

Article title:

Subjunctive medicine: enacting efficacy in general practice

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Abstract

Modern general practice is complex. Issues such as multimorbidity, polypharmacy and chronic illness management can make applying myriad single condition evidence-based guidelines increasingly difficult. This is compounded because the problems presented in general practice often require both clinical and social solutions. In response to these issues, generalist clinicians are now expected to practise ‘person-centred care’: enabling and empowering patients by combining the technical rationality of medical science with individual values, needs and preferences. To explore this difficult undertaking we conducted an ethnography of a general practice surgery in England, including participant observation, interviews, and focus groups with patients, clinicians, and support staff, from February 2018 to March 2019. Our findings suggest that clinicians in our study faced considerable constraints, broadly conceived as the limits of biomedicine and the structural constraints of general practice. However, they mitigated these by getting into good habits, which we conceive in two categories: using expert judgement and taking patients seriously. We further propose that clinicians did not merely will themselves towards these good habits but developed and adapted them by intuitively adopting a second-order ‘meta’ habit of *enaction* – treating each consultation as collaboratively co-created anew. This suggests an important feature of the general practice consultation: it is conducted as much in the subjunctive as the indicative mood. Developing this proposition, we propose a more general form of medical practice – *subjunctive medicine* – extolling the value of the co-created social order of the general practice consultation itself. We suggest that practising subjunctive medicine may help clinicians sustainably and resiliently achieve the aims of person-centred care in modern general practice.

Key words

England; person-centred care; general practice; ethnography; grounded theory; enactivism

Introduction

Modern general practice is complex (Procter et al., 2014; Salisbury et al., 2013). Uncertainty is widespread as generalist clinicians must “bring together the amazing products of specialised analysis into clinical synthesis appropriate to the usually unique requirements of real people leading independent lives.” (Tudor Hart, 2010, 106). Underlying this challenge are issues such as multimorbidity, polypharmacy, and chronic illness management (Barnett et al., 2012; Bodenheimer et al., 2002; Duerden et al., 2013; Huntley et al., 2012; Salisbury et al., 2011), which can make applying myriad single condition evidence-based guidelines more difficult (Greenhalgh et al., 2014; May et al., 2006; Montgomery, 2006; Rapley & May, 2009; Timmermans & Berg, 2003). These issues are compounded because the problems presented in general practice often require both clinical and social solutions (Elwyn et al., 2014; Tudor Hart, 2010).

In response to these issues, generalist clinicians are now expected to enable and empower patients by combining the technical rationality of medical science with individual values, needs and preferences. This difficult task is increasingly conceptualised through the framework of person-centred care. The importance of person-centredness has long been acknowledged, most notably through the concept of patient-centred medicine. In 1969 Edith Balint explored the possibilities of patient-centred medicine in general practice, noting that the patient “has to be understood as a unique human being” which necessitates the clinician opening up to the varieties of ways they can interact with the patient (Balint, 1969, 269). Patient-centred medicine has subsequently been explored and conceptualised in terms of a biopsychosocial perspective, shared decision making, and the therapeutic alliance, among many other factors (Langberg et al., 2019; Mead & Bower, 2000).

A more recent return to understanding and harnessing these factors – spearheaded by the University of Gothenburg Centre for Person-Centred Care (GPCC) – has informed a shift in terminology from patient- to person-centred care. This is not merely a verbal dispute. The GPCC explicitly make the terminological move to acknowledge that a ‘*patient-centred*’ focus, although well-intentioned, still contributes to objectifying patients and reducing them to their diseases (Ekman et al., 2011). The turn to *person-centredness* is characterised by a focus on practice, empowerment, the coordination of care, and the centrality of developing and maintaining interpersonal relationships (Britten et al., 2017; Hardman & Howick, 2019; Langberg et al., 2019; Scholl et al., 2014).

Given evidence that improved access (Campbell & Salisbury, 2015), more continuity (Aboulghate et al., 2012; Haggerty et al., 2003; Worrall & Knight, 2011), and a better patient-clinician relationship (Barry et al., 2001; Jensen & Kelley, 2016; Kelley et al., 2014; Little et al., 2001; Ong et al., 1995; Stewart, 1995) improve treatment outcomes, it is logical that general practice should be person-centred. In the UK, person-centred care has now been institutionally recognised insofar as it is embedded in guidance from the Royal College of General Practitioners (2018) and the Royal College of Physicians (2018). However, in modern general practice, clinician workload continues to rise (Hobbs et al., 2016; Paddison et al., 2018), continuity of care is declining (Levene et al., 2018), and a large minority of patients are not regularly able to see their preferred GP (Aboulghate et al., 2012; Campbell & Salisbury, 2015). These challenges make practising person-centred care increasingly difficult.

In response to this issue we conducted an ethnography of a general practice surgery in southern England, exploring how person-centred care is achieved regarding long-term conditions. With respect to person-centred care, our aims are to: identify the relevant processes and practices of clinicians; explore the views and experiences of patients and

clinicians; and generate theory on how person-centred care is achieved in modern general practice.

