

Debate & Analysis

Redefining quality:

valuing the role of the GP in managing uncertainty

INTRODUCTION

Less than half of the problems that patients present to their GP can be understood in terms of recognised disease processes.¹ The growing propensity to reward — and therefore preferentially place value on — the management of well-defined diseases only partially reflects the nature of what GPs do. Rewarding what can be easily measured has resulted in a number of significant changes to how GPs work: they have become more structured in the ways that they deliver care, more focused on the scientific evidence, and more willing to engage with systematic improvement interventions, such as guidelines, incentives, and performance management.² It does, however, have unintended consequences that are beginning to have a negative impact on quality of care.

The problem is the failure to recognise the essential role of GPs in dealing with the large proportion of presentations that are uncertain, ambiguous, or frankly paradoxical. The complexity and multidimensionality of general practice has long been recognised^{3–6} and is enshrined in popular working definitions of the discipline.⁶ Nevertheless, the incentives to focus narrowly on technical dimensions of quality, such as clinical effectiveness, accessibility, safety, and efficiency, are becoming more pronounced. Even though GPs spend much of their time operating at the margins of well-defined problems, this role is too often regarded as discretionary. As a consequence it is being crowded out in a system that barely has the capacity to deliver the established 'must-dos'.

I am going to explore the importance of the role of the GP in dealing with uncertainty. Drawing on a case study I will illustrate how the problems that people present often operate at the boundaries between conventional categorisations;⁴ I will then suggest ways of improving the understanding and raising the profile of these activities so that their contribution to improving the health and wellbeing of people is given as much value as the more technical elements of general practice care. I will attempt to make a case for redefining how 'quality' should be conceptualised and rewarded in general practice settings.

A CASE STUDY

Mohamed Madani is a 34-year-old man born and raised in Iran. He is a semi-

fictitious patient but one whose story (Box 1) would be instantly recognisable to any GP.

THE BOUNDARY CHALLENGES

What should the GP do for Mohamed? He will not be doing his patient any favours by passively accepting Mohamed's health beliefs or his lifestyle choices. At the same time, he knows that he will not be effective if all he does is adjust medications or challenge Mohamed for spending so much time at the fried chicken shop. The GP has to deal with the disconnect between the incentives in the system that encourage him to 'control' the patient's blood sugars, blood pressure, his weight and his diet, and the lived experience of the patient. This is not easy territory.

Mohamed's story illustrates three key areas of uncertainty that GPs have to deal with on a daily basis.

First, there is the boundary between health and wellbeing, illness and disease.⁷ Mohamed is a happy man, enjoys his food, and likes socialising with friends. He does not perceive himself to be 'ill'. Obesity is the norm amongst his friends and his diabetes is not causing him any problems. He might want better accommodation for his family and a good job but his lot is so much better than he had experienced before coming to the UK. Mohamed understands the longer-term consequences of his 'disease'. His GP worries about the poorly controlled blood sugar levels but Mohamed trades any long-term concerns off against his immediate priorities. After all, few members of his family had ever lived beyond the age of 60; what right did he have to expect more?

Second, there is the boundary between meeting the needs of individuals on one side and the collective needs of communities and populations on the other. On one side there is a deep belief among most GPs, supported by a growing body of research evidence,⁸ that trusting relationships lie at the heart

of their effectiveness and that this will only be maintained if patients believe that GPs will put their needs first. Mohamed's GP wants to be patient-centred, honouring his patient's preferences, but he can not ignore the evidence that people living in the poorest neighbourhoods in the UK live 7 years less than those in rich neighbourhoods and have 17 years less free of disability, or that about half of the current annual budget for health care is spent on dealing with consequences of health inequalities.⁹ So, in order to help people like Mohamed, he needs to be population-centred too, willing to work with the local council to shut the fried chicken shops.

Third, there is the boundary between encouraging self-care on one side and providing professionalised care on the other. Both of these functions are important and the boundary between them is poorly understood.¹⁰ The GP is aware that minor changes in Mohamed's ability or willingness to self-care could have a big impact on his use of formal healthcare resources. There are therefore practical as well as philosophical reasons for encouraging a high level of self-management. Understanding the tensions and the dynamic between self and professionalised care requires a deep understanding of Mohamed's health beliefs and the environment that he lives in, as well as technical expertise in encouraging behaviour change.

THE DILEMMA FOR GENERAL PRACTICE

GPs should bear some responsibility for the position that they find themselves in. The discipline as a whole has consistently failed to find ways of persuading policymakers and health system leaders that those issues which are not readily defined or tightly contained really do matter. GPs are responding to the health system drivers that encourage a narrow focus on the measurable elements

Box 1. Case study

Mohamed has been in the UK with his wife and two young children for 12 years and is currently unemployed. He is obese with a BMI of 32 and has type 2 diabetes and hypertension. He was invited to consult with his GP because he had very poorly controlled blood sugars, which had not responded to changes in his medication initiated by the specialist diabetic clinic in the local hospital. The GP decided to revisit Mohamed's diet. Mohamed said proudly that he ate 'very nice food'. On close questioning, this turned out to be two large meals a day of deep fried chicken and chips at one of the many fried chicken shops in the area. His GP asked him whether he cooked at home and in particular whether he ate any of the vegetables from the local market. Mohamed described how he lived in an apartment with 17 other people, mostly extended family. They had four beds, which they shared on a rota basis, and no kitchen. He visited the fried chicken shop when it was not his turn to sleep because the food was enjoyable, filling, and very cheap, and because that was where he found space both to think and to socialise with his friends. Mohamed was a content man, happy with his lot.

