Interview Schedule 63
3.6 Ethical Considerations 68

3.7 Data Analysis Using Grounded Theory and FANI 68
3.8 The Ten Themes 72
3.9 The Three Types 76

Chapter 4. Main Findings 83
4.1 Three GP Types: An Overview 83
4.2 In-Depth Descriptions with Data Illustrations 84
4.2.1 Type 1: GPcom 84
4.2.2 Type 2: GPreneur 125
4.2.3 Type 3: GPamb 139
4.3 Immediate Context: GP Partnership Model 169

Chapter 5. Summary and Discussion of Findings 172
5.1 Adaptations to the Role of GP 172
5.1.1 GPamb 174
5.1.2 GPcom 176
5.1.3 GPreneurs 177
5.2 Complexities 178
5.3 Defences Against Anxieties 183
5.4 Reflections on General Practice 185
5.4.1 General-Practice-in-the-Mind 185
5.4.2 Reflections on the Institution of General Practice 188
5.5 The Periodic Table as a Metaphor, and the Relevance of Valencies 189
5.5.1 The Use of Metaphor 189
5.5.2 Valency and Basic Assumption 191
5.6 The Groups of the Periodic Table as a Metaphor for GP Types 196
5.6.1 GPcom: BaD 198
5.6.2 GPreneur: BaP 199
5.6.3 GPamb: BaM 200
5.7 Reflections on the Periodic Table as a Metaphor 202
5.8 Further Thinking on Individual Valency 203
5.9. Further Research 205
5.10 Concluding Comments: The Changing Context 206

Bibliography 214

Appendix 1. UREC Approval Letter 227

Appendix 2. Assurance Letter, Central London CCG 228

Appendix 3. Participant Information Sheet, Version 2.0 230

Appendix 4. Consent Form 233

Appendix 5. Letter of Invitation to Participants 234

Appendix 6. FANI Questionnaire 235

Appendix 7. Example of Committed GP (GPcom)
Transcript with Themes 236

Appendix 8. Example Entrepreneurial (GPreneur) GP1
Transcript with Themes 241

Appendix 9. Example of Ambivalent (GPamb) GP12
Transcript with Themes 252

Appendix 10. Three GP Types' Different Attitudes
to Identification with Role and GP Surgery as Second Home 258

## List of Tables

Table 1. Relevance of GP themes: all types of GPs 79
Table 2. Relevance of GP themes: GPreneurs 80
Table 3. Relevance of GP themes: GPcoms 80
Table 4. Relevance of GP themes: GPambs 81
Table 5. Relevance of GP themes: summary of all types 81

## List of Figures

Figure 1. Pressures on general practice 17
Figure 2. Transforming experiences framework. 47
Figure 3. Diagrammatic representation of GPamb. 175
Figure 4. Diagrammatic representation of GPcom. 176
Figure 5. Diagrammatic representation of GPreneur. 177
Figure 6. Diagrammatic representation of the adapted periodic table. 197
Figure 7. Institution of GP surgery. 208
Figure 8. General practice ecosystem. 209

## Abbreviations

| | |
|---|---|
| A & E | accident and emergency |
| ACE | ambivalent, committed, entrepreneurial |
| baD | basic assumption dependency |
| baF | basic assumption fight/flight |
| baM | basic assumption me-ness |
| baO | basic assumption oneness |
| baP | basic assumption pairing |
| BMA | British Medical Association |
| BMJ | British Medical Journal |
| BNIM | biographic narrative interpretive method |
| CCG | clinical commissioning group |
| CQC | Care Quality Commission |
| DV | dependency valency |
| FANI | free association narrative interview |
| FIV | flight valency |
| FV | fight valency |
| GP | general practitioner |
| GPamb | ambivalent GP |
| GPcom | committed GP |
| GPreneur | entrepreneurial GP |
| NHS | National Health Service |
| PCN | primary care network |
| PCT | primary care trust |
| PHE | Public Health England |
| PV | pairing valency |
| QOF | Quality and Outcomes Framework |

## Acknowledgements

To my supervisors, tutors and colleagues, particularly Michael Rustin, Simon Tucker and Judith Bell: my gratitude to you all for your incredible breadth and depth of specialist knowledge, the application of your detailed experience to academic work and the doctoral journey, your generosity with your time, and your detailed consideration.

I also offer my deepest thanks to all the general practitioners who were interviewed for this research.

## Prologue

I will begin by setting the scene in general practice at the time of writing, in summer 2020. Since this research was undertaken, the international COVID-19 pandemic has had a deep impact on general practitioners' (GPs) work from March 2020 onwards, as I have heard first-hand from GPs in the Balint groups I co-lead. Among other changes, GPs are communicating with patients almost entirely remotely, as usual medical practice has been altered to avoid the high risk of symptom contamination. If patients are seen in person at this time, any doctor is ideally afforded personal protective equipment, although there are many reports of medical staff, particularly those working in hospitals, being insufficiently protected, and some even dying. Some GPs are keeping the doctor-in-the-mind alive among their elderly population with external visits and waving through windows, which serves the dual purpose of demonstrating to patients that they are held in mind and reassuring the doctor that the patients are alive and well. All of this means that everyday GP practice is somewhat suspended, with the usual testing and consultation for both acute medical concerns and ongoing health conditions severely limited, and with conditions that would usually be treated in secondary care now delayed and dealt with by GPs through telephone and virtual conversations with their patients. There has been a national call by the government for doctors to come out of retirement, including GPs. Trainee doctors are being brought into work before the formal completion date of their training. Furthermore, this pandemic threatens to unsettle national and international infrastructures, the health of the nation, the nature of healthcare, and the national coffers for many years ahead. Society in general and medical practice in particular may have changed permanently in some ways.

My research is situated in the years before the pandemic. My face-to-face interviews took place in 2015–2016, before the latest GP contracts were implemented in 2020, and before the National Health Service (NHS) ten-year plan. Today, gratitude from the nation – and indeed from the prime minister, who was provided with hospital care and thereby enabled to recover from COVID-19 – is being demonstrated by the public's weekly applause on their doorsteps. Our health is in the hands of medics, and we are under no illusions about it, although they remind us that we also need to play our part through social distancing, self-

isolation if necessary, and appropriate self-care. The mortality of doctors has also been brought to the fore, as a significant number, particularly among those from ethnic minority backgrounds, are dying in service. Anxiety about human survival returns us to dependence, to which the government has responded both financially and with some thought to infrastructure: doctors are apparently valued, albeit inconsistently, as more essential than ever, although some remain without personal protective equipment, exhausted and invited to be masochistic.

Having described the current context, I will now illustrate the situation and my own personal and professional motivations, intergenerational familial values and vulnerabilities as I considered undertaking research. By indicating some of my theoretical preoccupations, I will indicate a sense of my thesis journey.

# Chapter 1. Introduction

Perhaps my research can be understood as situated in a world prior to the pandemic. Neoliberalism was a strong presence in terms of competition within healthcare, and it had become essential for GPs to tender for contracts and meet government-set targets to ensure funding. The current stress in the system has demonstrated itself with a significant number of GPs retiring early, difficulties with taxes imposed on pensions above a certain level, and insufficient medical trainees opting for general practice. With retention and recruitment difficulties creating shortages, a dearth of GP partners has been one result; another has been that newly qualified GPs mostly opt for locum work. Tabloid headlines have described GPs as 'quitting', perhaps blaming them for the nation's ills (Borland, 2018). While writing up this thesis, I discovered a census survey from 2016 which provides a cross-sectional overview of the quitting intentions of all GPs in south-west England. The survey had a high response rate (67%), perhaps reflecting both the rigorous planning and implementation of the survey and the interest among GPs in the topic of workforce challenges. This survey must have been carried out while I was undertaking my own interviews, and its succinctly worrying results were published in the British Medical Journal (BMJ) in 2017 (Fletcher et al., 2017). It reveals serious issues with regard to the retention of the GP workforce: only half of female GPs want to work full-time and take a career break; younger GPs are hesitant about becoming partners, due to the financial risk, responsibility, and high workloads they have observed among their colleagues; GPs aged under 50 years are leaving general practice prematurely, and many GPs are leaving direct patient care. The article details the statistics:

> *Around 74% of primary care contacts take place with a GP. General practice has been described as 'the jewel in the crown' of the NHS. GPs are trained and have particular abilities in the diagnosis and management of patients with complex multi-morbidity. UK general practice is, however, facing major problems regarding maintaining the GP workforce, with imminent GP shortages and a concomitant potential risk to patient care. A near quadrupling of unfilled GP posts was observed between 2010 and 2013 (from 2.1% to 7.9%), associated with an overall reduction in the number of GPs in England from 62 per 100 000 in 2009 to 59.5 in 2013.*

> *An estimated 12% of 2947 GP training places were unfilled in England in 2013/2014. These issues are compounded by an ageing GP workforce (30% of the 43 000 current GPs are over 50 years old). Workforce issues are especially pertinent in inner city settings where recruitment and retention difficulties are further exacerbated by issues relating to the socio-demographic mix of the population and to increased demands for care.* (Fletcher et al., 2017, p. 2)

Nevertheless, non-doctors seem to have a fascination with doctors. Keeping the NHS under public ownership, extending its funding, and importantly increasing the current number of GPs by 6,000 were hot promises in the United Kingdom's general election in December 2019, along with leaving the European Union and establishing trade deals with the United States (with a denial that any such trade deals would include the NHS). It is notable that when politicians need to present clout, care and trustworthiness, they tend to associate themselves with medics and the NHS. That GPs were chosen as an electioneering symbol on which to pin reliability and reassurance perhaps demonstrates their stalwart position as social linchpins. It would seem that they are associated with a compassionate overseeing other, and with power at times of birth and death thanks to their interventions to enable the former and prevent the latter.

Dickens wrote a fictional story entitled 'Doctor Marigold'. It is about a man – as it would most certainly have been in Victorian England – of medicine, and the story refers not only to doctors' significance but also to their financial power. It is common knowledge that parents' gratitude for the doctor's part in the birth of their children would be such that on some (perhaps more poignant) occasions, the baby would become the recipient of the doctor's name – a token of gratitude, and perhaps a payment of the debt to the doctor. In the case of Dickens's story, the doctor's namesake is literal: the name adopted is 'Doctor'.

> *I was born on the Queen's highway, but it was the King's at that time. A doctor was fetched to my own mother by my own father, when it took place on a common; and in consequence of his being a very kind gentleman, and accepting no fee but a tea-tray, I was named Doctor, out of gratitude and compliment to him. There you have me. Doctor Marigold … the doctor*

> *having accepted a tea-tray, you'll guess that my father was a Cheap Jack before me. You are right. It was a pretty tray.* (Dickens, 1894, ch. 1, para. 2)

From just this short text, we can observe that Dickens, as a social scientist of his era, is outlining for us issues of power, finance, gender and access in relation to society and medicine. This was at a time before the creation of the NHS, when money, or payment in kind – in this case, a pretty tray – had to be found in exchange for medical care. He also draws our attention to the common generational passing down of trades and professions within families at a time when social demographics were much more static compared with the potential for mobility in recent times. In our current socio-political system, medicine is falling increasingly into the neoliberal domain, so that GP partners are to some extent similar to Doctor Marigold's parents in needing to consider which wares they can sell and how income can be achieved.

On 24 October 2019, an article was published in the *Metro* (a free newspaper available on the public transport network) about a life-size model created as a warning to office workers of the risk of health problems from staring at a screen with little exercise: '*Bent back, red eyes, varicose veins and a rotund tummy*' (Hamill, 2019, p. 11). Underneath there appeared another article by the same journalist, entitled 'GP Won't Seat You Now, It's a Standing Clinic'. Speaking about a trial led by Loughborough University, professor of behavioural medicine Amanda Daley said:

> *Historically, GPs and patients sit during consultations to facilitate good rapport. But we also know GPs spend a long time sitting down during the working day, which can contribute to poor health outcomes. Standing consultations could help GPs to be more active, as well as highlighting to patients the importance of reducing and breaking their sitting time.* (Brown, 2019, p. 11)

The newspaper page is striking, as the photograph of the markedly unhealthy-looking life-size model next to an article about the proposed standing clinic for GPs is suggestive of the unhealthy impact of being a doctor. It also implicitly

conveys the reality of the changed power dynamic between doctors and patients, with some patients now self-advocating, equipped with their own self-diagnoses and questions informed by the Internet and publications about personalised health. These members of the public do not simply respond to being told what to do.

Nevertheless, the article ends with a reminder about the importance of bedside manner from Helen Stokes-Lampard, chairwoman of the Royal College of GPs, who states: '*We need to be mindful that the GP-patient consultation relies on high-quality face-to-face communication and, in some cases, this will not be achieved if the GP is standing while their patient is sitting*' (Brown, 2019, p. 11). This is a pertinent remark, highlighting a continual thread which will manifest itself in varying publications, alerting us to the interwoven nature of doctor-patient pressures and preoccupations. I would add that the context in which the doctor is to a greater or lesser extent enabled or disenabled to work with patients performs a critical role. Patients' dependency needs support from doctors, who in turn depend on a facilitating environment; otherwise, the absence of such an environment may cause a breakdown in either participant. I have long appreciated the paediatrician and psychoanalyst Winnicott's thinking about the significance and influence of the infant's and then child's emotional environment and the way in which a good enough mother supported by a facilitating context will have more chance of contributing to a regulated secure child with capacities for play and concern. Winnicott (1990, pp. 96–97) informs us:

> *The baby grows in his or her own way if the environment is good enough. … [In] the average expectable environment … the conditions start with a high degree of adaptation on the part of the mother to the infant's needs, and gradually becomes a series of adaptations … related to the growing need of the child for meeting reality and for achieving separation and for the establishment of a personal identity.*

Crucially, Winnicott (1990, p. 71) also argues:

> *To do her job well the mother needs outside support; usually the husband shields her from external reality and so enables her to protect her child*

> *from unpredictable external phenomena to which the child must react; and it must be remembered that each reaction to an impingement breaks the continuity of the child's personal existing, and goes against the process of integration.*

It is the impact of the environment surrounding GPs in their working lives which I am curious to understand more about. First, I will offer my own internal psychological terrain, which sets the tone of my psychic context; I will then incorporate a key reference to Bion to situate the theory and metaphor I use later.

### *1.1 Origins of the Research Project*

I owe my very existence to NHS staff, without whom I would have died as a baby. Some of my family have relied heavily on medical provision and then died in middle age; some members are ageing now and need careful, sensitive, ongoing medical consideration. My family's values concur with the NHS ethos of providing medical treatment free at the point of access. Although there is a split in party political loyalties within the family, a commitment to public life is an important shared value across that divide.

Public service has been a value held dear by my grandmother, my parents and me throughout our lives. My grandmother worked as a nurse during World War II and later became a physiotherapist in the NHS. Although I did not know them well personally, I used to hear that my uncle was a vicar serving his local community, and that my grandfather had been a judge. Both my parents were teachers in primary and secondary schools, and then my father had a role in public life – in which I too served my part from toddlerhood! I was a frequent visitor with my father to many formal events and community venues for elderly and vulnerable people, and I would also be present in official settings, opening his post and meeting his colleagues. These experiences left their impression on me, although as I was perpetually in the shadows, I simultaneously felt that I was something of a depository for vulnerability. My internal relationship with my own authority, power and ability to make a contribution, exert an influence and make a difference has been somewhat of a struggle. As a young adult, I worked as a

tutor in adult education for ten years; halfway through this period of service, I trained to be a psychotherapist and started working as a clinician in GP surgeries and community venues. Eventually I allowed myself to become curious about the systems I had been working within, and I then also studied and started working as an organisational consultant while continuing my individual clinical work.

I was a self-employed NHS psychotherapist within the same GP surgery, with constant GP partners, for over a decade during 2005–2018. The target culture was explicitly introduced into my own NHS counselling sessions. This took the form of a new database that expected the assessment of measures of depression and anxiety via questionnaires to be entered electronically, preferably during every counselling session. Counsellors were informed by the Clinical Commissioners that the specified aim of these measures was to demonstrate patient improvement within the commissioners' expectations of the patient's clinical recovery and the therapist's accountability. This was part of a wider national remit for brief psychological therapies under the 'Improving Access to Psychological Therapies' programme, a government initiative that mostly offered cognitive behavioural therapy and some counselling. The idea was that this programme would more than pay for itself due to the resultant lessening of unemployment!

Having worked for quite a number of years in this role before these outcome measures were introduced, I began to be increasingly curious about my working context. When I had begun as an NHS counsellor, I had been working for the surgery under a locally enhanced service contract, operating alongside the GPs and reporting to the practice manager. Over time this changed dramatically: my clinical work became continuously monitored, and eventually my payment was partially performance-related under the newly formed clinical commissioning group (CCG), with which I also had an additional paid role for a few years as a member commissioning mental health services. In this way I witnessed GPs in roles such as 'commissioner lead' or 'GP with specialist interest in mental health'. I wondered about the conscious and unconscious motivations for GP clinical work and how they might be similar to or different from those for commissioning or advisory roles. I also wondered whether GP clinical work might be influenced by targets, or even avoided by turning more towards roles such as commissioning.

In my role as a counsellor I was recognised for my ability to offer role consultation, and so medical professionals who were struggling in their role were sometimes referred to me. In this way I worked clinically with a few hospital junior doctors and GPs, as well as with social workers, psychotherapists, nurses and teachers, among others. I had also become a regular member of a Balint group[1] and related training events, and in this way had been processing the doctor-patient relationship together with GPs, in a group setting. I was struck by the absence of any explicit focus on the system or overt shared observations about group dynamics in these meetings, and by the minimal exploration of unconscious processes in the role of the GP compared with the dominant preoccupations, which were oriented in the direction of the patient. Furthermore, the concept of valency (Bion, 1961; Hafsi, 2006, 2007, 2012a, 2012b; Stokoe, 2010) also came to mind. Valency was originally a measurement in chemistry of an atom's ability to combine with others based on the number of hydrogen atoms it can combine with or displace; the concept is therefore about forming bonds and alliances.

I wondered about the way Bion's (1961) original concept – with its application of predispositions towards group unconscious processes, creativity and work, or their avoidance – as well as more individually focused aspects of valency might be researched in relation to GPs (Hafsi, 2006, 2007 2012a, 2012b; Stokoe, 2010). Bion uses the term 'valency' to denote the capacity of the individual for instantaneous combination with other individuals in an established group pattern of behaviour – the 'basic assumptions'. In this avoidant state, the group is anxious, in an off-task state of mind, out of touch with current requirements and objectives, and preoccupied with survival in one of three main ways: by depending on a leader; by looking to a pair to create a phantasised new future so as to avoid the here and now; or by fighting or fleeing a real or phantasised threat.

I was also preoccupied with individual unconscious processes and motivations for GP work with its increasing and changing variables and how this might affect

---

1 The Balint group is probably one of the earliest methods of clinical supervision to be provided for family doctors. The group and method are named after Michael Balint, a psychoanalyst originally from Hungary. He and his wife Enid Balint started a series of seminars in London in the 1950s with the aim of helping GPs to reach a better understanding of what they called 'the psychological aspect' of general practice (Salinsky, 2013, para. 1).

GP surgeries. I had heard Stokoe (2010) lecture about individual valency as a relational unconscious hook based on individual psychological vulnerability, but it was not until writing this thesis that I discovered that Bion's concept of valency has also been considerably reworked and applied by Hafsi (2006, 2007, 2012a, 2012b), a little-known Japanese researcher at Nara University who has published substantial new conceptual psychoanalytic thinking focusing on valency at an individual intrapsychic and interpersonal level. Valency is discussed in more detail later in this thesis, together with the metaphor of the periodic table, which is based on the entire spectrum of chemical elements and the way they are grouped according to valency in its original sense – that is, chemical composition, the ability to make bonds, and volatility or stability.

All of these musings were the seeds for my research questions, which started to take shape in my mind. I honed these thoughts into a coherent research proposal, undertaking a literature review, carefully assembling a semi-structured interview schedule, and recruiting participants. During the later stages of interviewing, my own professional role as a counsellor in a GP practice was under threat. Eventually, over nine months while I was analysing my data from my research interviews, counselling was decommissioned as a local enhanced service. I had contributed in the early stages to the recommissioning of a reconfigured service, but delays meant a month-long gap during which the survival of the counselling provision was under threat; during that time I set up as an organisational consultant and psychotherapist in private practice. At this stage, I was preoccupied with a feeling that neoliberalism was dominating and ruining clinical services. Some of my colleagues also left at this time, while others were recontracted for a further six months as counsellors pending review, with tight restrictions and frequent outcome measures, and with the implementation of new service reconfigurations looming that would leave little room for clinical discretion and instead emphasise a particular predetermined notion of treatment and recovery.

My doctoral supervisors reminded me that within the primary care system, GPs are in a much stronger position compared with self-employed counsellors! This was a sobering moment, and it helped me to avoid overidentifying or imagining our roles to be more similar than they actually are. Costley et al. (2011) discuss

the ethical questions and possible allegiances that arise for insider researchers. I remained conscious that I was also subjected to the changing landscape in healthcare, and I attempted to maintain a third position (Shapiro & Carr, 1991). In attempting to occupy the stance of an open-minded researcher who was available to my interviewees, I thought of Bion (1967, p. 275):

> *Memory and Desire exercise and intensify those aspects of the mind that derive from sensuous experience. They thus promote capacity derived from sense impressions … [of] what is supposed to have happened and … has not yet happened. Psychoanalytic 'observation' is concerned neither with what has happened nor with what is going to happen, but with what is happening.*

In support of an open-minded approach, my use of a semi-structured questionnaire together with a deconstructed attitude provided the subjects' narrative with a strong outlet, and it enabled their voices and preoccupations to be made manifest through the discovery and mapping of the different kinds of adaptations to changing circumstances which I discovered the GPs had made. Certainly, when I felt inspired to research the experiences of GPs, I was filled with a particularly complex emotionality. On the one hand, I felt a deep respect and perhaps even reverence for GPs, the vital role they occupy and the status they have. Perhaps as a throwback to my childhood, during which I was exposed to many powerful adults, I felt somewhat stymied and anxious about appearing critical of GPs, of whom I also felt protective and deeply respectful given their stalwart position. Paradoxically, my interest in a holistic attitude to health assisted an independent standpoint through which I already had many degrees of separation from identification with GPs. Nevertheless, having been incensed by my own experience of changes to therapeutic practice as a counsellor in a GP surgery and what I found to be the creeping, overbearing nature of constantly imposed targets intertwined with funding, along with predetermined constructs of patients' psychological presentations, I began in something of a polemical, outraged position in relation to external interference in clinical work between practitioners and patients. The use of supervision and self-reflexivity supported me to develop a more open-minded research position, later aided by my ceasing

to work in the GP surgery from which I had developed my research questions and plan of implementation.

### *1.2 Development of the Research Questions*

The impact on GPs of the new era of healthcare in recent times was the target of my research in terms of societal, contextual and systemic issues. GPs have always been independent practitioners in relation to the NHS since the latter's formation. I wished to examine the systemic and organisational experiences of GPs in role in the context of the increased market orientation within the NHS.

I therefore aimed to undertake a piece of research with GPs, using a systems-psychodynamic perspective (Armstrong, 2005; Campbell & Huffington, 2008; Gould et al., 2001; Obholzer & Roberts, 1994) and narrative approach, to consider the impact of recent changes in healthcare on GPs' roles, tasks and boundaries.

A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery was thus undertaken, driven by my curiosity to discover expectations, successes, stresses, anxieties and defences, in terms of both what GPs bring to their role and what may be evoked by the changing context. Further research questions linked to my main preoccupation were:

- What are the primary orientations, motivations and valencies of GPs in relation to their work, and what stresses, satisfactions and dissatisfactions do they experience as GPs in the present context of general practice?
- What organisational, economic and cultural changes in the functioning of general practice are currently impacting on the experience of GPs?
- How are GPs responding to changes in the situation of general practice, and what strategies or defences are they taking up to adapt to them?

The next chapter provides my review of literature that supported my theoretical understanding of the medical and socio-political context, including

autobiographical writing and research by doctors themselves, and relevant working frameworks and consultancy models from systems psychodynamics.

# Chapter 2. Literature Review

## 2.1 *Introduction*

When considering the undertaking of my research, I initially attempted to orientate myself by utilising the Tavistock and Portman libraries' online search tool EBSCO, as well as Google and Google Scholar. EBSCO and Google searches for 'GP, UK', 'general practitioners in UK' and 'UK GPs view of general practice' elicited a plethora of abstracts, mostly in relation to medical conditions that GPs treat, with the assumption that the GP is in the position of medical expert. The last couple of years have seen publications concerning GPs' relationship to general practice and why they are leaving, but these abstracts had not been published at the time when I conducted my literature search and wrote my research proposal. Google searches for 'scholarly articles on crisis in general practice', which I describe in the next section, elicit a number of publications, most of which date from (or after) 2016, which is when I was undertaking my interviews.

In addition, I went to the library shelves, which enabled me to find literature concerning the Tavistock method, that is, systems psychodynamics and psychoanalytic consultation to primary care, such as work by Dr Launer (2002, 2005, 2007) and Wilke (2001). I revisited classic texts and papers by Jaques (1951, 1964, 1989), Menzies (1960), Menzies Lyth (1988), Lewin (1951), Bion (1961, 1967), and more recent authors such as Hinshelwood (2008) and Stokoe (2010). In discussions with my doctoral supervision group, ideas about GPs' autobiographies and biographies were brought to light, and one of my colleagues leant me *Some Lives* (Widgery, 1991), which stimulated my curiosity about other such publications. Having had my own experience as a counsellor in a GP surgery, and realising some of the impact of marketisation, managerialism and their trickledown effects, I was familiar with the work of Rizq (2012), where I found cited Hoggett (2010) and other theorists. My doctoral supervisors also raised wider concerns regarding the societal context and its impact, and we free-associated about relevant texts such as Parsons (2013) and Titmuss (1998). As a member of Wengraf's (2013) biographic narrative interpretive method (BNIM) email list, I was also able to ask fellow members whether they had researched

general practice using a narrative-based approach. Dr Sharon Spooner let me know that she had undertaken a study that was subsequently published in 2016, while I was undertaking my interviews; I will refer to this study later.

There are various angles of relevance and interest to which I turned to support an understanding of my research area in terms of societal history, political discourse, related attitudes towards healthcare and vulnerability, and accompanying theories. I explore this literature under the following subheadings:

- context at the time
- neoliberalism
- status, well-being and work of GPs and primary care
- doctor's narratives: autobiographies, biographies and novels
- doctors' narratives: recent qualitative research by GPs
- consultations to GPs
- vulnerability and splitting
- systems psychodynamics

I have chosen these areas because each conveys and illuminates the territory of general practice and how it has been understood to date, as well as insights revealed by GPs themselves, either through their own writing and research or to consultants using the Tavistock model. The literature concerning neoliberal developments sets out the context of change in which GP practices are located and where GPs work. The study of representations of GPs (Widgery, Berger, Dr Finlay) is helpful for understanding GPs' own conceptions of their roles and the values they embody to some degree. The psychoanalytic ideas are relevant to my interest in GPs' relationship to their own roles and what may lie behind the choices they make; the systemic model is relevant to my understanding of how GPs find themselves psychologically positioned as professionals and in terms of how GP practices function. Vulnerability needs consideration because it is at the core of dependency and is an inevitable state that we get into, to a greater or lesser extent, as patients needing treatment. I have kept the literature review tightly oriented to my approach and the socio-political issues which I feel have impacted on general practice.

### *2.2 The Context at the Time*

Publications resulting from searches on ‘crisis in general practice’ in the BMJ (Owen et al., 2019; Roland, 2016), *BMC Family Practice* (Dale et al., 2016), *British Journal of Medical Practice* (Irish & Purvis, 2012; Simon et al., 2018) and in particular from the King’s Fund (Baird et al., 2016) give a general sense that there is certainly concern in the sector about recruitment, retention, morale and low satisfaction among GPs, as well as wider issues relating to increased comorbidities in an ageing population, the underfunding of general practice and other services in the community, and yet greater responsibility. The King’s Fund has taken a keen interest in recent years, and in May 2016 it published a report entitled *Understanding Pressures in General Practice* (Baird et al., 2016), which summarises concerns following the King’s Fund’s own in-depth and substantial research and analysis of the impact of governmental decisions. This report also describes the way in which patient demand is strongly affected by government and the media, which influence public beliefs about what GPs should offer, such as rapid access, and instant cures for even complex comorbidities thanks to the many and varied medications and medical technologies on offer. This influence happens through public health campaigns which increase the demand for appointments as well as outcome expectations. The increased emphasis on preventative medicine, together with the transfer of secondary care responsibilities, all falls to general practice. The King’s Fund report also describes in detail how general practice was underfunded between 2004 and 2015 alongside these increased demands and expectations. Furthermore, funding streams are complex, inequitable, variable and administratively laborious. There has been an increase in full-time hospital consultants, while there is a shortage of GPs, who also face higher levels of burnout and a fall in their personal incomes, especially as partners.

Figure 1. Pressures on general practice (King's Fund, 2021).

Figure 1 is taken from this 100-page King's Fund report, which starts with the following statement:

> *General practice is in crisis. Workload has increased substantially in recent years and has not been matched by growth in either funding or in workforce. A lack of nationally available, real-time data means that this crisis has been until recently largely invisible to commissioners and policy-makers. … Our analysis of 30 million patient contacts from 177 practices found that consultations grew by more than 15 per cent between 2010/11 and 2014/15. The number of face-to-face consultations grew by 13 per cent and telephone consultations by 63 per cent. Over the same period, the GP workforce grew by 4.75 per cent and the practice nurse workforce by 2.85 per cent. Funding for primary care as a share of the NHS overall budget fell every year in our five-year study period, from 8.3 per cent to just over 7.9 per cent. … Our findings point to a service that has traditionally been seen as the jewel in the crown of the NHS coming under*

*growing pressure through a combination of factors. The Department of Health and NHS England have failed over a number of years to collect data that would have provided advance warning of the crisis now facing general practice. Action is urgently needed to reverse reductions in funding as a share of the NHS budget and to recruit and retain the workforce needed to meet rising patient demands.* (Baird et al, 2016, pp. 3–4)

The King's Fund also refers to a survey undertaken by Ipsos MORI (2016) in which patients' declining satisfaction is revealed:

*The national GP patient survey, carried out twice yearly by Ipsos MORI on behalf of NHS England, seeks views from more than 1 million people in the United Kingdom. It asks patients a set of questions about their experience with their GP practice, including questions about accessing GP services, the ease with which they got an appointment and how long they had to wait. The survey suggests that the number of people who are unable to get a GP appointment when they want one has been slowly increasing. In the latest survey, 85 per cent of patients said they were able to get an appointment to see or speak to someone the last time they tried, down from 87 per cent in December 2012. … People were also more likely to say their experience of making an appointment was 'fairly poor' or 'very poor'; fewer people were happy with the amount of time they had to wait for an appointment and patients are finding it increasingly difficult to get through to practices on the phone. … The latest GP patient survey also shows a slight decline in the ratings patients gave to their interactions with staff in GP practices. Compared with 2012, there was a slight reduction in the proportion of patients saying their GPs and nurses were good at listening (87.1 per cent and 78.3 per cent respectively), giving them enough time (84.9 per cent and 79.3 per cent respectively), treating them with care (82.6 per cent and 77.2 per cent respectively), and explaining and involving them in decisions (74.0 per cent and 65.3 per cent respectively).* (Baird et al., 2016, p. 19)

In the conclusions, a stark reality is stated: '*Deficits in general practice do not show up on the NHS's balance sheet; rather they are absorbed by GPs taking pay cuts and spreading staff more thinly*' (Baird et al., 2016, p. 82).

The following serves as an illustrative backdrop to the broader changing environment in which my interviewees practise as GPs. These varying contributory components will be revisited in the discussion, in which I will offer some hypotheses based on my research regarding GPs' varying ways of taking up the role in their given context.

### *2.3 Neoliberalism*

Healthcare delivery has been changing since 1948, when the NHS was set up after the war by medical professionals, funded by central government and based on the principle of healthcare for all that was free at the point of delivery, with costs paid through general taxation. From 1979, the ideology of marketisation was introduced and enforced, along with new structures of regulation and accountability, as part of '*the process by which market forces are imposed in public services, which have traditionally been planned, delivered and financed by local and central government*' (Whitfield, 2006, p. 4). A partial form of neoliberalism was applied only to the mechanisms of resource allocation, measures of efficiency, and competition between suppliers, rather than in monetary terms. Patients are still not charged directly.

There are huge issues with regard to the structure and funding of social care and its boundary with healthcare. Following the Griffiths Report[2] (Griffiths, 1983),

[2] The Griffiths Report (Griffiths, 1983) made a number of recommendations. The main ones included:

1. The secretary of state should set up, within the Department of Health and Social Services (DHSS) and the existing statutory framework, a health services supervisory board and a full-time NHS management board.
2. The role of the health services supervisory board would be to strengthen existing arrangements for the oversight of the NHS. It would be concerned with:
    a. determination of purpose, objectives and direction for the health service
    b. approval of the overall budget and resource allocations
    c. strategic decisions
    d. receiving reports on performance and other evaluations from within the health service.
3. It should be chaired by the secretary of state and also include the minister of state (health), the permanent secretary, the chief medical officer, the chairman of the NHS management board, and

managerialism – a model from industry to manage and cut costs – was introduced into the health service, together with the use of targets for accountability. This was the beginning of the split between clinical services and management until 2012, when CCGs were created. It is the job of CCGs to portion healthcare provision into chunks and consider any qualified provider via a tendering process. Thus market mechanisms were allowed to create a competitive culture of short-term contracts, with a mandatory percentage apportioned to non-NHS providers. This came in under the Health and Social Care Act of 2012, which provided the most extensive reorganisation of the structure of the NHS since its inception in 1948. It removed responsibility for citizens' health from the secretary of state for health, transferred healthcare funds from the now-abolished primary care trusts (PCTs) to several hundred CCGs (partly run by GPs), and enforced access for private service providers to compete with NHS provision. The proposals were primarily the result of policies by the then secretary of state for health, Andrew Lansley, on the back of New Labour's marketisation and privatisation agenda under Alan Milburn and Patricia Hewitt – to the outrage of many clinicians, including GPs, hospital consultants and nurses, who were also fearful that the integrity and leadership of the NHS would be broken up, taking it away from being a national, unified health service with central policies and central planning and leading it instead towards privatisation (Peedell, 2011, p. 1112).[3] Lansley was eventually replaced by Jeremy Hunt, whose task was to restore confidence and some stability. He perhaps did so to some extent, by extracting more money from the Treasury, but he remained desperately unpopular, as illustrated by the junior doctors' strike against new contracts.

---

two or three non-executive members with general management skills and experience. It would relate to statutory and professional bodies in the same way as ministers and the DHSS already did.

4. The small, multiprofessional NHS management board would be under the direction of the supervisory board and accountable to it. The role of the NHS management board would be to plan the implementation of policies approved by the supervisory board, to give leadership to the management of the NHS, to control performance, and to achieve consistency and drive over the long term. The board would have no separate corporate status.

[3] Key elements of the Health and Social Care Act of 2012 are now to be reversed, in the biggest legislative shake-up of the English health service in a decade. A draft White Paper, leaked to the website *Health Policy Insight*, outlines proposals to reverse major parts of Lansley's controversial reorganisation, including formally abolishing requirements to do with competition and competitive tendering in the NHS, and shifting control and decision-making power back to Whitehall (Iacobucci, 2021).

CCGs are run by GPs, with NHS commissioners, patients and clinical voices in attendance. The experiences of patients and healthcare professionals have been researched by the King's Fund (2011), and recommendations have been made for patient inclusion at all levels. It is expected that patients' well-being and empowerment – their ability to both contribute to their own individual healthcare and empower other patients – as well as their having a voice in CCGs will enhance the health of the population. With the idea that GPs would be at their helm, CCGs were set up in response to the complexity of increased demand due to longevity and changing demographics as well as technological advancements; it was supposed that competition between providers on the basis of measured outcomes, together with standard regulation and monitoring, would enable scarce resources to be more efficiently used. In recent years, primary care networks (PCNs) have been set up whereby GP surgeries have banded together in order to be eligible to tender for clinical services to large patient populations, pooling their medical provision and in some cases their back-office functions together with financial management. Practice managers are being made partners in some practices because their role is so key for managing budgets across PCNs. Although recent governments have insisted that clinical bids must be so sizeable that GP surgeries have to network together to survive, these governments have nevertheless stuck to the idea of (mostly) free healthcare at the point of delivery; they have almost certainly been obliged to do so by the strength of public feeling on this issue. This is a fast-moving and complex landscape, with public/private partnerships and use of the third sector as an alternative solution to the heavy demands on healthcare and the social care surrounding it.

Hoggett (2010) wrote 'Government and the Perverse Social Defence', a paper from one perspective about the socio-political backdrop affecting public sector professionals. This paper references other authors on neoliberalism (Hoggett 1996; Hood, 1991; Kikert, 1995; Newman, 2001; Pierre & Peters, 2000; Rhodes, 2000). Hoggett (2010) describes the intention of political policy as being to divest the government of responsibility for service delivery by passing it over to various combinations of semi-autonomous services run by the voluntary and private sectors, with a focus on the lowest bids and performance evidenced in a narrow manner.

Rizq (2012, p. 10) contextualises this in the domination of the public sector since the 1980s by managerialism, market forces and competition, with the privileging of what the consumer wants, so-called accountability, neo-bureaucracy and economic rationalism over public health professionals. Other areas of public service provision are similarly affected by the idea of getting more for less, referred to as 'new public management' by Hood (1991). Hoggett (2010) refers to the attitude of knowing about difficulties in service provision but turning a blind eye (Steiner 1985, 1993) and obsessing over an alternative, inconsequential replacement, an attitude he describes as 'fetishisation':

> *Public services today have increasingly taken on the form of a perverse social defence. It is not just that the screen of performance indicators create an 'as if' relation to reality but the relationship between the users of welfare services and providers has increasingly taken on an 'as if' quality. Besides the apparatus of regulation and surveillance the introduction of risk management and quality control systems introduced an intensified proceduralism.* (Hoggett, 2010, p. 202)

However, a counter-view is considered by Le Grand (1997), who suggests that a shift to a more self-interested type of human behaviour has been underpinning changes in social policy since Thatcher's governments. He suggests that in recent decades, public services have come under quasi-market forces, implemented through regulation and legal devices rather than fiscal methods such as the redistribution of wealth through taxes. He identifies three possible human attitudes – altruistic knights, self-interested knaves, and passive, dependent pawns – and makes the point that the emphasis on individualism and self-advancement has changed the balance of these behaviours, both in the population and in professionals. The idea is that if services are set up with the assumption that self-interested knaves are running them, then this is a safer model than assuming altruistic knights are in charge; he also notes that patients can no longer be assumed to be passive pawns. He does not, however, make any mention of political forces undoing the very fabric of a society that would enable a collective, community-minded outlook and support for dependency needs; nor does he consider the insult altruistic professionals may feel if they are treated as if they are motivated mostly by self-interest. But he does consider the

question of professional and public virtue and its complexity, as well as the consumer power of choice, which most patients like to exercise in relation to GP surgeries and GPs.

These various coexisting elements may have a bearing on relationships between GPs and patients, the way accountability is managed through bureaucracy and administration, and its balance with regard to direct contact with patients. Hoggett (2010, p. 206) captures the risks:

> *Drawing lessons from the experience of the old Soviet system of 'command and control', Bevan and Hood (2006) note how target systems in the NHS have encouraged units to neglect performance in areas not subject to targeting (because there are no incentives to perform well), to 'crowd' their performances towards the target (because over-performance often simply leads to a 'hiking up' of the relevant target the next year) and to engage in various deliberate 'gaming' strategies (such as manipulation of waiting lists). … According to Miller (2005), audit cultures draw the attention of professional staff away from the experience of actual service users to the demands of their virtual counterparts (auditors, etc.). … What progressively disappears is the idea of an encounter between two separate subjectivities in which the client/user is recognized as a unique locus of experience, a subject to be understood rather than an object to be acted upon via reskilling and reprogramming. Here, then, we see the spread of instrumental relations in welfare.*

The significance of the change in healthcare structures can be illustrated by looking back at American psychoanalytic sociologist Talcott Parson's work in the 1950s, according to which funding is on principle to be separated from the craft and dedication of medical practice. Parsons describes the crucial distinction between business and medicine:

> *Unlike the role of the businessman, however, it is collectivity oriented not self-oriented. … It is a crucially important fact that expertness in caring for the sick does not imply any special competence one way or another in the settlement of terms of exchange. … He tends to be relieved of much*

> *responsibility and hence necessarily of freedom, in relation to his patients other than in his technical role.* (Parsons, 2013, pp. 292–293)

With the position of GPs changing in relation to funding, this separation of roles is no longer clearly delineated. Rustin describes the way Parsons referred to the social construction of trust:

> *Professionals, like medical doctors, became socialised into a normative system which required them to act responsibly within the frame of their prescribed roles. Systems of socialisation and collective regulation had evolved to enable them to do so. Patients learned that they could rely on medical practitioners to behave responsibly, and that the situation of vulnerability and dependence in which they were placed in their relations with doctors was nevertheless a safe one.* (Rustin, 2015, p. 13)

However, it has to be said that some measures are most likely a necessary aspect of a functioning, accountable and responsive health service, despite the gaming and the possibility of unintended consequences. No system operates without its shortcomings. Moreover, medicine itself operates on the basis of probabilities. There have been instances of terrible systemic failings in NHS and private-sector clinical settings, as well as in individual clinicians, so appropriate feedback loops and accountability are clearly essential, although these are thorny, complex areas.

The healthcare context has a greater market orientation than ever before, resulting in a threat to the financial survival of individual GP practices due to the inbuilt nature of competition in tendering and managing funding streams together with other GP practices. Accountability also cannot be dispensed with, although how this is done is often contentious. Treatment from cradle to grave is the professional territory of GPs, and matters of life and death have always been their clinical preoccupations. However, since they were left as independent practitioners when the NHS was formed, the very existence of GP practices themselves is now under threat unless an active business approach to financial survival is taken. GPs' remaining on the periphery of the NHS and yet simultaneously the gatekeepers to hospital care has also perhaps left a systemic

conundrum. Furthermore, while in the recent past GP surgeries may have seen each other as competitors, currently the intergroup dynamic between GP surgeries needs to be one of cooperation in order for them to network and put forward joint bids. However, some GP surgeries may refuse to form PCNs.

From the literature it would seem that systems of regulation and accompanying budgets have been changing under neoliberalism since the GP contract changes in 2014, and that it is time for the development of a more cohesive understanding of the multiple factors that have contributed to the job of the GP from a systems-psychodynamic perspective on role, task and boundary, using a narrative approach. My interviews took place in 2015 and 2016, and hence my research gives a snapshot of that time; there has already been NHS strategic movement since then. The policy for general practice is in flux at the time of this writing, in 2020; I will refer to this in my concluding remarks.

### *2.4 Status, Well-Being and Work of GPs and Primary Care*

Primary care has incrementally become pivotal in healthcare provision, with increased clinical responsibility for various medical procedures being moved across to GP budgets and delivery, which may impact on GPs and their patients for better or worse. A seven-days-per-week service has become a reality in some areas. Meanwhile, some patient groups are increasingly better informed, less dependent, and more engaged with their own well-being. Following extensive research on GPs and patients carried out by the King's Fund, the following finding in relation to the power rebalancing between GPs and patients was published in a report in 2008:

> *A doctor's opinion is no longer regarded as sacrosanct and a new dialogue is developing between healthcare consumers and providers. … For some professionals it can be challenging – but professional attitudes are changing, and resistance is much weaker than it was in the past. We are moving rapidly towards a partnership model of decision-making, where both the professional and the patient bring something to the encounter.* (Dixon et al., 2008, p. 21)

Quantitative research on GPs' physical and emotional health goes back decades, with findings including alcohol overconsumption, smoking, self-medication with prescription drugs, and lack of self-care. Some suggest that this indicates a need for individual counselling or small GP Balint groups for the psychological processing of doctor-patient relationships; others suggest a need to target health promotions at GPs for themselves as patients. A qualitative study from 1996, using thematic analysis, considered stress among female and male GPs and their spouses, concentrating on the impact of the external pressures of the job on couples and the way the additional workload detrimentally affected family life; levels of suicide were reportedly up to three times higher for male GPs and five times higher for female GPs compared with the general population (Lindeman et al., 1996). Other research has largely considered GPs in the role of expert and the stressful impact of some patient presentations. Moscrop (2011, p. 346) considers the problem when there is a lack of clarity in the GP's mind:

> *The greatest flaw is the failure to disentangle the doctor and their feelings from the patient and their presentations. … The doctor's experience was subjective, but [he] perceived the problem and its solution to lie in his patients. The phrase 'heartsink patient' captures this ambiguity perfectly: it is the doctor's heart that sinks, but it is the patient who receives the label.*

In contrast, there has been a consideration of the importance of GPs' intuition in relation to patients' presentations, and a proposal that listening to one's gut feelings is a '*third track in general practitioners' diagnostic reasoning*' (Stolper et al., 2010), to be developed alongside a more seasoned GP with more clinical knowledge and experience. However, this does not involve self-examination or reflexive curiosity about what the GP brings to the table.

From these various sources, it would seem apparent that some doctors are stressed by the nature of their work, continually encountering the effects of poverty, deprivation, and physical and mental illness, and having to bear the responsibility for the latter two and the burden of the former two. This has been understood since at least the work of psychoanalysts Michael and Enid Balint, who understood that the GP's approach is part of the medicine, and that the

doctor-patient relationship needs due consideration for mutual benefit and a better chance of the discernment of patient need and appropriate treatment. There may be valencies and motivations for this work, including an unconscious attraction to the psychological stage of dyadic intensity, or a wish to repair significant others; these motivations may be part of the reason that some GPs select themselves for this work, and they may pay a particular price for them, or incur emotional threats. It is difficult to show deterioration or increased risk in GPs, and especially to find solid evidence for such facts or tendencies, although there are some indications of stress in the system and a turning away from GP clinical work, such as the weighty *General Practice Forward Review* (NHS England, 2016), which clearly outlines many areas of difficulty, including recruitment and retention:

> *Workload was identified by the 2015 BMA [British Medical Association] survey as the single biggest issue of concern to GPs and their staff. Latest research, published in the Lancet, suggests that there has been an average increase in workload in general practice of around 2.5 percent a year since 2007/8. … Three sources of bureaucracy experienced in general practice are: the processes used to make and claim payments; keeping up to date with information from commissioners and national bodies, and reporting for contract monitoring or regulation.* ( NHS England, 2016, p. 26)

Based on research, the report goes on to describe in detail, for example, the problem of balancing this increased workload within financial constraints, and the need to tackle issues such as irrelevant communications, duplicate reporting, unwieldy regulation and payment systems, and a chronic lack of investment compared with hospital specialisms. The report suggests a need to invest and reform, including for a broader workforce to ease the burden on GPs, and for a more holistic approach; investment in GP training, with sizeable incentivising bursaries; an increase in flexibility and pastoral support for the many considering early retirement; both philosophical and financial investment not only in GPs themselves but also in patients in primary care; and a bringing together of GP practices. Giving loose contracts to locums across GP practices for stability and cost-saving is also suggested. A more visionary role is also outlined, whereby

'*primary care professionals will increasingly work at different organisational levels, for example, their own practice, a neighbourhood of practices and across the local health economy*' (NHS England, 2016, p. 9). In the years since my research interviews, new GP contracts have begun to take account of some of these concerns of the BMA; I consider this in my concluding remarks.

### *2.5 Doctors' Narratives: Autobiographies, Biographies and Novels*

My research considers the impact on GPs of systemic organisational change in the delivery and management of healthcare and the psychodynamic implications for their personal and professional lives. High stress levels among GPs in relation to the demands of medical practice – in terms of patients' treatment and dependency, the emotionally alienating and dysregulating nature of medical training, and the healthcare context as a hostile environment – are strongly represented in publications, including a book on psychological research about hospital doctors entitled *Also Human* (Elton, 2018), a book based on consultancy to primary care by psychoanalyst Gerhard Wilke (Wilke & Freeman, 2001), a number of medical publications by the BMA, BMJ and BMJ GP, the Health Policy and Research Unit's ten-year study of the GP cohort of 2006, and other articles (Duffin, 2013; Jaques, 2013; Lloyds Bank, 2015; Nielsen & Tulinius, 2009; Rimmer, 2015; Soteriou, 2013a, 2013b). As I was considering my research interests in 2013, I read various articles in *Pulse*, an online publication for GPs, which reported that a considerable number of GPs were turning to individual counselling for stress, others were planning early retirement, there was a shortfall of new recruits, and there was pessimism in relation to short- and long-term healthcare provision:

> *One in eight GPs have sought help from pastoral or wellbeing services within the past year, according to a new Pulse survey which suggests that the profession is struggling to cope with a rising workload and an increasing risk of burnout. Some 12% of 441 GPs surveyed about a wide range of unrelated topics said they had sought help from local pastoral or wellbeing services in the past 12 months. … Respondents to the survey*

*blamed Government policy and changes to the GP contract as significant factors in exacerbating their difficulties.* (Duffin, 2013, n.p)

There has been much interest among GPs over the years in their own professional domain, expertise and relationships with patients, and latterly also in their working conditions. Since 2007, GPs' contextual experiences of their working environment have been manifested in half a dozen accessible, brief but explicit accident and emergency (A & E) and GP doctor autobiographies, and in a couple of novels (A. Brown, 2019; Copperfield, 2010; Daniels, 2012; Edwards, 2007). Edwards writes:

> *Why does the system have to impede me from caring for my sick patients and make me worry about figures and targets instead? … [It is the] effects of NHS reforms implemented without thinking about the possibilities of unintended consequences that really drive … doctors mad … distort clinical priorities and can damage patient care … [and] threaten the structure, efficiency and ethos of the NHS, driving it away from co-operation and caring towards incoherence and profit making.* (Edwards, 2007, pp. x–xi)

It would seem that doctors' narratives contain pertinent information that may usefully be brought back to the system. Dr Amanda Brown's autobiography conveys the reason she left general practice and – to her own surprise – became a prison doctor:

> *On 1 April 2004, the new GP contract would be introduced, in which the whole pay structure for general practice would change. The basic pay would be reduced, but bonus payments could be earned if certain questions were asked and checks were done during the consultation. I think it was intended to make GPs perform better, but I knew I'd struggle with it – gathering such information when perhaps a patient was deeply depressed or had recently been diagnosed with cancer, might feel inappropriate. … This latest scheme was threatening my core beliefs and principles concerning patient care. … Just like that it was all over.* (Brown, 2019, pp. 13–16)

A few decades before this more recent flurry of short autobiographical paperback publications, the GP and radical socialist Widgery wrote a self-reflexive, moving and passionate account of an East London practice. He considered the desperate lives of his patients, and how poverty and its impact on their outlook affected the total health of the person and the entire family. In this way, Widgery showed how the state that society is in is reflected in the arduous work invested by a GP, resulting in the

> *grinding down of the optimism with which I came as a doctor to the East End nearly twenty years ago, into a kind of grudging weariness punctuated with bouts of petty fury. When I came here in that fateful taxi down Hackney Road, I didn't know what the bruised face of a raped heroin addict was like, or how children could be locked up without food, four in a room, by a drunken father as punishment. … I know what decomposed bodies of alcoholics smell like after two weeks. … I think I wish I didn't. … My experience reflects much larger loss of hope, morale and optimism among those who live in the East End.* (Widgery, 1991 p. 16)

Written more than a couple of decades earlier, Berger's *A Fortunate Man* gives intricate descriptions of the working life preoccupations of an incredibly committed GP, Dr Sassal. This biography reads like a philosophical meditation on what it is to be human. Dr Sassal works alongside his patients and their struggles, and this allows his patients' preoccupations to be brought forth through conversations and accounts of their thoughts and symptoms. Following his many descriptions of the doctor-patient relationship, Berger writes movingly in his concluding remarks:

> *We in our society do not know how to acknowledge, to measure the contribution of an ordinary working doctor … to take the measure of a man doing no more and no less than easing – and occasionally saving – the lives of a few thousand of our contemporaries. … The doctor is a popular hero … the most idealised of all the professions … idealised abstractly. … One of the fundamental reasons why so many doctors become cynical and disillusioned is precisely because, when the abstract idealism has worn*

*thin, they are uncertain about the actual lives of the patients they are treating. This is not because they are callous or personally inhuman: it is because they live in and accept a society which is incapable of knowing what a human life is worth. … Man's worth to himself is expressed by his treatment of himself. … A doctor who has surpassed the stage of selling cures, either directly to the patient or through the agency of a state service, is unassessable.* (Berger, 1967, pp. 165–170)

It is all the more shocking, then, when Berger informs us in the afterword that Dr Sassal, '*the man he loved*', shot himself, 15 years after Berger had lived with and accompanied him in his working life for three months in order to write this fully informed, affectionate biography. In the introduction, *A Fortunate Man* is described as a memorial to Dr Sassal as an exceptional individual, and to an all-consuming way of working that '*has almost disappeared as a result of working time directives and the commercialisation of disease*' (Berger, 1967, p. 11). This alerts us that no matter how committed an individual may be, the job of a GP perhaps needs to come with a health warning. GPs have to cope in their surgeries with devastating patient realities, the onerous nature of dependency, and perhaps also with their own troubled internal patient self that is dominated by the GP persona.