Methods

Methodology

Our methodology was ethnography, which involves sustained participation and observation in a community (Charmaz, 2014; Eriksen, 2010; Pope, 2005). We adopted the following definition of ethnographic work: data collection is conducted in natural settings, uses a range of sources, and is in-depth and relatively unstructured; and data analysis is focussed on interpreting human actions and practices in their socio-cultural context (Hammersley & Atkinson, 2007). Our ethnography was situated in a theoretical framework of American pragmatism whereby inquiry is fallibilistic and focussed on conceived practical effects (Dewey, 1925/2013; Misak, 2013; Peirce, 1878/1982).

Study setting

The study was conducted from February 2018 to March 2019 at one general practice surgery in a small market town in southern England. The surgery was selected, through the local Clinical Research Network (CRN), to ensure it was large enough and provided enough services to constitute a sizeable community for investigation. The surgery has approximately 8000 patients and serves the town and surrounding area with a range of general medical services and specialist disease management clinics. At the time of the study it had eight General Practitioners (GPs), three nurses, two Health Care Assistants (HCAs), and a team of administrative support staff. Due to part-time working the GP full-time equivalent (FTE) at the time of the study was five. Given the population it serves, this was slightly above the average in England, which is 0.58 FTE GPs per 1000 patients (NHS Digital, 2019).

Data collection

The first author (DH) conducted all study data collection, primarily through participant observation. This included 100 consultations between clinicians and patients, and over 300 hours of observation in the wider surgery, including in administration areas, the staff room, and the patient waiting room. Observations were recorded in hand-written notebooks. We term our mode of observation ‘participant observation’ to acknowledge that the presence of the observer in any situation alters the data collected. In practice, the role of DH was more or less participatory depending on the situation.

We also conducted interviews and focus groups. DH conducted six audio-recorded semi-structured interviews with clinicians at the practice, including three GPs, two nurses, and one HCA. Each interview lasted approximately one hour. DH also conducted three audio-recorded focus groups with practice patients, which also lasted approximately one hour. The interviews and first focus group were conducted using a topic guide. In the latter two focus groups participants were asked to discuss four vignettes, which were developed by the research team based on emerging study findings. The focus groups comprised 9, 2, and 5 participants respectively.

In line with ethnographic best practice we used a combination of sampling techniques: convenience sampling for observations (including consultations), and purposive and snowball sampling to identify potential interview and focus group participants.

Data analysis

We conducted abductive analysis informed by constructivist grounded theory, in which data collection and analysis occur iteratively (Charmaz, 2014; Reichertz, 2007). We used grounded theory to focus the analysis of our ethnography towards theory generation (Charmaz, 2014; Timmermans & Tavory, 2007). Fieldnotes and audio-recordings were

transcribed for textual analysis. DH then conducted initial coding, followed by focussed coding and the creation of categories (significant focussed codes or further interpretations of those codes). Data were compared with emergent categories using the method of constant comparison (Glaser & Strauss, 1967/2009). Data discussion sessions and memo writing were conducted by the research team to develop theoretical concepts and the study line-of-argument. The backgrounds of the participant observer (social scientist) and the remaining research team (two social scientists and one clinical lecturer/practising GP) are likely to influence the data analysis and thus must be considered when reflecting on the findings.

Ethics

General ethical guidance was taken from the Association of Social Anthropologists' (2011) Ethical Guidelines, and the British Psychological Society's (2009) Code of Ethics and Conduct and (2011) Code of Human Research Ethics. All participants consented to their confidential data being used in the study, either verbally or in writing depending on the situation, as per the approved study protocol. Regarding those who gave written consent, patient participants are numbered (P1, P2, etc.) and staff participants are numbered (S1, S2, etc.). The study was approved by the University of Southampton, Faculty of Medicine Research Ethics Committee, given favourable opinion by the Proportionate Review Subcommittee of the National Health Service (NHS) Yorkshire & The Humber - Bradford Leeds Research Ethics Committee, and given final approval by the NHS Health Research Authority (HRA), project number 230742.

Findings

Our findings suggest that clinicians are confronted with considerable constraints in general practice, which we broadly categorise as the limits of biomedicine and the structural constraints of general practice. We outline how these manifested in our study before

describing how clinicians mitigated them. To anticipate, we frame this account as how clinicians developed good habits, conceived in the two broad categories of using expert judgement and taking patients seriously. We further suggest that clinicians developed those habits through the intuitive use of a second-order ‘meta’ habit of *enaction*, insofar as they conceived of the consultation as collaboratively brought into being with the patient. This, we propose, suggests the general practice consultation is conducted as much in the subjunctive as the indicative mood. We develop this proposition into a form of medical practice we term *subjunctive medicine*, which may help clinicians sustainably achieve the aims of person-centred care in general practice.

Confronting constraints

As outlined in the introduction, there are considerable constraints in general practice. Our findings reflect much extant literature insofar as these manifested in our study in two broad categories: *the limits of biomedicine* and *the structural constraints of general practice*.

