Exploring New Roles in General Practice

Diane Plamping

King's Fund Primary Care Group

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Introduction

This exploratory project was co-funded by the NHSE and the King's Fund. It was devised early in 1994 when the crisis in GP morale was becoming more widely recognised. The concerns were expressed in a variety of ways but well captured by the series of articles in the BMJ entitled 'Enriching Careers in General Practice'. In the last of that series Stuart Handysides wrote

> *"General practice is likely to change greatly over the next few years. It is important to pool resources, not only within practices but among other practices in the area - joint action will increase the ability to improve services for patients. If general practitioners have the opportunity to gain control of the changes the morale of the profession should improve. "*

This quote points to two issues which may be associated with falling GP morale. The first is linked to feelings of being controlled/ out of control and a possible loss of direction in professional leadership. The second relates to the challenge of reforming and realigning primary care organisations.

We assumed that any intervention should build on the traditions of professional leadership and independence and recognise the unique nature of the practitioners work in providing personal care. To this end, we have designed a participative educational event to be piloted with volunteer general practitioners. We wished to assess the acceptability and utility of this approach in helping GPs begin to explore possible new roles which are consistent with career development in general practice. In this report we describe the workshop design, the participants responses, the Kings Fund team's observations of the participants reactions to the '2010 GP roles' . Finally we suggest possible extensions of this preliminary work in the light of the Primary Care led NHS initiative.

'A day in the life of a GP 2010' is the title of a participative workshop which aims to help GPs explore possible future roles and reflect on their congruence with their personal and professional motivations. Two workshops were organised by the Kings Fund Primary Care Group on behalf of the NHSE in London and Newcastle during 1994/5.

Our perceptions of the crisis in GP morale.

Much of the professions response has been a focus on the discipline of general practice rather than the implications of increasingly complicated patterns of care for general practice as an organisation We are concerned with this relative lack of sophistication in understanding primary care organisations and professionals' roles within them, which contrasts with an increasing clinical/professional sophistication. However any attempt to redress the imbalance must address both the personal/ professional and organisational issues. GPs beliefs about change are a critical factor in supporting any practice (organisational) change.

These feelings about control and loss of leadership spring from many sources. General practitioners have an exemplary history of effective professional leadership during the 50's and 60's. In this period they successfully constructed a theoretical basis for their expertise (Balint and the consultation) and created a valued medical discipline. This was an extraordinary achievement given a widely disseminated and diverse membership/constituency. It culminated in the GP charter (1964) which

enabled the emergence of excellent general practice under the leadership of general practitioners. This gave further recognition to the importance of the GPs' gatekeeper role and facilitated both capital and human resource development in general practice. It was clearly tempting for many in the profession to believe that their previous leadership styles would fit the new environment and therefore little professional attention was given to finding alternative models.

There is the tradition of independent contractor status and sometimes this is believed to be synonymous with and necessary for the practice of clinical freedom. There is no doubt that many practitioners value this independence which contrasts with their experience of large organisations (hospitals) as constraining. In some cases this makes them literally refugees/escapees from organisations who perceive 'organisation as a burden' which equates with bureaucracy. They have little experience or understanding of 'organisation as relief' in which the organisation design facilitates their work and creates the conditions for renewal and support (Huntingdon). Many practitioners have used the relative freedom from organisational accountability to create the models of care which lead us to think that primary care could and should be at the centre of the NHS. But there is a conundrum here. Can the creativity of people who put themselves outside the system in significant ways be transplanted into the centre and survive ? Can we jettison the negative elements of being on the edge, such as being marginalised, and still retain the positives of being on the periphery, such as being near to local people and flexible enough to make appropriate adaptations to the local and national service needs ? We suggest that GPs have not explored these tensions explicitly nor their organisational implications . They have little understanding of the distinctive nature of small organisations or the models of leadership which can operate within them. Even less professional attention is given to understanding the necessary conditions for small organisations to succeed within a very large one, the NHS.

Their sense of independence has been battered by the attempts to manage clinical activity introduced in the NHS reforms. The creation of the FHSA - a late introduction of general management into their world and the introduction of the new contract has largely reinforced these beliefs that organisation = bureaucracy. These attempts of the NHS to hold GPs to greater account have exposed several pre existing issues which the profession has failed to confront. First is the ambiguous nature of their independence when the majority of GPs have only one contract and secondly, the strong feelings of both being part of the NHS while wishing a large degree of independence from NHS 'control'.

The introduction of Fund holding split the discipline and many of the most developed practitioners diverted energy into this project, undermining by the potential for maintaining a unified professional leadership. This is compounded the increasing, diversity within the GP population which is no longer overwhelmingly white and male. There are now many women (over 50%), black people and members of black and minority ethnic communities within the profession. These changes signal huge changes in society at large and probably impact on the traditional patterns of deference to and social status of doctors.

The patterns of health care delivery have also changed rapidly with an increasing emphasis on community (non-hospital) based care. This has implications for service care in general practice and led to an emphasis on the primary health care team as the most significant organisational form to support individual patient care. Paradoxically this development may have protected GPs from the recognition that their whole organisation needs radical development, not just the organisation of clinical care. They have adopted the 'dustbin approach' to organisational development i.e. one available mechanism is assumed to be an appropriate solution to all presenting problems. The current concentration on the primary health care team may have operated unintentionally as a device to ignore other challenges to primary

care organisations, in particular the need to reassess the roles of doctors within them and the nature of partnership. As partners their role has remained essentially unchanged since the inception of the NHS. (Laughlin et al)

This assertion may seem at odds with GPs' perceptions of change and threat. There have been significant changes and adaptations made by GPs to manage the tensions generated within their jobs. Their public reaction to what they see as an external threat has been to refocus on debate about the core values of practice. Their private accommodations have more often been to create increasingly diverse career portfolios to meet their personal needs and aspirations. Those who seem to be most comfortable with their jobs have extended the basic repertoire to include, audit, speciality interests, training, research, practice development and medical politics. All these fall within the confines of professional development and within professional 'comfort zones'. The exceptions are those GPs who have involved themselves in commissioning or used fund holding to develop an interest in strategic planning and reforming their own organisations to be able to engage more effectively with others in the NHS family. Both those involved in practice development and commissioning have experienced role overload and role conflict, either with other members of the PHCT or management (Harris)

This portfolio approach to careers predates the new contract. But these diversified career portfolios are not recognised as attempts to adapt an increasingly abnormal career trajectory - working in the same job with many of the same people in the same place for up to 30 years (personal view BMJ attached item 1). If we could bring the nature of the general practice career to the fore rather than colluding with the projection of all difficulties on external problems - patient charters and contracts - then GPs might be able to move forward by creating new portfolios adapted to the new environment. Their current stance seems similar to that of King Canute -i.e. that the problems are all external political factors and are potentially reversible. This analysis tends to underestimate other changes in the nature of health services which are likely to persist within any political administration.

Our assertion is that GPs cannot reassert appropriate control of their working lives by hankering after the return of a golden age (attach other paper on GP charter ?) An alternative approach would be to make a more radical **and** realistic assessment of what a GP will be doing in the future in such a way that new roles can be defined which honour the roots or core discipline but are not rooted in the past. We suggest this requires a better understanding of the nature of the practice as an organisation and its place within the organisation of the NHS. (Pratt) This is likely to result in GPs acting in new combinations of roles but in ways which still feel like being a GP.

Workshop design and responses

The intention was to design a workshop and field test it with 3 groups of GPs
1) A group of GP who we identified as leaders and commentators in the national arena.
2) A group of GPs working in the same city (Newcastle)
3) A group of London based GP trainees.
The third group proved too difficult to organise and two workshops were held.

Designing the scenarios
Future scenarios are tools for helping people act purposefully in the face of uncertainty. These scenarios are not intended as predictions of likely futures.

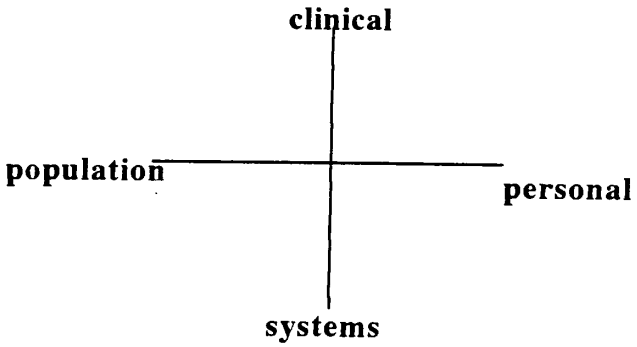
They are fictions or inventions of the imagination which are commonly used to identify robust strategies in times of social and environmental turbulence. They enable people to confront the apparent paradox that the future is inherently unpredictable but we have to make plans. The Kings Fund has developed several plausible 'future scenarios' relating to health services in the UK 2010. These were designed for use in the work of the London Commission. These scenarios draw on national and international data and have been extensively tested to improve their internal consistency. We have found them useful in helping people identify both preferred futures and strategies for action in environments beyond their direct control.

