Reflections on contemporary medical professionalism; an exploration of medical practice as refracted in doctors' narratives

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy

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Declaration

I confirm that this thesis is the result of my own work. The material contained within the thesis has not been presented either wholly or in part for any other degree or qualification. The use of all material from other sources has been properly and fully acknowledged.

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List of Abbreviations

BBC	British Broadcasting Corporation
BMA	British Medical Association
BMJ	British Medical Journal
CPD	Continuing Professional Development
DGH	District General Hospital
DoH	Department of Health
EBM	Evidence Based Medicine
EWTD	European Working Time Directive
FTE	Full-time Equivalent
GDP	Gross Domestic Product
GMC	General Medical Council
GMSC	General Medical Services Committee
GP	General Practitioner
HA	Health Authority
IT	Information Technology
JCPTGP	Joint Committee on Postgraduate Training for General Practice
JHO	Junior House Officer, a position of provisional medical registration
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NPfIT	National Programme for Information Technology
PCO	Primary Care Organisations
PBC	Practice Based Commissioning
PN	Practice Nurse

QOF	Quality and Outcomes Framework
R&D	Research and Development
RCGP	Royal College of General Practitioners
RCP	Royal College of Physicians
REC	Research Ethics Committee
SWRG	Self-Regulating Work Group
UK	United Kingdom
VTS	Vocational Training Scheme
WHO	World Health Organisation

Chapter 1

Contextual background to working in the UK National Health Service

"The NHS is a national success story. It is woven into the fabric of our society, and is a public expression of our social values. It is part and parcel of our national DNA. It touches all of us and all of us have a stake in its future."
David Nicholson, Chief Executive of the NHS in England, Dec 2011

1.1 The UK National Health Service; a national institution and a workplace.

When examining the lived experience of National Health Service (NHS) doctors in the UK, knowledge of characteristics of the NHS as an organisation and a workplace is a necessary prerequisite to viewing these experiences in the contexts which influence how they are formed (Buddeberg-Fischer et al., 2005, Chou and Robert, 2008, Ma and MacMillan, 1999). Important organisational aspects can be considered as those relevant to clinical activity, the funding of health services and political influence on the provision of health care.

Clinical activity

Direct contact between the public and health service staff can be gauged in part by the frequency with which services are accessed; records indicate that almost 3 million hospital admissions occur annually (H M Government, 2013) together with 73 million annual outpatient attendances (H M Government, 2012). With an annual estimated 300 million consultations with clinicians in general practice, it has been computed that on average each NHS patient makes use of primary care services on five occasions each year (UK Parliament, 2009).

Yet while figures confirm the significance of NHS-related activity in managing health needs, they inevitably encompass a wide range of interactions in which the impact and intensity of contact remains unclear. Individual accounts from patients have presented varied reports of medical contact including difficulty gaining access to services, receiving mixed responses from clinicians, and by providing perspectives of experiencing illness serve the dual purposes of informing other patients and providing insights on which NHS staff can build improvement (Hawkins, 1999, Wilcock et al., 2003, Bridges and Nicholson, 2008).

Financial investment

The magnitude of government spending on the NHS offers an additional indication of the scale of activity; annual expenditure on the NHS exceeds £100 billion (H M Treasury, 2013) which equates to around 8% of GDP (Appleby, 2013). Due to this vast expenditure by a complex organisation which is the chief provider of comprehensive health care healthcare under the NHS Constitution (Department of Health, 2013), and consequent on funding by public taxation, performance standards and effectiveness in the NHS are of vital public interest and under scrutiny by the NHS Confederation (NHS Confederation, 2011).

Political interest

Political manifesto statements on future plans for the NHS have reflected the perceived importance of universal health care to both prospective governments and the electorate (UKIP, 2010, The Green Party, 2010, Liberal Democrats, 2010, The Labour Party, 2010, The Conservative Party, 2010). Positions have been taken on matters including; levels of spending, promotion of greater choice for patients, retention of locally available services and required standards of performance and training, but always expressing intentions to retain and improve upon a universally available NHS. In recent years, where acceptable delivery of care has failed on a large scale, Public Inquiry investigations have examined witnesses to discover reasons for failure, seeking to understand whether attributable to factors such as

established practices, errors of judgement, service provision, or cultural norms could be identified and corrected (Francis, 2013, Bristol Royal Infirmary Inquiry, 2001).

Cultural expectations

Historical roots created a foundation for a 21st century NHS since, during its continual evolving course since 1948, earlier and later generations of NHS staff have trained and worked together. Progressive NHS modernisation which shaped the career experience of individual doctors has been accompanied by alterations in prevalent attitudes to health and to professionalism within society while underlying cultural norms of the NHS have been characterised in general terms by staff or others with close NHS links (Wakefield, 2000, Abbasi, 2011, Hanna, 2008). Since development of locally acceptable practices including bullying and a lack of transparency have been implicated in poor performance in Mid-Staffordshire, a general picture across the service could potentially furnish better understanding of interpersonal dynamics and how these might impact more widely on health service delivery (Francis, 2013).

Altered clinical priorities

One aspect of modernisation has been increased emphasis on health promotion which was not apparent at the inception of the NHS and followed advances in medical science and changing political goals (Rivett, 1998). As the NHS has evolved from an expected role of responding to conditions presenting as established illness, staff embraced new priorities such as risk assessment and disease prevention in populations and for specific conditions (Health Development Agency, 2004, Steptoe et al., 1999). Likely implications for those at the forefront of delivering a new emphasis on health promotion included constantly updating knowledge and providing pro-active healthcare while maintaining provision of necessary services. Perceptions by some doctors that opportunistic health promotion may not be effective contrasted with other views of health promotion as part of doctors' duty to the greater community (Robson et al., 1994, Butler et al., 1998).

While it is difficult to gauge generalizable public views regarding ongoing provision of comprehensive services, political positioning and public survey evidence suggested that, despite criticism, the NHS was widely valued and most patients reported general satisfaction with locally accessed services (Mori, 2012); NHS inclusion in the 2012 Olympic Games opening ceremony underlined an already high international profile and was reflected upon as an indication of public appreciation (Scott, 2012, MacDonald, 2012). Perspectives from patient-centred research added knowledge of how the experience of service users was affected by actions and attitudes of staff at all levels, though determinants of organisational culture appeared complex (Konteh et al., 2011, Davies et al., 2000).

Responding to public interest

Other sources of views of health care included literature and visual media which offered storied versions of medical care in controversial circumstances, some having drawn on advice from doctors before broadcasting potentially sensitive health issues or complex medical conditions (BMJ Anonymous, 1980, BBC, 1980, BBC and Troyna, 2002, BBC and Jofre, 2003, Cody, 2004). Medical stories as represented in documentaries and other media continue to supply popular access to observing medical care in action; the success of a recent award-winning documentary, *24 Hours in A&E*, surpassed all predecessors as it exposed patients and staff to public gaze during the 'normal' business of emergency care (Williams, 2011). Recording crews reported experiencing a wide range of emotional responses through witnessing tragedy, tension, determination and service as they followed human relationships captured through camera lenses (Flanagan and Philipson, 2013).

Exclusion of material which may have been deemed unsuitable for broadcast purposes, or for which permission to film was not given, must necessarily be omitted from fictional and factual programmes. Fictional hospital-based soaps reviewed by NHS staff were considered unusually well -staffed by attractive and multi-skilled workers who worked in large calm spaces. Clinical scenarios were judged only partially realistic while manager stereotypes

were portrayed as arrogant and focussed on saving money (Guardian review contributors, 2012).

Perhaps anything unknown holds fascination simply for its enigmatic character, but stronger reasons to take an interest in medical experience lie in an unpredictable but shared dependence on doctors for health care in a society where freely available conventional treatments tend to dominate despite rising numbers opting for complementary and alternative therapies (Ernst, 2000). Naturally, public interest in publicly funded services is linked to accountability and important concerns about loss of trust in the medical profession or NHS following medical malpractice or failings in hospital care are further discussed in Chapter 2.

Interpretations of professionalism

Concepts of medical professionalism evolving over time and interpreted across different cultures and contexts have eluded unified definition as writers attributed key aspects of professionalism with greater or lesser importance (van Mook et al., 2009a, van der Gaag, 2011). Attributes commonly discussed included medical behaviours in relation to patients; honesty, confidentiality, appropriate relationships. Character traits underpinning behaviours of clinicians were also considered; a sense of duty, altruism, respect and compassion for others (van Mook et al., 2009b, Swick, 2000). Commitment to achieving excellence, ability to self-regulate and accountability were listed as defining components, also ability to apply judgement to complex problems, mutual support and an inclination to reflect on decisions (Swick, 2000, van der Gaag, 2011).

The development of a core professional identity during medical education has been a significant focus of medical education and a central professional orientation viewed an essential platform for professional behaviour (Wilson et al., 2013, Hilton and Slotnick, 2005, Goldie et al., 2007). Consideration of modern interpretations of professionalism drawing

these qualities and behaviours together recommended strengthening of medical leadership, preparation for effective team work, a *'sustainable'* approach to ongoing appraisal of performance and career-long development to maintain doctors' engagement (Tallis, 2006, Royal College of Physicians, 2005).

In this thesis my approach to medical professionalism embraces understanding underlying beliefs, motivation and personal identity and through close attention to biographical narratives examines patterns of behaviour performed by professionals whether internally consistent or conflicting.

1.2 Gaining an inside perspective; behind the scenes of the NHS

Information on the perspectives of working doctors was provided in core medical journals in the form of reflection on service delivery and debate around health service matters (Richards, 2007, Simpson et al., 2005), while publications such as the Health Services Journal reflected thinking at management level and at the interface with political influences (Martin, 2006, Lewis, 2010). A series of large scale longitudinal research studies used questionnaires circulated solely to general practitioners (GPs), to probe opinions, views and intentions of doctors on selected issues; about workload, choice in working practices and job-related stress (Lichtenstein, 1984, Sibbald et al., 2000, Sibbald et al., 2003). These described trends, patterns and opinions on the topics included but remained unsuited to detailed understanding of the nature of working as a GP and could not accommodate reflection on motivation or a sense of professional identity.

Information about recruitment and retention of doctors has confirmed that the cumulative effects of demographic changes and choices favouring early retirement of experienced staff threaten the integrity of a strong workforce capable of maintaining future care (Sibbald et al., 2003, Evans et al., 2002, Taylor et al., 2008). Beyond examination of decreased job satisfaction and despite concerns about adequacy of a future workforce, other factors

contributing to intentions to quit were not deeply explored (Sibbald et al., 2003). Since individual preferences in the working environment may differ, additional investigation of these factors and adjustments where appropriate could represent a necessary condition for reducing premature withdrawal of experienced doctors with resulting additional pressure on those remaining to meet required service levels. Future patterns of medical work are of particular importance in guiding the expectations of prospective medical students. Although they may refer to various texts for background information or the NHS website for a checklist of their desirable aptitudes to guide decisions, opportunities to hear doctors reflect on their own experience have also been appreciated (Blundell et al., 2004, Eccles and Ward, 2001, NHS, 2013). Gathering together the stories from a group of senior doctors offers broader perspectives than single contacts.

1.3 Narrative accounts of NHS experiences

Responding to the above mentioned public interest in medical stories, a few 'celebrity' doctors have published books about their experiences in medical workplaces (Copperfield, 2010, Daniels, 2010, Edwards, 2007). These personalised accounts depicted the writers' reflections during a specific period of time rather than as an account of a substantial portion of their careers and are further examined in the next chapter. They formed unique and particular accounts of lived experience which has also been the principal focus of my research - examining the lived experience of doctors who, having qualified in the early 1980s and spent most of the intervening period in NHS employment were well positioned provide and reflect on detailed insights and information.

I elected to concentrate on biographical accounts, to encourage doctors to develop narratives which followed topics and issues of their own choosing (Wengraf, 2001, Hollway and Jefferson, 2000). In keeping with postmodernist thinking, this approach facilitated co-construction of an account in which the voice of each doctor spoke from recollections of working life as they have experienced and reflected on them (Slay and Smith, 2011,

Wengraf, 2001). Although situated within the general context of NHS work, each story described a unique trajectory and reflections as recalled by a single clinician and informed of organisational structures, interpersonal contacts and their own ideas as these interacted with and impacted on their NHS experiences (Riessman, 1993, Riessman, 2008). In Chapter 3 are embedded theoretical arguments which support the notion that such personal experience-based stories are valuable sources of insightful and considered comment on both external events and conscious sense-making.

Behind familiar scenes; insider research

My interest in medical narratives was not purely academic; I was researching from within having trained as a GP and continuing to work in the NHS (Gair, 2012, Ochieng, 2010, Rooney, 2005). In the course of general and specialty training, I too experienced a wide range of workplaces and incidents which shaped my choices allowing me to identify with narratives recalling long and uncertain hours of work as a junior doctor and to remember later choices and dilemmas. Shared background knowledge and language were powerful facilitators of communication but it remained necessary to resist allowing interviewees to assume that I necessarily shared their understandings and sense-making constructs.

1.4 Research intentions

The main objectives of my research were to explore dimensions of working as an NHS doctor during changes in medical knowledge, in NHS emphasis, in society and in the lives of medical staff. I also wished to situate these stories in wider debates about professionalism and contemporary medical practices and consider implications for current and future expectations of doctors. To achieve this I proposed;

To gather information from practising doctors about their lived experience as NHS clinicians during a 25 year period

To discover and understand how doctors reflected on their experiences at work in terms of personal motivation, goals and preferences.

To examine relationships between these reflections and responses to established or evolving practices in medical care and examine how doctors negotiate interpersonal dynamics in the workplace

To compare emerging concepts with historical evaluation of characteristics of the medical profession and draw out examples of how doctors interpreted and enacted professional roles as a result of these connected aspects of work

Utilising empirically-based insights about these interactions and their wider implications to inform a wider audience through engaging and accessible data presentation

1.5 Thesis organisation

A review of literature in Chapter 2 tracks many important changes in structure and process affecting health care during recent years with an emphasis on how clinicians have reported the impacts of these changes. Using a structural framework developed by Freidson, I have considered contemporary NHS activity in relation to sociologically important characteristics of medical professionalism (Freidson, 1970). My review also includes additional elements not present during his original period of study a review of societal attitudes affecting relationships between doctors and patients.

As already indicated, Chapter 3 traces theoretical underpinnings, research design and practice including discussion of the relative strengths and limitations of my choices. I address reasons behind participant selection and consider influences of my insider-researcher status. Iterative development of narrative and detailed analytical steps are described, as is my decision to transform data to poetic form (Hollway and Jefferson, 2000, Wengraf, 2001, Clarke, 2005, Riessman, 2008, Richardson, 1997).

In Chapter 4 stories from immediately after qualification provide a situated context by offering insights about transition and identity development and illustrate enduring effects of

early experiences with relevance for current and future training programmes. Chapters 5 to 8 draw more strongly on each area of Situational Analysis mapping incorporating multiple cross-linking elements from Freidson's analysis of professionalism and extending his analysis in response to include contemporary concerns.

Chapter 5 first establishes foundations on which doctors built their biographical narratives – describing in their 'reflective practice' narratives those aspects of doctoring which they most valued and believed beneficial for patients, and their interpretations of professional behaviour. Rooted in the Situational Map, this chapter examines the impact of structural change by exploration of the wide-ranging effects on medical work through use of technology-based process and practices.

Increased organisation of NHS staff into multidisciplinary teams and the dynamics of team interactions featured prominently in the Social World mapping area. Chapter 6 considers team working which, though determined by overarching organisational elements and by required tasks, develops and functions as a product of the attributes and attitudes of individual team members.

Consideration of medical identity as portrayed in accounts about work occupies Chapter 7 and notes how engaging in research contributed to revision of my own professional experience. Informed by categories from the Positional map, an inner professional is shown to lie at the core of how work is experienced and responses are generated.

Finally, Chapter 8 focusses on how doctors' decisions and actions were represented in relation to matters with moral and ethical dimensions and looks at their wider responsibilities for training junior colleagues. Although accountability was not discussed in Freidson's work, these issues underpin all aspects of medical work and are of particular interest in current discourses around professional behaviour.