The limits of biomedicine

It is uncontroversial to state that general medical practice extends beyond our understanding of biomedical mechanisms and single disease aetiologies (Howick et al., 2018; Little et al., 2001; Tudor Hart & Dieppe, 1996; Van den Bergh et al., 2017). This manifested in our study in various ways. First, through the need to consider the irreducible interconnection between a patient’s health and their broader life. For example, when a GP assessed a patient with Parkinson’s regarding his Heavy Goods Vehicle driving license – “*so, history of neurological disorders. That’s a yes unfortunately.*” (S13, consultation) – both parties knew it may eventually lead to the license being withdrawn and the patient losing his job. Or when a GP (S9, consultation) delivered a difficult diagnosis of a rare, genetic condition.

Consultation extract 1

“It probably is polycystic kidneys, I’m afraid it does look like that... I’m sure all sorts of things are going through your mind.”

“I know it can’t skip a generation, I’m sad for my boys”, replied the patient (P23), who initially bracketed the physiological effects of the disease, thinking first of the consequences for her children.

Second, complex problems such as chronic illness management, multimorbidity and polypharmacy were major challenges for clinicians and patients in our study. For example, a patient (P12, consultation) with diabetes who indicatively noted that “*at the moment I’m really struggling*”, and that “*at certain points it does get me down, feeling I have to be good all the time*”. In coping with multiple conditions over long periods, patients often ended up taking many different medications, which as a nurse (S7, interview) noted “*is difficult*” because “*if you read the side effects of medications, quite often they cause what you’re actually giving them for*”. These problems are unsurprising given research in primary care shows that patients with two or more chronic morbidities are now the norm not the exception (Barnett et al., 2012; Huntley et al., 2012; Salisbury, 2012; Salisbury et al., 2011).

These issues can also create tension between a patient and clinician as each may be pursuing divergent agendas, as demonstrated in extract 2. This can significantly impact the potential for person-centred care as, despite good intentions, it can undermine interpersonal understanding.

Consultation extract 2

The patient (P16), leaning heavily on his stick, entered the consultation room and sat in the chair adjacent to the GP’s (S13) desk. Each of the patient’s black shoes was fastened with a thick Velcro strap. He had come primarily to discuss his blood pressure.

“It was a while back” said the patient, “you said it was dodgy, I said it was alright! Same conversation!”

“You’re on fairly substantial drugs to treat your blood pressure” replied the GP, before discussing the potential options available. “Do we add in more? Do we hope for the best?”. They talked about previous readings and how one was fine with another GP at the practice.

“Which I was surprised about” said the patient, “as everyone is scared of her!”.

“It’s too high [now]” said the GP, “in the context of your diabetes.” They continued the discussion about what to do, including the potential side effects of some proposed changes to medication and dose.

“Worse of two evils!” said the patient. After further discussion they alighted on an agreeable plan.

“We add one on, if I have any problems I come back to you?”

“Ok” agreed the GP as he turned to the computer to check the exact situation regarding the patient’s medication. He stopped. “We’re stuck!” he exclaimed, “You’re [already] on maximum treatment.” There was a pause as both the patient and GP thought it over. “You’re going to have to exercise a bit more instead!”

“I’m knackered with the knees” replied the patient.

“There’s no more drug treatment we can do” said the GP.

The structural constraints of general practice

The limits of biomedicine are well acknowledged in general practice. Similarly well acknowledged are inherent structural constraints, notably clinician workload. In this regard, a recent retrospective analysis of 100 million general practice consultations in England showed a substantial increase in consultation rates, consultation duration, and total clinical workload (Hobbs et al., 2016). As one of the receptionists in our study (S20, wider observation) noted, “*I never see [the GPs] stop, they’re here in the morning and after I leave. They are constantly on, they never get any time to themselves*”. This increased workload can be linked to the challenges of multimorbidity and chronic illness management, outlined above: “*Two*

problems” said the GP (S13, consultation) as he typed up the first consultation of a fully booked morning surgery, “*I could have referred the second one as well, but there was no time. I’m already 5 minutes late!*”.

Increased workload informs a central tension that general practice surgeries contend with: balancing patient access with relational continuity of care. At the practice in our study this balance was weighted towards access, with many appointments only bookable on the day. Although in practice receptionists would sometimes transgress, providing flex in the system: “*I’ve done something naughty*” said one (S14, wider observation), booking in a patient for tomorrow’s surgery. “*She’s 93!... I’ll fall on my sword for this one*”.

Getting into good habits

Reflecting much recent research, clinicians in our study faced considerable constraints in general practice. However, they also regularly mitigated these constraints. We suggest they did so by developing and adapting useful socially-shaped dispositions to act: by getting into good habits. We conceive of these good habits in two broad categories: *using expert judgement* and *taking patients seriously*.

Using expert judgement

Modern interpretations of Evidence Based Medicine (EBM) – the dominant paradigm for teaching and practising clinical medicine – have highlighted the need for expert judgement over abstract rule following (Chin-Yee & Fuller, 2018; Greenhalgh et al., 2014; Lown & Peters, 2018; Montgomery, 2006). This partly informs the turn to person-centred care in general practice. Reflecting this development, clinicians in our study used expert judgement in several ways.