Broadcast in the 1960s and again in the 1990s, *Dr Finlay's Casebook* showed a type of GP represented by Cronin's fictional character. The show had two runs on primetime BBC and ITV television and it was also broadcast on the radio. Clark (2018, para. 1) describes *Doctor Finlay's Casebook* as

*set in a pre-NHS medical practice in the fictional Scottish town of Tannochbrae. However, the daily medical needs of a sleepy lowland community between the wars proved hugely successful with viewers [and] … was one of the most popular programmes of the 1960s.*

In his book entitled *Medicine and Literature*, Dr Salinsky offers short chapters about doctors and their relationships with patients from classic literary texts as an educative tool for attaining what he describes as follows:

> *Our mission as family doctors was (and is) not just to scribble on the pad but to connect with our patients as human beings, experience the spark of empathy and mobilise our resources, both human and medical – and to reach out to them with compassion, insight and wisdom* (Salinsky, 2002, p. 9).

However, in his introduction Salinsky also makes an interesting observation that may provide food for thought: '*Most literary doctors show a dismaying lack of moral fibre, decency or professional competence*' (2002, p. 4).

Some of my interviewees referred to being influenced by television or literary representations of doctors, either in terms of their motivation to study medicine or in contributing to their fantasies about what a doctor's life would or could be.

### *2.6 Doctors' Narratives: Recent Qualitative Research by GPs*

My literature search revealed research projects by GPs about their colleagues. In 2012, Dr Sharon Spooner undertook a study in northern England using BNIM. Spooner's study explored changing aspects of professional practice over 25 years and influences on medical practice and culture, drawing on symbolic interactionism and phenomenology. I heard about Spooner's research through the BNIM network while she was writing up her thesis and I was undertaking interviews. In 2016, she published her findings under the title 'Unfashionable Tales: Narratives About What Is (Still) Great in NHS General Practice' (Spooner, 2016). She found that the large majority of her GP interviewees, who had each worked for 25 years in the role and most of whom were GP partners (and her colleagues), still loved their work and still experienced much satisfaction, challenge and stimulation from the job, particularly from ongoing, long-standing relationships with patients, with whom they felt they made a difference. In a separate study, Spooner later researched the recruitment choices of junior doctors:

> *Because of an ongoing shortfall in the proportion of doctors entering general practice specialty training and concerns about GP workforce*

> *retention, this study focused primarily on attitudes to GP work as expressed by doctors choosing and not choosing GP careers. These factors included their experience of workplaces, working practices and colleagues and the importance of finding a balance between their medical work and other priorities* (Spooner et al., 2017, p. 2).

Spooner et al.'s concluding summary states that their qualitative research highlighted the importance of working experiences, perceptions of different specialities, and the importance of work-life balance. The details point to specific and achievable changes that could be instituted to support the long-term goal of a balanced, fit-for-purpose workforce during training, so as to ensure that specialists treat each other respectfully rather than denigrating GP students' choices, and to ensure the undertaking of specific training and taster sessions in general practice in addition to a wide range of hospital specialisms.

A research project which has some parallels with mine is that by Napier (2017), who undertook funded systems-psychodynamic research with 12 retired GPs in Westminster, London, using BNIM (Napier, 2017). As a GP, Napier had close proximity to her research topic and to GP colleagues in the same geographical locality, and she provides some evidence intermingled with her own views to support her hypothesis that

> *managerial initiatives in general practice have imposed extra-professional social defences, in a rational-instrumental attempt to control dependency and erase doubt. This has reduced opportunities for reparative satisfaction, eroded the resources available for managing the anxieties arising from the work, and, in part, contributes to reduced recruitment and retention of general practitioners.* (Napier, 2017, p. 1)

There are frequent articles in *Pulse* written (and read) by GPs bemoaning their recent working realities and complaining of the paucity of political support for the profession.

### *2.7 Consultations to GPs*

The appreciation from psychological and psychosocial perspectives that GPs need support to undertake their work has become somewhat established, and brief mentoring, coaching and psychotherapy interventions have been made available through the BMA specifically for NHS trainees and qualified doctors.

Schwartz rounds, which originated in the United States in 2009, are a reflective space in a structured form where all clinical and non-clinical staff regularly come together to discuss the emotional and social aspects of working in healthcare. These are run in 100 NHS trusts, mostly in acute settings but also in community, mental health and ambulance trusts:

> *The Schwartz Center for Compassionate Healthcare was founded in 1995 in memory of the late Kenneth Schwartz, an American attorney who had been diagnosed with lung cancer and who, during his treatment, observed how important the connection was between caregivers and patients. The aim of the Schwartz Center is to promote compassionate care.* (Robert et al., 2017, p. 1)

Trainee GPs are often offered self-reflective development in the form of Balint groups within their curricula. A small percentage of qualified GPs continue with their Balint work, and there is a national and international society. The focus is on the doctor’s associations towards the patient as they arise within the consultation, which then evokes thoughts within the group. Balint made a vital and pivotal realisation:

> *By far the most frequently used drug in general practice was the doctor himself … the whole atmosphere in which the drug was given and taken. … [But] no guidance whatever is contained in any text-book as to the dosage in which the doctor should prescribe himself … [nor] on the possible hazards.* (Balint, 1957, p. 1)

This laid the foundation for the development of professional reflective practice mechanisms in the Tavistock tradition, which have continued in various forms

until today (Rustin & Bradley, 2008). However, it is a minority tendency in the GP profession.

There are other examples of psychological thinking about doctors and their work, and how they may or may not metabolise the impact of patients and the healthcare context. In his short paper 'How Our Patients Make Us Ill', psychiatrist and psychoanalyst Rob Hale considers the impact of patients' emotional demands on medical doctors, and he focuses on defences against anxieties in institutional hospital, psychiatry and forensic settings (but not in general practice):

> *To deal with these anxieties we build defensive structures both at an individual and an institutional level. For the most part, our defences serve us well. They allow us to work. But they may become excessive, turning us into malfunctioning doctors; or they may fail – in which case we become psychologically or physically ill.* (Hale, 1997, p. 254)

Hale briefly considers the impact of systems psychodynamics on medical professionals, emphasising the internal world of the doctor's unconscious within a flexible psychotherapy session time framework. Hale also set up Med Net (Tavistock and Portman NHS Foundation Trust, 2014), a service for medical doctors needing psychotherapeutic support. Nowadays, brief psychotherapy or counselling services of six sessions can be accessed via the BMA, paid for by the GP; there is also online cognitive behavioural therapy. The London Deanery was set up to offer a coaching/mentoring service of four sessions by specially trained doctors in 2008.

More systemic support was offered in the 1990s by Drs Elder and Launer, who made a consultative state of mind available when they were employed at the Tavistock Clinic (Launer, 2005, p. 7). They promoted wide-ranging links and multidisciplinary training in primary care, and seminars for therapists working there. Launer, a GP and family therapist using the Tavistock model of consulting, taught postgraduate medical training and published extensively, developing 'narrative-based primary care' (Launer, 2002). Together with social work and psychotherapy colleagues, he considered that '*primary care itself may be in need of a "talking cure"*' (Launer, 2005, p. 12). His text is punctuated by a number of

observations from various contributors that take account of the impact of the healthcare context on clinical work. Launer himself acknowledges:

> *Reflection may be a particularly precious resource for primary care workers, especially at a time like the present (2005), when they seem to be beset with major problems of workload and morale, a plethora of government demands, and increasing public scrutiny.* (Launer, 2005, p. 5)

Crucially, Senior and Mayer (2005, pp. 56–57) refer briefly to my own preoccupation:

> *The context of the clinic not only permitted its development but also shaped the style and nature of the clinical work. … If models of intervention do not fit the context or lack sufficient flexibility, they are unlikely to succeed*.

Senior and Mayer observed a decline of the influence of systemic thinking and Balint groups on primary care, with the result that '*the paternalism of medical practice was being challenged, and within the doctor-patient relationship the doctor could increasingly be seen as the person who was "stuck"*' (Senior & Mayer, 2005, p. 57). Senior and Mayer described an expected shift from a centralised approach to local care under the New Labour government, although their hope was perhaps misplaced:

> *This centrally driven public health agenda has many highly desirable aims but has inadvertently, threatened to change the nature of primary care. … At the time of writing a new chapter is about to be written with a retreat from central control and a return to 'localism', with practice-based commissioning and the encouragement of unique local arrangements. All of this, allied to patient choice and the money that follows, may recreate the conditions for innovation … in primary care.* (Senior & Mayer, 2005, p. 68)

Further work from a consulting perspective appears in a little-known book in the field, written by Wilke, a psychoanalyst, in 2001 – perhaps before the healthcare

context had changed so dramatically as to become overtly driven as a marketplace. Wilke considers GP preoccupations in terms of psychoanalytic mechanisms. There does not appear to be a concern about the survival of general practice per se; by contrast, Wilke portrays a benign context which allows the space for curiosity and interest about one's own unconscious preoccupations as a clinician. Wilke's approach is steeped in mature intrapsychic processing, enabling systemic diversity and creativity, and he uses many psychoanalytic concepts to reflect on his preoccupation with 'how to be a good enough GP' while he was working with GPs as a consultant during the reforms of the 1990s. He summarises his psychological work with the GP's internal mind as follows:

> *First, recovering forbidden thoughts and feelings and learning to perceive them as part of the whole self: second the reintegration of split-off feelings which were located in the external aggressor like envy, rivalry, lust for power, neediness, helplessness and rage. … It is vital for any person to own these negative feelings … as a resource to renegotiate a role, reconstruct a professional identity and fulfil the potential within the self in a changing group context.* (Wilke & Freeman, 2001, p. 118)

However, this approach leaves the problem and the solution with the individual GP, who can then benefit their external professional setting.

### *2.8 Vulnerability and Splitting*

Wilke thus brings us into contact with psychoanalytic theory. Patients live in a particular context, to which doctors are exposed both vicariously through their patients and from their own perspective in their public/private lives. Long helpfully informs us that '*Fromm, Foulkes and Hopper take the idea of the unconscious and centre it in the idea of social unawareness*' and defines context as '*the environment within which a social system occurs … [which] includes the physical, political, economic context for the system. What is currently occurring in the context will have an effect on persons, organisations and social system'* (Long, 2016, p. 74).

Splitting is frequently used as a psychoanalytic defence in response to the threat of being overwhelmed. In a paper suitably entitled 'The Duty to Care and the Need to Spilt', Foster (2001) encapsulates the active dilemma confronting those in the helping professions. Patients may have contempt both for their own vulnerability and for health workers, into whom they may project unwanted parts of themselves; being in touch with this contempt may confront staff with psychologically disturbing responses to the charges in their care. Furthermore, if the context does not allow for the processing of the inevitable oscillation between love and hatred, or if it actively insists on insensitive so-called professionalism, then a more defensive denial of this challenge may ensue, and a dangerous practice may result in which the patients' needs become neglected. Foster gives the clinical example of Henri Rey's claustrophobic-agoraphobic dilemma, which gives a psychological consideration of patients with borderline states of mind. It may be the case that we all veer into a fear of falling irreparably apart, or become trapped as if in a stone-like unresponsive body or mind, if the threat to our emotional or physical security becomes too great. In more challenging situations, 'often we have to find ways of being alive to and emotionally in touch with what the client wishes to remain ignorant of' (Foster, 2001, p. 83).

Foster helpfully conveys that workers in the helping professions are necessarily in the midst of emotional turbulence, where we are

> *in danger of swinging between persecutory anxiety with its accompanying paranoia and deadening despair, and depressive anxiety with its guilt and accompanying dangers of manic over-involvement and omnipotence. When we find ourselves on this sort of emotional roller coaster we lose confidence in our professional skills and thereby experience even more persecutory or depressive anxiety, as we fear that we are not functioning well.* (Foster, 2001, p. 84)

If we shield ourselves defensively, then '*this approach may achieve some success in risk-avoidance when clients are "managed" in the sense of being monitored, but as workers lose their humanity, so clients lose the opportunity of meaningful relationships*' (Foster, 2001, p. 84).

Foster (2001, p. 86) also refers to the persecutory approach whereby individual staff are found to be inadequate rather the team being held responsible. This culture prompts a retreat into health worker/doctor-patient dyadic exchanges rather than sharing in the professional group.

Dartington sets the scene for considering the complexity of vulnerability in a different way, and the varying responses it can evoke:

> *Where there has been a wish both for unacknowledged dependency needs to be met – in the providers as well as the users of services – and an unacknowledged hatred of that dependency … health and social care systems have to manage the incompatible contradictions of human service organisations, working with heroic and stoical responses to the human condition.* (Dartington, 2010, p. 28)

Writing in a journal for nurses, Dartington expands on this challenge, which surely also applies to GPs:

> *Services around vulnerable people are influenced by two states of mind. … The heroic response to illness and debility is to fight back, never with an admission that the suffering involved is acceptable. A stoical perspective is more accepting of situations and recognises that illness and suffering are inevitable. … Fear and intimidation have no place in a management culture that should support care staff's natural empathy and compassion. We have to trust our staff's capacity to respond appropriately to need as it happens, heroically at times and stoically when that is more appropriate.* (Dartington, 2013, p. 12)

### *2.9 Systems Psychodynamics*

Turning now to systems psychodynamics, I will refer to some relevant texts. There have been considerable and increasingly rapid changes over the last 60 years in healthcare provision and practice. When the NHS was formed, GP partners were left as self-employed professionals, running their own small

businesses, employing other GPs, and attached to the wider NHS, in which hospital doctors are employees. This has a particular bearing on the complexity of GPs' working environment. As a result of recent government changes in tendering guidelines, and sometimes simply for the sake of efficiency in clinical coverage of a greater population, GP surgeries have networked together in recent years. GP partners and their practice managers have had many challenging decisions to make, not only in how to structure their services but also in how to raise sufficient revenue to maintain the GP practice itself. Ultimately, GPs have been trained to be medical doctors for patients, so that to a greater or lesser extent they use the self as a tool in relation to their work. The sentiment conveyed succinctly by Long (2016, p. 4) is a crucial point for my study: '*Personhood is essential to a system and the system is essential to the person*'. This is particularly pertinent to GPs working in GP surgeries, a working environment that to a great extent is still run like a small business – sometimes like a family business, but more often now also as part of a wider GP network. Furthermore, GPs are professionals operating within a healthcare system in society. Hence, my research study is 'psychosocial' in the sense of '*conceptualising human subjects as, simultaneously, the products of their own unique psychic worlds* and *a shared social world*' (Gadd & Jefferson, 2007, p. 4, as cited in Hollway & Jefferson, 2013, p. xiii).

Let us consider the intrapsychic world of the individual first. Since its inception under Freud at the turn of the 20th century, psychoanalysis has offered complex and evolving theories of human drives, instincts, motivations and relationships, providing an understanding of the unconscious mind. Psychoanalytic theory has developed over time since Freud's preoccupation with biological instincts, towards a more relational psychoanalysis. Following Freud, Klein offered sophisticated representations of our early-life symbolisation and made a significant contribution, particularly with regard to infant and child development and its influence on the rest of psychic development. If sufficiently stressed or provoked we can regress to infant and child development; if it was particularly traumatic, we may continue to be psychically trapped within it. Her crucial part-object relations theory offered a representation of unconscious life as symbolised by a split into 'good' and 'bad' elements, which Klein (1975) described as the paranoid schizoid position. This split may mature and become integrated so that

good and bad can coexist around one and the same element and be recognised as such – a state of affairs known as depressive-position functioning:

> *I have often expressed my view that object relations exist from the beginning of life, the first object being the mother's breast which is split into a good (gratifying) and bad (frustrating) breast; this splitting results in a division between love and hate. I have further suggested that the relation to the first object implies its introjection and projection, and thus from the beginning object relations are moulded by an interaction between introjection and projection, between internal and external objects and situations. These processes participate in the building up of the ego and super-ego.* (Klein, 1946, p. 99)

Other Kleinian theories concerning envy, rivalry, love, guilt, reparation and projective identification are relevant to my research because these unconscious processes affect personal and professional identity. In the process of projection and introjection, emotional and psychic positions are pushed between ourselves and others, and if we have ‘an eye to fit the hook’ or vice versa, we insidiously take on as our own, or push away towards another, a psychical charge which in turn impinges on or depletes our identities. Given that these psychical processes occur within and between people, this starts to venture into unconscious exchanges in psychosocial territory. It was knowledge about unconscious communications between patient and doctor that prompted Balint groups to be set up by their namesake.

Bion, who was deeply influenced by Klein both conceptually and as a result of being her analysand, extended Klein’s concept of projective identification by introducing the container-contained:

> *The container is able to transform the distressing experiences from infant to mother who, as container, through reverie and a capacity to think, is able to transform the distressing experience into an experience that is tolerable. … Bion was convinced … that the psyche needs not simply to express and protect itself but needs to pursue truth in order to develop … a deeper non-sensory understanding of emotional experience … and [he]*

*places unconscious processes at the heart of creativity.* (Long, 2016, pp. 61–63)

Bion's container-contained model, which operates to manage threats to survival and nameless dread, furthers our understanding in that he conceptualises the two to be reciprocal,

> *the container influencing the contained, and the contained influencing the container. … [Thus] we can think of the psychoanalytic process as itself constituting a social institution, in which both internal realities (those of analyst and analysand) and 'external' ones (those arising from the setting and the traditions of psychoanalysis) have influence. The setting and its effects may become most visible when it is at risk, which may be for internal reasons (acting out) or because of external disruption.* (Armstrong & Rustin, 2015a, p. 5)

In 1988, Reed and Armstrong at the Grubb Institute wrote a paper about professional management. Their paper considered the crucial elements of a functioning system, which values and respects the inherent capacity of staff in a managed system to be self-motivated to be on task and meet targets within a boundaried structure, if sufficient division of roles with appropriately endorsed responsibilities is supported. The subcomponents are 'person and role', 'system' and 'authority and power'. These concepts are described in depth to disabuse us of the usually prescriptive, static, depersonalised, limited ways in which we understand these terms. Crucially in relation to my research preoccupations,

> *a role is defined … as a person identifies the aim of the system they belong to, takes ownership of that aim as a member of the system and chooses the action and personal behaviour which from his position best contributes to achieving the aim. … Since circumstances are always changing, both internally (within the working unit or organisation) and externally (in the context or environment) a role in this sense is never static. … 'Psychological role' … expresses the individual's own idea in the mind … [with] which one organises one's behaviour in relation to a specific situation.* (Reed & Armstrong, 1988, p. 2)

This concept of 'psychological role' is the precursor to 'organisation-in-the-mind'. It considers the role of authority rather than simply power, and the way in which this allows the 'taking of a role', which relates to inner conviction and competence, potential creativity and innovation, and the development of transferable skills. Reed and Armstrong (1988, pp. 1–3) go on to explain how to understand personal effectiveness:

> *In a working environment the context includes the task, the organisation structure, the other people involved (managers, colleagues and subordinates, customers, clients, suppliers etc.), and the culture of the enterprise or agency. In order to work at all, the individual has to know how to engage with this context. … Only the role-taker can define the (psychological) role and can thereby be seen as one who has 'autonomy', 'self-management ability' or 'who exercises authority'. As circumstances are always changing, role in this sense is never a fixed pattern of response or behaviour.*

The Grubb model emphasises idiosyncratic intrapsychic preoccupations, that is, the emotional life within the individual and how this is unique and distinct from external reality. This links strongly to the Kleinian theory of object and part-object relations, which are formed from our internal symbolic representations of significant others and their attributes as we see them during our early development, as described above. Long (2016, p. 55) conveys the complexity:

> *The internal object is partly a representation based on the infant's and later the adult's perception of the external object and partly a phantasy fuelled by projections into the external object and then reintrojected into the self, such phantasies being representations of primitive instinctual drives. Felt to be real and active, the internal objects are able to give the person pleasure or pain. They tend to take on a dynamic life of their own and very often conflict with each other.*

Implicit in this way of thinking are two ways of conceptually understanding ‘organisation-in-the-mind’, which was firstly developed by Hutton et al. (1997, p. 114) at the Grubb Institute:

> *'Organisation-in-the-mind' helps me to look beyond the normative assessments of organisational issues and activity, to become alert to my inner experiences and give richer meaning to what is happening to me and around me. [It] is about what is happening inside my own head – it is my reality – and has to be distinguished from any other reality 'out there'. It is the idea of the organisation which, through experiencing and imagining, forms in my inner psychic space and which then influences how I interact with my environment.*

Armstrong evolved this thinking over time. He brings it alive in his way of understanding internal representations, which he adds to Bion’s theories of the group unconscious and to the emphasis on the intrapsychic presented by the Grubb Institute, which draws heavily from Klein:

> *Internal models, images, or fantasies, located in the individual, might rather be a response to something more primary that was a property of the organisation as a whole, something that was intrinsic to the organisation as one socio-psychic field. From this perspective, each individual’s internal model or constructs, conscious or unconscious, might perhaps better be seen as a secondary formation, a particular, more or less idiosyncratic, response to a common, shared organisational dynamic … a response to something elicited* by *the organisational field and not simply imposed* on *it (cf. the distinction between* en*actment and* in*-actment).* (Armstrong, 2005, pp. 4–5)

Armstrong (2005, pp. 4–5) makes his ideas more explicit in relation to organisation-in-the-mind and the stirring up of the individual by the organisation in the following well-known description, which is a significant contribution to the field of organisational consultation:

> *[Organization-in-the-mind is] not the client's mental construct of the organization but, rather, the emotional reality of the organization that is registered in him or her, that is infecting him or her, that can be owned or disowned, displaced or projected, denied, scotomized – that can also be known but unthought.* (Armstrong, 2005, p. 52)

The combined consideration of the internal world of the individual and the system's impact on it builds on Bion's preoccupation with small groups and incorporates work from group relations to include an organisational element. Bion (1961) helpfully looks at the unconscious in groups – known as basic assumption functioning – in terms of dependency, fight/flight and pairing; these are further developed by Turquet (1974) and Lawrence et al. (1996). In each of these cases, the group is avoiding its primary task, which is only in focus when the group functions as a work group – in other words, when relationships are sufficiently unimpeded by the attribution of unconscious processes, particularly anxiety. With his psychoanalytic focus within therapeutic groups, Bion (1961) was preoccupied with cycles of defence, avoidance and repression. Redressing Bion's emphasis on anxiety, Armstrong explores the role of the work group as well as basic assumption functioning in relation respectively to progressive development or regressive avoidance of its purpose:

> *The work group is an expression at the group level of a development push … [or] … compulsion to develop which is built in to the human organism. Correspondingly, the basic assumptions are an expression of a regressive pull, equally built in, that seeks to evade development and the mental burden or pain that development implies.* (Armstrong, 2005, p. 145)

Ten years later, French and Simpson took each of Bion's basic assumptions from the perspective of attention and distraction – in other words, in line with development and undertaking the primary task or anti-task attitudes. I will consider this as it becomes pertinent in my chapter on the periodic table. Redressing the balance away from group dysfunction, French and Simpson (2014 p. xvii) emphasise groups working well, which they see as dependent on the pursuit of truth through '*evenly suspended attention* [gleichwebende Aufmerksamkeit]' (Freud, 1912e, p. 111) and also focus:

> *Dynamic movement between attention and distraction lies at the heart of Bion's insights. … A group that is distracted will tend to make only limited progress in relation to its task because without anyone realising it, some new purpose has been assumed in place of the real one. … Attention depends on the capacity to stay with the experience of the unknown as well as the known.* (French & Simpson, 2014 p. 6)

French and Simpson illustrate the inevitable oscillation in groups between attention and distraction, and they emphasise the necessary dual capacity for both positive and negative capability. The former sustains focused attention; the latter was coined by Bion in reference to Keats (Gittings, 1970, p. 43), who described the capacity for '*being in uncertainties, mysteries, doubts without any irritable reaching after fact and reason*'.

Describing the Grubb Institute's '*framework for transforming experience into authentic action through role*', also known as the '*transforming experiences framework*', Long writes about the complexity of role and the impact of systemic processes. Role is crucial, as that is where decisions and actions are made:

> *Role in work systems is not a simple position description, or set of instructions. It is more dynamic and complex. The task system is made up of particular roles that are taken up in relation to tasks and those tasks in turn are related to organisational purpose. The task system has many roles that influence each other. Moreover, there is a continual process of negotiation between roles as the role holders go about engaging tasks together.* (Long, 2016, p. 3)

Long's transforming experiences framework links to Armstrong's organisation-in-the-mind, as it suggests starting with the group and context first and then the person in role, together with the awareness that this is all in continual dynamic flux. Long also writes of the ongoing need for good management to constantly work at the boundary of person and system, allowing the person in role within a system to be effective and purposeful while being nurturing and supportive of health and well-being. She describes being actively engaged with source – our

impact and relationship with an overarching philosophical meaning, which links to our organisation-in-the-mind. On the location of role at the intersection of four domains of experience in social systems and contexts, Long describes the framework for authentic action in terms of

> *the experience of being a person (psychological), the experience of being in a system, the experience of being in a context, and the experience of connectedness with source … the domain of deeply held values … that links us to the whole of humankind in its connectedness to the natural and physical worlds.* (Long, 2016, p. 4)

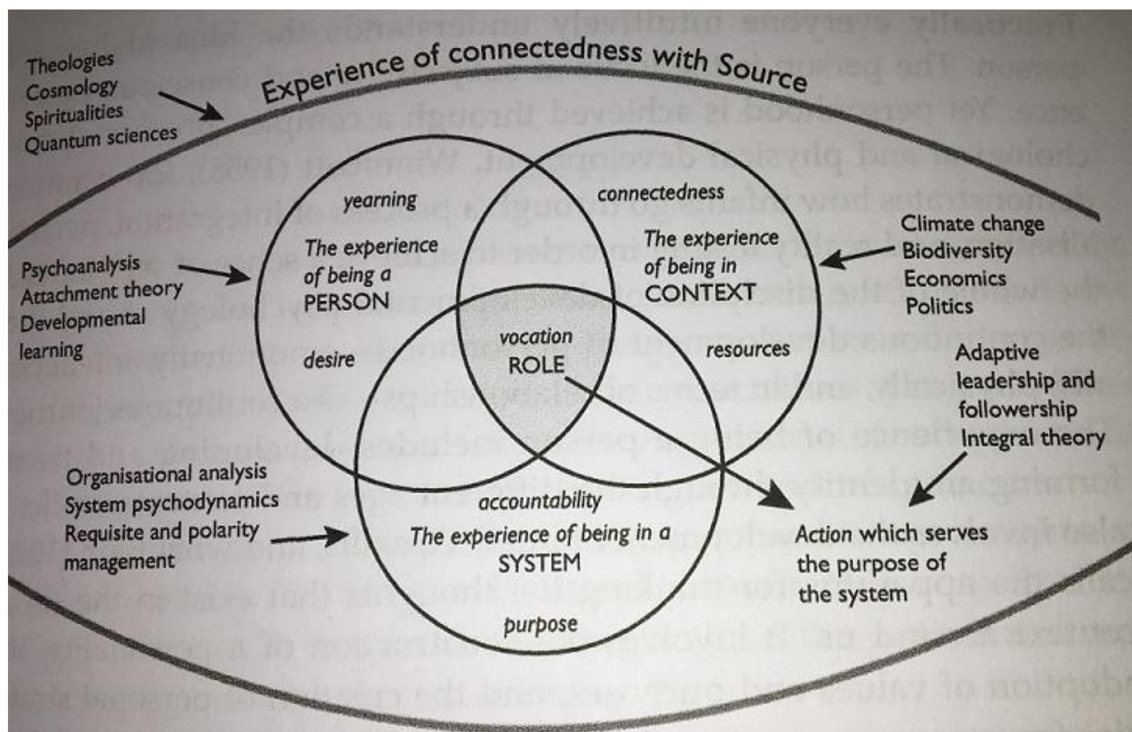



Figure 2. Transforming experiences framework (Long, 2016, p. 5).

Given that my research is about the GP role in the changing healthcare context, Long’s Venn diagram (Figure 2) and description underpin my preoccupations:

> *Action is taken by a person in a particular role at a particular moment in the history of that system (i.e. the context) in the light of an overall purpose (link with source). This might or might not be consciously apprehended by those making the actions. … Persons in roles are subject to the pushes*

*and pulls of … forces that originate in systems and contexts.* (Long, 2016, pp. 4–6)

Long (2008, 2016) has written about the way the conceptualisation of the unconscious has been expanded beyond the individual through this socio-analytic lens. She also writes about five key aspects of perverse dynamics – narcissism, turning a blind eye, engaging accomplices, misuse of power, and corruption – and the way these processes promote individual gain at the expense of the group or society.

The concept of socio-analysis (Long & Sievers, 2012) has been developed to consider issues that lie under the surface in groups, organisations and society from a psychoanalytic and systems theory perspective. Various identifying factors are included, as follows. Unconscious processes occur in groups and systems, but are expressed through individuals according to their roles, personal biographies, valencies and experiences. Representations of a whole system can occur within subgroups and may be neurotic, psychotic or perverse. Creativity is enabled both within agreed, defined boundaries and simultaneously via sharing in boundarylessness (Long, 2016, p. 73).

The term 'systems psychodynamics' (Armstrong, 2005; Campbell & Huffington, 2008; Gould et al., 2001; Obholzer & Roberts, 1994) has been coined to demonstrate a consultative approach, mostly through a series of single organisational case studies rather than rigorous qualitative research. Systems psychodynamics was nevertheless historically employed to potent and creative effect by the Tavistock Centre in London, starting with traumatised soldiers after World War II, under the inspiration of Bion, Rickman, Bridger, Main and others (Long, 2016, p. 66). Gould et al. (2001, p. 3) describe the approach:

*The 'systems' designation refers to the open systems concepts [including] design, division of labor, levels of authority, and reporting relationships; the nature of work tasks, processes and activities; its mission and primary task … and nature and … patterning … of sentient boundaries. … The 'psychodynamic' designation refers to psychoanalytic perspectives on individual experiences and mental processes … unconscious group and*

*social processes … [that are] both a source and consequence of unresolved organisational difficulties.*

This method has evolved over time, and its application has included many aspects of health in manufacturing, financial, corporate, public and third-sector services. Ultimately, it was social psychologist Kurt Lewin (1951) in the first half of the 20$^{th}$ century who coined the term 'group dynamics' to describe the positive and negative forces within groups of people. Throughout his career, he researched how group dynamics could be applied to real-world social issues. Lewin described 'field theory', of which he was a pioneer, as

> *best characterised as a method … of analysing causal relations and of building scientific constructs … according to which the boundary conditions of a field are essential characteristics. … Processes of perception which should be related to the boundary zone depend partly on the state of the inner part of the psychological field i.e. the character of the person, his motivation, his cognitive structure … and partly on the stimulus distribution … as enforced by physical processes outside the organism.* (Lewin, 1951, pp. 45–57)

Jaques was a pioneer in considering unconscious individual preoccupations and their influence on social processes, as in his Glacier Project (Jaques, 1964). He later went on in his book *Requisite Organisation* (Jaques, 1989) to consider company infrastructure in terms of the management system and allocation of roles, responsibilities and accountability:

> *The idea of social defences against paranoid and depressive anxiety has grown from a working hypothesis put forward by Jaques in 1955 into a theory of social defences against the distressing and unbearable emotions aroused by organizational tasks and dynamics. Jaques reneged on his early ideas, dismissing psychodynamic causes and embracing structural explanations. But the application of social defence theory beyond micro-systems to broader systems dynamics has meant that psychodynamic and structural ideas of system and role have now become more integrated.* (Long, 2006, p. 279)

Jaques (1951) also considered frustration in relation to insufficient discretionary responsibility and the way this affected morale. Menzies (1960) further utilised the concept of social systems as a defence against anxiety in a groundbreaking study of nurses in a hospital setting. This study reported the internalisation of external institutional pressures, which was particularly felt by nurses who were concerned to have ongoing relationships with their patients, both for the health benefits resulting from continual care and also for their own personal/professional satisfaction from long-term involvement where possible, with appropriate levels of discretion. Like Jaques (1951, 1964, 1989), Menzies (1960), Menzies Lyth (1988) recognised nurses' motivation by the unconscious role of reparation for the phantasised damage of internal objects, but she emphasised the resulting unconscious impact of defensive systemic structures on the primary task of caring for patients:

> *Menzies Lyth proposed that the system would function more effectively in almost every respect if underlying anxieties were acknowledged rather than denied, and if the hospital system became more committed to maintaining human relationships, both between nurses and their patients and within the nursing hierarchy itself.* (Rustin, 2015, pp. 26–27)

Menzies specifically itemised anxiety, guilt, doubt and uncertainty as the characteristics which were being avoided in the social defence system at play in nursing, and she observed that little attempt was made to positively support nurses to tolerate and deal more effectively with anxiety (1960, p. 109). She described the process whereby an emotionally avoidant systemic way of operating materialised:

> *The needs of the members of the organisation to use it in the struggle against anxiety leads to the development of socially structured defence mechanisms which appear as elements in the structure, culture and mode of functioning of the organisation. … A social defence system develops over time as the result of collusive interaction and agreement, often unconscious, between members of the organisation as to what form it shall take. The socially structured defence mechanisms then tend to become*

> *an aspect of external reality with which old and new members of the institution must come to terms.* (Menzies, 1960, p. 101)

Menzies went on to illustrate the resulting defences in nursing practice in the study that she undertook. She concluded that fully confronting the potential anxieties in nursing was perceived as too personally and socially threatening in this case, even though avoidance could never be fully successful insofar as the social defence system itself aroused secondary anxiety. She also helpfully linked the struggle to undertake the nursing task to primitive aspects of the psyche, such as unconscious reparation, libidinal longing and fear of aggression, which were stirred up when nurses were working with patients and when they were thwarted. Menzies observed frustration in relation to insufficient satisfaction, both in relation to insufficient discretionary responsibility and in response to the restriction of relationships with patients and their treatment to partial components. Ultimately, the more psychically mature student nurses who could not tolerate this defensive structure left the profession. Menzies explained:

> *Defences are, and can be, operated only by individuals. Their behaviour is the link between their psychic defences and the institution. Membership necessitates an adequate degree of matching between individual and social defence systems. … If the discrepancy between social and individual defence systems is too great, some breakdown in the individual's relation with the institution is inevitable … commonly … in the individual's membership.* (Menzies, 1960, p. 115)

Long (2006) takes the concept of social defences into the dynamics of macro-systems, utilising the concepts of intersubjectivity, true self, core values and authenticity, and suggests that an organisation is more than a system of positions in the task system. Long (2006, pp. 290–291) refers to Jaques and then offers her own thinking about the integral role of subjectivity:

> *He regarded the organization per se as only a system of positions in the task system rather than a system of roles that engaged subjectivities also at the community system level. It is as if we experience our roles in*

> *different systems (e.g. task- and community-level systems) as split off from one another rather than integrated through our subjectivity.*

Hinshelwood (2008) addresses what he refers to as a schism: a focus on either individual or organisational approaches to psychic defences, as taken up by Jaques (1951, 1964, 1989), Menzies (1960) and Menzies Lyth (1988) respectively. Hinshelwood warns us that '*we can decline into an individualistic view of* organizations *that is merely an expression of individual psychology … or … we can become over-collectivizing, with a depersonalized "*system*" in which we lose sight of personal experiencing*' (Hinshelwood, 2008, p. 68). He observes that this split has continued since the disciplines of psychoanalysis, field theory and then systems theory came together through group relations and systems psychodynamics, and he offers a considered approach that holds both aspects in mind:

> *A lot of personal experience is very private, idiosyncratic, and personal baggage, and can be significantly restrained from affecting the* organization *as a whole in most circumstances, by attention to boundaries, role and task. At the same time, another batch of personal experience is that which the working* organization *(and especially its work task) provokes as a kind of public unconscious.* (Hinshelwood, 2008, p. 70)

In summary, Hinshelwood looks back to Bion as an essential reference, suggesting that we need to perpetually consider '*Bion's notion of the individual at war with himself over his groupishness; the dynamic entails the emotional complex of people both struggling to be themselves while struggling to perform organizational roles*' (Hinshelwood, 2008, p. 75).

Furthermore, in a recent publication aptly entitled *Social Defences Against Anxiety* (Armstrong & Rustin, 2015b), a reworking of theory and an application of systems-psychodynamic thinking and organisational consultation is described across different sectors, including health and nursing, the private sector, social welfare and education. Social defences creep into the workplace – for example, in ritualised, unthinking behaviour devoid of empathy, in blame and scapegoating,

or in avoidance techniques resulting from internal and external threats, such as the psychological demands and inherent anxieties within the task, which may include desire for and disgust at patients' bodies in medical work, challenges within the work context, and internal emotional conflicts. '*Mirroring effects of anxieties transmitted across different levels of an organization is one of the most powerful psycho-social ideas to have emerged from the understanding of the processes of projective and introjective identification*' (Armstrong & Rustin, 2015a, p. 12).

Developments within this body of work are demonstrated through a more nuanced appreciation of social defences. Importantly, Halton (2015) explores the nature of the defence described by Menzies, observing an obsessional-punitive mechanism which blocks the development of an integrated empathic relationship. This serves the function of repressing anxiety and also denies feelings, which prevents attachment. At the same time a punishing, hostile, ritualistic regime is imposed by senior nurses on juniors, into whom irresponsibility and ineptitude are projected. Halton refers to Freud's (1926d, pp. 111–123) concept of the superego to describe the persecutory surveillance and obsessional mechanisms employed in nursing techniques to avoid anxiety, with the result that '*as a socio-technical system, the technical tasks of nursing are achieved but the social system obstructs the nurse-patient relationship*' (Halton, 2015, p. 31).

Other contributions to Armstrong and Rustin's edited volume consider that the defence is against not only anxiety but also, as Long (2015, pp. 39–69) points out, pride, greed, envy, sloth and anger. Long refers back to the Grubb Institute's idea that role is the place where person, system and context meet and are connected through source, an idea I refer to in more depth later in this thesis. Hoggett (2015, pp. 50–69) refers to the state embodying anxiety and government interventions based on quick fixes. He considers the hyphen within the word 'psycho-social', referencing Rosenfeld, Steiner and Meltzer to describe the psyche as an internal society. He also states that he does not believe there is '*any such thing as primary task; the task of a team or organization is always problematic, contested, and socially constructed*' (Hoggett, 2015, p. 51).

The principal goals of an organisation are socially constructed, such that individuals working in the same role and context have different ideas about the primary task and its normative (what we feel we ought to be doing), existential (what we believe we are doing) and phenomenal (what we hypothesise we are doing) variations (Lawrence, 1977), around which there may also be conflict. Particular types of anxiety, such as demands to know the solution and threats to patient recovery, may result in a fear of ignorance in the doctor, and may lead to a fear for one's professional survival. The resulting defences are unconsciously constructed to manage the anxiety, and they become absorbed as implicit or explicit rules, which all gel together to create social defences.

Additionally, over decades there has been a culture of enquiry and consultation into individual and organisational stress in the human services, including baby care units, residential care settings for young and elderly people, schools, health and social care, and human welfare (Cooper & Lousada, 2005; Dartington, 1979, 2010; Obholzer & Roberts, 1994). A series of organisational consultancy case studies have been conducted from a systems-psychodynamic perspective, demonstrating the interplay between individual role, organisation and wider context, published in *Researching Beneath the Surface: Psycho-Social Research Methods in Practice* (Clarke & Hoggett, 2009). These texts demonstrate that the wider context has a direct impact on how work is experienced and how people function at work. Although the number of in-depth qualitative studies executed, analysed and critiqued in the literature is limited, there have been more individual case studies that can be mined for broader relevance to consulting practice and theory. However, there has been limited consideration of GPs in the changing context of the healthcare system using the systems-psychodynamic tradition. This stands out as an oversight in comparison with the psychoanalytic focus on GPs as doctors relating to their patients, albeit in (Balint) groups or within multidisciplinary teams.

This literature aroused my curiosity about whether my subjects were different from each other in relation to these issues, and it prompted my thinking to include questions in my semi-structured questionnaire that would reveal:

1. whether my sample group would recognise the psychosocial/emotional issues that my approach was concerned with, and see the use of these ways of thinking
2. whether it would help them and their work if they did so, and what would then need to be considered from a systems-psychodynamic perspective

Thus, I explored relevant literature, including to a limited extent the history and trajectory of neoliberalism; the well-being, status and work of GPs and primary care; autobiographical and biographical narratives and research with and by doctors; consultations to GPs; the nature of vulnerability and splitting; and systems psychodynamics. From this informed position, I set about constructing a means with which to undertake my research.

## Chapter 3. Methodology

This is a qualitative study with 12 GPs that researches their in-depth experience and what it feels like to be a GP. It explores the following research preoccupation:

- a systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery

Research questions linked to my main preoccupation include:

- What are the primary orientations, motivations and valencies of GPs in relation to their work, and what stresses, satisfactions and dissatisfactions do they experience as GPs in the present context of general practice?
- What organisational, economic and cultural changes in the functioning of general practice are currently impacting on the experience of GPs?
- How are GPs responding to changes in the situation of general practice, and what strategies or defences are they taking up to adapt to them?

### *3.1 Critical Realist Position*

Through my development as an organisational consultant working with systems and professionals in role, and as a psychotherapist affected by general practice in the NHS primary care context, contentious questions evolved in my mind. At the core of this internal exploration was the question of what defines primary task and professional role, and how they are recognisable to professionals themselves and external others. A subsequent question followed on from this: what conditions would need to be in place to maintain the recognised status quo, or to disrupt or disturb it? Thus my approach includes a critical realist stance. This philosophy of physical and human worlds was developed by Bhaskar (1997), who wrote prolifically as an independent writer and in collective works.

> *The critical realist conception stresses that society is both (a) a pre-existing and (transcendentally and causally) necessary condition for intentional agency … but equally (b) as existing and persisting only in*

*virtue of it. On this conception, then, society is both the condition and outcome of human agency and human agency both reproduces and transforms society. … Agents are always acting in a world of structural constraints and possibilities that they did not produce. Social structure, then, is both the ever-present condition and the continually reproduced outcome of intentional human agency.* (Archer et al., 2013, p. xvi)

From this critical realist position, I am looking to draw inferences from the interview transcripts not only about the interviewees' subjective experiences, but also about the social structure (organisational forms) that the GPs' narrations make evident. My perspective that GPs are defended subjects presupposes an unconscious dimension to subjects' responses. The purpose of free association interviews is to enable the scope and psychological space for the revelation of this unconscious dimension. The interviews were loosely framed by a semi-structured schedule, which allowed interviewees' preoccupations to take centre stage and determine the length of the interview, which varied between one and a half hours and three hours. I found the experience fascinating and moving, and a range of values and histories were revealed. It was a sustaining experience to undertake the interviews; however, analysing my data and writing up the thesis proved a taxing challenge, especially in the face of losing my counsellor role. It made me starkly aware of my own powerlessness. In my reflective journal, I wrote:

*I feel that the whole situation is a forgone conclusion and nothing can influence it! So I am in two minds* – give *up or* fight*. It could not be a more pertinent time for me to consider the mesearch in this research, as this current climate is exposing similarities and differences between my own role and that of GPs. For example, if GPs' jobs at the surgery were threatened in the way that mine is, then there would likely be much stronger and wider reactions in the patient population.*

My sense of betrayal is also somewhat evident in this journal entry:

*There are instructions to make psychological therapies ever shorter, more specified, administration heavy and with a focus on saving money on*

> *welfare payments. This is an instrumental way of using counselling in which counsellors and patients are objectified and the process of counselling is seen as a means to an end. This feels like it defies the actual ethics and principles of therapeutic interventions.*

My morale and motivation were low at this point, and perhaps were also linked to a feeling that GPs had many options while I had to fight for my own professional survival and income.

### *3.2 Rationale for the Research Method*

In terms of choosing my methodology, I took account of the probability that GPs are frequently, and to some extent through necessity, defended subjects who '*invest in discourses when these offer positions that provide protections against anxiety and therefore supports to identity*' (Hollway & Jefferson, 2013, p. 21). Keeping this actively in mind, I put together a semi-structured interview schedule, and I listened out for anecdotal evidence and illustrative remarks that when pieced together demonstrated what was under the surface of the comments that GPs made. I also pondered on my countertransference reactions. My critical realist stance, together with my systems-psychodynamic understanding, led me to listen to what was overtly stated and implicitly relayed through what GPs expressed, both consciously and unconsciously. I listened out for descriptions of what they brought to their job as individuals in role, the impact on them of their work with patients, and their relationship to the wider context.

### *3.3 Interview Sample*

This is a small-scale, qualitative investigation with the aim of capturing a range of significant connections between elements of GP experience in the current healthcare context. As such, this study cannot claim to be representative of the field in a statistical or formally accountable way.

In terms of sample selection, I successfully met my aim of recruiting 12 GPs working in the NHS in England, in roughly equal proportions as regards male and female, at different stages in their careers, and with different areas of responsibility and expertise. I sought out this level of variation by approaching different professional colleagues who were themselves at different stages in working life, who helped me to attract the range I needed. I also specifically targeted newly qualified GPs, salaried GPs, locums, GPs located in A & E and community roles, GP trainers, Balint group leaders, partners in mid-career, and retired GPs, for example.

I recruited interviewees from my existing professional networks. I recorded these interviews with their permission, had them transcribed, and then presented the transcripts with themes to my two supervisors. This was a complex process that took time, and I employed multiple informal pathways. I had thought briefly that perhaps the most suitable strategy would be to target practice managers or commissioners, who might be the appropriate professionals in the hierarchy to approach about finding GPs to interview. However, I knew instinctively that informal routes via my own contacts were much more likely to be a fruitful avenue. I therefore used both methods.

The least productive route for recruiting interviewees was writing individual formal emails to all the practice managers in an inner-city borough. This elicited only one reply, which informed me that her GPs were currently uninterested. I thought to myself that GPs might only be willing to be interviewed if the request came from a trusted mutual connection who knew of my work and my approach sufficiently well to convey both reassurance and gravitas. Thus, I set about asking other collegial professionals I knew whether they had GP contacts who would be willing to be interviewed. I asked:

- GPs in the practice where I worked – resulting in one GP interviewee
- my collegial counsellors working in other GP practices – resulting in one GP interviewee
- fellow doctoral students and doctoral supervisors – resulting in three GP interviewees

- GPs I met directly at Balint conferences, who then spoke to their GP colleagues – resulting in seven GP interviewees

At the time of seeking GP interviewees, I was working as a counsellor in primary care alongside GP colleagues in central London. I did not request that these GPs become participants, but I asked them if they had colleagues who might be interested. Obviously, my direct GP colleagues would not have been appropriate interviewees, as this would have caused a conflict of roles, given that we had ongoing professional relationships and they referred their patients to me for counselling. As one of 30 counsellors in GP surgeries working across London, I also networked with them in order to find participants. Other colleagues from the field of consultancy put me in touch with GPs whom I interviewed, and another such colleague told me that an NHS commissioner had let it be known that her GPs were willing to be interviewed; one of these was forthcoming. However, some leads ran cold. At that time, I also worked in homeless day centres as a counsellor, and I approached one GP who had worked there, but family illness prevented her availability. Achieving the interviews in north-east England was a heavy task and took many months of negotiating and emailing the questionnaire. Perhaps these GPs from north-east England imagined that they were safer in the knowledge of what they would be asked having seen the questionnaire. There were others with whom I made email contact and to whom I sent provisional descriptions of my study, but they gave no response. I undertook the first interview in April 2015; my 12th and final interview was in November 2016.

While I continued to find interviewees and undertake my role as a counsellor in a GP surgery, my own role became threatened. My requests on the whole evoked curiosity and agreement to be interviewed, and this validated the importance of the territory I was investigating. My plan had been for this to be a study to take place with GPs either in London or within three hours' travelling time. I interviewed four participants in their own place of work at their GP surgery, four in their own homes, and four in my private consulting room in London.

A mixture of middle- and working-class origins were revealed. There was some cultural diversity, including between northern and southern England, and three interviewees were from different parts of western Europe and south-east Asia. All

of the GPs were practising in urban environments within England: two were working in north-east England, one on the coast of south-east England, and nine in different boroughs of London.

My sample includes:

- GP partners, and salaried and locum GPs
- commissioners and non-commissioners
- group practice GPs, GPs who are part of a consortium of practices with varied demographics and practice sizes, GPs working in primary care at A & E, and GPs in community roles working with the elderly
- newly qualified GPs, GPs that have been qualified for a few years, mid-career GPs, and GPs approaching retirement or recently retired
- Specialists in minor surgery, dermatology, mental health and psychiatry
- Balint group leaders
- Trainers of medical trainees and/or GP trainees

### 3.4 *Research Study with a Sample of GPs: Free Association Narrative Interviewing*

I initially considered using BNIM, which would have entailed asking one main question and possibly supplementary questions, paying attention to the order of the told story so as to stay aligned with the unconscious communication. However, I felt that this approach might either elicit an unwieldy amount of information that would not be pertinent to this specific study or be met with a defensively limited reply. Thus, I had the idea of using the free association narrative interview (FANI) method, which would take account of the defended nature of subjects, maintain the ethos of curiosity, and provide room for openness and unconscious linking, but within a tighter definition. By utilising a semi-structured questionnaire of approximately six (main and supplementary) questions, I hoped to provide focus and containment. My thought was that this approach would be more in keeping with the modus operandi of a ten-minute GP consultation with its question-and-answer style, and more likely to elicit data under the surface. Obviously, as part of my ethical stance, I made it clear to all of

my interviewees that they could stop the interview at any time, and that I could facilitate them to access ongoing support as necessary. FANI was developed by Hollway and Jefferson (2013, p. 49) with the active intention of facilitating unconscious material to surface; in a later study by Hollway (2015) it was combined with an observation method. Crucial tenets of FANI include

> *four interviewing principles designed to facilitate the production of interviewees' meaning-frames (or Gestalts), namely: use open questions, elicit stories, avoid 'why' questions and follow respondents' ordering and phrasing, aiming to elicit participants' experience in a form dictated as little as possible by the protocol of questions.* (Hollway, 2015, p. 43)

A few open questions set by the interviewer do provide some framework while allowing the researcher's interest to feature loosely. As this is a qualitative approach with minimal structuring by the interviewer, it gives the greatest scope for the interviewee's conscious and unconscious cultural, societal, systemic and individual presuppositions, subjectivities, values, processes and expressions. FANI supports research into the lived experience of individuals and collectives, and it may enable their preoccupations to emerge with less imposition than other methods. It is a narrative interviewing technique – a methodology designed to speak to professionals in role and to consider the under-surface dynamics. I am interested in what kinds of life stories, motivations and valencies (Bion, 1961) brought GPs to their work, and how they have sought to manage change. This approach facilitates an understanding of both the internal and contextual worlds of persons through their lived experience in a dynamic period of time, with equal value placed on psychological and societal considerations (Hollway & Jefferson, 2013; Wengraf and Chamberlayne, 2006).