Data extracts and poetic sections support my interpretative observations; poems, which frequently cut across several themes, replicate essential characteristics of the interwoven reflective narratives from which they are drawn.

Stepping back from presented data, Chapter 9 reviews a complex array of issues drawing particular attention to the emerging characteristics of modern medical practice in managed situations, to interactions between colleagues and with patients and reflects on how aspirations and actual careers have developed. Discussion of doctors' awareness of aptitudes, preferences and their enacted clinical roles in different situations may help explain existing unanticipated reactions and assist effective future NHS planning. In concluding, I discuss the implications of these narrated experiences when considering the development of modern interpretations of medical professionalism.

Chapter 2

Literature review and general background

During the 25 year period of interest to this research, wide-ranging changes in structural organisation have occurred, developments in medical knowledge and new interventions have altered health care and movement of patients' expectations and public attitudes have modified how clinicians experience work. For contemporary senior doctors, these contexts, practices and cultures profoundly influence their experiences of work. (Baldry and Barnes, 2012, Eustace, 2012, Cohen, 1993, Herzberg, 1968, Chalofsky, 2010, Kirk and Wall, 2011). This chapter draws on a substantive body of diverse literature to examine how medical professionals may be affected with reference to three areas; major changes in structural organisation of the NHS, influences of societal change, and how doctors view their adjustments to new practices and their professional position.

Since changes in one part of a complex, inter-dependent NHS can produce consequences in another, presentation of these crossing and parallel movements in a coherent manner is best presented within a clear framework. To achieve a more purposeful overview, I have considered how major characteristics of professionalism as identified in Freidson's studies, have been challenged or supported during this period of organisational change, followed by discussion of medical perspectives of workplaces, teams and personal principles (Freidson, 1970, Freidson, 1975, Freidson, 1994). The chapter closes with indications of where insufficient information is available about aspects of everyday working and discusses why exploration of these deficient areas is important.

2.1 The NHS as a changing organisation in relation to medical professionalism

The 21st century National Health Service (NHS) has undergone progressive change since announced by a new Labour government to an austerity-affected post-war Britain in 1948. It was established on three continuing core principles (Department of Health, 2009, Rivett, 1998);

- that it meet the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay

Political, administrative and clinical activity and public attitudes combine to determine how effectively the NHS can function; fluctuating levels of investment, variable morale amongst staff and development of diverse subcultures have been documented with consequences for the speed and scope of services, differences between clinical and managerial priorities and quality of care delivered (Jones, 1978, Klein, 1978, Royal Commission on the National Health Service, 1978, Rivett, 1998, Davies et al., 2000, Oni, 1995, Francis, 2013). Major structural changes are listed in Appendix 1, however to understand how it had been to work within such an organisation and the deeper roots from which cultural norms develop, I considered how medical professionalism operated in relation to organisational structures.

2.1.1 The nature of medical practice; what characterises medical professionalism?

In *Profession of Medicine* (1970), Freidson presented an overview of the medical profession in manner similar to that applied to other occupational groups. He wrote of *professional authority* based on claims of specialist knowledge and assertions of credence based on scientific evidence. Built on this authority, doctors claimed *functional autonomy* and *self-regulation* was an established convention; each medical practitioner was expected to act within boundaries permitted by government and professional bodies. Exclusive rights were claimed for only recognised practitioners to practice medicine and hierarchies maintained by restricted access through training and licensing procedures.

After *enculturation* during medical training (Becker, 1977), Freidson noted s*ocialisation* with other professionals which was marked by an exclusive behavioural orthodoxy, compliance with accepted ethical standards and accompanied by development of an established medical '*gaze'* underpinning perceptions of health and illness (Freidson, 1970, Foucault, 1963). While simple rules were applied to deal with cases of negligence, comprehensive detailed protocols were undeveloped and doctors were expected to exercise good moral and ethical judgement, demonstrating *clinical mentality* (Freidson, 1975).

Technologies took form as facilities and equipment used in clinical settings which served to emphasise the significance of procedures associated with them. Freidson depicted clinicians as preferrers of practical clinical skills rather than book knowledge; reliant on results more than theory and on first-hand experience more than second-hand reports (Freidson, 1970).

While Freidson and others included discussion of wider *multiple perspectives* of medical settings (Parsons, 1951, Foucault, 1963, Cockerham, 1983), the social construction of illness and patient-clinician relationships lie beyond the scope of this thesis (Frank, 1995, Kleinman, 1995, Mol, 2003). However, it was argued that progressive societal changes which reduced medical autonomy could be viewed as *deprofessionalisation* or *proletarianisation* (McKinlay and Arches, 1985, McKinlay and Stoeckle, 1988) and Lupton's study of how doctors perceived their role in society, demonstrated diminished levels of confidence. Rather than supporting arguments which primarily linked deprofessionalisation with macro-level relationships between structural or policy issues and doctors, she concluded that understanding their diminished professional status required appreciation of micro-sociological aspects of everyday medical work (Lupton, 2004). She proposed *reprofessionalisation* a more apt description of an altered situation in which doctors reflexively considered the ethical nature of negotiated status. This micro-social effect resonated with Freidson's view on the importance of localised work settings and was reinforced by advice from Cruess et al that physicians must understand their ongoing

professional responsibilities to strengthen and maintain their contracts with society (Cruess et al., 1999).

A framework drawn from Freidson's analysis of medical work

Under categories of: Professional authority, Medical autonomy, Self-regulation, Clinical mentality, Socialisation, and Technologies in medicine, subsequent sections explore important relevant structures, processes and interactions apparent in today's NHS and affecting healthcare personnel with adaptation where necessary to include elements not present during Freidson's study. Clear separation of categories is unachievable since the effects of evolving systems overlap; I have therefore organised information to bring together discussion of closely related aspects.

2.1.2 Technologies in medicine; life-saving innovations or information treadmill?

Medical technology defined as *'any intervention which influences health and society'* (Berger, 1999), recognises multiple modes of medical intervention through technologies including; clinical facilities, medical equipment, pharmaceuticals, and application of information technology for record-keeping and data processing. This represents a significant movement from Freidson's observations; early discussion of this category reflects the prominence and influence of progressively developing technologies on medical practices.

Medical equipment which bestows attached significance to those using it is instrumental in (re-)defining unseen illness (Stanton, 1999, Löwy, 2011) and can contribute to unnecessary procedures and unanticipated outcomes (Deyo, 2002). Patients may also access online accredited health education information as well as 'un-vetted' websites to obtain medical information outside consultations (Haynes et al., 1994, Kenny et al., 1998, Sillence et al., 2007).

Use of computersystems in GP consultations has expanded to record and measure clinical activity and, despite resistance to wider data-sharing, has become almost universal (Department of Health and Social Security Great Britain and Joint Computer Policy Group, 1986, McWilliams, 1986, Millman et al., 1995, Pyper et al., 2004, Mandl et al., 2001, Public Accounts Committee, 2011). Since increased IT activity represents a significant structural change I considered it imperative to consider how its use appeared to alter dynamics of clinical consultations and to affect doctors' thinking patterns. I have also discussed how access to comprehensive data has allowed NHS managers an unprecedented ability to monitor clinical activity and gauge the cost-effectiveness of practitioner actions. Effects of these changes on core characteristics of medical professionalism and altered patterns of management; are considered in Chapter 5 though influences of IT also emerge in Chapters 6-8.

2.1.3 Professional authority; knowledge, dominance and scientific evidence

Freidson recognised professional authority as contingent upon specialist knowledge, which, with societal permission, supported professionals to act with autonomy and operate under self-regulatory restraint (Freidson, 1988). Others offered concepts of professional authority in terms of dominance; e.g. through doctor-definition of illness and unilateral treatment decisions or as an enabling form of *power to do something* rather than a potentially conflict-inducing *power over someone* (Law, 1991, Elston and Gabe, 2013a). Professional authority may be challenged by political policies, management decisions, patient attitudes (access to knowledge or self-help groups) and by upskilling of other health care workers (Kelleher, 1994, Harrison and Ahmad, 2000, Hunter, 1991).

Bloor favoured an embodied view of consultations, where embodiment of professional dominance acted to deny a role for patient choice by adoption of operational procedures which countered any resistance (Bloor, 1976, Hak, 2004). This resonated with Saks' division of recognisable professionalism according to two distinct accounts; a trait account based on

professional attributes which were present but unrelated to function (high level theoretical knowledge and skills, altruism and adherence to a code of conduct), and a functional account which grounded functional relevance in the social system or relationship between professional and client or patient (i.e. a doctor's activity in health care delivery), indicating a functional relationship between professionals and public (Saks, 1983). Maintenance of a professional position was linked with altruism, discipline and peer sanctions of deviant behaviour (Fournier, 1999, Sullivan, 2000, Foucault, 1977, Becker, 1964).

Adequate knowledge according to standards maintained by medical schools and Royal Colleges and monitored by the GMC have been further defined following the Modernising Medical Careers (MMC) initiative (Department of Health et al., 2004). However, debate ensued as to whether shorter specialist training programmes could deliver the level of training required by surgical trainees (Devey, 2005, Delamothe, 2007, Paice, 2005, Madden and Madden, 2007). Although little empirical evidence had indicated a decline in public trust new measures of performance were introduced in GP and hospital practice (Elston and Gabe, 2013b, Calnan and Rowe, 2008).

The Quality and Outcomes Framework for general practice

In the 2004 GP Contract, the Quality and Outcomes Framework (QOF) introduced a complex array of audited clinical and administrative tasks and a performance rating from patients (Appendix 10 provides a summary of major QOF characteristics). The QOF brought clarity of income streams and tighter links with clinical care than previous arrangements and, although a voluntary scheme, high participation was stimulated by payments which could exceed 20% of GP income (Roland, 2006, Elovainio, 2010, NHS Confederation and British Medical Association, 2003, Department of Health, 2004a).

In hospital, interpretation of performance data was contested since dissimilar spectrums of activity were not suitable for comparative assessment (Jarman et al., 2005, Roberts et al., 2009), but a Confidential Enquiry into Peri-operative Deaths (Cepod et al., 1987), *star ratings* and *key targets* were followed by multiple specific targets for hospital teams (Bevan and Hood, 2006, Robert, 2006).

2.1.4 Challenges to medical autonomy

Ability to direct one's actions was integral to Freidson's definition of professionalism; autonomy, whether as practical enactment of self-determined actions or setting one's moral compass, corresponded with Foucault's principle of recognising physicians as *'endowed with the power of decision and intervention'* (Foucault, 1963) Observed at micro, meso and macro levels (Elston and Gabe, 2013a, Harrison and Ahmad, 2000) autonomy also required co-operation of patients (Horner, 2000) and as pressure to optimise cost-effectiveness grew, selected restrictions were imposed (Harrison and Choudhry, 1996); the *Limited List* for prescribers, geographically-variable restrictions on elective treatments and protocol-driven decisions (Irwin et al., 1986, Henderson, 2009, Clarke et al., 2008, Kuhlmann et al., 2009).

It was argued that apparent short-term savings may result in greater long-term expenditure (Horner, 2000), yet pressure to act within recognisable parameters was increased by awareness that all prescribing and referral data was now available to NHS managers and by the introduction of regular appraisal and revalidation. Studies of doctors' responses to guidelines, which varied from conditional acceptance to resistance or rejection as a threat to physician autonomy, attributed varied reactions to '*multiple occupational identities'* present in the profession rather than evidence of new forms of professionalism (Spyridonidis and Calnan, 2011).

Progression of management influence on clinical work

With alterations to structures determining the roles and power-balance of managers and clinicians after the Griffiths Report it was argued that rising '*managerialism'* may threaten clinical autonomy (Griffiths and National Health Service, 1983, Exworthy and Frosini, 2008, Horner, 2000). Contested views were expressed about who should exercise authority in clinical matters as doctors feared coming under ever closer scrutiny based on financial criteria or expediency and were unconvinced of managerial competence and perceived unshared priorities (Thorne, 2002, Oni, 1995). Thorne described clinical directors as;

> '*at the nexus of the contested clinical and managerial jurisdictions in the organisation, [which] embodied the ambiguity and challenge of clinical management in public and workplace jurisdictions'* (Thorne, 2002, p:18).

Greater managerial control was augmented through new contracts for consultants which more precisely time-tabled their NHS commitments. Lead clinicians sought to defend medical professionalism from management interference by learning a new management discourse and employing whatever adaptive skills would enable them to survive in a managed environment (Waring and Currie, 2009). Pressure to increase operating efficiency led clinicians to develop local guidelines or protocols to shape care pathways efficiently and safely but staff could become demoralised and exhausted (Adams, 1995), and negative relationships develop between clinicians and managers (Davies et al., 2003).

A fundamental shift boosted Primary Care Organisations' managerial influence when non-GPs became eligible to hold primary care contracts and health spending was limited (Sheaff, 2009). Competition in an internal market under *'Fundholding status'* avoided fixed purchasing decisions made by the HA (Department of Health, 1989). Here too, contested views of the balance of power in primary care were created by complex and often ambivalent relationships between managers, GPs who participated in managerial processes (as part-time employees of management organisations) and the remaining GP body.

Re-situating professionals as team players

The nature of working in teams is explored in greater depth in Chapter 6 but it is useful here to review developments around team working in the NHS which evolved with organisational change following the Griffiths Report (Griffiths and National Health Service, 1983). Teamwork was seen to benefit from structures which facilitated effective working within the organisation, attention to processes which enabled the team to function, and showed better outcomes where team members had the requisite skills and an understanding of how to work together (Boaden and Leaviss, 2000). Complementary skills, shared goals, a thoroughly evaluative approach, excellent communication and joint decision-making could enhance outcomes for staff and patients (Xyrichis and Ream, 2008) through utilising a range of available skills for greater productivity and innovation (Salas et al., 2000, Salas et al., 2005).

Mutual support enhanced job satisfaction and retention (Griffin et al., 2001, Heywood and Jirjahn, 2004) while communication facilitated coherent and safe patient journeys (Richards, 2007) Success, by engagement with team-working practices, was hindered by continuous reorganisation, a competitive culture, unshared objectives or inadequate protected time to develop cross-disciplinary working practices (Macleod et al., 2007, West and Poulton, 1997). Wider analysis challenged the rhetoric of a necessarily constructive contribution of teamwork, finding imbalances where members came from diverse backgrounds, and when priorities of managers and clinicians were poorly aligned (Finn, 2008, Finn et al., 2010).

Re-shaping recruitment; balancing incentives

Doctors had been accustomed to relative freedom when choosing further training and employment; progression along one career path need not prevent a change in direction. When general practice became a recognised entity with improved equipment, motivation, teamwork and responsiveness, it became a popular career choice (Department of Health and Social Security and Scottish Office, 1986, Maynard et al., 1986, Marinker et al., 1986,

Gray et al., 1986). Rapid growth of the primary care team was advocated to stem rising hospital costs (Day and Klein, 1986) and payments for health promotion introduced in a revised GP Contract (1990). Such incentives however appeared inadequate as morale and recruitment waned with perceptions of an increased workload (Taylor and Leese, 1997, Lambert et al., 1996). Flexible and part-time opportunities in general practice widened to encourage recruitment and retention (Calman and Department of Health, 1993, Warden, 1996) but after further contractual change, freedoms which had once characterised GPs independent contractor status appeared less optional as they worked to achieve the financial benefits of QOF and other service-related payments (Roland, 2006, Willis, 2009, Lipman, 2006).

After vocational training became mandatory for new GPs, specialist training programmes which added structure and stability underwent further transition when the MMC programme further challenged doctors' sense of control over the direction of their career (Rivett, 1998, Keighley, 2005, Bolton et al., 2011). Shorter specialist training schedules made them more attractive but difficult negotiations accompanied resistance to enhanced managerial control under the revised consultant contract (Williams et al., 2006, Smith, 2002b, Fahy, 2002, Welsh, 2002).