We adapted the technique for this project. Just one plausible possible future scenario served a as a mechanism or device for 'unhitching' the participants from the present and recent past to refocus on a range of possible roles for GPs in the future. To this end, one of the scenarios was selected and reworked to make it more applicable to GPs' work (appendix 1). The intention was not to propose simplified jobs in the future but to enable the participants to 'experience' each aspect of their work separately and assess the advantages and disadvantages of each. It was hoped that this approach might help them explore the implications of a 'mix and match' to produce an appropriately tailored career for themselves.

Rationale for Roles

The 2010 roles were constructed with reference to the key dimensions of GP work that we observed within current but innovative general practice. We proposed that Doctors who are currently GPs could develop to occupy any one of the cells in the matrix below.

figure 1



The limitation of a matrix is that it requires bipolar axes and it forces membership of one set. A spiders web diagram implies that any GP could develop to have a different pattern in relation to each dimension and in this case each axis does not have to represent a continuum.

figure 2 Dr Finlay Archetype

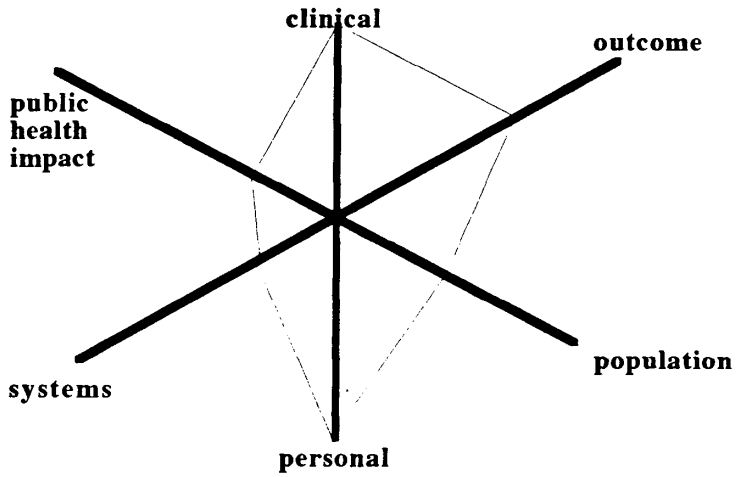
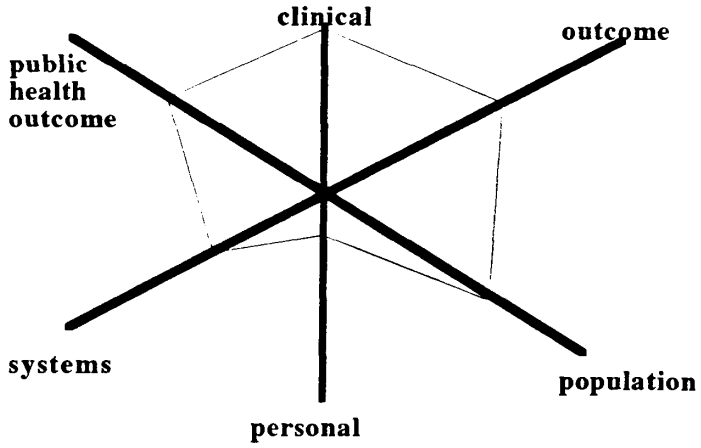


figure 3 Dr Gillespie (DR Kildare's medical Director) Archetype



Four roles were accompanied by brief descriptions and a more detailed analysis of their key characteristics (Appendix 1).

Clinical servant- key characteristic of this role is the responsibility of ensuring their care is up to normative standards and puts evidence-based interventions into practice. Their concern is to deliver the clinical care with the best outcome to their individual patients working within traditional clinical relationships.

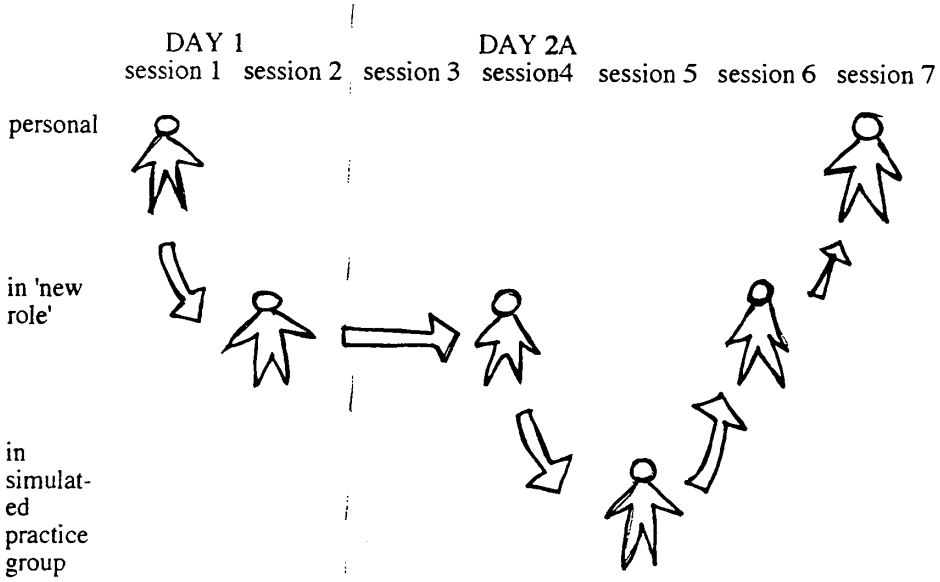
Health Councillor- which gives primacy to the patients' wants and act as a personal decision consultant and advocate. They are concerned to help the individual and take responsibility to fight the system on their behalf. They seek the best personal outcome which need to understand but not be confined to clinical outcomes.
Chief Executive Officer (CEO) - The primary concern is to deliver the greatest impact on the health of the practice population. They set priorites among services competing for resources and monitor service performance. This is the role with the overt management functions relating to corporate governance and practice accountability.
Care Shaper - has a public health orientation within the context of the practice population. Within any specific clinical domain (mental health, respiratory disease etc.) they are concerned to shape or design the service to best meet the practice populations health needs.

These 4 roles were created for use in the context of the chosen future scenario (appendix 2) and this material is the core around which a 2 day educational programme was built.

The 2010 two day programme.

The main aim of the one day event involving group 1 was to test the salience of the new roles we had devised. In the second event , in Newcastle, we also aimed to examine their usefulness to the participants as a way of understanding possible futures as a first step to taking some control over their own future careers. To this end the flow of the programme took the participants through a series of exercises which moved them from their current personal motivations, through experiencing the 'new role', for part of the time in a simulated practice grouping and back to their own personal aspirations.

figure 4 The workshop overview



A sample programme is available in appendix 3.

A variety of educational techniques were used including personal reflection, small group work, mini-lectures. visualisations , role play, story telling and creative feedback using drama, charades, poetry etc.

Participants' Responses

Both the workshops were evaluated. In the case of the London programme the task was undertaken by Andrew Harris, GP who had helped us contact the 21 participants who attended the event (appendix 4). The participants evaluated the programme themselves in Newcastle (appendix 5)

The 4 roles we created, as a device for exploring career futures, were understood by the participants. They were seen as valid in terms of their internal consistency although some care had to be taken throughout the events that they were descriptive rather than evaluative or predictive. There were marked differences between the London volunteers and those in Newcastle.

The London GPs were selected on the basis that they were iconoclasts and/or politically active in NHS politics and the wide divergence in personal values undermined some elements of the group work. They seemed much less able or willing to explore personal motivations, preferring to report external constraints and problems. In the Newcastle event we modified the first session and the facilitators' role to reflect these difficulties but the greater engagement in Newcastle may result as much from them the difference between the groups as from modifications in the design. In particular the Newcastle group rejected our description of poor morale in GPs as an appropriate trigger for this intervention, while the London group felt entirely at ease with this line and reinforced it.

The London group took part in a one day event in which a proportion of them found some difficulty in reaching a sufficient understanding of the ideas on which 'futures' work is based and failed to make the distinction between preferred and plausible futures. This didn't completely undermine the value of the approach. They found the ideas interesting and potentially useful but suggested we rethink the pace and style of presentation. As a consequence we redesigned the workshop. We extended the programme over two days to include a dinner session in which participants were seated with others assigned to the same role. This seemed to give the time to explore and question the roles and the future scenario which had been introduced in the early evening session. This adaptation proved successful.

The Newcastle workshop evaluations were favourable (appendix 5). The consensus from both groups were enjoyable and thought provoking. The workshop materials were considered relevant and our approach was seen as an acceptable way of engaging GPs in discussions about their future role(s). It was not clear to participants how to take their interests forward within some career planning process but there was a general feeling that this sort of workshop would be a useful start. Before discussing if or how to extend the project, it might be helpful to report the insights gained by development team who facilitated these events.

