The culture of general practice

A key feature of the current NHS reforms is a recommended 'change in the culture of health organisations'.[1] Using qualitative research, Marshall *et al*,[2] in this month's issue of the BJGP, have studied the 'culture' of 50 senior primary care managers (including 12 GPs and two nurses), charged with this task. Their study reveals the value these managers place on their practices' commitment to public accountability, their willingness to work together and learn from each other, and their ability to be self-critical and learn from mistakes. However, from a managerial perspective, the main barriers to achieving clinical governance include the 'high level of autonomy' of their GP practices. The authors also point to a certain confusion in how the word 'culture' is used in NHS documents.

The 'culture' of general practice

From an anthropological point of view, the concept of 'culture' — the shared world-view, beliefs, and practices of a group of people[3] — is only partly applicable. Although, within a broad framework, there is considerable overlap between practices, the notion of a uniform 'culture of general practice' in the UK is largely a myth. The key characteristic of general practice is its enormous diversity. Each practice has — to some extent — its own sub-culture: its own unique assumptions, expectations, behaviour patterns, attitudes to patients, internal organisation, use of space and time, and ways of delivering health care. Although much deplored by the bureaucratic mind, the way that practices reflect and adapt to their local communities is really the source of their strength and vitality — and not their weakness. Practices vary enormously in terms of the ethnic, religious, social, and gender composition of both their patients, and staff. How valid is it, then, to compare an inner-city practice with one in a rural village, or that on a multi-cultural council estate with one in a leafy suburb in the Shires? Thus Marshall *et al* 's paper suggests a basic incompatibility between some of the attitudes of NHS managers — especially their controlling, homogenising tendencies — and the realities of general practice.

General practice does not exist in a vacuum. It is always imbedded in a much wider cultural, political, economic, religious, and demographic context. In recent decades, a number of new, external factors can be identified, which have had a major impact on that central aspect of general practice — the doctor–patient relationship. Gradually this special, intimate, therapeutic relationship — so highly valued by patients[4] — has been reformed as a series of what might be termed clinical triads (Box 1). The relationship is now crowded with other, powerful presences — some visible, others not. Although they have modernised practice, making it more efficient and accountable, these new elements have also reduced clinical autonomy and eroded some of the uniqueness and particularity of the doctor–patient relationship. We have come a long way from the 1969 definition of the GP as a doctor who provided 'personal, primary and continuing care.'[5]

Clinical triads

(a) Doctor–Patient–Manager

Increasingly, the culture of 'managerism' has had a major impact on general practice. However, along with its dedication to increased efficiency and accountability, it attempts to control and standardise the 'high level of autonomy' of general practices. Although managers (and accountants) are essential to the running of the NHS, the long-term effects on patient care of their increasing influence and involvement in clinical practice needs further evaluation. This is particularly relevant with the development of Primary Care Organisations. As Wilson[7] points out, practitioners are 'moving from solely being part of a practice to also being part of a larger organisation'.

(b) Doctor–Patient–Lawyer

More complaints against GPs, and frequent litigations are increasing features of general practice. Their impacts are many, including the increasing use of chaperones, the writing of more detailed and expansive notes than before, and a tendency to investigate or refer patients — sometimes unnecessarily — as part of American-style 'defensive medicine'. Well-publicised cases of medical malpractice and a wider 'complaint culture' have all led to a growing mutual suspicion between doctor and patient. Now, in many GP consultations, the lawyers (for the defence, as well as the prosecution) hover as an invisible presence within the consulting room.

(c) Doctor–Patient–Statistician

As Roland and Marshall[9] point out, GPs now live in an 'age of measurement', dominated by performance 'targets' and the constant measurement of rates of screening, prescribing, referral and immunisation. In this milieu, the statistician is now a key, though invisible, player in the doctor–patient relationship. The growing effects of data overload on practitioners,[11] require EBM as one way of assessing this huge mass of new information, some of it scientifically unreliable. However, it is possible that some doctors may now make clinical decisions based on statistical (and financial) grounds, rather than on the requirements of an individual patient. Furthermore, there is little research on the natural progression of diseases, as presented in primary care, and this presents particular difficulties in forecasting long-term prognosis early in the disease process. Not every phenomenon can be measured, or reduced to numbers — especially those intangible elements of a successful doctor–patient relationship: trust, affection, compassion, understanding, humour, and a shared history.