Clinicians explicitly acknowledged the uncertainty of general practice and the consequences of this both for themselves and patients. For example, one GP (S8, interview)

indicatively noted that general practice is “*about managing uncertainty and dealing with uncertainty and living with uncertainty*”. This focus on uncertainty is reflected in the findings of an ethnographic study exploring knowledge management in general practice, in which clinicians relied on collective, socially constructed knowledge in practice as much as explicit evidence from research (Gabbay & le May, 2004). For clinicians in our study, a central aspect of dealing with uncertainty was the process of managing expectations.

Consultation extract 3

“Right, ok, I had hoped it might be a bit more positive” said the patient (P40) towards the end of the consultation.

“It is positive!” replied the GP (S13).

“I’m still on crutches.”

“No, no. The pain will get better. You can expect it to get better. The tablets are not for the pain but to reduce the risk of future fractures.”

Consultation extract 4

“I was thinking about an antibiotic!” said the patient (P47), “what do you think?”.

“Good news is that the symptoms are getting better” replied the GP (S9) after a brief examination,

“antibiotics can help, but generally [only] when it’s quite bad... I think I’d probably start on a nasal spray, perhaps hold the antibiotic in reserve?”.

Beyond managing expectations, GPs made a notable effort to communicate not just a diagnosis and treatment plan, but the underlying concept, often using analogy: “*Nowadays, your heart beats a little off. [It] jumps like a clock, which is impossible to show by taking your pulse. The ECG shows that it’s normal. It’s a bit like having a car misfiring*” (S13, consultation).

One GP (S13, interview) noted that not providing a workable conceptual understanding “*encourages paternalism and disenfranchises [patients] from decision making*”. Another (S11, interview) noted that “*if people understand the concepts and understand where you’re coming from, then they’re more likely to self-manage next time*”. Such a focus on self-management was another strategy of clinicians.

Consultation extract 5

“I’ve been doing yoga and meditation” said the patient (P47) in response to her blood pressure coming down.

“I’m quite happy with that!” replied the GP (S9)

“You turn to the alternative treatments.”

“I’d much rather patients adopt lifestyle measures than take tablets!”

Consultation extract 6

“The other thing you can do, if you start exercising it does the same as statins! Takes 4 percent [of risk] away” said the GP (S13).

“What do you mean by exercise? Walking?” replied the patient (P59).

“The rule of thumb is sustained exercise for 20 minutes a day, [whereby you feel] slightly out of breath. Do a bit more, a bit more, and it’s as good as taking a statin.”

“I did try to walk here... stop, go... stop, go.”

“Really good! Keep doing that and it’ll get easier. A lot of your problems are related to being inactive. Changing that will help you a lot.”

One GP (S12, consultation) further suggested that the context and timing of advice is as important as its content: “*She wasn’t quite ready [for an exercise prescription]. We need to get the tests done first. She was thinking it’s a medical problem*”.

Taking patients seriously

Beyond debates on clinical judgement, there are longstanding concerns about the dehumanising effects of increasingly technical medicine (e.g. Busfield, 2017; Kleinman, 1973/2010; Tomes, 2007). These concerns cannot be dismissed but clinicians in our study were acutely aware of them: *“You need to show a bit of sympathy and actually acknowledge why they might be feeling sad, what’s going on, before you then start coming up with solutions”* (S11, interview). In addition to using expert judgement, therefore, clinicians in our study explicitly sought to take patients seriously.

Consultation extract 7

I (DH) knocked on the consultation room door, entered, and perched on the end of the treatment bed, ready to observe. I usually sat in the spare chair, but the next patient would be accompanied.

“How late am I running?” asked the GP (S21), while furiously typing up the notes from his previous consultation.

“About 45 minutes” I replied, glancing up at the clock on the wall.

“I’m asking patients about stuff they didn’t even come in for” he replied, “that’s why I’m running so late I think. I’ve been handing out statins all day!”. He finished typing and called the next patient (P60), who came with his wife. In the context of the summer-long heatwave, the patient was smartly dressed in a white polo shirt, trousers and sandals.

“Did I ask to see you or did you ask to see me?” said the GP.

“You asked us to come in and go through some blood tests” said the patient’s wife. The GP looked briefly at the patient’s records.

“As a set of blood tests you are all good” said the GP, “[but] that’s not the full story?”

“Yes, I don’t feel that good.” said the patient.

“Did you have a specific question?” replied the GP.

“You are getting tired a bit lately” interjected the patient’s wife. The GP took the patient’s blood pressure.

“It’s very rare to pick something up on a blood test. [It could be to do with your] thyroid, [or it could be] anaemia. In your case it could be the Parkinson’s disease.”

“... stuttering...” said the patient, trying to respond.

“It’ll come, don’t worry” replied the GP.

“I can’t get my words out” said the patient.