The Kings Fund (KF) team Observations

This section is based on observing GPs role play role-play first in groups of like-role players, then mixed groups or 'practices' having all 4 of the roles within it and giving dramatised feedback to the whole group. At the end of one of the workshops the KF team (appendix 6) took part in a fish-bowl exercise to enable the workshop participants to hear what we had observed / learned during the event and there was some interest in finding ways to work with this material. For now, these insights can only illuminate the range of issues this workshop generates. Whether there is a sufficiently compelling case to suggest that it can become the initial part of a more extended intervention to help GPs find effective strategies to deal with the issues needs further consideration.

Clinical servant

A key characteristic of this role is the responsibility of ensuring their care is up to normative standards and puts evidence-based interventions into practice. Although the GPs liked some elements of the role, such as working with individual patients, it did not feel as familiar to everyday current practice as we had expected. In this role the participants felt *"oppressed"* by the constant and insistent flow of information through the new computing and information technology and used terms like *"technological overload"* to describe this feeling. They saw this as a future with less patient contact, as if they felt diverted into a relationship with the computer screen and they perceived themselves as driven by external forces - the ubiquitous Cochrane Centres and clones.

Being confined to this role appears to conflict with some of the internal motivations described by GPs, particularly their desire for independence. They still hold a traditional image of the expert who has the necessary knowledge in his/her own head i.e. under internal control. The perceived threat to their authority and expertise was also played out in the skit, where a well informed patient challenges the doctors clinical competence having read the literature on the investigation himself. There is a need to explore how the job is really done which does not rely on faulty models about professional decision making and holding all the knowledge in your head. The vast body of changing information is taking less and less time to reach the mass media and the occasions when patients are more informed than their doctors will increase. The Open University have described part of this reformed professional role as being a 'decision consultant' and this seems more consistent with the needs of an increasingly well informed population.

Although GPs are probably the most computer literate group of doctors they still use computers for very few functions, mostly word processing and local data manipulation. If evidence-led decisions are to be compatible with feeling independent, then new interactive techniques may help in ways that simple transmission models -putting more effectiveness bulletins on E-mail - will not suffice. There has also been recent attempts to report research/ effectiveness data in more clinician relevant modes e.g. replacing 'x% reduction in mortality' with 'x,000 tests will be needed identify one positive case where an intervention will improve prognosis' (Fahey et al). However the poverty of research on effectiveness in primary care limits its application to general practice

If this role is to become valued and be experienced positively by GPs the NHS continuous medical education and R&D budgets should focus on developing and supporting in existing practitioners, particularly to identify consensus on appropriateness in primary care. The new medical curriculum concepts which emphasise the ability to retrieve rather than memorise information will also be key. More interactive information technology will be required and those producing information will have to better understand the workings of the generalist clinician's mind. This might in the future be characterises as **'high tech. and high touch'**

(Naisbitt)Finally a more creative approach will be required to 'measure' or at least make available in the public domain, the humanistic aspects of the work to harness the primary motivation to work with whole people - We seem to be seeking an accommodation somewhere between reductionism and obscurantism.

There is a strong motivation among GP to work with the *"whole person and the whole family"* and the therapeutic use of self is recognised as central in personal services such as primary health care. Here the new technology offers opportunities as well as threats. In Banking, for example, most service users welcome the faceless hole in the wall money machine but their need for personal support is recognised in other situations. Banks' adverts now emphasise named personal bankers etc. Health professional will have to be helped to recognise where the opportunities lie to distinguish when the therapeutic use of the relationship is important and when it is not. This may result in an mutually acceptable way to begin to take control of the overwhelming demands they experience on their time.

As with all the roles no-one wanted this one as 100% of their job. This role raises discomfort about the relationship between the scientific and humanistic elements of medical practice. While GPs are articulate about their practice being both art and science, they are not clear how they manage this dichotomy or how they choose to operate in one mode or the other. Perhaps the enforced clarity resulting from separating out strands disrupts the necessarily complex nature of their work and it may prove necessary to protect the 'fudge' inherent in the integrated roles model. Indeed GPs often seem to disappear into the realms of the mystical when describing the nature of the consultation. An alternative hypothesis is that, through reflective practice, the complex relationships between different elements of the work could be more transparent. This understanding might produce a more informed capacity for appropriate adaptation. Such a process might start but not end with the crude reductionism used within our educational device

Their resistance to simplistic codification of complex tasks is understandable. This is common among all sorts of practitioners who work with social processes and/or in consultant/client relationships based on influence with little direct power to implement.. But some method of triangulation around distinctive methodologies and impacts are a reasonable requirement of reflective professional practice. A richer understanding of the locus of control theory, which identifies the three independent dimensions, might be helpful. (Rotter et al).

figure 5 Locus of Control

internal
strong----------weak

powerful others
strong----------weak

chance
strong----------weak

Their current experience of the move to evidence-based medicine is one of increasing external control. This is entirely reasonable. The presentation of information technology as an unalloyed benefit to professional 'knowledge workers' fails to address its likely impact on the nature of professional and other white collar work. For the first time this work, which was always practised away from the prying eyes of supervisors, will become as transparent as the work on assembly lines has been for generations. In addition globalisation, contrary to expectations, will not always lead to more choice. With respect to some types of commodity there will be more choice but at the cost standardisation in other respects - the 'Benetonisation' of the world

produces more choice of colour and style of sweaters but homogeneity is created as high streets around the world lose their local diversity .

Professionals will have to get smart about legitimate areas for professional judgement but defensive reactions can be expected in the struggle for new forms of professional autonomy to emerge. The reaction to protocols can be understood in this context. A new consensus is needed about what is no longer professional activity i.e. need not be practised by autonomous professionals and can be made routine or delegated or handed over to non professionals i.e. patients or to people in new or revised professions. This is an area which needs to be addressed explicitly at many levels and which the current debate about 'skills mix' leaves untouched.

Professional people must lead this discussion if they are to feel in control of the agenda. It is clear from the their own descriptions of their own motivations that GPs could prove a fertile ground for such developments. They are used to living with high levels of uncertainty which they describe as *"enjoying living on the edge"*, or *"Knowing what I don't know"* or *" awareness of a lack of competence"*. These were given as characteristics which distinguish generalists from specialists.

Health Councillor

This is the role which gives primacy to the patients' wants and in which the doctor acts as a non-judgmental system negotiator. The participants felt this role was familiar in many ways . It involved a lot of *"hassle in getting things done"* beyond the practice boundaries. They enjoyed the unambiguous *"moral high ground"* associated with being the patient advocate. They didn't like being seen as *"a thorn in the flesh"* of their colleagues in the other roles and appeared discomforted by exposing a usually hidden and internal dialogue. There are no external checks and balances to apply to the dilemmas inherent in their multiple roles. Within the General Medical Services (GMS) no one is appointed advocate for the patient treated by the GP. This contrasts with the role GPs adopt as advocates for their patients treated in other parts of the NHS. Some articulate people may force a more public exploration of the issues but these 'difficult' patients and their discussions are not always welcome. Indeed, in the feedback they gave to illuminate this 2010 role, the patient was not ascribed an informed role . The patient was portrayed as demanding but never more than a passive receiver of information.

In this role, they felt guilty about fighting for inappropriate prescriptions/ interventions. Perhaps we can draw some inferences from the content of their skit which focused on a patient's request for an assisted suicide. In such a case, simple discussions of effectiveness or outcome driven decisions do not address the central issue. It seems that this role was uncomfortable because it exposed the lack of a clear/ transparent framework for dealing with situations which emotion, fact and values - a heady cocktail. Different solutions can be useful in other settings. This might best be illustrated with reference to the practice of law and justice. Any defendant has the right to a defence which lawyers are bound to supply (on rote if necessary). This is distinct from the right to a fair judgement (and legally enforced action) which is enacted by another legal professional and sometimes a lay jury. These functions have been conflated in doctors' practice. Patients may experience this as a rather paternalistic - 'I will help you fight for things I think are right for you' or that 'I think you have a right to' . Doctors tend to be judgmental and indeed their judgements on some issues are highly valued. But they do not seem to be clear how advocacy **and** judgement should operate for the best outcome for patients. (Vickers)

The participants' disliked this 2010 role which may relate to its unidimensional quality -just plain boring. All the single role players reported missing the interest their multi-role jobs provide. It could also point to a reluctance to expose the power which comes with combined roles. GPs seem implicitly to accept the intense sense of

responsibility which accompanies so powerful a role as an acceptable trade off against the fulfilment of the desire to be doing a serious, important, valued if difficult job.

The participants were motivated by the desire to have an impact or *"make a difference to people"* . They exhibited a self awareness which associated this with *"liking control over peoples' live '"and "being controlling"* . With commendable honesty, others mentioned enjoying *"being elite"* and *"privileged"*. Yet the challenge to professionals as traditional patterns of deference breakdown was not mentioned The omission is noteworthy and may point to a failure to understand that one of the most predictable changes that will take place in the next 15 years will be in public attitudes and their expectations of professionals - all professionals. This trend is already well advanced. It is not a temporary aberration associated with the patients' charter although the emphasis on consumerism and patient as consumer may not persist within a different political administration.