(d) Doctor–Patient–Journalist

In the Information Age, the journalists responsible for disseminating medical information — via newspapers, magazines, books, radio, TV, or the Internet — are now a powerful presence in general practice. The newspaper or maga-

The clinical triads

1. Doctor–Patient–Manager
2. Doctor–Patient–Lawyer
3. Doctor–Patient–Statistician
4. Doctor–Patient–Journalist
5. Doctor–Patient–Computer

Box 1. The clinical triads.

zine article on the latest 'wonder drug' — waved in front of the doctor's eyes at a Monday morning surgery — is becoming a familiar feature across the land. The overall effect of medical journalism has been positive, increasing patients' knowledge of health issues and leading media campaigns against medical malpractice. However, in some cases, overzealous journalistic campaigns have raised patient expectations to unrealistic heights, while increasing anxiety, dissatisfaction, and a preoccupation with the supposedly ubiquitous 'risks' of everyday life.[12]

(e) Doctor–Patient–Computer

The role of diagnostic and other technology within medicine has grown increasingly over the past two centuries from the invention of Laennec's stethoscope in 1816. However, until fairly recently, one of the defining characteristics of general practice, compared with hospital medicine, was its minimal use of technology. The computer's arrival has changed this. By 1996, most GP practices in Britain had been computerised[13] and many were also paperless.[14] Computers have become an indispensable third party to the doctor–patient consultation. However, despite their many benefits, social scientists have argued that, in both psychological and cultural terms, computers are not neutral objects.[15] They can subtly change the ways that people relate to one another[12] and how they think of themselves. Computers might alter the dynamics of a consultation in a negative way, by reducing eye contact time, or by forcing the patient to compete for attention with a VDU. Turkle[15] suggests they can reinforce a mechanical, non-human notion of the self, with the computer being seen as a 'mind' (a 'second self') and the mind itself seen as merely a type of computer.

Cultural shifts

These five 'clinical triads' have developed against the background of other cultural, economic and demographic changes in the wider society. In Britain, these include the growth of consumerism — with a shift from passive patient to informed consumer;[12] the decline of organised religion, and the medicalisation of modern life[16], with medicine now providing the new moral discourse of the Age (converting a 'sinful life' into an 'unhealthy lifestyle', 'gluttony' and 'sloth' into 'over-eating' and 'lack of exercise', and 'drunkenness' into 'alcoholism'[16]); the growth of the private sector (including non-orthodox or complementary medicine[17]) as an alternative and more individualised form of health care; and the increasing cultural and ethnic diversity of the population.[18]

Multiple roles

In this situation of flux, the modern GP has multiple, often contradictory roles [19] — not only as medical scientist, but also as an educator, priest, beautician, government representative, researcher, marriage guidance counsellor, psychotherapist, pharmacist, friend, relative, financial adviser, as well as anthropologist — intimately familiar with the local community, its needs, traditions, dialects, and ethnic composition. In the future, not all these roles will be covered by Lipman's concept of the future GP as a 'community generalist'.[20]

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References

1. Department of Health. *A First Class Service: Quality in the NHS.* London: Department of Health, 1998.
2. Marshall M, *et al*. A qualitative study of the cultural changes in primary care organisations needed to implement clinical governance. *Br J Gen Pract* 2002; **52:** 341-345.
3. Helman CG. *Culture, Health and Illness* (4th edition), London: Arnold.
4. Kearley KE, Freeman GK and Heath A. An exploration of the value of the personal doctor–patient relationship in general practice. *Br J Gen Pract* 2001; **51:** 712-718.
5. Royal College of General Practitioners. The educational needs of the future general practitioner. *J R Coll Gen Pract* 1969; **18:** 358-360.
6. Byrne PS, Long BEL. *Doctors talking to patients*. London: Her Majesty's Stationery Office, 1976.
7. Wilson T. General practice, primary care and general practitioners. *Br J Gen Pract* 2000; **50:** 1017.
8. Pringle M. The Shipman inquiry: implications for the public's trust in doctors. *Br J Gen Pract* 2000; **50:** 355.
9. Roland M, Marshall M. General practice in an age of measurement. *Br J Gen Pract* 2001; **51:** 611.
10. Watkins C, Harvey I, Langley C, Gray S, Faulkner A. General practitioners' use of guidelines in the consultation and their attitudes to them. *Br J Gen Pract* 1999; **49:** 11-15.
11. Haines A. The science of perpetual change. *Br J Gen Pract* 1996; **46:** 115-119.
12. Muir Gray JA. Postmodern medicine. *Lancet* 1999; **354:** 1550-1553.
13. NHS Executive. *Computerisation in general practice survey*, *1996.* London: Department of Health, 1998.
14. Waring T. To what extent are practices 'paperless' and what are the constraints to them becoming more so? *Br J Gen Pract* 2000; **50:** 46-47.
15. Turkle S. *The Second Self: Computers and the Human Spirit*. London: Granada, 1984.
16. Smith R. In search of 'non-disease'. *BMJ* 2002; **324:** 883-885.
17. Thomas KJ, Carr J, Westlake L, Williams BT. Use of non-orthodox and conventional health care in Great Britain. *BMJ* 1991; **302:** 207-210.
18. Baker P and Eversley J. *Multilingual Capital.* London: Battlebridge Publications, 2000.
19. Helman CG. General practice and the hidden health care system. *J R Soc Med* 1987; **80:** 738-740.
20. Lipman T. The future general practitioner: out of date and running out of time. *Br J Gen Pract* 2000; **50:** 743-746.