A balancing act; professional autonomy vs. patient priorities

Publication of the Patient's Charter (1991), committed government to improving health service quality, to be responsive to public needs and to act to resolve deficiencies (Cabinet Office Great Britain, 1991). In addition to existing NHS services, patients were promised access to medical records and proper explanation of proposed treatment. Waiting times were to be limited and patients' views respected (Warden, 1991). Further promises accompanied a vision for NHS modernisation to reduce inequalities of health experience across the population and greater choice for patients (Department of Health Great Britain, 2000b, Department of Health, 2004b) .

In practice, achievement of equity of access to services was disputed, as was public confidence in non-independent data (Magee et al., 2003), and tensions were created by encouraging greater choices in health care while at the same time attempting to actively manage (or control) service provision. This produced a complex interaction as patients, unable to independently gain information about health on which to base decisions, needed to trust doctors but should not feel so disempowered as to be unable to question the basis of medical advice (Greener, 2003).

Decline in deference afforded to specialist knowledge or medical expertise led to perceived threats to clinical autonomy arising from deprofessionalisation through challenges to GP's medical expertise by lay persons (Weiss and Fitzpatrick, 1997, Davies, 2000, Calnan and Sanford, 2004). Access to non-medical resources on many detailed aspects of illness and a concept of the *'expert patient'* marked a cultural shift which sought to develop a useful role for disseminating practical information and encouraging an idea that self-management could offer greater stability and empowerment (Tattersall, 2002).

2.1.5 Policing professional practice; can self-regulation be trusted?

Self-regulation, which Freidson deemed an essential marker of professional status, was adjudged an insufficiently effective mechanism after two landmark inquiries. Public confidence in ethical and moral medical action was severely dented by the Shipman and Bristol cases (see below) leading to calls for a new approach which would be credible to both public and profession. Opinions within the profession differed; some favoured tighter external regulation but others preferred a more trust-based internal responsibility (Smith, 1998, Irvine, 1997a). Klein argued that doctors had failed to correctly interpret their individual role in protecting patients from mistreatment by colleagues, lacked clear lines of communication about matters of safety or quality and may require additional training for independent practice or remedial training after poor performance was identified (Klein, 1998).

Increasing performance monitoring of doctors' clinical decisions facilitated external scrutiny of performance which, while helpful to increase public confidence, could further damage professionals' self-esteem and contribute more to a climate of fear and defensive practice among good doctors who performed well rather than lead to exposure of those who under-performed (Watts, 2003, Jewell, 2000). It was proposed that since self-regulation appeared inadequate, greater lay involvement in medical regulation would be better aligned to general public interests (Wilkie, 2002, Fullbrook, 2008).

Can regulation be objective and enforceable?

Freidson recognised tensions created by external regulation of a complex and disputable activity where scientifically-proven practice may not adequately treat the patient's problem (Freidson, 1994). He deemed it inferior to interactive, situated peer review which was capable both of making demanding judgements and providing professional support. Despite recognition that setting standards and enforcement were difficult areas for professional and regulatory bodies (Perlis and Shannon, 2012), they combined self-regulating processes with external regulatory control to safeguard medical care through agreed standards for training, competence and conduct of members. This combined effort risked increased costs without matching improvements in medical practice and with unproven effects on public confidence (Dixon-Woods et al., 2011, Dauphinee, 2005, Smith, 1998, Cruess and Cruess, 2005, Sullivan, 2000). Effectiveness of moral and ethical teaching, which included responses to misconduct, was proposed an essential component of modern training programmes (Rennie and Crosby, 2002, Gonnella and Hojat, 2012). However, despite legal protection for whistle blowers, doctors remained wary of reporting deficiencies (Dyer, 1999, Dobson, 2001, Cohen, 2010, Kammrath, 2011, Patrick, 2012),

Monitoring professional standards; the role of the General Medical Council

Concern about mismanagement of paediatric cardiac surgical cases in Bristol, criminal activities of Dr Harold Shipman, rising consumerism, and lower deference, signalled a new

context for the GMC and procedures were introduced to remedy deficiencies in self-regulation (Allsop, 2006, Irvine, 2006). Guidance on professional standards were circulated to doctors, and the GMC took oversight of training and revalidation, and was involved in aspects of performance monitoring and risk management (General Medical Council, 2006, Lloyd-Bostock and Hutter, 2008). Doctors who were under investigation were suspended to protect patients, but others argued that a more open and honest dialogue between clinicians and patients would serve to build confidence more effectively than a regulatory approach could achieve (Case, 2011, Checkland et al., 2004). Annual appraisals were introduced as a reflective peer review process and to provide evidence for revalidation (General Medical Council, 2012, Walsh, 2006) .

2.1.6 Moral and ethical medical practice; adopting a clinical mentality

While Freidson noted a convention of distinguishing professions from non-professions by an orientation of service to clients rather than for personal interest – in the term *clinical mentality* he included the ethical and moral principles guiding responsible decision-making (Freidson, 1970). This *clinical mentality* was associated with doctors' tendency to view health problems through a narrowed lens of their own clinical experience and in contexts with which they were familiar; the presence of a specific ability to perform certain functions was another suggested component of clinical mentality (Goldstein and Donaldson, 1979, Parsons, 1951).

Traditional competitive medical school entrance requirements had not assessed students' aptitudes for compassion until introduction of scenarios where attitudes compatible with *clinical mentality,* patient-friendly agendas and reflexivity could be demonstrated (Powis et al., 1988, Bore et al., 2009). Whereas previous generations of clinicians were expected to learn ethical or moral practices by observing senior colleagues, comprehensive teaching about ethical issues was recommended throughout training as explicit and hidden components (Hafferty and Franks, 1994, Rolfe et al., 2004, General Medical Council, 2002).

By early alignment of their moral compass new doctors might feel more confident to raise concerns if they witnessed behaviour which breached expected ethical standards (Perkins et al., 2000).

Clinical mentality has been largely subsumed into discourses of moral and ethical aspects of medical practice which cannot be fully included in this thesis, however practical aspects of acceptable boundaries in relation to ethical or moral practice are discussed in Chapter 8.

2.1.7 Socialisation and situated medical identity

Mindful of the above workplaces, team structures and societal expectations, I propose now to consider doctors as individuals who are identified by their position at the centre of medical work. As they apply knowledge to define illness and interact with colleagues and patients, their own narratives are fundamentally grounded in enactment of this role and may convey how doctors express understandings of their selves, as professionals or as members of society (Engel, 2008).

Development of a medical professional identity

Like Becker's exploration of enculturation during medical training (Becker, 1977), Freidson, described a process of socialisation as an induction to prevailing characteristics of the medical world (Freidson, 1970). During undergraduate training, students could develop a '*hypothetical'* identity (Niemi, 1997) and, through a reflective approach, nurture development of attitudes and behaviours compatible with medical practice (Goldie et al., 2007, Stephenson et al., 2001). Contact with non-medical colleagues allowed greater cross-disciplinary understanding in contrast to social exclusivity which reinforced a stronger sense of professional identity (Helmich et al., 2010, Weaver et al., 2011).

A period of proto-professionalism prior to more complete professionalization was viewed as a lengthy progression in which experience, maturation and application of a practical wisdom developed alongside knowledge and technical skills as new doctors merged with a greater

professional body (Hilton and Slotnick, 2005, Good, 1994a). Young doctors reported non-uniform identity characteristics – hospital physicians saw themselves predominantly as *'technically oriented curers'*; while primary care doctors considered themselves to be '*humanistically and socially oriented carers*' (Fulop and Linstead, 1999, Kumpusalo et al., 1994). Doctors' views on their professional position and personal viewpoints are discussed in section 2.3 with deeper exploration of the formative, provisional, contingent period when each newly emerging professional could clarify ideas about their sense of professional identity in Chapter 4 (Fitzgerald and Teal, 2003, Jakobsen et al., 2011, Lingard et al., 2002).

2.2 One NHS, viewed through multiple lenses of stakeholders

Since professional medical activity did not occur in isolation, Freidson's analysis incorporated views of clinical and non-clinical staff working on hospital wards and views of patients (Freidson, 1970). During his investigation of an inpatient facility, patient, public and staff members' points of view emerged as products of diverse backgrounds, influenced by personal or reported encounters with health care, specific training and shaped by individual motives.

Patients' and public views of the NHS

Cross-disciplinary work exploring *'patient journeys'* through illness or *'service-user'* accounts which have become accessible in many publications, have revealed selective compliance with medical advice (Baker and Graham, 2004, Simpson et al., 2005, Davis, 2006, Roberson, 1992) . Hospitalised elderly patients spoke of trying to maintain control over their lives by developing relationships with staff to boost a sense of security (Andersson et al., 2011) and expressed appreciation of holistic therapies which enhanced calm and humanised unfamiliar technology (Brown et al., 1999). Patients preferred care delivered with respect and acceptance more than the application of technical skills and competencies usually associated with higher quality performance (Williams, 1998).

While distrust in management of the NHS and its finances had remained prominent, individual patient experience indicated significant continuing trust in clinical encounters (Calnan and Sanford, 2004). Confirming this relatively unharmed doctor-patient relationship, IPSOS MORI, which has conducted research to rank the most trusted professions in the UK since 1983, revealed that doctors again topped a poll in June 2011 as the most trusted professional group with 88% of adults across the UK saying they trusted doctors to tell the truth (Ipsos MORI Veracity Index, 2011).

Who is responsible for effective usage of the NHS?

As a nationally funded organisation, NHS budgets and spending priorities have changed according to health policies determined by elected governments. A mood of social change which emerged in 1980s called for a shift in the balance of power and responsibility with a proposal that patients should take greater responsibility for their lives while doctors should promote disease prevention (Kennedy, 1981, Black, 1981). Even as the Patient Charter encouraged patients to seek consumer satisfaction, the BMA proposed an English NHS charter to remind patients of their obligation to take reasonable steps to maintain their own health and use health services appropriately (Cabinet Office Great Britain, 1991, Cohen, 1996, Schmidt, 2007)

An emphasis on gatekeeping, as a clichéd reference to the GP's role to refer patients to specialist services, brought pressure on the GP workforce to justify clinical decisions by implying they should demonstrate greater consideration to indicators of quality and the best use of public funding (Day and Klein, 1986) rather than solely act to meet the preferences and expectations of an individual patient (Bain et al., 2002). In this role, GPs experienced a tension between advocacy for a patient meriting treatment and as a rationer of public resources - an issue of increasing prominence with the introduction of Fundholding and GP Commissioning (Evans et al., 2002). Additional unease due to rising litigation increased use

of defensive practices; increased follow-up, referral, investigations and prescribing, but appeared to diminish job satisfaction (Ellis, 2002, Kessler et al., 2006, Edwards et al., 2002).

Media representations of health issues

Media coverage of health issues holds considerable potential as a modifier of the utilisation of health service resources and online presence of organisations such as British Heart Foundation, Coeliac UK, etc. increased dissemination of information and built public awareness (Grilli et al., 2002). Programmes dealing with specific issues were sometimes helpfully informative but others were criticised for partial information, misleading conclusions, and a lack of sensitivity for adversely affected cultural groups (BMJ Anonymous, 1978). Doctors expressed concern about a breakdown of trust between medical professionals and the media despite little evidence of an objective link (BMJ Anonymous, 1980, Cody, 2004). This was sufficiently stressful for some doctors to consider leaving medicine or moving abroad to avoid media criticism (Goldacre et al., 2003, Edwards et al., 2002, NPCRDC, 2009).

Participants and eyewitnesses; perspectives from nurses

Relationships between doctors and nurses have suffered a vast range of characterisations in popular fiction and at times been stereotyped as openly adversarial professional rivals competing for power in health settings. Pressure on teams to deliver services has driven both groups to improve communication and work constructively to achieve targets through an *'interdependent symbiotic partnership'* with clarified boundaries, established standards and agreed accountability (Thompson and Stewart, 2007). Extensive literature on nursing perspectives, which is multiple, varied and permeating the entire fabric of the NHS, lies outside the scope of this thesis.

The importance of culture in the NHS

Following investigation of reported failure to provide expected levels of care to patients in Stafford, the Francis Report focussed on findings related to *culture* in the behaviour of staff members. It described a culture characterised by qualities such as; lack of openness to criticism, lack of consideration for patients, defensiveness, looking inwards, secrecy, misplaced assumptions about the judgements and actions of others, an acceptance of poor standards, a failure to put the patient first in everything and of prevalent bullying and fear (NHS Confederation, 2013). Final recommendations likewise adopted a *cultural* theme; a shared culture of caring, a positive and open culture, a culture which supports training for accreditation, and a culture with honesty and transparency.

As ripples have continued from Francis' scores of recommendations, the lasting significance of his findings remain unclear with varied responses questioning the best role for regulation of health care, on quality as a central principle and possible consequences of a duty of candour (Moore, 2013). The RCGP response to the Francis report reflected on a monitoring role for GPs while the NHS Confederation spoke of a more inclusive management approach retaining a strong regulatory system to monitor a positive and open culture of care (RCGP, 2013a, NHS Confederation, 2013) .

2.3 Medical perspectives; what is known of the experience of working in the NHS?

Having considered the interface between enacted medical professionalism and NHS work situations and attitudes, this section reviews situated evidence of medical working experience before a more detailed review of doctors' evaluation of their professional position.

Perspectives on doctoring have appeared in many forms, from diverse viewpoints and on multiple aspects of working life (Guardian review contributors, 2012, Pal, 2013, Devey, 2005, BMJ unattributed, 1984, Kerridge, 1986, Villar, 1987, Royston, 1987, Lear, 1992, Charlton, 1993). Topics debated in professional journals included; loss of professional status,

overwork, distraction by the demands of regulation, lack of professional leadership and disruption of the compact with patients. (Smith, 2001, Smith, 2004, Checkland et al., 2004, West et al., 2001, Jones, 2002, Finlayson, 2002, Edwards et al., 2002, Ham and Alberti, 2002, Watt et al., 2008).

Articles in a BMJ *Personal View* column contributed by doctors, carers, managers and patients, conveyed experiences from a vast array of diverse medical encounters (Davies, 1988, Rich, 1990, Prior, 1992, Foreman, 1992, Launer, 1986, Thompson, 1992, Johnson, 1993, Spencer-Gregson, 1984, Sykes, 1985). Several confirmed stress, disillusionment and workload difficulty among junior doctors (Dillner, 1994, Firth-Cozens, 1994, Rout and Rout, 1994, Symons and Persaud, 1995, Chambers et al., 1996). Interviews with consultants revealed concerns about inadequate funding, curtailed services, staff shortages and deterioration due to lack of investment (Smith, 1988a, Smith, 1988b, Smith, 1988c, Smith, 1988d, Smith, 1988e, Smith, 1988f).

Biography, memoirs and ethnography

Subsequent to the observational depth of Berger's *A Fortunate Man* (1967) studies of medical workplaces have offered insightful, though at times contested, views of medical settings (Katz, 1981, Cassell, 1991, Cassell, 1996, Cassell, 2005, Hafferty, 1992, Brody, 1992, Good, 1994b). Accounts permitted consideration of gendered aspects of surgical work or revealed tensions between professional groups and confirmed a culture where doctors closed ranks in response to criticism (Millman, 1977). Joining a growing trend for publishing insider revelations, three texts representing different styles but with similarly revealing outcomes served to illustrate this genre; *Confessions of a GP: life, death and earwax* by Daniels (2010); *In stitches: the highs and lows of life as an A&E doctor* from Edwards (2007); and *Sick notes: true stories from the front lines of medicine* by Copperfield (2010).

Daniels' unusual cases often appeared self-indulgent, accompanied by blurred ethical boundaries and his personal ideas for an NHS independent of political influence (Daniels, 2010). As he engaged in a 'game' of maximising his GP income, his story nourished an image of a progressively disenchanted, self-seeking operator whose professionalism was poorly aligned with idealised views of good medical practice.

Basing his tales on clinical encounters, Edwards brought stereotypical classifications of medical and nursing colleagues and many gripes about unintended negative effects of new regulations or procedures on patient care (Edwards, 2007). He demonstrated limited understanding about more far-reaching issues; flippant and exaggerated elements could reduce public acceptability of his writing, but reflective portrayal of his struggles to save lives or cope with the wider effects of trauma, exposed his latent vulnerability.