The deference which was seen as the due of a middle-class white male group has already been eroded as doctors are drawn from visibly more diverse backgrounds. In our experience, many in this new cohort of doctors do not crave the social kudos and local leadership which attended the 'Dr Finlay' role (Vaughan). But doctors are likely to have ambivalent feelings about these changes in public expectations and behaviour . An unwritten deal seems to have been broken - something about accepting the doctors definition of what constitutes wasting the doctor's time. There is little discussion of how an advocate will work if or when the needy **and** non-deferential clients are the norm. The concern seems to have been displaced onto discussion about inappropriate demands and charters. GPs offer few images or models for new professional behaviour in their feedback, beyond the broker with red braces - an icon of the unacceptable marketplace.

The challenge to reinvent professionalism without paternalism is not new and the PHC team may become a strong enough mechanism to break the mould. This will not happen by chance. Other analogies may help create more acceptable images. They may be able to develop new models such as patient participation groups linked to revitalised community health councils. School governors offer another possible model. Primary schools employ about the same number of people as a large practice and patent governors have the right to 'hire and fire'. Care will be needed to adapt any model to the unique characteristics of small organisations and the unique nature of care giving but neither of these constraints are reason not to address the issue. Any externally imposed solution will further damage morale but real leadership is needed if inappropriate interventions either through market or other mechanisms are to be avoided.

Defensive reactions to this agenda are already in place. This is partly due to work overload and increasing expectations. Efforts to manage demand are necessary which transcend developing new skills in this role More work is needed to assess whether additional experiences could be designed around the roles and scenario materials to overcome the resistance. The purpose would not be to undermine the importance of GPs or the work they do with patients but to seek more appropriate ways for them to act powerfully.

CEO

This was the role with the overt management function and the least chosen option. It is arguably the most different from the participants current roles and they have difficulty finding any thing to attract them to it. Some could only parody the role with reference to mobile phones and flashy lease cars. When in role they enjoyed bringing *"management and doctors"* (**note not managers**) nearer together and they identified the major advantage as adding management-speak to the doctors' vocabulary.

In their skit the CEOs met a future right wing labour minister (called Michael Portillo). It is remarkable how powerless they appeared. There is clearly an important implication from this that managers' business is political but they translated this straight into a party political national framework - politics with a capital 'P'. The more local forms of politics within organisations and between parts of local health care systems was ignored. The perceived link with and susceptibility to national political agendas caused discomfort. The managers were played as part of a command and control model of organisation, which was the only time in any of the feedbacks that any organisational relationships played an obvious role. In all the other roles personal relationships predominated. Another difference in the portrayal of this role was the absence of discussion about ethical responsibilities. The CEO role seemed to be without ethical dilemmas, as if there were no ethical basis for managerial action Although medical politics are rife and medical politicians abound the introduction of Politics into medical practice and service delivery is seen as improper. Is this an example of theory espoused rather than the theory in action ? (Argyris and Schon) This splitting is untenable within the CEO role and may explain their avoidance of it.

In many of the feedbacks politics were present but it was always external to the profession and the team. In nearly all cases their fears about the impact of means testing and rationing were exposed. This exclusion of politics/management from their workplace probably supported the feeling that " work is integrated with my world view". There is even a tendency to confuse the practice with the community. This may be an attempt to protect the public service ethic against the prevalent market ideology. More work would be needed to explore this and its implications for a primary care led NHS.

The role-players understanding of the role contrasted with the vignette given on the first evening by a doctor who has chosen to become a medical director of a Trust. She demonstrated a relish for the politics and saw the need to combine within organisational forms which can survive in new conditions. She had found a way to enjoy being influential largely through her ability to translate the different worlds to each other (doctors and managers as the two main power brokers). She clearly enjoyed the strategic aspects of the role. It seemed to give her a way to work more openly with the many dilemmas hidden within the practice of medicine. It was interesting to note that she had first been drawn to this role while working abroad and her first experiences were not tainted by association with a political administration towards which she felt hostility.

In some ways it is surprising that GPs of all doctors fail to appreciate management as a process rather than a series of events - a series of administrations. Like many doctors they fail to differentiate between management and administration. They have the usual professional reflex reaction to management as the incursion of business methods and reject 'doing business in the temple'. This holds even though independent practitioners recognise the need to be business like. Many of their current decisions are business led but this creates tensions within them that they would prefer to project on to the government than confront. In significant ways general practice differs from a small business. It operates in a highly protected environment and with a marked co-dependency between providers and patients which is inimical with the shopping around ethos of a real market place. This would be a fertile area in which to develop the work.

In this context management is not an intellectually challenging activity and most of their experience of management is in fact administration and relatively risk free. These tasks can be delegated to a practice manager or someone often fairly junior in the FHSA. Unlike most hospital doctors, GPs will not have met many senior managers. FHSAs had a very small senior team and the new commissions are tending to send quite inexperienced people to meet with practitioners. Even fund holding,

which can introduce GPs to ideas about strategic management is relatively low risk - you can always leave it and return the GMS 'cash cow'. Special consideration needs to be given to how to give GPs an understanding of senior mangers' motivations if it is ever to become accepted as an intellectually challenging activity.
It needs to be connected with their own motivation of living *"on the edge"*.

Care Shaper
This role has a public health orientation within the context of the practice population. The GPs experienced this role as one having an overview which they enjoyed and found intellectually stimulating. They appreciated the time to focus on issues other than those raised in the consultation.

In role, they had some concerns about accountability to patient or population but less than might have been expected. They had experience of some parts of this role already through their involvement in commissioning and seemed to accept it as a legitimate form of engagement. They were less able to operate using this approach within the workshop 'practice' grouping. There was much less ease with the role when they tried to imagine helping the 'practice' make strategic or priority decisions. In this context they appeared to have no way of separating the executive role (CEO) from the more internal consultant, developer role implied in the care shaper profile used in this exercise. In their feedback they acted out charades one of which was *"balancing the books"* and *"juggling"*. We had not understood this role to have special responsibility for making the choice, rather it was intended as a resource to the whole practice to support informed decision making. The confusion may lie in the role construction but may point to a lack of sophistication in their grasp of corporate governance.

We did not explore the nature of partnership or their actual experience within their real practices. There was some interest to repeat a suitably modified workshop with practice groups. Their suggestion was to work with the primary health care team although they could foresee difficulties given the plethora of professional responsibilities. It is not clear that this was a desire to grow a new form of corporate governance rather it seemed that they were failing to address governance at all. The PHC team can be seem as the emerging operational unit(s) in general practice but it is unlikely that it will become the strategic unit as well. The partnership is currently the only organisational form they have for making many of the strategic decisions. The partnership is a device to create the infrastructure GPs need to share overhead costs and is clearly not sufficient to engage in the new environmental conditions and yet they did not identify the need to work with the partners. This may be a reflection of the non functioning of many partnerships in these respects. Often they operate to protect individual partners freedom rather than to create coherence and the capacity to act 'corporately'. It is almost as if this necessary function of effective organisations is invisible to them. It would be interesting to devise the workshop based on the current materials, for partnership groups to focus more directly on this issue

It would appear that this role already has some legitimacy when interpreted as an analytical activity. They did not adopt this role as one of data production but seem comfortable with using population data to make a case. This follows on interpretation of public health. Dr Zimmern has said *" you can do epidemiology without producing change. To do public health medicine you have to produce a change as a result of doing epidemiology.... to improve the population's health"*. It was not clear from the way the role was played, who would actually do the epidemiology but this might be another area which could be shared within the PHC team. It was easy to see how a programme like COPC could help clarify the roles as well as enhancing the necessary skills within the team.

One of the most influential books in the 1960's was Michael Balint's "The doctor, his patient and the illness". June Huntingdon has suggested this should be recast for the 1990's as *'the practice, its population and the illness'*. While a symbiotic relationship may be forming between the personal care and the population approach, the complexities and tensions embodied in the shift from response to demands to responding to need were only partially acknowledged. Similarly there was little evidence in these workshops that the shift of focus from practitioners to include the practice as an organisation - there are only the ubiquitous references to the team.

Possible Extensions

The preceding analysis supports our contention that primary care doctors have a limited understanding of the need for organisational development in primary care organisations or a vision of the role(s) of doctors in these organisations in the future (Schein). Despite their relative success as small business units, business values remain heretical to those in the clinical professions. Some of the paradoxes should be addressed. In a public service we have 'private' management and quite paternalistic attitudes. While in the private sector (trade) public scrutiny is seen as legitimate. we need to develop some distinctive models of organisational accountability which are appropriate accommodate the special nature the work. It is imperative that we find new ways of understanding organisations in particular the small organisations which characterise primary care. Perhaps there could be a new coalition for the millennium to produce a general practice charter to replace the GP charter. It could be productive to engage GPs in this exercise after surfacing and exploring some of the issues we have raised in this project.

Any change involves risk - including no change. If doctors continue to hark back to a 'golden age' they will miss an important opportunity to influence the future. They urgently need a sense of how the job is changing and a vision of how it should change - a GP centred view. Yet they appear unprepared and have no language for the future except on of resistance and defence of the discipline .