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Communities of practice

WITHIN the international debate about improving health, others look to the United Kingdom model as an interesting experiment, with its paradox of a supposedly primary care-led service but centralised controls on the cost, quality, and organisation of the service. Recently, the ideology of competition is again being argued as the answer to inefficiency in health care. We are currently in the era of performance management. Those in power have yet to decide the balance between micro-managing health care workers from the centre and empowering them to get the work done themselves.

In the past, management consultants were paid, both to prescribe tools for solving problems in the NHS and to put them into practice, but the experience of using these people was mixed. Now the NHS has created its own internal consultancy in the form of the Modernisation Agency. This new body has selected a few tools to put the government's prescription of the NHS plan into practice. Targets have been set though the National Service Frameworks and a policing role has been created in the very new Commission for Healthcare Audit and Inspection (CHAI), with the not-quite-so-new Commission for Health Improvement (CHI) having to renegotiate its role between sergeant at arms and facilitative coach.

In talking about tools for organisational change in the NHS it is easy to forget that the organisation consists of people and that the 'prescription' for organisational change may need to be carefully tailored to their local needs as well as their patients'. It can be paradoxical, relating genuinely to individuals while simultaneously trying to have them meet performance targets. It would be interesting to learn how far this is recognised by those who see themselves as agents of organisational change.

Organisational development

The rhetoric of modernisation brings with it the agenda of quality and performance management. Evidence for the correct approach to improve quality is controversial and the NHS now has a Service Delivery Organisation Research and Development programme (SDO R+D) to provide the 'science' to support it. In the Modernisation Agency the current favourite has been the model of Breakthrough Collaboratives, the origins of which are in the health quality movement in the United States.

The SDO R+D jury and others have yet to decide how well the model of Breakthrough Collaboratives is going to work and no doubt this will remain a politically contentious issue. Just how much people can force others to do things differently through the direction of any change model or plan is up for debate, although some senior politicians apparently see command and control as the right model. In exploring organisational change models, Stacey argues that the qualities of engagement and participation may be more important than the change model itself in supporting the emergence of genuine and new patterns of activity.[1]

The government wants us to hurry up and be compliant with the medicine they have prescribed. As a part of the 'organisational patient,' we may have opinions about how much use their elixir is going to be for us locally, and what constitutes a safe and sensible pace to drink it.

Complexity

There is a growing interest in the unpredictability of outcomes that occur in complex environments. The weather is a complex system. By its nature, accurate forecasting beyond a few days is not possible. Attempts have been made to transpose these insights from the natural sciences into understanding the way people interact in organisations.[2] The models remain contentious but none the less are informing the debate about how people think one can make change happen in health care in the USA[3] and the UK.

An example of the unpredictability of outcomes in a complex environment was the previous system of fundholding and the internal market. Paradoxically, in a climate with the ideology of competition at its heart, it was from the local collaboration of fundholders and the realisation of their collective power, that a primary care-led health service emerged. Nobody could have predicted from the original design that fundholders would collaborate, in the way they did. Fundholders were active participants in inventing the 'practice' of fundholding.

The practice level

The 'practice' of primary care is complex and rich. This is particularly true for the health of the elderly. In caring for a single elderly individual there will be a collaboration of people from numerous disciplines and agencies: acute medicine, old age psychiatry, social services, private provision, primary care, community care, and independent and family carers.