FANI provides a methodology for both data-gathering and analysis. Psychoanalytic theory and psychosocial constructs are only used to interpret the data, not as illustrative or illuminating tools during the interview itself. Use is made of the interviewer's subjective experience along the lines of transference and countertransference phenomena, projective identification, self-reflexivity, subtlety and intuition. Two structured ways of summarising a whole case are used: an approximately two-page description that maintains the inconsistencies,

paradoxes, contradictions and puzzles in the narratives; and an in-depth consideration of each case looking at the themes, clusters and areas of significance across the data, both within and between cases, while remaining 'n*one the less faithful to our theoretical principles about the self … without sacrificing the complexity and uniqueness of people's stories. … The categories part of our analysis … emerged out of a grounded theory approach*' (Hollway & Jefferson, 2013, pp. 99–100).

This approach allowed me to enquire about GPs' experiences and states of mind in an exploratory, unfolding way within the framework of a somewhat evolving semi-structured questionnaire, which I edited occasionally as necessary, according to insights during the supervisory discussions that followed early interviews. In this way, the research was an iterative process such that the feedback loop of reflection and supervision enabled reflexivity (Parker, 2005b, p. 117) and dynamic interaction with the research process. On occasion I identified profiles of new GPs who might be informative given the current data indications. Thus the research process was responsive to the data as it emerged.

### *3.5 Developing the Interview Schedule*

When considering my line of research enquiry, for some time I found it difficult even to imagine how to separate my research question from the actual interview questions that I would ask of GPs. I wondered whether this had any parallel with the fact that GPs often have to ask their patients sufficiently open questions to elicit information without forming a diagnosis prematurely. I therefore formed a main research preoccupation, which allowed space for any variations in response without presupposing negative and stressed experiences. Supervision was crucial in supporting me with this, enabling me to observe my proclivity to superimpose my own experience of strain in my primary care role onto my GP interviewees. My research project was a systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery.

I was left in a quandary about how to formulate interview questions that would elicit relevant data. I was curious about interviewees' original motivations for the

role of GP, the valencies in general practice itself, and how these might or might not be affected by changes in the healthcare context. However, to keep the focus on the 'person in role affected by context', and to effectively employ my researcher position, I was careful to loosely follow my semi-structured schedule so as to focus my research and support this endeavour. This approach kept me on task as opposed to veering into my other habitual seats as psychotherapist or organisational consultant. I attempted to elicit data about: motivations for clinical work and other aspects of the role; broader attitudes towards general practice and the context; experiences, relationships, discretion and interactions as a GP and how these had changed over time; value systems and subjective meanings; and support, creativity and sustainability.

I devised an interview structure with two explicitly distinct parts. For the first part, I designed a semi-structured questionnaire, and added supplementary questions in order of revelation so as to capture the subjective experience of my sample with regard to how they had become GPs, their experience of the work over time, and their satisfactions and challenges. In the second part, I asked interviewees some structured questions in order to elicit information and associations directly with regard to their organisational contexts and their perceptions of this changing professional environment across their careers.

In response to the material gathered during interviews, and in discussion with my supervisors, I subtly edited my semi-structured questionnaire. I did this firstly in terms of the order of questions. Given my interest in valency, during supervisions we had the realisation that it might be more helpful for interviewees to have more time to consider their motivations, not only internally and intrapsychically but also externally and interpersonally. Therefore, I reordered the questionnaire and put first the questions that were designed to allow space for preoccupations about coming towards the role. These early questions were as follows:

> 1a. Can you tell me about the time when you realised that you wanted to become a medic and then more specifically a GP?
> 1b. Details and time periods

2a. Can you tell me about a time when the experience of being a GP stands out in your memory?
2b. Details and time periods

3a. Can you tell me about a time when work has kept you up at night?
3b. Details and time periods

In addition, I added a question about the most significant relationship – that between doctor and patient, which I placed next in order before enquiring about the context:

4a. Can you tell me whether you think the relationship between GPs and patients has changed?
4b. Details and time periods (this question was added)

5a. Can you tell me about times when the wider setting of healthcare, such as targets, patient interest groups and commissioning, have impacted on your role – has this changed?
5b. Details and time periods

I managed my own bias about targets from my counselling role by asking the open question below. This proved to elicit an important indicator about GPs' attitudes and foci, and indeed provided significant response variations.

6a. Can you tell me whether you think the whole method of target-setting has a positive or negative impact? (This question was added, to make explicit my curiosity.)
6b. Details and time periods

I also added the following questions at the end, as they had come up during my previous interviews, and it felt important to attempt to purposefully collect data on these variables by asking about them directly:

7. What are your thoughts about being salaried or self-employed, and how important is this issue to you?

8. What are your thoughts about the government's plans for changing contracts?

9. Do you attend a Balint group, and do you have any thoughts about it, positive or negative?

10. Are there any issues that are important to you in your life as a GP that you would like to raise?

The final change involved clustering my questions into themes, which helped me to orientate myself during the interview and was useful when analysing the data. The clusters materialised from discussions during supervisions and observations of emergent data. I also reordered some questions to better fit their cluster; for example, the following question was moved to cluster one:

> Can you tell me about earlier times in your life when you've been particularly moved?
> Details and time periods

GPs' own health and attitudes to their own healthcare frequently came up in the data, and were placed in cluster three:

> Can you tell me about how you manage your own health needs?
> Details and time periods

In cluster four, the following question concerning the societal aspect of being a GP was teased out from a previous question that had also included the social standing of GPs:

> Can you tell me how you experience your role as a GP in society or the community?
> Details and time periods

The following clusters emerged:

Cluster one: taking up the role
Cluster two: possible changing impacts on the role
Cluster three: personal motivation
Cluster four: role in context

Questions about relationships with patients, personal motivations for being a GP, and interviewees' interest in medicine often evoked autobiographical revelations. The following question also led to some personal disclosures:

> Can you tell me about earlier times in your life when you have been particularly moved?

Furthermore, some interviewees simply started to talk about themselves, their early-life experiences, their families and adult-life challenges spontaneously, in intimate detail and at length, without the prompt of a direct question. The process of being interviewed and the self-reflexive demand that this made created the conditions for personal and professional revelations. The interview length was determined by each interviewee's response to the interview schedule. Some took about one and a half hours; most took approximately two hours, with a couple of interviews taking several hours.

An email version of the questionnaire was created and edited in landscape orientation in response to a request from a GP and her colleagues in northern England. The idea was that this would make participation more accessible, but in practice both respondents found the questionnaire fairly impossible to answer. On this basis, they agreed to be interviewed.

I had thought that I would undertake focus groups, but as I went through the data with two supervisors and an adviser, this proved a sufficiently challenging reflexive group to support me to examine the data. FANI interviews can be psychologically challenging for interviewees. Some participants were clearly interested in the study and enquired about any subsequent publications, insisting on its pertinence and high potential interest. Some were particularly worried about confidentiality, given their more identifiable roles and interests. Still others

expressed relief at being able to convey their experiences, and it seemed to me that the process enabled some participants to reflect on their private/public personae, gain some catharsis or clarity, and usefully consider the themes of the research and its relevance in their own or intimate others' working lives.

### *3.6 Ethical Considerations*

Confidentiality within safeguarding practice is a crucial aspect of this research, given the highly responsible and significant position held by GPs in relation to the general public. Although GPs are generally thought to be robust, as good practice – and particularly given the indication of high stress levels and the psychologically in-depth nature of FANI – the impact of the research on participant GPs was monitored, and I honoured my duty of care by detailing support services such as counselling, psychotherapy, organisational consultancy, executive coaching from an organisational perspective, role consultation, mentoring, and Balint groups if required. Data was stored securely, and confidentiality was maintained. Participants were given assurances regarding the handling of the recorded files, transcripts and any subsequent write-ups, with the reassurance that once the doctorate was completed the data would be destroyed. Correct permission within the organisational system was sought, protocols and policies adhered to, and safeguarding guidance and practice implemented. The option to withdraw at any stage of the research process was offered. Indeed, one GP did take a pause during the interview for a comforting drink and snack, as she found the process demanding and had recently been signed off work with depression and anxiety. I paced the interview according to her needs.

### *3.7 Data Analysis Using Grounded Theory and FANI*

This qualitative research project makes enquiries from a range of professionals in the role of GP. Notably, my interviewees potentially had above-average robustness and creativity in the role in comparison with the examples of stress in the profession, including suicidality, evidenced in the literature I reviewed in the previous chapter. It is worth noting that seven interviewees were recruited from

direct or indirect connections with Balint work. There was some evidence of strain in my participants, such as a recent breakdown, falling out of love with general practice, wishing to retire early, an intention or wish to change profession or move away from so much clinical exposure, feelings of being saturated by demands on all fronts, and also some physical symptoms of chronic and acute illness. There were some descriptions of colleagues who had or were at risk of burnout. But given the extent of vulnerability among doctors discovered in the literature review, my sample was perhaps less fragile than might have been expected – a bias arising because those who were willing to be interviewed were perhaps more able to expose themselves due to their being reasonably intact. However, it would seem that some GPs were willing to be interviewed for a variety of reasons, such as wanting a witness for their efforts, wanting to reconnect with a therapeutic dialogue, being curious about the research process, having an interest in organisational approaches, wanting a way to process retirement, or wishing to support the health of the profession. This small study is a contribution of ideas from in-depth exposure to the idiosyncrasies and similarities revealed by this process of enquiry.

In my analysis of the data, I used grounded theory (Charmaz, 2014; Glaser & Strauss, 2008) through line-by-line analysis of the GPs' biographical narratives, combined with the FANI approach of writing brief interviewee biographies and free associations with pertinence to the revelations during the interview process. In effect, I adopted a two-stage method of analysis and presentation. The in-depth biographies provided a first overview of the members of the sample, and these were then used to support my evolving analysis of the transcribed interview material. For reasons of confidentiality and the identifiability of the subjects, these biographies cannot be included in this thesis, although they were crucial in providing an overview of the collective group and its subgroups. The disclosure of individual psychological predispositions, professional identifications and personal valencies contributed to my understanding of my sample. Perhaps, in considering the valencies and bivalencies within my sample, I was drawn to both their specific elemental qualities and the potential groups that they occupied. The metaphor of the periodic table as a visual representation of my sample thus emerged, with its elements of varying valency and its groups with similar specific characteristics. In this particular study, the whole sample commands additional

attention, given that GPs are a workforce that runs primary care and is often constellated into GP practices run by GP partners. The manner in which the different elements can compound together therefore has additional interest, particularly given the sentiment conveyed by some participants that general practice as an entity is not going to survive in its current shape. Thus, in a microcosmic way, I considered my sample as a mini version of what might be going on in the wider system. As Hollway (2015, p. 187) puts it:

> *The diversity of our sample was carefully thought out. Our research design was fashioned in order to tell us something beyond single cases … a holistic, affective kind of knowing that changes the knower. … The whole that I am drawing on, I cannot limit that to the whole set of data; rather it includes the myriad encounters whereby it has come to mean what it means, encounters that include my own biography.*

However, in addition to Hollway and Jefferson's approach of '*psychoanalytically informed epistemology*' (2013 p. 187), it also felt important to explicitly use grounded theory (Charmaz, 2014; Glaser & Strauss, 2008) in order to have a flexible strategy to manage the detail and bulk of the transcribed interviews. Rustin (2019, p. 4) summarises grounded theory as recommending that

> *research be undertaken not from the perspective of preconceived theories, but rather by drawing inferences from empirical experience, that is, from data gathered in a field setting … based on observations or dialogues with ordinary human actors [which] could be understood as representing their perspective on the world, a view 'from below'.*

*The Discovery of Grounded Theory* was published in the United States in 1967 by two sociologists, Barney Glaser and Anselm Strauss, who developed a new approach to research. Instead of verifying theory, they suggested the discovery of theory from data as a new way to uncover new findings: '*Theory based on data can usually not be completely refuted by more data or replaced by another theory. Since it is too intimately linked to data, it is destined to last despite its inevitable modification and reformulation*' (Glaser & Strauss, 2008, p. 4). Glaser and Strauss explain that grounded theory goes beyond logical deduction or simply

tacking on explanations; rather, '*the adequacy of a theory for sociology today cannot be divorced from the process by which it is generated*'. They go further: '*Canons for assessing a theory, such as logical consistency, clarity, parsimony, density, scope, integration, as well as fit and its ability to work, are also significantly dependent on how the theory was generated*' (Glaser & Strauss, 2008, p. 5).

Charmaz (2014, p. 13) supports a reflective approach with her emphasis on a '*constructivist grounded theory*' attitude, which starts with '*the assumption that social reality is multiple, processed and constructed … [taking] the researcher's position, privileges, perspective and interactions into account as an inherent part of the research*'. Capturing this in a phrase, Charmaz writes that '*subjectivity is inseparable from social existence*' (2014, p. 14), and she informs us that how research participants identify the researcher influences what they will tell him or her. With regard to the researcher's attitude, Charmaz (2014, p. 33) emphasises the importance of establishing rapport, aiming to gain access with an open mind and an accepting demeanour, and thereby entering subjects' worlds. From a psychoanalytic perspective this brings us into the realm of transference and countertransference phenomena, which I considered in the interviewee biographies. I tried to implement a similar approach to Hollway (2015), undertaking biographies and using self-reflexivity, consistent with a psychoanalytic, systemic and social-cultural understanding of subjectivity. Again, I found Hollway and Jefferson's approach (2013) through FANI invaluable as a way of being able to make use of data, with a more holistic approach to both carrying out the interviews and receiving information in a multitude of ways to get more inside the body of each individual's position.

As I wrote up the full biographies, I was able to use pertinent quotes from transcripts. But in considering the umbrella, and searching for some shared features in my sample, I also used grounded theory to discover commonalities between them. The specificity of grounded theory, with its line-by-line consideration, deepened the process and enabled me to discover themes and different styles of attachment and adaptation to task, role and system across individuals. These two processes together – writing in-depth biographies and using grounded theory to elicit theory from the data – enabled the identification

of distinct types or categories of adaptation to the GP role. There are examples of the line-by-line analysis I undertook with each transcribed interview in the appendices. I attempted to extrapolate key issues and create gerunds – verbal nouns representing current actions – to reflect what was happening and indicate the interviewees' dynamic preoccupations. We discussed these in supervisions so as to triangulate my thinking, and these detailed explorations also further enabled me to exhaust the emerging issues and carefully consider my choice of interviewees.

### *3.8 The Ten Themes*

In discussion with my supervisors, I noted striking identifiers from the first interview. This created an initial list of themes as a baseline on which I could then build and compare. In accordance with grounded theory, I tried to understand more about each emergent theme in the subsequent interviews, making some attempts to shape my sample with an awareness of aiming to saturate my curiosity before pursuing other lines of enquiry. As previously described, I also subtly adapted my semi-structured interview schedule according to pertinent issues revealed during the interviews.

My attempt to delve broadly and deeply was supported by my deliberate effort to target GPs at different stages of their careers and with varying types of responsibility. I then gathered all of the key issues and gerunds from my 12 interviews and looked for repetitions and headlines. This was a tortuous process, as the bulk of data felt overwhelming and unwieldly. Nevertheless, I sorted key issues and gerunds from the interviews into groups, which produced themes. I developed an intuitive feel for the variations at play, and I found that most expressions constellated under the ten themes listed below, although there were varying attitudes towards them:

1. Long-term patient relationships – dependency and intimacy
2. Identification with role and GP surgery as second home
3. Underpinning ethical value system
4. Satisfaction in role as clinical GP

5. Takes systemic leadership role
6. Overwhelmed by context
7. Business-minded approach to financial state of surgery and context
8. Determines own timetable
9. Family or own illness acts as motivator
10. Family aspiration acts as motivator

I have already described the initial sampling I undertook, whereby I established criteria regarding whom to interview and how to go about accessing these interviewees. The first interview that I undertook was with GP1, and following line-by-line analysis of this interview for gerunds and associations, I had some provisional categories to consider. I then gathered more data through subsequent interviews and further considered these categories and their properties. Through this process of theoretical sampling, I was seeking and collecting pertinent data to elaborate and refine categories in my emerging theory. As more revelations unfolded during the interviews, I obtained more data to explicate my categories and saturate their properties by clustering similar descriptions together. In filling out the properties of these categories, I defined pivotal qualities of the studied experience, which revealed concepts and theory from the data. I fine-tuned these categories into themes by choosing those which came up frequently, seemed particularly significant or coalesced a number of subthemes. This resulted in focused coding, which would eventually explain more than the data from which the emergent themes were constructed. I sought statements or events to further illuminate my thinking by adding new participants with different roles and workplace settings. The evolving theoretical categories became my ten themes. From early in the research process, I checked the emerging questions as I compared data with data, and I noticed three particular types of response. Supported by supervision, I remained aware of my own preconceptions and preoccupations: living in a socio-political environment under the heavy influence of capitalism, competition and individualism; the increased managerialism of statutory systems, and the simultaneous lessening of state provision; the possible reduction of patriarchal power in professions and the empowerment of patient populations through Internet access. I also compared incident codes with incident codes, and having undertaken about eight interviews, I noticed that a fair proportion of interviewees had strong but negative attitudes towards the ten

emerging themes. I was aware of the tension in theoretical coding between emergence and application, and I tolerated ambiguity as ideas, associations and constellations unfolded. But initially I found myself confused: for example, with regard to the theme of whether the surgery felt like a second home, sometimes it strongly applied, but at other times the surgery seemed to create feelings of alienation or was not homely at all. I realised that this was a position of disidentification. It was particularly at this stage that I utilised abduction (Peirce, 1998), which involves imaginative reasoning about puzzling findings and making inferential leaps. The OEIS Foundation describes sophisticated patterns and states by applying Peirce's ideas:

> *In rough terms,* abduction *is what we use to generate a likely hypothesis or an initial diagnosis in response to a phenomenon of interest or a problem of concern, while* deduction *is used to clarify, to derive, and to explicate the relevant consequences of the selected hypothesis, and* induction *is used to test the sum of the predictions against the sum of the data. It needs to be observed that the classical and pragmatic treatments of the types of reasoning, dividing the generic territory of inference as they do into three special parts, arrive at a different characterization of the environs of reason than do those accounts that count only two. These three processes typically operate in a cyclic fashion, systematically operating to reduce the uncertainties and the difficulties that initiated the inquiry in question, and in this way, to the extent that inquiry is successful, leading to an increase in knowledge or in skills.*
> (OEIS, 2020, 1.3 Abduction, Inquiry in the pragmatic paradigm, para 2)

I maintained an open-minded attitude and critical stance through triangulation in supervision. In this way, I arrived at the most plausible theoretical interpretation of the observed data: three types of GP. Using abductive reasoning, I then carefully thought through my new theoretical interpretations in relation to my data and whether they made sense. I was confronted by puzzling data, which seemed to present me with opposing manifestations in relation to the same topics. Once I could see that there was a subgroup of GPs who shared the same values and reactions, I looked for other subgroups, and this was how I discovered three types. Together with my two supervisors, who oversaw and interacted in this

process, I considered this evolution by starting from a line-by-line examination of interview transcripts, clustering repeating notions, phrases and ideas, which then became themes, and finally noticing three distinct variations of response, which we recognised as types.

Abduction makes use of existing knowledge to interpret data, but it also leads to the generation of new knowledge. I brought together the ten themes, which resulted from the process described above, with my prior knowledge of three different types of valency: dependency, me-ness and pairing. Thus, it was possible to see three types of GP relating differently to the ten themes. The first type related to their work with full commitment to the idea of caring for dependent patients within a system which needs containment. The second group of GPs could be seen to pair up with other aspects of the healthcare system in an entrepreneurial manner, creating new clinical pathways and tendering bids to deliver new and existing clinical services within a business framework. The third group of GPs were seen to operate as if they were not part of any group; rather, they were preoccupied with their own survival (me-ness). As such, they took flight from responsibility for the business of the wider healthcare system or from managing the surgery. These three types had attitudes towards the ten themes in keeping with these positions as I have described them.

Thus, I realised that under these ten themes were three different types of response, which eventually I was able to gather together according to the similarities in GPs' attitudes and preoccupations, which I then identified as three types. There is naturally some overlap, and I consider the intersections between types later in this chapter. But the hue and flavour of attitudes to GP work, the identifying traits, the language, the repeating refrains, the approach to context and patients, and common features, notions and attitudes constellated into three distinct categories of adaptation to the GP role. I observed varying levels of attachment and alignment, and sometimes negative attitudes to the themes listed above. The emergent differences related to GPs' relationship with the clinical work itself, management of the GP surgery, and the wider system of healthcare. I also noticed that commitment to the ethos of general practice was key to identifying GPs with similar outlooks, as was an outward-facing preoccupation with the wider system, such as having a visionary attitude, commissioning new

services, or contrarily focusing only on patient care in real time. The more I looked at the data, the more I could see these three constellations, and I identified the three types accordingly. From this construction of a meaningful typology, I generated further concepts and theories. A document entitled 'Three GP Types' Different Attitudes to Identification with Role and GP Surgery as Second Home' is provided in an appendix to provide a sample of subthemes that were enveloped under this main theme. It also demonstrates the different orientations towards this theme among the three types.

### *3.9 The Three Types*

Committed GPs (GPcoms) embraced the dependency of patients and a long-term relationship to the sustainability and quality of general practice, including running the GP surgery. An example of the application of grounded theory to a partial transcript of GP11 is given in the appendix entitled 'Example of Committed GP (GPcom) Transcript with Themes'. The left-hand column shows the verbatim interview transcript, the central column contains the derived themes, and the right-hand column presents the resultant abstractions. This illustrates the extrapolation of themes such as 'long-term patient relationships – dependency and intimacy', 'identification with role and GP surgery as second home' and 'underpinning ethical value system'. GP11 described his early-life fascination with medicine in his interview. This excerpt illustrates his commitment over the course of his professional life to the tasks of being a GP. In his case, this includes the role of clinician and partner. He considers the organisation of the specific GP surgery where he has always worked, and the wider NHS. Also illustrated is his experience of contextual challenges despite his commitment. He communicates his sense of devastating loss when the system is fragmented, represented by the moving metaphor of the tree outside his window being shockingly cut down after 18 years, during which time both he and his patients had benefited from its beauty, its life-affirming qualities and the privacy naturally afforded by its organic, wholesome presence. Ironically, the tree – which had both shielded the doctor-patient relationship from prying eyes and contained singing birds and the promise of new growth – was cut down with the intention of creating a garden. His

emotional attachment to and meaning of his work as a GP was movingly conveyed in this heartfelt communication.

Entrepreneurial GPs (GPreneurs) dedicated their energy and focus to creating new clinical pathways, engaging with the business side and financial viability of general practice, and liaising with various stakeholders. An example of the application of grounded theory to a partial transcript of GP1 is given in the appendix entitled 'Example Entrepreneurial (GPreneur) GP1 Transcript with Themes'. This interview excerpt makes manifest GP1's preoccupations, such as 'business-minded approach to financial state of GP surgery and context', 'takes visionary systemic leadership role', and '(dis)satisfaction in role as clinical GP'. Here, GP1 shows us his preoccupations with setting up new clinical services, submitting tenders and managing successful bids, and the relief this affords him from direct clinical work with patients as an alternative activity to the frustrations of the day-to-day running and management of general practice. GP1 thus conveys his entrepreneurial attitude.

Ambivalent GPs (GPamb) focused on patient clinical care as it presented in real time, but they did not engage in running the GP surgery or in the wider system of healthcare. An example appears appendix 9 entitled 'Example of Ambivalent (GPamb) GP12 Transcript with Themes'. GP12, a GPamb, describes the personalised shame of a broader failure. The following themes were extracted from the interview: '(dis)identification with role and GP surgery as (not) second home'; 'overwhelmed by clinical demands and administration'; '(failure of) long-term patient relationships – dependency and intimacy'. Although the GP is a public face representing the most accessible arm of care in the NHS, GP12 had insufficient resources to respond to demands, even in the face of death. This was catastrophic for this individual GP's mental health, for which no systemic occupational health approach was even available. This would appear to be a failure in the dependency of patients on the doctor, and a failure of the doctor by the context, perhaps causing an increase in ambivalence in this GP. Systemic problems appear to have become located in the individual GP, who has valency for feeling failed and rejected. Psychotherapy was at least made available for this GP by NHS provision for doctors, but occupational support had to be privately sourced as it is not an integral part of the GP system. Returning to work did not

involve a systemic review of the difficulties in the GP surgery, which left the problem positioned in the individual GP.

Table 1. Relevance of GP themes: all types of GPs

| GP themes | Long-term patient relationships | Identified with GP role & GP surgery as 2nd home | Ethical value system | Satisfaction in role as clinical GP | Visionary systemic leadership role | Overwhelmed by context | Business-minded approach | Determines own timetable | Family or own illness as motivator | Family aspiration as motivator |
|---|---|---|---|---|---|---|---|---|---|---|
| Theme number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GP1 partner for 2y | | | | | ✓ | ✓ | ✓ | ✓ portfolio | ✓ | |
| GP2 qualified 4y locum | | | | | | ✓ | | ✓ | | ✓ |
| GP3 newly qualified salaried & locum | ✓ | | | ✓ | | | | ✓ | ✓ | |
| GP4 retired partner | ✓ | ✓ | ✓ | ✓ | | | | | | ✓ |
| GP5 retired partner | ✓ | ✓ | ✓ | ✓ | | ✓ | | | ✓ | |
| GP6 partner for 8y | | | | | | ✓ | | | ✓ | |
| GP7 partner for 19y | ✓ | ✓ | ✓ | ✓ | | | | ✓ portfolio | ✓ | |
| GP8 retiring partner | ✓ | | | | ✓ | | ✓ | ✓ portfolio | | |
| GP9 partner for 4y | ✓ | | | ✓ | | ✓ | | | | |
| GP10 front-of-hospital locum | | | ✓ | | | | | ✓ | | |
| GP11 partner for 30y | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |
| GP12 salaried | | | | | | ✓ | | ✓ 1 day pw | | |

Table 2. Relevance of GP themes: GPreneurs

| GP themes | Long-term patient relationships | Identified with GP role & GP surgery as 2nd home | Ethical value system | Satisfaction in role as clinical GP | Visionary systemic leadership role | Overwhelmed by context | Business-minded approach | Determines own timetable | Family or own illness as motivator | Family aspiration as motivator |
|---|---|---|---|---|---|---|---|---|---|---|
| Theme number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GP1 partner for 2y | | | | | ✓ | ✓ | ✓ | ✓ portfolio | ✓ | |
| GP8 retiring partner | ✓ | | | | ✓ | | ✓ | ✓ portfolio | | |
| GP11 partner for 30y | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |

Table 3. Relevance of GP themes: GPcoms

| GP themes | Long-term patient relationships | Identified with GP role & GP surgery as 2nd home | Ethical value system | Satisfaction in role as clinical GP | Visionary systemic leadership role | Overwhelmed by context | Business-minded approach | Determines own timetable | Family or own illness as motivator | Family aspiration as motivator |
|---|---|---|---|---|---|---|---|---|---|---|
| Theme number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GP4 retired partner | ✓ | ✓ | ✓ | ✓ | | | | | | ✓ |
| GP5 retired partner | ✓ | ✓ | ✓ | ✓ | | ✓ | | | ✓ | |
| GP7 partner for 19y | ✓ | ✓ | ✓ | ✓ | | | | ✓ portfolio | ✓ | |
| GP9 partner for 4y | ✓ | | | ✓ | | ✓ | | | | |
| GP11 partner for 30y | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | |

Table 4. Relevance of GP themes: GPambs

| GP themes | Long-term patient relationships | Identified with GP role & GP surgery as 2nd home | Ethical value system | Satisfaction in role as clinical GP | Visionary systemic leadership role | Overwhelmed by context | Business-minded approach | Determines own timetable | Family or own illness as motivator | Family aspiration as motivator |
|---|---|---|---|---|---|---|---|---|---|---|
| Theme number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GP2 qualified 4y locum | | | | | | ✓ | | ✓ | | ✓ |
| GP3 newly qualified salaried & locum | ✓ | | | ✓ | | | | ✓ | ✓ | |
| GP6 partner 8y | | | | | | ✓ | | | ✓ | |
| GP10 front-of-hospital locum | | | ✓ | | | | | ✓ | | |
| GP12 salaried | | | | | | ✓ | | ✓ 1 day pw | | |

Table 5. Relevance of GP themes: summary of all types

| GP themes | Long-term patient relationships | Identified with GP role & GP surgery as 2nd home | Ethical value system | Satisfaction in role as clinical GP | Visionary systemic leadership role | Overwhelmed by context | Business-minded approach | Determines own timetable | Family or own illness as motivator | Family aspiration as motivator |
|---|---|---|---|---|---|---|---|---|---|---|
| Theme number | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| GPcom | 100% | 80% | 80% | 100% | 40% | 60% | 20% | 20% | 40% | 20% |
| GPreneur | 67% | 33% | 33% | 33% | 100% | 67% | 100% | 67% | 67% | 33% |
| GPamb | 20% | 0% | 20% | 20% | 0% | 60% | 20% | 80% | 40% | 20% |
| All GP types | 58% | 33% | 42% | 50% | 33% | 58% | 25% | 58% | 50% | 25% |

Tables 1 to 5 present the 12 GPs I interviewed in relation to the typology. The ten themes, which became manifest during the data analysis as described above, are represented in the table columns. The table rows present the numbered GPs and their employment status.

In a qualitative study such as this, it is unavoidable that the types are rarely, if ever, going to be represented in the sample in a pure form, because of the orientations and adjustments that also emerge from the data. However, in this case the types are sufficiently pure for differences, patterns and consequences to be clearly identified, at least to an extent. In the next chapter, I outline in more detail the three types, each with their own sufficiently distinct characteristics, resulting from the ten themes.

## Chapter 4. Main Findings

The most important finding I have identified is that there are ten themes of different kinds of adaptation to the GP environment among my sample of 12 GPs. Within the ten themes there are three clusters of attitude, which I have described as types of GP. It is from these three types that other findings have developed about how the environment has pushed GPs towards these different modes. These elements were developed from the interview material, in part inductively and in part by using abductive logic to extrapolate concepts from the empirical material. I developed a theory from the data that internal 'valencies' within each GP played a part in how their choices were made. This later led me to the idea that currently the whole system may rely on there being these different valencies, and therefore different kinds of GP, in coexistence with one another, which meets the needs of GP practices.

### *4.1 Three GP Types: An Overview*

Although these three categories are my own conceptual constructions arising from the data, I believe that they correspond to real differences in the attributes and orientations of the members of my sample. Some cross-referencing back to elements of my literature review can be made here. It turns out, for example, that my GPcom type can be likened to Drs Berger and Widgery, who in their different ways lived alongside their patients and their complex lives from cradle to grave. The material about marketisation in the literature review connects with the GPreneur, whose entrepreneurial adaptation ensures financial and systemic sustainability by interacting with other elements of the healthcare context, winning bids and commissioning services. The GPamb type can be seen as a response to the pressures described by the King's Fund, such as diminishing investment, pressures from government and the media, the imposition of a huge increase in telephone triage, the requirement to meet funding targets, outcome measures and expectations in less time, the ageing population, and increasingly complex medical technological advances and medications.

### *4.2 In-Depth Descriptions with Data Illustrations*

In this section, the three different GP types are described in detail, illustrated by extracts from the interviews. I consider the ten themes outlined in the previous chapter in relation to each GP type, which illuminates the three different styles of engagement and psychological attitudes towards general practice. Naturally, there are also some minor variations within the three types.

#### *4.2.1 Type 1: GPcom*

GPcoms have a common philosophical set of values: the humanity involved in the work, clinical efficacy, and the economic efficiency of long-term relationships with patients and their families within a structure that GPs actively support and to which they contribute. This brings intimacy to GPs' clinical task in relation to dependent patients, satisfaction in their role as GPs, emotional containment of the anxiety in the system, and a commitment to the whole as being more than the sum of its parts.

There was a question about whether some might have become so identified with the task of their role in its system that they had merged personally with the job of GP. Perhaps they had gone beyond the duty of care, and their work had become an all-encompassing way of life and the GP surgery a second home. The psychological contract of being all-providing appeared to be a fit. The stress to patients resulting from impoverishment, unsuitable housing, lack of support in the community and/or a reduction in other types of health and social care provision did appear to be putting a strain even on GPcoms. As such, their location on the border between society and healthcare certainly posed challenges, as they were either gatekeepers to more medical provision or sentries on duty to protect the fortress. For example, the incentivising or disincentivising of referrals was seen to undermine professional judgement. The removal of government funding for the treatment of marginalised groups was painfully felt and added to the feeling of heavy burden.

GP4, whom I perceived as a GPcom, described his view of different levels of attachment and investment in the GP role, which unfolded as a description that befits the difference between the GP types. In relation to being or not being a partner, he made the following comparison:

> *[It's] a bit like the difference between getting married and just living with someone. You don't have the same … maybe I'm old-fashioned in that respect. Should we say not being in a partnership with somebody where you have a joint investment in the future? Emotional investment as well as sharing bank accounts and that sort of thing.*

While many of the participants put a good degree of conscientious effort into their professional undertakings, a few were specifically invested in the role of GP and the associated tasks that enabled and supported the profession's sustainability, development and social standing, particularly within the partnership model. I refer to this type as GPcoms. Those whom I define under this category maintained a bulk of direct clinical work with patients over an expanse of their career, and yet they might also undertake additional activities that supported general practice, and they had an underpinning philosophical approach that both sustained them personally and committed them to an idea of the greater good – something of the wholesome, reliable family-doctor-in-the-mind. This kind of GP appeared to share the ethos of altruism – the spirit of the welfare state at the inception of the NHS. This interface is complex, given that the formation of the NHS left GPs as self-employed medical professionals, running their own businesses outside the NHS and yet gatekeepers to it. In this regard, a helpful exploration of the boundaries of finance and health, profit and ideology might be found in 'The Gift of Blood', a paper by Titmuss (1998), who served the British government as deputy director of the Social Medicine Research Unit at the Medical Research Council and as a member of the Royal Commission on Medical Education. Titmuss tracks evidence from the United States of a change over time, from the process whereby blood was donated by altruistically motivated donors in the 1960s – which showed few deleterious and mostly beneficial effects on the blood's recipients – to the purchase of blood, which had the opposite results: 'No matter what method of case finding was used, the lowest incidence of post-transfusion hepatitis was seen when commercially supplied blood was avoided' (Titmuss, 1998, p. 93). His

paper explores the risks of making health a profitable enterprise, at the expense of both the often hepatitis-infected destitute who sell their blood and the so-called beneficiaries, who may be initially saved only to become contaminated, with devastating outcomes including chronic ill-health, life-threatening disease and death. Titmuss makes the point:

> *If blood is morally sanctioned as something to be bought and sold, what ultimately is the justification for not promoting individualistic private markets in all other component areas of medical care, social work skills, the use of patients and clients for professional training and other 'social service' institutions and processes?* (Titmuss, 1998, p. 97)

GPcoms presented as strongly aligning with Titmuss's final sentiment, which contests 'both the death of ideology and the Philistine resurrection of economic man in social policy. It is thus concerned with the values we accord to people for what they give to strangers, not what they get out of society' (Titmuss, 1998, p. 97).

Some of the GPs in my sample of 12 conveyed a consistently socially minded attitude, similar values, and dedication, which imparted a vocational commitment. This tie to the role appeared to be constituted by a feeling that they could not think of any other job. This included an embrace of dependency; an enjoyment of human closeness and connection; a wish to understand human stories and bodies; an intellectual rigour; courage to jostle and strive for colleagues and patients; and a belief in the value of the generalist in primary medical care. There was also an inbuilt sense of what it meant to be a good GP and work for one's patients:

> *They come in with a cold and also a mole that needs sorting and they're depressed. And while they're here they can have their smear test. So, in terms of the yield of what happens in the ten-minute consultation, we are cheap as chips.* (GP7)

Within this preoccupation, some GPs were more medically minded and preoccupied with biochemistry and pharmaceutical and technological

progressions than others. But what was most striking was their holistic view of dependency – making a difference from a number of angles, together with efficiency and the good use of resources:

> *In general practice it's the whole person. And the context of that person: their family certainly, sometimes their extended family and sometimes the wider community. You have almost the freedom to roam. … It's amazingly fruitful and sometimes exciting, almost always rewarding in some kind of way.* (GP11)

GP11 also explained the fundamental core of GP work as he saw it, and the role of personhood and bearing witness, resulting in professional intimacy:

> *A lot of our work is really about witnessing people's distress and hopelessness, but there's always something that you can offer, even if it's just a bit of yourself for ten minutes, that makes people feel a bit different, and you can't do that if it's just a job in a hospital, even though you're called a GP or you're a locum.*

GP4, GP7 and GP11 were clear examples of the GPcom type. They were at different stages professionally. GP4 had retired from his inner-city GP partner role but continued as a locum and trainer, and he remained a senior member of the Balint Society, where I met him. GP11 was heading towards retirement; a senior colleague had put us in touch. Nevertheless, he carried a heavy workload: despite currently undertaking the minimum of patient clinical work and attached administrative tasks, he remained an active and creative partner who took leadership responsibilities in an inner-city practice. GP7 was in mid-career as a GP partner and a trainer, assessor and lecturer for trainee doctors. Initially determined to specialise in haematology, she described having had an attitude of disdain for general practice until she took it up for pragmatic reasons while pregnant and instantly adored it. She had responded when a GP colleague who ran Balint groups contacted his network of GP trainers asking for GPs who would be interested in being interviewed.

GP5 and GP9 were also very committed to the task and role, and to the local system of GP partnership, but perhaps less so to general practice in a wider sense than GP4, GP7 or GP11, who had become local leaders in different ways including through Balint work, training medical students, and commissioning and interfacing with government bodies. GP5 had just retired as a GP partner, which he had found '*much more traumatic than expected*', as the partnership, patients and doctor role had been deeply significant to him. He continued to be engaged in Balint work and the pastoral care of GPs, but he no longer saw patients. GP5 and I met at a Balint group training; during a break, we discussed our current interests, and I explained my research preoccupations. He agreed enthusiastically there and then to be interviewed. GP9 was a GP partner of four years; she had previously been salaried at the same practice for a similar period of time, juggling work and childcare. She revealed that she negatively compared her status and salary with those of other professions, such as law. Like some other interviewees, GP9 revealed that she had been a top-set student at school, which meant that medicine or law were assumed options. There were no medical professionals in her family, and the allure of hospital medicine came from glamourised television. She demonstrated a strong commitment to her patients' ongoing dependency needs and supported her colleagues within the partnership model. Her interview took place in the surgery, and she appeared to be well organised and pragmatic at the beginning of the clinical day.

I will now look at the group of GPcoms according to the aforementioned themes, using cross-case analysis.

*Theme 1: Long-Term Patient Relationships – Dependency and Intimacy*

In different ways, GP4, GP7 and GP11 conveyed their spirited nature, and their sense of freedom and scope for individual decision-making. However, GP4 emphasised his enjoyment of closeness, while GP11 warned against exclusive patient dependency on one GP.

Of all my interviewees, GP4 appeared to be the one who most embraced patient dependency, but he did so in a considered, reflective manner that recalled a bygone era:

> *When I started off in general practice, I said that I valued the independence, and I quite enjoyed the fact that I could roam. … Being a doctor, anyway, I liked within reason. And if I wanted to be friendly with somebody who's a patient, I could be. There would be no rules against it. … I was never very good at boundaries. … I like getting to know people better than doctors now consider proper. There was never anything improper, but … some people seem very needy, and I like them.*

GP7 had become a GP as a stopgap, to honour her commitments to her own young family; she had then grown into the role and become totally committed to one surgery, and to teaching:

> *The idea of general practice, because I was already involved in medical education, was that I would be able to work locally and flexibly for a while, while the kid was little and consultant husband was working 100-hour weeks. And then go back to what I really wanted to do, which was haematology. So I had very low expectations for general practice when I joined. But thank God I did it, as I never looked back right from the first day. I started in the practice I still currently work in. I only worked in one practice.*

GP11 conveyed an absolute love of general practice – the discipline, the challenge and the personal interaction:

> *Actually, yesterday morning I had nine really difficult patients, and I thought, isn't this brilliant? Everyone was fascinating, a challenge, people I liked or even those I didn't like, I tolerated or knew, again it felt just brilliant. To try and impart that and keep hold of that even for myself, impart it to other people.*

GP7 was more interested in her patients as people and their stories:

*I am a member of a medical humanities network. … I'm far more interested in humanity than their symptoms, if you like. I hope I address both, but most their stories and their perceptions and their lives and agendas. But also being hugely involved in medical education, designing and implementing a medical session and trying to ensure it's creative and stimulating and thought-provoking and inspiring is quite a creative process. … The humanness of working with people, that's what matters most.*

GP9 powerfully conveyed the ongoing sense of being there to contain patients' anxiety, sustain them in their chronic but stable conditions, and enable good deaths:

*It's not in one example I can think of as much as years of keeping them contained and preventing things going wrong. … Preventing those things happening feels satisfying. The people are still coming with problems, and things are still happening, but I feel we're preventing things getting a lot worse. I suppose a couple of times there's people who have died where it's gone well. That's definitely a satisfying part of the job.*

GP9 also demonstrated her awareness of the poverty and deprivation in the local community and its impact in various ways on the health of patients, as well as the social requirements to prove patients' entitlements, both of which impacted heavily on the workload of GPs. At the same time, GP9 showed that she felt reassured by being part of a team who were all part-time, but who could all rely on each other and feel sure that patients were safe in colleagues' hands. GP9 was also aware of the critical role of the practice manager in terms of gaining vital funding to counteract deprivation. She conveyed that she was both satisfied and at times overwhelmed in a general way by the amount, bulk or time of the work; she did not specify details or patient examples, but instead spoke in general terms:

*A huge amount of what we do is just hoarding uncertainty and dealing with things, looking at a test result and saying it's not quite right but I'm not*

*going to do anything about it. I don't quite know what this is, but I'm going to try this and hope for the best and see how it goes.*

She described settling down over time in terms of her confidence and anxiety management:

*More and more comfortable with knowing the patients better, which helps when putting things into context, and we have more experience of the same kinds of things happening, knowing what's likely to be the problem and what to do about it.*

GP9 used the term 'our' often and had the attitude that there was a collective comprising partners and administrative staff. She was clearly able to think about the whole system – total telephone patient access and its impact on vulnerable patients, receptionists and GPs. She spoke as a GP with experience and sensitivity towards patients, and as a partner with the GP surgery system in mind:

*[Patients] not seeming happy with the phone triage and saying I really want to come in, and when they come in they admit that they want to talk about something else that was more psychological, because they just feel more comfortable doing that face to face. We do know. We tell new starters, and we have it as part of our protocol, that if somebody really is asking to come in, even if you don't think they need to come in from what they've said so far, bring them in. Then if it's clear that they've got any kind of chronic mental health problems or several mental health problems or learning difficulties, we would have a lower threshold for bringing them in, because it's much more difficult to assess.*

She also conveyed sensitivity during the interview towards those experiencing deprivation and/or mental health issues, looking out for indicative signs and responding appropriately in relation to managing appointments. It was no surprise when she informed me that she was the mental health lead in the practice, which involved

*regular meetings with our community mental health team consultant and our lead, and my role is coordinating those meetings and making sure patients get discussed, and also making sure we hit our financial targets, which for mental health patients are boring things like making sure we've checked their blood pressure each year.*

GP4 described responding to patients' needs as an individual and how his role as a GP trainer had exposed him to the opposite attitudes towards dependency:

*I teach some junior doctors … and they are absolutely horrified. … They would feel persecuted by someone having their mobile phone number. They would feel they were being stalked, I would think, even though the phone never rang. The risk of it seems very apparent to them, which it didn't to me. … I felt I could trust these people not to abuse it. … There weren't many, but there were a few who I gave my mobile phone number to just in case. It made them feel better to have it. Sometimes it was quite important.*

However, GP11 expressed concern at the health dangers of absolute dependency – certainly for the patients, who might perhaps end up with delayed treatment and consequent permanent health problems, and perhaps also for doctors, who might become ill from being overburdened:

*It's the case with all of us partners, and we've all been here a long time, that there are too many people who want to see us and us alone for it to be easy. We've got one partner off long-term sick at the moment, and the fallout from her patients is huge, which troubles me, actually. Fallout in a sense that they just feel lost without her, and it troubles me because actually I don't think you do your patients any favours if you become that important to them. I think it's a terribly difficult balance that you work really hard to establish relationships with patients, which is ultimately the thing that gets most of us out of bed in the morning. It's not finding a rare case of serum rhubarb elevation. … I tell the story to all my trainees about a lovely woman, Greek Cypriot, didn't speak a lot of English, and I was on holiday for three weeks, and she had a retinal detachment, which if you*

*get there quickly, you can save people's sight, but she refused to see anybody but me till I got back. We saved some of it, but not as much as we would have done otherwise, and it haunts me to this day that she felt that I was the only person that she could talk to or could help her. … When I'm talking about what we as doctors do for our own sakes, because it gratifies us creating dependency, we all want to be wanted and like to be liked, but the downside of that is firstly how much you take home at night to your own and your family's detriment, but also because we're not there forever, and as this colleague's patients are finding out, and mine are to an extent, because I'm not there as much, it doesn't do for them to – I only want to talk to Dr A. Having said that, another story I treasure is of one of my patients who I'm still great friends with and had the most terrible, terrible life history. I got to know her really well, and she was talking to the health visitor, and she said I met that Dr T the other day. He's lovely. Just like Dr A used to be.*

When GP11 described survival techniques, it did leave a feeling that aspects of the current situation were unsustainable:

*We've got a salaried doctor at the moment who's absolutely wonderful but who's seeing all the [long-term sick] doctor's patients, I'm seeing her wasting away in front of me. She becomes more haunted by the responsibility of looking after this very difficult list, and I really worry. … Well, physically she's kind of wasting away. She's just becoming older before my eyes, and I'm terribly concerned about her, and partners as well who become burnt out, and I've done as much as I can in terms of – I think we've all responded by reducing our workload, dropping sessions, which of course means dropping income, and as a way of trying to stay afloat.*

GP4 gave details that fit with my notion of the family doctor who will come out when a patient is distressed and at risk. He described the way he carried the concern of a patient in his mind throughout an evening at the theatre, so much so that he undertook a night visit despite not being on duty. Furthermore, he was able to distinguish genuine patient distress resulting from physical ill-health from the usual emotional outbursts:

*I was on my way to a theatre, and I'd seen this lady earlier in the day, and umh … she had some breathlessness. … Known for being emotional and histrionic and panic calls. But somehow this sounded different, umh. … So I put my coat back on and got in the car and went round and saw her and thought that she might have some clots in her lungs, a pulmonary embolism, and sent her into hospital*.

GP4 described an idiosyncratic, personalised approach to his interactions with patients, which was exemplified in the following:

*Well, I did more daft things when I was younger. … Well … I had a number of conversations with a depressed young man, in his early 20s I think, and uh, it was very difficult to get him to talk, uh, and he said I can't relax here in the surgery. If we could have a talk in a pub I would be much better. So I said ok, and we arranged to meet in a pub, and we had a drink, and he actually talked very freely, and I got to know him much better, and … that was the only time we did that. After that he came to the surgery, but that somehow allowed him to free up a bit. … Regarding your doctor as a human being and someone you can talk to. … I did have some friends as patients, that's another thing you're not supposed to do.*

I was quite struck by this and wondered whose needs were being gratified. GP4 stood out in his descriptions of crossing the boundary to become personally involved with his patients. But his concern, sensitivity, flexibility and individualised patient care were evident, particularly when he described retiring and handing over his most vulnerable patients:

*When I retired … I handed over a group of about ten ex-heroin addicts, who were really nice people, actually, when you got to know them. And I had to see them once a month, because they couldn't have prescriptions of methadone for longer than that, and so I got to know them very well. And I felt I had to prepare the ground quite carefully for my leaving, and give them someone else for them to latch onto, as it were. 'Cause they were getting older, and they were getting more chronic illnesses, and they*

*really needed a GP, quite apart from the prescriptions. So I did find, after I left, the regime had got much stricter for them than it was under me. … They would be put on a stricter regime if they transgressed once. They would have to come every week instead of every month, and were strictly regulated and grilled 'bout what they were doing. … But I trusted them.*

Trust between patients, patients' relatives and doctors is also powerfully described in this vignette from GP11, enabled by the investment of time that in the past could be made in long-term relationships between family GPs and families through the continuity of healthcare, home visits at times of death, and ongoing dependency. Also manifest is class culture and an understanding of threats made in the context of grief and upset, such that the whole experience becomes integrated into firm human connectivity:

*A youngish man, early 40s, lung cancer, and in those days, and I say in those days because I couldn't possibly do it now, and also the whole palliative care thing has changed. But I visited him every day. Sadly it's pretty unthinkable nowadays, and he was really very much in his last few hours. His family were all around, it was a big Kentish Town working-class family, and his brothers were there, and they'd been drinking a bit, and I went up to check him over and lay on hands, as it were, and the brother came in and grabbed his brother physically and was going, 'Don't die. Don't die'. Then he turns to me and said, 'If you let my brother die, I'm going to come down with my gun and I'm going to fucking kill you'. And he meant it at the time. Because I was already so integrated with the family – not this particular brother – I wasn't scared, and I saw it for what it was and was able to try and rescue the poor patient, who was trying to die and not being allowed to, and just talk the brother down, and we became best of friends and got Christmas cards for 20 years afterwards. That felt an amazingly privileged experience. Helping people to die well and their family is something which even palliative care don't do in the same way, because they don't have the same long-term relationship. And when you've known the family well prior to that, two young kids, and I continued to support them for years afterwards as well as his widow, that's a unique position to be in.*

GP5's bias towards the humanity side of being a GP had become more of a priority in his way of working than the science part, particularly as he had developed a GP consultation on a ten-minute psychotherapy model. But as GP5 – who was exposed to much strain as a child – said, some GPs carry the anxiety more heavily than others:

> *Very high level of anxiety to tolerate No doubt about it. Especially now, it's intolerable I think. Up to now you're living on adrenaline and you often waking up at night, which you shouldn't do, you know, but you do often wake up, and you're ruminating about a missed diagnosis or something like that. It's a very fraught job … and should you admit it or shouldn't you admit it, and that sort of thing. You know, I don't think all doctors are like that, but certainly I was, and I can say my colleagues were as well. … If it was a chest pain, was it a pulmonary embolism or was it a heart attack or wasn't it, just you go through these things in your mind, and then you have to calm yourself down, literally, and then you get in in the morning and you find out everything is fine and you had no need to worry. … But it was frequent, I'd say.*

*Theme 2: Identification with Role and GP Surgery as Second Home*

GP11 acknowledged that for him, being a GP – specifically in the practice within which he had always worked – was crucial to his identity, and he believed that what this represented for him had a similar meaning for patients and local society. The use of the words 'more sensible' is interesting here, and perhaps gives voice to some disquiet about the loss of the GP's position as a social stalwart:

> *That's what I think is facing a lot of people. Some people who are more sensible than I am perhaps, or younger, haven't taken on that to the same degree and that sense of belonging, not just as a doctor, but to this place. To this practice, this group of people, this group of patients, that is really, if you can distil it, the thing that is going to be lost. People will lose that sense of place and community, which I think still, even in an area like this,*

*can make a huge difference, that the fact that you know the area, the people, and they know you gives you a huge head start, I think, in actually being able to help them.*

GP4's focus was often on the dyadic relationship between doctor and patient. Following retirement, he felt that he owed some sort of ongoing care to the patients he had induced to rely on him:

*A Jewish immigrant, Holocaust survivor, is one of four people I decided I've known for so long that I decided I had influenced them to become dependent on me, perhaps too much, and that I owed them something in return. And although I could not be a doctor to them any longer, I could be some sort of friend of the family, or some kind of counsellor, and see them once a month, just to see how they're getting on, have* a *chat, help if I could in any way, if they were having problems with medical services. So that's what I've been doing. Saw one of them today.*

We might wonder about the difficulty of giving up a job that for GP4 was such a vocation that the doctor-in-the-mind was a large part of him – he may have been identified with the role. In his description above he seemed to misrepresent the role of counsellor, which irritated me! He reflected on his relationship with dependency and his closeness to the patient who had survived the Holocaust:

*Dr Balint himself gave a sort of extreme example of a doctor who went round and cooked Christmas dinner for a patient, and that would be going too far. But my line is always dependence isn't always that bad, it can be a good thing, and hopefully it's a bridge to becoming less dependent and more independent. Rather like psychotherapy. … Someone might say that is your need that you're catering to and not the patient's, and maybe there's some truth in that. I don't know, but I feel happier that I'm doing it than if I had decided not to do it. … We had something in common, no doubt very deep in the unconscious, but that had to be there to enable me to take on this sort of thing comfortably and indefinitely. … So I allowed some overlap to take place there. Although there were other people who*

*wanted to be friends with me who I was quite clear that I was not going to be friends with them*.