In most future scenarios, it is possible that the nature of doctors power will change. The job could become less safe or less independent whether they become real small businesses operating in a market or employees with clearer conditions of employment. If we are to retain the qualities of an empowered professional group in the future we need to help GPs be active in shaping this future - such a future we believe would have both appropriate and accountable PHC organisations and excellent generalists practitioners.

This joint enquiry is particularly relevant now as people throughout the health care system are trying to make a primary care led NHS and GPs are being invited to take on even more roles, heaping confusion upon confusion.
A reference to systems theory might help in this situation. 'Soft' systems are seen as comprising of the following elements

- Clients
- Actors
- Transformations
- World view
- Owners
- Environments

Some clarity about each element and their inter-relationships is necessary for a system to function effectively. Traditionally the NHS has confused and conflated these roles. In theory, the owners are the taxpayers/citizens but groups of powerful doctors were able to act is if they owned the service, so-called 'provider capture'. They are also clearly actors and the purchasing providing split went some way to delineate this as their primary role while proposing the purchasers as owners - at least proxy owners or 'champions of the people'. While the roles are still contested there has been no parallel attempt to identify appropriate role definitions in general practice. As independent practitioners they are in real terms owners (and employers) as well as being paid as actors within health services. Indeed the new emphasis on GPs as purchasers has further compounded the confusion of roles. It is hardly surprising that both GPs and other significant co-operators in the system are uncertain how to proceed and that GPs are feeling over burdened.

If PHC is to move to the centre of the NHS, both GPs and others must engage in clarifying roles to enable GPs to function effectively . We believe this requires a programme of organisational development which includes

1) exploring appropriate roles for GPs (including leadership roles)
2) the internal development of general practices as effective small organisations
3) the development of local/national health care systems capable of embracing many small organisations.
4) New employment contracts to undertake new roles

We suggest this project has produced a development tool which can be used to engage GPs in the first and second strands of this change programme.

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cial breaks into three parts. Unfortunately, most of the first part was sensationalist, kicking off with a mixture of gore and dramatic newspaper headlines concerning a violent attack on one young man by seven others. Dr Trevor Turner, a community psychiatrist from London, walked in gunslinger mode as "The Mediator" into Fitzwilliam, a mining village near Pontefract in West Yorkshire, to the strains of guitar music seemingly from a B-movie western. The action cut to the victim and his mother, who suffer from post-traumatic stress disorders as a result of the violent attack. Their sad stories were almost drowned by wailing violin music. Then the action cut back to "The Mediator" and the highly irritating western music. I was tempted to switch off the television at this point.

However, when the distracting camera work and music subsided, the rest of the programme allowed Dr Turner to skilfully present how and why he did what he did. The victim, perpetrators, and families movingly described their experiences and palpably gained relief from their suffering through Dr Turner's intervention. He met the mothers of the young men involved individually, then brought them together and, through the mothers, brought some degree of reconciliation between the young men involved.

I was left disturbed by the way in which fights are an accepted part of life in Fitzwilliam. Both the young men and their families seemed to view the fight as one that just went too far; no one seemed to think that fights can or should be stopped altogether. The programme did show how changes in attitudes can be brought about quite quickly and effectively (at least in the short term) in cohesive communities such as mining villages. Dr Turner caricatured Yorkshire women as tough in the way they hide their emotion; but they are also tough in the way they generally try to support each other in adverse circumstances.—RICHARD MORRISS, *senior lecturer in community psychiatry, University of Manchester Guild NHS Trust*

PERSONAL VIEW

I should have been more selfish

I am 51, a female general practitioner, married to a consultant physician for nearly 25 years. We have three children. I have been with the same practice for 18 years. I am also clinically depressed and all the preceding facts are contributory.

Depression in a middle aged woman is a common phenomenon and any gynaecologist will tell you about the empty nest syndrome and hormone changes, but there is more than this in my case. I think the fact that I have been with the same general practice for so long is a major contributing factor. Over that time I have built up good relationships with many patients and their families and the local community. I have seen children born and grow up, have seen families through tragedy and bereavement. I know some of them well and, equally importantly, they know me. A consultation with a patient I have known for 17 years is different from one with a new patient.

But where else in the health service is it an advantage to stay in one place for so long? I recently heard someone from the family health services authority say that she really ought to be looking for a new post as she had been there a full three years. Another official was accused of lacking personal ambition for staying in a post for seven years. Many people will change posts after short periods of time, looking for more senior and better paid positions. Such job mobility in general contrasts markedly with the idea that a general practitioner can become better only with experience in one place.

I agree that the more I get to know my current patients the more I may be able to help them. But this ability to help patients is at the expense of my own personal development. Shouldn't I be moving along the career path of my chosen specialty of general practice?

And here is another problem. There is no career path. The career structure in general practice is flat. Once parity is reached the job stays the same until retirement. There are no generally accepted career moves for a senior general practitioner. This is in marked contrast to my husband's career in hospital medicine where career moves can be planned and expected.

A modern sharing management style has also contributed to my depression. The practice has worked hard to change from the previous senior partner's style of autocratic leadership. The most junior partner in our now democratic practice has the same responsibilities and the same salary as me, one of two senior partners. I do not wish to return to the old days of exploitation of junior partners but I do begin to see some of the advantages of the old style senior partner.

> ***"There are no generally accepted career moves for a senior general practitioner."***

Although in theory responsibilities are shared equally in practice the staff are likely to look to the longer serving partners for help when there are problems. A junior partner may not be willing to see that I am tired and burnt out and wish to cut my hours down a little. In the old days I would have done it without consultation.

Our particular practice had some extra stresses apart from the general experiences of the new general practice charter in 1990. I think that we coped well and learnt to adapt. We acted proactively and learnt ways to overcome problems. Looking back I realise now that I spent too many hours thinking about my work and the practice and the best way of coping with the new contract. I set up the ill fated health promotion clinics and spent many weekends preparing protocols and forms and devising a way to audit the results. The partners were not particularly appreciative—even though my efforts brought in a tidy sum. They did not ask me to spend so much of my energy on the practice affairs. I just felt that I ought to. What I had done was to put the practice's needs above my own.

I now realise that I should not have put myself automatically second. I am left behind when those for whom I stood back have gone on to higher things. My three bright children are doing well now and are nearly independent. I am proud of them and pleased that they no longer need me. They seem to have good relationships with each other and their friends and are doing well socially and academically. I have no regrets about helping them when they were younger. But why did it always have to be me taking time off from work to attend their school shows and open days? Why did I feel that my work was less important than my husband's? This is not his fault but mine. He did not put himself first but I put myself second.

Most general practitioners will seek personal fulfilment by indulging in politics or becoming trainers. This has a useful side effect of helping general practitioners in general. I thought that this path was closed to me as others in the practice had gone that way. I had encouraged and supported them believing that they would be better at these jobs and that my place was within the practice—a typical depressive symptom but also the result of many years of taking a back seat.

The end result of not being more selfish in earlier days at home and at work is depression and misery now. I am pulling myself together by taking advice from a career consultant by confiding in my family health service authority, whose female chief executive was supportive, and by becoming a reluctant patient. I told my own general practitioner a last of my unhappiness and finally I told my partners. Of course, they were sympathetic and have allowed me to work part time temporarily while I contemplate what to do next. I went to a psychiatrist and continue to take the tablets. I am looking at ways of enlarging my horizons while still keeping a firm general practice base. I have started to teach medical students, which I discovered I enjoy and can do well. I have put the word around on my network that I am available as an experienced general practitioner for input into various planning processes. The depression is receding but I wish that I had not allowed myself to get into such a state in the first place. I would like young women general practitioners to read this and avoid the mistakes that I made.

Exercise 2: General Practice roles

In the short paragraphs that follow and the accompanying matrix we have attempted to invent possible future focuses for doctors who are currently GPs. This is our first attempt to construct these frameworks for exploring alternative futures. Mistakes, inconsistencies and suggestions for additional dimensions (left hand column entries) would be much appreciated. When reading them, please remember:

* these are inventions, not predictions
* each of the four career options are indicators of a principal rather than the exclusive focus within the role.
* the dimensions we considered in designing them were primarily:

  - interest in personally delivering clinical care
  - interest in ensuring the system provided care
  - weight given to the outcome for a particular individual
  - weight given to the outcome for the population
  - impact on public health
  - concern as to the effectiveness of a treatment.

* ideally, each column should be internally consistent.

1. Clinical Servant (focus is the clinician-patient interface)

   The primary concern is together with the patient to assess individual health needs and deliver clinical care with the best possible outcome for each individual. Thus the medical care provided is based on the latest outcome data together with informed, individual patient choice. Expert systems may be used to assess the latest data and to record symptoms, but the expertise for interpretation remains with the clinical servant. Within the clinical team, the clinical servant is the senior professional, working with other team members and fully utilising their skills to complement her own. He or she has expertise about clinical care within a primary care setting.

