Does general practice have a unit of analysis problem?

We're big on The Self these days, aren't we? Self-care, self-management, self-disclosure, self-efficacy, self-directed learning, self-examination, self-testing, self-administration of medication, self-actualisation: you name it, the 21st century Western individual is depicted as doing it or striving for it. What is more, professional practice and medical ethics are increasingly defined in a way that valorises the patient's Cartesian self. We must respect their autonomy, share decisions with them, make ourselves accessible to them, and protect their data, where 'them' is actually a singular term, referring to 'him' or 'her'.

Yet as family doctors, we also know that few people — and even fewer truly healthy people — are remotely autonomous. We are social beings. We live in groups. Our early relationships within the family profoundly influence our later ones beyond it. The people we classify as vulnerable, needy, and so on are generally those whose lives are all too autonomous as a consequence of bereavement, redundancy, retirement, marital breakdown, or the inability to form close relationships in the first place.

Indeed, it is a truism of general practice that 'family doctoring' is mainly the business of dealing with people who lack families or other close social groups with reciprocal allegiances and commitments. These are the people who most readily fall sick, present late, and struggle with treatment regimens.

Social psychologists know this, and they have various ways of measuring the nature and strength of our family ties and, more broadly, the size, composition, and quality of contact in our social networks. Actor-network theorists go a stage further: they take the view that both humans and technologies are linked in dynamic networks of interdependencies and interactions; the 'self' is no more or less than what we become as a result of a particular position in the network. As the assumptions about the Cartesian self become ever more entrenched in policy, so the science of the non-autonomous individual becomes ever more sophisticated and fascinating.

Despite this, and with few exceptions, the protocols, guidelines, decision support systems, and other tools of our trade in general practice are predicated on a Cartesian (individual, autonomous) rather than social (networked, interdependent) self. It is time we demanded better theories, better models, and better clinical tools.

Here's a good concept for starters: distributed health literacy.[1] In a detailed longitudinal qualitative analysis, Edwards and colleagues showed that health literacy was best conceptualised not as something that an individual person has more or less of, but as a product of the knowledge, action, and ability to access information possessed by all the individuals in the person's social network. Furthermore, particular individuals acted as 'health literacy mediators', assisting the index person to access information or other resources that they lacked the capacity or contacts to access alone.

As these authors observed:

'The distribution of health literacy supported participants to manage their health, become more active in healthcare decision-making processes, communicate with health professionals, and come to terms with living with a long-term condition.'

This model of health literacy, as the product of a network rather than something that sits inside the patient's head, has profound implications for how we define and deliver good general practice. Perhaps it's time we asked to be known as 'family doctors' again.

Trisha Greenhalgh,
GP in north London, Professor of Primary Health Care at Barts and the London School of Medicine and Dentistry, London.

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ADDRESS FOR CORRESPONDENCE
Trisha Greenhalgh
Global Health, Policy and Innovation Unit, Centre for Primary Care and Public Health, Blizard Institute, Barts and The London School of Medicine and Dentistry, Yvonne Carter Building, 58 Turner Street, London, E1 2AB, UK.
E-mail: p.greenhalgh@qmul.ac.uk

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