A former GP partner, GP4 also found the inspection process onerous, because he felt it emphasised the wrong criteria and made a mockery of general practice – something about which the next generation were perhaps also getting some hints:

*On retirement, I am glad to be free of, I haven't even mentioned the CQC [Care Quality Commission]. … We had our first visit from them end of last year. And they just descend on you like a plague and occupy all the space and start inspecting. … The evidence that people are actually getting infections due to things not being as pristine as they might be is non-existent. Really obsessional things about the practice premises, and our experience of patient care was fine, and you know, no problems there. We got good marks for that. But unfortunately, they could not say that we passed completely satisfactory, because of these items to do with obsessional cleanliness and tidiness. If something was found out of place that someone could trip over, all sorts of health and safety gone mad.*

GP5 let me know that retiring had been a difficult and painful adjustment, perhaps partly because the investment in and commitment to the role had been significant:

*So you see we ran this small business with a great intensity. Because it was a small business, it had about a million pound budget, and then there was all the patients, and there was the staff, and we had a fantastic manager. So I absolutely loved [it].*

According to various interviewees, this context was changing for the next generation of GPs. GP11 described intimate experiences:

*Patients that come in and say, you've got a new picture, I can smell coffee. And it makes them feel familiar and held, in a way. These are the intangibles, and a lot of that you could make a case for the efficiency of general practice, and it's hugely efficient.*

But devastatingly, GP11 described the opposite situation where what had previously afforded privacy between doctor and patient was no more. This is conveyed in the interview excerpt in appendix 7, which left me feeling so upset that I had a sense of the hit to my interviewee, the system and the patients.

*Theme 3: Underpinning Ethical Value System*

GP4, GP7 and GP11 conveyed an overarching, all-encompassing philosophical position in relation to being a GP, and their internal value system underpinned their approaches to the work. GP4 and GP11 described themselves as socialists, and GP7 as an active Labour Party supporter. GP5 did not specify a political party allegiance, but he had actively avoided army conscription in his country of origin. GP9 described herself as wanting to help to make a difference politically, but as in flux in terms of party political allegiance. They all brought their thoughts about the greater good and support for the socially vulnerable into their descriptions, not only in terms of attitude and work with individual patients, but in various other ways too. GP4, GP5, GP7, GP9 and GP11 described the job of GP as either important to their identity and/or the best job in the world, and they conveyed a love of the work from birth to death, and an emphasis on doctor-patient and collegial relationships and support for the next generation of GPs. Having loved his work for the duration of his life as a GP, GP4 described what enabled sustainability: for the benefit of all, the doctor needed to maintain curiosity and interest in the patient's human journey and the doctor-patient relationship:

> *There is a problem of people getting burnout and getting disillusioned and cynical and unhappy with what they see as treating the same illnesses over and over again. Or trying to persuade reluctant people. … If you have something of Balint in you, it is sustaining in the long run … if you feel you are free to take an interest in your patients as people.*

My sample of interviewees had a heavier bias towards feeling positive about Balint groups than would be found across the GP population, because this was partly where I recruited my interviewees, as I am a Balint group member myself.

Originally set up by psychoanalysts, Balint groups consider the conscious and unconscious exchange between doctor and patient. Nevertheless, of my GPcoms, only GP4 and GP5 were much involved in Balint group work. GP7 and GP9 regularly attended long-standing study groups from their training days, and GP11 looked at his whole GP practice as a professional family.

GP7 offered an explanation as to why there might be such an investment in the doctor role, and the psychological defences involved:

> *I think doctors are rubbish at being patients. That however much we are caring and compassionate for other people in times of vulnerability, I think there's an unwritten rule that we belong to the other side. We belong to the well. And there's a crisis of identity when one becomes unwell. … Something that goes right back to childhood that I alluded to before, about being the provider of care and the strong one.*

GP4 and GP7 both described their external resources, which contributed to internal sustenance and added to the internal dedication that they felt socially and politically as well as psychologically. GP11's fascination with medical work and his socialist principles appeared to have sustained him in his past and current endeavours. For GP7, the partnership model was a crucial support, and she let me know that she felt

> *hugely well resourced, I'm very fortunate. I've got some really good partners, a very strong partner relationship team. My study group, these people I've met with for three hours, even now, and for the last 16 years, is invaluable as a resource. … So when the medical students arrive, they are made to feel very welcome and valued by everybody, as I was when I first joined the practice.*

GP9 also described feeling well supported by a study group of which she had been part since her trainee days, as well as by her GP partners and her family. She described looking forward with interest to various career options once her children had attained school age, such as continuing to be a partner but with more involvement in teaching medical students, which she found satisfying, as well as

appraisal and commissioning. GP4 described in detail how he too had felt sustained and had enabled trainees:

> *There aren't all that many training schemes that include what we like to call proper Balint groups. … I think it's part of the role of the group with trainee doctors to keep emphasising the human side of medical practice. And I say things to my trainee group that would not be necessary in my grown-up group, such as, how do you think this patient got to where he is now from where he started off? … Balint groups are very useful in maintaining the core values and reminding them that the patient is a person too, and that you are a person too.*

GP7 made the link to the broader medical landscape, and in this way went from reflecting on herself to considering the wider field:

> *I think it could be quite revolutionary, quite dramatic. I think the idea that you expect … society expects, medical schools expect medics to be caring when they are not cared for, when they have not received compassion or care or empathy, is really questionable.*

GP4 also had the reference point of his brother's experience as a GP before the NHS was created. He explained the struggle for all concerned:

> *I was interested in how the health service got started in the first place, with Bevan and so on. The BMA objected to the whole thing very much and fought it politically for a while until they were eventually reconciled. But my brother told me where there were practices with relatively poor people, they welcomed it because they were previously in a position where they had patients who were not in a position to pay their fees, because GPs had to charge money in order to get an income, and so they had to charge more to the richer people and forget about the debts of the poorer ones. … It was a business, and not a particularly profitable business, umh. This is probably going back to before the war, but I've read one or two accounts of general practice then, and one of the people you always had to engage to help you was a debt collector.*

With this historical backdrop as a reference, GP4 warned of the likely threat to the partnership model, but also the challenges of it: '*The main sort of business is run by the partners, and that's very traditional, going back to before the NHS, and the government would like to get rid of it, I think. They would prefer us all to be salaried*'.

GP11 made similar observations:

> *They [the government] have always thrown at us the fact that the BMA opposed the founding of the NHS and GPs were against it because they're losing their independence. In fact, they didn't lose their independence, and GPs are a fantastic support of the NHS, the huge majority. The notion that we don't regard ourselves as part of the NHS is insulting, but it's convenient. … It's certainly* exasperating*. They always say that managing general practice is like herding cats, and certainly temperamentally a lot of people go into general practice because they don't like the hierarchy and constraints of hospital medicine.*

In this remark, GP11 conveyed information about some of the personality types that might enjoy the partnership model for the benefits it afforded to partners: a certain amount of freedom, and an ability to influence decisions and take independent action. It seemed somewhat curious that a government that in principle expressed approval of small businesses and the entrepreneurial spirit preferred to employ salaried GPs rather than to have the partnership model. Meanwhile, socialist partner GPs felt aggrieved at the threat to break up their 'smallholdings' and the idea that they should not run small independent businesses. Ironically, government policy encouraged other businesses to infiltrate the NHS, as GP4 explained:

> *The government is encouraging this kind of … hmm, fragmentation really of the NHS, and so I was always very much against it and still am. … I think it is against the spirit of the NHS, and all sorts of people are making money for themselves out of it which seems to me would be better spent on patients. … Drug firms benefit. People who run private hospitals,*

*private patient services benefited from it, because they were able to bid for contracts for services for various kinds, and they were able to put in low bids 'cause they had lots of resources that they could concentrate on it and, hmm, as a result the private sector is a lot more involved than I would like to see.*

*Theme 4: Satisfaction in Role as Clinical GP (and Fear of Its Erosion)*

GP11 conveyed that GPs' expertise was underestimated: '*Medical students who come here – the scales fall away from their eyes when they see actually what GPs do and how much they do and how much they know*'.

In terms of the necessity of being open to patient dependency and the importance of the doctor-patient relationship, GP4 placed this at the core of his value system both personally and professionally. He described his great satisfaction in such attachment as it was happening, and also when looking back on it following retirement:

*The pleasure about it, as you know, is knowing people for a long time, over decades. I think when a patient appreciates the fact that you've known them for a long time, they feel they know you. It is nice to be appreciated in any job you're doing, but if people come in. … People were doing this when I told them I was about to retire, that they remembered episodes in their lives where they feel I had done particularly well for them. I don't know if I had done or not, but that was the impression that I'd given them, something that had made them feel better, or referred them in the nick of time. I'm aware that people's recollection of this may be a bit rose-coloured, but it's nice all the same to feel you've done some good.*

GP9 conveyed a sense of pride and attachment to her work:

*Occasionally, when I've felt really stressed with work and thought about quitting or doing something else, I thought that the loss of that part of my*

*identity I think I would find difficult, because it does feel something I'm proud of and something I feel is part of who I am.*

GP5 conveyed a sense of satisfaction:

*I will finish my career, and I'll think I'm one of the luckiest people, to have spent my working life doing a job like this. Because it was so thrilling, you know, and so rewarding. … I joined the practice in 1990, and it was pretty apparent to me soon after that that it was the right choice, the right career for me. I think I just totally loved the human interaction and helping people. The sheer intellectual excitement. … You know, it's a great mixture of science and humanity. And somehow that just appealed to me. You're dealing with a huge variety. It was very adrenaline-charged, it was a very exciting job in many ways. But I also felt I was not cut out to be a specialist in a narrow field. I much preferred this wide open, cradle-to-the-grave stuff.*

GP7 described the revelatory discovery of the depth and breadth of GP work building over time:

*Hugely crucial issue of continuity of care that GPs provide. And that seeing somebody only for a brief moment of time over a long period of time, building up a database of not only who they are but also how they fit in within their family unit, their wider community, their culture, and all that knowledge informing what you do with them and what's right for them and working well for them was a whole window on medicine that I had not got before … about being a GP is being in possession of patients' records from cradle to grave.*

GP7 also conveyed the power of the patient narrative: being able to make sense of their presentation via the medical history and knowledge held over time by a GP, which flew in the face of the medical superiority of hospital consultants according to the hierarchy conveyed in medical training:

*When you see patients in haematology or A & E context, you don't really know why they are tricky. Except you know they are vulnerable at that*

*time. But often if people are tricky in general practice, and by tricky I do mean anything from challenging to not engaging to aggressive to self-medicating with drugs and alcohol. … It's all really there for you in the biography of their life, which is the GP record of everything that has gone before. And with that comes huge understanding of the things that affect us.*

GP4 stated on the one hand that he did not feel that the relationship between GP and patient had changed much over time, but then stated that there was now an idea of what was proper within specified boundaries. The value GP7 placed on relationships with patients and GP colleagues was most evident in this statement:

*The time I realised I was directly called somebody's doctor stands out as a massive privilege. … They didn't belong to you as patients, you belong to them, that I was somebody's doctor. I think the second thing that stands out very early on is the positive formative relationships in the practice. … And the discourse we had at lunchtime about all sorts of things, the power of diagnosis, giving a diagnosis versus withholding it.*

GP9 did not give specific examples of striking situations, but rather a general sense that spending a few extra minutes with patients was worthwhile, even if it was stressful and something of a struggle at the current time:

*Sometimes, when you've spoken to them for a couple of minutes and thought 'I think you need a bit longer', and you've spent a bit longer, and although you're more than half aware that there's hundreds more ringing and you're adding to the stress of your day by spending time with this one person, it's sometimes just doing that which feels really useful. … At the moment it feels like there's fewer times when it feels like it's really a good, standing out in my memory, a good example of being a GP, because it does feel that there's just so much of the keeping up with everything, with the demand, that there's not enough time to do things well.*

GP5 described the pivotal moment when he committed psychologically to GP work after the satisfaction and enjoyment he had felt while treating a patient and helping him to understand his health condition:

> *A truck driver pulled into the surgery when he was having his first migraine, and he didn't even know what a migraine was. ... And I just remember the intense pleasure I got out of just sitting him down, explaining to him what a migraine was. And it was at that stage I really knew it was right for me.*

GP11 passionately conveyed the inspiration he had felt at the outset, and a desperate attempt to hold onto what he valued:

> *I came here as a medical student … and was inspired by this practice and … said I just have to work at this practice. Decades in this practice – its ethos, politics. It was a very left-wing practice. It was one of the first health centres in the country. It certainly was one of the first primary healthcare teams, so there were people, social workers, nurses, physiotherapists, doctors, students all working together, having coffee and lunch together, and it just felt this was a real team. … It chimed with my politics, my view of how healthcare should be delivered. … I've spent a huge part of my professional career trying to keep the extended healthcare team together in the face of cut after cut and change after change. … We were down to our last student health visitor, who was about to leave because she was carrying the whole practice.*

GP4 described a '*feeling of independence, which was one of the things I liked about being a GP*', and a sense of apprenticeship in the old days. He commented on the impact of the flattening of the hierarchy, and its implications for others in the form of ambivalence about responsibility, with a resulting shift away from being a GPcom among younger doctors**:**

> *In the first couple of decades of the NHS, partnerships would take on a new doctor as an assistant who was paid a salary, because they did not feel like sharing their profits with him. But they would sweeten this by saying it's an assistantship with a view to partnership, which means that if*

*the doctor proves satisfactory after an unspecified period they might be lucky enough to be offered a partnership. But now things have turned around the other way rather, because young doctors are less keen to become partners now. Ok, they may get a bit more money that way, but they don't want the responsibility of running a business and commissioning and negotiating and this kind of thing. So they prefer to be salaried. … [They] don't stay very long in the same practice, they may move around after a few years.*

GP4 illustrated the implications of changing attitudes and reduced investment personally and professionally, with the resulting pattern that there was little desire to be a partner or even a GP at all:

*For a time there was a shortage of partnerships. These things are always going up and down. Then when a cohort of doctors retires, suddenly there are partnerships open. And when they get filled, you have to wait longer. But now anybody who wanted a partnership straight away would be welcomed. They might not even be competed for, because there is a shortage of GPs.*

GP4 altered his analogy: where before he had compared GP partnership to marriage, he later compared it to living together with commitment – possibly as a result of picking up something from my unspoken emotional response. In this way he demonstrated an ability to update himself to stay in keeping with current cultural norms, an ability he also demonstrated during the interview in relation to patients' use of the Internet when trying to understand their symptoms. Perhaps we might surmise that his stance was not based on a nostalgic sense of wanting the old ways to continue, but rather had a foundation in a deep ethical base. From his remarks, we get an idea of GP4's value system – the satisfaction that came from committing oneself personally and professionally to one's GP colleagues, from the ongoing relationships with patients, and from running the GP surgery itself and adapting accordingly:

*People come in sometimes having looked up their illness on the Internet, and they probably know more about it than you do at that point. And you*

*are then in a position to advise them about which websites are actually worth looking at and which aren't. And as we have computers on our desks, which are online, you know, we can … you can look up the site that they are telling you about and whether it is any good or not. So it does have power for people, and it needn't be offensive to the doctor of patients taking that interest.*

GP9 was a supporter of the partnership model, although she did describe inequity within it. Her message seemed to be that when it worked, it worked well and could enhance team creativity and continuity of care for vulnerable patients, as the GPs provided shared patient knowledge and containment by working in subgroups:

*Just in general being a partner makes being a GP and a partner a lot more satisfying, because I have a say, and I have an input into how anything in the practice happens, so although I can't affect the targets and the way they've been set up within the practice, I can completely decide how we implement things, and that's very satisfying – we're quite a forward-thinking practice. … Micro teams is a project we started a few years ago, which is to try to help with that cross-cover when the usual doctors are not in on certain days, and for the particular core patients that really need continuity, that we've divided into teams. So there are three teams amongst the GPs. I'm in a team with two others, and we cross-cover the week, so any day that I'm not in, one of the others is in, and we have a core group of patients that we know of each other's patients. … We're trying to break into lots of little work groups.*

GP5 also encapsulated the joy and efficiency of a working partnership despite various struggles, and the risks and penalties he had witnessed and associated with its erosion:

*There's something about that family atmosphere and the mutual dependency and the commitment to the practice that is the bedrock, I couldn't say that too much really. And that's being significantly eroded now. The partnership model is not the one the government particularly wants, and there is the complete failure. I mean, I once had to appraise*

*four doctors whose practice had been taken over by the PCT, and none of them knew each other, none of them cared. They just wanted to come to work, do the job, get paid and go home. There was no cohesiveness, there was no team spirit. … And there are constant complaints about salaried doctors, that they don't have a commitment to the practice, don't take a proportional part of the workload, don't have that commitment, so the way things are happening now, things are moving more and more towards salaried doctors.*

GP5 expressed the attachment between partners and the daily contact, although his focus was on his internal psychological maturity, which he had developed sufficiently through his own psychoanalysis for this to become possible:

*You see, our practice was pretty unique, I think, in terms that we [GP partners] met up every single day for 25 years of our working life, during the working day, around the table at 11 o'clock in the morning, and we bonded over many years. And we discussed cases, whenever we got too worked up about things. … We absolutely loved each other, it was an incredible thing. And being an appraiser and now being in pastoral care, I can tell you it is just rare. You more or less see the opposite in practices. Failure to communicate and hostility.*

*Theme 5: Visionary Systemic Leadership Role*

GP4 and GP11 let me know that there were no longer affiliated professionals such as physiotherapists and social workers with whom to share expertise and patient needs, or with whom to have lunch; nor were there reliably attached, identifiable health visitors to pick up and identify struggling young families. GP11 showed me the great lengths to which he went to maintain the extended team and practice ethos that had attracted his loyalty and commitment from his days as a trainee onwards. He also described political games:

*We were down to one student, who had just qualified and who was about to leave. I managed to get a grant from a city livery company to pilot a*

> *project. … I had a particular interest in safeguarding, child protection. From there we built a proper health visiting team. … Again, it was recreating that multidisciplinary approach for health and social care. … Communication between social workers and doctors … is absolutely key, certainly in terms of child protection. So we had this amazing team, which was crawled all over by external appraisers, and the model was regarded as being so key that it should be rolled out, and the PCT who were the authority at the time commissioned this report to evaluate us and then suppressed it because it was inconvenient, refused to publish it because they couldn't afford it. So I managed to get hold of a secret copy, otherwise I would never have known.*

GP11 suggested a fierce protection of his professional family, like a father desperately trying to hold everyone together; but in the end he described the defining principle of the GP's clinical task: '*I had successes … [but] … the consultation, the conversation, is your key diagnostic tool, and it's your key therapeutic tool. It's not reaching for a prescription pad or investigation or a referral. It's having a conversation*'.

GP4 also explained the impact of collegial relationships on patients, and how his own professionalism and case coordination was now questioned:

> *But the loss is that you don't know the person your patient is being referred to any more, and you don't get much in the way of feedback. … A committee for commissioning just decided that they would save more money by having the service contracted out, rather than paying for salaries for individual people in individual practices, and if you wanted to send a patient to see a surgeon, for instance, originally you wrote to them and they got an appointment and that was that. But now your letter is intercepted by a referrals committee, who has a look at it and goes well, that one's ok, but surely this one the GP practice could have done more by non-surgical methods or something that does not involve a specialist. … If I, taking my line from my patient's preference, referred somebody with a skin rash that I couldn't work out what it was all about, I would tend to refer them straight to the consultant, because I knew they were likely to*

*get there in the end anyway. And some of these were politely returned to me saying please can you not refer to the consultant at this stage?*

GP4 alerted me to the reality that his idiosyncratic way of relating personally to patients was managed differently in medical training nowadays:

*Yes,* p*art of it is the climate they've grown up in. They are taught and told a lot more about medical ethics and the General Medical Council. They come out with lots of principles about how to be a good doctor, which include quite a bit about boundaries and not stepping over them.*

On the surface, these sound reasonable and perhaps even commendable attitudes, but GP4's tone suggested that they were more about following a protocol than about being an open, warm-hearted GP who took up his or her own authority, which GP4 linked to being less anxious:

*And I also think that … when doctors get outside the hospital, they feel a bit vulnerable on their own. Whether this is something more to do with being young and inexperienced or a big cultural change … I'm not sure. I think … I think it's a bit of both. … They do loosen up a bit when they get into doing general practice, and doing it for a few years, they realise they are human, and they can be a bit more outgoing towards patients.*

GP7 also conveyed the efficiency and efficacy of the work over time. She seemed passionate about conveying to her GP trainees their vital *raison d'être* and how an informed approach would result in competent medical and financial models:

*Evidence about efficiency from continuity of care is you are less likely to refer, you're less likely to investigate people unnecessarily, you're less likely to prescribe if you know that person. So apart from the relationships and the trust and the longevity and the holistic care and belonging to somebody, it actually is a very efficient model. … It is only financial models that make a difference to our political policy … so that's important to stress. It's not just me enjoying my job.*

This seemed to be particularly the case with complex patients: GP7 presented in a calm, reassuring manner, and she described the benefits of the seasoned doctor located in one practice over time for doctor and patient alike. This was what she told her trainees:

> *Two things happen as you get older as a GP. One is patient might have seen me 20, 30 times. … There's a huge lot of forgiveness there, because we've known each other for a long time … they know I'm generally on their side. Whereas when you meet them for the first time, they don't know that about you. … The second thing … so generally, seeing long-term complex comorbidity patients who have chosen you as their doctor, it's easier to get it right with people like that than when you're meeting people for the first time, when they don't know your style and they don't have a database of experiences of you and don't know you're on their side. And haven't decided they like the way you do things.*

GP7 had considered her changing role over time, and as a GP trainer she was in a context where she could test her own hypotheses:

> *So even in the 16 years I've been a GP it's changed. … Patients consult more often. The culture we live in means quite a lot of them want to be seen immediately and don't want to wait. They want to access care through computers and telephones, rather than in person, 'cause it's convenient. They are far more likely to, I haven't had any so I don't want to tempt fate, complain when they think something has not gone right. In amongst that, the change in expectation of patients, they have access to as much information as I'll ever know about symptoms and conditions. Three clicks on Google. So information isn't power any more, patients can find out all they want to know about the causes of a cough on the toilet. … So my role is far less about provision of information, if you like, and much more about … working with the person behind the symptom, trying to understand what works for them, rather than having a big encyclopaedia of knowledge of all the facts in my head. … And of course, general practice has changed 'cause patients are discharged earlier from hospital, patients are ageing, the complexity and chronicity of illnesses is growing, and the*

> *amount of work that used to be done in hospital clinics that used to be done when I was first a GP and that is done as part of our day work in general practice is exciting, but means the demands on our appointments are huge and greater still. In amongst that time we've taken on this QOF [Quality and Outcomes Framework] stuff.*[4]

GP11 could be described not just as being committed to patients from cradle to grave, but also as having quite a socially entrepreneurial approach to medical systems. He let me know how much he juggled as a result of his taking responsibility in such a holistic way, despite being close to retirement:

> *I had a lot of involvement with a local medical committee with the CCG in its infancy, I chaired a provider network, which was an organisation of GPs trying to bring all practices together in the locality, so I did quite a lot of stuff outside the practice.*

He helpfully put the organisation element into context:

> *This triangle, I see it in my head all the time, and I look at what's going on in the practice and how to change it. You've got quality of patient care at one corner. You've got the viability of the organisation, whether it's as a business or just as a functioning organisation, at another point, and then you've got the quality of life and resilience, work/life balance, call it what you will, and the practitioner on the other. And if you try to change any one of those, it impacts on the other two. And so whenever you think about a change, yes, we could do this and that would make it a lot better.*

GP11 presented a picture of himself not only creating new systems but also desperately attempting to recover what had been in place at the start of his career as a trainee GP, in the one practice where he had worked his whole professional life:

[4] The Quality and Outcomes Framework is a system for performance management and payment.

> *We won prizes, I can't remember what categories they were. Nothing major, but it was quite a rated venture. That was to try and get back something of what this place had been when I came here as a medical student, and since then for one reason or another they'd all gone, and now we don't have any health visitors based here at all.*

GP11 gave me a real sense of trying to keep the baby of the NHS from being thrown out with the bathwater when he described care for infants and their parents:

> *We just have one designated health visitor, and they have a corporate caseload, so they see families from other practices. Lots of different health visitors see our patients. We don't know from one week to the next who our health visitor is going to be at the baby clinic, and whereas we used to have two baby clinics a week where people could drop in, get their baby's weight, talk to the health visitor about feeding and sleeping problems, and that's where you pick up all your vulnerable families.*

This really conveys this GP's experience of a break-up of dependency and nurturing in the NHS system. The concept of continuity of care from cradle to grave is already fragmented at the point of birth, as the NHS health visitor – whose role it is to respond if infants and parents are struggling – will not be holding in mind the development or deterioration of the same cases across time. This might even act as a metaphor for the NHS itself: GP11 was desperately attempting to give cardiopulmonary resuscitation to a collapsing health system whose heart was failing.

GP11 similarly held in mind and nurtured the system that was his own family: '*My average working week is 40 hours, but Fridays is sacrosanct. I look after my grandchildren, and I don't do as much work as I used to do at the weekends now*'. This made me think about GP11's own value system and integrity as a consistent thread throughout his private and public life, and also about how his entrepreneurial attitude had enabled him to understand the ever-changing healthcare model and what was needed for practices to survive.

*Theme 6: Overwhelmed by Context*

GPcoms clearly articulated intense pressures from the context, including:

- clinical targets that invade clinical appointments
- the pressure to become a big practice
- the need to be political
- the healthcare system not being fit for purpose
- the tedium of commissioning audits
- a funding methodology that is skewed and inefficient
- the social environment and its negative impact on patients' health
- the huge burden imposed by the increase in phone appointments
- problems of pay, status and lack of public respect

GP4 encapsulated his belief in the strength of professional individuals in role, but also their political inaction – and its costs:

> *GPs are pretty resilient on the whole. We've been through so many changes of administration in the last 40 years. But the core part of the doctor-patient relationship does remain. That is quite strong. It might overcome all these attempts to change it. … We've just let it happen. And I would blame myself as well, among other people, you know. Being a political activist is quite a time-consuming thing to do. … Got to be in a lot of activities that are fairly repetitive to have a chance of influencing people politically.*

GP7, GP11 and GP4 also described wanting to carry on working while they noticed those around them retiring early or being subsumed by GP surgeries that were forming large conglomerates. GP7 said:

> *Well, I hope to remain a GP as long as I can stand up. I hope to resist the pressures that are turning a lot of GP practices into big practices where patients are never seen by the same doctors but by huge numbers of salaried doctors who come in, do sessions and go home.*

GP11 said:

> *I think I'm the oldest GP in my area now [late 60s]. That's quite old, but the 70- and 80-year-olds have long gone, and people are now just counting the days till they can get out. Most people are getting out before they are 60.*

GP11 also complained about the target culture:

> *There's a difference between accountability and performance management and also target-driven work, and a lot of the work that you now do is driven not by the patient's agenda, which is what you're taught to address, but actually by the agenda that the GP has. I can't go into a patient's notes without lots of pop-ups coming up telling me what I must do in order to achieve this or that target.*

GP9 clearly conveyed some of the challenges in the current healthcare system, and suggested that it was not fit for purpose for those in most need:

> *At the moment the relationship feels a little bit more pressured, because our time pressures are now so much. Which makes us feel more pressed whenever we're speaking to or seeing our patients, and I think we feel that our patients feel that as well, and some of them are unhappy with that. … Our system is great for a young, fit, working person who just wants to be seen that day and be in, out quite quickly, that's great, but for the very tiny number of our patients who are actually the majority of our workload, it doesn't work so well. … So the ones who really need our time and headspace to concentrate on them, and who value actually just the contact with us as part of the therapeutic intervention, I think some of those are starting to feel that they're losing that, and we feel that we're losing that, which is a really valuable part of what we do. … I offer very little by just sitting there and spending time with them and talking to them and thinking things through with them. … Empathy, which also feels like it's being*

> *squashed. … I've found it quite difficult at first to get the idea of there just being a never-ending workload, but there is nothing you can do about that.*

GP9 described her commissioning role, undertaking audits and report-writing as somewhat tedious, and she explained that she could have had more influence: '*When you have more input it makes things a bit more satisfying, but I'd have to do so in my own time*'. She conveyed that prescribed targets might cause GPs to ignore non-incentivised issues, and might result in patients feeling that the GP's agenda dominated at times. Nevertheless, she also insisted:

> *On patients I think it has a positive impact. I didn't work in general practice before the new GP contract came out 12 years ago, but I know that's when the targets initially started, and since then they've been changing. There are lots of new ones, but in general I think it made a huge difference to overhauling general practice systems and actually incentivising practices to more proactively address health promotion and current disease management in a way that wasn't really done before. I think in a lot of ways it's a lot better.*

However, GP9 was clearly aware that the funding methodology was seriously problematic, skewed and insufficient:

> *You get paid a certain amount per patient per year, but they can contact you as many times as they want to in that year. You don't get paid any more for that. And having the ability to put in more time with people, that need still isn't incentivised anywhere, and that's where we're feeling we can't do everything. We've got too much workload … and we have to squeeze everything.*

GP9 was thoughtful about how to define the issue and was specific about how she saw the problem:

> *People with lots of medical problems, sometimes mental health, vulnerable, sometimes just complex for some other reason … a few hundred patients out of our 11,000, who probably take up 95%, or a huge*

*proportion of our workload … they're a frequent attender. … Years of knowing we need to try and work on this group, it's not been overtly incentivised in any way, so if we're going to work on it has to be in our own time.*

GP9 described the impact of the social environment on patients and therefore on the practice, and the way GPs were at the interface between patients and the government:

> *Huge lack of housing in this area and huge amounts of overcrowding, so we're constantly asked to write letters for patients to help them get up the housing ladder. I think that's getting worse, because there are more people moving into the area, there's just no new housing in this area. … Benefits appear to be being cut. … A lot of our patients who have been on long-term benefits for a long time are being asked to go for assessments and being told that they're fit for work, even if they seem to be people we would have quite happily said they're not fit for work, and that's a difficult area in itself. We get an awful lot of requests for people wanting to be signed off sick just because they will need the benefits, and that's better than Job Seekers' Allowance, and they don't want to have to apply for jobs all the time – which means trying to balance being a patient's advocate with some kind of responsibility towards the overall finances of the government.*

GP9 conveyed how exposed GPs were while other social provision was being stripped back:

> *The other area it impacts on our workload is that we're far more available than anyone else at the moment for them to see, so anyone that can possibly help them with any of these things, like a social worker or the Job Centre or the benefits office. … So we get an awful lot of phone calls, contact just because we're here. … It does cause distress and anxiety and unhappiness.*

She described the pressure on GPs to come to work and sacrifice their own health due to concern at the load they would be putting on colleagues, rather than out of worry for their patients:

> *If I'm unwell I'm quite likely to come to work anyway, because we're just so busy and short all the time that all of us, I think, the sickness absence amongst the doctors here is miniscule compared to admin staff … which is at times quite high, and at times that's reflective of the stress that they're having. But with the doctors, it's even when we're having a lot of stress we just don't, because we feel so guilty of what it does to our colleagues*.

GP9 helped me to understand how the strain on the individual practice system and its impact on individual GPs compared with the previous model:

> *Because of our telephone system, if you're off, the workload doesn't go down at all, it just is divided between fewer people, whereas in the old system, if you were off sick, all the patients that you'd see that day would be cancelled, and it wouldn't really impact on the workload for others, except there might be a few that needed to urgently be seen. … Luckily none of us actually have got too many health problems and are fit enough to cope with coming in when we've got coughs. … I think we all recognise that it can easily lead to burnout, that level of inability to be off.*

It would appear that there has been a lessening of dependency in the wider social system, but an increase of it in GP surgeries. But there is no financial recognition of this. GP9 described the previous six months and her pending maternity leave as a mentally helpful break from work, with minimal contact. But recruitment during her absence was something of which she was aware:

> *One of the difficulties we're having is with recruitment of staffing. … We generally don't have a very high turnover of reception staff, but when we do lose people and we do need to recruit, in the last few years we've found it more difficult to find people who don't leave. Certainly, recruiting GPs is very, very difficult the last few years.*

The wider system of GPs and trainees got to hear about the nature of particular GP surgeries, and they were mostly avoidant of salaried posts and partnership roles:

> *We know the qualified people are just wanting to locum because it's a lot easier, better money and less work than being a permanent doctor somewhere. They come in, they see their patients and they go, and they don't have any of the extra admin. We worry that word has got out that our practice is very busy and works our doctors very hard, and we know that from talking to our salaried doctors that they feel they are worked very hard and they are under a lot of pressure, and that the trainees in the area know that.*

There were three aspects that she conveyed which were demoralising: pay, status and public respect:

> *To ensure that we're able to maintain our current staffing levels and to give them pay rises every year, we partners stayed the same. I've certainly never had a pay rise since becoming a partner. So in the last four years my income has stayed the same. … We will never have enough coming in to be able to ever justify increasing our own pay. It will always stay the same or go down. But what I feel unsatisfied with is not so much how much I earn as the potential for earning any more, which is probably almost none. I think that's partly the government doing that on purpose to try and control us better, and with teachers. … A steady decline in general public perception. … More demanding of people coming to you and saying this is what I want you to do, rather than coming to you for an opinion and you coming to a shared agreement, and less of a valuing of your training and experience. … Although polls show that doctors are more trusted than politicians.*

She was aware of the stress in the wider system that had become lodged in administrative staff, and the difference between that subsystem and GPs:

*Admin staff as well. It's a very stressful job, and they have to cover a lot of each other in the same way that we do. And there's sickness absence. The few people that keep turning over, we have most people in their roles, and that has an impact on the rest of them. Whereas at least with the doctors, although we're struggling to recruit, when people come they largely stay. I think that makes it easier to work with each other, whereas the admin staff have a little bit of constantly having to train new people and then losing them. … They have patients angry and shouting at them in reception. That is very stressful for them. Most of them have been with us a really long time and feel very supported by us and know they can call somebody down to help and that we will always have their back, but at times when it's really busy, that's when it's more difficult to feel supported*.

GP7 had an in-depth view of the changing environment in the wider healthcare setting and its impact:

*Competition in healthcare has affected patients in a negative way. I think it has destabilised secondary care trusts, because they don't know if they will be commissioned to do patient operations next year, and that makes them very unstable. I think this notion of patient choice in healthcare and competition between providers is very destructive and has allowed private provider to emerge. There's an awful lot of money wasted in commissioning by people putting in bids and tendering for services. … The idea that health is a commodity that you can trade in and can be run by private providers for profit is spine-chilling, to say the least. And the people that it is really easy to make profit on are those that you can measure. So all the people who don't vote, all the marginalised people we've been talking about, don't get prioritised.*

*Theme 7: Business-Minded Approach to Financial State of Surgery and Context*

GP11 conveyed both his aptitude and his passion for the enterprise that was general practice, but simultaneously his despair at its decline, with his efforts exalted and then discarded by authority figures. He was the only GPcom who

was so directly and extensively involved and preoccupied with these wider issues which I discuss further in the section about complexity. He pieced all the component parts together to help us understand the business perspective and the impact of staff churn and patients' attitudes:

> *QOF and all the enhanced services account for 30–40% of our income, and if you don't do it, and don't record that you're doing it, you don't get paid. Huge number of practices are becoming non-viable because basically the goal posts move all the time. The targets increase, because we can't recruit a practice nurse [and] … if you're practising in Muswell Hill … you'll get lines of elderly people walking dutifully up … for our flu injections. You can't do that around here.*

GP11 appeared consistent in his underlying motivation for tending to the business side of the equation, which was care for patients by a cohesive staff team working as a group, offering preventative medicine and supporting well-being. He did not speak as an entrepreneur detached from this. However, he did consider the discrepancy between GP training and the demands of the GP role:

> *I used to go to the national conference every year, where you put motions which when debated on become policy. Rather tongue in cheek … my speech was all about we don't tell trainees about P60s and how to put a business case in and how to run a portfolio career. What we're teaching them is how to talk and listen to people.*

He was also acutely aware of the healthcare context:

> *Instead of having primary and secondary care, you have accountable care organisations, where you bid to provide an overall service where what you get paid is outcome-based, and the whole system is contained with a responsible provider coordinating primary and secondary care to manage the health of the community. In practice what that means is that at the acute trusts in the future, not yet, because there's not enough money in it, could be Virgin or Aviva or whoever will be given a contract to provide primary and secondary healthcare to a defined population.*

He also helped me to understand the way hospitals and general practice were currently fighting for the same resources and patient contracts in order to survive. He described how practices were being forced to group together to provide planned care services, sometimes forming super-practices of 300 doctors. These super-practices had a pooled management and human resources department and a smallish number of equity partners, who mostly had salaried doctors working for them, along the lines of big law or accountancy firms:

> *What you're tendering here is actually people. I want a bit of this person. I'll have the COPD [chronic obstructive pulmonary disease], you have their diabetes, and I'll have their physio. … So you're bidding against hospitals, other community trusts, private organisations, bigger practices, bigger practice configurations, so-called confederations, for a piece of the action and of course the patient. Because [hospitals] have got surplus real estate, what they can do is change the notices on the door, Department of Primary Care, and charge a bit less for it and it's the same thing. You then make sure that all the investigations come to you, the referrals come to you, the operations come to you. So you've got your captive market. And they've got control of what they see as the budget for general practice, and what the government have got is they're only having to deal with one organisation instead of lots of independent ones.*

GP11 had an impressive grasp of the current tensions and momentum that were creeping under the surface. The direction of travel as he described it suggested an eventual outcome of the commodification of patients, and perhaps doctors, in a healthcare system based on neoliberal political strategies. GP11 offered a description of the entire primary care/secondary care tension, the likely winner being the latter because it had the most real estate. Secondary care would then become the ultimate controller, with a monopoly on its captive patient population.

*Theme 8: Determines Own Timetable*

Two of my GPcoms had retired, so here I consider their descriptions of their working lives as partners. All the GPcoms described very busy professional working lives, constituted of a myriad of demands over which they had some autonomy in terms of what initiatives they instigated or joined, how they structured their time, and how many direct clinical hours they contracted to undertake. Clinic times were predetermined but mostly extended according to need, and a high minimum was necessary to be a partner. GP7 described something of a portfolio career, including teaching and assessing medical trainees. Additional time was given to Balint and study group activities.

*Themes 9 and 10: Illness and/or Aspiration as Motivators*

Among the interviewees, motivations for being a doctor came from: childhood illnesses, and good experiences of receiving medicine; caring deeply for an elderly relative; having to be the 'good girl' in the family, and to look after – and be successful for – a vulnerable mother; or being fond of a pet. In addition, there was also the motivation of becoming a doctor in order to avoid being a patient, as GP5 states:

> *I was terrified of going to doctors … [a terror] of being invaded, of being killed even. You know, it was a serious thing. So a lot of talk basically in psychoanalysis was that instead of finding my own GP, I actually became one. I got appendicitis a couple of years ago. I sort of knew what it was and just calmly left my house, I walked down to the hospital, which is a minute walk away. Checked myself in, had the scan, had the operation, stayed in hospital for a few days, then out again. I might have died five years or ten years earlier, because I might not have gone to the hospital.*

GP5 clearly described how he was enabled by his psychoanalysis, and conveyed that he had developed '*a reputation for being a very humane doctor, you know, someone who genuinely cared. So that was what I found important*'.

GP5 also drew to my attention the person of the doctor and the way too much private trauma or grief could result in a self-protecting retreat from the role. In a similar way that family illness had motivated him at different levels of conscious and unconscious preoccupation to undertake the work to become a doctor, a premature death from a nasty form of dementia in the family might have equally prompted him (perhaps alongside guilt at his own absence and powerlessness) to lose compassion for elderly people with dementia, and even to feel contempt for their families' attempts to keep them alive:

> *We used to have an old people's home with a lot of dementia, and I couldn't face it any more. … And I just used to go into this home, and the spouses were desperate to keep these ghastly demented people. … I didn't have sympathy with them any more. … I haven't really given this one a lot of thought, to be honest, but it may have a lot to do with not being able to face it. My relative had Lewy body dementia, which is a very nasty thing. … It was an extremely unpleasant death she had for the last two, three years with the progressive neurological degeneration.*

#### *4.2.2 Type 2: GPreneur*

During the interview process, some GPs described a combination of medical expertise and entrepreneurship. I refer to these as the GPreneur type. They revealed a flair for thinking systemically about patients' needs and finding innovative ways to respond clinically to their local populations given current local medical resources. They demonstrated an ability to take creative action with a particular patient group or clinical need in mind. They made medical provision available by setting up local or national services in response to patients' needs where there were current gaps. During my interviews, I came across a few GPs who described their way of utilising local and national knowledge, connecting and linking them meaningfully to provide new medical services, and pooling and disseminating resources and training in order to offer a locally commissioned service. The way these GPreneurs were able to utilise their medical knowledge, power, influence and status in their roles as GP partners, commissioners and

members of consortia, in close proximity to patient need, had clearly changed clinical provision.

For some, the motivation to operate as a GPreneur seemed to have taken over from their original interest in being a GP and may have overlapped more with a business entrepreneur's outlook, with an emphasis on attracting funds into the GP practice. For others, being a GPreneur appeared to be in the service of a commitment to their ethos and wish to sustain general practice as a public institution, which perhaps made them more like social entrepreneurs:

> *The critical distinction between [business] entrepreneurship and social entrepreneurship lies in the value proposition itself. For the [business] entrepreneur, the value proposition anticipates and is organized to serve markets that can comfortably afford the new product or service, and is thus designed to create financial profit. … The social entrepreneur, however, neither anticipates nor organizes to create substantial financial profit for his or her investors – philanthropic and government organizations for the most part – or for himself or herself. … The social entrepreneur's value proposition targets an underserved, neglected, or highly disadvantaged population that lacks the financial means or political clout to achieve the transformative benefit on its own.* (Martin & Osberg, 2007, Shift to Social Entrepreneurship, para. 3)

GP1 and GP8 had both had original aspirations to be hospital doctors but for different reasons had become GPs. Both GPs' drive, ambition and ability to think systemically were used to creative effect. It struck me that the application of diverse, creative forward-thinking could potentially be dynamically employed by GP1 and GP8, both locally in their GP surgeries and in terms of clinical practice more broadly within the wider system. All of this may also have been vulnerable to personal and/or environmental forces, and may have been variously motivated. GP1 presented as a young, enterprising full-time partner, energetic about operational planning and change in clinical services, as can be seen in appendix 8, which is an excerpt from his interview. He came across as friendly and enthusiastic, motivated to make a difference – particularly at a service level – and yet simultaneously disappointed by the dwindling pay and huge demands, and

concerned about the impact on his own young family. He was categorical on the phone that he only had one hour, and yet he wanted to carry on the interview for an additional half hour, particularly with regard to the organisational aspects of his work. In contrast, I interviewed GP8 on the eve of her retirement, and she seemed to regret not having made more of a national impact. She let me know that her first love would have been to become a hospital consultant; but she had been a wife and mother, and at that time it had been less possible than it is today to perform the role part-time. She planned to continue with mental health and child and adolescent mental health service commissioning, because she felt it was so integral, was badly done locally, and was dear to her heart due to her having grandchildren. She was married to a GP, and they had been partners in the same practice for 30 years, but she had never lost her ambition to have an influence nationally. She had also been an independent thinker, creative in her approach to solving the limitations confronting the medical scope for local patients. She had brought different systems together, transforming local provision in some medical services, and she had been determined to challenge limiting factors – within patients, within the medical system, or both.

*Theme 1: Long-Term Patient Relationships – Dependency and Intimacy*

GP1 and GP8 shared similar attitudes, with evident care for their patients, but with a clearly different emphasis from the attitudes of GPcoms. They did treat patients directly, but both had been worn down by complaints. Their energies seemed most focused on enabling clinical pathways and setting up clinical provision. Neither of them used the phrase ‘from cradle to grave’; nor did they talk about intense, ongoing relationships with patients and families over time that enabled the containment of anxiety and development of trust. Their focus was wider than their own GP surgeries and the immediate demands of surgery management. They both described preoccupations with the wider healthcare system, albeit in different ways.

GP1 described being pursued by a mother for negligence after omitting the antigen when inoculating a group of children. He had realised immediately what he had done and notified all concerned. I wondered whether he had turned to

influencing the clinical system at a time when he had felt attacked as a GP who had made a human error. Potentially, his all-knowing medical status had been punctured in the mother's mind: the unconscious relationship between all-knowing doctor and dependent patient and child had collapsed, causing fury in a vengeful mother. Perhaps the perpetual child-patient in his unconscious did not identify with a godlike consultant; feeling ineffective in the face of such a demanding context, he became not simply a GP instead of a hospital consultant, but a mortal GP who occasionally missed out the active clinical ingredient. There was a question in my mind about whether his dynamic focus had actually shifted to the medical system and away from individual patient clinical care as the responsibility and risk of harm had become overwhelming. At the end of the interview, he let me know how refreshing he found my interest in his organisational achievements, the impact of the context on him, and his influence on it; he was used to being asked questions only about doctor-patient relations and clinical presentations.

GP8 described her entrepreneurial approach and out-of-the-box thinking, drawing on her broad approach and extensive experience:

> *For the vulnerable and the people with long-term conditions, it's so important to problem solve, and quite often people come in with something and you actually turn it round and they've got something completely different. Usually, it's something psychological, and I think you need doctors who are really aware of a number of different things and aren't disease-orientated. There's something very special about that. … Having a GP articulate what is actually happening to you, why would you be able to? It's very hard sometimes. … And if there aren't the services locally, what do we need to do to set them up?*

GP8 and GP1 managed patient need partly by influencing systemic change. What this also implies, of course, is less time in clinic as a doctor, which for some GPs may be a way of managing dependency demands and/or frustrations with the system.

*Theme 2: (Dis)identification with Role and GP Surgery as (Not) Second Home*

GP1 and GP8 were different from GPcoms: they had been hugely industrious in their roles but had taken up responsibilities beyond their immediate setting, and they identified more as catalysts of new clinical enterprises than as GPs working in their own consulting rooms. GP1 let me know that he had only ever worked as a doctor, would need a break at some point, and was motivated to work with systems. GP8 conveyed frustration with the GP role. In these ways, GP1 and GP8 were not identified with the role and not wedded to their GP surgeries as if they were second homes.

GP1 helped to draw my attention to the GP's unconscious need to be in a medical setting and what that might mean. He had been through multiple surgeries as a child, so hospital had been a second home to him; but he had chosen the GP surgery setting instead, due to his irritating experiences of pomposity and humiliation at the hands of medical consultant trainers in hospital settings.

Throughout the interview, GP8 referred to her experience of her family and professional life, and how they interwove. She described the way in which the needs in her family focused her mind on the issues she had influenced as a commissioner. But she also described feelings of ineptitude when she had to be among non-clinicians: for her as an off-duty GP, being a woman with a family had had its challenges:

> *I felt very bad at it, whereas you perhaps were a bit more in control of your professional life, but you weren't very good as a new mum, and you have to give up everything and join a group of ordinary mums at antenatal class, and some of them are loads better than you, most of them are loads better, you know, at being mums, and yeah, I think it can be quite demoralising, yeah, no, I'm sure that affected me a lot at the time.*

Despite being aware of the struggle in the partnership model between individual GPs, she was nevertheless committed to the model, and this was integral to her

creative thinking to effect change at ground level: '*The huge strength about general practice is that we do run it ourselves and we are amazingly efficient.*'

*Theme 3: Underpinning Ethical Value System (Through Working Systemically)*

In their different ways, GP1 and GP8 solved patients' problems by being the instigator of new clinical services locally. They both liaised with other stakeholders and thought creatively to enable this. They also described their direct work with patients and the challenges involved, but most striking was their way of utilising the wider system of healthcare to support innovation in clinical provision. Partly, they both managed feelings of disappointment, overwork and overwhelm by turning to entrepreneurial activity, and by seeing their influence have creative and remedial effects in their local patient populations. However, both of them had experienced litigious action from patients, which added to feelings of weariness with direct patient work and of being unrecognised for the huge amount of work they did. GP1 and GP8 maintained their motivation, focus and sense of responsibility for patient welfare by taking up leadership roles, focusing particularly on systemic change. GP8 had undertaken research to positively influence the process of assessing doctors' suitability, so that the focus is now on relationality and patient-centredness rather than rote learning and the dominance of a procedural attitude. In summary, both GPs had invested systemically and educationally in the local clinical provision of general practice beyond their own surgeries, and they had instigated treatment pathways locally that would ordinarily require referral to specialists, often at some geographical distance.

*Theme 4: (Dis)satisfaction in Role as Clinical GP*

GP1 and GP8 can be described as having diversified their focus away from direct clinical work and gaining satisfaction from their entrepreneurial activity. Nevertheless, GP1 conveyed both initial satisfaction and subsequent sadness in the same clinical case:

*I resuscitated a child that was born a little bit premature. I was the paediatrician junior on call. The baby was premature and had stayed in hospital for a number of weeks with jaundice. I had a nice relationship with the parents, and initially it was a success story 'cause I saved the baby. The mother had had a stillbirth ten years ago, so this was happiness and success. However, eight or ten weeks later I was on call again, and I got called out to the A & E department and was brought a baby that was basically blue. I recognised the child and then had to try and resuscitate him again, but he had died. Unfortunately, his mother had fallen asleep on him when she was breastfeeding him and smothered him. I then had to try and resuscitate him. But he was dead before he got to me.*

It did rather seem that GP1 often felt that he would try to breathe life into his clinical work, but he would be thwarted by target outcomes flashing up on his computer screen and interfering with the consultation, or by the lack of social support for vulnerable patients. He clearly articulated that there was no longer any additional funding for deprived patients, and this had had a devastating effect.

GP8 had had some disappointment that was not only personal but also systemic in the medical hierarchy:

*I would have liked more recognition, and I think that's what you would get if you were a hospital consultant, I think. I feel the same for my husband. … Yes, I think that's the problem really, that general practice is still the poor relation. I don't see how you can change that really, there's still hospital doctors will say to a bright student why are you doing general practice, you know. … Well, all the time I was working in the deanery, of course, I was actually working with hospital doctors, because I was head of the school of leadership for a bit, and the GPs didn't want to learn about leadership. so I was doing it with the hospital doctors. … I didn't tell them I was a GP, and I got more respect when they thought I was an educator from the university.*

GP8 still clearly expressed that she did not really want to retire, although her recent experience of litigation sounded as if it had been wounding:

> *No, I don't want to go, I don't really want to stop at all, but the one thing I recognise is that the sort of litigiousness bit, and you do start to worry that things are different, and I've never had a complaint until this last year. It's a particularly nasty one, because there were clinical errors made but it was partly because, you know, they were such an odious group of people. You did everything you could to help them. I wouldn't want to go through that kind of thing again, really. … Reason it was missed was that the patient's behaviour was totally unreasonable throughout, you know, and we bent over backwards to try and accommodate that, and I'm aware that there are people like that out there, and they now know they've got rights, and they've got solicitors who will take it up on their behalf. … Then the expert witness that the MDU [Medical Defence Union] brought in said that they thought I'd been clinically negligent, having not read my report, and you just think, hang on a minute!*

*Theme 5: Visionary Systemic Leadership Role*

GP1 had a number of specialisms, including minor surgery and obstetrics, and thus might also have been sublimating his original aspiration towards hospital medicine into his ability to think strategically about clinical provision.