2. Health Councillor (focus is the patient-system interface)

   The primary function of this individual is to act as advocate for the individual patient and help them to get the most out of the system, even fighting the system on their behalf. The wishes of the patient are paramount, irrespective of the potential outcome. The role is to take the individual and their health problem and work to achieve the outcome desired by the patient by using networks, contacts and knowledge of the system. He or she is particularly well informed and skilled about referrals and clinical care variations within a secondary care setting, and has authority and expertise in specifying services to be provided by others for an individual patient. How the role works varies at times informing and empowering patients to be their own advocates and avoiding paternalism. This role might be a natural development of locality coordinators who use anecdotal experience to seek to influence the decision makers.

3. Chief Executive Officer (CEO) (focus is clinician-management interface)

   This is the corporate expression of general practice. The primary concern is that the system delivers the greatest possible impact on the health of the population. They agree values, set objectives and priorities amongst different services competing for resources and commission evaluation or directly assess the clinical outcome of services. They (for a large practice or consortium of practices) negotiate and agree contracts with commissioners on behalf of the organisation. They manage a system of subcontracts (service level agreements) with other provider organisations including other primary care providers. They represent general practice externally, thus being the main contributors to LMC activities.

4. Care Shaper/Development Manager (focus is clinician-public health medicine interface)

   This role conducts systematic needs assessment in priority areas to changes in services. It bridges micro purchasing decisions (for individuals) and macro purchasing through contracts. Within specific clinical domains (eg mental health, maternity etc) they are concerned to shape and specify the service to best meet the population's health needs. They work across organisational boundaries attempting to achieve support for change and influence acute, community, GPs and voluntary organisations to deliver outcomes required in the purchaser's specifications. An example might be exploration of a local problem of conduct disorder in children under eleven years in a locality and the associated access problems; working with hospital and local authority to generate changes in the school health service with a new role for the school nurse to meet these needs.

	CLINICAL SERVANT	HEALTH COUNCILLOR	CHIEF EXECUTIVE OFFICER	CARE/SHAPER DEVELOPMENT MANAGER
Focus	Clinician-patient interface	Patient-system interface	Clinician-management interface	Clinician-public health medicine interface
Key definition of effective-ness	Happy patient (primary care) good recovery	Happy patien (secondary care) speed and seamless access	VFM show impact on popultation GP voice heard	Achieving change in practice match care groups need with system
Key tradeoff	risk vs advantage for patient	excellence for individual equity	advantages for clients vs to society	feasible charge in system vs vs desired change for groups
Concern for effective-ness of clinical outcome	high; reactive to studies;	very low; reactive	moderate; proactive;	high; reactive
Concern for impact of Rx on population	low	low	high	moderate/high
Nature of team-working	GP as soloist and leader in string quartet	librettist and amplifyer of network	conductor and managerial coordinator	impressario and change-agency
Nature of power internally	clinical expertise	influence-who they know	control of resources	population knowledge + public health skills
Relation-ship to other people	professional	lobbyist	supplier/ customer	population and organisational consultant
Accountable to	profession, patient, practice	principally patient	holder of corporate contract	multiple: care group, purchaser profession
Career trajectory	professional education + clinical interest + research	worked in different parts of the local system/hospital specialist interest	clinician into management audits	public health medicine/research
Transfer-able skills	diagnostic/ academic	influencing/ networking	management	systems consultant/social scientist

Peer leadership	Royal College GPs	CHC, College of Health/ Specific faculty	NAHAT	Vol orgs, Faculty PH, Public Health Alliance
Relation-ship to organisation	Primus inter pares	manages the external	leader	corporate change agent/R&D
Relation-ship to system	minimal	network manager	contractual and cultural	integrator and implementor
Source of accredit-ion	RCGP member-ship (via examination)	local monitor-ing by user groups; possible specialty diploma	King's Fund/ Business School	Public Health Faculty/assess-ment
Working hours	8 hour day-shifts	9-5 plus evening advice surgeries	9-5 plus on-call for untoward incidents	9-5 plus evening meetings
What take home	clinical journals plus case notes on laptop	letters to send by e-mail and OU course on professional decision-making	business plans contracts and Journal of phc management	action learning research reports to write and Journal of Public Health
Relation-ship to system Drivers	independent	fixer	corporate insider build successful PHC organisation	developer challenger build a needs led service
Key partners	patients and other practitioners academe	patients	the board and other organisations	members of the care group commissioners, researchers

One Scenario for 2010; a background/orientation paper.

International Context:

In this future the emphasis within international relations is on reducing trade barriers. The successful completion of the Gatt Agreement in 1994 led to improved trade relations between the super powers, and the expanded EEC has become a full economic union (EC). The significant globalisation of trade has produced economic growth (3.5% in developed countries) and increased population flows for economic reasons. There is less bureaucratic regulation from Brussels than in the nineties, with scope for national and regional governments to vary applications of EC law.

Deregulation and lessening of controls has also been applied to the arms trade despite several UN sponsored initiatives to reach agreement on limitation of conventional arms. The arms trade supplies the still significant number of international and nationalist conflicts which have produced large numbers of refugees. Defence expenditure has fallen in the UK but income from arms production has continued to rise.

Kathleen Kennedy, president of the USA federal government has reluctantly agreed to the State of California's demand to be allowed to join the PREC (Pacific Rim Economic Community). Californians will retain US citizenship but the border with the US will be strengthened, like the border with Mexico, to keep out economic migrants.

The promise of dramatic new energy sources has not been fulfilled and fossil fuels remain the major energy source. Nuclear reactors continue to produce energy but prices reflect real costs since government subsidies were removed at privatisations in the 1990s.

EC rules have ensured that women have achieved equal pay and there are tax credits for child care to support working parents. Employment policy operated through economic incentives has enabled some enterprises to increase productivity while decreasing accidents and stress. The impact of the incentives is uneven but they have benefited small and flexible businesses. Large multinational companies still dominate some markets and fund most of the research in their own areas of interest.

New forms of social combination have evolved into such things as regional development banks and organisations for investor directed allocation of funds - these grew from the ethical investment plans pioneered in the 1980s. Trade unions have, in some cases, returned to their roots in the 'friendly' societies negotiating for benefits for their members and their families from third parties e.g. health insurers and pooling risk, as in loan collectives.

UK Social Environment:

The debate about civil society and the role of the state continued. Governments are still experiencing difficulty in balancing the ecological concerns with market demands. For example, tobacco advertising has been banned but the development of genetically engineered foods, many with high fat content, is not controlled. Aggressive counter advertising is allowed so that the marketing of some health promoting products contributes to better health outcomes for some consumers. The political imperative in industrialised countries is to reduce or contain levels of direct taxation. The higher levels of government expenditure common in northern Europe in the 50s and 60s have not returned and have remained within the range found in the 1990s. Consumer spending includes expenditures on private education, health care and social care, particularly insurance for old age. Class differences persist

but are more closely linked to income than traditional affiliations and behaviours.

There have been major changes in the voluntary sector following the change in legislation covering charities. Many function solely as not or profit provider organisations. This year, the Rowntree Foundation is having its charitable status questioned for pursuing political purposes in its study of poverty in places such as Brighton, Barrow, Oxford and Oldham.

The distribution of wealth within the UK has changed and there is no longer a clear divide between north and south. Some industries have benefited from deregulation and the areas in which they function have thrived while areas close-by, have experienced no growth. This uneven development is represented in the unemployment figures - currently 1.4 million - which is less than the totals achieved in the 1990s. Infra-structure investment has been patchy in the UK. The 'information highway' has progressed slower than expected although homes are now being linked by the type of fibre optic network that have been in place in Singapore since 2000. This network brings access to consumer tailored information about health prevention, diagnosis, treatment and outcomes, encouraging self care and questioning of professional physicians and carers.

White collar working has largely been mechanised. You don't 'go' to the bank, post office or any other 'office' anymore. transactions are made from home. We are getting used to the idea that many of our children don't have 'proper' jobs with pensions but instead have 'portfolio' careers and PPPs(personal pension plans). Their children are well integrated into one of the two streams of education -training for industry or traditional education.

There has been no significant change in the rates of marriage, divorce and remarriage over the last two decades but the roles and responsibilities of parents have been made more explicit.

the birth rate has been relatively stable since the 1990s with the expected reduction in 'carers'. Paid employment in this sector has absorbed some of the displaced white collar workers but has further contributed to shifts in the population. Increasingly, expect for the well-off, those with choices do not live in the city.

Government has a reduced role in the demand side of public provision (provider) but remains active in the supply side (purchasing). Pluralism in provision of publicly financed health and services is well developed.

