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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