“It’s ok, it’s difficult” said the GP, before allowing time and space for the patient to speak.

By explicitly acknowledging and accommodating the difficulties of living with Parkinson’s, in extract 7 the GP set the conditions for a good relationship. Later in the same consultation, in extract 8, the GP built on this by acknowledging the difficulty of taking multiple medications.

Consultation extract 8

“You do 10 minutes in the garden” said the patient’s wife, “then you are knackered.”

“If I was to take all the pills you are on I’d be knackered too!” said the GP to the patient.

“I was wondering if it is a combination of any of the tablets?” asked the patient’s wife.

“You’re probably right” said the GP, “for example the beta-blocker, that could make you tired.”

“Is that the one that makes the heart go slower?” asked the patient’s wife.

“Yes,” said the GP “perhaps we’ll keep that one.” Together the GP, the patient and his wife discussed the list of medications the patient was on and the potential for reducing or removing some of them.

The need to take patients seriously also explicitly reflected the views of patients:

If it’s a long-term thing... it’s that sort of connection of ‘take me seriously, this is, this is not doing well’ (P70, focus group).

There is that guilt of like 'hello, yes, it's just me again, and yes, I know I'm saying the same thing again', but it's that thing about, 'but it's serious for me, it's having a big impact on my life and I want it to be taken seriously' (P73, focus group).

A central factor in clinicians meeting this patient need was respecting patients' intelligence and accepting that patients can accrue considerable knowledge themselves.

Consultation extract 9

“And they say you shouldn't self-medicate!” said the patient (P50).

“There's self-medicating” replied the GP (S11), “and there's someone experienced [like you] who understands their symptoms”.

In this regard, clinicians attempted to give patients time to get across their problems in their own words: “*watch carefully, listen carefully, and don't say anything*” advised one (S11, interview) reflecting recent research and guidelines (Kreijkamp-Kaspers & Glasziou, 2012; Phillips & Ospina, 2017).

Beyond respecting patients' intelligence, a crucial factor in taking patients seriously was the establishment and maintenance of trust:

Oh [trust is] crucial. I think the danger is you take for granted how much people trust you... the danger is that the information you've been given, that you're so used to hearing, kind of loses its significance (S13, interview).

You've come out of that door and you know that you've seen somebody that has more experience than you, that has more knowledge than you, that you put your trust in... That they are in it because they really, genuinely want your life to be better (P73, interview).

Trust was vital in allowing clinicians to be frank with patients about possible solutions.

Consultation extract 10

“[Some nights] I just can't get to sleep until 4 or 5 in the morning” said the patient (P32).

The GP (S13) paused. “You won’t” he said, “you have to resign yourself”. This was a consequence of the drugs the patient was on. “The downside is that you’ve got two days a week when you, say, have to get the DVDs in. You have to accept that, be pragmatic”.

Trust also allowed clinicians to admit when they had made a mistake without undermining their relationship with the patient: “*I’ve got a bit of humble pie to eat here today*” said the GP (S11, consultation), “*I didn’t tick all the right boxes... I cocked up. It’s going to need to be another blood test*”.

In taking patients seriously, clinicians set the conditions for making decisions with, instead of for, patients. Such a model of shared-decision making has been promoted to make medical practice more person-centred (Charles et al., 1997, 1999).

Consultation extract 11

“I’m not anxious about getting anything done” said the patient (P40).

“You don’t have to get it done, [but if you don’t] you run the risk of a strangulated hernia. When the hernia gets bigger the nature of the surgery becomes more difficult. [It’s a case of balancing] putting up with your symptoms against running the risk of surgery.” said the GP (S13).

“What happens after the operation? I don’t want to give [my wife] more to do?”

“You wouldn’t be out of action for long, [just] a bit sore for a week.”

“Right, ok, fair enough.”

Indicatively, one GP (S11, interview) thought that it’s “*not about compliance so much anymore, but concordance – the patient and doctor being on the same path*”. He further noted the difference between primary and secondary care, inasmuch as “*you’ve got that opportunity to have a second bite at it rather than having to do it all in one outpatient clinic*”; and the difference between present and previous general practice, inasmuch as “*it used to be the GP for everything, [but] now we’ve got diabetic nurses and COPD nurses, and other nursing staff who are very expert and very good at doing these different things*”. This reflects

sociological research highlighting the distributed and collective nature of modern clinical decision making, particularly in general practice, which suggests that shared decision making can be conceived of at the team as well as the individual level (Clinch & Benson, 2013; Elwyn et al., 2014; Entwistle et al., 2012; Rapley, 2008; Rapley & May, 2009). This is particularly important given the multidisciplinary trajectory of modern general practice (Royal College of General Practitioners, 2019).

Beyond willing

We have illustrated how clinicians in our study mitigated the considerable constraints in general practice by getting into good habits, conceived in two categories: using expert judgement (including managing expectations, communicating concepts, and encouraging self-management); and taking patients seriously (including respecting patients' intelligence, establishing trust, and conducting shared decision making). However, getting into good habits is not easy and clinicians in our study did not merely will themselves towards these good habits, "that notion is magic" (Dewey, 1922/2002, 20). Moreover, different habits are useful in different situations, with different patients, at different times. The good habits outlined previously, therefore, should not be viewed as principles by which to conduct person-centred care in general practice.