Health System UK:

Health care consumes 10% of the gross national product, a level much more in keeping with other OECD countries. The government only contributes 5.5%, via a complex weighted capitation formula which reflects age, sex, mobility and a social welfare weighting which is varied by policy makers. The rise in expenditure on health care has been made possible by a larger role for insurers and consumers as purchasers of health care. In 1996 legislation established GPs as major purchasers in the system, but the incoming Labour government abolished fundholding in 1997. Health purchasing evolved into a responsibility of more accountable local authorities which purchased (and provided some) social health and educational care, and had close involvement of local community representatives, and the professions. General practitioners had strong voices in the organisation, and had delegated budgets for limited 'purchasing' of community day care and day treatment services. The bulk of secondary sector commissioning is decided by the local authority. These organisations focussed on development of caring services, and detailed quality and monitoring. There is less emphasis on contracting, and more developmental service agreements. The regional offices of the NHS management executive have grown into regulatory regional bodies with

strategic planning, super-information activities (collecting and providing information to and from consumers, professionals and scientific databases) and market regulators and auditors ensuring probity and efficiency. More health products and health related services are sold. Private medical insurance has grown, partly as 'top up' policies to supplement NHS coverage, and partly to cover 'non-core' NHS services, such as long-term residential elderly care. The need for rationing and prioritization of public finance and public disquiet about the inadequacy of services led to a defined basic range of public services, excluding a number of expensive specialist treatments and long term residential care.

Accreditation has become the norm for all health care provider organisations. The pharmaceutical industry has restructured but continues to thrive and is by far the largest sponsor of medical research and scholarships for training. The number of medical graduates has remained constant. But there has been a migration of doctors from USA, Europe and Eurolasia, which has resulted in some unemployment among UK graduates. Services remain physician dominated, but with greater delegation to other primary care practitioners. Midwives have largely replaced doctors in antenatal care. Nurse practitioners are now accredited to conduct child health assessments, vaccinations, and have a limited prescribing role. There is huge controversy over the Royal College Nurses proposal for family planning and cervical screening to be a nurse led primary care service, using doctors for referral of complex cases. The focus is still on treatment but progress has been made on behavioural interventions. There is a vastly improved pool of epidemiological knowledge of risk and co-morbid factors. Smart cards are now commonly carried by service users. They include comprehensive medical records plus test and imaging results. New appliances are available to allow individuals to monitor health and some sections of the population have access to self diagnosis using these and networked technology. This allows GPs to 'see' patients without face to face consultation. Secondary care centres are more focussed in the range of care they supply. There is greater use of the private sector for elective care and much more extensive use of non-invasive techniques. There are large diagnostic centres linked by satellite to subscribers throughout the EC. These secondary care providers have a contractual interface with primary care.

Medical Science:

The genome project has progressed to increase our understanding of most major disease processes. It has as yet delivered few affordable treatments for common health problems. However there is much excitement about the clinical trials for both the viral and genetic components of Alzheimer's. This is the fruit of the boost to research on ageing in recent years. Diagnostics have improved with new generations of technology. Biotechnology driven assays and probes have been commonly available since 2005 and were proceeded by a new generation of 'super' scanners at the turn of the century. These have been particularly useful to providers linked by fibre optic networks. Deplaquing agents are available to treat cardiovascular disease.

New technologies and drugs have been subjected to cost effectiveness studies organised by an international network of Cochrane Centres. The public health service is required to apply the findings but, in a climate of deregulation, their use is not mandatory in the private sector.

A DAY IN THE LIFE OF A GP 2010

A joint meeting held by the Department of Primary Health Care, University of Newcastle and The King's Fund Centre, London

28th -29th March 1995

PROGRAMME

TUESDAY 28th MARCH

6.30 pm Registration

SESSION 1: PASSIONS (30 minutes)

7.00 pm **Introduction:**
The sponsors (The King's Fund and NHSE) - Introductions
Why the event might be helpful; Experience of London workshop

Motivations and Passions: group work in four *local* groups
Natural local groups with a King's Fund facilitator in each group
Being a GP; what is essential for you to hold on to, regardless of what the future may bring. An opportunity for individuals to focus on positive features of general practice for themselves; perhaps start with a 5 minute silence for reflection and recording individual motivators. The aim is for clarity, not consensus. Key points to be grouped and summarised, for later use in evaluating possible futures.

SESSION 2: FUTURES (30 minutes)

7.30 pm **Futures:** plenary
Short pragmatic introduction to design and use of future scenario and roles, as a means of influencing the future.

Roles: presentations
Four local practitioners each present a hypothetical future role:
Chief Executive, Clinical servant, Care Shaper, Health Advocate.

8.00 pm *Participants break into four roughly equal groups, choosing a hypothetical role that is both distinctly different from their own present role, but not one which engenders overt rejection. Each participant should already have the scenario paper and roles description, for discussion in their role group.*

8.30 pm **Dinner**
Participants sit in their role groups at four tables, with a member of the King's Fund team. At dinner, discussion should include fleshing out and deepening understanding of each role.

WEDNESDAY 29th MARCH Morning:

SESSION 3: A SCENARIO (45 minutes)

9.30 am **One scenario for 2010:** presentation
A talk through the scenario for 2010. How to link roles and scenario.

10.00am **Questions:** plenary
Question and answer session on the technique. An opportunity to voice problems from evening discussions or queries from the event's papers.

SESSION 4: ROLES (one and a quarter hours)

10.15am **Visualisation:** plenary
An exercise to visualise yourself in your new role and experience the future.

10.30am **Role groups:** group work in four *role* groups
Clarify what you like and dislike about this role; in what way were your motivations and passions expressed or constrained? The group prepares a FIVE minute feedback to the plenary in the afternoon, using any means except flip charts, to give the flavour of the experience.

11.30am Coffee

SESSION 5: PRACTICES (one hour)

11.45am **My general practice in 2010:** group work in *practice* groups
Participants break into new practice groups of 4 members, each consisting of one of the four hypothetical roles.
Share insights from previous role group, and explore consequences for your hypothetical practice, of having these four role functions. Practices may choose to have the roles represented in their primary health care team, or envisage the functions elsewhere in the community, or even dispense with the role. Discussions then can consider issues such as professional ethics, accountability, working relationships and leadership.

12.45am **Lunch**

WEDNESDAY 29th MARCH Afternoon:

SESSION 6: SYNTHESIS (one hour)

2.00pm **Feedback:** plenary presentations

Participants return to the role groups.

Four 5 minute role presentations from Session 4, without using flip charts.

2.20pm **Reactions:** plenary discussion

Individual comments from session 5, reactions to Feedback.

SESSION 7: REFLECTIONS (one and a half hours)

3.00pm **Individual Futures:** group work in original *local* groups

An exchange of ideas about:

How to link individual motivators and passions to the future

The value of the hypothetical roles - are any worth developing, and how?

Are there any roles omitted that might be useful?

How did this workshop influence your views about the future of general practice, and your role in it?

What are the individual steps to move from the present to the desired future?

4.00pm **Conclusion:** plenary

Has the technique been useful?

Should it be adapted or disseminated?

Where now?

4.30pm **Tea**

APPENDIX

A DAY IN THE LIFE OF A GP 2010
THURSDAY 6TH OCTOBER
REPORT OF PROCEEDINGS

1.0 Introduction.

This meeting was the first of three, using future scenarios to test a workshop process as a way of defining preferred futures for general medical practitioners.

This report is an internal King's Fund Centre commentary written to enable the primary health care group to reflect on perspectives of the first meeting to inform the process of holding the next two.

2.0 Attendees

The choice of 'maverick' individuals with active imaginations may have led to an excessive focus on certain individual's agendas especially in group work. Some participants would have preferred a move typical group of GPs. This may have implications for the generalisability of the outcomes of the workshops. Anecdotally a number of participants questioned the purpose of the meeting, which the felt was for the centre's benefit, rather than assisting their own development, although it was generally well enjoyed by those to whom I have spoken since. Some commented on its remoteness from current day practice, and that they did not feel enabled to visualize a path from the present to any of these futures.

Despite considerable efforts, the failure to attract many GP trainees was unfortunate. There might have been added benefit had there been stronger educationalist voices from both undergraduate and postgraduate sectors.

As far as I know all FHSAs agreed to reimburse attendees for surgery sessions, but this did not prevent some prospective attendees from not coming due to difficulty, finding suitable locums.

3.0 The Programme

The timing of the sessions appeared to be a little difficult, with a feeling of insufficient time in the afternoon especially for the last component of session 3. There was little opportunity to apply the thinking of session 1 in the final session, which partly was a result of lack of time, and partly the structure of the last session.

The opportunity to gain participants' evaluation of the process was not provided at the end of the meeting. Nor were participants greatly assisted in taking forward the thinking from the workshop, into their work environment.

4.0 Session 1

Diane's introduction hit all the right notes and was clear and suitable length.

An atmosphere of informal discussion was provided, but the freedom to roam beyond the motivations and fulfilments of practice, may have diminished the individual value of this session. A more structured one in which individuals were facilitated to formulate their own, motivations and passions and in which contributions from all members of the group were balanced by a facilitator, may have been preferable. It may also have enabled the session to be shorter.

A number of contributions were negative, lamenting the current state of general practice. Encouraging participants to structure well formed outcomes for themselves, expressed in the positive would have helped relate this session into the rest of the proceedings.

4.1 Session 2

The coffee break was taken at a time which resulted in the need for many participants to have another unscheduled comfort break for the loo, just before entering groups in session 2.