'GPs are responding to the health system drivers that encourage a narrow focus on the measurable elements of their role ... [but] they are increasingly uncomfortable about the impact that their behaviour is having on ... patients.'

of their role but at the same time they are increasingly uncomfortable about the impact that their behaviour is having on the patients, communities, and health system that they care about.

Many GPs are not challenging the imposition of a contained role that moves them away from managing uncertainty, because superficially at least the restrictions make sense. Who could argue with the need to be more focused, to demarcate, to concentrate on areas where the evidence suggests that they can have real impact? Who could disagree with their desire to make their work more doable? GPs used to claim proudly that they were the only part of the health system that did not say 'no', but, increasingly, we are seeing GPs under intense pressure saying 'this is not my problem'. General practice is retreating into silos at a time when the need to address boundary challenges is greater than ever.

A WAY FORWARD

A number of solutions might increase the value given to managing uncertainty.

First, GPs need to be more explicit about the existence and the nature of their role. Some policymakers appear to believe that there are simple solutions to health care's problems and that people just need to try harder to implement them. But as Handy points out, most decisions are not between right and wrong, but between right and right.¹¹

Paradoxes need to be embraced rather than resolved. This paper argues that GPs actually do manage uncertainty effectively most of the time, but they do this implicitly and the role is not understood or valued by others. It is almost as if GPs have two jobs: in their public role they carry out the simple tasks, and they are happy to talk about and be rewarded for these. But they also have a private role, which is important, fulfilling, demanding, and the most stressful part of their work. It is hardly surprising that policymakers and managers fail to understand this role or help GPs to deliver it. So, both professional leaders and front-line clinicians need to describe with pride

where the role adds value, and with humility about their very partial understanding of how to fulfil the role effectively.

Second, a more sophisticated approach needs to be adopted to managing change. There is a set of core, non-discretionary, and consensus-based activities that may reasonably be managed, incentivised, and regulated. But there are significant unintended consequences when attempts are made to manage complex boundary activities in this way because it leads to mindless compliance and gaming behaviours, demoralisation and damage to intrinsic professional motivation. It would help to differentiate more clearly between the straightforward and the complex, and provide more discretionary space to allow practitioners to deal with the latter.¹² Leading companies in the business sector are starting to understand this imperative, shifting their organisational development focus from an emphasis on changing behaviours to an emphasis on changing mindsets.¹³ There is some way to go before such approaches become acceptable in the health sector.

Third, it is necessary to build both the capabilities and the capacities of people working in general practice to deal with uncertainty. Managing the tensions between conflicting goods is a skill that most GPs currently learn on the job. The knowledge and skills required to manage uncertainty can and should be taught more explicitly during general practice specialist training and reinforced as part of a commitment to continuing professional development. This requires medical educationalists to focus on the development of practical wisdom ('phronesis')¹⁴ and to learn the skills of negotiation from the worlds of diplomacy and business.

Finally, better theoretical and empirical research is needed to help develop an understanding of the nature of operating at the boundary and the effectiveness of solutions to help manage this role in practice. The task of the research community is to identify empirical questions that are sufficiently nuanced to represent the complexity of boundary activities.

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A reasonable starting point might be theory-based qualitative investigations of the challenges experienced by GPs in managing uncertainty in practice, and of the views of patients of the trade-offs inherent in managing these tensions. Useful theories might include those relating to complexity, individual and organisational learning, and professionalisation. Policymakers, leaders, and practitioners need to work with the academic community and research funders to make a case for investment in research to better understand this complex role.

To summarise: over recent decades, general practice has made massive strides in its development as a specialty. Its fundamental role in the delivery of high-value care is now widely recognised. It is therefore ironic that many GPs are finding it increasingly difficult to be effective, and in some countries morale is starting to plummet. In this paper I have attempted to make the case that the position GPs find themselves in is in part a consequence of an overly narrow understanding of their role and a failure to recognise all elements of high-quality general practice care. A GP's job is to act as a boundary specialist, to operate at the interface between areas where there are legitimate competing demands. These tensions are becoming greater as health care becomes increasingly sophisticated and complex. They are inherent to the nature of health and health care, so pretending that they do not exist is unrealistic and unhelpful. General practice will only thrive and deliver benefit for individuals, communities, the health system, and wider society when its role as boundary specialists is made more explicit by GPs themselves, and is understood and valued by others.

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