If habits are taken to be the vehicles for carrying past experiences into the present – "acquired dispositions to act that we develop as we become adept at recognizing and consistently resolving recurring types of problems" (Welchman, 2010, 170) – then they must be reviewed and adapted as situations change. This means developing multiple, flexible habits that can be used in particular situations; so that, if required, a bad habit can be replaced with a better one. In this sense, what is important is an "increased power of forming habits [which] means increased susceptibility, sensitiveness, [and] responsiveness." (Dewey,

1925/2013, 280). Such a dispositional account in which habits are *flexible* not fixed, accords with Ronald Epstein's (2017, 84) suggestion that "you build the mental muscles to prepare for the moments when you feel the least prepared". This provides a useful balance between the value of the Zen concept of the 'beginners mind' (Suzuki, 1970) on the one hand, and relevant experience on the other.

One way for clinicians to support the development of multiple, flexible habits is the development of a second-order 'meta' habit that "will make us more reflective about our [first-order] habits" (LaFollette, 2000, 409). Through interpreting how clinicians in our study made sense of and accounted for their own practice, we suggest they intuitively developed a meta habit of *enaction*, which informs and guides person-centred clinical practice.

Enacting efficacy

In her ethnography of the diagnosis and treatment of atherosclerosis in a Dutch university hospital, Annemarie Mol (2002, vii) explored how "medicine attunes to, interacts with, and shapes its objects in its various and varied practices". She conceptualised this as "the way medicine *enacts* the objects of its concern and treatment". This captures a sense of clinicians and patients actively bringing the consultation into being together, which defines our proposed meta habit of enaction. For example, consider the effects of two different consultations on changing anti-depressants.

Consultation extract 12

"So you recommend Amitriptyline?" said the patient (P41). "What anti-depressant do you recommend?"

"Fluoxetine... you've had that a long time ago..." replied the GP (S8)

"When I came off it I felt so good... as I had been on it for 20 years."

“... I can't say... I don't know I'm afraid...” said the GP. They talk a bit about tolerance of anti-depressants. “Don't know... has a longer half-life... too quick acting? I don't know.”

“I'm confused, completely” said the patient “about what's the right thing to do.”

Consultation extract 13

“[My occupational therapist] said my depression score was 21. She recommended changing anti-depressants... she recommended that I didn't work through that transition” said the patient (P89).

“It will probably take 6 to 8 weeks to get you settled on a new one” replied the GP (S10)

“I think you suggested Venlafaxine? She suggested [some different drugs].”

“How's your sleep?”

“Not good.”

“Mirtazapine is a good one for the sleep as it's a sedative.”

“I would prefer not to have one that encourages me to put on any weight...”

“I would suggest let's go with the Mirtazapine. [That will] get you into a better sleeping pattern.

Ok, what we would have to do is drop off the Sertraline and get you on the Mirtazapine.”

Uncertainty is unavoidable. But even when the aetiology is not fully understood and the potential treatment only partially effective, the way in which the diagnosis and treatment plan are brought into being is important. For example, in extract 12 the GP reflected the patient's confusion: “*I can't say... I don't know I'm afraid*”. Although by the end of the consultation a treatment plan was agreed upon, the process left the patient unsure of how long she would be on antidepressants – “*will I ever be off them?*” – and struggling for hope: “*I've got a good life, nothing to complain about. I find it strange that I can't get out of it. Why can't my body lift itself out of this depression?*”.

In extract 13, despite being faced with similar uncertainty, the GP gave a clear rationale for the choice of treatment: “*Mirtazapine is a good one for the sleep as it's a sedative*”. The

GP further focussed on elements of the treatment process they could control: for example, the timescale of changing medication, “*you can leave it a couple of weeks if you want? Sertraline works over weeks not days so you may feel some withdrawal symptoms*”; and cultivating the patient-doctor relationship, “*ok, I’ll see you in 4 weeks’ time. Obviously it’s an open door before then if you’re struggling*”. This highlights the importance of not just the diagnosis and treatment plan, but how they are brought into being and how this process is influenced by both clinician and patient.

The importance of how consultations are brought into being also reflects our findings that clinicians broadly viewed success in two ways. First, in terms of biomedical treatment outcomes:

I think [success is based] first and foremost on the outcomes of the consultation. So, the correct diagnosis is made, [and] the correct treatment or investigations are planned (S8, interview).

Well obviously getting somebody better, getting somebody’s blood sugar down, the actual treatment point of view obviously, that’s a successful thing (S7, interview).

And second, in terms of developing shared understanding:

When it feels like you’ve reached a shared sort of place and you’re both singing from the same hymn sheet. When it feels like there was agreement (S8, interview).