Throughout Copperfield's writing, a cynical undertone suggested that his GP career had not matched expectations or proved entirely satisfying (Copperfield, 2010). He exploded with indignation about inefficiency inherent in NHS systems and evident lack of understanding when rules and protocols were handed down by a distant body. He also noted it had become increasingly difficult to maintain communication and mutual respect between GPs and specialists.

Each author held an uncontested platform, and in his own style voiced angst, joy and frustration, but took advantage of anonymity and creative license to venture into what might otherwise be controversial, politically-incorrect, or unpublishable in conventional medical discourse. Online reviews indicated a mixed public response; a complaining form of therapy, an excessively political tone, entertaining or informative. Reviewers claiming to have inside knowledge of the NHS, uniformly confirmed the credibility of these revelations.

Research evidence on aspects of experienced medical work

Sequential studies of GPs between 1987and 2010 analysed responses on topics including; income, hours of work, freedom of method of working, opportunities to use abilities, variety of work, degree of responsibility and overall satisfaction (Sibbald et al., 2000, Whalley et al., 2006, Whalley et al., 2008a, Whalley et al., 2008b, Hann et al., 2009, Hann et al., 2011, Sibbald et al., 2003). Results fluctuated with changing contractual circumstances and though similar smaller surveys also demonstrated deterioration in perceived satisfaction, interpretative analysis was limited by lack of contextualising information (Rout and Rout, 1994, Appleton et al., 1998). Reduced stress attributed to removal of GP responsibility for 24-hour care (Whalley et al., 2008b) was followed by concerns that greater clinical involvement in commissioning arrangements would reduce time available for direct patient care (NPCRDC, 2009, NPCRDC, 2011).

2.3.1 Doctors' evaluation of their professional position

A professional overview

When Watt asked doctors with different backgrounds and experience about the proper role of doctors in the 21st Century, they reflected on medical education, current work, views on the state of the medical profession and spoke about personal or professional fulfilment (Watt et al., 2008). Nostalgia for past camaraderie when working long, exhausting hours with responsibilities right on the edge of their coping abilities, contrasted with regret at having been so immersed in their career that marriages or young families were neglected. While acknowledging the value of a published knowledge-base, doctors believed that junior colleagues, in whom they observed a 9-5 mentality, now had reduced opportunities to gain intuitive or tacit knowledge which could threaten future practice.

Through clearly articulated insights and experiences, participants reported an ambivalence inherent in being detached, rational, effective, protocol-observing clinicians while interacting

with patients with empathy, caring and sensitivity. They portrayed themselves as normal human beings; working to the best of their abilities, juggling responsibilities and everyday tasks (Watt et al., 2008). Watt's paper has remained a relatively isolated publication though supported by studies of physicians taking ethical and empathic approaches to patients on the basis of their pre-developed professional values (Roland et al., 2011, Cox, 2011).

Professional identity in working with patients

Enactment of a professional role has been viewed as a social construction in which both parties adopt roles, both drawing on learned responses as part of their constructed identities (May et al., 1996). Interruption of a recognisable consultation pattern associated with constraints on autonomy, restricted availability of services, increased monitoring, external regulation and adverse media coverage, has meant that a psychological compact which had existed in the past was no longer applicable (Edwards et al., 2002, Landon et al., 2003). Whereas doctors were idealistically portrayed as having studied and worked long hours to bring patients treatment they believed to be beneficial in return for reliable income, job security, clinical autonomy and general respect, a new situation focussed on targets, guidelines, protocols, evidence-based advice and audits. Team working and delegation were increasingly encouraged to achieve and maintain specified levels of performance. Observed responses to an influx of innovative technology interfered differentially with how doctors from different generations constructed their identity (Korica and Molloy, 2010).

Clinician responses to NHS reforms

Although clinicians stated that NHS reforms had affected their own professional position positively, their view for the prospects of the NHS were contrastingly negative (Goldacre et al., 1998). Investigation of positions held by NHS stakeholder groups (patients, managers, clinicians) proposed that although each group shared a common vision that the NHS existed for the provision of patient care, conflicting views of how this should be accomplished endangered its achievement (Brown et al., 1994). Referring to an uncertain future for

professionals, Heath proposed that to maintain a vocational commitment to patients, doctors should retain '*moral literacy'* in making professional judgements (Heath, 2012).

Factors affecting morale and job satisfaction

A complex interrelationship between partnership arrangements, personal style and workload influenced doctors' morale and how wellbeing and distress were experienced at work. Respect for different approaches, flexibility, fairness and good interpersonal communication proved supportive and professional autonomy was more highly valued than income (Huby et al., 2002, Stoddard et al., 2001, Watt et al., 2008). Delegation of routine tasks to less-qualified staff could intensify doctors' work by concentration of complex cases and although thoroughly integrated team-based interventions were associated with higher morale, resistance could develop in response to challenges to pre-formed identities (Charles-Jones et al., 2003, Gemmell et al., 2009, Powell and Davies, 2012). .

Responses to challenge or disruption

When unable to achieve a curative outcome for patients, doctors have continued to provide supportive care in challenging circumstances while working under emotional stress (Johansen et al., 2012). Complaints could seriously disrupt doctors' sense of their medical selves, triggering reactions which tended to regard a complaint as a challenge to their competence or expertise rather than as a possibly legitimate grievance or arising because the complainant had experienced difficulty (Allsop and Mulcahy, 1998). If no supportive structures were available, a culture of blame caused difficulties at all levels (Edwards et al., 2002). Multiple organisational factors and stresses experienced in the workplace have been linked with medical burnout; loss of a sense of personal or professional identity has also been implicated - confirming the importance of developing and maintaining an identity compatible with expectations (Deckard et al., 1994, Ozyurt et al., 2006, Olkinuora et al., 1990).

2.4 Revisiting contexts of medical practice

It seems clear that while some aspects of medical work have been studied, understood and documented, the picture remains incomplete. With developing medical knowledge, innovative technology, progressive changes in society, revised priorities and altered perceptions of professional status, medical workplaces have been transformed. Investigation of the effects of such change on clinicians working according to new patterns has not received sufficient attention to grasp whether the new situation is compatible with previously described dimensions of medical professionalism.

Detailed studies of isolated aspects of medical work form part of a larger scene; a small number of self-selected spokespersons from the medical profession, whose distilled memories and opinions are available through their writing, informs to a limited extent but may not provide a balanced representation of a broad sweep of medical experience. Statistical analyses of particular trends, while useful to identify and track specific movements, facilitate theoretical development, or to inform future planning, exclude everything outside the scope of the study. Analysis of medical work by sociologists who have gained access behind the scenes provides valuable insight but remains patchy and contested.

Sociological interest in professional authority, autonomy and self-regulatory mechanisms links with parallel study of other professional groups and societal change. Public perceptions of interactions with doctors, often gained through fleeting and stressful encounters, can suffer from a mismatch of ideas or communication difficulties which may profit from real-life understanding of a hidden medical world; important public engagement in difficult moral or ethical dilemmas must benefit from greater insight behind a professional façade. For non-clinical managers grappling with resistance to progressive changes, explanation of an alternative viewpoint may help negotiate through difficult decisions with new insight fuelling a more efficient transition. Prospective medical students adding background knowledge to

first-hand sampling of medical settings may be better prepared for medical training, more adaptable and more ready to accept future changes. And doctors who feel unable to publicly reveal contradictory feelings of deep concern or profound privilege may appreciate knowing that others have been able to voice these sentiments.

Extensive reading of background literature added texture and context for the stories I expected to hear from doctors working in regular, everyday settings over a prolonged period of time. My motivation behind this research grew from a desire to discover and understand how current doctors viewed their work, their professional status and how they interacted with managers, colleagues, patients and a wider public and to consider this against wider debates about central components of professionalism. Obtaining greater depth of description, multiplicity of layers, detailed imagery, unhidden emotion, frank reactions and considered reflections of doctors from a range of specialties, required an approach which privileged personal accounts as a basis for analytical study. Chapter 3 explains the methodological considerations which underpinned this research, indicating how gathering individually shared narratives of a group doctors opened connections to a more comprehensive study of the nature of being a doctor in today's NHS.

Chapter 3

Methods

In this chapter I explain underpinning ontological and epistemological arguments which supported my research into the working lives of NHS doctors during a period of change in many areas as described in the previous chapter. By collecting their perspectives I hoped to reduce a gap in knowledge of how current doctors experience and react in their working environment. Details of my chosen data gathering and analytical methods are followed by explanation of my preference for presenting selections of findings in poetic forms.

3.1 An ontological and epistemological platform for understanding human experience

The study of ourselves in the moments of our lives is not a novel idea. In the 18th Century Kant wrote of viewing our existence through a synthesis of what we perceive as observed experiences in the physical and social world and how we mentally process what we encounter, and signalled a departure from considering the basis of our existence in terms of a physically present set of objects (Kant, 1881). Having defined enlightenment as *'human being's emergence from his self-incurred…inability to make use of one's own understanding without direction from another*' (Kant, 1784, p:1) he introduced concepts through which to describe how we understand and relate to our social world; the study of human life.

Towards the late 19th Century, recognisable constituents of perceived human experience, described by Durkheim as the *'social facts'* of our human lives, were seen as external influences evoking different responses from individuals, and evident in society as independent ideas, attitudes, practices – yet functioning as phenomena which can be

identified at the centre of human activity and capable of altering social interactions (Durkheim, 1972, Durkheim, 1953, Durkheim, 1982).

Although he acknowledged the impalpable and unobservable nature of social facts, Durkheim argued that social life should be studied as objectively as scientists study the natural world, with *social facts* considered as formative influences on human behaviour. Instead of responding to a distant objective view, he noted that our analysis of ideas generated by close and familiar objects exerted greater influence on reactions and behaviour than distant realities (Durkheim, 1972, Durkheim, 1982).

Weber agreed that study of social life should focus on individual human beings as the basic units of society, each a '*sole carrier of meaningful conduct'* (Weber, 1948). He shared Durkheim's desire for greater *'precision'* of concepts developed on the basis of the best achievable exploration of meaning (Weber, 1962). Rather than social structures, he regarded socially active units (human beings) as potentially transformative background forces within society, whose conduct should be studied not simply as descriptions, nor limited to analysis and interpretation, but by proposing causal explanations of social processes (Weber, 1968). In contrast to Durkheim who believed humans a complex amalgam of many influences, Weber introduced the term '*ideal types'* to enable consideration of *'typical'* responses; this has been represented as a device better suited to retrospective analysis than applied to current and fluid social processes (Durkheim, 1953, Weber, 1962, Weber, 1948).

Since in Mead's conceptual frame, minds and selves arise within and are modified by social interactions, and develop in cooperation with others' demands through communication of roles and attitudes, it follows that experience feeds expectations, informs responses and changes in how it is perceived as new experiences are added (Mead, 1934). As these frames are in turn reflected back into society and onto the individual, Mead drew attention to

the importance of interaction between individuals by viewing the characteristics of a society as determined by social constructions between those who constitute it, according to whatever meanings they attach to anything they encounter, adopted roles, interactions and by whatever operating rules or structures they have created (Mead, 1934, Stryker, 2008).
He viewed human variability as a consequence of socially determined influences; in effect that we behave in response to social forces acting on us as they are perceived in our consciousness and reflected upon as remembered events, images or gestures (Mead, 1913). Proposing a theory of symbolic interactionism, his theoretical frame specified *'a manageable set of assumptions and concepts assumed important in investigating particular social behaviour'*, which alerts the researcher/observer to what is likely to be important to observe or investigate (Stryker, 2008).

Although Mead did not extensively write beyond his primary theoretical frame, Blumer's later explication established these basic premises:

1."Human beings act toward things on the basis of the meanings they ascribe to those things."

2."The meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society."

3."These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he/she encounters."

(Blumer, 1969, p:3-5)

On this foundation Blumer and others established methodological developments which equipped researchers to develop theories about observed behaviours and test those theories (Stryker, 2008). Assuming with Mead that *"the individual mind can exist only in relation to other minds with shared meanings"* (Mead, 1934), he proposed that a means of understanding social actions, individual behaviour, and interactions with others, lay in exploration of interactive processes involved in living in a world comprised of objects to

which we attribute meaning and with multiple individuals whose meanings are shared or dissimilar (Blaikie, 1993, Lee, 2005, Rao et al., 2003). Access to inner meanings is however only possible to the extent that they can be communicated by language or gestures (Weber, 1962).

Influences from phenomenological perspectives developed following Husserl's lead as *Logical Investigations* described a model in which he sought to strip back to *'the 'sources' from which the basic concepts and ideal laws of* pure *logic 'flow"* (Husserl, 2001, p:166), in order to bring *'clearness and distinctness'* to understanding '*lived experience*'. Rather than focus on observable interactions, Husserl considered phenomena, objects to which human minds attach meaning, as components essential to understanding the essence of a thing (event, cause, effect, etc.) and what may be understood by knowledge of it– though his implied position, that experience is the source of all knowledge, was countered by Heidegger's concept of human existence and actions as being *'in the world'* (Husserl, 2001, Heidegger, 1962).

Making sense based on experience

Since plain description of phenomena did not effectively convey the '*whatness*' or '*aboutness'* of natural objects and social processes, the emergence of hermeneutic phenomenology marked a growing of interest in interpretation of what is observed or expressed (Husserl, 2001, Heidegger, 1962, Gadamer, 1975, Gadamer, 1976, Dilthey, 1976, Merleau-Ponty, 1964). Describing this interpretive understanding as an art rather than a rules-based science, and one which built on '*a natural power'* of interpretation, Gadamer believed that it should be undertaken by a researcher motivated only by a desire to gain knowledge while Dilthey held that depth of understanding depended on investment of sustained attention (Gadamer, 1976, Dilthey, 1972, Van Manen, 1990).

When interpreting other viewpoints it is important to recognise the influence of our own perception of the world, our own *being in the world,* and alert to a fusion of horizons created by experiences from the past and present (Heidegger, 1962, Merleau-Ponty, 1964). These may be demonstrated by mediating influences of each on the other, underlining the importance of shifting back and forth, relating the whole and parts of experience to obtain a better view, to identify connections between them (Gadamer, 1975, Dilthey, 1972). Taking this perspective, where no *a priori* assumptions were considered necessary, was characterised by first seeking to describe the meaning attributed to objects rather than to explain or account for either meaning or actions and demanded that a researcher enter the field of study without preconceived ideas (Pivčević and Husserl, 1970, Husserl, 2001, Johnson, 1982).

For Schutz, whose guiding principle was to focus on the subjective consciousness of the individual, the entirety of human experience was considered open to greater understanding through gaining deeper insight into the meanings individually attributed to everything within the compass of existence (Schutz, 1967, Etzrodt, 2008). In his methodological text, *The Phenomenology of the Social World,* he theorised that behaviour was not distinct from underlying meanings which gave rise to that behaviour, recognised that attributed meanings may change with the passage of time and that experience was not perceived in a completed manner while continuing to be experienced. Effects of past experience, reflection from a more distant perspective and current thought processes combined to produce a continual flow of pooled experience on which an individual might draw for the future.

Schutz proposed that whilst the most intimate experiences occurring closest to the core of an individual (and linked to *Dasein*, the word applied by Heidegger to encapsulate an individual's presence in the world as an entity interacting with and in the world) might be inaccessible to conscious recall, these unconscious experiences could affect actions which were difficult to account for on other grounds. By delving deeper than other interactionist

approaches, he sought to establish '*taken for granted*' assumptions which elsewhere emerged as notions of '*common sense'* despite their very particular origins in individuals or cultural settings.

The effects of performance and presentation on interpretation of lived experience

The above assumptive positions established a view of human life as a lived reality, experienced by individual perceptions, modified and shaped by encounters in the physical and social world, shared by language, gestures and images, and through various means of communication made available for interpretation by another person. In contrast to study of natural science looking in from the outside, study of social phenomena *'requires an understanding of the social world which people have constructed and which they reproduce through their continuing activities'* (Blaikie, 1993); a study which attempts to see with the eyes of another, to dig under their skin.

By exploring secrets and intimacies which constitute the world, phenomenological research examines how individuals orientate themselves in their world (Van Manen, 1990). Through ongoing interactions and interpretations, meaning and relevance constantly shift, generating social processes which inform a mutable understanding of social life (Touraine, 1974).