GP8 – who had originally aspired to be a hospital consultant running a department and having a national impact – sublimated her energy and interest into her entrepreneurial attitude, which included setting up local specialist clinics and cascading training to other GPs and nurses in particular techniques. She started her interview full of concern about GPs being appropriately assessed so as to be sure that they were not damaging; she had researched this issue, performed the function of assessor, and played a practical role in contributing to assessment frameworks to keep patients safe:

*Some people who are just not very trustworthy and you can't have them being doctors, you know, and they can get through these assessments no problem because … they'll give a good history of gallbladders. … But what you can't trust them to do is do the same thing the next time they see that patient if they've been on their phone and they're looking at social media, or you know, there are other aspects of being a doctor, you get a feel about somebody who persistently is late, who's persistently chaotic, persistently you know, maybe a bit of alcohol. … It is more the sociopathic tendencies that are difficult, I think, people who are sensitive and find it overwhelming will say, you know, I can't work this morning. … It's the lack of insight that is the problem, the ones who are a danger are the ones who don't have any insight into how they are with other people.*

Later she further illustrated her view of the essential nature of GPs and their particular expertise:

*My husband's mother was in hospital recently, and it was totally chaotic, it would have been good if there had been a really good geriatrician who'd said oh, well, we must look at your glaucoma and your heart failure. … I worry that it's becoming too fragmented, and that I think GPs have got to hold the ring really, but whether they can. … I understand why that's happened, because medicine's advanced so much that you have to be a super-specialist, but we do need people to be generalists.*

GP8 was also thoughtful about parts of the NHS which were not set up in a way that was fit for purpose, and she compared this with her experience of running a GP practice where she could make instant changes:

*I mean, I know because I work in the hospital one day a week, and I know what happens. It is the most inefficient thing, you know. I'm supposed to see two new patients on a Monday morning, I do Mondays. You know, psychiatric patients don't like Monday mornings, they don't get up, so if you're going to have new patients, you put them in the afternoon, or you put them for 11 am, and I've said this, oh, now we run our new patient*

> *clinics in the morning, you know, so I sometimes sit there all morning not doing anything.*

I was really struck by GP8's broad thoughtfulness and evident leadership skills, and I partly felt that some of her enthusiasm came from frustration at not being a hospital consultant, which had been her early-life ambition.

> *Wherever I go, whatever I'm doing, I'm very enthusiastic, and very quickly people clearly think I'd be useful, and I know that I go in and they immediately say*, 'oh please come and join our board' and 'please come and do this'. *I can contribute quite a lot, and I think that had I had the opportunity to do that in a hospital setting, I could have probably done more.* I *would have just been more influential, probably. … In general practice you can do small things, you can do things at CCG level, but you couldn't perhaps influence, say, the stroke pathway nationally.*

GP8 undertook other wide-ranging duties: within the assessment and brief treatment team in geriatric mental health one day per week; as mental health commissioner lead for the local CCG, with significant influence; as a postgraduate trainer in dementia for nurses and GPs, and sitting in on their consultations; and as an educational supervisor for nurses. Her enterprising spirit was demonstrated in this diverse range, and in the application of her knowledge and thinking, although she spoke of the previous pressure to have children young and the struggle that women used to face if they wanted to work full-time:

> *It's much easier for women to go part-time in hospital medicine now than it was. … When I was training, you were part of a team, and the hours were dreadful, but it was quite difficult to be a part-time woman, it would have been really difficult to get the same kind of team spirit.*

Perhaps this team-spiritedness had enabled her to further develop a systems approach and a varied approach to working life:

> *Yeah, I think most people don't have such a portfolio career [as me], and if they do, they don't usually end up doing quite so well. … I moved straight*

*into being the associate dean, which was the sort of area organising for all the GPs in training … so I cut down some of my general practice.*

For GP8, medicine was her second degree, which she had undertaken as a mature student. She had ideas about how to provide motivation for trainee GPs to commit to struggling practices and still gain professional development:

*I think portfolio careers are great, and I think that's what we should be encouraging in general practice, because I think it will make people want to come into it, you know, you can do a bit of specialty, you can be flexible. … If an area gets frustrating or upsetting, you can leave it for a bit … you don't need to input your emotional strength into it. … Like a fellowship … you'd do two days a week in the failing practice, and then you'd maybe improve yourself and do specialty … paid for and supported.*

*Theme 6: Overwhelmed by Context*

GP1 clearly conveyed being overwhelmed by the relentless nature of the GP partner job, and he felt that he could leave seeing patients behind: being a GP was not a child-friendly profession due to the long hours, and his GP brother had now left the NHS to become a sports medicine consultant. Interestingly, he self-prescribed an antacid because it was cheaper to do so, but he had not seen his own GP for 16–20 years. It struck me that his place of work struggled to be the place of care that he had thought being a GP would entail, and he conveyed an experience of being significantly overworked and chronically tired, with paperwork in stacks around him. There was disappointment in the air, and he referred to endless unproductive meetings. There was something about the relentlessness of being a GP partner that seemed to be getting him down, and at times left him feeling punished. It seemed that his interest in being interviewed stemmed from wanting to be considered psychologically, but particularly from the organisational emphasis in my research, about which he had ample curiosity. GP8 seemed most weary of her experience of litigation and the unfairness of it. She was also disappointed that her myriad of efforts were not more recognised.

*Theme 7: Business-Minded Approach to Financial State of GP Surgery and Context*

GP1 and GP8 described satisfaction from setting up new provisions, liaising with various stakeholders, and winning bids to do so. GP1's involvement and ability to set up new clinical pathways and provision was evident, and he gave many examples where he had changed local provision and access to medical care. One way he managed to feel that he had agency, had a voice and could make a significant difference was to collaborate with other partners within his surgery to change procedures and protocols; he had also set up new initiatives across the borough as a member of various professional bodies comprising GPs from different practices. This had been a way of keeping his ambivalence at bay and bringing out his entrepreneurial spirit in the context of commissioning.

GP1 stated that he was clearly motivated by fixing things and taking action. He described in detail his strong involvement in commissioning services, creating effective pathways and setting up responsive local services with other local GPs. He was evidently interested in the organisational side of patient care and frustrated by the accompanying bureaucracy, and also by the dominance of targets in terms of the outcome-focused agenda that overshadowed patients' concerns during clinical appointments. He appeared to be proud of enabling creative resources in his deprived area for impoverished patients. I marvelled at his effectiveness at a service level, with his creative and effective solutions and his ability to work with others across systems to create new clinical networks providing locally targeted care to the patient population.

GP8 demonstrated a pioneering creativity and leadership flair, with a pragmatic approach. She influenced and enabled others to overcome hurdles and become similarly equipped by making presentations and allowing other GPs to make their own comparisons:

> *Well, the biggest thing was persuading people that it could be done, so all these GPs who said, 'I couldn't possibly take on all that, I can't look at*

*eyes, I'm not going to be any good, I'm not going to take people out of the hospital'. I said, ok, well, if the problem is retinal examination, then we have to do it for you, and this is how we can do it, so it's much more around, so you've got to enthuse people, because if you don't keep people going they won't do it, and it was getting the arguments to persuade them, and I remember going round to all the practices … with plastic overheads, you know, and I knew that in order to get people to listen you've got to show it on the wall so everybody sees it. You can't give them sheets, they've got to see their own figures, they've got to see to be able to compare.*

GP8 used her imagination at work, taking a systemic approach to matching clinical provision to local patient need. The first example concerned sight affected by diabetes:

*We set up retinal screening, and it was brilliant, all the patients locally who had diabetes, whether they were at the hospital or just in general practice, had their eyes looked at with a retinal camera, which wasn't happening anywhere else in the country, and we got reports back, and the reports were looked at by an ophthalmologist, so it was quite high-powered, and we must have had about 1,000 patients early on. … The retinal screening did work, and we got the highest QOF scores in the country.*

GP8 was one of the few GP interviewees who expressed keenness about the introduction of QOF outcome measures, as she was already abreast of this approach in her own clinics. The second example was invaluable for patients and rewarding for staff:

*I wanted to set up a memory assessment in general practice, and NICE [National Institute for Health and Care Excellence] guidance said you couldn't diagnose it unless you were a specialist. So I went to a specialist university department and asked, because I knew they were interested in general practice and looking at GPs learning about memory. There was a very good lady there, and so we set up a course together, which is a postgraduate certificate in dementia studies for people who want to provide services, and it's been a success, I mean, we recruited 14 GPs*

*who all got a postgraduate certificate, which is amazing because you don't have many people who have postgraduate certificates in general practice, and they now run the memory assessment service, so we tendered for it, we did it as a pilot, and then we retendered for it, and we got the contract. So we run memory assessment across the county, and we've now got some nurses and a pharmacist trained as well.*

*Theme 8: Determines Own Timetable*

Both GP1 and GP8 were working full-time but had lessened their direct clinical work with patients in general practice by becoming involved in commissioning, sitting on boards, teaching, and undertaking specialist work in other medical disciplines. They both conveyed very full professional lives, although GP1 described being overwhelmed by demands on his time as a partner in mid-career. He said this was unsustainable, as it was too high a cost to his family life with children. GP8 was at the end of her career, and she emphasised the importance of being able to manage having a family alongside being a GP, which in her day had been the only medical career where this was a realistic option. They were both caught up in external timetabling pressures that did not necessarily make good sense – for example, extensive and multiple meetings, or working with new referrals in a mental health hospital setting on Monday mornings, the least favourable patient option.

*Themes 9 and 10: Family or Own Illness as Motivator*

GP8 explained that watching her mother's powerlessness in the face of her father's illness had been a significant influence in her wanting to become a doctor:

*Dad was always ill, and a number of times he had heart failure and things, so yeah, I think there was definitely a feeling that I wanted to be in control of my own health. I used to see my mum floundering with not knowing what was going on with my dad and not having the help. … She would worry about something, and looking back when I got older, I thought well, I don't*

*want to be in that situation, I don't want to be in a situation of not knowing what this means or misinterpreting something, I want to be the person who knows, and I can take control.*

GP1 had been born with a congenital condition and as a result had spent lengthy periods of time in hospital. He described feeling well cared for by hospital consultants and nurses – quite literally, hospital had felt like a second home. From his own experience as the recipient of multiple surgical procedures, he had learnt as a teenager the value of a considerate bedside manner and commitment to care, both from the hospital staff and from a sensitive, kind, caring girl who had sat by him after his surgery, and with whom he still shared a lifelong camaraderie.

### *4.2.3 Type 3: GPamb*

I learned that some of my interviewees took up a way of working which enabled the avoidance of patients' ongoing dependency needs and collegial relationships. I hypothesised that this was a social defence to retreat or withdraw from overexposure. It was achieved by perpetually undertaking locum work in one or perhaps several surgeries, which might also avoid the formation of ongoing collegial relationships with other GPs and staff in practices. I was informed that there are anomalies in that some locums are based in the same surgeries for years! There are also GP practices where patients rarely see the same GP due to the appointment-booking model, even if the GP is a partner or salaried, which – among other issues such as heavy administrative work, dwindling pay or systemic challenges – may also contribute to ambivalence in GPs who are partners or salaried.

Locums are self-employed. For older GPs, locum work was what one did when one was first qualified, as an opportunity to look at different practices – a temporary measure before one chose a surgery and got to know one's patients and colleagues in depth over time. The part of the GP role that locums are left with is short-termist clinical interfacing, sometimes grappling with local referral pathways or the idiosyncrasies of different settings, although some locum GPs have an ongoing temporary arrangement with specific clinical providers. Deciding

where and how much to work may lead a locum GP to regulate their exposure both to the system of general practice and to clinical demands, such as patients' expectations of instantaneous responses to trivial matters, as well as the ageing population with its associated ills. Other interviewees said that being attached in any other way than as a locum had become too administratively burdensome, or that they wanted to be in charge of their own timetable. Some locums said that they brought to their clinical work the same approach and diligence that they would bring to work in A & E: in both cases the work entails stand-alone interventions, as doctors cannot easily offer a wait-and-see approach if they have no continuity in role. Given this simultaneous investment and detachment, I ascribed the description of GPamb to this type. Other GPs that fell into this type had partner or salaried roles and yet withdrew and retreated emotionally, and/or retired early or worked fewer days. Thus the GPamb type is variable, and ambivalence shows itself in quite different ways, but it nevertheless runs as a common thread.

Ambivalence was conveyed by some interviewees who were newly qualified GPs feeling the strain, but also by others who either had retreated or would like to retreat from the full onslaught of GP clinical work or partner roles. It may be that this involved a valency for basic assumption me-ness (baM) – operating as if there were no group – or perhaps fight/flight, in which 'need and intimacy' was the enemy. It is worth noting that at the time of the interviews, a perhaps unintended consequence of locum roles was that the rate of remuneration was significantly higher than that for salaried GPs. According not only to my interviewees but also to Balint group conferences and publications in *Pulse*, the least popular role at the time of the interviews was that of GP partner, for which there were many vacancies nationally. During my interviews, GP partners reported decreasing incomes, increasing administration, and difficulty with staff recruitment and retention; some of them had their own creeping ambivalence about the ongoing effort and sustainability, despite being otherwise invested in the role.

I will now consider in detail the GP interviewees from my sample who exemplified features of the GPamb type, describing their mixed feelings about their level of professional, emotional, personal and financial investment in the GP role. I will

also consider their attitudes to the themes, as I did for GPcoms and GPreneurs, although GPambs' responses sometimes demonstrated negative attitudes to the ten themes.

GP12 was employed one day per week but was publicly vocal about the importance of locums, running support groups and using social media platforms. I found this paradoxical, as she had informed me that being continuously on duty with changing locums had eventually resulted in her mental breakdown because she had felt like a failing doctor with insufficient support. She felt she had dealt inadequately in one clinic with three issues relating to death. A sense of strain was evident throughout the interview, and she took a break and refreshments after describing her breakdown. Simultaneously, she presented as motivated to contribute and participate in telling her own story and that of the wider GP context. GP12's ambivalence about being a GP ran like a recurring refrain throughout the interview and in her avoidant interaction style.

GP2 had qualified a couple of years before the interview, and already her heartfelt self-description was as follows:

> *I can't do general practice full-time, that's for sure, I've learnt that. … 'Cause I was doing nine to ten sessions a week … for about four months … and that nearly killed me, figuratively. … After that I said nope … definitely not a full-time GP. I'd kill myself if I have to do this day in and day out. … But I think a good balance would be about three … three and a half days in general practice, and then … because I was doing, like, you know, locuming in dermatology as well, that allowed me to break up my week quite well.*

As she sat on the floor in my consulting room during our 90-minute interview and described red-flag bowel symptoms, I felt concern for her and actively restrained myself from suggesting she take care of herself. I wondered whether the young promise of what was meant to be a dream was in reality rather different. She described frustrations with convoluted referral pathways resulting from changes in commissioned services, the onerous nature of seeing 40 people a day for ten minutes each, and nonsensical targets. She also made comparisons, describing

her income as pitiful, especially compared with contemporaries '*who weren't even that bright*'. At the same time as explaining that she could not do anything else, she simultaneously suggested that she definitely needed more variety in her week than just general practice – perhaps baking, or retraining. She had made many sacrifices to train and work as a doctor in England, and her family back home remained a priority in terms of how she managed her working hours and sleep patterns so as to allow for Skype conversations. She blamed herself for taking on too much work when she felt burnt out or was driven to drinking wine every night, and she would take six weeks out to recover and start again. She also described objectifying her own body.

GP3 was recently qualified and seemed sensible, rational, well informed, and interested in ongoing relationships with patients and helping people to have a good death, for example. But in the end, there seemed to be some disappointment and ambivalence about the job, albeit with simultaneous attachment to the role of doctor and its potential. GP3 expressed a need to feel part of the 'right' group of professionals while also being familiar with occupying a lonely position:

> *I'm the only medical one in my family. I was a very intelligent child. I think I was quite shy, and I jumped out and said 'boo!' to the wrong group of people. I went 'argh!' and ran away crying. I haven't really considered another career, so … I don't know what I would have done if I hadn't got into medical school.*

GP6's motivation for becoming a GP was to avoid going into the army. The whole approach to medical school is evidently different in other parts of Europe:

> *So, when I left school at the age of 19, I did not know that I wanted to become a doctor. You didn't have to know at that point, because your A' level results are valid just by the grades and not by the subjects. So, you can apply for medical school anyhow. I worked then for nearly two years in a nursing home as a healthcare assistant, which I had to do to fulfil my requirements to the general state, because we still had compulsory military service. And the only way to get out of that was to do some type of social*

*work experience. The pay grade of the lowest-paid soldier, so I did that. And during that time, I actually discovered that medicine was quite an intriguing subject. And I saw a lot of GPs at work, and maybe that's where it came from. I never was a scientist. I stopped all the sciences as soon as I could, I only dragged on with the sciences as much as I had to, and not very successfully at school.*

Like GPcom GP5, GP6 helped me to consider that individuals with a pacifist orientation, who came into healthcare to avoid the army at a time when dependency was at the core of social and medical provision, may find the current aggression in the system exhausting, leaving them in an ambivalent, beleaguered state. GP6 described how the new access to daily telephone appointments resulted in relentless patient demand without a protective shield for the doctor. GP6 gave the impression of a hard-working GP trying to survive the job without collapsing under its weight. He described recent changes in processing patient need as causing him to retreat:

*We have always had a quite valued continuity of care, but in the past – three years ago – patients were able to book instantly with reception, like in the old-fashioned model, you go to reception, and you say to the receptionist 'I want an appointment with this doctor', and they say 'there's an appointment tomorrow or in two weeks', and you pick the one that you want. You now have to ring, so it's complete telephone access, and you speak with the doctor first, and the doctor decides together with you if you should be seen, whether it can be dealt with over the phone, and/or if you should be seen or can be seen by someone other than me. So, I see a little less patients in person than I used to. I think because I do speak with them on the phone, I have maintained a relationship. I've probably shut myself a little bit more than I used to now. … I never committed myself to doing, to being on call over the weekend, nor to giving patients my personal mobile number to say if something happens over the weekend they can call me.*

GP10 had been a GP partner for many years and had felt trapped in a '*corner shop mentality*'. She now made work fit in with her life as a divorcee, and she had a portfolio of professional activities and a varied personal life:

> *I do locum sessions in the walk-in centres where I work as employed … when it suits me, and I also work fairly regularly for the out-of-hours service. I have slots that I work to over a 12-week rota that are recurring, … then I pick up extra slots again, depending on how much I want to earn, my social commitments, and then the third or fourth thing I do is I teach communication skills and the biopsychosocial aspects of medicine. It provides students with their first real encounters in the community with patients.*

I will now consider each theme in turn.

*Theme 1: Long-Term Patient Relationships – Dependency and Intimacy (or the Lack of Them)*

GPambs mostly described more objectified, distant attitudes to patients and a need to recover and distance themselves from the onslaught of patient need by retreating or diversifying into less intense medical activities. They conveyed a sense of the strain and threat in the system, which affected their caring for patients.

GP6 explained in a resigned manner the impact of the social context:

> *It's always about money. It's about can I afford to buy myself a pack of paracetamol at 20 pence or do I need a prescription from the GP? And that's not such an uncommon example. That's an extreme example because paracetamol is so cheap, but items that cost a pound or two, people will say I need a prescription for that because I can't afford to buy them.*

GP6 helped me to understand how the external socio-political scene affected him in his clinics and the way in which poverty in the patient population had a direct bearing on the experience of being a GP:

> *Well, first of all, the whole set-up and ethnic and poverty distribution of patients has a great effect on me. The patients with a lot of requests that should not go to me. But they come to me because those patients can't go anywhere else, and they have needs that I accept they have. It's about housing, it's about benefits, it's about money … 'I think it's a better use of your time that you spend five minutes of your time on the phone and you give me a prescription in order to save me two pounds' … because we're a free service.*

GP6 managed to sufficiently convey that he found professional life hard and tried to protect his own health, and his family life with his wife and children, from being dominated by his work. He also conveyed the pressure that many GPs described being under and the sacrifices that he felt were expected. He left the powerful thought in me that in the current general practice system, there is a real danger that either the patients' health will be attended to while the GPs destroy their own health or else the care of patients will be neglected in order for the GPs to maintain their own health. GPambs described feeling particularly alert to this through their own experiences of feeling compromised and needing to retreat, to a greater or lesser extent, in some form or other. GP6 presented as stressed about the encroachment on his personal time and energy, and he implied that there was a possibility that both his own well-being and the doctor-patient relationship would suffer as a result of his reducing his face-to-face contact with patients: '*Yeah, a lot of frustration about time pressures. About me not being able to look after patients as well as I probably should. Ignoring patients sometimes consciously, because if they don't call it's fine*'.

GP6 described how patients' total access via telephone appointments, through which the need for face-to-face appointments was determined, had had a huge impact on him personally in the previous three years. The personal cost was that he could no longer attend choir or play football because he was working up to an

additional two hours daily. GP6 explained that the current model of incentivisation might leave quiet, uncomplaining patients at risk of being overlooked:

> *It's always this balance between people who do actively call you all the time and want your involvement and the quieter people who suffer at home and still doing something helpful with them. But you don't, 'cause they're not asking, and you have plenty of other work to do otherwise.*

GP12 had been off sick for three months as a result of feeling like a bad doctor to patients nearing death, as can be seen from the transcript in appendix 9 referred to earlier. This was a tragic example of a GP becoming completely overwhelmed as a result of feeling chronically under-resourced and overstretched. As a result of insecurely attached GPs, appropriate care was not sufficiently afforded to the patient, with the result that medicines were prescribed in the last few days before death without the GP having seen the patient. Understandably, this felt like a catastrophe. A systemic lack of care then ensued for the GP: in the transcript, GP12 describes how no NHS occupational health service is available to GPs.

Both GP12 and GP6 raised the issues of threats of litigation, time pressures, and the anxiety involved in the work, such as concern about missing life-threatening conditions or being less up to date than patients armed with information from the Internet. GP12 helped me to see that she felt somewhat threatened by patients who had been powered up by knowledge from the Internet and their right to litigation:

> *There's growing pressure. People are bringing a much more clear set of views and expectations with them, and the general litigation and high expectation culture. Expectation of convenience and so on. Then it's changed because I've changed, and I've become better at managing the tensions between patients' and doctors' agenda. … One brings an element of you feeling judged a lot of the time because of the wait people have had. The Internet means you have to be that much more secure about your assessments and advice you give so you feel you're on firm ground, and often because the range of problems is so wide you do accept that*

*you have to go and look things up in order to advise a patient, but if they've looked things up more recently than you have, you feel uncomfortable. The litigation side makes you focus on writing very much more detailed medical records and doing everything in a much more detailed way. It also means you are less flexible about fitting in an extra problem. If they've come with two problems, then want to fit in a third, you have to be more inflexible. You know, you can't do a litigation-proof assessment and consultation in the time that's left.*

GP6 described his main concerns as the misdiagnosis of children who would be dead the next morning, and the long drawn-out nature of complaints, for which the individual GP rather than the practice is held responsible. He also worried about missing cancer diagnoses in patients. The concerns were for the patient and about losing his career, and how such a case might hang over him perpetually without satisfactory resolution. He described the ongoing impact of one such case:

> You don't get a letter saying this is closure. … You never really know what happens. … I would want a letter that says this is where it stands with this case, the other party has not taken any action, which now means the case is closed. … But that's not what I get.

GP6 took active steps to recover at weekends, access support, and vary his working life, as follows. First:

> *I am in a study group that's a peer support group. Of all GPs who finished their training around the same time … 15 years ago, and we do talk specifically about patients as well … not in a strict Balint style … every three weeks, but we might talk about new hypertension guidelines, random patients, how you practise medicine, last home visit, or your last patient that you sent to hospital, or your last child you saw, or the patient that you found difficult.*

Second:

*If I worked in the job and the team was not good, I would stop working here. 'Cause the job is far too stressful to do it without support. … I think it's everybody. It's difficult to have a team that functions well as doctors but not then with reception or admin staff.*

Third:

*Diversify, so you stop being a GP, or you reduce being a GP and increase being something else related to being a GP. I am programme director for the GP training scheme here. … So that's one way you reduce clinical work and increase other work. I also do a little bit of dermatology. So I'm a GP with special interest in dermatology, which is a much more protected environment than general practice. We don't get this endless demand for patients to speak with you. We have a nice appointment system where we can do what we want. … But as a GP, I cannot destroy my health to accommodate your health need.*

With GP3, I received the impression that she was focused on finding solutions and being positive and would go out of her way not to be neurotic, although she openly said that she found it easy to correct herself if she was wrong and telephone a patient to explain or ask a colleague for help. This demonstrated an ability to bear the anxiety of not knowing, and to address it by asking colleagues for help, without feeling humiliated or judged:

*I don't mind ringing a patient and saying, look, I just wanted to check this or make sure you understood this. Because I'm so recently qualified I'm quite prone to worry about things. … I try to … in the immediate … I'm probably overcautious, which I think most newly qualified GPs are. … Umh, I'm more likely to kinda realise I'm worrying about it at the time and then do something. If I don't, I might think about it but … maybe I'm not caring enough, it won't keep me up all night. But then I haven't been doing it for so long.*

As a pragmatist, GP6 referred to waves in relation to recruitment and the popularity of GP partnerships, and he felt that at this time it was simply going

through a trough in the usual cycle. Simultaneously, he seemed to suggest that in five years being a partner might be even less appealing than it was now. Nevertheless, it would seem that having experienced an early painful loss in life, he had perhaps managed this by looking overtly on the bright side: '*I am innately a very positive person, and I will not accept that recruitment is a permanent problem, at the moment, but the fear is there, definitely*'.

GP10 described the load of being a partner – a role from which she had decided to resign – and how being an employee had become a common preference, as it lessened the load:

> *Statistically, the number of doctors who've become salaried has hugely increased from 2004, when the new contract came in. … Not having the responsibilities of partnership for the workforce, for the outcomes of the CQC inspections. All those things that made me feel acutely anxious on the day that I took up that partnership.*

GP10 described her realisation, for the first time in her already long medical career, that when she undertook GP training she needed some self-awareness in order to do the job well:

> *Never had I considered my well-being as a general practitioner, the aspect, the concept of housekeeping, that you have to sort yourself out before you can sort anybody else out. … Not in my undergraduate training and in the training for being a specialist in hospital, it wasn't, but in general practice training at that time it was, and they've always led the way on communications and self-care. And they've always led the way in specialist education full stop.*

In this way she conveyed two powerful phenomena – the greater scope and flexibility to express oneself professionally as a GP, and the need for self-awareness: '*Your own baggage would influence your response to a patient*'.

But GP10 also described the load on her as a result of the challenge of being a friendly GP, which attracted patients and challenged her boundaries. She

described how she came to have a dread of both her GP partner and a particular patient, whom she was pleased to get rid of:

> *This patient was somebody who should have been in psychotherapy, in my book, and she was using me in that way. … Therapist assessment had told her that psychotherapy was not what she needed. She needed a listening ear. So that's me. … I decided that she'd get an hour every two weeks, but it wasn't at a cost to any other patient. It wasn't upsetting the receptionists. … When I was thinking about leaving the practice, the main thing was the [GP] partner, but I also thought about the patient, I thought it would get me away from that as well.*

However, GP10 also had huge concerns about the barriers to patients. Her parents had been young adults during the war, and GP10 started the interview by detailing their cultural differences and the impact of the war. Later in the interview, she used a stark metaphor related to Nazi guards and prisoners of war, but in reverse:

> *It is like you've got several fences, like they used to have in the concentration camps. One was barred, and the next one was barbed wire, and another barbed wire fence, then a ditch. And it's like patients have to get over all of these hurdles, and the most pervasive hurdle at the moment is phoning up on the day for an appointment. That's the biggest hurdle, again nothing that doctors invented, it was something that came out of the performance indicator. … I have this picture in my mind. I can see how difficult it is for a prisoner to get out of the concentration camp, and what I'm saying is that it's that difficult for a patient to get into a surgery. It's as difficult as getting – actually, what you are dealing with, the currency there is life or death, whether you're being shot at or whether you're able to access healthcare.*

In this metaphor, patients are kept out and thwarted from accessing care, while GPs are insulated. However, the GPambs among my interviewees were not saying they felt protected; they were describing feeling exposed. The freedom of having appropriate sustainable access to GPs and therefore healthcare was

largely violently denied by the system, which negatively affected patients and GPs alike and made the process resemble a fight.

*Theme 2: (Dis)identification with Role and GP Surgery as (Not) Second Home*

For GPambs, there was evidence of attachment to their work and its meaning, but they presented as more attitudinally mixed about it, and certainly the surgery was a provocative environment for them, according to their own idiosyncratic outlook.

For GP12, applying for GP training had been a comparatively low-stress option, which had not been the case for some of my other interviewees:

> *I wanted to become a medic with the intention of becoming a researcher, [but] I realised research wasn't going to be for me. Something about the uncertainty of the success and outcomes of research, in contrast with the more immediate immediacy of day-to-day goals of looking after people, as a completer finisher from an early stage. … Then the decision to do general practice came after a succession of crisis points in my early career when I realised hospital work was not for me and had led me to become very anxious and depressed. … I applied for GP training when there were 50 vacancies and four applicants*.

She started by describing the context in terms of unpredictable, temporary collegial relationships that had the cumulative effect of making her feel unsupported and ill at ease. Although GP12 appeared to be a fierce defender of GP locums, when it came to three intensely demanding clinic tasks, this model of staffing had proved inadequate in terms of both managing anxiety and having suitable staffing levels to undertake the responsibilities. In the vignette in appendix 9, we can see issues of staff dynamics and the use of technology – phone consultation – in the face of intense patient dependency in terms of end-of-life care and death. According to GP12's perspective, this experience had been met with derision from her colleagues, in relation to whom she had already felt peripheral and different, as well as harsh personal judgement. Each case had been about death and the doctor's response. These experiences appeared to

have triggered a plummet in her professional self-regard, and she appeared to be haunted by them. GP12 had felt unable to work for three months; there was a hierarchy in her mind whereby direct GP work was the most challenging of her varied types of work, and so she had given that up first. This may have been because it was while she was in that particular role that the trauma had occurred, and also due to the nature of the relational/clinical demand. She had then discovered that the feeling of inadequacy was more pervasive and had stopped all forms of work. GP12 seemed to absorb the guilt in the system specifically in relation to the treatment of these dead or dying patients. Being the face that fronted inadequate care around death had left GP12 deeply ashamed. She had taken a break from general practice to recover, although she had already been feeling under strain prior to her breakdown.

Perhaps GP12 had a valency for taking up the position of feeling inadequate, which she also described as her position in her family. Unlike some GPs in the sample, GP12 recognised herself as a patient:

> *I had access to psychotherapy services 20 years ago, when I was ill, and I hadn't had a positive experience, not positive memories of that. [This time] eventually I contacted the person here who does psychotherapy for GPs and medics. It was very helpful, and obviously seeing my GP and support from colleagues and friends.*

She described accessing help as the first step, and then being signed off work for an extensive period of time in the face of feeling quite withdrawn and collapsed. It was particularly striking that there were no formal lines of occupational support for GPs' mental health needs, the emphasis in the system being on GPs' physical needs – an idiosyncratic, private route had to be found:

> *I asked my practice manager to get me some occ. health support, because I didn't want to be the person negotiating those adjustments. She clearly didn't have any idea. … So she eventually referred me to a GP in another area who does private occ. health work, and I had an appointment with him, and he wrote a report which I was allowed to have an input into about the need to return with reduced workload with support and not be working*

*unsupported. … I felt I even had to negotiate with him and say actually I can't see how I can possibly be back to my normal capabilities after working four days. Fortunately, there was no pressure from my manager to do more. Once I'd returned, I was completely in control of the pace at which I did my work. The hardest thing was to impress upon her that I couldn't go back to this situation where I was just working always alongside a stranger, always on my own. … In the back of my mind, I wonder whether she just was hoping that I would leave.*

The theme of group dynamics was interesting. GP12 clearly felt judged by long-standing colleagues but in stark contrast supported by a younger, new colleague who provided a supportive function, holding GP12 actively in mind in her absence and taking it upon himself to ease her back to work. GP12 conveyed a feeling of vulnerability to being retriggered by work, and perhaps even a dread of becoming depressed again:

*In the lead-up to going off sick, I was really very, very disrupted in terms of sleep. … I've had a couple of nights of insomnia again, which I haven't had for quite a few weeks, on the back of things at work. I'm feeling slightly like, oh no, is this all going to go in the wrong direction again. A common scenario in recovery from depression. Worry about things sliding back, about your resilience in the face of the same stress … same individuals, same team, same dynamics recurring. … Yes, it's interpersonal dynamics of feeling dismissed and laughed at. Disrespected. I know I should be able to rise above it.*

However, GP12 also conveyed harsh self-criticism, and this interacted with a demanding clinical context:

*Quite often I convince myself that I'm what's wrong. That I have a difficulty in maintaining positive or healthy relationships with co-workers. … I've lost a lot of sleep over the years over interpersonal relationships with colleagues. Whether that means I'm bad at them or that I'm just more sensitive than the average person, I don't know. A lot of the time I convince myself I'm bad at these relationships because I'm too overcritical. … I end*

> *up feeling like an outsider quite a lot. How much of that is by virtue of the fact that I'm part-time in several roles.*

Yet simultaneously, GP12 described her own ability to have a positive effect, and how she had

> *really changed the nature of the community here and the fundamental status of a lot of locums that's more accepted, it's a legitimate choice, and you can do locum work and other high-profile roles, and it's not something you have to be ashamed of. There are very strongly held prejudices around locums being people who haven't been able to get a proper job, not as committed, not as professional. There's all these negative stereotypes: locums are just in it for the money. There's so many people going into locum work now that it's becoming more accepted that it's a means for a lot of people to carry on being GPs rather than leave altogether.*

GP12 also felt supported by younger colleagues, in a long-standing peer support group and in virtual forums. She described feeling jeered at and somewhat mocked by her contemporaries, which prompted me to recall in my mind her reference to her academically superior brother.

GP2 described how she was always going to be a hospital doctor – either in cardiology or dermatology, and as part of a team – but now as a GP was often alone, which added to her sense of isolation. GP2 was attracted to being a medic in the sense that she had tried alternative employment but missed medicine, although as with GP12, her capacity to sustain engagement in the role of GP was unclear. This may have been linked to her struggle for self-care, and again like GP12 she described '*feeling in a system of uncare*'. She described a poor experience as a patient to her own GP, who she felt had a deeply unsatisfactory approach to mental health concerns when she revealed anxiety and depression. She described having had some psychotherapy in recent years; she had found it difficult to attend with her work demands, and then had dropped out, but she possibly needed to return to it. She had taken a break from medicine to try a career in maths and economics, but she had found the absence of human

responsibility unsatisfying. She described recognising that friends did not have the same skill as she did in talking to people and eliciting information, which had been a surprising realisation. Interestingly, in contrast to GPcom interviewees, she described how easy it was for her to put herself in patients' shoes. As she sat at my feet during the interview, it felt as if I had a young child in the room who was homesick, lonely and really in need of being looked after. I wondered whether part of her motivation for coming for interview was a wish to reconnect with a psychotherapeutic way of thinking, as she knew that I also do that work. She was friendly with a counsellor colleague in her surgery, with whom I had discussed my research, and she had kindly offered to be interviewed and was open and easy to engage.

GP2 let me know that she was always going to be a doctor but had fallen into becoming a GP, which was not her dream, because she could get her top choice of GP training, whereas for hospital medicine she had been offered her last choice. There was similarity with GP12, who felt that becoming a GP meant having a lower status than her academic family. Furthermore, GP2 had been confronted by her limitations, in terms of both how many days she could tolerate the job and her limited influence on family medical treatment back home, from which of course she was also geographically distant. Her grandfather's poor hospital treatment in Asia had caused her fury and sadness about the neglect that he had experienced. She had utilised her medical status in an attempt to influence his treatment. She described being significantly distressed about the lack of facilities or medical sophistication back home, and being frustrated in relation to the limits of her impact there, although she had used her Western qualifications with a passion as an arsenal to try to influence the medics there. Like GP12, GP2 was preoccupied with her own survival, and she had a repeating refrain at various points during the interview: '*I'm not dead yet, so just carry on*'. She herself let me know that she readily identified with the patient's position during consultations – partly I think due to her having prematurely left home in order to travel across the world to study medicine. This adolescent experience seemed to have left in GP2 a permanent sense of feeling somewhat empty inside, with little internal emotional resource to draw on during her clinics. Being a locum appeared to have given her the flexibility to phone home for most of the night, but simultaneously made her feel adrift and unanchored professionally, and not

valued personally. She also described explicit disappointment about the intellectual attainment involved in becoming medically qualified and society's lack of regard for the effort, both in terms of regard for GPs and financially. She complained that her less bright contemporaries had ended up with much better-paid roles in other sectors, and said how difficult this made it to accept her own position with such a low take-home salary, with all its implications. Thus similar themes were manifest as with GP12: inadequacy, shame and retreat. GP2's boarding school would have operated *in loco parentis*, and from there her educational journey had perhaps merged with her personal journey as they became so intertwined; as a result, she may have been more attentive than others in my sample to issues of failed dependency in the system. I found myself feeling concerned about her reckless, absent-minded attitude towards herself. She described herself as lost in jobs which did not involve human closeness. Although she struggled with the context surrounding these medical interactions – such as changing referral pathways, the accompanying paperwork, and the intense and increasing level of demand – she nevertheless informed me towards the end of the interview that she had accepted a part-time salaried GP role in a surgery where she had been previously a locum. Perhaps there was a longing after all for belonging and stability of sorts.

GP3 presented as a little ambivalent about taking a salaried role due to the burnout stories and deluge of paperwork she had heard about. However, her presentation struck me as somewhat different from that of GP12 and GP2, whose ambivalence seemed much more entrenched and related to their own personal struggles, which the context exacerbated:

> *With my family, I'm sort of an on-call GP-ish, but only because I want to be, not that they would make me. But I like that I can help them like that, I suppose. It's an important part of who I am, I don't think it would always have to be. You know, I think I would be able to do something else and function perfectly well … I hope, anyway. I've got a few friends who have moved out of medicine and went to allied sorts of things. I definitely don't feel I'm so branded to general practice that if it became worse and worse that I would still stay in it. Which is kind of a pity 'cause most people feel like that and I don't know if … well, there's already not enough GPs.*

GP3 came across as sensible and quite settled in the role of GP. As a newly qualified GP, it came across that if she felt comfortable with a practice she might be persuaded to become salaried and perhaps work towards becoming a partner in time. She described on the one hand the recognised status of being a GP, and yet on the other the insufficient recompense:

> *[Being a doctor is] something I'm quite proud of. … It's nice having a job where when you say what you are, people understand. … [But] in the end no one goes into medicine for the money, because compared to most other careers with a similar level, kind of education and responsibility, you don't get paid that well.*

GP3 appeared not to position herself in a socio-political context; her focus was on the clinical task: '*[I'm] certainly not political, just want to get on with the job*'. It was hard during the interview to discern what she had actually experienced as opposed to what she had heard about. As a result, I felt that the interview was a little flat at times.

As with a number of my interviewees, GP10 had not been enamoured with becoming a GP initially, but had been burnt out from medical training:

> *My medical training had the attitude, surely you go into general practice if you're just not very clever and you can't hack it as a hospital specialist. So, when I finished my house jobs I was absolutely burnt out already. I thought I would become a microbiologist. … And then I wouldn't have to talk to patients any more. I'd be in a laboratory. … Somebody else got the job.*

GP10 managed to convey what it was like to be a flesh-and-blood woman in a scenario where there was threat, seduction and accusation, in the job and in the wider culture. I felt as if GP10 was allowing me right inside her private/professional journey and giving me a full sense of its impact as we spent over four hours together. In the examples that she gave, she relayed a high preference for working in a good team rather than in isolation. About halfway

through the interview – which was appropriate, given the chronology of her professional journey – she informed me of a transformation:

> *My very good friend, whom I met in the GU [genito-urinary] clinic when she was working there in an assistant role, was in general practice. She's quite high up in the training. She said, 'why don't you come into general practice?' I despised them as a cohort because I didn't think that they had any particular knowledge. Where was the textbook that you could learn? That was the way that I thought about knowledge in those days. There is so much knowledge involved in general practice that you could never write the textbook, that's the point. When I got into it, I realised that it was the most flexible way of expressing yourself professionally. There are so many things you could do with it. And the expertise that you needed in all the different areas far exceeded the requirements of the knowledge base of specialists.*

GP10's remarks demonstrated a clear attitudinal shift, from holding GPs in contempt to feeling fascinated by the work and having admiration for them. Her comments about adjusting to general practice were striking:

> *The first thing I can remember about general practice was how terrifying it was in general practice for the first time as a trainee. … People were coming through the door who weren't sick, in my book. They didn't have hyperthyroidism, diabetes, they didn't have lung cancer. They came with symptoms that you couldn't make into anything. They didn't make up a chapter of anything. And that's what I used to get acutely anxious, because I wasn't able to cope with the undifferentiated nature of the presentation. It required a complete change in the way that you diagnostically reason, and also a vast widening of your knowledge base, and also an understanding of disposal, so how do you dispose of this patient. Because when a patient comes in, you're already thinking about how you're going to get the patient out.*

GP10 explained that she had managed her finances efficiently, and this had given her the flexibility and freedom to eventually leave the GP partnership and create

a very different life/work balance, without either the responsibility of long-term chronicity and dependency in patients or the struggle of working together with a partner that she despised and with whom she fundamentally disagreed. GP10 was also deeply committed to Balint work – which was how we had met – and its style of thinking. This perhaps simultaneously demonstrated her capacity to consider the doctor-patient relationship deeply and her wish to have sufficient freedom from feeling stuck 24/7 within a restricting environment – like being behind the counter in a corner shop with customers *in situ*, and thus to some extent with a monopoly on local provision. GP10 presented with a low boredom threshold and a wish for new experiences of excitement, and yet she showed how she used her work to protect herself and create security in her personal life:

> *It serves its purpose, having my work here. Having dependants here, and enjoying what I do here, and knowing that if I moved anywhere else it would compromise that, and that would be a very high price to pay for moving in with somebody.*

*Theme 3: Underpinning Ethical Value System*

Some interviewees said that they were industrious in the medical work that they did undertake and treated each and every appointment as needing detailed attention. Each stand-alone clinical response was sound, and this was more arduous than the 'luxury' of repeating consultations with patients over time, where one could manage anxiety and hold off from immediate diagnosis or prescription. There was a sense in which some GPambs might have been approaching general practice as a series of one-off consultations – an approach more common in other parts of the healthcare system – rather than the ongoing doctor-patient relationships of which GPcoms tended to speak. However, other GPambs were doing ongoing work with their patients but were very much in touch with feeling overwhelmed by it, and they were trying hard to offer clinical treatment as ethically as they could manage despite feeling compromised. Their focus was on survival.

GP10 had specifically sought employment as a GP at the front of A & E, so in this way was identified with breaking down the barriers to emergency contact.

However, in so doing she had removed herself from the pressures of ongoing care for chronic patient needs and the never-ending challenges of partner colleagues. Perhaps this was how she now avoided dependency and intimacy. She referred to a ‘corner shop’ mentality whereby GP surgeries have a captive market and to some extent a monopoly on the local patient population, who will buy whatever they are sold, whatever its quality – or lack of it.

GP10 was thoughtful about contextual issues, both societally and medically: ‘*I think now that general practice is seen as just lots of stuff you can do nothing about. What can you do about all these social problems? Nothing*.’ Simultaneously, in her current role as a GP working in A & E, she was exasperated by the muddle and inability to pin down responsibility for poor communication or decision-making:

> *She categorically denied anybody coming to her from reception with this query. … I don’t mind people getting it wrong and saying hands up. Sorry. Misunderstanding. Stupid me. Do it better next time, really apologise. But what I do mind is when people lie … not being able to trust your colleagues. … I might stick one on one of the consultants in A & E because I’m so frustrated.*

Perhaps after all a loss had been incurred from working in a GP practice and being able to influence and address issues as they arose, which GPcoms described as a key strength of the partnership model.

*Theme 4: Satisfaction in Role as Clinical GP*

GPambs generally conveyed the challenges of the work at every level and how they tried to survive it. Nevertheless, what they found satisfying was the clinical work with patients when they had more time.

But GP12 also let me know that there were parts of the system which appeared split off and unintegrated with the more luxurious style of working directly endorsed by the prime minister:

> *Hub work is a particular kind of work that's funded, it used to be called Prime Minister's Challenge Fund work. It's a luxury, but you see patients from a whole locality in a hub. In a room in a practice you get access to the full medical records, but they are 15 minute appointments. So it's very nice that way, and you don't have all the admin and restrictions that you'd normally get in a locum. You're in this virtual service. You're not part of a team. You never get to see the people who lie above you in that organisation.*

GP3 spoke of her current role as going to the elderly at home to help avoid their having to go to hospital:

> *December or so of last year, and I kinda saw her [elderly patient] quite regularly, and she died in July. And it was quite … I suppose I felt like I was being more of a proper GP, in that I was getting to know her, and I kind of had a lot of continuity with her, looking after her, and that to me … I mean, admittedly, I could not say she remembered me, because she got quite demented towards the end, and she didn't know who I was. But for me, that was the sort of idea that a GP is all about … I suppose as well.*

The question perhaps was: what would enable her to like a practice enough to commit to it? She was in the extremely early stages of her professional career and finding her feet by testing the ground, after which time she said she would most likely settle in one practice. However, like some of her friends, she also said she would move on to affiliated work if the NHS became too onerous. I would say that she currently presented as indecisive, and how she proceeded would be largely determined by how she felt treated, both in role and contextually. She was a floating voter, so to speak, who had the capacity to become committed given fertile conditions! It would seem that she was unlikely to consider herself failing and more likely to continuously reappraise her own working context to determine whether or not it was a good fit.

*Theme 5: Takes Visionary Systemic Leadership Role*

At the time of the interviews, it appeared that a heavy cost to personal well-being was being paid for systemic failures, which further cemented an outsider position and a feeling that the only way to survive was by being peripheral or a locum, thereby reinforcing the problems. GP10 and GP6 were both trainers of trainee GPs and in this way contributed to the development of the next generation. GP2 and GP3 were working as locums early in their careers; as GP2 told me, she did not get offered the opportunity to work as a commissioner or have any influencing role. As a GPamb, GP12 avoided being caught up in the GP surgery itself or the wider healthcare system. But she worked in a voluntary capacity to support locum colleagues. She was preoccupied with the demands that the context was making and the pressure it was creating. GP12 appeared to convey that the support in the role had decreased but the demands had increased:

> *The whole of the NHS is under such huge strain. You can expend a huge amount of energy on 'there's a boundary there, that's your job not ours'. If you just accept everything that comes your way, it becomes even more unsustainable. …The main thing is that you feel much less supported in dealing with adults with quite complex, involved mental health problems. … QOF certainly becomes a distraction from whatever the patient brings. … You get these centres that sift through GP referrals to decide whether they're legitimate or not. You get CCGs making blanket decisions about certain operations not being available any more. Then there's all this talk about these STPs, Sustainability and Transformation Plans, which are perceived to be all about finding ways of delivering cuts.*

GP12 was aware of the wider system of GP practices, how the landscape was changing, and how it might evolve in the future:

> *Couple of different models. There's ones where an acute trust takes over several practices, we used to call them ACO [accountable care*

*organisation], and then there's the model where you get several practices clubbing together to form a super-practice. They've got their plus and downsides, but at a time of cuts in services there's no doubt there are economies of scale in having a lot of the systems done at a larger scale. … There's just so much uncertainty.*

GP12 conveys a particular state of mind in this description, one in which it is a better landscape for her if there is a disconnected array of disparate options. It was not that she was emphasising the strength of practices being run as small, efficient partnerships, as was the case with GPcoms. It was more about objectifying, dividing and recovering: if there were issues in one practice, she could simply move on to another, using their isolated nature to split them apart in the mind as disparate part-objects.

This demonstrates how failure gets deposited into individual GPs, which makes them ambivalent about both their own roles and the organisation, which is not held accountable. Furthermore, because insurance is held individually, clinical blame can only be held at the level of the individual GP, not systemically. There are serious implications when team dynamics go unaddressed, which may lead some GPs to become more ambivalent and peripheral. Encouragingly, however, in GP12's case a new colleague was supportive, so perhaps there was potential in the next generation to support and enable. For some, being sessional workers makes GP work survivable and is changing the landscape of the partnership model. This may be a protest against the workload of GPcoms. Like GP12, those who feel failed by the system may become champions of the GP(amb) status, despite experiencing its failings first-hand – a defence perhaps against humiliation. Currently, problems are projected into single individuals with valency for being rejected by the team and feelings of low confidence. GP12 shows us her valency for ambivalence and low self-worth, but also her systemic experience of feeling pushed to the periphery of an overstretched system that has shown lack of care. She also informs us of the domino effect of GPs feeling overwhelmed and retreating to locum positions, leaving partners overwhelmed, so that when they collapse or leave there is nobody to replace them – with the result that the GP surgery folds, patients are absorbed by nearby practices, and the whole

process happens again. GP12 had set herself up as a champion of locums: GPambs on the periphery.

*Theme 6: Overwhelmed by Context*

All of the GPambs described overwhelming levels of administration, the personal toll it took, and the measures they took to try to either avoid or manage it.

GP3's local context seemed to expose her, like many of her contemporaries, to administratively overwhelmed partners who were burning out, overly demanding patients, and a wish to avoid all that. She also frequently spoke in the third person, as in the following example:

> *In terms of filling actual GP jobs, and filling empty spaces, I think for me it's probably people wanting to … not wanting to get stuck there till nine or ten at night under a pile of admin. … Just in terms of stress and level of responsibility, people would rather stay out of it and kinda do their job and go home.*

Although GP12 defended locums' position and thought they should have more employment rights – she referred to Uber drivers as being in a similar position – she also recognised that the whole model of general practice might collapse:

> *That's one of the anxieties at the moment, that you can't sustain general practice if everybody moves into locum work. You've got to have people who are based in a practice or health centre maintaining systems and continuity. That role has become so unsustainable that there's essentially this domino effect happening in practices where if a practice loses partners and can't replace them, or doctors, and it becomes unsustainable for everybody else in that practice, and then they can't get locums, the practice folds. The patients get redistributed to neighbouring practices, who then also can't cope, who then can't recruit.*

She showed me images that she had put together of GP locums en masse; I found them faceless, nameless and somewhat eerie. I was reminded of an army of robots rather than of individually recognisable doctors with patients' narratives and concerns in their minds.

*Theme 7: Business-Minded Approach to Financial State of Surgery and Context*

None of my GPambs described being involved in creating new clinical pathways or raising bids or funds for any of the practices where they were working. However, GP10 did describe having undertaken a business degree before she became a GP partner and how this had enabled her to manage the role efficiently, although working alongside other partners who had no training had been incredibly frustrating. Ultimately, she had given up her role as a partner. GP2 described herself as representative of recently qualified GPs in that she had not played a role in commissioning or managerial aspects – and nor, she said, had any of her medical contemporaries:

> *Class of 2013 … none of us have taken on a lot of managerial commissioning sort of roles – still very much an old boys, old girls sort of club. You still need that clout, you need some sort of a … not like a patron, but someone to really take your hands and introduce you around and give you stuff to do, otherwise it just gets taken up by the big dogs, and … you just sit there looking like a numpty.*

Educated in a private English boarding school, she perhaps had some direct knowledge of the 'old school tie', which is based on who you know, where you were educated, your accent, the class system (to some extent), homogeneity and familiarity. Given her Asian nationality, and feeling like an outsider in any case, she perhaps noticed these issues keenly, although a number of interviewees described discomfort with the medical hierarchy and an ensuing feeling of humiliation.

*Theme 8: Determines Own Timetable*

GP2 conveyed her struggle to commit to the role of GP and feel a sense of belonging. Choosing locuming had enabled GP2 to find relief from the continual demand. It meant that she felt in charge of her own timetable for the first time since qualifying, and crucially she had prioritised relationships with family and friends across the world via Skype, often during the night when they were awake. GP12 also described the importance of being able to be flexible, and said that being a locum meant that if you burnt your boats with one practice, you could always find work in another. GP12 stated categorically that being able to dip in and out was vital to one's survival as a GP; otherwise, more would leave the profession. GP10 communicated how she fits her work around her personal commitments and took on more or less depending on what else she wanted to do. GP3 was mixing different roles for the sake of variety.