I think a successful [consultation], for me, is when somebody is happy to open up and talk, and feels comfortable coming in (S7, interview).

Moreover, as one GP (S8, interview) noted, although “*the two elements to a successful consultation don’t always tally together... the ideal successful consultation would be the one where [they do]*”.

Mol (2002, 32) suggested ‘enact’ is “a word with not too much of an academic history” and that she chose it for that reason. We, instead, ground our choice of enaction more

explicitly in the enactive turn in cognitive science, which conceives of the living body as “a self-producing and self-maintaining system that enacts or brings forth relevance, and that cognitive processes belong to the relational domain of the living body coupled to its environment.” (Varela et al., 2016, xxv). In this regard, sense making in the consultation (and cognition more generally) is an enculturated, creative, and participatory process (De Jaegher & Di Paolo, 2007; Thompson, 2010). The explicitly creative and participatory nature of the general practice consultation was reflected in the views of clinicians.

I may be wrong, completely wrong there, but it's an observation I think [it's like] if you're kind of doing it like you're acting (S13, interview).

I felt entirely during medical school, and ever since, that I was learning to act, that I was learning a role. Definitely. A clinical role. I often find I put on my stethoscope around my neck and it's like a priest putting on his robes or something (S8, interview).

A lady came in last Friday, I knew what she had as soon as she had opened her mouth. But I didn't go 'that's what you've got, here's your information sheet, go and read that and goodbye'. I listened to her, I examined her, although I didn't need to... It's listening to their symptoms, and sometimes playing a part. You know, you act like a doctor (S11, interview).

This suggests an important feature of the general practice consultation: it is not, as might traditionally be assumed, only conducted in the indicative mood (things ‘as they are’). It is also conducted in the *subjunctive* mood (things ‘as if they are’). This, we propose, has implications for achieving sustainable ‘person-centred’ care in general practice.

Subjunctivity

The subjunctive mood is important linguistically as it allows us to meaningfully discuss a situation for which the required antecedents are not necessarily true (if they had done X, then Y would have happened). This is most commonly understood through discussion of counterfactuals. But the subjunctive is not merely constrained to

counterfactuals. The inherent layer of past tense morphology (if they had done...) can also be interpreted modally as an “exclusion feature” (Iatridou, 2000, 246), which “marks the worlds talked about as distinct from the actual world of the speaker” (von Stechow, 2012, 475). This is vital for thinking beyond what is directly in front of us as it allows the consequent of a conditional to be seriously considered even if the antecedent does not hold outside a particular situation, through what is termed *subjunctive conditionality*. The anthropologist Terrence Deacon (1997) goes so far as implying that this marks humans out as a symbolic species, allowing us to think imaginatively.

Such broad anthropological interpretations notwithstanding, in the context of general practice, subjunctive conditionality means that good interpersonal understanding between patient and clinician (the consequent of a conditional) can be seriously considered even if the clinician being genuinely engaged (the antecedent) does not hold outside the consultation (the particular situation). In the subjunctive mood it does not matter if the clinician is still genuinely engaged out of the practising context; it only matters that they are genuinely engaged during the consultation. To reiterate the words of a GP in our study (S13, interview), it is ok “*if you’re kind of doing it like you’re acting*”. This echoes Byron Good’s (1994, 153) critical account of medical knowledge and practice, in which a “subjunctive world” is important because it is one in which “healing is an open possibility”.

The turn towards person-centred care explicitly acknowledges both the patient-as-person and the clinician-as-person. In moving away from a situation in which a patient is “acted on”, person-centred care “highlights the importance of knowing the person behind the patient... in order to engage with the person as an active partner” (Ekman et al., 2011, 249). Such an approach suggests that there is a ‘real’ person hiding somewhere behind the mask of the patient, which if the clinician can discover will lead to connection, opening up myriad possibilities for healing. Although we agree with proponents of person-centred care that the

paternalistic model of acting on patients is misguided, our subjunctive interpretation of the consultation suggests that the person-centred approach has moved too far towards transcendent sincerity – towards searching for unity in a person – which may be restricting clinical opportunities.

Through our modal interpretation “the subjunctive creates an order that is self-consciously distinct from other possible social worlds” (Seligman et al., 2008, 20). This allows the clinician to act differently in the consultation than they would elsewhere, which may be beneficial for the patient. As nurse in our study (S7, interview) noted, “*I’m not a different person... I’m [just] perhaps a more confident, knowledgeable version of myself than I am at home*”. And as a GP (S13, interview) suggested, “*you can never sort of get into a rut and do the same thing every day. You’ve got to be imaginative with how you approach people*”. In his account of the human seriousness of play Victor Turner (1982, 93) conceived of this ‘acting differently’ – of the importance of our imagination – as “*poiesis*, rather than *mimesis*: making, not faking”. This meets our Deweyan notion that habits, being flexible not fixed, are creative and transformative.