Schutz emphasised a need to carefully acquire and analyse both *'external'* data which was effortlessly told and less-accessible *'internal'* data, while Geertz referred to details of life experience as discovered prominently on the surface or discerned through deeper interpretive analysis (Schutz, 1967, Geertz, 1983). Geertz believed cultural influences and contexts of historical importance influenced how these constructions of meaning and relevance were enacted, but their effects were not universal – each individual engaged with the world as they encountered and were conscious of it, adorning objective existence with subjective meaning (Geertz, 1973, Crotty, 1998).

Gaining phenomenological insight did not for Schutz represent an end in itself; he viewed it as a means to the proper formulation of a sociological problem;

> *'The intended meaning of a lived experience is nothing more nor less than self-interpretation of that lived experience from the point of view of a new lived experience' (Schutz, 1967, p:78)*

Uniting internalised and interactional aspects of individual experience as represented by Goffman (1922-1982) resonates with my general understanding of how each person in their particular cultural setting reflects on their encounters with the natural and social world, forms attitudes and organises actions in relation to others (Goffman, 1990). New encounters are processed to fit into a framework of understanding which is determined by and contributes to making sense of any event (Littlejohn, 1977). Presenting social life as occurring through how one presents self through verbal and non-verbal communication, Goffman noted that while the former is relatively easily controlled, non-verbal cues and behaviours tend to escape conscious control, conveying messages to an observer who naturally attempts to match both forms of information (Goffman, 1990).

Part of the purpose of a controlled *'performance'* is to achieve an expected response of being treated as presented, a form of *'impression management'* (Tseelon, 1992); in this way a doctor might adopt an approach which is expected of a health professional when in consultation with patients to elicit a patient-response from them, but may carry this into other social situations to elicit positive reactions from others (Goffman, 1967).

Social life is knitted together by interpersonal communication – negotiations of status, roles, and social relations are facilitated by trust, though performers may opt to misrepresent (through impersonation, distortions, exaggerations or by cynical performances). Strategies to defend or protect specific interests may be adopted; performers may decide to produce an erroneous performance or even persuade themselves of its veracity. Settings for interactions

may be chosen where physical surroundings or indicators of status serve to boost the credibility of a performer; e.g. 'clinical' décor, medical equipment, uniforms, computers, assistants. Similarly a certain manner of speaking style or use of language may enhance an intended image. An *'idealised'* interview performance – constituted by recognisably co-operative behaviour – may be displayed by acting according to what a researcher would regard as a good informant, but by adhering to an idealised pattern, more difficult or contentious topics which extend beyond an *'ideal'* view may be omitted.

The complexity of team interactions was accorded separate consideration in Goffman's writing. Since each team member's experience is contingent on colleagues and coherence of performance in public depends on joint performances, relations between team members determine internal balances and impressions conveyed outside the team. Effective induction of new team members, tactful dealing with public mis-performances, negotiation of internal decision-making – all may serve to create team cohesion built on loyalty and shared success. More difficulty is encountered when considering how far a team member will bend their own opinions or motivations to maintain a joint team performance; whether they can privately or perhaps jokingly object to the constraints of team-rules but in practice observe them – in a balancing act of maintaining face and not breaching team rules (Goffman, 1955, Goffman, 1967, Goffman, 1990).

Making sense through organisation of experiences according to a frame or multiple frameworks allowed Goffman to classify actions at different levels and to observe how they triggered culturally influenced responses (Goffman, 1986). Miller argued that Goffman tended to overstate impression-management aspects of everyday life – proposing instead that individuals were constantly gauging and responding to developing situations in a contrived but explicable manner; a concept of behavioural predictability bearing some resemblance to Bourdieu's more settled *habitus* (Miller, 1986, Bourdieu, 1977). In contrast to Foucault's focus on relations of power, Goffman's observations produced representations

of everyday life where agentic individuals controlled interactions including their adoption of deviant practices (Misztal, 2001). His emphasis on individuals and their interactions with others can be seen as a small-scale counterpart to large-scale systems prominent in Foucault's writing (Hacking, 2004).

Applications of Goffman's work encompass many fields including study of behind-the-scenes behaviour in operating theatre (Tanner and Timmons, 2000), analysis of the effects of using computers during medical consultations (Pearce et al., 2008, Pearce et al., 2009), study of employees' behaviour when breaching accepted norms (Morgan and Krone, 2001), and as a frame for understanding organisational change (McCormick, 2007). With these diverse applications, his legacy has powerfully supported development of person-centred research (Treviño, 2003).

Drawing on these concepts, I proposed to investigate the lives of a group of clinicians recognising each as a subjective and objective individual who against background cultures and contexts would construct meaning and generate responses to the actions of others depending on the influences of prior experience (Bourdieu, 1977, Geertz, 1973, Geertz, 1983).

3.2 Theory to practice; the relevance of epistemology to methodology

These theoretical perspectives (phenomenology and symbolic interactionism) offer much support when developing an explorative study of lived experience in the medical contexts which are central to this research. Both approaches reject key arguments favoured by positivist thinking; such as that an absolute or universal truth lies at the centre of our understandings, or that observable evidence can justifiably be detached from situated meanings of what is observed (Van Manen, 1990). Methods chosen to gather and analyse data must take account of inherent limitations in both symbolic interactionism and phenomenology as an appropriate 'match' for the practicalities of the research situations –

which in this project is conveyed through articulations based on experience (Burrell and Morgan, 1979, Crotty, 1998).

Unlocking the inner world of an individual to gain their perspective on the external world is largely dependent on linguistic communication – and in person-to-person communication where there is acceptance of tacit rules of language, words convey a comprehensive expression of what is present in consciousness; it is *de facto* the common currency of our social interactions (Berger and Luckmann, 1967). Since meaning is expressed in language, analysis of language-based communication therefore provides a basis for hermeneutic reasoning (Polkinghorne, 1988), however gestures, hesitations, gaze and other bodily movements observed during face-to-face encounters may confirm or counter the verbal message adding a further dimension beyond transcript data (Blumer, 1969, Goffman, 1990, Riessman, 2008). Likewise, to develop ideas from this range of empirical data, analysis methods which fully address these expressions of interaction and meaning are required (Carter and Little, 2007, Clarke, 2005, Glaser, 1967, Lieblich et al., 1998).

Criticism of certain aspects of a symbolic interactionist approach has included charges that emotional and reasoning aspects of human life are considered to be mutually incompatible, or that it struggles to deal with macro-scale issues and therefore proves an inadequate basis to account for the influence of power in society (Stryker, 2008, Dennis and Martin, 2005, Fine, 1993). However, a symbolic interactionist approach addresses the 'big picture' aspects of social interactions, social processes which develop when people interact with each other and recognises that humans are not merely automatons; that while we all arrive into a pre-existing society which shapes us as individuals, we can also act back and within society to make some modifying imprint. By seeking to explain all social actions with reference to external criteria, the element of individual choice or preference in a larger social world is relatively diminished (Denzin, 1997b).

Application of symbolic interactionism includes fields related to medical practices and institutions (Benzies and Allen, 2001, Musolf, 1992, Tanner and Timmons, 2000), stories of adjustment to illness (Charmaz, 2004) and has been applied to studies of science and technology (Strubing, 1998). Researchers continue to find this theoretical model useful in interpretive analysis of narrative accounts as presented in interviews and when examining identity or working with an ethnographic orientation (Oliver, 2012, Polletta et al., 2011, Raz, 2005, Ezzy, 1998, Smit and Fritz, 2008).

Like symbolic interactionism, the popularity of phenomenology has varied and opinions differ on how best to characterise the theoretical position of individual writers (Wagner et al., 1975, Lanigan, 1988). If dominated by an extremely narrow focus on an individual and the subjective, this perspective limits consideration of those interactional components which integrate an individual in their social world and leads to problems explaining interactional behaviour (Etzrodt, 2008). Externally applied meanings may be incompatible with internally generated constructed understandings and complex amalgams of personal interpretation; what is perceived may differ from veridical experience (Weber, 1978, Noë, 2007, Miller, 2009). White reminds us that, in any study of social interactions, is not simply the occurring events which prove most interesting, but awareness of the significance of events to those reporting them (White, 1996).

What seems clear is that, despite foundations which arise in apparently opposing positions, when applied to practical sociological research both approaches demonstrate important similarities by endorsing the essential nature of empirical observation and both are compatible with an interpretive methodology (Etzrodt, 2008, Hycner, 1985, Benzies and Allen, 2001, Oliver, 2012, Pringle et al., 2011). What may be seen as weakness of symbolic interactionism when seeking to accommodate individual creativity and enactment of individual choices as implied by an objective or externalised approach, contrasts with inclusion of more subjective awareness in phenomenology. Likewise, a restriction of viewing

angle through adoption of a deep and narrowed phenomenological perspective gains benefit from a more expansive complementary consideration of wider interactive social processes through a symbolic interactionist lens (Bolton, 1981).

Demonstrating this convergence, researchers draw on strengths of both paradigms according to how they best support specific research situations and the nature of data available for study and research focus (Charmaz, 2004, Johnson, 1982, Glaser, 1967). Celebrating an emergence of life stories as a vehicle for study in social science, Plummer argued that increasing attention to theoretical complexity should not mean we lose sight of the human being at the centre of social action- a living, breathing, embodied and feeling human (Plummer, 2001). Amidst multiple refracted perspectives of a plural world, which constantly change and where nuances of meaning are re-negotiated, each individual in society remains part of society with an important role in overarching public issues (Mills, 2000, Denzin, 1997a).

Perspectives representing three foci of sociological study; history, biography and structure, cannot simply be assembled as pre-determined items. Grounded in individual perspectives, they may exhibit tensions characteristic of two modes of thought described by Bruner as; a formally descriptive and explanatory logico-scientific mode, and an imaginative, narrative mode which produces stories, drama and believable accounts (Bruner, 1986). To these inclusive '*documents of life'* Plummer and Denzin brought an interpretive understanding which allowed retention of a plurality of perspectives confirming them as appropriate reservoirs for partial stories, nuanced tales and multiple perspectives which typify lived experience narratives. Drawing on what is available for observation, drilling through to meanings which emerge within a constructivist, feminist paradigm therefore offers a valuable means to uncover underlying viewpoints of medical staff (Denzin and Lincoln, 2003).

With this ontological background and epistemological balance in mind, I believe a hermeneutic approach to detailed, personal, storied reflections of working experience represents an effective methodology which is appropriate to the data and for achieving the objectives of this study.

Influences from ethnography and ethnomethodology

Emerging from different heritages but focussing on interpretive approaches to the life-worlds of individual social actors, ethnography and ethnomethodology also offer potential methodologies from which to explore medical lives (Pollner and Emerson, 2001). As a prominent ethnomethodologist, Garfinkel used evidence of behaviour, conduct and speech, to comprehend how individuals understood their place in their own lives and maintained sense in various social contexts. Where situations challenged this sense of self, he identified how '*management strategies and justifications'* were displayed in defence of a threatened or unknown position (Garfinkel, 1967).

To achieve this understanding demanded an immensely detailed knowledge of thinking patterns and the devices by which a rational account was constructed by an individual, and a deep probing of psychological aspects was necessary to accomplish this task. For many practical reasons an NHS-based study of such depth and complexity presented problems; finding a doctor or group of doctors willing and able to devote many hours and much effort to disclose this level of information would be difficult and, it could be argued, likely to produce a skewed sample of the medical workforce.

Study of a shared culture through ethnography also demands significant periods of observation when a researcher is present with individuals whose actions and words, observed and recorded over a period of time, allow a picture of their lives to develop in the researcher's understanding (Van Maanen, 1995). Wolcott debated the incompatibility of ethnography with brief encounters, which, for reasons of access as described above,

renders traditional ethnography unattainable with most practising doctors (Wolcott, 2008). He also spoke of entering the field with a set of questions and structures which would obstruct my primary explorative objectives. By contrast, Ellis' approach to hear and give voice to the storied experiences of others, opened their social world and allowed a sympathetic exploration of their cultural niche (Ellis, 2004).

While spending time watching doctors at work and listening to their naturally occurring conversations remains an attractive option, it is not easily negotiated and potentially faces criticism that objectiveness could yet prove elusive, in part due to the variance between first-order and second-order concepts (Maanen, 1979) and it is difficult to dismiss claims that the very presence of a researcher necessarily alters the dynamic of 'natural' settings and interactions (Blomberg et al., 1993, Haynes and Horn, 1982).

To gather unreported data and more directly test the verisimilitude of reported and actual interactions, strategies such as video recording workplace interactions or generation of visual narratives have been used as partial substitutes for prolonged or intrusive periods of direct observation (Katzeff and Ware, 2007, Bautista Garcia-Vera, 2012). Contemporaneous journal reflections by participants at different stages of the research can add supplementary contextualising information and personal perspectives (Hawkes et al., 2009). However, these participant-led data collection methods can enable participants to be highly selective in what they chose to record in their journals and they may (un)consciously alter their behaviour during video recording. Therefore additional interpretive difficulty may be introduced if the participant retains editorial control as, after reflecting on the image projected they may permit analysis of only idealised impressions or extreme examples (Pink, 2013, Rich et al., 2000). While such techniques can be utilised to further investigate everyday medical experiences, for this exploratory research I preferred a more directly-responsive and interactive approach to data gathering (Ross et al., 2014).

With first-hand medical experiences prior to beginning fieldwork and consistent with my theoretical framework, I believed my interviewing encounters with colleagues despite the absence of extended periods of observation, would tend towards an ethnographic perspective. While seeking to absorb as much ethnographically informative material as possible during contact with participants, I would adopt an interview style with traits of ethnographic interviewing; e.g. listening, respectfulness, engagement, self-awareness, awareness of the research relationship, openness to discovery but with recognition of partial knowledge as each observable component feeding into my analytical and interpretive work added perspective and depth which further informed the process (Spradley, 1979, Heyl, 2001).

3.3 Investigating lived experience from the inside

To understand the nature of doctors' working lives through their eyes, my investigation of diverse and complex working environments of the NHS required knowledgeable informants to provide detailed, wide-ranging and useful accounts (Lieblich et al., 1998).

Being considered an elite group due to professional training which leads to specialist knowledge and consequential power, access to doctors can present difficulties, though the extent of this may be unjustifiably magnified and, as further discussed below, diminished by effects on research relationships due to my own medical background (Odendahl and Shaw, 2002, Ostrander, 1993). Although links between personality traits and clinical performance have been demonstrated by psychometric testing, this has been infrequently performed in the UK medical workforce raising no evidence to expect that doctors' cognitive and emotional characteristics should make them function differently from non-physicians and therefore requiring a particular research approach (Firth-Cozens et al., 2003, Odendahl and Shaw, 2002). I did not consider psychometric elements relevant or appropriate to my chosen research methods.

My position as a general practitioner (GP) from the same university as my participants placed me in the unusual position of an insider or member-researcher which by Brannick and Coghlan's description acquired a distinct research dynamic;

> '*Inquiry from the inside involves researchers as actors immersed in local situations generating contextually embedded knowledge that emerges from experience*.' (Brannick and Coghlan, 2007, p:60)

This presented challenges and benefits throughout the research process since by approaching this group of doctors, my peer position exerted influences on the research process on levels of direct involvement and reflective interest. Regardless of previous acquaintance, my researcher-self must interactively behave in keeping with acceptable social norms yet probe to elicit meaningful stories and retain an appropriate balance between distance and proximity during each encounter (Hockey, 1993).

Meeting NHS doctors required negotiation of the NHS research ethics process, pressures of limited time due to workload, or even a disinclination to engage - induced by fear of criticism which was viewed as *'doctor bashing'* in previous publications (Pope, 2005, McKinlay, 1977). To proceed, I must adhere to the same rules as any other researcher, but prior personal contact altered the context of my invitation to participate; my status as a former fellow student and colleague may have encouraged participants' belief that I would better understand and empathise, which in turn may have encouraged greater openness to share what was difficult or controversial (Hockey, 1993). Alternatively, fear of the consequences for a clinician of disclosing knowledge or actions which could contravene expected standards of professional behaviour, could deter full and frank representation despite guaranteed confidentiality (Goffman, 1990) .