GP12, who was salaried one day per week, was aware of the benefits of the current system, with its quirks and different subsets, which meant that one could potentially move around, recover and reinvent oneself:

> *On the positive side, there's a shortage of GPs, so you feel you can invent yourself endlessly, reinvent yourself, even if you burn a bridge at one practice there's always other practices you can approach. Once they start to amalgamate into large organisations, it limits your ability to reinvent yourself. That flexibility you had in small practices to say, actually for the next month I'd like to start my afternoon surgery at this time instead of that time, you can imagine once you're in a big organisation it's going to be much more standardised. I have considered for a while moving out into locum work, and I worked as a locum for several years and at a time when there was huge demand. When there's a lot of demand for locums, working as a locum is great, because you can pick and choose.*

*Theme 9: Family or Own Illness Acts as Motivator*

GP12 seemed to have gone through a process of elimination in order to ascertain what had made her feel emotionally stressed, as a way of identifying what she

could not do so that she could be clearer about what she did feel able to undertake:

> *Looking back, I'd had some periods of depression as a student, so they were decisions coloured by what can I do that will allow me to stay well. … I was somebody who needed quite a bit of control, and working in a hospital had a lot of factors that made me feel out of control. … Not knowing whether you'd have a supportive senior, and whether the nurses would do what you felt needed to be done. … Having a responsibility for patients without the authority to execute plans you felt needed to happen. It was this feeling of powerlessness.*

Clearly her focus was broad and was also about her own survival and that of others in the medical system:

> *I realised pretty early on that full-time clinical work of any kind wasn't going to be for me. I carved myself a role that was a mixture of education, union and clinical work. … [The union work] very early fulfilled something for me around finding a network of similarly minded people who felt they could challenge the status quo, but also an opportunity to write and develop ideas, and write policy, analysis and strategy documents. An opportunity to do those types of work that weren't available in my clinical role.*

In this self-analysis, I felt there was an indication of a personality arising from GP12's psychic development that would always find ongoing emotional proximity and exposure to others – particularly dependent patients – oppressive. I found it interesting that she utilised the medical community to help her contextualise her feelings and provide her with a validating feedback loop, which appeared to help by giving her a sense of having her existence witnessed and affirmed and her personal and professional identity validated.

GP6 let me know that his older brother had killed himself as a young man. At the end of the interview, I asked a specific question about his motivation for becoming a doctor and whether this might have come from family need at all; he denied

this, saying that all the family were healthy. It was only then that I felt able to come back to his brother's death, which he had disclosed early in the interview:

> *My brother committed suicide. So obviously, that was a bit of a different kind of illness, if you like. And still very difficult for us to understand then, and even now. 'Cause he was never formally diagnosed with a psychiatric illness. … It is probably difficult to say what went wrong with him.*

There seemed no scope to appropriately ask more.

*Theme 10: Family Aspiration Acts as (De)motivator*

By working as a doctor, GP2 – who was originally from Asia – was fulfilling her father's dream, but she was doing so on the other side of the world from her family and friends. The doctor-in-the-mind was a hospital doctor; being a GP was second rate by comparison. Being a locum in dermatology was closer to her original idea of being a doctor. This view that GPs have lower status compared with hospital consultants and other professions came up in many interviews. GP12 let me know that there might be a harsh critic inside her mind, which needed to be mitigated by an army of like-minded people:

> *I come from a very achievement-orientated family, very academic. Both my parents are professors. My brother is a professor, and academic success is very highly regarded, and I know they don't consider general practice to be in the same league of achievement, much like within medicine itself, general practice is regarded as a lower-status choice. There's a sense that I'm more ordinary within my family than other members.*

GP10's well-educated working-class father's attitude to work had highly influenced her, and she identified GP training as much more akin to the apprenticeship of an engineer or mechanic. GP3 described caring for her grandmother, who had told her she would be a good doctor, which became an aspiration.

### *4.3 Immediate Context: GP Partnership Model*

GPs work in a variety of contexts, although the most common is still a general practice run by GP partners, even if some are joining together to form PCNs. Some strong views were expressed by the different types of GP. GP10, a GPamb who used to be a partner, conveyed quite powerfully and with a number of examples that GPs, particularly partners in surgeries, could have the capacity to think for themselves, have agency, and influence their immediate surroundings in an efficacious and productive way, but also that GP training had a bearing on other medical training:

> *We don't do well in organisations that are tiered. Where there are tiers of authority. The creativity amongst general practitioners, the desire to be self-managing and self-motivating, the desire to make changes where changes can be made quickly, without undue consultation, that desire to react quickly to the environment. That quick thinking that can pick up on something that isn't written in a textbook. … In general practice you come in the morning and something's wrong at reception, you sort it out, and it's sorted by 5 pm. If you come into the hospital and there's something going wrong in reception, like one of the receptionists isn't trained, you can't just put it right. They're not your receptionists.*

In a sense, what GP10 may have been conveying was that the freedom and separateness that could be enabled by the current partnership structures constituted a crucial contribution to healthcare, which could otherwise be rather bureaucratic or like a stuck machine.

GP8, a GPreneur, recognised the power of the partnership model:

> *I hope successive governments understand its [the partnership model in general practice] value and understand how the independent contractor status contributes to its value. I think it won't be the same if you have loads of salaried people, it won't work in the same way, and an awful lot will be*

*lost. … Huge strength about general practice is that we do run it ourselves, and we are amazingly efficient.*

GP5, a GPcom, had fought personally and professionally to make it possible to manage the undertaking of the role of GP and then GP partner. He also informed me of what was at stake in the neoliberal attitude to healthcare:

*One of my close friends, who I saw yesterday after quite a long time, her practice has just been taken over by Virgin, and basically the whole dynamics has changed overnight. The management is poor, and the doctors have the feeling, well, it's not my practice any more, I don't care if the nurse arrives or if she doesn't. It's not my problem any more. These doctors were taken over by Virgin not so long ago, about three months ago. They say it's been a shambles for three months. They say it's been very poor management, and Virgin don't make much money out of general practice anyway. They're only doing it to get a foot in somewhere. So you ask me, take away the partnership model and you'll lose practically everything that I hold dear.*

GP11, a GPcom who had been industrious in the management and finances of his GP surgery, expressed in a nutshell his understanding of the enterprise of general practice, and helped me to understand that the context that he had been striving to maintain and embellish, despite many cuts, was all-important:

*The loss of the attached dietician and podiatrist and physiotherapists, so all the professions allied to medicine, which used to be co-located in our premises, and then that's been followed over time by the loss of our practice-attached district nursing and health visiting teams, who were the core health professionals of the primary healthcare team. They've written books about this practice and primary healthcare teams, and to lose that because of reorganisation and finance and this notion of corporate caseloads and so on is hugely detrimental to joined-up healthcare.*

In summary, as is well known, GP partners run GP surgeries as small businesses as well as clinics. GP partners often employ salaried GPs and hire locums to

execute clinics. A number of GPs in my sample do not believe that the GP partnership model will survive. In recent years PCNs have been created, whereby a few general practices come together and pool their resources to form a cluster of medical services and submit joint bids. However, there is concern that the integrity and care that goes into the decisions that partners make – based on their knowledge of patients and their relationships with their immediate staff – will be lost if the partnership model collapses. GP partners describe a sense of ownership, going the extra mile and immediately being able to affect and influence the GP system, in contrast to unwieldy hospital structures where it is impossible to effect change in the immediate to short-term. One of the GP partners in my sample expressed feeling at a loss as to why small businesses such as GP practices would be attacked: surely they were an efficient business model that was highly effective and would fit a business culture for health in line with neoliberalism much more effectively than other business models! GP7, a GPcom who was a partner, said: *'We're cheap as chips, and that's just looking at it financially, because we're so efficient, because we know our patients and we can deal with multiple issues at once'.*

This chapter has given an in-depth analysis of the interview data under the three GP types, describing their attitudes to the themes. The next chapter offers diagrammatic representations and further considerations, turning to social defences and valency as theories to explore the system in GPs and the person undertaking task in role within their context.

## Chapter 5. Summary and Discussion of Findings

In this chapter, I look back at my original research questions and use these as a basis to assess how my findings contribute to the aims I set myself at the outset. Following some deliberations, I arrive at some holistic conclusions from the findings. The research that I undertook was 'a systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery', including additional research questions about orientations, motivations, valencies, stresses, satisfactions and dissatisfactions in relation to role and context. I also attempted to uncover what situational, organisational, economic and cultural changes in the functioning of general practice are currently impacting on the experience of GPs, and what strategies or defences they are taking up to adapt to them.

From my study of the situation and experience of 12 GPs, I constructed typologies of three different kinds of adaptation to their environment. I will use this as a basis for reflecting on what is happening to general practice, and what might be done to further develop and make practical use of my findings. Having considered the context of general practice and the wider NHS system earlier in the thesis, I can now deduce from the data that neoliberalism does appear to have had an impact, both as an ideology and in its pragmatic implications, and that it has had far-reaching effects. Budgetary implications and clinical practice are intertwined in a particular fashion such that the phenomena of bidding, commissioning and demonstrating compliance with externally imposed clinical targets and measuring outcomes, partly to ensure funding, are at the core of general practice. These components are not only determining the joining together of practices but also infiltrating GPs' responses to their job.

### *5.1 Adaptations to the Role of GP*

Adaptations to the role of GP seem to occur in three main ways, as I have described: first, by becoming 'entrepreneurial', that is, responding to the demands and opportunities of a more competitive and market-oriented system; second, by remaining steadfastly 'committed' to the values and practice of patient care as

the family-doctor-in-the-mind, striving in a myriad of ways for its sustenance; third, by being somewhat on the edge, either by choice or as a result of being professionally positioned there – 'ambivalent' about the central administrative, bureaucratic and business elements of general practice, and mostly peripheral to ongoing patient and collegial relationships. Within the larger state of general practice and its changes in the context of the current NHS and GP system, my study and the three GP types demonstrate the impact of the environment on a role which is usually associated with a steady, identifiable, reasonably stable profession. It shows us that the nature of professional life is not static; on the contrary, people in role respond differently, moving towards or away from contextual demands, and they may take up a position of heroic enactment, stoical determination or retreat. In this case, my findings suggest that attitudes to task, role and system among the medical profession in general practice are strongly affected by the political milieu, with its attitudes towards and impact on clinical provision and its funding. Neoliberal circumstances do not just affect patients in their daily lives and their attitudes to being customers, but also impact on GPs on a continual basis, in terms of providing a service and in relation to their overarching orientation to the job at hand. The three adaptations that have been revealed through my research are different responses to this contextual confrontation. Positions such as GP partner, locum, GP commissioner, trainer, mentor, Balint group leader and so on enable GPs with different proclivities to take up the kind of work for which they have a conscious and unconscious fit. These various positions require different kinds of GP, and this also has a bearing on who is left to attend to the bulk of patient-facing clinical work. Nevertheless, the business nature of healthcare is omnipresent and may seep into every pore of general practice, although it may be more explicitly evident in some areas of the work.

The main findings of this research study are that there are different adaptations to the GP role in the current system of healthcare. Each of the three GP types involves turning towards preferred operational components while simultaneously implementing social defences so as to avoid certain aspects of the task, role and system. Two particular issues are particularly significant for each type: the type of organisation-in-the-mind, and the definition of the primary task. It may seem obvious that the primary task is the clinical task of attending to patient needs, but

perhaps part of what determines a GP's type is his or her relationship to what he or she actually does. The Royal College of GPs curriculum for 2019–2020 is a weighty document which summarises the complex range of tasks into a page and a half, so it is hardly surprising that different practitioners home in on different components. But how consciously or unconsciously determined is this process? The complexity of the primary task, as described by Lawrence and Robinson (1975), is open to interpretation, and it may be defined differently by various members in a group or in component parts of a system, such that what the person or group is supposed to be doing or is paid to accomplish or deliver (normative) may be different from what the group members think they are doing (existential). If these are out of alignment, then there may be engagement with a phenomenal primary task in which a conscious/unconscious split may be played out. It might be that the three different GP types have varying primary tasks in their mind, as well as contrasting ways of taking up the role. In the three descriptions that follow, I refer to the 'task' as the direct clinical work of supporting patients medically, the 'role' as the bureaucratic, administrative and managerial components of running general practice, and the 'system' as the wider system of healthcare, such as hospital medicine, other practices within PCNs, private providers, charities, community provision and other stakeholders. If all of these elements are synchronised, then the role and system should support the clinical task of patient care. The transformation of health in the patient population now includes discerning levels of patient activation, enabling patients to shift towards proactive approaches to health and well-being and to engage with community provision. It may be, however, that the relationships to task, role and system are diverse, resulting in different GP types.

### *5.1.1 GPamb*

GPambs focus on the direct clinical task as it presents itself in space and real time in the patient's body/mind in front of them, while mostly avoiding wider issues such as managerial and bureaucratic responsibilities for running the practice, managing budgets or bidding for tenders. Feeling less encumbered may enable them to focus on patients' clinical needs and be highly dedicated to patient care. While they may benefit somewhat from the flexibility in their timetable and location

of work, and sometimes from a higher hourly rate, they may become isolated and split off, and feel unsupported and insufficiently embedded in the GP surgery system for a coherent service to patients and a professional sense of belonging. This may add strain to other GPs of any type, as the long-term issues and structural elements of the surgery become neglected over time. I have attempted to illustrate this skew towards the immediate clinical task in Figure 3, where the focus is shown as a half-moon shape towards the task end of the GP surgery system. There are some settings – such as front-of-house primary care in A & E, and out-of-hours or walk-in clinics – where being able to focus acutely on the clinical need of the presenting patient in the here and now is essential. Thus, this GP type has an important role in the system of healthcare. But the red half-moon shape attests to the resulting outcome of GPambs' bias and their narrow approach to the job. Simultaneously, this means that there is insufficient attention to the ongoing administrative and managerial role of running the GP surgery, which is usually undertaken by GPcoms, and an inadequate focus on tendering, commissioning, envisioning and enabling new clinical pathways and monetary strategies, which is usually implemented by GPreneurs; these aspects are therefore shown in pale blue lines.

**GPamb – clinical task focus**

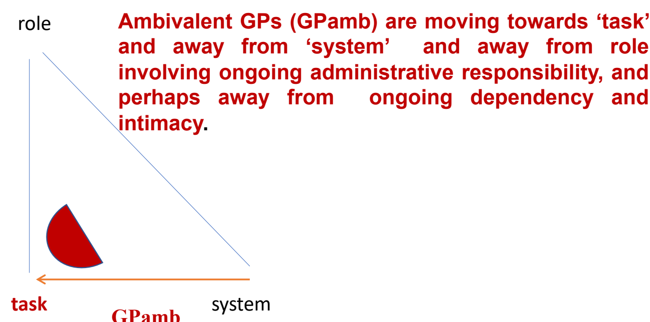



Figure 3. Diagrammatic representation of GPamb.

*5.1.2 GPcom*

GPcoms energetically invest in the ongoing clinical task and relationship with their patient population and the role of managing the practice relationally, administratively and consistently in terms of its financial stability, underpinned by social morality. At the same time, they may become overburdened with heavy responsibility and dependency, and may turn inwards, away from the rest of the wider setting. Many GPcoms express an attachment to the partnership model as an essential and necessary structure to underpin and support the work of GPs and patient care. These role and task foci are shown in Figure 4, with the purple line showing arrows in both directions, and a resulting purple half-moon illustrating the skew in the GP surgery, which lacks a wider systemic focus. The effect in a GP surgery dominated by GPcoms may result in a bias whereby there is insufficient entrepreneurship for the new challenges required in current times. Surprisingly, the GP surgery may even suffer if there are no GPambs plugging gaps to create flexibility and enable GPcoms to take time off due to their own sickness or when away on holiday – although GPcoms may want neither the financial cost to themselves nor the introduction of temporary medical treatment for their patients.

**GPcom – role and task foci**

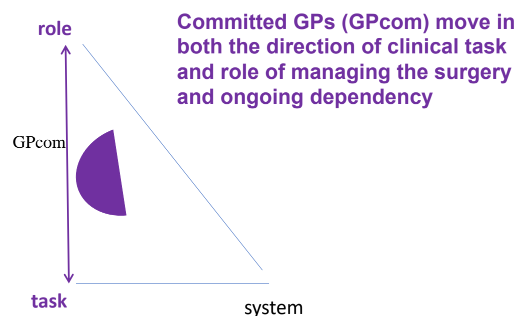



Figure 4. Diagrammatic representation of GPcom.

*5.1.3 GPreneurs*

GPreneurs actively engage with the business and monetary viability of general practice and the wider healthcare system, including tendering for bids, envisioning new ways of working, commissioning new services, and engaging with private provision. But there may be a turning away from their own direct delivery of clinical work from day to day and in long-term patient and collegial relationships, as well as from the ongoing management and administration of general practice. I have illustrated this focus in Figure 5 with the green arrow directed towards the wider healthcare system, with a resulting green half-moon situated away from task and role, so as to show their bias towards the enterprise of the GP surgery. In this case, the danger is an insufficient focus on the task of tending to long-term clinical issues in patients and collegial relationships, and also on administrative and management investment in the GP surgery itself, as GPreneurs are away tending to commissioning or generating new interests, or are predominantly externally preoccupied. This does, however, play the increasingly vital role of creating new clinical pathways, engaging with the community, and considering funding to ensure the financial survival of the practice, on which clinical viability depends.

**GPreneur – wider system focus**

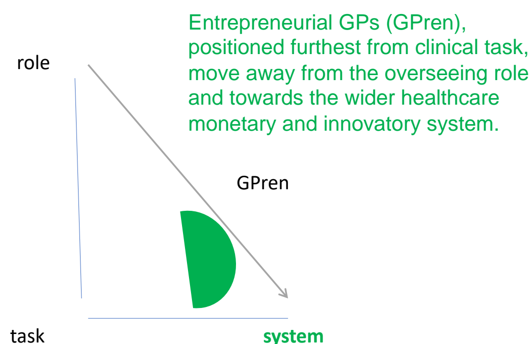



Figure 5. Diagrammatic representation of GPreneur.

In the next section, I consider the way in which traits from more than one type coexist in some GPs. This then leads on to my ideas about attributes and valencies, and how there needs to be a complementary relationship between them to enable a well-functioning GP practice. This will mark a shift of focus in my research findings, from a phenomenological exploration of different types of GP to a more holistic understanding of how these attributes may complement each other, each of them being partial outcomes of the history and current environment of GP practice.

### *5.2 Complexities*

Naturally, not all cases are pure examples of a distinct type. Here, I describe some of the nuances conveyed by my GP interviewees. Some of the GPs whom I described above as GPcoms had aspects in their presentations which carried some components of either the GPreneur or the GPamb. For example, in his determination to sustain the ethos that he had joined, GP11, a GPcom, showed me his development into somewhat of an entrepreneur – procuring funds through successful negotiations, and being creative with the system in which he was effectively a business leader, with the purpose of sustaining his surgery. GP11 demonstrated an attitude that integrated commitment to patient care through ethical practice with the additional capacity to consider general practice as a small business within a wider NHS system. This required an entrepreneurial creativity, which he undertook from a socialist perspective. In his interview he described his struggles when the governmental attitude of neoliberalism dominated his professional life.

GP5, a GPcom, conveyed periods of ambivalence in his role as a GP and how he had worked to develop his ability to be committed. Emotional relationships underpinned partnerships as well as patient care, and GP5 had struggled with both at the beginning of his career:

> *There were quite a few complaints about me. I was very prickly and not very easy to get on with in the early days of general practice. Through lack of confidence. And so I had to endure quite a few years, say the first five*

*years, of odd complaints. And then after that I had no complaints for the rest of my career. But it was quite a difficult first five years, I'd say. The colleagues took a very long time to gel, before you really settle down with your colleagues. … Yeah, my partners. We had a very close relationship. We were together for more than 20 years. But to get to know each other … there were frequent outbursts and tempers and God knows what else. … If she hadn't walked in the door that day, I would have just left after nine months. … I grew to love them very much. So, it was a pivotal moment.*

GP11 referred to the clinical room as virtually a personalised sanctuary. In stark contrast, GP5 conveyed the impact of an unpleasant space that had affected his attitude:

*I was put in a converted cupboard, actually. My surgery was a little converted cupboard, and I had no space. It was very primitive conditions in those days. It was hard to imagine what practice was like in 1990 compared to today. And they had promised me when I joined that they were moving to the new building. That fell through, and then the recession hit, and so the new building was delayed. Then finally we moved into a beautiful building about six months later, and that saved the day as well.*

GP5 managed to convey a sense of the threat of engulfment which had perhaps pervaded his emotional life. His Jewish immigrant roots were apparent at times, particularly when he described being on holiday and coming across huge numbers of migrants on trains, when in his mind he was thrown back to the Holocaust, spontaneously giving all he had to offer at the time, which was his home-made sandwiches:

*My girlfriend and I went down the Danube on a bike, and a beautiful ride we had, at the height of the refugee crisis. This train was waiting to pull out of the station, and hundreds were going to be shipped out to some other part of Germany. But I just remember the smell of body odour. They obviously didn't have a shower for weeks or months. … So we got on our bikes, and that morning I had got some sandwiches for us in a little bag. And we headed off to the Austrian border, and just before we got there a*

> *minivan stopped and about 25 refugees all pulled up on the Austrian side to cross into Germany. And I just instinctively put my hand in my bag, and as we cycled past I pulled out the bag of sandwiches, and I just dangled it in front of me. And one of the guys just grabbed it. … The train, the symbolism of it all was just … if you were Jewish, you just immediately think one thing. And it has nothing to do with it whatsoever. But trains and even benign German guards and people huddled in little groups – it was momentarily quite unsettling.*

I was left digesting this graphic representation for a long time afterwards, and I thought that perhaps NHS patients had begun to feel like a desperate stinking mass to whom a GP could only offer a drop of help amid an ocean of need – or perhaps a miracle was needed. GP5 also conveyed the feeling of guilt and the threat of litigation that he had been left with even after retiring, after he had missed a case of prostate disease, which proved to be terminal, despite historical treatment, in an avoidant patient. He conveyed feeling beleaguered and simultaneously tenderly concerned for the patient and family, and this was made profoundly more painful by the long-standing nature of his relationship with the patient, who had valiantly managed other difficulties and complex relations about whom GP5 had known as the family GP. Perhaps it can be said that GP5 was a GPcom in relation to the psychotherapy aspects of the job and the partnership model, but a GPamb in relation to the rest:

> *For me, general practice was a very emotional job. I found that the science and the diabetes and the chronic lung disease started to become, almost, it was just too much to deal with. You had to focus on all the new issues that were coming along that the Balint type of work I was used to doing was starting to. There wasn't enough time for it, really. And that's why I retired. That's genuinely why I retired*.

Ultimately, GP7, a GPcom, helped me to consider GP characteristics that are attributable to GPcoms who are seasoned and others who may be anxious to 'fix' people, the latter perhaps being an aspect of the GPamb type:

> *A shift between when you are a new novice and when you're an experienced GP is you don't expect patients to necessarily do what you say or assume that they will. But you're not frightened by complexity [as you are when a new GP]. So, I think the new recruits who are just fresh out of medical school and have got the medical model whereby what makes a good doctor is somebody who can fix somebody. I also think they don't enjoy the same respect and long-term relationships, and I'm going so far as to say love, that our patients hold for us. And therefore, they get their sense of identity and agency and ability to be a good doctor from making people better. As opposed to standing shoulder to shoulder with them in their tricky lives.*

Otherwise, GP7, a GPcom, offered the idea that GPs with this 'fix it' attitude might sometimes get more stimulation from firefighting, perhaps more resembling the fight/flight mentality of a GPreneur:

> *There's a certain satisfaction in the siege mentality of getting through a busy day, but that's different from the sense of identity and joy that one gets from a day of wonderful general practice based on relationships and time and care … using science. … Those days are the ones that fill you up, make your heart burn with pride and privilege of the work we have, and feeling like you have a sense of purpose.*

In GP1, a GPreneur, there was a sense both of energy for the work and simultaneously of partial defeatism or ambivalence, which perhaps came from fatigue with the relentless demands. His approach seemed to be captured metaphorically in the most striking memory he described: rescuing a baby from dying at birth, only to be confronted with this same baby dead some months later. This could be translated as breathing life into medical initiatives only to be thwarted by social issues, relentless intense need, or deadly government directives.

GP3, a GPamb, might become a GPcom, given favourable conditions: she described valuing long-term relationships with patients when they did happen, as well as developing trust with senior colleagues. She also expressed the idea that

being attached to a specific surgery might feel satisfying – but only so long as the terms and conditions of work and renumeration did not worsen. GP10 might once have been a GPcom, but she had moved out of this position following a divorce, a feeling of long suffering at the hands of a GP partner, and a wish for flexibility in professional life to support a more varied private life.

The GPamb category is more complicated than the other two, and it is mixed in its composition – GPambs could perhaps also be described as ‘flexible’ or ‘uncertain’ as well as ‘ambivalent’. These GPs were difficult to classify due to this complexity, and some were not fully adapted to a GP role. They certainly were not merely ambivalent between the two strong roles of GPcom and GPreneur. There were different subvarieties within this type:

- One or two just seemed to find the role difficult, perhaps because of particular unsuitabilities or vulnerabilities, in the way that some individuals in every profession are uncomfortable in the role they have chosen.
- A second category might be thought of as transitional, or as still in transition – for example, they might well become a partner.
- Then there were those whose discomfort or ambivalence lay in the deficiencies of the system as they experienced it – the main problems were external to themselves.
- One or two were doing quite well, but were not as fully involved in the vocation as others.

The examples given above demonstrate that not all of the GP types are ‘pure’ cases. The presence of these hybrids does not defeat the purpose and insight of categorisation, since the GPcom (committed to the values and practice of patient care) and GPreneur (entrepreneurially responding to the demands and opportunities of a more competitive and market-oriented system) orientations are the most important and present in the modern GP world.

### *5.3 Defences Against Anxieties*

Considering social defences against anxiety in different professions, Armstrong and Rustin (2015a, p. 13), hypothesise that 'many primary tasks are liable to have associated with them a corresponding primary anxiety'. From my data, I have tried to show that among GPs, different adaptations are made to the demands, pressures, expectations and aspirations in their work. As the variation available in the role of GPs has expanded, the options for social defences have broadened. This may demonstrate the role of individual predisposition as to which gravitational pull or defence is taken up. It may also be that due to both external demands and internal proclivity within the GP partnerships that operate general practice, in an attempt to avoid anxiety, feeling overwhelmed or burnout, GPs tend to orientate in one of three main directions, as I have illustrated. It may be that unconsciously they define the primary task differently. These phenomena could be described as social defences, adaptations that are there to manage anxiety, burnout, or feelings of being overwhelmed. Each GP type would appear to have a predisposition towards particular social defences.

The GPcom may predominantly have an inward focus. At best this involves high levels of person-centred care and a huge contribution to the GP partner model, but there is a risk of overidentification with the role, and the GP surgery may become like home. Psychological stuckness in the dyadic stage of overdependency may ensue as a retreat, perhaps motivated by reparation, but with a risk of feeling suffocated, claustrophobic, resentful and burnt out, with the sacrifice of oneself and one's health, and perhaps a need to retire early. GPcoms' focus – perhaps the primary task as they see it – may include the need to rescue both patients and general practice itself. There may be a retreat and withdrawal from the wider context.

The GPreneur has an outward focus. At best this supports the business of general practice through engagement with commissioning, coordinating or interacting with the wider GP surgery network and stakeholders, enabling creative contracts that utilise local clinical GP expertise, and engaging with the community to treat the local NHS patient population. It may also involve making contracts with private providers or offering private clinics to paying customers.

The risk is that this dynamic focus on enabling organisational change becomes so appealing, or meeting targets – which may be the primary task in their mind – becomes so all-consuming, that there is little energy, commitment or focus left for NHS patient-centred clinical work, or that they neglect administrative and managerial necessities within the GP surgery itself.

The GPamb seems to be neither in nor out in terms of personal-professional investment, although GPs in this category are also more variable, and their characteristics are harder to define. At best, this develops variety and the creative use of different skills, sustains the GP role, and enables gaps in the system to be plugged. But it does so at the risk of precariousness, avoiding dependency, keeping a distance, and minimising multiple contacts with the same patients and especially with administrative demands so as to sustain the self. There are costs to the system through ignorance of local protocols, the loss of ongoing patient and collegial relationships, and a possible threat to the health of patients and even to the health of GPs. This may result in a perpetual feeling of being objectified and on the edge. I have said above that GPs in this category are the most varied. Some may be overly preoccupied with their own survival, which may overlap with the primary task in their mind of tending to the patient.

Looking at each type in more detail, we can see the personal/professional interface. Each GP's individual needs, strengths, motivations and previous experiences will influence to an extent which type they become. However, the context also makes its demands and therefore creates pressure, causing necessary adaptations to being a GP. This may mean that GPs with a natural proclivity for ongoing relationships with patients and colleagues may need to turn away from the overwhelming administrative or managerial demands which are part of the role of partner, becoming ambivalent and retreating to a peripheral engagement without so much personal investment. Meanwhile, those with an entrepreneurial flair and vision for creating new clinical pathways delivered by local GPs to their patient population can only engage in this kind of potentiality if the healthcare system supports out-of-the-box thinking and portfolio careers. Otherwise, their creativity may be wasted, or they may become demoralised by the tendering and bidding process, which demands so much time and inevitably has losers by virtue of the competitive process. GP types are forged over time

and result from various elements, including the context and the GPs' own unconscious predispositions, resilience and vulnerabilities. These include the patient-in-the-mind, whether in themselves or in actual patients, which leaves them with varying levels of commitment, ambivalence, entrepreneurship or an intersection of all three in relation to task, role and system. Furthermore, the identity of the GP role as a national stalwart is impacted by environmental, sociopolitical, technological and demographic forces. Social defences may emerge in the systems of general practice that operate to distance individual GPs from the challenges, anxieties and threats of clinical work, the survival of the GP practice or the overwhelming nature of the administrative demands. Bion summarises the challenge of the 'sophisticated/work group' (W) which is able to apply itself to the primary task and the continual challenge: '*If the W group were the only component in the mental life of the group, then there would be no difficulty. But … the W group is constantly perturbed by influences which come from other group mental phenomena*' (Bion, 1961, p. 129).

Having considered the differing foci of the three types using diagrammatic representations, and the social defences and valencies that may be at play, I will now give further consideration to the context and environment, to whose impact my sample have alerted us.

### *5.4 Reflections on General Practice*

The aim of this research project was to investigate the experience of GPs, and the state of general practice, in the light of changes that have been taking place in the NHS environment, where neoliberalism and marketplace mechanisms have a larger role than ever before. In the main part of the thesis, I examined the experience of a sample of GPs, using a FANI method.

#### *5.4.1 General-Practice-in-the-Mind*

This study has borne witness to the disruption of change where there is a dual culture of both dependency and fight/flight (tenders, money etc.). The varying GP

types that I have identified – the committed, the ambivalent and the entrepreneurial – are three different solutions to this underlying dual cultural problem. Taking a situational approach, we can see that these varying types are reactions to a context which induces fragmentation. Each approach is in some way still helping the GP enterprise, but the roles are unconsciously split into covering the necessary jobs. For example, GPambs have extracted the clinical aspect (task) of the GP job, while the GPreneur focuses on business sustainability (system), and the GPcom relates most strongly to the role of family-doctor-in-the mind. Halton (1995) has written on the tension and splits created in counsellors and teachers in clinical and educational settings respectively who are caught up in a neoliberal paradigm; he explores the defensive strategies and loss of professional integrity which result in a substantially reduced service to counselling clients and undergraduate students. Halton (1995) considers that it is extremely difficult to sustain depressive-position functioning in the face of a threat to survival. In the current organisational healthcare culture – and perhaps even more so now, under the cloud of the COVID-19 pandemic – fears about survival seem to dominate, not just in patients but in doctors too. The cost of unconscious splitting and the resultant social defences in GPs need further consideration in relation to the cradle-to-grave service that we assume they will provide. While technology may make more clinical tests and data available, we may need GPs to interpret the medical implications of these results for us as humans, support us emotionally, and consider treatment options. The GP-in-the-mind and the GP-surgery-in-the-mind may therefore have an ongoing and essential permanence in their meanings, even if their tasks evolve. We have seen government and public reliance on medical advice and treatment being heightened exponentially during the current pandemic, although some doctors have not been sufficiently supplied with personal protective equipment, about which there is an outcry. There are doctors' deaths too, which may challenge the notion that GPs are not patients! Doctors from ethnic minority backgrounds are considerably more likely to die from COVID-19, but the healthcare system has not protected them, even with this awareness.

Above I have summarised my findings from this collection of data, which identified three different kinds of adaptation and orientation among GPs to the recent and present situation. This typology can be summarised as an ACE (ambivalent,

committed, entrepreneurial) model, or perhaps an EAC (entrepreneurial, ambivalent, committed) model if emphasis is placed on entrepreneurialism as the uppermost consideration. It is possible that if I had interviewed a larger sample, additional kinds of career orientation might have emerged. Nevertheless, I hope that I have shown that the three types I have identified are fairly robustly evidenced in the data from my interviews.

However, there are some questions which were central to my study at its outset which have not been fully answered by these characterisations of how individual GPs adapt to their situations. These questions concern the organisation and functioning of the general practices themselves, and the division of roles and functions that exist within them in this changing environment. These questions are institutional in nature, involving groups within wider systems, whereas my principal data source focused on individuals. However, in my work as an organisational consultant, I actively hold in mind the system in the individual as well as how the person in role is situated in the organisational context. This refers back to concepts explored in the literature review at the outset of the thesis, such as Jaques (1951, 1964, 1989), Menzies (1960) and Menzies Lyth (1988) and their respective preoccupations with unconscious defence mechanisms that come from within the individual or are imposed on the person in role as a result of the demands of the institutional system. It also links back to contrasting concepts of the organisation-in-the-mind and their different emphases. The Grubb Institute model focuses on the internal psychic mechanisms in the individual in role and how they are brought into the organisation. In contrast, Armstrong (2005) developed the principle that the organisation dynamically affects the psychology of the workforce. I also considered Hinshelwood (2008), who proposes the necessity for awareness of both the individual psyche's contributions to the culture and the impact of the system on personal psychological functioning, so that both individual and social defences play their part. Similarly pertinent is Kurt Lewin's (1951) field theory, outlined earlier, in which the subject of social analysis is necessarily a holistic field of human interactions: individuals are understood to be both actors and acted upon by structures and customs external to themselves, with which they emotionally interact.

If we take the perspective that individuals internalise models and expectations of the organisations to which they belong, and are thus essentially social beings, then what are the corresponding organisations-in-the-mind in relation to each of the three occupational adaptations identified in my research, and what inferences can be made from the perspective of a holistic assessment of the current situation and trends within general practice? By asking these questions, I hope to make use of what individual GPs in role can tell us about the wider system, that is, the institution of general practice itself and its context.

### *5.4.2 Reflections on the Institution of General Practice*

In reflecting on my three ACE orientations, I came to realise that in reality these GPs did not belong exclusively to only *one* type, but invariably embodied *some* elements of the others. For example, my entire sample demonstrated a significant normative commitment to the values and responsibilities of being a GP with a primary concern for patients – even though this is more overriding as a purpose for GPcoms than it is for the others, who are induced by institutional or personal circumstances to give greater weight to other values.

But I also came to realise that if we considered the situation from the perspective of the practice as an institution, rather than from that of a GP as an individual, it was likely that all three ACE orientations would have some part to play in the way a practice actually functioned. Actual practices, and perhaps especially practices that were well adapted to their situation, would be likely to depend on the complementary functions of more than one of my three orientations, albeit in different balances. It seemed to me that a trend could be inferred towards the entrepreneurial – a lessening of the force of the primary normative commitment to the values of general practice – as a consequence of changes in the wider NHS environment and the broadly neoliberal social climate of recent decades. It is also fair to surmise that avoidance of the bureaucracy, administration and management of general practice results in a number of GPs feeling ambivalent and occupying peripheral positions.

### *5.5 The Periodic Table as a Metaphor, and the Relevance of Valencies*

As described above, I have tried to think out how the three different types may work together in actual general practices, even though I have not undertaken an organisational study of these relationships. Rather unexpectedly, Mendeleev's periodic table was instructive for my reflections on the multiple qualities of the members of my sample and how they might be thought to comprise a holistic complement of attributes. Having worked in surgeries, and drawing on the variance among my interviewees, I hypothesise that general practices are likely made up of complementary combinations of orientations and capabilities. Indeed, they might need to be so in order to function well, and we could put forward the hypothesis that a 'good enough' general practice is one that embodies a mixture of each of these attributes in the form of a division of function between practice members. It seems clear that practices can be expected to differ in regard to what the dominant orientation is: there is evidence of this from my GP sample, and it might also be in a process of historical transition.

The periodic table is discussed in detail in section 5.6. First, I would like to discuss the idea of metaphor in this context, and to make the link with Bion's notion of valency.

#### *5.5.1 The Use of Metaphor*

I use the periodic table not as a substitution or comparison metaphor, which is carefully explored by Black (1955), and which would be more readily replaced by literal explanatory descriptions. Instead, I intend to use it as an interactive metaphor, which Black (1955, pp. 291–293) outlines in considerable detail:

> *Their mode of operation requires the reader to use a system of implications … as a means for selecting, emphasizing, and organizing relations in a different field. This use of a 'subsidiary subject' to foster insight into a 'principal subject' is a distinctive intellectual operation … demanding simultaneous awareness of both subjects but not reducible to any comparison between the two. … Suppose we try to state the cognitive*

> *content of an interaction-metaphor in 'plain language'. … The set of literal statements so obtained will not have the same power to inform and enlighten as the original. … The literal paraphrase inevitably says too much – and with the wrong emphasis … [entailing] a loss in cognitive content.*

Alternatively, Duhem (1954, p. 97, as cited in Bailer-Jones, 2002, p. 111) refers to analogy as '*a correspondence [which] serves "intellectual economy", and it can also "[constitute] a method of discovery" by "bringing together two abstract systems"; either one of them already known serves to help us guess the form of the other not yet known*'. Bailer-Jones (2002, p. 114) explores the link between analogy and metaphor:

> *A metaphor is a linguistic expression in which at least one part of the expression is transferred from one domain of application (source domain), where it is common, to another (target domain) in which it is unusual. … This transfer serves the purpose of creating a specifically suitable description of aspects of the target domain, where there was no description before … when the two domains between which the transfer occurs can be viewed as being related: by similarity of object attributes, or by similarity of relationships. Thus, the relationship of analogy is usually an important factor in being able to understand a metaphor.*

She goes on to explore Martin and Harré (1982, 1988) and other theorists who consider the way in which use of metaphor can include vocabulary and partial or entire models, and she quotes Black (1993, p. 30): '*Every metaphor may be said to mediate an analogy or structure correspondence*'.

In the field of systems-psychodynamic consultancy, Gareth Morgan (1997) writes comprehensively on the nature and application of metaphors, their inherent paradoxicality (applying his own examples) and their role in understanding organisations and management. He emphasises the necessary use of intuitive processes at a subconscious level, and he explains that, albeit often implicitly,

*metaphor exerts a formative influence on science, on our language, and on how we think, as well as on how we express ourselves on a day-to-day basis. … No single theory will ever give us a perfect or all-purpose point of view.* (Morgan, 1997, pp. 4–5)

### *5.5.2 Valency and Basic Assumption*

There is a point of connection between my study of GPs and the dynamics of the periodic table. This lies in Bion's idea of valency, which is the unconscious or partly unconscious disposition that links individual members of a group to the basic assumption group to which they belong. My periodic table metaphor draws an analogy between this psychoanalytic or group relations concept of valency and the physiochemical valencies which the periodic table assigns to the various atomic elements based on how readily they bond with other elements. It seemed to me that Bion's psychosocial valencies could be assigned to my ACE types, which could help to explain why they were oriented to general practice in the ways that they were. This has a connection to Bion's concept of 'basic assumptions', and the way in which they shape the unconscious dynamics of group and indeed organisational behaviour. For example, it seems clear that recent decades have seen a weakening of valencies of 'dependency' in citizens' relations to the welfare state and the role of GPs (especially GPcoms) as providing safe containment for dependency needs, and a strengthening of the valency of 'fight-flight' in the growing culture of competitive individualism. One might suggest that the GPreneur orientation is the one that most comfortably adapts to this 'fight-flight' orientation – although perhaps, in its hope of finding new ideas and projects to resolve difficult situations and make progress, it also embraces the 'pairing' orientation, which is preoccupied with the future and creating something new. One might suggest that the whole contemporary ideology of finding 'partners' for projects of different kinds embodies such messianic hopes of pairing and coupling.

Having introduced the usage of the periodic table as a metaphor to explore valencies within the different types, the next subsection further explores

variations and their propensity for interactivity. This supports the development of the idea of general practice as an institution with dynamic components.

In trying to consider GPs' unconscious group dynamics, I turn to Bion's definition of the term valency, which, as noted above, he borrowed from chemistry, where it denotes the power of atoms to combine. Bion uses this term to refer to an inbuilt driver, although it may vary in strength. He states that valency is

> *the individual's readiness to enter into combination with the group in making and acting on the basic assumptions; if his capacity for combination is great, I shall speak of a high valency, if small, of a low valency; he can have, in my view, no valency only by ceasing to be, as far as mental functioning is concerned, human.* (Bion, 1961, p. 175)

With regard to how the readiness to combine may be apparent, valencies '*may hardly be called mental at all but are characterised by behaviour in the human being that is more analogous to tropism in plants than to purposive behaviour*' (Bion, 1961, p. 175).

According to Bion, the sophisticated work group is on task, but it will inevitably deteriorate into the basic assumption functioning to which individual unconscious vulnerabilities are drawn. Distinct behaviours, thoughts and feelings reveal Bion's three basic assumptions, which dominate a group's functioning when it is not a work group on task: basic assumption dependency (baD), basic assumption fight/flight (baF) or basic assumption pairing (baP):

> *A group dominated by baD behaves as if its primary task is solely to provide for the satisfaction of the needs and wishes of its members. The leader is expected to look after, protect and sustain members of the group … which inhibits growth and development. … Any attempts to change the organisation are resisted, since this induces a fear of being uncared for.*
>
> *In BaF the assumption here is that there is a danger or 'enemy', which should either be attacked or fled from. Members look to the leader to devise some appropriate action … [which] provides a spurious sense of*

*togetherness, while also serving to avoid facing the difficulties of the work itself … [or] without actually planning any specific action to deal with the perceived threat to its service.*

*BaP is based on collective and unconscious belief that, whatever the actual problems and needs of the group, a future event will solve them … as if pairing or coupling between two members … will bring about salvation. The group is focused entirely on the future, but as a defence against the difficulties of the present.* (Stokes, as cited in Obholzer & Roberts, 1994, p. 21)

Bion discusses anti-task, disruptive group dynamics, which Stokes describes more accessibly:

*The leader will be followed only as long as he or she fulfils the basic assumption task of the group. The leader in baD is restricted to providing for members' needs to be cared for. The baF leader must identify an enemy either within or outside the group, and lead the attack or flight. In baP, the leader must foster hope that the future will be better, while preventing actual change taking place.* (Stokes, as cited in Obholzer & Roberts, 1994, p. 23)

In addition, a fourth and fifth basic assumption have been suggested by subsequent theorists. In basic assumption oneness (baO), the fourth basic assumption, members seek an undifferentiated state of wholeness – there is no sense of individuality, only oneness and homogeneity within the group. The group commits itself to a 'movement', a cause outside itself, as a way of survival:

*Members seek to join in a powerful union with an omnipotent force, unobtainably high, to surrender themselves for passive participation in order to feel existence, well-being, and wholeness … to be lost in oceanic feelings of unity or, if the oneness is personified, to be a part of a salvationist inclusion.* (Turquet, 1974, pp. 357–360)

BaM, the fifth basic assumption, is the opposite of baO. In this mode of functioning, group members act as if there is no group – each member behaves as an individual, with no connection to the whole. The denial of the group serves to defend members from the destructive aspects of group life and is in accordance with modern Western values of individualism:

> *As the environment becomes more persecuting in reality one response is for individuals to make themselves more cut-off from the effects and to withdraw into the inner world of the self. Another way of expressing this is to say that we are witnessing socially induced schizoid withdrawal … being made to behave so because of social and political conditions.* (Lawrence et al., 1996, p. 35)

Furthermore, the importance of the work group has been further developed by Armstrong (2005) and French and Simpson (2015) in relation to its fundamental importance in Bion's comment: '*Work group function is always in evidence with one, and only one, basic assumption … [although it] can be changing frequently*' (Bion, 1961, p. 154). French and Simpson describe each basic assumption in turn from the perspective of attention and distraction:

> *BaD [can] manifest as attention in situations that merit clear leadership and followership. … The acknowledgement of a manager's decision making authority can be one basis for the orderly, purposeful behaviour of a group of staff. As distraction, dependency can be evident in unthinking behaviour on the part of group members … passivity of group members who continue to wait to be given directions.* (French & Simpson, 2014, p. 96)

> *[BaF] can manifest as attention when different members of the group acknowledge that they hold different perceptions of a situation and are prepared to address the real challenge to group effectiveness such differences can represent. … As distraction … behaviours simply confront the perceived threats or challenges head-on.* (French & Simpson, 2014, p. 97)

> *[BaP] can be seen in the way we link up with others in the hope of mutual support or regeneration … the belief that the group does indeed have a future … that the pair can inspire the production of something. … In distraction, the emergence of a pairing can allow other group members to think they can avoid doing the emotional or practical work necessary for dealing with perceived difficulties here and now.* (French & Simpson, 2014, p. 98)

Given that Bion acknowledged that groups are predominantly in work group mode, it is helpful to further consider when basic assumption functioning is effectively sublimated for the benefit of the primary task and working relationships. We may assume that the work of a GP must involve a heavy dose of baD. Stokes also writes of Bion's reference to '*sophisticated use of basic assumption mentality*' where '*a group may utilise the basic assumption mentalities in a sophisticated way, by mobilising the emotions of one basic assumption in the constructive pursuit of the primary task*' (Stokes, as cited in Obholzer & Roberts, 1994 p. 250). Stokes writes about the tension in a multidisciplinary medical team due to their varying sophisticated uses of the basic assumption mentalities. In my research there is evidence that GPs are diverse in their sophisticated uses of basic assumptions – not simply baD – due partly to the changing terrain and culture and also to extensive variations in the role, which create the professional stretch from locums to clinical specialisms, partnerships, training and commissioning. Doctor-patient expectations may be variable due to an instantly demanding patient population armed with information from the Internet on the one hand and a historically dependent ageing population on the other, alongside ever-advancing technologies potentially for all. I try to represent this below in terms of GP types and how these may link to different sophisticated uses of basic assumption mentalities, and Bion's

> *view of the specialized work group as having as its function the manipulation of the basic assumption to prevent its obstruction of the work. … [Nevertheless,] organization and structure are weapons of the [sophisticated/work] group. … It must be regarded as a failure in the specialized work group if dependence or fight-flight group activity either ceases to manifest itself within the specialized work groups or else grows*

> *to overwhelming strength – the main group has to take over the functions proper to the specialized work group, and yet still fulfil its work group functions.* (Bion, 1961, p. 135)

Bion (1961, p. 157) warns us that '*if the specialized work group cannot, or does not, cope with the basic assumption phenomena that are its province, then the work group function of the main group are vitiated by the pressure of these basic assumptions*'.

### *5.6 The Groups of the Periodic Table as a Metaphor for GP Types*

In 1864 the German chemist Meyer organised the elements by atomic mass and grouped them according to their chemical properties. Within ten years, the Russian chemist Mendeleev had organised all the known elements according to similar properties, leaving gaps for what he thought were undiscovered elements, about which he made predictions based on repeating patterns.[5] Within the periodic table, families of elements are ordered in vertical columns due to their similar properties, characteristics and reactivities.

Group one elements are known as the alkali metals and are the most reactive elements of the metal class. Alkaline earth metals are found in group two and are almost as reactive as the group one metals. The transition metals are the larger block of elements extending from groups three to 12. Transition metals have high melting points and boiling points, often form coloured compounds that are highly stable, and can serve as good catalysts. A catalyst is an agent that helps to speed up a chemical reaction without itself being changed in the process. Group 17 elements, known as halogens, contain very reactive non-metals. Group 18 elements, the noble gases, are extremely stable, unreactive, and rarely form compounds. There are additionally some other types.

[5] The periodic table recognises 118 chemical elements, pure substances that cannot be broken down into simpler chemical substances, which are represented by a one- or two-letter code: from left to right, metals, metalloids and non-metals.

So far I have written about each GP type separately, drawing on the data from my semi-structured interviews. Here, I am attempting to consider a representative image of the data as a whole by using the metaphor of the periodic table for the different types as I have understood them (Figure 6). I am using the idea that a full shell of eight electrons is overall the most attached, stable and committed to task, role and system. Columns of elements with fewer than eight electrons are motivated to react with others so as to strive for a full shell. I use this as a way of considering the different types of GP presentation as I have grouped them.

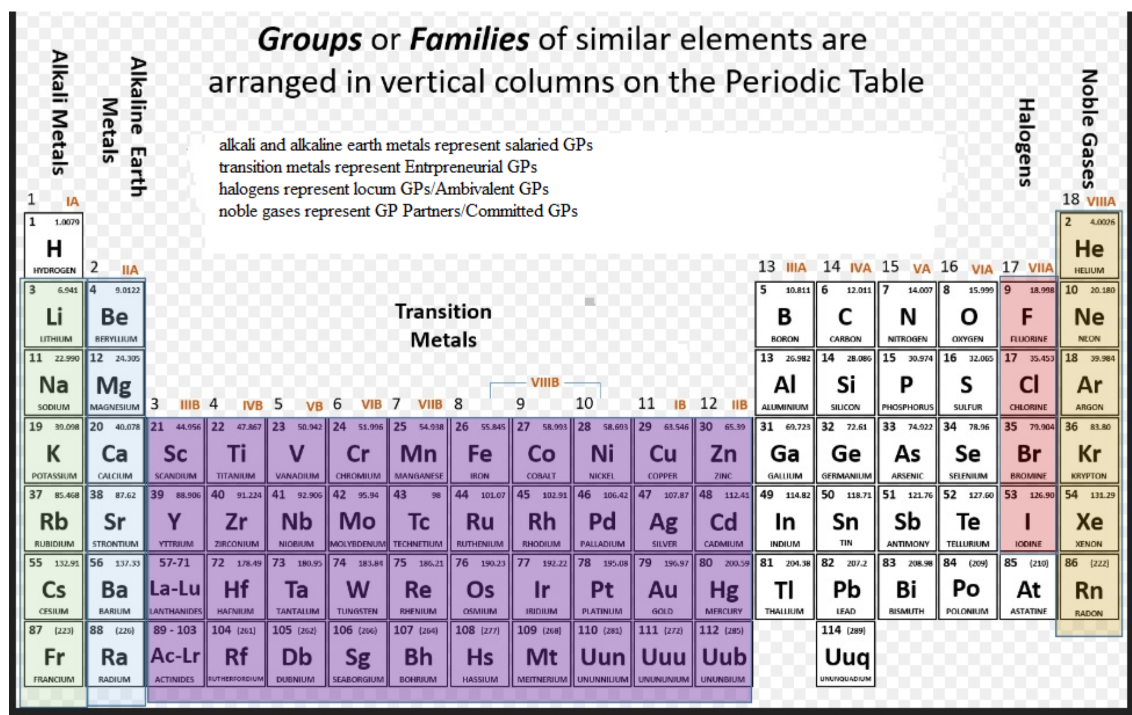



Figure 6. Diagrammatic representation of the adapted periodic table.

My research found that my different GP types demonstrated varying valencies – that is, individual predispositions and sensitivities in their personality structures, as described by Stokoe (2010) and Hafsi (2006, 2007, 2012a, 2012b) – and a tendency to unconscious group constellations. Previously I described the sophisticated use of basic assumptions according to Stokes, whereby their deployment is utilised in service of productive work. GPcoms have a capacity to tolerate and even enjoy high levels of responsibility and intimacy with their patients and GP colleagues, both at a personal level and as a group. They are focused on the needs of others and preoccupied with their well-being while offering leadership, which is the arena of baD. GPreneurs are perhaps able to employ their ability to envision hope and new enterprise or clinical provision by

getting together with others or bringing disparate elements into unison with a view to new pathways or productivity. In this way, they work like catalysts; this is in the territory of baP. GPreneurs may also be seen as fighting to win tenders and/or perhaps in flight from the daily ongoing clinical work with patients, which could be considered baF. GPambs appear to be retreating from the system, and from being trapped by overwhelming demands or expectations in a system from which they feel alienated; perhaps they could be described as being in baM, in that they behave as if there is no group. Here, I will use the periodic table as a metaphor for these valencies.