Furthermore, if we accept the proposition that consultations are collaboratively enacted, then we also don’t want the *patient* to be as they are outside the consultation either. It is beneficial if, in some way, they play their role too. Not the Parsonian role of the docile patient to be ‘acted on’, but the engaged patient to ‘enact with’. We suggest that by practising subjunctively, clinicians can create the conditions to help patients become what Epstein (2017, 289) terms a “mindful patient”, improving potential for a good treatment outcome. This suggests an interpretation of person-centred care in which the patient-person distinction is not seen pejoratively. By both clinician and patient ‘acting differently’ in a consultation they create a social world which is “temporary, fragile to be sure, but not false – a world

where differences can be accommodated, tolerance enacted (if not fully understood) and openness to others maintained.” (Seligman, 2010, 15). In the words of a nurse in our study:

Because, sitting in here, in my uniform, I'm not somebody just wandering down the street or meeting them in the shop or having a cup of coffee. It's like a closed area, and they can sit and talk to me about things they know won't go beyond the door (S7, interview).

In framing interpersonal relationship building as an imaginative and generative process, subjunctivity may also allow clinicians to be more resilient. As one GP (S13, interview) noted, “GPs who perhaps struggle with projecting something, maybe find the job more stressful... you have to have a persona which you portray, and if you can't do that I think that it would be exhausting and I think it would finish you”. The importance of a ‘clinical role’ is reflected in the views of other GPs who noted the difficulty in offering medical advice outside the clinical setting:

I find it difficult if people tackle me for ad hoc consultations outside of work. I [have to] change from being my usual ‘self’ in society to being my ‘doctoring self’ (S11, interview).

It becomes hard when things overlap, when there's not a clear defining line. So, for example, if a family member asks you a medical problem, that's a difficult one (S8, interview).

Moreover, clinicians did not take ethical issue with the adoption of different clinical roles insofar as they did not see it as a form of deception. As a HCA (S4, interview) noted, “I don't think I'm consciously trying to play out, you know, like some sort of role. But I think, just by putting the uniform on, you are in a different role”. And as a GP (S13, interview) reflected, “there's an argument that you lose some sort of social integrity in a way [by acting differently in different situations], but then I think actually that's who you are, your ability to do that makes you who you are so it doesn't really matter in that sense”.

Subjunctive medicine

By conducting consultations as much in the subjunctive as the indicative mood, clinicians in our study did not imitate their role but constantly re-made it through collaboratively enacting each consultation anew. We term this mode of clinical practice *subjunctive medicine*, and suggest it may be a useful way to sustainably develop the multiple, flexible habits necessary to achieve the aims of person-centred care in general practice. To summarise, we propose three principal actions that comprise subjunctive medicine.

1. Conceive of each consultation as collaboratively enacted anew.
2. Exploit the importance of the imagination in developing interpersonal relationships.
3. Explicitly adopt a clinical role to improve resilience.

To conclude our analysis, we discuss subjunctive medicine with respect to the interpretation of person-centred care promoted by the GPCC. Established in 2010, the GPCC aims to develop and implement person-centred care in clinical practice through three action-oriented regimes focussed on initiating, working, and safeguarding the patient-clinician partnership (Britten et al., 2017; Ekman et al., 2015; Ekman et al., 2011). Central to this approach is the importance of eliciting the patient's narrative, putting their views at the centre of care (Ekman et al., 2011). Given Rita Charon implicitly alludes to subjunctivity when describing the effect of acting with narrative knowledge in healthcare – “with such knowledge, we enter others' narrative worlds and accept them – at least provisionally – as true” (Charon, 2006, 10) – we suggest that practising subjunctive medicine may be a useful way to achieve such narrative-focussed person centred care. Furthermore, in a key GPCC paper, Ekman et al. (2015, 1) note that the “co-creation of care between the patients, their family and carers, and health professionals is the core component of person centred care”.

Such co-creation, we propose, is best achieved not through the narrow ‘sincerity’ of the indicative, but through the open imagination of the subjunctive.

Strengths and limitations of the study

The in-depth fieldwork permitted a deep understanding of the specific general practice environment, which aided and informed theory generation. However, the general practice surgery in this study has a slightly lower than average list size, and is located in a small market town with low deprivation and a relatively socio-culturally homogenous population. Further, due to ethical concerns consultations booked on the same day were not included in the study. These issues must be considered when interpreting the findings more widely.

Conclusion

Based on an ethnographic study of person-centred care in a general practice surgery in England, we highlight the considerable constraints facing clinicians – broadly categorised as the limits of biomedicine and the structural constraints of general practice. We suggest that clinicians mitigated these constraints by getting into good habits, conceived in two categories: using expert judgement, and taking patients seriously. We further propose that clinicians did not merely will themselves towards these good habits but established and maintained them by intuitively developing a meta habit of *enaction*. This suggests that the general practice consultation is conducted as much in the subjunctive as the indicative mood. Developing this proposition, we propose a more general form of medical practice – subjunctive medicine – extolling the value of the co-created social order of the general practice consultation itself. Given the conditions and constraints we outlined in our introduction, we suggest that practising subjunctive medicine may help clinicians sustainably achieve the aims of person-centred care in modern general practice.

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