In the to and fro of social interaction, Blumer recognised a formative process where meaning was formed, sustained, transmitted and transformed, which led him to recommend that for

greater interpretive strength researchers should gain as much familiarity as possible with the worlds they explored (Blumer, 1969, Van Manen, 1990). Goffman also recommended close familiarity with the life-world of those contributing data for study and further elaborated on physical circumstances and relational elements which may influence the flow of data (Goffman, 1989).

Shared back-stage behaviours of medicine formed part of my common currency with participating doctors, though to a lesser degree than would apply if they were regular work colleagues. Further support stemmed from Denzin's encouragement of engaging in research in which researchers had a vital and ongoing interest, where they were unafraid to reflect on their own position, ready to recognise pivotal points in past experiences, and to uncover and present findings as authentic representations of what has been voiced (Denzin, 1997a). In my experience of interacting with doctors as colleagues and friends I recognised patterns similar to those Goffman described; hidden boundaries lay between what may and may not be publicly expressed, cultural influences regulated the language and attitudes which accompanied clinical stories and coloured background justifications or contextualised aspects of each account (Lawler, 2002).

The depth of my immersion in the research field was not negotiable; my insider status imposed tacit understandings and total subjectivity was impossible (Denzin and Lincoln, 2003). These encounters between us demanded careful checks to detect where underlying assumed meanings may not be comparable; at times demanding that I distanced my own understanding in the manner of Schutz concept a *'stranger'* in an unfamiliar situation (Schutz, 1976). Emergent themes, concepts or ideas whether they immediately resonated with my existing knowledge or countered my prior expectations must be scrutinised for confirmation of meaning or might after comparison with other data be recognised as a potentially new and emerging insight (Hockey, 1993, Kvale, 1996).

Career trajectories have taken us from student colleagues to different levels in a profession where hierarchies remain important (Lingard et al., 2012, Mackintosh and Sandall, 2010). Potential challenges to relative social power as a confounding factor might however be present in our research relationship; it would be naïve also to imagine that being female would have no bearing on the research process despite a near equal gender balance in our year group (Foucault, 2000). Reactions to me as a woman might generate a different dynamic in conversation when compared to a man in ways that were impossible to evaluate, while any reactions to current feminisation of the NHS workforce may be modified in response to my gender-compliant role as a part-time GP (Ozbilgin et al., 2011). Impossible as it was to eliminate or even be aware of the totality of influences which as an insider I brought to this research, part of my task was to recognise and work through how these impacted on my interpretation of data (Skeggs, 2001).

Since no participants were current colleagues and only one has remained among my occasional social contacts, whatever camaraderie existed when sharing lectures and tutorials has been diminished by a separating distance of 25 years. Avoidance of potential conflicts and complications of researching workmates would allow us to address work issues without considering how this could affect ongoing working relationships or fears that confidentially shared thoughts could affect other aspects of our interactions (Tilley et al., 1996). As historical acquaintances, we were aware of shared roots during training; our common experience of enculturation equipped us to jointly exploit whatever benefits resulted from close familiarity with early experience of NHS-based work (Etzrodt, 2008).

Objective recognition of what constituted the familiar backdrop of working in the NHS was a challenging aspect I faced in analysis and interpretation. Consistent with a feminist perspective I propose that this collected data should not be considered an amorphous pool of experiences but as individual narratives viewed in native contexts, those pertaining to the narrator and to specific work settings – grounded in their experiences (Maynard and Purvis,

1994). By setting my research data in wider NHS and social contexts and external historical settings identified in Chapter 2, it may be possible to note where reported 'facts' were not confirmed by historical records, or to detect where constructed meanings held by different groups deviate from each other. Unlike cases where life or work experience of a researcher bore no resemblance to the research group and led to significant challenges in bridging the knowledge gap, my proximity to similar workplaces added to my knowledge of what is generally expected but could not be assumed to represent a universally held view or necessarily to yield identical data or interpretations as could be assembled by duplication of research (Etzrodt, 2008). Like any other researcher, my task was to gain access to a picture (including expressed actions and behaviours) which was as complete as possible through all available means, and, by questioning how that world was experienced, to know it better (Van Manen, 1990).

Deeper probing into the perspectives of individuals might suggest background explanations for why certain responses and motivations occurred. I aimed to communicate on any delicate matters with sensitivity – mirroring Silverman and Perakyla's '*elegant interactional work',* expecting pauses or hesitations but allowing the narrator space to proceed (Silverman and Perakyla, 1990). Emphasising an individual construction of reality recognised the importance of a world composed of discrete and separate actors whose sense of self, their reactions to success and failure, and their reflections on achieving balance between work and personal responsibilities were integral to their unique narrative accounts.

Together these ideas suggested that to research the lived experience of doctors I must discover how they perceived the world in which they worked, how they orientated themselves to structural elements of organisation in the NHS and society and to interpersonal relationships, and discover their view on how they fitted into this same picture. By close examination of meanings attributed to objects, structures, social practices and their own roles as they expressed them, I could add to my understanding of the influences acting

on and around them in their workplaces. My theoretical framework supports an interpretive approach to interpersonal interactions, relationships with managers, responses to new processes, protocols or policies, achieving objectives, adapting to altered goals, negotiating positions related to power and gendered expectations.

As a GP, I have been privileged to hear patients' deeply personal stories which, though related to health or illness, are tales which situate them in their social world or as survivors of major disruption following illness or loss and often bring glimpses of a sense of how they see themselves. These stories convey re-inventions and re-constructions which become acceptable and necessary in order to adjust to a new situation. Although I could not know in advance whether any participants would share stories reflecting significant difficulty, I suspected that some may have had experiences which provoked a rethink of career or made them reappraise their professional position and could be awkward to share. However I felt that sparse evidence and unhelpful silences have done little to dispel myths and mystery which have long surrounded the world of medicine and those who practise the healing arts.

Based on my experience of clinical work, my research method of choice seemed obvious and reflected in my thoughts as follows;

> *'If several years of consulting with patients have taught me anything it is this: that whoever the person, whenever the occasion, whatever the situation, wherever the location and however it is happening, there is always a back-story. And back-stories are invariably interesting. These are the stories of events, relationships, concepts, concerns, motivations, interactions, and more, which place people where they are and reveal much about how they see themselves as individuals and as people in their family, work or cultural settings. It follows that, if I cannot see a way to personally, physically access the work situations of multiple doctors, then the most effective way to discover their experience of work is to explore their stories. It's deceptively simple; I need to hear about whatever they have to say around the subject of work - all I need to do is to identify some willing participants and arrange to meet and talk.'* SMS

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3.4 Narratives; refracting lived experience

Narratives surround us to the extent that they are inescapable; in them we position ourselves in relation to time, organising experiences into '*temporally meaningful episodes'* (Carr, 1986, Ricœur et al., 1984, Polkinghorne, 1988). Ricoeur depicted narratives as representing;

> *'a person acting, who orients him- or herself in circumstances he or she has not created, and who produces consequences he or she has not intended…the time of the "now that ... ," wherein a person is both abandoned and responsible at the same time'* (Ricœur, 1980, p:176).

We may use narratives to make sense of our lives, of who we are and where we are going (Taylor, 1989), or as a means to construct a moral self (May, 2008). Personal narratives recount how we have interpreted our own lives and become intertwined with a broader perspective, a collective narrative in which we position our individual narratives (Gonick et al., 2011).

Exploring narratives transports us closer to the core of understanding, as Richardson stated;

> *'If we wish to understand the deepest and most universal of human experiences, if we wish our work to be faithful to the lived experiences of people, if we wish for a union between poetics and science, or if we wish to use our privileges and skills to empower the people we study, then we should value the narrative'* (Richardson, 1990, p:65)

Narratives to gain knowledge

Through examining the working lives of medical doctors from an internal perspective (Denzin and Giardina, 2011), this exploration aimed to provide answers to how it *is* to be a doctor; how it *feels* to take on the duties and responsibilities of a clinician, what a doctor *thinks* when emergencies arise, how they *cope* with failure and success, how they *adjust* to changing

expectations, or how they *view* themselves as professional people and how they *interact* with colleagues and managers.

Consistent with my theoretical position, first-hand accounts were my preferred route to access what is closest to lived experience; phenomena on which individuals base reflections and thick descriptions through rich and meaningful stories (Chalmers, 1995, Varela, 1996, Geertz, 1973, Hollway and Jefferson, 2000, Hinchman and Hinchman, 1997). Getting as close as possible to doctors' lived experience was the primary purpose of my time spent with them. Unlike a questionnaire-based series, my objective was to embrace the totality of working experience (Sibbald et al., 2000, Whalley et al., 2006, Sibbald et al., 2003) through examination of individual reflective stories which retained author privilege and a visibly grounded authenticity (Suárez-Ortega, 2013, Davies and Gannon, 2006).

Sharing narratives through '*reality-constructing, meaning-making occasions*' has been described as a co-construction conversational event, or a speech event which is contextually grounded - emphasising the importance of maintaining context in the widest sense (Denzin and Lincoln, 2003, Mishler, 1986, Elliott, 2005, Holstein and Gubrium, 1995). Probing questions encouraging greater elaboration or clarification need not distract from the transfer of information (Roberts, 1981, Paget, 1983).

Allowing participants to steer in directions of their own choosing and seeking to maximise detail in its native context, supports interpretive study while omitting a researcher's own categories. Focusing on participants' agendas, it permits 'on-message' analysis, includes unanticipated issues, and is comprehensive of 'whole' lives, motives and strategies (Potter, 2002, Silverman, 2007). Therefore a biographical narrative account was my positive choice, among the best available methods to explore lived experience (Van Manen, 1990).**3.5**

Participant selection – a theory-based approach

As is evident above, I accept that it is impossible to capture a complete understanding of lived experience in the NHS. Practical limitations and unpredictable biographical variation shaped information provided by the selected doctors whose stories would inform my research (Rock, 2001).

Among my leading criteria for participant selection was access to willing and knowledgeable informants, preferably from diverse situations and who were sufficiently independent and confident to share first-hand accounts (Johnson, 1990, Lieblich et al., 1998). Inclusion of mature, reflective narratives from ordinary doctors was preferred in order to privilege the voice of non-prominent practitioners and considered more achievable due to my insider status (Odendahl and Shaw, 2002, Ostrander, 1993).Options to recruit such a group included; requests to work colleagues, open advertisements and recruitment at medical conferences but each raised difficulties e.g. due to over-familiarity and disclosure difficulty, attraction of self-appointed spokespersons, narrowed field of interests etc.

Taking these factors into account and according priority to experienced doctors whose voices may not usually be heard, I elected to choose mature clinicians from a single cohort to reduce a tendency for powerful voices to over-power a wider group. I first approached my own university cohort whose career experiences matched these essential criteria and brought potential benefits from common undergraduate preparation and an even power balance in our research relationship, Minimal social contacts had survived our dispersal but a complete list of members provided a useful starting point (Mason et al., 1973, Glenn, 1977, Glenn et al., 1977). These doctors entered professional work at the same time, were of broadly similar age and experience and I hoped that any reticence to assist an unknown researcher may be overcome by a spark of collegiality or genuine interest in contributing to a personally-relevant project.

Although purposive sampling was not an option due to limited relevant pre-interview information, a spread of experience could reasonably be expected (Patton and Patton, 1990). Having worked more than 25 years in geographically scattered NHS posts, they could be assumed to have progressed into generalist and specialist posts and cognisant of the views of both senior and junior colleagues. Selection inevitably excluded perspectives not directly represented in a cohort sample, for example observable differences in cross-cohort data; any trends strongly linked to increasing maturity and experience might not be separable for independent assessment (Glenn, 1977). Perspectives relevant to other cohorts may remain outside the study though some could appear in reflective stories or be introduced as second-hand accounts.

Research approval requirements recruitment and final selection

The relevant approval route for this research (as at January 2009) was through the National Research Ethics Service via a local Research Ethics Committee (REC) which approved my application in March 2009 (REC reference number:09/H1203/1); copies of submitted documents are in provided in Appendices 2-6. Additional approvals from the Research and Development (R&D) department with responsibility in the locality of each participant were requested after participants had confirmed their involvement but prior to commencing research activity.

Public sources of contact details (library copies of *The Medical Directory*, *General Medical Council Registers* and online searches) were used to trace UK-based doctors. From 88 identified, I excluded only myself and one whose work was clearly non-NHS. To the remainder, I mailed a personal invitation to participate, together with a REC-approved information sheet and consent form.

Consistent with my exploratory approach, I chose not to pre-judge sampling through additional profiling information and having obtained R&D approval for 20 of 29 positive

respondents, I chose to begin fieldwork by interviewing those who were most geographically accessible. As interviews progressed, I was reassured to observe diversity within the growing group and that it broadly reflected the relative proportions of generalists and specialists, and men and women in the entire cohort and NHS medical workforce. Included doctors had been active in management roles, medical research, under-graduate and post-graduate training and assessment, and a mixture of full-time and part-time doctors as well as clinicians from medical and non-medical family backgrounds and from diverse ethnic groups (see Appendix 9 for further socio-demographic information on participants). My rationale regarding when to finish fieldwork is discussed below in Section 3.8 though an option to later include additional participants remained open until completion.

Data security and processing

Arrangements to meet each doctor were arranged for their convenience and at their preferred location. I recorded our conversation and made field jottings prior to and following each interview. An experienced transcriber produced initial transcripts, after which I listened to the entire interview to clarify any indistinctly-heard speech or correct rare errors.

I have not problematized transcription; my decision regarding personal or independent transcription was made on the basis of how best it seemed to fit with my situation; personal transcription would incur delay and extra pressure with distraction from the essence of the study. Partial personal transcription could incur a risk of regarding data differently by undue prominence or relative neglect. Instead, I was able to examine and analyse with freshness and confidence of accuracy and I believe that external transcription did not reduce my ability to maintain close contact with content and context. Although others have argued that transcript text represents a key component in the interpretive process (Riessman, 2008), for me, the textual element in this study served mostly as a reminder of the interview as an event experienced. Repeated reading the text and listening again to every recording, I

recalled background details of each interview; the prominence of the event remained in my consciousness and was therefore strongly drawn upon for interpretation.

3.6 Confidentiality and ethical considerations

A combination of pseudonym anonymisation of data and use of secure storage of linking and demographic information guarded participant confidentiality from the outset. With the removal of other identifiable data where necessary, it seems highly unlikely that disclosures could be traced to individual participants, patients, colleagues or workplaces. Although one doctor with a more unusual narrative declared herself unconcerned about anonymity I have done everything possible to avoid breaching confidentiality while accepting that this acts to prevents individual choice to be known and heard (Lofland, 2006). Profile details in Appendix 9 are intended to assist with this objective.

I prepared in advance for a possibility that doctors may reveal personal need of professional support. Since this could draw me into difficult areas regarding reporting any deficit in their ability to perform to expected standards, I accessed details of bodies which could advise and support. No disclosures warranted such referral; doctors who had encountered difficulties had already found effective solutions.

Principally I believed my responsibility as a researcher did not stop at maintaining confidentiality, anonymity, and ensuring participants and patients were unharmed by the interview process. My approach was to privilege the accounts of those whom I interviewed and having heard these valuable, personal, insightful stories, with a duty to diligently study to understand and set them in context (Hollway and Jefferson, 2000). Although doctors appear articulate, educated and influential, because of the restrictions placed on them by a reticence to speak out for fear of censure or adverse consequences, I believe the voice of the ‘ordinary’ doctor, working in ‘everyday’ practice is not frequently heard. Participants in this research, who had not been selected for their prominence or because they had

volunteered as spokespersons, were a source for less-heard voices from this professional group.