The introduction by Martin was too complex and conceptual for some participants to grasp. Terminology was unfamiliar and words such as 'scenario' and 'role' were used liberally, but more precise usage would have helped clarity. Confusion about whether the future roles were in any way related to personal motivators, and about the possibility of their being full time part-time or temporary was not adequately resolved before the group work began. The exercise may have been aided by talking about possible future career structures for GPs that were externally consistent. The relationships between the four future roles required more fleshing out to boost their plausibility and integrity. For example if primary care is to be the future centre of purchasing,the nature of the contributions of the CEO and development manager could usefully be sharpened. "...Managing a system of subcontracts..." is probably not very meaningful to participants and on one reading could be the micro-purchasing which the development manager is leading.

The hypnotic plenary visioning introduction was well written. It would have been more vivid and productive had there been discrete physical areas where each of the groups of new roles could aggregate and sense the new future. It was a mistake to change people's roles, to alter numbers in groups, after this exercise. This could be psychologically disturbing and demotivating. One possibility that may be worth considering is the allocation of participants to role groups in the coffee break, based on their individual motivators. If facilitators in session 1 were asked to classify elements of individual aspirations into one or more of the four roles, the group work in session 2 might be enriched by the ability of participants to associate with the future, rather than some having to dissociate to envisage their new role. Otherwise "staying true to oneself" may be impossible.

The descriptions of the roles by staff as the outset was both entertaining and helpful. However, they varied in depth and detail. It appeared that the roles of health councillor and development manager/ care shaper might have benefited from

further definitions. The possibility of breaking into groups between these presentations and the hypnotic visualisation would enable the tailoring role of the visualisation exercise to each different role group, which may be more powerful.

4.2 Group Work

The group work appeared to work well. However certain individual agendas dominated some groups any may have excessively coloured the final presentation. A number of participants ignored the background paper in considering their future roles. Ways needed to be found of enabling the linking of the context with functions of future roles. Perhaps providing a summary of the change areas in the future context, which participants should be asked to incorporate in their visioning and group work would be helpful.

4.3 Plenary

The plenary feedback was an outstanding part of the workshop. The imaginative requirement for this to be without visual aids generated valuable creativity. An opportunity needed to be provided in the programme for reflection on these in plenary. Two particular possibilities emerge. The first is the significance of the differing styles and tone of feedback. The fact that the CEO group argued about how they were going to present their adversarial role play, and that poetic peace was found in the clinical servant role, deserved exploration. Participants could have been asked to study particularly the actors non verbal language to draw impressions of the congruity and fulfilment in the role. Secondly the possibilities of exploring the inter-relations between these roles, and perceived conflicts particularly raised by the health councillor group, could have been very helpful in organizing individuals thoughts and feelings, before going into the final session.

5.0 Session 3

John's presentation, and in particular his funnel, were found to be a very helpful way of looking at things by a number of participants, but this session appeared to be confusing and rushed for some participants. At times it seemed unrelated to earlier work in the workshop. It needed a process which enabled that work to be fed into it. Despite the restated objectives to "Hold onto what is important" and "define robust things to protect general practice of the future", I am not sure these were fully met! A useful number of practical suggestions and steps (eg. stop the RCGP producing any more policy papers!) were mixed with generic issues (eg. putting trust back into the system) but little emerged about the shape of desired futures. Nevertheless, there were emerging currents around more education and less training, change management, explicit decision making, local strategies to reverse the inverse care law and skill mix reviews, which may be key building blocks.

6.0 The difficulties is this last session may reflect some unresolved tensions in the design of the workshop. There is a desire to characterize and vocalize any emergent futures that have support, but at the same time to enable every individual participant to gain clarity about their own future. It may be the workshop fell somewhere between the two, and that by sharpening its educational and other objectives, we can make the last session a more usable framework.

Overall the workshop was successful and enjoyable and merits repeating elsewhere. The process of sharing the organisers perceptions is important before proceeding to further events, as some aspects may merit redesigning.

Andrew Harris
26 October 1994

GP 2010 - EVALUATION FORM

Evaluation of this format for PGEA presents some problems because you have been doing the work. The organising group is most interested in what did and didn't work and what you feel you got out of the event. Therefore, with apologies to Roger Neighbour and 'The Inner Consultation' we would be grateful if you could fill in the boxes (1-5 where 1 = awful and 5 = excellent) and add free text if you are so inclined in the spaces available.

Goal setting (Sessions 1 and 2, Tuesday evening)

Interest 3.9

Usefulness 3.5

Good things .....

.....

Bad things .....

.....

Skill building (Sessions 3, 4 and 5, Wednesday morning)

Interest 3.9

Usefulness 3.5

Good things .....

.....

Bad things .....

.....

Getting it together (Sessions 6 and 7, Wednesday afternoon)

Interest 4.1

Usefulness 3.9

Good things .....

.....

Bad things .....

.....

Any other comments .....

.....

A DAY IN THE LIFE OF A GP - 2010

Free text comments from evaluation questionnaires

Goal Setting (Tues eve)

Good things

Great group - time to think about what we do and want and what our roles are.

Made me feel positive, ie reinforced my belief that GP is still a good career choice.

Set the scene and then left enough time (afterwards and overnight) to let the roles sink in.

Small group - easy meat - relaxing time to talk.

Insight into morale of other local GPs.

Focusing

Time out. Chance to vision.

Presentations by four individuals were very helpful in clarifying the roles and eating in role groups facilitated wide-ranging discussion.

Just stepping back and thinking about my role.

Using local individuals to present roles.

Bad things

Another evening meeting.

Not enough focus of end points. What did you want? Why are you here? 'If this had been a successful meeting what would have to have happened?'

The future? Still feel very pessimistic.

The original role descriptions somehow did not convey the 'feel' of the roles accurately. (Or is this just my perception?)

Big group. ? enough brief ice breakers - we didn't all know each other.

A bit dry.

To set a scenario of generalised disillusionment as motivation for attendance was misjudged in this group.

Difficult to grasp the general future scenario. Failure to book vegetarian food for dinner.

Skill building (Wide ou)

Good things

Day out. Intellectually stimulating. Enjoyed the release the fantasy gave me to gloss over practical problems.

Visualisation was good. Variety of thoughtful ways of getting us to think. Helpful to talk to real live care shaper.

Took me out of reality.

Excellent process with the 'disjointment' from current role.

Guided fantasy.

Interesting intellectual exercise.

Breakdown of roles and recognition of roles which need to be developed.

Useful to explore issues around bringing four roles together and to see different perspectives of these roles.

Enjoyed exploring different roles when subdivided.

The discussion of what we would like/dislike about the roles was very interesting.

Abstracting - getting totally away from present allowing greater imagination.

Bad things

Worries about things left undone in the practice. 2010 didn't seem far enough ahead.

Took me out of reality.

To regularly slip back into reality.

Slightly more guidance and health service funding/organisation possibilities would have speeded discussion up.

Not sure what skills focusing on, needed to be pitched further ahead than 2010 and more visual.

Role conflict exaggerated.

Roles changed as scenario changed (nothing can be done about this as scenario cannot be set in stone).

One of the difficulties in the practice groups was that we ended up discussing each other's roles and disagreeing about these rather than seeing how we could fit together.

Getting it together (Weds pm)

Good things

Coming full circle to appreciate what's good/not so good at present. Being given the definite scenario and seeing its pros and cons enabled us to consider a model future.

Fun, enjoyed creative feedback, discussion.

Time for reflection.

Presentations were fun. Good to reflect on connection to present.

Looking forward.

Regeneration of holistic GP.

'What is the future?' Suddenly a realisation that life may not be the same in 15 years, if it isn't, how to be in control of changes - not to lose contact with patients and only be concerned with 'overview' and management.

Meeting together with like minded doctors.

Feedback session very entertaining but also quite illustrative.

Making up and seeing sketches.

Bad things

Found it difficult to link it with everyday practice.

Left nothing hanging in the air about the way forward for individual/profession.

Ran out of agenda by 3 pm.

Probably not enough chance to discuss how we could fit some of the ideas into our own practice or individual life.

Cynicism and negative feelings of some of the scenarios.

Any other comments

Great to have the opportunity to think for once and condense out our own feelings/views etc.

Thanks.

Could have done more on 'What you might' take away.

Correct about it not being London.

More on what we made of it.
Yes, helpful to have presentations of roles.

Thank you.

Different.

Very enjoyable course - certainly improved morale about the future.

Healing (and lack of it).

Poor venue and meals. Everything else good.

Link in (at end) to our own personal development.

Left rather hanging in the air about the way forward for individual/profession.

Pretty awful food.

The 'fishbowl' process at the end was very helpful - to see what was 'behind' the design of this exercise.

We should meet again in 2010!

Enjoyed the day and a half.

Might have been good to have more personal introductions - by the end of 1½ days there were still people I hadn't spoken to/didn't know anything about.

Idea of letting us watch the King's Fund discussion very positive.

THE KINGS FUND TEAM

Martin Fischer
Pat Gordon
John Harries
Andrew Harris
Diane Plamping
Gina Shakespeare

King's Fund
54001000671258
20000 048572 020C