### *5.6.1 GPcom: BaD*

Noble gases might be a useful metaphor for GPcoms, as these represent stable elements with a full shell of eight electrons. They are predictable and mostly non-reactive with other elements, although there are exceptions. This full outer shell might be a metaphor for the different responsibilities that a GPcom undertakes, such as providing ongoing clinical care of patients, investing in collegial relationships, managing the staff in the GP practice, undertaking administrative duties, meeting targets and protocols in order to attract government funding, taking care of the building, and so on. These GPs flourish with high levels of responsibility, facilitate dependency in others, and have a high threshold for bearing patient needs – a sophisticated use of baD. Metaphorically, the word ‘noble’ certainly has moral overtones, which perhaps could be said to link with loyalty to the Hippocratic oath and service to patients’ health and their narratives. Perhaps like gases, GPcoms could be said to have an ethereal quality whereby their core values support them above and beyond everyday medical practice as an underpinning philosophical position. They appear to have a family-doctor-in-the-mind, a stalwart in society carrying heavy responsibility for both patients and the maintenance of the GP surgery, with a vocational calling underpinning their conscientious attachment.

My research revealed some GPcoms who had portfolio careers in treating patients, commissioning and/or training, and who were ultimately working in medical service in a myriad of ways for the outcome of attending to patient needs.

Perhaps these GPcoms could be thought of as being committed but also taking on some of the spirit of GPreneurs for the development, application or sustainability of quality medical services. GP partners who maintain a focus on clinical need use their entrepreneurial aptitude to enable the GP practice and patient care to remain coherent and meaningful while attending to the need to create bonds with other services and new clinical options, all while attending to financial viability.

*5.6.2 GPreneur: BaP*

GPreneurs may be likened to catalysts, as they forge new links and pathways within the health system. They perhaps can be said to make sophisticated use of baP, or perhaps baF, to realise a new entity. At an individual level, GPreneurs demonstrate either an aptitude for wider societal concerns, thinking outside the box, with high levels of curiosity and creativity, or else a turning away from direct clinical work towards creating or fighting for business or new systems. Within the periodic table, transition metals perform catalytic activities, and this would therefore seem a useful metaphor for entrepreneurship among GPs. Transition metals have multiple valencies, and they can adapt according to what is necessary – in other words, they can switch between either lending or taking electrons from other elements. When added to chemical reactions, these catalysts increase the rate of the reaction, and the pathway is eased.

The quintessential transition metal is iron. It makes an enormous, varied and crucial contribution to health, but if not well held within the body system it can become toxic, as occurs in dementia. Thus, if we consider the implications of the metaphor of transition metals for GPreneurs, the NHS system needs to carefully consider the aptitude of GPs who have this catalytic energy, so as to ensure that they are contained within a system to which they can be of enormous value if well contained. The NHS system may become forgetful of the assets brought by GPreneurs, or they themselves may be more interested in machinations such as nailing a deal for its own sake, forging new contracts, and hammering out systems than they are in medical care or serving patient need per se. Thus, some GPs will shift more into the GPreneur type, abandoning their clinical focus on patient

care, while others will manage to integrate a catalytic attitude within a GPcom position. To enable such integration, a level of care towards GPs may be required from the system.

*5.6.3 GPamb: BaM*

In recent years there has been a shortage of GPs applying to become partners, and others have been retiring early to avoid the level of commitment involved; this was illustrated by my data. A wish to work with one foot out of the door, so as to calibrate the amount of contact with patients and reduce the bureaucratic, managerial and administrative responsibilities, is seen as essential to survival and continuing to be a GP. In my data, this was enabled by working as flexibly as possible, by being either a locum, salaried part-time, or in a peripheral role that would facilitate fluidity and temporariness, at least to a degree. In this way, these GPambs avoided being caught up in the full extent of dependency demands, and there was a feeling that ongoing long-term clinical need and its trappings were the enemy and their own human survival the priority – a sophisticated use of baM. At an individual level, these GPs presented as feeling on the edge or peripheral to a group to which they may accord high conceptual value, but from which they felt personally excluded.

Within the periodic table, the noble gases (GPcoms) are flanked by groups of reactive elements which have very different properties: one group is the halogen gases, and the other the alkali metals. When two elements come together, one from each group – which they have the valency to do – stable compounds form such as sodium chloride, i.e. salt.

Halogen gases are non-metals which are highly volatile and changeable and readily bond with metals. Adaptability is an important attribute in complex systems. In order that specialists and extra staff can be brought in as needed, locum doctors – who may well be GPambs – are likewise essential to general practice. They have multiple functions, come in all forms, and like halogen gases they variously combine with other elements to provide essential services. Some of these locum GPs may be in flight from being part of a system by which they

are fearful of being overwhelmed; they plug the gaps in the current system, whereby patients and doctors are co-modified. In my sample, there are ways in which locums represent precariousness and increase the load on more attached others (i.e. GPcoms) in terms of performing administration, knowing the patients over substantial time periods, and holding the GP practice/surgery together. The social defence employed by GPambs is to avoid full involvement via baM and thereby avoid ongoing relationships with patients and other GP colleagues. Under current systemic arrangements, they are available to plug the gaps and cannot be done without. It may be that there are healthy and unhealthy uses of locums. For example, experienced GPs, or GPs with special interests and/or extensive experience, may positively supplement permanent GPs who are less experienced and have to carry the routine burdens of administration and managing the practice. At the opposite end of the spectrum, there may be inexperienced casuals who have not succeeded in obtaining permanent employment.

Alkali metals and alkaline earth metals conduct electricity. These two groups are malleable and readily form a huge variety of compounds by giving away electrons. The salaried GPs in my sample seemed to be mostly ambivalent and wished to avoid getting caught up with the heavy bureaucratic responsibilities and financial commitment of being a partner; as such, they might be likened to these elements, as they need to form compounds with multiple others. Some of the interviewees I defined as GPambs indicated that if the conditions were favourable, they might be persuaded to become more committed. Salaried doctors and locums may need to form alliances with each other, albeit tenuously, in order to compound their efforts to form hands-on provision together (like salt) under the structures set up by GP partners or other healthcare systems. Locum doctors may need to form ties with various other stakeholders in the system to ensure sufficient predictable work and compound efficiency. However, too much salt causes a rise in pressure, while too little causes fainting and collapse. The metaphorical suggestion is that this current healthcare system, whose primary task is to care for patients, currently requires a balance of stability that is sometimes provided by salaried GPs, with an injection of locums for sustainability given the current context.

### *5.7 Reflections on the Periodic Table as a Metaphor*

The periodic table is of course only a metaphor in this context, illuminating only some aspects of this GP 'field'; it is not to be considered as a literal equivalent. Nevertheless, it is a valuable heuristic tool given its structure into groupings of elements with similar properties, as well as its visual representation of all the known elements within the conceptual framework of their reactivity towards each other. It was this that drew my attention to kinds of complementarity and multifunctionality that I had not previously recognised when I was so closely focused on my individual GP subjects.

The topic of the periodic table has previously been utilised in literary ways. The qualities of chemical elements are utilised by Primo Levi (1995), a survivor of Auschwitz, in his autobiography *The Periodic Table,* which mingles history, anecdote and personal reminiscence. In utter contrast, Tim James (2018) wrote an informal scientific book, using unusual historical stories and references to human life on earth to explain the functions of different elements and compounds. In a rather different vein, it was helpful in my case to think about valencies in an organisational way, prompted by Bion's (1961) use of valency. I am using groups within the periodic table as a basic metaphor and visual representation, utilising key features that are ordinarily applied to clusters of similar elements to represent the GP types that have emerged from my data. There is obviously a limit to this metaphor, with the main extrapolation being the idea that each element has been positioned in a pattern together with other similar elements due to their shared qualities. For example, the grouping of similarly structured and reactive elements under the single descriptor 'halogen gases' is similar to my idea of GPambs and how they behave in the system of general practice. I am utilising the notion of groups of elements with similar levels of chemical reactivity in terms of their ability to bond with other elements, which is known as chemical valency. I am drawn to the periodic table as a metaphor, as I stated earlier, due to Bion's having originally borrowed the term 'valency' from science. My hypothesis, for example, is that GPambs are readily able to bond with various components of the medical system, and this can arguably be represented metaphorically by the reactive halogen gases, which readily compound with other elements. Clearly, GPs are not literally

elements! I have also borrowed something of the periodic table's style of utilising symbols for my GP types, such as 'GPamb' for ambivalent GPs. This is a useful short-hand, and it also keeps the metaphor of the periodic table in mind. It is worth recalling, as Bion reminds us, that

> *each [basic assumption] state, even when it is possible to differentiate it with reasonable certainty from the other two, has about it a quality that suggests it may in some way be the dual, or reciprocal of one of the other two, or perhaps another view of what one had thought to be a different basic assumption … [which] cannot be regarded as a rigid formulation.* (Bion, 1961, pp. 165–166)

It struck me that this was a helpful way of thinking about my three types. Some of my interviewees did move between two or perhaps all three types, but they might have one dominant type, at least at the time of the interview.

### *5.8 Further Thinking on Individual Valency*

In this section, use is made of the periodic table as a metaphor, but first I will consider valency from other perspectives. Stokoe has written about a more current use of the term 'valency' as a disposition to be mobilised towards an emotive position:

> *In terms of the learning and deductions from group relations and from organisational consultancy, it is clear that the individual's valencies are larger than a simple predetermination towards a particular basic assumption. Our particular individual psychic vulnerabilities also serve as valencies, so that the group will appear to choose the same individual again and again to express something that will seem to be as much about that individual as it is about the group's functioning.* (Stokoe, 2010, pp. 155–156)

Hafsi (2006, 2007, 2012a, 2012b) has used a broader definition, which he describes as bringing Freud and Bion together, based on the idea that valency

can be defective or healthy, and that the group is present in the individual and – even if only in phantasy – the individual is similarly present in the group. He goes as far as to reapply Bion's group basic assumptions as individual aspects of personality, distinguishing four different types of valency: dependency valency (DV), fight valency (FV), flight valency (FIV) and pairing valency (PV):

> *DV allows the person to establish bonds or interpersonal relationships wherein he can depend or rely on someone and have this person rely on him/her, [also] associated with various secondary individual features such as low self-evaluation, unconditional trust of others and altruism, empathy*.
>
> *FV is characterised by confrontation … [and] comprises self-assertiveness, outspokenness, competitiveness, criticism and aggressiveness.*
>
> *FIV is conflict avoidance … manifest lack of excessive activity, self-assertiveness, overt aggressiveness and dependency.*
>
> *PV allows the person to establish intimate bonds. … A need for intimacy … values highly freedom and quality.* (Hafsi, 2007, p. 117)

Hafsi suggests that we have a valency constitution so that if we are functioning healthily, then we are polyvalent; he describes one main or active valency and additional auxiliary valencies.

In summary, valency in Bion's terms is an unconscious pull towards a basic assumption way of functioning in a group; Stokoe takes the perspective of individual vulnerability; Hafsi adds basic assumptions from a personality structure approach. I turn back here to the original usage of 'valency' in relation to the chemical bonding of elements in the periodic table as a way of thinking about how these different elements are clustered together with similar types but also have the capacity to bond with other variables to create compounds. As noted above, I have used the periodic table as an interactive metaphor as described by Black (1955).

Having tentatively utilised the periodic table as a metaphor to hypothetically consider the interactivity between the different GP types in general practice that have emerged from this study, the next section ponders the usefulness of further research.

### *5.9. Further Research*

To consider what might follow my research, it might be useful to further explore how robust and informative my ACE categories are, and how much explanatory work they can do. I cannot currently assume that they already contain the key to how GP practices need to be organised or how consultants can work with them, as the ACE categories emerged from only 12 interviews. The most important limitation of this research is that it is a study of individual GPs, and not of individual GPs *and* the holistic context of their practices or work environments. The method I utilised had an individual focus. This is a 'methodologically individualistic' study rather than a piece of research on the institutions within which individuals work. The use of the metaphor of the periodic table is a tentative, speculative and theoretical exploration of the ACE model applied to institutional functioning, but I have no evidence regarding how complementary or mutually supportive the three types may be in actual general practices.

There are three potentially useful pieces of further research that might be undertaken:

1. To explore with additional GPs how robust the ACE model actually is, to determine whether there are other varieties, and in particular to determine the variances within the GPamb type.
2. To gain access to one or more GP practices and conduct an observational study there, taking an approach similar to Menzies (1960). This would include sitting in on meetings; conducting interviews with the entire range of staff, including receptionists, nurses and others; asking and observing who does what, and how they relate to one another. In this way, it might be possible to discern the practical importance of the three ACE orientations to the functioning (or otherwise) of a practice. Are there

differences not just in GP orientations, but in entire practices, with regard to how they function and their central goals? Another topic here would be to see how far my hypothesis of adverse pressure on the GP system is borne out, not merely by interviewing individual GPs, but by observing and studying one or more practices at work.

3. There is a question of whether consultation to GPs or GP trainees as individuals, individual practices or clusters in PCNs might be helpful to clarify the dilemmas which I have raised and to enable GPs and practices to find better solutions to them. This would also be a way of further testing and expanding my findings.

Research into the organisational systems and dynamics of GP practices would give a fuller picture of these issues, but this was beyond the scope of this small-scale qualitative study. No claim can be made that the findings of this study are representative of GPs nationally in England. Nor is it a quantitative study of GPs, and it does not claim to offer a representative sample. On the contrary, this qualitative study, based on a narrative approach to a small sample, looks in depth at individual experiences and offers some hypotheses to make sense of the findings. Further research could be undertaken in other settings, such as charities, education or business, to test the relevance in such contexts of the ACE model of role (ACE-in-the-mind) that has emerged in this research.

Having considered the potential interactivity between GP types through the metaphorical use of the periodic table, and having suggested further research to deepen this knowledge, application and understanding, in the final section I ponder general practice as an ecosystem within the current paradigmatic challenges.

### *5.10 Concluding Comments: The Changing Context*

In this study of ‘a systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery’, my research questions were:

- What are the primary orientations, motivations and valencies of GPs in relation to their work, and what stresses, satisfactions and dissatisfactions do they experience as GPs in the present context of general practice?
- What organisational, economic and cultural changes in the functioning of general practice are currently impacting on the experience of GPs?
- How are GPs responding to changes in the situation of general practice, and what strategies or defences are they taking up to adapt to them?

Through my research, I have discovered the following:

- I have discovered the states of mind and adaptations to the changing work situation among a sample of GPs. My interview method and data analysis enabled me to present a phenomenologically rich account of these GPs' relationships to their work roles.
- From the interviews, I have been able to infer the nature of the pressures on GPs' work role from changes in the wider environment of the NHS and society more broadly. This is consistent with my critical realist stance, which takes the view that the individual and external structures are dynamic, mutually interactive and influential.
- I have identified three distinct types of adaptation. These may be further substantiated by further investigation with larger samples. They may also be tested out through presentations and discussions of the thesis.
- I started out from a methodologically individualistic focus on individual GPs and further developed my perspective to consider the different attributes and attitudes they brought to their roles. Thus, I came to think holistically about GP practices, and the complementary attributes which GPs bring to these. It is a limitation of my research that I did not observe GP practices or my interview subjects *in situ*. Further research could either use a larger sample to test and increase the scope of the findings and/or study GP practices as institutions, taking all members into account, through participant observation or organisational consultancy, as Menzies did with nursing staff in 1960.
- In arriving at this more holistic focus, I made metaphorical use of the periodic table, which occurred to me as highly relevant thanks to Mendeleev's concept of valency, which Bion applied by analogy to groups.

I have identified considerable problems of adaptation which GPs and their practices are having to face. I have identified issues in GP work which might be relevant to NHS planners more generally, with regard to GP training and support. Some of my sample described the role of Balint groups as being important, which would point to the need for psychological issues and stresses in GP practice to be taken seriously in how the GP role is configured and supported.

As one of my GPcoms described, there are three interdependent issues at stake, which are shown at each vertex in the equilateral triangle in Figure 7. If quality of patient care is the output, then this is reliant on GP well-being, which needs to be supported by the organisation and training, as well as the viability of general practice. Each related component is equally crucial; otherwise, all areas will suffer, resulting in poor-quality patient care delivered by a suffering GP in a collapsing system that is constituted of declining professional relationships and financial collapse.

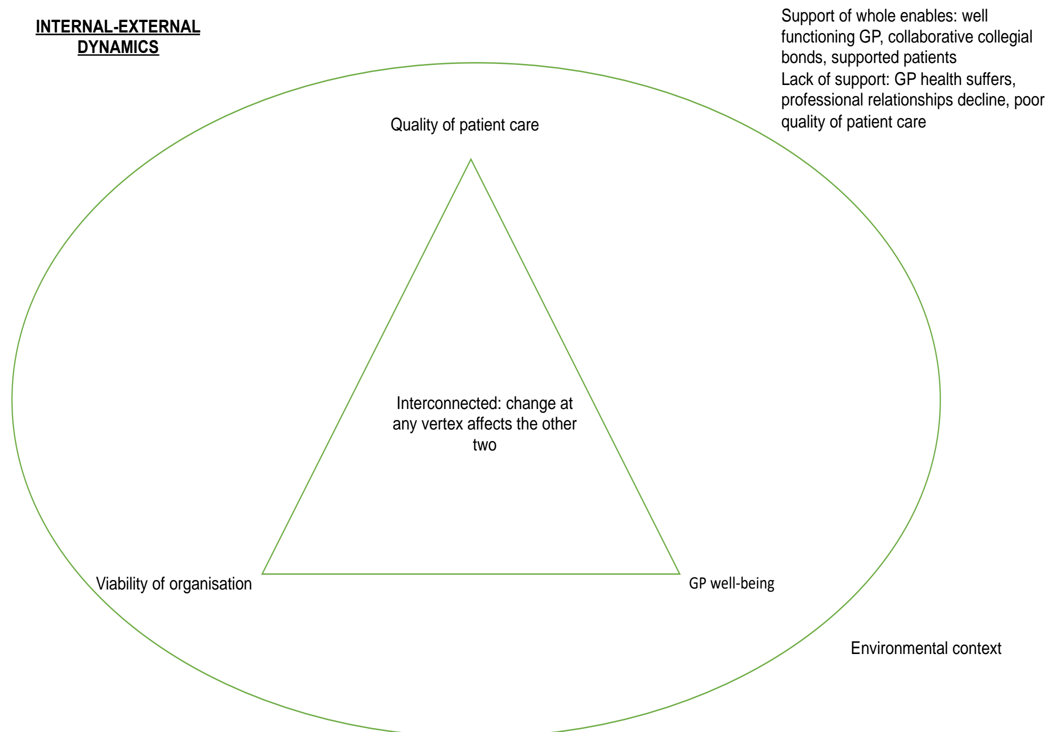



Figure 7. Institution of GP surgery.

I have outlined the way that the valencies of individuals and groups may have a role in adaptive positions. As one of the GPs remarked: '*These adaptations may actually be contributing to the psychic survival of GPs themselves and general practice, although there are costs*'. In tentatively considering the three types my research has revealed within a holistic structure, I am suggesting that general practice can be seen as comprised of an approximation of the dynamics shown in Figure 8. This figure simply brings together the three types previously represented pictorially in terms of their own foci. There may well be other types, which as I have suggested further research may reveal; in the absence of a study of general practices as a whole, I can only speculate as to how the components that have been revealed to me may come together as a system. As Armstrong's organisation-in-the-mind (2005) would suggest, there is a way in which the organisation is as much in the individual as the individual is in the organisation. Based on this way of thinking, I offer the model in Figure 8 as a suggestive representation.

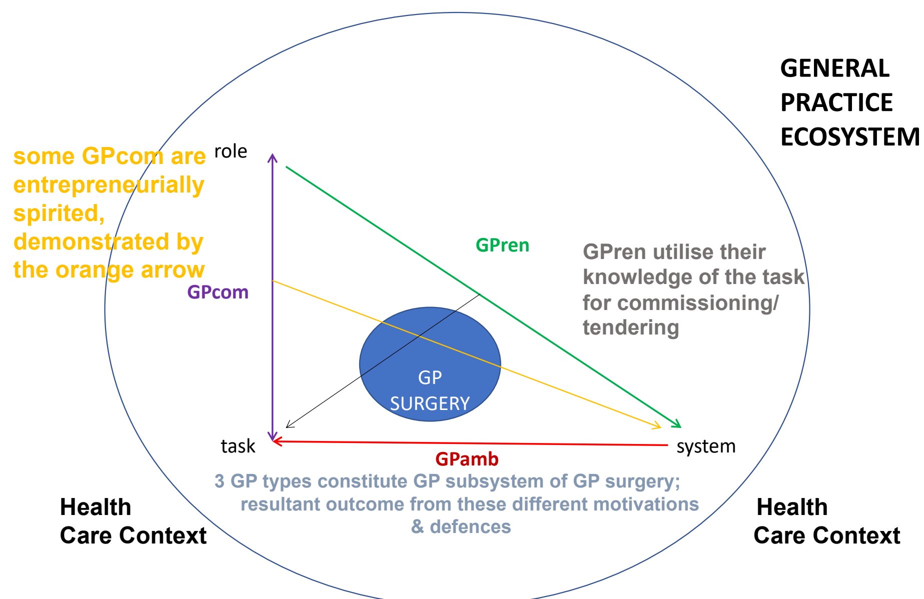



Figure 8. General practice ecosystem.

In this diagram (Figure 8), the arrows indicate the focus of conscious/unconscious intentionality. GPambs move towards clinical 'task' and away from 'system'; GPcoms move in the direction of both clinical task and role of managing the surgery; GPreneurs are positioned the furthest from directly undertaking the

clinical task (although the thin pale green arrow shows how actively they may hold its value in mind), moving away from the daily overseeing role of managing the surgery and towards the wider healthcare monetary and innovatory system. This diagram also illustrates that some GPcoms are entrepreneurially spirited, demonstrated by the orange arrow. These different GP types here hypothetically constitute the whole of the GP subsystem in the GP surgery – the outcome of their different motivations and defences. General practice can therefore be seen as an ecosystem made up of the different GP types with their varying adaptations in response to the current context, together with other staff such as administrators, practice managers and finance professionals, who may also get pulled in these different directions.

It would seem likely that in order to function, a GP surgery needs all of these parts to play their role as a full complement. In other words, the provision of patient clinical care requires the healthy operating function of all elemental groups: the undertaking of the clinical task of patient care in real time; the role of managing and running the practice, and the ability to develop new business models and relationships to support new clinical pathways. The complex context is created by the interface between, in no particular order, the government, society, political forces, NHS England, inspectorates, the Royal College of GPs, the BMA, private providers, the economy, patients, health conditions, technological contributions, medical treatments, worldwide pandemics and other contributing dynamics. Where decisions are made about clinical structures or incentives, the impact needs careful assessment, including the risk of unintended consequences. Varying foci and social defences need to be consciously considered and their impact understood. The nature of the context and the resulting impact might then be better appreciated for its potential power in affecting GP professionals and their relationship to the job. Importantly, the balance of GP types will also affect patients, and there will be a need for a sufficient focus on direct patient clinical care over time within the containing, enabling context of a sufficiently buoyant business.

This research was obviously undertaken before the release of the new GP contract in 2019, which has now been further updated for 2020, and which has outlined a substantial investment of £20,000 in new GP partners, three years of

business training as part of the GP training, specialised contracts for locums who are willing to commit for a few years, an increase in GP numbers as a whole, and more years in general practice during training. There has been a consultation with more than 3,000 people – GPs, other healthcare professionals and patients – and the ambitious resulting document produced by the Royal College of GPs (2019a), entitled *Fit for the Future*, acknowledges the neglect of proper funding in recent years and the strain on GPs, and conveys the message that general practice will become a revitalised profession at the core of public health. This builds on a document previously published by NHS England (2016), 'General Practice, A Forward View', in which there were plans to rapidly and extensively increase the recruitment of GPs, although this did not result in much of an increase in full-time equivalent GPs. There are ambitious plans for primary care by 2030, which will continue the plan to recruit multidisciplinary teams – for example, occupational therapists, vocational rehabilitation advisers, dieticians, health coaches and mental health professionals – to be overseen by GPs, who will have clinical responsibility. It is also expected that many secondary care tasks will be brought into general practice. The Conservative government made a substantial commitment to general practice and GPs during the 2019 election, and categorically denied that the NHS would be sold or traded as part of any deal with the United States. As it turned out, since March 2020 the COVID-10 pandemic has taken centre stage, and this dominates the clinical focus at the moment, but it has also demonstrated the essential need for the NHS as a national, coordinated service, and the vital importance of hospital doctors and GPs. Worryingly, however, contempt for doctors and disrespect for their human vulnerability may be grossly and tragically manifest in the lack of systemic efficiency to keep doctors safe with appropriate personal protection equipment while they treat highly contagious patients. We have also seen the private contracting of the testing and tracing service, even though previous such arrangements have failed badly, including in the probation service, which failed practically and in business terms – Capita even went broke. While the usual hospital provision has understandably been concentrating on the pandemic, it has fallen to GPs to cope with the fallout for other patients, whose conditions must be managed mostly over the phone by GPs, some of them called back out of retirement.

Since the NHS was set up, social services have weakened substantially. For example, there has been the closure of day centres for patients with mental ill-health, Sure Start provision has mostly closed,[6] the role of active religious affiliation and worship has substantially lessened overall, affordable housing has been severely limited, both parents in a family need to work, families have been geographically dispersed, and so on, such that individuals are expected to be more self-sustaining. It may be for this reason that as GPs are one of the few national stalwarts left, offering free open access to the general public – virtually, by phone and also in person, albeit less so – GP surgeries have come into heavy demand. The mixed patient population now comprises some who are assertive and technologically savvy, others who are more dependent and hold the old consultation model in mind, still others who are impoverished and left behind, and some who are somewhere in-between. Regulation and control by audits and measures form the necessary process of accountability, but some of my interviewees reported unintended consequences or inappropriate pressures in some specific medical areas, resulting in the neglect of other areas. Meanwhile, under neoliberalism, competition is now a modus operandi throughout general practice, with bids for clinical services and the management of real estate part of the daily reality. The political system seems volatile, which is perhaps illustrated by the unexpected closing down of Public Health England (PHE), which has been responsible for protecting and improving the nation's health and well-being and reducing health inequalities, while the COVID-19 pandemic remains unpredictable. PHE will be replaced by the National Institute for Health Protection – noticeably without the word 'public' in its title – to control infections and improve the nation's health through health-related data collection, research and analysis, which is to be led not by a scientist, but (similarly to PHE) by a management consultant. The impact of Brexit on healthcare is still unclear.

My research has attempted to capture the state of play from the perspective of GPs based on interviews conducted in 2015 to 2016 to demonstrate the impact of the healthcare context and its effect on relationships with different aspects of

[6] Sure Start was a centrally funded nationwide initiative announced by the Labour government in 1998 with the aim of 'giving children the best possible start in life' (Wikipedia, 2020) through improvements to childcare, early education, health and family support, with an emphasis on outreach and community development. In 2005 the Labour government transferred control to local government; then in 2010, the subsequent coalition government cut general funding from central government to local authorities by almost half. Money for Sure Start was not ring-fenced, and so many centres under the scheme closed.

role and task. It is further hoped that the resulting social defences have been demonstrated. In this regard, we need to hold actively in mind that GPs are influenced by their surroundings and the structures and sociodynamics thereof. In this research, three different defences have been realised – ambivalence, commitment and entrepreneurialism, which constitute the ACE model. It is essential to at least attempt to make conscious the notion that different socio-political and thus clinical environments will produce variations in types of GPs with their varying attitudes to their patients, clinical provision and the system of healthcare. If Doctor Marigold (Dickens, 1894, p. 1) was named as a result of a GP attending the birth of an infant in exchange for a pretty tray, perhaps we would do well to attend to the implications of what is traded 'in kind' at the interface between society, doctor and patient. Unintended consequences may impact on the membrane of doctors through which clinical outputs are processed. This reference back to Dickens shows us that doctors have had an archetypal quality across time immemorial and refers to the GP-in-the-mind. Doctors – particularly those that accompany us along the journey of life from cradle to grave – are also human. GPs are therefore – like their patients – a product, consciously and unconsciously, of the environment that we all create.

Bibliography


Adlam, J., Aiyegbusi, A., Kleinot, P., Motz, A. & Scanlon, C. (2012). *The Therapeutic Milieu Under Fire* London: Jessica Kingsley.

Archer, M., Bhaskar, R., Collier, A., Lawson, T. & Norrie, A. (2013). *Critical Realism: Essential Readings*. London: Routledge.

Armstrong, D. (2005). *Organisation in the Mind.* London: Karnac.

Armstrong, D. & Rustin, M. (2015a). Introduction: Revisiting the Paradigm In D. Armstrong & M. Rustin (Eds), *Social Defences Against Anxiety* (pp. 1–23). London: Karnac.

Armstrong, D. & Rustin, M. (2015b). *Social Defences Against Anxiety.* London: Karnac.

Bailer-Jones, D.M. (2002). Models, Metaphors and Analogies. In P. Machamer, & M. Silberstein (Eds), *The Blackwell Guide to the Philosophy of Science* (pp. 108–127). Oxford: Blackwell.

Baird, B., Charles, A., Honeyman, M., Maguire, D. & Das, P. (2016). *Understanding Pressures in General Practice*. London: King's Fund.

Balint, M. (1957). *The Doctor, His Patient and the Illness.* New York: International Universities Press, Inc.

Balint Society. (2013). Theoretical Aspects of Balint Work. https://balint.co.uk/about/theoretical-aspects-of-balint-work/

Ballat, J. & Campling, P. (2011). *Intelligent Kindness: Reforming the Culture of Healthcare*. London: RCPsych Publications.

Beck, C.U. (2011). *Psychodynamic Coaching: Focus and Depth*. London: Karnac.

Belbin, R.M. (2008). *Management Teams: Why They Succeed or Fail* (2nd ed.) Oxford: Butterworth-Heinemann.

Berger, J. (1967). *A Fortunate Man: The Story of a Country Doctor*. London: Penguin.

Bhaskar, R.A. (1997). *A Realist Theory of Science.* London: Verso. First published 1975.

Bion, W.R. (1961). *Experiences in Groups and Other Papers.* London: Tavistock.

Bion, W. (1967). Notes on Memory and Desire. *Psychoanalytic Forum, 2*(3), 271–280.

Black, M. (1955). XII: Metaphor. *Proceedings of the Aristotelian Society, 55*(1), 273–294.

Black, M. (1993). More About Metaphor. In A. Ortony (Ed.), *Metaphor and Thought* (pp. 19–41). Cambridge: Cambridge University Press.

BMA. (2020). Psychotherapy for Doctors: DocHealth. https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/psychotherapy-for-doctors-dochealth

BMA & NHS England. (2019). *Investment and Evolution: A Five-Year Framework for GP Contract Reform to Implement* The NHS Long-Term Plan. Redditch: NHS England. https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

BMA & NHS England. (2020). *Update to the GP Contract Agreement 2020/21 – 2023/24*. Redditch: NHS England. https://www.england.nhs.uk/wp-content/uploads/2020/03/update-to-the-gp-contract-agreement-v2-updated.pdf

Borland, S. (2018, 14 June). Four in 10 GPs Quit After Five Years of Training as They Opt to Work as Short-Term Locums on Much Higher Pay, Move Abroad or Leave the Profession Entirely. *Daily Mail*. https://www.dailymail.co.uk/news/article-5846035/Four-10-GPs-quit-five-years-training.html

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. London: Routledge.

Brown, A. (2019). *The Prison Doctor.* London: Harper Collins.

Brown, F. (2019, 24 October). GPs Could Ban Sitting to Make People Less Lazy. *Metro,* 11.

Burck, C. (2005). Comparing Qualitative Research Methodologies for Systemic Research: The Use of Grounded Theory, Discourse Analysis, and Narrative Analysis. *Journal of Family Therapy, 27*(3), 237–262.

Campbell, D. & Huffington, C. (2008). *Organisations Connected: A Handbook of Systemic Consultation.* London: Karnac.

Charmaz, K. (2014). *Constructing Grounded Theory*. London: Sage.

Clark, A. (2018). Dr Finlay's Casebook (1962–71). *BFI Screen Online*. http://www.screenonline.org.uk/tv/id/481822/index.html

Clarke, S. & Hoggett, P. (Eds). (2009). *Researching Beneath the Surface: Psycho-social Research Methods in Practice*. London: Karnac.

Clarke, J. & Newman, J. (1997). *The Managerial State: Power, Politics and Ideology in the Remaking of Social Welfare*. London: Sage.

Clews, G. (2013, 16 August). Exclusive: Most GPs Say Their Job Has Become More Stressful. *GP*. https://www.gponline.com/exclusive-gps-say-job-become-stressful/article/1207601

Cooper, A. & Lousada, J. (2005). *Borderline Welfare: Feeling and Fear of Feeling in Modern Welfare.* London: Karnac.

Copperfield, T. (2010). *Sick Notes: True Stories from the GP's Surgery*. Cheltenham: Monday Books.

Costley, C., Elliot, G. & Gibbs, P. (2011). *Doing Work Based Research: Approaches to Enquiry for Insider Researchers*. London: Sage.

Cotton, E. (2017). *Surviving Work in Healthcare: Helpful Stuff for People on the Frontline*. Abingdon: Routledge.

Dale, J., Potter, R., Owen, K. & Leach, J. (2016). The General Practitioner Workforce Crisis in England: A Qualitative Study of How Appraisal and Revalidation Are Contributing to Intentions to Leave Practice. *BMC Family Practice, 17*, 84. https://doi.org/10.1186/s12875-016-0489-9

Daniels, B. (2012). *Confessions of a GP: A Year of Life, Death and Earwax.* London: HarperCollins Publishers

Dartington, T. (1979). Fragmentation and Integration in Health Care: The Referral Process and Social Brokerage. *Sociology of Health & Illness, 1*(1), 12–39.

Dartington, T. (2010). *Managing Vulnerability: The Underlying Dynamics of Systems of Care.* London: Karnac.

Dartington, T. (2013). Meeting the Needs of Vulnerable Patients. *Nursing Management, 19*(9), 12.

Derrida, J. (2000). *Of Hospitality*. Stanford: Stanford University Press.

Dickens, C. (1894). Doctor Marigold. London: Chapman & Hall.

Dixon, A., Goodwin, N., Poole, T. & Raleigh, V. (2008). *Improving the Quality of Care in General Practice.* London: King's Fund. http://www.kingsfund.org.uk/sites/files/kf/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf

Duffin, C. (2013). One in Eight GPs Have Sought Help for Stress in Past Year. *Pulse*. http://www.pulsetoday.co.uk/home/battling-burnout/one-in-eight-

gps-have-sought-help-for-stress-in-past-year/20003871.article#.UtrkeMJFDug

Duhem, P. (1954). *The Aim and Structure of Physical Theory* (2nd ed.). Princeton: Princeton University Press. First published 1914.

Edwards, N. (2007). *In Stitches: The Highs and Lows of Being an A & E Doctor.* London: The Friday Project.

Elton, C. (2018). *Also Human: The Inner Lives of Doctors*. London: Basic Books.

Fletcher, E., Abel, G.A., Anderson, R., Richards, S.H., Salisbury, C., Dean, S.G., Sansom, A., Warren, F.C. and Campbell, J.L. (2017). Quitting Patient Care and Career Break Intentions Among General Practitioners in South West England: Findings of a Census Survey of General Practitioners BMJ Open. https://bmjopen.bmj.com/content/bmjopen/7/4/e015853.full.pdf

Foster, A. (2001). The Duty to Care and the Need to Split. *Journal of Social Work Practice, 15*(1), 81–90.

French, R. & Simpson, P. (2014). *Attention Cooperation and Purpose.* London: Karnac.

Freud, S. (1912e). Recommendations to Physicians Practising Psycho-analysis. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, pp. 109–120). London: Hogarth Press.

Freud, S. (1926d). Inhibitions, Symptoms and Anxiety. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20). London: Hogarth Press.

Gadd, D. & Jefferson, T. (2007). *Psychosocial Criminology*. London: Sage.

Gittings, R. (Ed.) (1970). The Letters of John Keats: A Selection. Oxford: Oxford University Press.

Glaser, B.G. & Strauss, A.L. (2008). *Discovery of Grounded Theory: Strategies for Qualitative Research*. London: Aldine Transaction.

Gosling, R. & Turquet, P.M. (1967). The Training of General Practitioners. In R.H. Gosling, D.H. Miller, D.L. Woodhouse & P.M. Turquet (Eds), *The Use of Small Groups in Training* (pp. 13–75). London: Karnac.

Gould, L.J., Stapley, L.F. and Stein, M.E. (2001). *The Systems Psychodynamics of Organizations.* London: Karnac.

Greener, I. (1999). *Shifting the Paradigm: Managerialism in the NHS*. Paper presented to Critical Management Studies Conference, public sector stream, Manchester University.

http://www.mngt.waikato.ac.nz/ejrot/cmsconference/1999/documents/public%20sector/cmspaper.pdf

Griffiths, E.R. (1983). Griffiths Report on NHS October 1983. *Socialist Health Association.* https://www.sochealth.co.uk/national-health-service/griffiths-report-october-1983/

Guardian. (2020, 20 August). Sick Politics at the Heart of Public Health England Closure. *The Guardian*. https://www.theguardian.com/society/2020/aug/20/sick-politics-at-the-heart-of-phe-closure

Hafsi, M. (2006). The Chemistry of Interpersonal Attraction: Developing Further Bion's Concept of Valency. *Memoirs of Nara University, 34*, 88.

Hafsi, M. (2007). The Valency Theory: The Human Bond from a New Psychoanalytic Perspective. *Memoirs of Nara University, 36*, 106.

Hafsi, M. (2012). The Anatomy of the Relatedness Means: Valency Theory Revisited and Compared. *Memoirs of Nara University, 41*, 213–229.

Hafsi, M. (2012). Personality Under the Light of Valency Theory: A Shift to 'Sociality'. http://repo.nara-u.ac.jp/modules/xoonips/download.php/AN10533924-20130300-1002.pdf?file_id=6117

Hale, R. (1997). How Our Patients Make Us Ill. *Advances in Psychiatric Treatment, 3*, 254–258.

Halton, W. (1995). Institutional Stress on Providers in Health and Education. *Psychodynamic Counselling, 1*(2), 187–198.

Halton, W. (2015). Obsessional-Punitive Defences in Care Systems: Menzies Lyth Revisited. In D. Armstrong & M. Rustin (Eds), *Social Defences Against Anxiety* (pp. 27-38). London: Karnac.

Hamill, J. (2019, 24 October). Working in an Office is Having a Terrible Effect on Your Body, Expert Warns. *Metro*, 11.

Harre, R. (1988). Where Models and Analogies Really Count. *International Studies in the Philosophy of Science, 2*, 118–133.

Hawton, K., Malmberg, A. & Simkin, S. (2004). *Suicide in Doctors: A Psychological Autopsy Study*. Oxford: University of Oxford, Centre for Suicide Research.

Hinshelwood, R.D. (2001). *Thinking About Institutions: Milieux and Madness.* London: Jessica Kingsley.

Hinshelwood, R.D. & Skogstad, W. (Eds) (2000). *Observing Organisations: Anxiety, Defence and Culture in Health Care*. London: Routledge.

Hinshelwood, R. (2008). Systems, Culture and Experience: Understanding the Divide Between the Individual and the Organization. *Organisational and Social Dynamics, 8*(1), 63–77.

Hoggett, P. (1996). New Modes of Control in the Public Service. *Public Administration*, *74*(1), 9–32.

Hoggett, P. (2010). Government and the Perverse Social Defence. *British Journal of Psychotherapy, 26*(2), 202–212.

Hoggett, P. (2015). A Psycho-Social Perspective on Social Defences. In D. Armstrong & M. Rustin (Eds), *Social Defences Against Anxiety* (pp. 50-58). London: Karnac.

Hollway, W. (2015). *Knowing Mothers: Researching Maternal Identity Change*. Basingstoke: Palgrave Macmillan.

Hollway, W. & Jefferson, T. (2013). *Doing Qualitative Research Differently*. London: Sage.

Hood, C. (1991). A Public Management for All Seasons? *Public Administration*, *69*(1), 3–19.

Huffington, C., Armstrong, D., Halton, W., Hoyle, L. & Pooley, J. (2004). *Working Below the Surface: The Emotional Life of Contemporary Organizations*. London: Karnac.

Hutton, J., Bazalgette, J. & Reed, B. (1997). Organisation-in-the-Mind. In J.E. Neumann, K. Kellner and A. Dawson-Shepherd (Eds), *Developing Organisational Consultancy* (pp. 113–126). London: Routledge.

Iacobucci, G. (2021). NHS Shake-up to Reverse Lansley Reforms. *BMJ, 372*(377), https://www.bmj.com/content/372/bmj.n377

Ipsos MORI (2016). GP Patient Survey: National Summary Report. Leeds: NHS England. https://gp-patient.co.uk/surveys-and-reports#jan-2016

Irish, B. & Purvis, M. (2012). Not Just Another Primary Care Workforce Crisis. *British Journal of General Practice, 62*(597), 178. https://bjgp.org/content/62/597/178

James, T. (2018). *How the Periodic Table Can Now Explain (Nearly) Everything.* London: Robinson.

Jaques, E. (1951). *The Changing Culture of a Factory: A Study of Authority and Participation in an Industrial Setting*. London: Tavistock.

Jaques, E. (1964). Social-Analysis and the Glacier Project. *Human Relations, 17*(4), 361–375.

Jaques, E. (1989). *Requisite Organization: The CEO's Guide to Creative Structure and Leadership.* Arlington, VA: Cason Hall.

Jaques, H. (2013, 25 June). BMA Must 'Act Now' on Stress and Burnout, Say Doctors. *BMJ Careers*. http://careers.bmj.com/careers/advice/view-article.html?id=20013164

Kikert, W. (1995). Steering at a Distance: A New Paradigm of Public Governance in Dutch Higher Education. *Governance, 8*(1), 135–157.

King's Fund (2011). *Improving the Quality of Care in General Practice: Report of an Independent Inquiry Commissioned by the King's Fund*. London: King's Fund.

King's Fund (2021). Pressures in General Practice. *The King's Fund*. https://www.kingsfund.org.uk/projects/pressures-in-general-practice

Klein, M. (1928). Early Stages of the Oedipal Conflict. *International Journal of Psychoanalysis, 9*, 67–180.

Klein, M. (1946). Notes on Some Schizoid Mechanisms. *International Journal of Psychoanalysis, 27*, 99–110.

Klein, M. (1975). Our Adult World and Its Roots in Infancy. In *Envy and Gratitude and Other Works, 1946–1963* (pp. 247–263). London: Hogarth. First published 1959.

Launer, J. (2002). *Narrative-Based Primary Care: A Practical Guide*. Abingdon: Radcliffe.

Launer, J. (2005). Introduction. In J. Launer, S. Blake & D. Daws (Eds), *Reflecting on Reality: Psychotherapists at Work in Primary Care* (pp. 1–17). London: Karnac.

Launer, J. (2007). *How not to be a doctor and other essays.* London: Royal Society of Medicine Press Ltd.

Lawrence, W. G. (1977) Management Development: Some Ideals, Images and Realities. *Journal of European Industrial Training, 1*(2), 21–25.

Lawrence, W.G. (1999). Centring of the Sphinx. *Psychoanalytic Study of Organisations Socio-Analysis, 1*(2), 99–126.

Lawrence, W.G., Bain, A. & Gould, L. (1996). *The Fifth Basic Assumption.* London: Free Association Books.

Lawrence, W.G. & Robinson, P. (1975). An Innovation and Its Implementation: Issues of Evaluation. CASR Document 1069. London: Tavistock Institute of Human Relations.

Le Grand, J. (1997). Knights, Knaves or Pawns? Human Behaviour and Social Policy. *Journal of Social Policy, 26*(2), 149–169.

Levi, P. (1995). *The Periodic Table.* London: David Campbell.

Lewin, K. (1951). *Field Theory in Social Science: Selected Theoretical Papers.* New York: Harper & Brothers.

Lindeman, S., Laara, E., Hakko, H. & Lonnqvist, J. (1996). A Systematic Review on Gender-Specific Suicide Mortality in Medical Doctors. *British Journal of Psychiatry, 168*, 274–179.

Lipgar, R. & Pines, M. (Eds) (2003). Building on Bion: Branches – Contemporary Developments and Applications of Bion's Contributions to Theory and Practice. London: Jessica Kingsley.

Lloyds Bank. (2015). *Lloyds Healthcare Index Report 2015*. London: Lloyds Bank plc. https://www.lloydsbank.com/assets-business-banking/pdfs/Lloyds_Healthcare_Index_Report_2015.pdf

Long, S. (2006). Organizational Defenses Against Anxiety: What Has Happened Since the 1955 Jaques Paper? *International Journal of Applied Psychoanalytic Studies, 3*(4), 279–295.

Long, S. (2008). *The Perverse Organisation and Its Deadly Sins*. London: Karnac.

Long, S. (2015). Beyond Identifying Social Defences: 'Working Through' and Lessons from People Whispering. In D. Armstrong & M. Rustin (Eds), *Social Defences Against Anxiety* (pp. 39-49). London: Karnac.

Long, S. (2016). *Transforming Experience in Organisations*. London: Routledge.

Long, S.D. & Sievers, B. (Eds) (2012). *Towards a Socioanalysis of Money, Finance and Capitalism: Beneath the Surface of the Financial Industry*. London: Routledge.

Martin, J. & Harré, R. (1982). Metaphor in Science. In D.S. Miall (Ed.), *Metaphor: Problems and Perspectives* (pp. 89–105). Hemel Hempstead: Harvester Press.

Martin, R.L. & Osberg, S. (2007). Social Entrepreneurship: The Case for Definition. *Stanford Social Innovation Review.*

https://ssir.org/articles/entry/social_entrepreneurship_the_case_for_definition

McConnell, J. (2014). *The Country Doctor: Captivating Tales from a Young GP's Case Notes.* London: Corazon.

Menzies, I.E.P. (1960). A Case-Study in the Functioning of Social Systems as a Defence Against Anxiety: A Report on a Study of the Nursing Service of a General Hospital. *Human Relations, 13*(2), 95–121.

Menzies Lyth, I. (1988). *Containing Anxiety in Institutions: Selected Essays* (Vol. 1). London: Free Association Books.

Miller, E. (1993). *From Dependency to Autonomy: Studies in Organisation and Change*. London: Free Association Books.

Morgan, G. (1997). *Images of Organization.* London: Sage.

Moscrop, A. (2011). 'Heartsink' Patients in General Practice: A Defining Paper, Its Impact, and Psychodynamic Potential. *British Journal of General Practice, 61*(586), 345–348. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080217/

Napier, J., 2017. Changing Social Defence Systems: Narratives of UK General Practice. *Organisational and Social Dynamics*, *17*(1), 1–18.

Newman, J. (2001). *Modernizing Governance: New Labour, Policy and Society*. London: Sage.

NHS England. (2016). *General Practice: Forward View*. Redditch: NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Nielsen, H.G. & Tulinius, C. (2009). Preventing Burnout Among General Practitioners: Is There a Possible Route? *Education for Primary Care, 20*, 353–359.

Obholzer, A. & Roberts, V.Z. (1994). *The Unconscious at Work*. Hove: Routledge.

OEIS (2020). Inquiry. https://oeis.org/wiki/Inquiry

Owen, K., Hopkins, T., Shortland, T. & Dale, J. (2019). GP Retention in the UK: A Worsening Crisis – Findings from a Cross-sectional Survey. *BMJ Open*, *9*(2), e026048. https://bmjopen.bmj.com/content/bmjopen/9/2/e026048.full.pdf

Parker, I. (2005a). *Narrative in Qualitative Psychology: Introducing Radical Research*. Buckingham: Open University Press.

Parker, I. (2005b). *Qualitative Psychology: Introducing Radical Research.* Maidenhead: Open University Press.

Parsons, T. (2013). *The Social System*. London: Routledge. First published 1951.

Peedell, C. (2011). Further Privatisation Is Inevitable. *BMJ, 342*. https://www.bmj.com/bmj/section-pdf/186303?path=/bmj/342/7807/Observations.full.pdf

Peirce, C.S. (1998). A Syllabus of Certain Topics of Logic. In *The Essential Peirce: Selected Philosophical Writings* (Vol. 2, 1893–1913) (pp. 258–324). Bloomington: Indiana University Press. First published 1903.

Pidgeon, N. & Henwood, K. (1996). Grounded Theory: Practical Implementation. In J.T.E. Richardson (Ed.), *Handbook of Qualitative Research Methods for Psychology and the Social Sciences* (pp. 86–101). Leicester: BPS Books.

Pierre, J. & Peters, G. (2000). *Governance, Politics and the State*. Basingstoke: Macmillan.

Reed, B.D. & Armstrong, D. (1988). *Notes on Professional Management*. London: Grubb Institute.

Rey, H. (1979). Schizoid Phenomena in the Borderline. In E. Bott Spillius (Ed.), *Melanie Klein Today* (Vol. 1) (pp. 203–229). London: Routledge.

Rhodes, R. (2000). *Transforming British Government* (Vols 1 & 2). Basingstoke: Macmillan.

Rimmer, A. (2015, 15 April). A Third of GPs Are Considering Retirement. *BMJ Careers*. http://careers.bmj.com/careers/advice/view-article.html?id=20021782

Rizq, R. (2012). The Perversion of Care: Psychological Therapies in a Time of IAPT. *Psychodynamic Practice, 18*(1), 7–24.

Robert G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., Taylor, C., Shuldham, C. and Maben, J. (2017). Exploring the Adoption of Schwartz Center Rounds as an Organisational Innovation to Improve Staff Well-Being in England, 2009–2015. *BMJ Open.* https://bmjopen.bmj.com/content/bmjopen/7/1/e014326.full.pdf

Roland, M. (2016). Tackling the Crisis in General Practice. *BMJ, 352*, i942. https://doi.org/10.1136/bmj.i942

Rosenthal, G. (1993). Reconstruction of Life Stories: Principles of Selection Generating Stories for Narrative Biographical Interviews. In R. Josselson & A. Lieblich (Eds), *The Narrative Study of Lives* (Vol. 1) (pp. 59–91). London: Sage.

Royal College of GPs. (2019a). *Fit for the Future: A Vision for General Practice*. London: RCGP. https://www.rcgp.org.uk/-/media/Files/News/2019/RCGP-fit-for-the-future-report-may-2019.ashx?la=en

Royal College of GPs. (2019b). *The RCGP Curriculum: Being a General Practitioner*. London: RCGP. https://www.rcgp.org.uk/-/media/Files/GP-training-and-exams/Curriculum/curriculum-being-a-gp-rcgp.ashx?la=en

Royal College of GPs. (2020). *The RCGP Curriculum: Professional & Clinical Modules*. London: RCGP. https://www.gmc-uk.org/-/media/documents/RCGP_Curriculum_modules_jan2016.pdf_68839814.pdf%20accessed%2001/08/2018

Rustin, M.J. (2015). What Happened to Psychoanalytic Sociology? In A. Elliott & J. Prager (Eds), *Routledge Handbook on Psychoanalysis in the Social Sciences and Humanities* (pp. 259–277). London: Routledge.

Rustin, M.J. (2019). *Researching the Unconscious Principles of Psychoanalytic Method.* London: Routledge.

Rustin, M.E. & Bradley, J. (Eds) (2008). *Work Discussion: Learning from Reflective Practice in Work with Children and Families.* London: Karnac.

Salinsky, J. (2002). *Medicine and Literature.* Abingdon: Radcliffe Medical Press.

Salinsky, J. (2013). Balint Groups and the Balint Method. *Balint Society*. https://balint.co.uk/about/the-balint-method/

Senior, R. & Mayer, R. (2005). A Systemic Outreach Clinic in Primary Care: Which Tier Is That? In J. Launer, S. Blake & D. Daws (Eds), *Reflecting on Reality: Psychotherapists at Work in Primary Care* (pp. 56–127). London: Karnac.

Shapiro, E. & Wesley Carr, A. (1991). *Lost in Familiar Places: Creating New Connections Between the Individual and Society*. London: Yale University Press.