3.7 Interview patterns and narrative generation

Informed by Geertz's identification of the need for '*thick descriptions'*, but influenced too by Wenger's *Biographical Narrative Interpretive Method* (BNIM) and Hollway and Jefferson (Wengraf, 2001, Hollway and Jefferson, 2000), I settled on an in-depth, face-to-face, narrative-inducing interview approach with individual doctors. Each would be unique and unreproducible, intended not be considered as representative of doctoring experience in its totality but as a representation of the experience of an individual doctor. Aiming for an ethnographic style of interviewing, equipped with a framework to serve as an aide-memoir (Wengraf, 2001, Heyl, 2001, Hollway and Jefferson, 2000, Riessman, 2008), I sought a pattern where the interviewee spoke at length to develop narratives, while I focussed on content and maintained emotional engagement with minimal encouraging verbal and non-verbal responses (see Appendices 7-8).

Exactly half of the participants chose to meet at their family home, five at their workplace and one in a university office. Photographs of scenes from close to their workplaces together with field notes about physical environments and interactions added ethnographic dimensions to the spoken interview. Pre- interview notes were simple jottings about what I could recall about the person I was to meet and impressions from our preparatory email contacts (Emerson et al., 2001). Each interview began with re-confirmation of consent, a brief summary of objectives, and a reminder that at any stage we could stop or change focus.

I then invited them to **tell me how it had been for them to be a doctor in the NHS**.

As expected, one story led to another; an interviewee might launch into detailed explanation, or slip over something of interest to which we would later return to explore further, constantly negotiating a flow of talk. Specific incidents were explored with visual detail and reflection on the effects of such events. Giving precedence to the voice of the interviewee, I would listen and begin a process of interpretive thinking; an interviewing style designed to utilise a socially interactive capacity to learn from what is new and to develop greater objectivity (Hammersley and Atkinson, 1995).

Iterative development of interviews continued as I explored more deeply in new areas which had been introduced by earlier participants and, as data opened through analysis, additional data and understanding built layer on layer as fieldwork progressed (Charmaz, 2001). I followed the BMIN principle of probing by re-using terms first used by interviewees. Specific incidents to which interviewees attached particular significance preceded explanation of subsequent decisions and actions.

Interviews continued for 85 to 140 minutes with a short period before or after the recording where social 'catching-up' occurred but this did not upset our tacit understanding that my presence was dedicated to the 'work' of an interview (Pope, 2005). All were informal and suffered little interruption. Narratives developed as we spoke, to and fro, as equals negotiating in a language where one is attempting to understand what the other is attempting to communicate. To comments like, *'you know how it is'* I frequently responded by asking them to clarify what they meant by particular statements, believing it better to partially estrange myself from this assumed shared knowledge while trying to avoid an incongruous naivety (Rock, 2001, Hammersley and Atkinson, 1995). Transcripts confirmed that my interjections were minimal as the balance of talk was dominated by interviewees.

Naturally, doctors differed in how they preferred to present both themselves and their stories. All were fluent, as is often the case in elite groups accustomed to holding an

audience (Pope, 2005), and conversed freely on a wide range of topics and links with previous comments. Occasional hesitance or experimenting with how best to express thoughts confirmed likelihood of ideas which had not previously been voiced – perhaps developing a story in the telling of it or one which had only been shared with a very restricted audience (Smith, 1978). A sense of performance marked particular stories (Riessman, 2008); the single most shocking statement was delivered from behind my back at a point immediately before a doctor left allowing me to absorb it before we resumed. This carefully managed pause, together with use of speech patterns and shared humour, indicated that in many respects this interview approach allowed interviewees to mimic the structure of naturally occurring conversations. Stories of decision-making were often accompanied by a reasoned explanation and a message of things having turned out 'quite well in the end' was common. My prepared list of pre-selected topics proved unnecessary and since participants had arranged an open schedule; the talking continued for as long as seemed necessary.

Interview conclusions differed; after a comprehensive account, one doctor appeared satisfyingly drained of her 'whole story', another's optimistic mid-interview stories ebbed away to reveal a darkly pessimistic view of future NHS medical practice– I was relieved that when I left his lively family were already home. For some it felt cathartic to speak about things which had been semi-forgotten, good to 'get it out' and surprise that it could prove interesting. Usually, as recording ended, talk transferred briefly to asking about contacts with other colleagues; 'normalising' activity which effectively returned us to our former non-research, social relationship. Afterwards I paused to make notes of anything which might help situate the interview; smart surgery building, dingy office, thoughtful choice of refreshments, frank opinions which escaped the recording. I also set down my immediate reactions to what I had heard; what was expected or surprising, enlightening or depressing and, in a temporary shadow of fatigue and uncertainty, naively wondered if the interview would yield useful data.

Although my original intention was to conduct an interviewing process over more than one interview (as per BNIM) this proved unworkable; participants were instead willing to devote time to a prolonged initial interview, talking until they had covered everything they wished to say. Although we agreed on opportunities to have later email contact, no participants spontaneously offered further data. Clarification of specific points was only partially successful; it appeared that having stepped away from the context of the interview, it was difficult to re-visit the conversation in a meaningful way; one responded only to say that she had 'moved on'.

3.8 Saturation; evaluation of having obtained sufficient data

Data saturation, in the sense of exhaustively uncovering every possible angle and nuance was not deemed an achievable endpoint (Denzin, 2009) however, literature confirms that during an explorative study, data saturation may be required from fewer sources when using of in-depth interviews, taking a phenomenological approach and with pre-existing knowledge of the field since these characteristics add depth, detail and reflection in data gathering (Charmaz, 2012, Morse, 1994, Creswell, 1998, Jette et al., 2003). Several studies also confirmed emergence of indicative answers to research questions through the level of information supplied by modest numbers of participants while avoiding undue repetitiousness (Mason, 2010, Marshall, 1996, Morse and Field, 1995, Holdsworth and Robinson, 2008).

Data gathering and preliminary analysis indicated that individual narratives covered many diverse working experiences yet, despite an open and undirected interview style, considerable consensus and overlapping of themes emerged to the extent that interviews 11 and 12 revealed few new themes and increasing repetitiousness. In narrative development doctors did not simply tell a story, they put themselves into the story – an angry outburst was accompanied by calmer assessment of what lay behind annoyance or frustration,

embellishing fact with feeling. Further, more self-revealing stories were shared as we progressed through the interviews and 'natural' conclusion was reached when new stories waned.

Reviewing data at this point, I judged it sufficient to make significant contribution to a credible exploration current medical practices and understanding how doctors saw themselves and their professional position with consensus across narratives from diverse backgrounds adding to trustworthiness (Atran et al., 2005, Griffin and Hauser, 1993, Guest et al., 2006).

3.9 Analysis – a theory-based methodical approach

Applying an interpretive approach to narratives

Drawing on Leiblich's discussion of building rules for narrative analysis, combined thematic and holistic processes supported a process of *'reading for understanding'* (Lieblich et al., 1998). Overview analysis of developing narratives within each interview and of how they demonstrated links to other stories enabled detailed initial evaluation of themes or issues which populated the accounts. Rather than divide stories into emplotted parts, it seemed useful to examine the terms in which they, for example, referred to work teams or accounted for their actions (Labov and Waletzky, 1997, Presser, 2005). Analytically-revealing questions from Lofland described an interrogative process; asking how each narrative conveyed characteristics of type, in terms of frequency and magnitude, the structures and processes which were active, where causes originated and consequences led, and an overarching consideration of active human agency which developed strategies for making things happen (Lofland, 2006).

Analytical and interpretive processes which began during interviews continued through each new encounter, building iteratively on preceding accounts (Charmaz, 2001). Close attention

was given to order, sense and meaning to help focus on how each issue or event had been introduced (Silverman, 2007, Hollway and Jefferson, 2000, Riessman, 2008, Wengraf, 2001),

Interpretive awareness is part of working towards the validity of narrated accounts (Cope, 2004), including remaining mindful that stories are incomplete versions of events; accidental or deliberate omissions and distortions may occur (Barbre, 1989), an *idealised* self presented (Goffman, 1990), and differentiation between self-stories and narratives may lead to deeper levels of disclosure (Denzin, 1989). As Riessman described it;

> *'Narratives do not mirror the past, they refract it. Imagination and strategic interests influence how storytellers choose to connect events and make them meaningful for others. Narratives are useful in research precisely because storytellers interpret the past rather than reproduce it as it was. The "truths" of narrative accounts are not in their faithful representations of a past world but in the shifting connections they forge among past, present, and future. They offer storytellers a way to reimagine lives ...*' (Riessman, 2005, p:6)

By processes of experiencing, making meaning, remembering and relating, narratives are necessarily the refracted representations on which we reflect and which can be shared and studied; refraction shapes how they are remembered and moulds how they are retold.

Attitudes of contributors necessarily influences how each approaches the selection of stories, responses (Alvesson, 2011) and the content which they share ((Doby, 1967) quoted in (Hammersley and Atkinson, 1995)). Unsuspected motives or unconscious reactions may determine the prominence of particular aspects; the tone and cadence of individual stories differs; some hesitance suggested a less - shared story, or one pushing the limits of inner knowledge or perceived suitability for disclosure.

While viewing language as the vehicle of our communication rather than itself the subject of analysis (Riessman, 2008), observance of these speech patterns or associated body movements, adds to the totality of the account (Polkinghorne, 2007), and confirms that any attempt to interpret language according to strict definitions or literality may be misleading (MacLure, 2011). As oral accounts, their emergent immediacy may be seen as a flow of story-telling uninterrupted by self-censoring later revisions which can occur in composed texts as narrators reflexively re-live their life story and tailor it for access to a particular audience (Portelli, 2009, Clandinin and Connelly, 2000, Hinchman and Hinchman, 1997)

All aspects of stories warrant attention to tease out threads which link and counterbalance. In the context of doctors, a tension between what is expected by patients, by employers, by professional organisations and by family and friends, must be simultaneously and successfully accommodated and can be expressed through stories of how these roles are juggled; participants who reflect on their own identity and role in events, facilitate exploration of identity development as revealed by a succession of narratives (Mishler, 1986). Constraints of time available with each participant which prevents gathering complete life stories inevitably curtails the extent to which authoritative individual analysis is possible (Myerhoff and Tufte, 1975).

A methodical analytical process

While it is recognised that formulaic replication of interpretive analysis risks reduction of the richness of new insights (Morse, 1997), trustworthiness of research findings demands analysis which is thorough, sensitive and reflexive; the stages I used when analysing each transcript are set out below;

- Transcriptions were promptly compared with recorded speech to confirm accuracy
- An initial summary captured impressions, significant themes and contexts. I allowed time to digest, ponder and consider the relative importance of themes in each narrative(Ryan and Bernard, 2001).

- Line by line reading followed; adding annotations and comments to prepare for the next level of interpretive work, including cross-referencing how data appeared consistent with or contrary to previous data. (Hammersley and Atkinson, 1995). An iterative list of interrogative questions drove constant probing for perceptive study; questions like:

  How does the situation impinge/impact on the individual?

  What makes for a supportive environment and how is it reported?

  How is self presented ?

  What terms are used?

  What are their reasons for choosing option x?

  Is there an explanation for why x happened as it did?

- I experimented with use of an MS Excel spreadsheet displaying each participants data under emerging themes – setting out how each doctor's narrative contributed to an overall picture of meaningful themes (Mishler, 1986) under category headings with sub-categories such as (seen later in Figure 3);

  <u>Medical Identity:</u>

  a doctor

  expectations of self

  influenced by others

  ideals

  researcher identity

  a human being

  gender/insider issues

  a teacher

- Themes remained linear and unconnected until Situational Analysis mapping was applied to open data further and facilitate visual representation of links which were

stated, implied or proposed likely to operate between mapped categories (Lofland, 2006, Clarke, 2005). Representation of a small sector is shown in Figure 1.

Throughout analysis, I pondered on how interviewees spoke about specific aspects; skipping over large periods but dwelling on a meaningful or pivotal story and the terms in which personal positioning was explained (Lieblich et al., 1998, Riessman, 2008). Aided by jotted field notes, I recalled settings and non-verbal aspects, constantly looking out for '*socially embedded artefacts'*; socially mediated concepts (Spradley, 1979), asking questions of the data and applying knowledge from background reading and experience. Describing narrative interviews like these as '*social products',* Lawler emphasised not merely the character of narratives but highlighted how they must be approached to analyse and interpret, reinforcing the importance placed on coherency of theoretical assumptions, the type of data obtained and analytical strategies (Mishler, 1995).

These *social products* were used as interpretive devices and to create a representation of their selves in the midst of a storied world which was governed by tacit expectations (Lawler, 2002). As such they consisted of characters, actors and structures which populated their experience including how they altered with the passage of time and as multiple connections and interactions occurred. Although incomplete in their scope and partial in telling an individual perspective (Clandinin, 2006), because biographical narrative stories make meaning for those who tell them, it remains a valuable and legitimate activity to look for the meaning they hold (Bruner, 1997). With a constructivist, reflexive approach matching the co-constructed nature of these narratives, I found Lofland's approach ran parallel to the visual approach of Situational Analysis (Lofland, 2006, Clarke, 2005).

3.9.1 Situational Analysis

Clarke's cartographic approach builds on three co-existing areas developed after Strauss who claimed wider situations and cultural settings were integral to how social behaviour was constructed and reconstructed (Strauss, 1987, Garrety, 1997, Chen, 2011, Mills et al., 2007). Distinctions made by Clarke between these influences can be applied to medical experiences as follows;

Situational map (SM) - the situations, organisational structures and processes in which participants work

Social world/arena map (SW) – the social worlds/subcultures which they construct and inhabit,

Positional map (PM) - the positions which they take regarding situations, social expectations which reflect underlying motivation and expectations

Prominent SM features affecting the NHS included national political and medical organisations, national professional bodies, regulatory authorities, sites of work, medical equipment and medical treatments.

The SW map was populated by professional and non-professional groups, locally supportive clusters, shared awareness of expected professional roles and responsibilities when dealing with patients and their relatives, and with a substantial component involving team-based activity.

Finally, the PM demonstrated how aspects relating to individual attitudes, principles, and aspirations come into play, also self-esteem and the basis of decision making.

Although adjacent arrangement of all three maps had not previously been described, it seemed appropriate for my data to modify Clarke's method by placing maps alongside each other on a single combined map where links across mapping boundaries indicated many emerging connections. A mapping complex was created in this way for each interviewee. A section is provided in Figure 1 and a simplified whole-map version in Figure 2.