The practice of thinking about caring for the population of elderly people is just as complex. While the public health agenda of health improvement is very important, it is incomplete. At a population perspective, domains of organisational form and function include expertise in health economics, health informatics, health and social policy, organisational development, knowledge and project management.

So how do we effectively share peoples' understanding and particular expertise in this complex multidimensional environment of the organisation? The epistemology of communities of practice is beginning to shed some light on this.[4] These are analogous consultation skills to those we promulgate in primary care but within the larger organisation. It is a considerable skill to be able to support effective conversations among people with different understanding and professional identity but with overlapping areas of interest. These skills are necessary if there is to be intelligent accountability[5] of the expert patient, the expert doctor, the expert public health physician, and the expert manager.

Mechanisms for implementing change are hotly contested areas in the political and the intellectual fields of health management. In this month's *BJGP* journal, Iliffe *et al*[6] invite us to take a closer look at another model of service development. It evolved out of work by the King's Fund in the early

1990s on Community Orientated Primary Care[7], which itself developed in response to the need to reorganise a fragmented service in Israel 20 years ago. In the1990s, with the purchasing of services in primary care, fundholders needed to learn about the population perspective. A route for helping to draw together the disciplines of public health and primary care was offered through the work of the King's Fund.

Iliffe *et al* offer a cyclical methodology, with similarities to that of the breakthrough collaboratives, in which four general practices had the privilege of a network of professionals to support and engage with them in the clarification of health improvement measures, appropriate for their particular population of elderly people. This was combined with an exploration of mechanisms for their implementation. They acknowledge the dangers of extrapolation from the four practices in the study. This is important because if you look at the people in organisations closely enough you will always find differences, which could account for successes or failures in organisational change, making generalisation of the model difficult. Iliffe *et al* describe the incorporation of the innovations in 'local practice' in the then Health Authority and local Primary Care Groups. It would be interesting to know in more detail, in what way this has happened; how much it was the experience, learning, and local knowledge of the people involved in the project, that allowed the integration of their new experience into broader activities on their patch, and how this process can be supported.

Generally, it is not easy to recreate changes that are occurring in one part of an organisation, in another. This is the problem of diffusion of organisational innovation.[8] Learning, change, and meaning are fiercely argued about in the disciplines of sociology and organisational development. To highlight the existence of some new ways of thinking, it would be interesting to know how much the adoption of the innovations described by Iliffe *et al* was related to the model of 'community-oriented primary care' described, and how much to the situated learning[9] that arose from the participation, or the patterning of communicative interaction[10] among people. These authors are looking for new ways to make sense of the processes of relationship among people in organisations. I argue that they mirror and unknowingly attempt, to translate the discipline of primary care with its commitment to genuinely supporting the ongoing relationship between the doctor and the patient, into the realm of the processes that occur among people in groups. I believe primary care has more to offer than it realises.

In the spirit of collaboration and communicative interaction we have set up a collaborative website to which you are invited. (http://pcsc.kcl.ac.uk/rcgpcd.htm) We welcome you to read and join in the online discussion, which Steve Iliffe and myself are running. We invite you to discuss what we have written, to offer your understanding of how change does or doesn't happen in organisations and to think about what creates a successful community of expertise.

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References

1. Stacey RD, Griffin D, Shaw P. *Complexity and management: fad or radical challenge to systems thinking?* London: Routledge, 2000.
2. Greenhalgh T. Complexity science: the challenge of complexity in health care. *BMJ* 2001; **323:** 625-628.
3. Institute of Medicine. *Crossing the Quality Chasm: a new health system for the 21st century.* Washington: National Academy Press, 2001.
4. Wenger E. *Communities of Practice.* Cambridge: Cambridge University Press, 1998.
5. O'Neill O. *A Question of Trust.* Cambridge: Cambridge University Press, 2002. [http://www.bbc.co.uk/radio4/reith2002/]
6. Iliffe S. Applying community-oriented primary care methods in British general practice: a case study. *Br J Gen Pract* 2002; **52:** 346-351
7. Gillam S. *Community Orientated Primary Care.* London: King's Fund; 1994. Press; 2002. **(Author check)**
8. McNulty T, Ferlie E. *Re-engineering health care.* Oxford: Oxford University Press, 2002.
9. Lave J, Wenger E. *Situated Learning.* Cambridge: Cambridge University Press, 1991.
10. Griffin D. *The Emergence of Leadership.* London: Routledge, 2001.

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