Shaw, G.B. & Laurence, D. (1987). *The Doctor's Dilemma: A Tragedy.* London: Penguin.

Simon, C., Forde, E., Fraser, A., Wedderburn, C. & Aylwin, S. (2018). What Is the Root Cause of the GP Workforce Crisis? *British Journal of General Practice*, *68*(677), 589-590. https://bjgp.org/content/68/677/589

Soteriou, M. (2013a, 16 September). GP Exodus Looms as Stress Hits 15-Year High, DH Poll Reveals. *GPOnline*. http://www.gponline.com/gp-exodus-looms-stress-hits-15-year-high-dh-poll-reveals/article/1211968

Soteriou, M. (2013b, 21 June). GPs Most Stressed of All UK Doctors, Survey Reveals. *GPOnline*. http://www.gponline.com/gps-stressed-uk-doctors-survey-reveals/article/1187333?HAYILC=RELATED

Spitz, V. (2005). *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans*. Boulder: Sentient Publications.

Spooner, S. (2016). Unfashionable Tales: Narratives About What Is (Still) Great in NHS General Practice. *British Journal of General Practice, 66*(643), e136–142. https://bjgp.org/content/66/643/e136

Spooner, S., Pearson, E., Gibson, J. & Checkland, K. (2017). How Do Workplaces, Working Practices and Colleagues Affect UK Doctors' Career Decisions? A Qualitative Study of Junior Doctors' Career Decision Making in the UK. *BMJ Open*, *7*(10), e018462.

Steiner, J. (1985). Turning a Blind Eye: Psychotic States and the Cover-up for Oedipus. *International Revue of Psychoanalysis, 12*(2), 161–172.

Steiner, J. (1993). *Psychic Retreats.* London: Routledge.

Stokoe, P. (2010). The Theory and Practice of the Group Relations Conference. In C. Garland (Ed.), *The Groups Book: Psychoanalytic Group Therapy – Principles and Practice* (pp. 152–172). London: Routledge.

Stolper, E., Van de Wiel, M., Van Royen, P., Van Bokhoven, M., Van der Weijden, T. & Jan Dinant, G. (2010). Gut Feelings as a Third Track in General Practitioners' Diagnostic Reasoning. *Journal of General Internal Medicine, 26*(2), 197–203.

Tavistock & Portman NHS Foundation Trust. (2014) Consultation for Doctors and Dentists: MedNet. http://www.tavistockandportman.nhs.uk/consultationmednet

Titmuss, R. (1998). The Gift of Blood. *Society, 35*(2), 88–97.

Tucker, S. (2010). An Investigation of the Stresses, Pressures and Challenges Faced by Primary School Head Teachers in a Context of Organisational Change in Schools. *Journal of Social Work Practice, 24*(1), 64-74

Turquet, P.M. (1974). Leadership: The Individual and the Group. In G.S. Teoksessa Gibbard, J.J. Hartman & D.M. Richard (Eds), *The Large*

*Group: Therapy and Dynamics* (pp. 349–371). San Francisco: Jossey-Bass.

Wengraf, T. (2013). *BNIM Short Guide Bound with the BNIM Detailed Manual: Interviewing for Life-Histories, Lived Periods and Situations, and Ongoing Personal Experiencing Using the Biographic-Narrative Interpretive Method (BNIM)*. [Unpublished manuscript].

Wengraf, T. & Chamberlayne, P. (2006). *Interviewing for Life Histories, Lived Situations and Personal Experience: The Biographic-Narrative-Interpretive Method (BNIM) – Short Guide to BNIM Interviewing and Interpretation.* [Unpublished manuscript].

Western Oregon University. (2020). Atoms and the Periodic Table. In *CH104: Chemistry and the Environment*. Monmouth: Western Oregon University. https://wou.edu/chemistry/courses/online-chemistry-textbooks/3890-2/ch104-atoms-and-the-periodic-table/

Whitfield, D. (2006). *A Typology of Privatisation and Marketisation*. Adelaide: European Services Strategy Unit. http://www.european-services-strategy.org.uk/publications/essu-research-reports/essu-research-paper-1/essu-research-paper-1-2.pdf

Widgery, D. (1991). *Some Lives: A GP's East End.* London: Sinclair-Stevenson.

Wikipedia. (2020). Sure Start. https://en.wikipedia.org/wiki/Sure_Start

Wilke, G. & Freeman, S. (2001). *How to Be a Good Enough GP.* Abingdon: Radcliffe Medical Press.

Winnicott, D.W. (1990). *The Maturational Processes and the Facilitating Environment.* London: Karnac. First published 1965.

# Appendix 1. UREC Approval Letter

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

**08 June 2015**

Dear Liz

| | |
|---|---|
| **Project Title:** | **A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery** |
| **Researcher(s):** | **Liz Greenway** |
| **Principal Investigator:** | **Dr Simon Tucker** |
| **Reference Number:** | **UREC_1415_87** |

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered at the meeting on **Wednesday 20th May 2015**.

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

**Approved Research Site**

I am pleased to confirm that the approval of the proposed research applies to the following research site.

| **Research Site** | **Principal Investigator / Local Collaborator** |
|---|---|
| GPs' and researcher's premises and Tavistock Consulting | Dr Simon Tucker |

**Approved Documents**

The final list of documents reviewed and approved by the Committee is as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| UREC application form | 2.0 | 03 June 2015 |
| Draft interview questions | 1.0 | 05 May 2015 |
| Participant information sheet for GPs | 1.0 | 03 June 2015 |
| Participant information sheet for focus group members | 1.0 | 03 June 2015 |
| Consent form for interviews | 2.0 | 03 June 2015 |
| Consent form for focus groups | 2.0 | 03 June 2015 |
| Recruitment advertisement for GPs | 2.0 | 03 June 2015 |
| Recruitment advertisement for focus groups | 2.0 | 03 June 2015 |

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

**Please note, it is your responsibility to retain this letter for your records.**

With the Committee's best wishes for the success of this project.

Yours sincerely,

Rosalind Eccles
University Research Ethics Committee (UREC)
UREC Servicing Officer
Email: researchethics@uel.ac.uk

## Appendix 2. Assurance Letter, Central London CCG

**WeLReN CIC**

Brent CCG

Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex
HA0 4UZ

Tel: 020 8795 6730/5

Email: ricky.banarsee@brentpct.nhs.uk

Liz Greenway
Organisational Consultant
NHS Central London CCG

Date 22 July 2015

Dear Liz

| | |
|---|---|
| **Project Title:** | A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery |
| **NHS REC** | Not applicable staff only / UREC 1415 87 |

The West London Research Network (WeLReN CIC) is the lead Research Governance (RG) office for the North West London CCGs and GP practices/pharmacists/dentists.

NHS RG assurance for the above research has been given on the basis described in the application form and supporting documentation approved by your University Research Ethics Committee (REC) subject to the conditions listed below and overleaf. Assurance is given on the understanding that the study is conducted in accordance with the Research Governance Framework and NHS Trust policies and procedures. Assurance is only granted for the activities for which a favourable opinion has been given by the REC.

Please note that the ultimate decision as to whether to take part in a study lies with the Primary Care Independent Contractor.

This assurance, on behalf of the CCGs in North West London, covers our GP practices/services in Westminster (Central London CCG). Please give a copy of this letter to each participating site.

If you require any further information or advice, do not hesitate to contact Sylvia Westrup our Research Governance & Management Manager (s.westrup@imperial.ac.uk)

With kind regards

Ricky Banarsee
Director WeLReN CIC/Applied Research Unit
Sent via email
Student Supervisors; simontucker@siriusconsultancy.org.uk, jbell@tavistockconsulting.co.uk
Principal Investigator and Student; liz.greenway@nhs.net; liz.greenway@yahoo.co.uk
Academic Quality academicquality@Tavi-Port.nhs.uk
Research Ethics researchethics@uel.ac.uk

## *Listed Conditions from Central London CCG*

**Research Governance assurance is given subject to the following conditions:**

There will be no call upon NHS resources other than any mentioned in the application and agreed with the Primary Care site.

The research sponsor or the CI or the local PI at the research site may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The Research Office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D office should be notified within the same time frame as the REC and any other regulatory bodies.

The Sponsor organisation must have in place procedures for detecting and dealing with misconduct and fraud. All researchers must be aware of these procedures and any instances must be reported to the R&D Team alternatively suspected incidents may be reported, in confidence, directly to us.

We are required by the Research Governance Framework to maintain a comprehensive database of all research projects. Unless the Study Team requests otherwise, we will include details of this project on our secure database.

Please respond to any requests from the WeLReN CIC, which hosts the audit function, and provide it with any project amendments, project extensions or terminations.

Once your study has finished please inform this office. Please send a copy of the final report and/or a summary of the findings to this office.

Only members of the clinical care team can access patient identifiable information without the patient's consent. Researchers are not part of the clinical care team and therefore require a patient's consent for access to their confidential data.

You must comply with current information governance (IG) requirements. GP indemnity for routine clinical practice is covered by GP Medical Defence Union arrangements.

# Appendix 3. Participant Information Sheet, Version 2.0

**A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery**

### As a GP, you are invited to take part in a research study

I am seeking volunteers to take part in research interviews that will contribute towards a

**A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery**

- Before you decide to take part it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the following information carefully.
- Please contact us if there is anything that is not clear or if you would like more information.

### Important things that you need to know

- You are free to decide whether or not to take part in this study and free to withdraw your consent to participate at any point in the study.
- If you decide not to take part or to withdraw it will not affect any current or future contact you have with University of East London, Tavistock and Portman NHS Foundation Trust
- The research has received approval from the University Research Ethics Committee (UREC) and will be conducted in line with the University's Code of Practice for ethical research.

### What does participation entail?

- Participants will be invited to undergo a research interview

### What next?

- If you wish to participate in this study please sign the attached consent form and return it in the enclosed envelope.
- You will then be contacted to arrange the date and time of the interview.

**Consent to participate in a research study**

The purpose of this leaflet is to provide you with the information that you need to consider in deciding whether to participate in this study.
Attached to this leaflet is a Consent Form that you will need to sign if you wish to be part of the study.

**University Research Ethics Committee**

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:
**Catherine Fieulleteau**
Ethics Integrity Manager, Graduate School, EB 1.43
University of East London Docklands Campus
London E16 2RD Tel: 020 8223 6683
Email: researchethics@uel.ac.uk

**How to contact us**

If you have questions about this study please contact the lead researcher: **Liz Greenway**
**Mobile: 07931435072**
**Liz.greenway@yahoo.co.uk** **The Principal Investigator is:** Dr.Simon Tucker: Tavistock Consulting, 94 Belsize Lane, London NW3 5BE Telephone: 020 8938 2475 Mobile: 07879775766
Email:
STucker@Tavistockconsulting.co.uk
or
simontucker@siriusconsultancy.org.uk

## Further information for participants

**Aim of the investigation**
The aim is to advance the theory and practice of systems psychodynamics consultancy in relation to the impact of context on the working lives of professionals

**Research Methodology**
The focus of the study is on responses of GPs over the course of their professional lives to determine whether context impacts professionalism and personal and working life experience

**What will happen in the interview** GP interviews will be conducted individually by the researcher. The total length of each interview will vary according to each individual. The groups will be audio recorded and transcribed. The data will be analysed.

**Potential benefits to participants**
The hope is that the interviews will be interesting and stimulating for members and provide an opportunity to reflect on aspects of their organization and work setting. The researcher is an experienced consultant. The outcomes of the research may contribute to the consideration and management of working lives by professionals and perhaps policy making of professional environments and the management and organization of services.

**The Chief Investigator**

**Liz Greenway**

**Study status**

This study is defined as research and is being undertaken in partial fulfilment of the requirements of the Professional Doctorate in Consultation and the Organisation at the Tavistock and Portman NHS Foundation Trust/University of East London.

**Why the research is important**

GPs are retiring early and also hard to recruit. Primary care has been changing. The aim of this research is to produce new understanding of how context impacts on professionalism. It is hoped that this research may lead to improvements in organizational practice.

## Further information for participants

**Risk analysis**

A risk analysis has identified certain issues and action taken to minimize them.

Potential hazards for participants

- Discussion of work experiences and organizations may expose you to strong feelings and possible emotional disturbance.
- You will have to attend at the site for the interview which involves risks associated with travel. Or the interview may be carried out at your place of work.

Mitigation of potential hazards

- The research site has been chosen to minimize the risks to the researcher and participants.
- The researcher's experience as an organizational consultant will be used to minimize risks associated with the potential for participants to be disturbed emotionally by the research process.
- The interviews will be facilitated to provide an emotionally containing environment that will encourage participants to reflect on their work experience in a way that is safe, controlled and well held.
- At the end of the interview the interviewee will be given information about contacting a suitable therapist if they are personally affected and/or an organisational consultant (other than the researcher) if the experience uncovers issues about their work setting that they wish to explore further.

**Confidentiality of the data**

The data associated with this study will be stored in accordance with both Data Protection policies of the University. Audio recordings and the transcription of these will be securely stored. Individuals will not be identified in the data or any subsequent papers as names and personal details will be anonymised, although as the sample will be small this may have implications for absolute anonymity and you may recognise yourself in publications.

The aim is to publish the outcomes in a peer review journal which will refer only to anonymised data. By agreeing to take part in the study participants are also giving consent for anonymised data to be used in publications. Once the study is completed all data will be destroyed securely.

**Definition of terms: Systems-psychodynamics**

'Systems' refers to division of labour, levels of authority, and reporting relationships; nature of work tasks, processes and activities & 'pychodynamic' refers to individual and group experiences and mental processes both a source and consequence of unresolved organisational difficulties.

## Appendix 4. Consent Form

Centre Number: Study Number:

Participant Identification Number for this trial:

### CONSENT FORM

**Title of Project**: A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery **Name of Researcher**: Liz Greenway

Please **initial** box

1. I confirm that I have read the information sheet dated……………….. (version…………) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

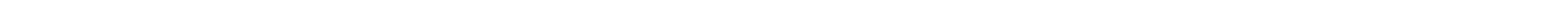
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.

3. I understand that the interview may be video and audio recorded and the recording transcribed and anonymised. I understand that all data will be stored confidentially and destroyed securely once the study has been completed.

4. I understand that by agreeing to take part in the study I am also giving consent for anonymised data, including anonymised quotes, to be used in future publications in peer review journals and conferences.

5. I agree to take part in the above study.

Name of Participant Date Signature



Name of Person taking consent Date Signature

*To be sent as an email to contacts of* Liz Greenway Psychotherapy and Consultancy Practice

## Appendix 5. Letter of Invitation to Participants

Dear Colleague

**You are invited to take part in a research study**

I am seeking volunteers to take part in interview that will contribute towards a systems-psychodynamic exploration into A systems-psychodynamic exploration into GP experiences of current changes in healthcare delivery. I am writing to you as someone who may be interested in supporting this research. The study is being undertaken in fulfilment of the Professional Doctorate in Consultation and the Organisation at the Tavistock and Portman NHS Foundation Trust and has been approved by the University of East London.

Participants are required for one or two interviews. Each interview will take place in your place of work, Tavistock Consulting or other secure premises in London. Participants will be asked questions about their experience as a professional in role. Interviews will be anonymized. The hope is that the interviews will be interesting and stimulating and provide an opportunity to reflect on aspects of their own professional lives, organizational and work setting.

If you might be interested in taking part in this study please email me via liz.greenway@yahoo.co.uk or call 07931435072 and I will then send you a detailed Participant Information Sheet and Consent Form that you can consider before agreeing to be a participant.

I am happy to discuss the study if you require additional information.

Liz Greenway
Organisational Consultant
Liz Greenway Psychotherapy and Consultancy Practice

**Email: liz.greenway@yahoo.co.uk**

## Appendix 6. FANI Questionnaire

**Below is a draft questionnaire for FANI method:**

**Interview Questions**

- **1a. Can you tell me about the time when you realised that you wanted to become a GP?**
  - **1b. [follow up in terms of detail and time periods, following order of narrative]**
- **2a. Can you tell me about times when the wider setting of healthcare such as targets, patient interest groups and commissioning have impacted your role – has this changed?**
  - **2b. [as in 1b]**
- **3a. Can you tell me about a time when the experience of being a GP stands out in your memory?**
  - **3b. [as in 1b]**
  - **4a. Can you tell me about a time when work has kept you up at night?**
  - **4b. [as in 1b]**
- **5a Can you tell me about something that you've read, seen or heard about recently that caught your attention and motivated you to act? Anything [not necessarily about your work].**
  - **5a. Can you tell me about earlier times in your life when you've been particularly moved?**
  - **5b. [as in 1b]**

  - **6a. Can you tell me about how you experience your role in medicine alongside being a member of society and your own health needs?**
  - **6b. [as in 1b]**
  - **7a. How do you see your career progressing?**
  - **7b. [as in 1b]**

**FACTUAL STRUCTURED QUESTIONS ABOUT CONTEXT:**

**I AM NOW GOING TO ASK YOU SOME FACTUAL QUESTIONS ABOUT YOUR WORKING CONTEXT:**

**8What kind of practice do you work in – for example how many partners are there?**
**9What kind of services does the surgery offer?**

10. **Do budgetary considerations affect your work?**
11. **What changes in healthcare provision in recent years have affected the surgery generally and your work specifically?**
12. **How has GP commissioning responsibilities affected your working life?**
13. **Has this affected your role specifically?**
14. **Have commissioning and any of these other changes affected patient care?**

## Appendix 7. Example of Committed GP (GPcom) Transcript with Themes

| GP11 interview | Themes | Abstraction |
|---|---|---|
| **GP11:** *ultimately yes my space is very important to me and the constancy is very important to me. It's trying to recreate an environment that I'm comfortable in and if I'm comfortable in it my patients will be*<br><br>**INT:** *This is really your room. You've got your coffee machine, speakers and music, artwork. This is your room.*<br><br>**GP11:** *Yes.*<br><br>**INT:** *Even your curtain is –*<br><br>**GP11:** *I've had a lot of people say, including people who come to appraise me, it's the* | Individualised, personalised, intimate treatment room breaking the rules – carpet, cloth curtain, books<br><br>Bucking the system – rebelling against the squeezing out of all the intimacy | Personal/professional interface and breaking the rules to fight for intimacy– keeping consulting room homely and containing, identification with role and GP surgery as second home. |

| | | |
|---|---|---|
| *nicest consulting room they've ever been in. now CQC would have gone mad if they'd known that I'd actually replaced this carpet with a carpet and no lino because the regulations. They're squeezing out all the intimacy of –*<br><br>**INT:** *Within your own mind as well as what you can offer with a patient?*<br><br>**GP11:** *Yes. I've been really upset this week because we're trying to turn this into a community garden for patients, it's a fantastic initiative. Everyone is terribly excited about it. The gardener is full of enthusiasm just suddenly I saw this beautiful tree that had been outside my room for 18 years with blossom in the spring and birds which gave me light, colour, beauty and also gave me and my patients a level of privacy. If you look, I'm* | Losing tree of beauty that had bloomed for 18 years that afforded patient and doctor privacy and yet simultaneously an open vista and then significant sudden loss, left exposed and upset. Experiencing loss and grief due to lack of systemic thinking. Bearing witness to roots being ripped up.<br><br>Environment matters – familiarity, enrichment, ownership<br><br>Evidence of containment and being familiar | Under guise of trying to create uniform public spaces – all disrupted, disturbed and laid bare. Privacy removed, professional exposed, beauty and grace destroyed. Exposing of patient/professional relationship. Sadness of non-systemic approach. End of an era. Robbed of a way of being.<br><br>Having a sense of belonging together with the environment<br>Feeling robbed and exposed by systemic oversights |

| | | |
|---|---|---|
| *completely overlooked by those offices there. They cut it down. One morning they cut it down. I was almost in tears. As a metaphor for how if you don't have a system's approach. when we built this building, we own this building, it gave me another 10 years just coming to work to a lovely place - these things are terribly important and they're important to patients too. These are the intangibles and a lot of that you could make a case for the efficiency of general practice and its hugely efficient.*<br><br>**INT:** *Financially and otherwise?*<br><br>**GP11:** *God yes. In terms of what we hold and what our relationship with our patients and our knowledge of our patients allows us to do, this notion of us being gatekeepers.* | Intangibles that demonstrate efficiency<br><br>Managing anxiety through knowing the patient well enough and avoiding over investigation | Being committed: Commitment and intimacy is the efficiency of general practice, which comes from being committed, ownership, long-term investment. Financial efficiency due to doctor-patient relationship<br><br>Longterm patient relationship – dependency and intimacy. Intimate doctoring is efficient and prevents over examination/over referral. containing anxiety in patient and doctor. |

| | | |
|---|---|---|
| **INT:** *You're not over examining for the sheer hell of it.*<br><br>**GP11:** *If you know them well enough you can contain the anxiety.*<br>*And trainees do over investigate, over refer and that's what we were talking about before, partly they're scared and they don't know the patient well enough to know that it's not necessary and they don't have the experience of what's happened to manage the risk and the uncertainty that you have to manage.*<br><br>*I think there's a level of disconnect between the health policy makers and what general practice is and what patients want from a GP and that's driven firstly by people who are making a career of managing the health service rather than come up from within it, it's* | Trainees struggling to contain patient anxiety leads to over investigation and over referral<br><br>Superimposed managerialism, as opposed to coming up through the ranks, is problematic.<br><br>Being dismantled by dark forces, we are no longer NHS providers | Risk managed by doctor-patient relationship. Trainees challenged to manage anxiety and therefore risk.<br><br>Underpinning ethical value system – outraged by misfit of managerialism and marketisation in NHS |

| | | |
|---|---|---|
| *partly driven by market forces, austerity, all these things and there are dark forces at work. The health service is already dismantled -no longer a universal provider of health. It's a commissioning agency and health provision- we used to be called NHS providers, we're now called providers to the NHS.*<br><br>**INT:** *It begs the question what is the NHS?*<br><br>**GP11:** *Exactly. It's a very subtle change but terribly important.* ***We're not part of the NHS now.*** *When it was politically expedient we were small businesses and what's the difference between us and Virgin after all. We're just smaller.* | GP Partnerships were small businesses being sold out to big business<br><br>negative impact of expedient government attitude | Commodification of health is problematic has already dismantled health service so GPs now providers to NHS!<br><br>Entrepreneurial awareness – why have small business model of GP practices been take over by bigger businesses like Virgin?<br><br>Length of service and keeping abreast of socio-politico-health dynamics enables understanding of the wider system: holding the history of government attitude in relation to general practice and NHS in the mind |

## Appendix 8. Example Entrepreneurial (GPreneur) GP1 Transcript with Themes

| GP 1 interview | Themes | Abstraction |
|---|---|---|
| **INT** *Can you tell me about times when the wider settings of health care like targets, patient interest groups or commissioning have impacted your role as a GP*<br>**RES** *Yeah well, for me I had quite a lot to do with a lot of these things. So we had something … the GP Network group was made here. So I got involved in the setup of that and that was about year and a half ago. So in the out of hour's service, I sit on the board of that. It's more strategic decisions. I don't actually do the out of hours work more the thinking of how to take it forward and make it successful and all that sort of stuff. So I guess that's all related to that idea - more into the management roles of* | Setting up management structures to strategise moving on to the next systemic issue<br><br>Enjoying wider non-clinical responsibilities and thinking strategically and also a relief from patient dependency<br><br>Being enterprising by setting up new services and ways of working collectively with other GPs and surgeries<br><br>Being offended by political interference as if change is being made. | Making shift from working clinically to managerial insights and responsibilities to enable change for better patient care in current context.<br>Acting beyond individual patient care and seeing wider picture.<br>Thinking outside the box.<br>Energetic social entrepreneurial spirit.<br>Business minded approach to financial state of GP surgery & context<br><br>dissatisfaction<br>Feeling in conflict with forced compliance to political demands. |

| | | |
|---|---|---|
| *general practice. So I really enjoy it and it's a great outlet for something different than seeing patients every day.*<br><br>**INT** *So you talked about the friction between GPs and within yourself*<br>**RES** *I think I get cross when I see all these different things. It does make me angry. And more … not angry outwardly angry but angry that there so much stuff done in … that it is completely unnecessary … I have two things today in our meeting at lunchtime: having to give a name of a GP to every patient… the fact that you cut that whole system out and then one year you decide to reinstate it. The system is remaining the same, but they are instigating everyone knowing the name of a GP even though they may never* | Experiencing dissonance when having to carry out governmental demands which look like something they are not<br><br>witnessing loss and cover up<br><br>feeling personal and medical effort and time is wasted for political effect<br><br>'Person in role' as 'revolutionary' GP partner – making a difference systemically, problem solving, making change<br><br>Preferring to solve problems with a can do attitude | Having to be part of a systemic face caught up in political posturing<br><br>Feeling impassioned by mismatch and being motivated to support patients through management of surgery in wider context.<br><br>Describing areas of change in terms of organisational aspects rather than clinical work itself<br><br>Avoidance of being stuck with problems, starting with self belief to make change happen<br><br>Confident in own systemic catalytic ability if unimpeded |

| | | |
|---|---|---|
| *see that GP from one year to the next. And that's just political posturing because they want to get to the people who feel that having a named GP is important. It's not for the good of the patient and it really isn't for the good of the surgery, but how it looks.*<br>**INT** *Can you tell me about something you've read, seen or heard about recently that particularly caught your attention or motivated you to act not necessarily at work*<br>**RES** *… I went to a talk … by one of the students who started off the revolution in Serbia against Milosevic and …listening to him, he … cause I'm quite an activist as in I like to act rather than … the problems I can understand but I like to find the solution. … just listening to him he made me think. So if you want to make things better for* | Starting with an idea of yourself as catalyst<br><br>Active disliking of people who bring problems<br><br>Empowered if I get my own way<br><br>Demonstrating consistent focus and interest at systemic level and dislike for focus on problems<br><br>Awareness - not being like other GPs – more active systemically<br><br>Striving to make things better<br><br>Realising different to many other GPs by having focus to improve system of general practice | Recognises self as active agent and other GPs as sitting back<br><br>Dislike of being exposed to others' problems<br><br>Taking systemic leadership role<br><br>Embracing the taking up of position as entrepreneurial, change catalyst across GP Practices<br><br>Improving patients lives by being the orchestrator of setting up good quality, local clinical provision serviced by local GPs who know the patients and the local area |

| | | |
|---|---|---|
| *anyone or anything even in smallest way you actually need to start thinking that you can do that. The actual idea that you can make a difference in some way or another has got to be the … starting point of the whole thing.*<br>**INT** *So you see yourself as an activist practicing revolutionary?*<br>**RES** *not revolutionary I don't think so I think more as in I like … I'm not a man who likes people who bring out a lot of problems. I find that difficult. I would much prefer you looked to try and solve it in the best manner that causes the least amount of issues to anyone else. That would be my … yeah. Not a revolutionary. Well not unless I get my own way with things*<br>**INT** *Do you see being a GP as an activist* | Identifying and setting up priority care for vulnerable and needy patients in keeping with their difficulties and thus reducing referrals - sound economically | Making the difference by being entrepreneurial – providing networked, accessible services to patients in need whilst keeping an eye on incentives to reduce referrals<br><br>(dis)satisfaction in role as clinical GP<br><br>Business minded approach to financial state of GP surgery & context |

| | | |
|---|---|---|
| *kind of stand point or a position*<br>**RES** *I think different people see it differently. I think I do see it as something where I can channel a lot of my energy and that's what I've tried to do with the out of hours service which is part of my enthusiasm and energy of how to make things different and I channel it into that. Since I've got here, I put energy into trying to make things better and run smoother … but I can see how a lot of GPs tend not to want to be that type of person to make the change and prefer to sit back and … keep the status quo and I can understand that too. If it's not broken then there's no need to change things so. But I'm not like that I kind of strive to make things better.* | <u>EXPERIENCE AS A PATIENT:</u> extensive, many operations, pain, bloody, life limiting, a lot in hospital. Kindness from friend – significant: first time emphasis on 'being with' in the interview,<br><br>Receiving individual attentiveness valued<br><br>Entertaining idea of giving up patient contact commitment for organisational/ systemic work<br><br>Grouping together to rescue clinical provision when private tender failed<br><br>Utilising local knowledge of patients and area to offer successful, patient centred service | Human values: kindness, innocence and generosity, choosing to 'be there'<br><br>Enjoyment of strategic activity may mean end of direct work with patience<br>Takes visionary systemic leadership role<br>Working inter-group across GP practices, to good effect for benefit of patients<br><br>Demonstrating effective social entrepreneurship<br>Discovering motivation and enthusiasm as a networker in response to circumstance<br><br>Enthusiasm as a young partner for change |

| **INT** *Can you tell me about things that you've changed* | | |
|---|---|---|
| **RES** *Yeah ok … I've started up the child health clinic to start with here so that was a big* | Coming together organically in service of patient need and in face of government demands | |
| *change, sorted out all the prescribing here which was quite hap-hazard … and got the prescribing adviser much more involved in the practice. Basically they weren't doing much with the vulnerable patients before I came here but* | Hitting the ground running, dynamic. Fulfilling ambition to make a difference | Demonstrating deep understanding of a complex landscape with multiple entrepreneurial skills and determination |
| *now we have a very active sort of vulnerable patient register and we kind of keep on top of it and actually the* | Being confronted with multiple moving parts: financially, clinically and systemically | |
| *patients… it means we have a lot less emergency visits and more regular visits. Keeping on top of housebound patients. That has made a big difference. So I'm trying to make a difference in keeping referrals down … before I came we were two of the highest* | Nevertheless having to battle not to be overlooked | |

| | | |
|---|---|---|
| *in the number of referrals so we've come down a bit.*<br><br>**INT** *Can you tell me about an earlier time in your life when you've been particularly moved*<br>**RES** *moved … I guess growing up I had lots of operations… a girl I didn't know very well … she spent the whole evening with me chatting to me and kind of being … That was quite an evening. I will never forget that. And that was just human kindness and innocent generosity she could have done what she wanted… that's my moving moment*<br><br>**INT** *can you tell me if you can see giving up seeing patients* altogether<br>**RES** *Ah yes definitely I can imagine giving up seeing patients altogether. I think I would miss it but I think there* | | |

| | | |
|---|---|---|
| *are definitely things I can organisationally get involved with… I'm someone who actually enjoys kind of strategic looking at things, trying to make things better a bit.*<br>**INT** *you have said some things already, but how would you say budgetary considerations affect your work*<br>**RES** *Private company tried to come in and run out of hours here and obviously it failed horrendously so they retendered it and we all grouped together and made a social enterprise brought together by all the four different practices that work and all of the doctors who work in the practices here and they fill the shifts up … the quality and the outcomes are phenomenal - they are doing very very well and I'm very proud to be part of that going forward now. Any contracts that* | | |

| *have been put out to tender have been swallowed up by our GP Practices Network because we are all in the right place to offer the care the patients are already here we don't have to make them go to other kind of place where they have to travel and not have any parking and whatever.*<br><br>**INT** *and how did the Practices Network come about*<br>**RES** *It kind of came about off the back of the changes that have been made to contracts and the CCG said they weren't going to be offering contracts anymore just to singular practices. So we were going to lose a lot of our services otherwise to our patients and the Network was formed from that idea. They can give one contact to the Network which can decide how* | | |
|---|---|---|

| | | |
|---|---|---|
| *it's going to fulfil that contract*<br>**INT** *and was it the GPs themselves who thought of forming the Network?*<br>**RES** *Yep they came together. I was a new partner at that time and young … I was enthusiastic and wanted to get involved in it.*<br>**INT** *So were you quite a key player in*<br>**RES** *I guess yeah … I was early on in it*<br><br>**INT** *What changes in health care provision in recent years have affected the surgery generally and your work specifically*<br>**RES** *I'm thinking … surgery … that's a difficult one. Think the fact that you're getting your contracts from so many different places that's really hard and also that they also keep taking the money away like for the deprivation…* | | |

| | | |
|---|---|---|
| *all the cuts to the social budget has made a huge difference to the pressure on us. Also the people in the commissioning group are tending to ask peoples opinion which is probably better than it was like with the PCT but they still don't really take that into account when they make decisions … it seem they pay more lip service to us than actually listening to us. The GPs full time are not high in their priority to listen to.* | | |

**Appendix 9. Example of Ambivalent (GPamb) GP12 Transcript with Themes**

| **GP12 interview** | **Themes** | Abstraction |
|---|---|---|
| INT: *Can you tell me when the experience of being a GP stands out in your memory. How long have you been a GP?*<br><br>**GP12:** *16 years. I feel a bit thrown when asked to do something I don't understand the ultimate purpose of.*<br><br>**INT:** *You're wondering what's driving my question.*<br><br>**GP12:** *Yes. I find it difficult to choose because I've got this sense that there is a right answer. But I don't know what the right answer is.*<br><br>**INT:** *There isn't a right answer.*<br><br>**GP12:** *The question is a precursor to exploring something else.* | Asking interviewer to make explicit thinking behind question<br><br>Feeling anxiety about getting it wrong<br>probing interviewer wanting to know what's in the mind of the interviewer – but then ultimately revealed mental breakdown<br><br>Creating awkwardness and feeling under scrutiny | Demonstrating high anxiety about failing, causing an interpersonal awkwardness and suspicion and applying pressure to establish rigid rules<br><br>overwhelmed |

| | | |
|---|---|---|
| **INT:** *It's just a question of what stands out for people in their own practice. By definition it can't have a right and wrong because it's such an individual phenomenon.*<br><br>**GP12:** *A few months back I was working in my current practice and it was just me and a relatively newly qualified locum. We're all salaried in my practice. There were 3 home visit requests all for palliative care patients and in our practice we have just under 5000 patients. Most days of the week there are normally 3, for many months I was the only regular member of the team and a locum which often would change. I had this period of several months of uncertainty of coming into work and never knowing would I be on my own or with a stranger?* | Eventually self revealing<br><br>Straining to sustain negative impact of regularly working with different locums | (dis)identification with role & GP surgery (not) as second home<br><br>Overwhelmed by clinical demands and administration<br><br>Oscillation from attitude of closed, guarded and suspicious to, once trust achieved, exposure and revelation<br><br>Ambivalent about the job<br><br>failed dependency due to high frequency of locums with their limited familiarity with patients and system, uncontained failure of long-term patient relationship – dependency & intimacy |

| | | |
|---|---|---|
| **INT:** *One day a week was it?*<br><br>**GP12:** *Yes. I only work one day a week at the practice. On this day unusually there were 3 palliative care visit requests and I didn't feel I could ask this newly qualified locum to see them. It didn't seem fair. Palliative care is quite challenging even for quite an experienced GP. It's challenging if you're not the patients' regular GP. I felt I had to deal with all 3 myself. It would have been impossible to visit all 3 so I decided to see what I could manage over the phone.*<br><br>*One of them I ended up spending about 45 minutes talking to the husband and palliative care consultant in order to draw up a drug chart with their end of life medicines. Best practice would have meant that* | Protecting locum from palliative cases but at cost to self<br><br>Failing to manage challenge of palliative care adequately due to not being patients' regular GP and being the only regular GP on site<br>Being overwhelmed by 3 clinical cases related to death<br><br>Making impossible choices alone<br><br>Failing good practice protocols in relations to death<br><br>Resorting to telephone treatment for palliative care to replace critical visits to decide pathway to death<br><br>Feeling compromised by not feeling able to visit | (dis)satisfaction in role as clinical GP<br><br>Salaried GP tries and fails to compensate for lack in locum in relation to clinical issues concerning death.<br><br>Confronted with impossible task.<br>Ambivalent about job<br><br>systemically wish to turn away from what is dead in the GP system – wish not to see, pass the responsibility on. Decisions taken out of |

| | | |
|---|---|---|
| *you would never write up these drugs without going out face to face to see the patient and relative because this chart usually heralds the last 2-3 days. I wasn't under pressure. The husband felt supported by the palliative care team and the consultant palliative care didn't transmit any judgment of me over the phone. One of the other visits was a request to view a corpse of a cancer patient required for cremation forms and the body had been taken 10 miles away to a funeral director, impossible to go and see, for any of us, on any day to go and see that body.*<br><br>*Too much to fit in on the day.*<br>*It was too far away. I raised this with the funeral director and they said we'll bring the body to you. It was somebody else's patient in our* | patient to ascertain suitability of medicine for last few days of life<br><br>Feeling terrible pressure despite no apparent external tangible critic.<br><br>Setting up undignified way of viewing a corpse<br><br>Not knowing the protocol for viewing a dead body<br><br>Feeling ashamed of arranging a corpse to be viewed by a GP colleague in the funeral car in the GP surgery car park<br><br>Breaking down due to feeling like a bad doctor | GP hands. Has dignity in dying NHS been lost? The oft prized notion of a good death under threat. Internal critic dismayed.<br><br>Experiencing a series of failures in relation to dying patients<br><br>Ambivalence in GP system towards dependency to being the representative face that fails to have sufficient resource even for death<br><br>(dis)identification with role & GP surgery (not) as 2$^{nd}$ home<br><br>Reinforcement of feeling unworthy as a professional |

| | | |
|---|---|---|
| *practice. So I made an arrangement that they would bring the body to be viewed by my colleague the next day after morning surgery. I've never come across this scenario before. So the next morning they brought the body in a funeral car and, I wasn't at work that day, my colleague went out and viewed the body in the back of this car in a car park and we later discussed it and she felt very uncomfortable. I felt ashamed that I'd been part of this plan because I hadn't been able to think on my feet of a way round this solution. That was one of the memories that I subsequently went off sick with depression for 3 months between April and July this year. One of the enduring memories of those months leading up to my going off sick was this awful day where I felt I'd just been a terrible doctor. Made* | as result of doing wrong thing in relation to pending death or death of patients<br><br>Feeling ashamed for playing a part in the uncomfortable resort of identifying dead in car park, resulting in depression for 3 months. Anger and sadness in systemic indignity becomes personalised, loss of self respect as doctor.<br><br>Revisiting the devastating memories of the day when being a bad doctor to death became etched on professional self-worth<br><br>Retreating socially and withdrawing from work<br>Feeling devastated<br>Turning to colleagues for comfort<br><br>Going off sick, initially from clinical work and then withdrew from | Existential crisis in professional meaning<br>(dis)satisfaction in role as clinical GP<br><br>Sickening experience of indignity triggering existential crisis of being bad<br><br>Casualty of strained NHS is dignity of patient and self-respect of doctor who feels forced into making terrible mutually compromising decisions and Ambivalent GP position is then humiliatingly reinforced<br><br>Knowledge in system not coherently shared or filed, remains inaccessible to sessional workforce reinforcing ambivalence<br><br>Local knowledge lost<br><br>Breadth of general practice means variety of unknown challenges without answers |

| | | |
|---|---|---|
| *these dreadful decisions. Writing up palliative care medicines without going to see the patient. Arranging the viewing of this corpse in the car park. I felt I was a complete rubbish doctor. I didn't stop all day and –*<br><br>*I kept thinking back to this episode during my periods of illness. I became socially very unconfident and reticent and I guess there was an element of shame and I would find that when I was with other people in a professional context I became very tongue tied and completely lost my fluency. It hasn't fully returned.* | appraisal and eventually all face-to-face work<br>Being unable to be the face of the NHS doctor/being unable to face being a doctor<br><br>Losing face and public persona, losing articulation becoming socially avoidant and guilty. Social avoidance: Feeling generally ashamed, tongue tied, losing fluency | Dying aspects of NHS get deposited into individual clinicians as if the failing is theirs. This leads to greater ambivalence about the role and seeing self as bad, rubbish doctor.<br><br>Being a doctor too unwell to practice – high cost to NHS system. Collapse of task and role in uncontaining system. Failed dependency or care of GP. Feeling ashamed and worthless. Losing face, voice and confidence and ultimately professional persona. |

**Appendix 10. Three GP Types' Different Attitudes to Identification with Role and GP Surgery as Second Home**

**Committed GP**

Giving of your personal self in professional work
Deeply identified with role of doctor, friendship with ex-patients post retirement – perhaps never not in role! In role so flexibly, imperceptibly out of it! Overlap between private and social life sounds extensive.
Maintaining allegiance to same practice from trainee to salaried to partner
Developing the rarity of an alternative loving family with colleagues – general practice as therapeutic community, meeting daily
Nature of relationship/relatedness
Can't imagine doing any other job.
Merges with profession – commitment great, observes ambivalence in others
GP – long-term territorial commitment but has changed: Previously like Marriage to work ie Partnership –but now long prolongation of adolescence – young people live at home longer and want to be locums; Used to be live with parent, then got married
Partners like Parents in the mind
Touching people and their lives
Relating to peer colleagues is pivotal as sharing, professionally supportive and containing of anxiety
Being part of a group of partners with similar attitudes
Relating intimately with colleagues, bonding and building and loving each other over time – meeting daily – tight container; Working model of partners can succeed wonderfully or fail miserably; Learning to relate to other partners is a process that takes time and work
Partnership functioning well is crucial even with personal support from husband and study group
GPs strong sense of team identity and loyalty
Practice manager creating culture of sub-work groups, creative and collaborative thinking
Providing containment and continuity of patient care in Sub GP teams providing cross cover, groups of 3 GPs– sharing patient dependency
Diverse possibilities to maintain curiosity and interest
Evidence some locums changing to becoming salaried as want continuity and satisfaction -
Fascination of general practice
Being GP is so much part of who I am- fear of not doing it
Embodying role of doctor
GP for life
Social defence: become a doctor to avoid needing one or being a patient - Internal doctor/patient relationship – doctors don't want to be patients - Doctor as social defence of being patient/ill
Belonging to the side of the well as an identity from childhood; Projecting vulnerability into patients; Being cared for becomes a compromising dual role experience
Resourcing self enables realisation of practice as good enough GP
Initially put persona of GP on and then with experience true self comes through
A good professional fit; General practice flexible enough to come back to and top up training later in life.

Power in being GP/partner in a surgery of being so attached to the whole entity for yourself and patients and community – not possible as a locum or in a hospital
Importance of space and constancy
Individualised, personalised, intimate treatment room breaking the rules – carpet, cloth curtain, books
Bucking the system – rebelling against the squeezing out of all the intimacy
Losing tree of beauty that had bloomed for 18 years that afforded patient and doctor privacy and yet simultaneously an open vista and then significant sudden loss, left exposed and upset. This is evidence of lack of systemic thinking – simply clearing space for an agreed garden was focus but without thinking that the tree is garden already in existence. Roots ripped up.
Environment matters – familiarity, enrichment, ownership
Evidence of containment and being familiar – smell of coffee
Intangibles that demonstrate efficiency
Being a GP is such a different job to hospital medicine – it relates to the whole person and their whole life - GP work as archaeological dig in contextual surroundings
GP has freedom to roam in relation to patient – family info
Substantial majority core of diverse patient population who stay registered
Stayed the distance as a GP – from student from 1970s over 40 years
Powerful attachment to practice and working team that was based on multi-disciplinary close working relationships
Humanizing the inhumane system that is medical training; Shifting focus and preference from medical and procedural haematology to relational general practice; Describing what gave up – the power of medical science and the God like actions of consultant; GP-in the mind equals failure in medical training; Representations of general practice by senior medics is poor; Buying into concept of general practice not being real medicine; Making a difference means cutting it in hospital medicine; Having a baby changed practicalities
Is scope of work too enormous now to be done safely?
Alternative model for healthcare is needed – specific, specialist care for elderly eg Geriatricians for care homes
Constant pressure to take more risk on yourself– individualising the work – consulting room doors shut
Wait for secondary care as backlog affect and fraught anxiety – funding dropped waiting lists up
Glory days of true independence in the past
Diminishing independence affecting professional identity
Being undervalued and under attack by government has impacted GPs psychologically
Disempowered GPs
Nature of GPs not to strike but to keep selves comfortable and care for patients
Currently levels of anxiety intolerable, job in any case fraught – up at night worrying
Worrying about misdiagnoses
Being in fear of missing threats of death to patients
Being honest about or covering up errors
Waking up in a sweat
Having GP's ongoing life disrupted and made upset by patient cancer misdiagnosis
Experiencing feeling on top of thing always short lived, relentless pending threat under the surface

Loss of income as partner compared to salaried, earn less than some other professionals such as lawyers in private sector
Ceiling on prospect of earning more money is hard – in fact taking cut likely
Partners take pay freeze to keep other staff and give them pay rise
Before the war, before Bevin - GP as not very profitable businessman with debt collector. BMA Resistance to NHS. But previous to Bevin poor couldn't pay, charged rich more
Clement Atlee's legacy is important

**AMBIVALENT GPs: (DIS)IDENTIFICATION WITH ROLE AND GP SURGERY (NOT) AS SECOND HOME**

Identifying as freelancer in gig economy
Highlighting systemic issues for freelancers
Deciding NO LONGER A CALLING/VOCATION: don't feel I'm so branded to general practice that if it became worse and worse that I would still stay in it working the minimum number of shifts that I can, to get enough money
Falling into profession
Struggling to find a balance between finding fault and managing interpersonal dynamics
Holding system to account - feeling seen and affirmed by the system that can at other times feel so exploitative or indifferent
Recovering self in the eyes of others and self - Locum's focus is patient only but this is not viable as a partner
As a partner – wellbeing of practice is part of responsibility
GP partner status as trap
Realising full-time clinical work not for me so carving out a bespoke role combining education, BMA union and clinical work
Can't bear to see own GP/hate being patient?
Treating locum work like Accident and Emergency (A&E) – one off meeting, needs a plan
Doctor-in-the-mind: hospital doctor – dermatology or cardiology part of a team ; even trainee GP in a team – it's just you and you deal with it, alone
Not a scientist; A conscientious objector; education system different – medicine intriguing as social rather than science route
Forever a doctor even off duty – expectations of health advice; personally attacked for other GP failings
Observing locums seen as nameless/faceless
Challenging prejudice towards locums as uncommitted, in it for money
Being locum only way of not leaving GP role altogether, so they need looking after
Appealing for privacy and yet longing for recognition
Becoming a patient: Insomnia as went off sick, Feeling of dread of becoming mentally unwell again, Worrying that insomnia is a slippery slope to depression
Fearful of lack of resilience
Needing reassurance and empathy
Challenge of being a patient and seeing your own GP when no longer able to assess self or feel like a collegiate conversation
In the end unable to undertake either non-clinical nor clinical work due to extensive breakdown of capacity

Downside of GP going on what you say – sometimes you need objective assessment
Experiencing steep dropping off of functioning
Being one removed and in comfort from main thrust usually
Being unable to face the thought of being alone in unknown territory figuratively in general practice with patients or on holiday with family
Staff team dynamics of feeling dismissed and worthless is a big stress and contributory factor to depression
Losing sleep resulting from finding interpersonal collegial relationship difficult perhaps as overly critical
Feeling on periphery with several roles and part-time
Identifying with daughter's misery when away from home
Being ganged upon by a group of friends (feeling bullied by GP colleagues)
Wanted to be hospital medic but no job of choice compared to 1st choice in general practice
Many friends are doctors
Proud of being doctor
Friend left medicine and happy doing sg else
Narrow/focused life? Don't know what else is out there
GP identity at the moment, quite an important part of who I am, I don't think it would always have to be
I like the idea of doing something a bit different to have some variety. I don't think I could do just normal general practice every day
Perhaps passion to be a surgeon remains: popular - aspiration to do minor surgery as GP
Locum in same practices
Only want to work (even as locum) where know referral pathways, services and computer systems – averse to change
But I kinda want to find my feet somewhere
it's still a misconception that people who do general practice are the ones who failed at the sexy specialties in hospital … so like the dumbing down of the profession
general practice was a six week attachment in years three and five and that's not enough
It's not an easy job … fact I think it's a lot more difficult than … not just about medicine, a lot more human psyche involved … they come back to you. You are the non-moving part in the whole patient/health care experience
So I feel it is a very responsible … and very in some ways privileged… you look after the whole patient so …
Reference to hospital doctoring particularly A&E as a barometer! Spent most of career in hospital – even though trained as GP!
Creating awkwardness and feeling of scrutiny
Multiple options as a GP
Making choices in order to stay mentally well
Recognising need for control in the face of so much challenge
Working in a system without sufficient authority, feelings of powerlessness
Being legitimised by union activity
General practice seen as low status choice by family and other medics – irritated and impacted by family dynamics
Having a varied working life in roles that suits social commitments and earning what want: a few sessions doing salaried diagnostic work, locum sessions in walk-in as and when; regular out of hours slots; seminar leader for medical

undergraduates teaching bio psycho social aspects; *twice a year give talks to the general practice registrars who are leaving*
Interacting with medical academia – training out of hours registrars
Losing interest in and giving up mainstream general practice - not wanting regular commitment in work or private life, wanting freedom in life generally
Being a doctor says something about intellectual capacity, otherwise could quite happily never have gone back to medicine after my son
Valuing my brains, evident in the title of Dr.
In the environment of general practice you are an autonomous individual and in that way Cinderella goes to the ball but *the wicked stepsisters (media) have hijacked the town crier and vilified it*
General practice training model which they self-organised has now been rolled out to whole of NHS in terms of supervision and mentoring and this may have given new credence and definition to hospital specialisms
System is acting as a threat to people's lives if they are unable to access healthcare
GPs use their own discretion to put themselves out there or not
Knowing your patient makes general practice efficient but some practices disrupt continuity with the way appointments are accessed
Battling administration by advocating for vulnerable patients
GPs needing to fight to access patient's actual doctor for conversation
Collaboration between secondary and primary care difficult
Being in the inner sanctum

Experiencing therapy changed my attitude to working as GP or locum – no longer need to be needed to that extent and no longer terrified of being unable to earn money. This has lead to greater freedom of choice in work - Change of valency after therapy?
Feeling more robust and adaptable and lost need to please or feel indispensable
Undervalued, Overworked, Underpaid
Partner no longer desired role; having mixed feelings about being a partner
Reference to media representation of fictional village GP as ideal
Comparison with past 5/10 years- more hoops less money causing burnout of partners
Need adequate pay or what's the point?
Being held to account individually in litigation cases – has to be pinned on someone, can't be on a Practice
Future possible model of general practice: Private healthcare providers with cheapest GPs who don't go extra mile as focus profit but with benefit of appointments easily and quickly but not much continuity
ADVICE TO NEXT GENERATION – think carefully before medical training. Lots going to work in banks
In our GP training scheme, there was a lot of negativity from the kind of lead GPs in charge of it … this is very depressing week after week
ABSENCE OF PROFESSIONAL POLITICAL REPRESENTATION
JUNIOR DOCTORS PAY CUT GOT ME RILED UP – they're going to be working a lot more for a lot less
By extending sociable hours by 3 hrs it's a 20% paycut
Being a locum means feel less taken advantage of

**ENTREPRENEURIAL GP – mixed (DIS)IDENTIFICATION WITH ROLE AND GP SURGERY (NOT) AS SECOND HOME**

Drawing on various diverse aspects of doctor role such as salaried, locum, expedition doctor abroad and now partner
Preferring to act and see the solutions to the problems rather than the problems themselves but the problems I can understand but I like to find the solution
Making a difference in some way or another has got to be starting point of the whole thing
Bringing in younger staff as older staff retire late – fresh blood helps – more vibrant and active.
Enjoying strategic thinking and trying to make things better – setting up new services and ways of offering clinical services and engaging with broader healthcare system
turning things around and problem solving in a diverse way taking into account the psychological is the speciality of a GP
Wanting to be a physician as more scope– but becoming GP as pragmatic for family life
Difficulty of giving things up/making choices
Picking up geriatric psychiatry ad-hoc like a side line with hands on supervision only
Being pregnant and becoming a GP - Sacrificing hospital medical career for family - Female medics used to have limited options
Desiring national influence in a medical pathway;
Experiencing been thwarted in terms of medical ambition
Influencing daughter into emergency medicine
Ambitious and interested in clinical and academic excellence
Feeling judged by society as female doctor linked to:
- expectations on younger age of pregnancy
- male gender bias in hospital medicine and - no availability of part-time working
Loss of team working and team spirit as slowly stripped away in general practice
Being undermined by career service view of medicine as rote learning!
Getting away with limited top up for medical training
Taking unusual pathways at school, in training and at work – taking a circuitous more arduous path – medicine second degree - more breadth and diversity which supported thinking outside box later and setting things up
Relief to have variety of work in setting clinics up, training and commissioning enabled getting away from direct clinical work