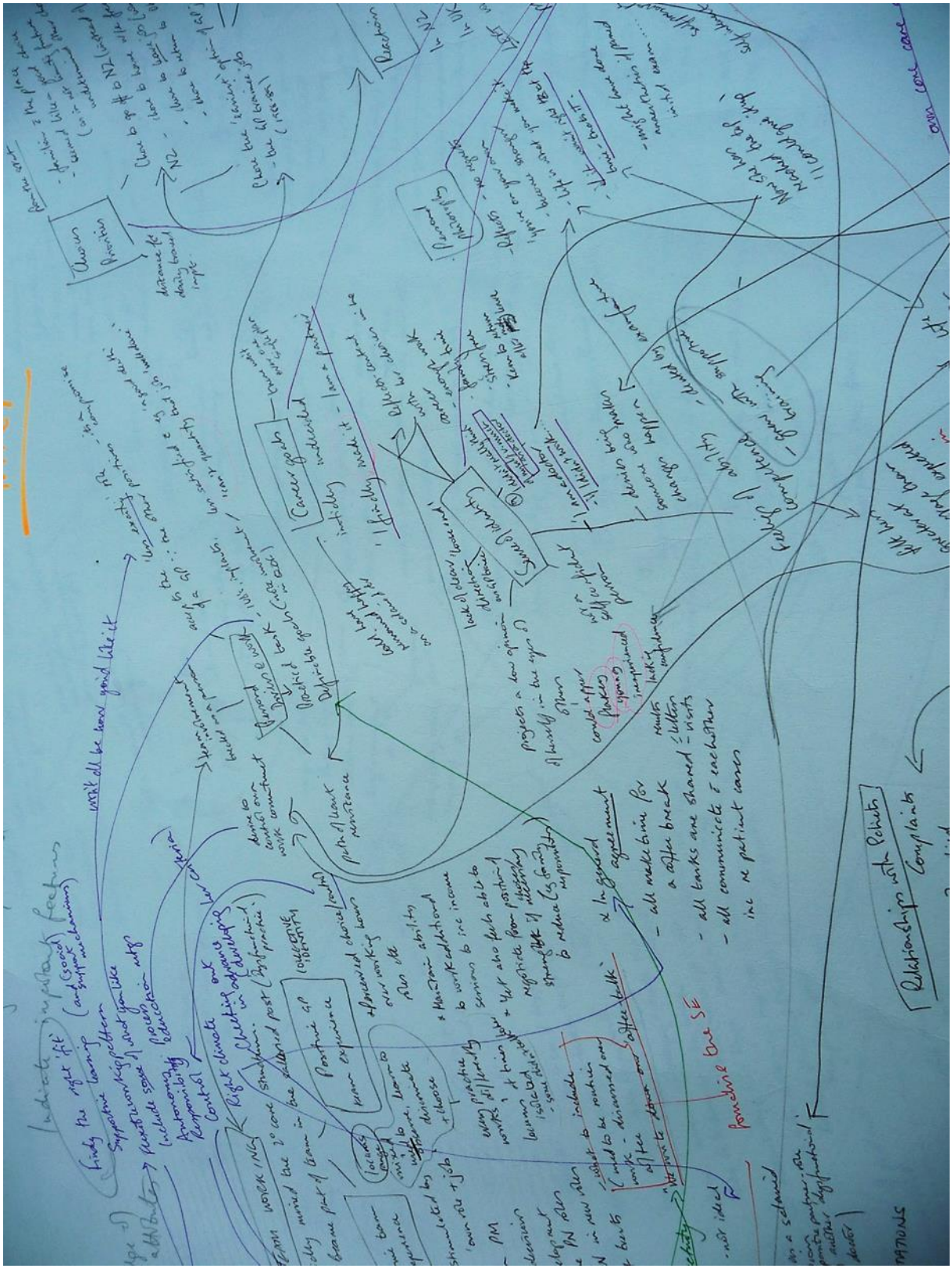

Figure 1 Section copied from hand-drawn original mapping complex

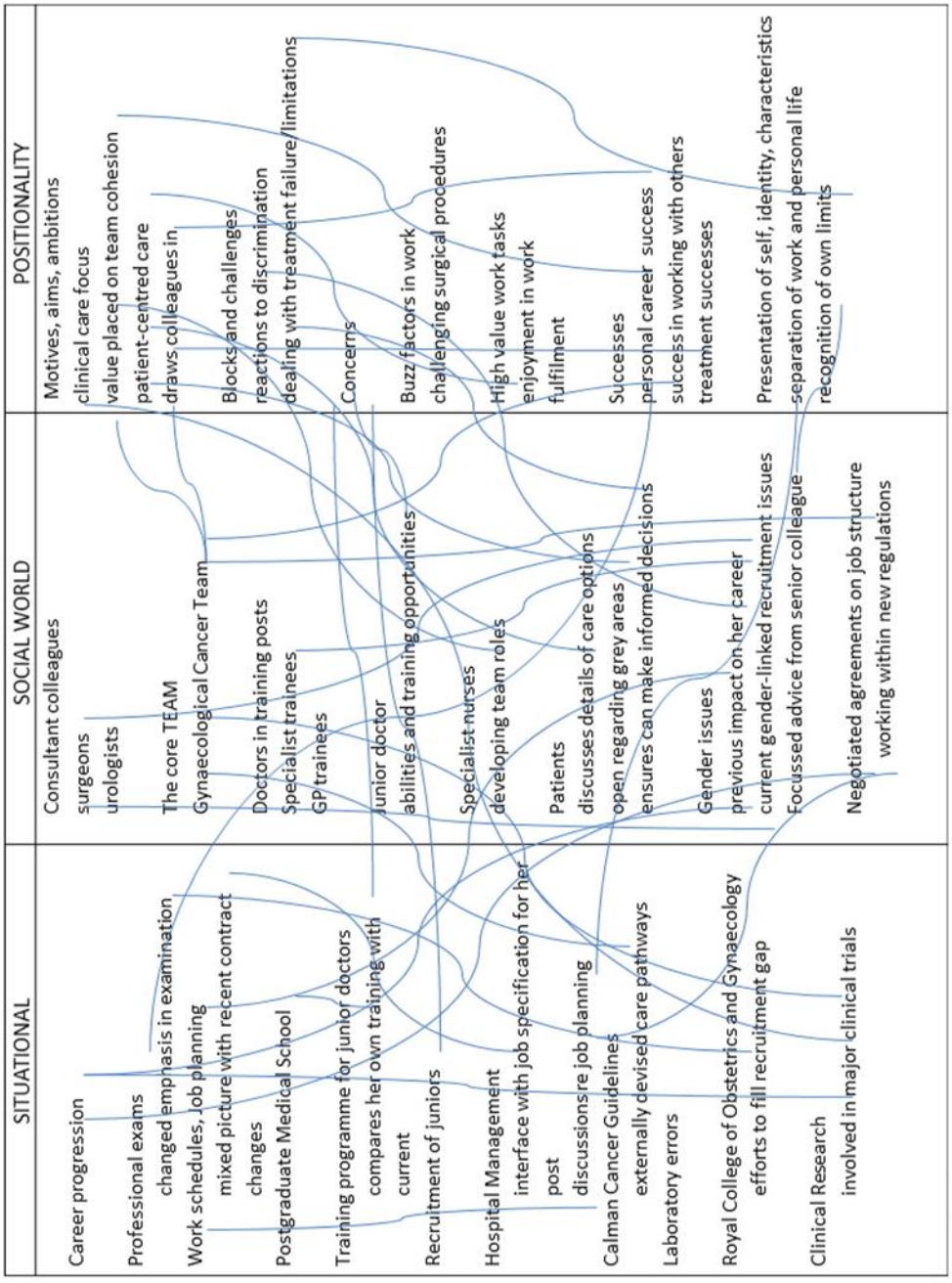

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Figure 2 Simplified version of mapping complex

As a structured system to open up layers of ‘digested’ (coded/categorised) data, this enhanced analysis through demonstration of connections between the constituent categories. It allowed application of pre-existing knowledge and facilitated a reflective step

back to view the data from new angles offering greater objectivity to my insider position, allowing me to better see the silences and reflect on incongruities which emerged.

Drawing on categories and connections evident on the maps I further mined the data to discover how specific themes were represented. For example, I studied how aspects of identity were expressed and been facilitated or inhibited by everyday social world and situational elements. Figure 3 shows an outline of data contributing to wider themes.

Returning to Lofland's work, it became clear that responses to the questions he advocated appeared in the maps as follows ; *types* were represented by categories, referenced lists illustrated *frequency and magnitude*, SM categories were dominated by *structures*, chronological data showed *processes*, interlinking criss-crossing lines demonstrated c*auses* and *consequences* while background reflective work on all mapping complexes evoked ideas about *agency* (Lofland, 2006). Importantly, analysis did not primarily depend on capturing the pattern of these links, but on the interpretive understanding which was gained through their creation – the development of theory occurred as I interacted with the data (Lofland, 2006).

All interviews contributed on an equal basis to my overall analysis. Their comparable and contrasting perspectives presented in direct quotations and poems, tend to draw on narratives which spoke in more depth or with greater reflective insight on particular themes. I have been careful to ensure that observations and insights which appeared prominent for each doctor received due attention and to avoid imposing my own priorities. My use of pseudonyms was intended to foster reader engagement with participants as coherent individuals

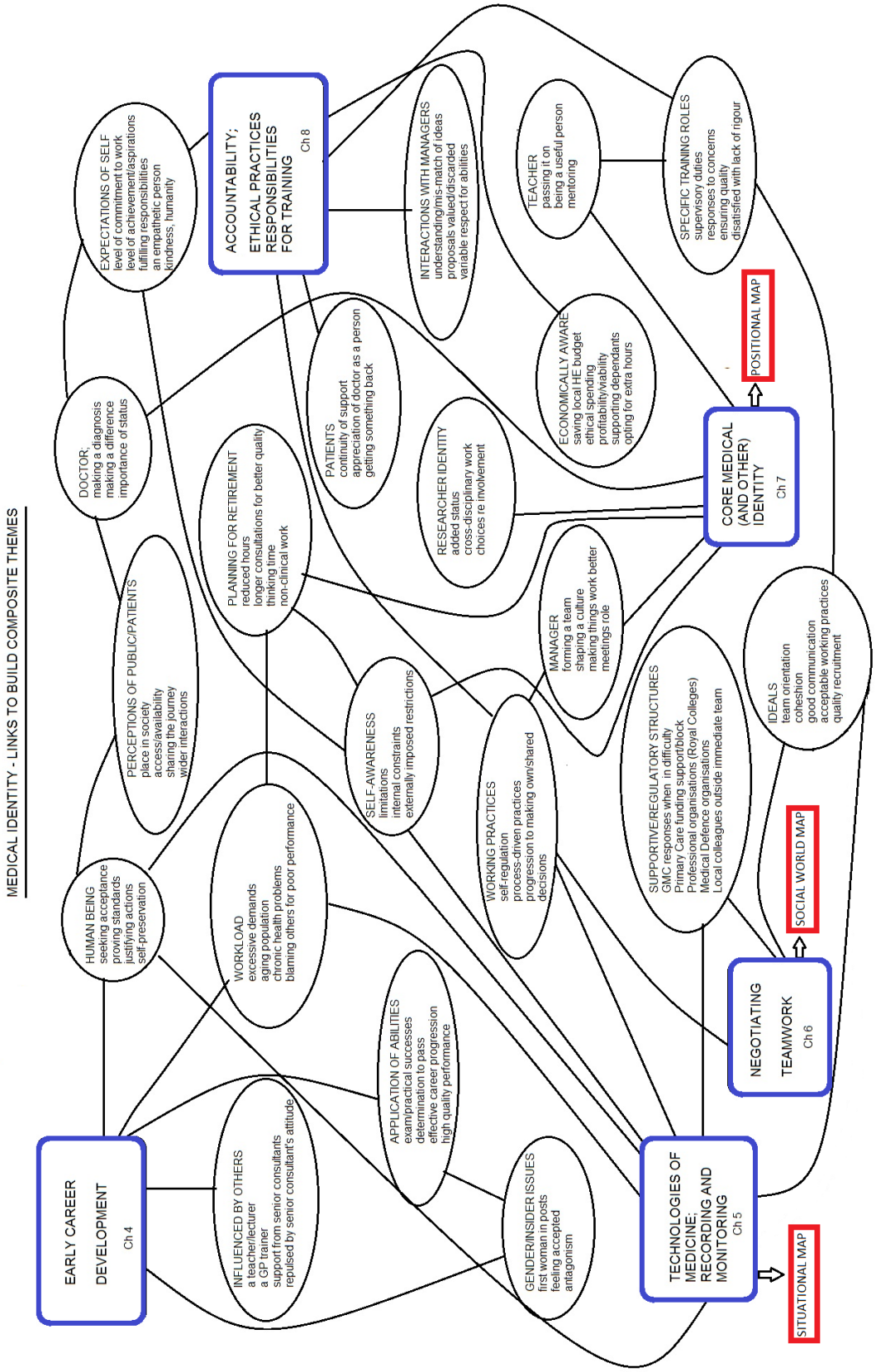

Figure 3 Data from detailed analysis contributing to development of wider themes

3.9.2 Additional actions to confirm trustworthiness

In the absence of predetermined themes or semi-structured questioning, deep engagement with data during a period of many months produced multiple ad hoc lists. Proposed explanations and interpretive mechanisms were formulated and compared with data, informally tested in everyday conversations with work colleagues and medical friends who sometimes agreed or disputed the reasonableness of proposals.

When a potentially important new theme emerged from any of these discussions or through focussed reading, I returned to transcripts, annotations, summaries, spreadsheet and maps to evaluate its significance, weighing this evidence before promoting it as an enduring category or placing in a less prominent position. Having personally conducted all interviews I was able to mentally retain much of what had been discussed which facilitated cross-referencing alongside ability to maintain coherence of individual doctors.

Formal discussion of data occurred in supervisory meetings after supervisors had prior opportunity to read and reflect on data. These external, non-medical perspectives brought invaluable additional challenge to unconscious assumptions. In analysis workshops, peer researchers studied sections in depth and exchanged ideas about analytical methods and findings.

At the request of a number of interviewees I agreed to send a summary of the main findings of my research but I have not chosen to return to individually confirm whether they shared my understanding of their narratives. Although accepting that their intended story may differ from my interpretation and that the original remains theirs, since my assumptions may not coincide with those they brought to the data, any conflicting outcomes and possibilities for contested meanings could prove challenging to negotiate and lead to an unresolvable conflation across the data (Lofland, 2006, Lee and Ackerman, 1994). Consistent with my theoretical position, my duty was to present my interpretation of the findings according to the

principles which guided my research and with an open reflexivity (Etherington, 2004). Discussion following several external presentations of data added confidence that many medical colleagues shared the perspectives of participants.

3.10 Presentation of findings

Translating stories told in interviews to communicable pictures of lives experienced challenges available methods for reporting and publishing research findings. Foremost among factors considered in this decision were; analysis-related factors, data-related factors, audience characteristics, and researcher competencies and preferences.

Writing my findings contributed to my analysis process as a practical method of working out which thoughts and interpretive developments deepened and sustained understanding the data. To achieve thoroughly grounded results, use of analytical notes, field notes, and summaries of sections of data served to further develop my thinking and prepare data prior to formal dissemination (Hammersley and Atkinson, 1995).

The nature of personal narrative data; context, richness, imagery and evocative content, is better suited to presentation methods which adequately support depth and abundance of material. Sheer volume and a wide range of themes may, as in this case, dictate that careful contraction of data is necessary to capture essences from the whole, with selection of this data and its interpretation determined by my underlying epistemological assumptions and ethical responsibilities (Kendall and Murray, 2005).

Academic audiences generally welcome data in forms they can recognise and perceive as a valid product from empirical findings. However, I believe that if a form of presentation can also prove more widely engaging (including those whose stories are re-presented) it can be readily transmissible across a spectrum of audiences. Avoidance of dense or exclusive language which permits the reader or listener to feel engaged in their own reflective

interpretation of the presented data, facilitates a more diverse and inclusive audience to share in the resulting dialogue (Richardson, 1990).

Personal preferences, skills or experience in presenting material must also influence how the findings of this study can be disseminated; my degree of comfort and confidence with traditional and contemporary styles of presentation affects the quality of work produced and determines the eloquence with which it is communicated.

3.10.1 Grounding poetic representation in the language of narratives

Although conventional and familiar forms of data presentation readily inspire academic confidence, questions remain regarding whether the reality of lived experience can be accurately reflected in any linguistic or textual form (Derrida, 2007). Theatrical productions proposing to bring the audience closer to the lived realities of living communities from which the stories emerged, indicated that verbatim performances produced resonance and strongly engaged the audience (BBC and Lee, 2012).

If the stories revealed in this study are to be understood when shared widely, they must be accessible and able to similarly transfer understanding. They ought to remain true to the essences of the lives of the participants, resonate with others working in similar situations and ideally should be in a form which is pleasing to read or hear, but without loss of substantive sociologically informative content (Richardson, 1997). Re-productions of talk from transcripts can produce unwieldy text which is often either too lengthy to fit within a discussion, too dense to be grasped, or too fractured to convey the meaning in context and therefore fails to carry a sense of the lived experience.

After battles around ideas of illegitimacy in the academy and a fight to establish alternative writing approaches, the use of poetics has gained popularity as a means to '*communicate*

findings in multidimensional, penetrating and more accessible ways' (Cahnmann, 2003) . As noted by Kendall and Murray;

> *'We live in a world full of text; and where … accounts are presented as a large block of text, people may tend to skim read them, whereas if presented as a poem, people may approach them more slowly, expecting to hear them in their heads and being more alert to their patterns of sound, image, and ideas and more willing to engage emotionally with what is being said.*' (Kendall and Murray, 2005, p:746)

Recognising that my strategies for writing these narrative findings was a moral decision as well as a literary choice (Richardson, 1990), and having witnessed the effectiveness of this both as audience (Simmons, 2011) and when presenting to medical and non-medical audiences (on several occasions as listed in Appendix 11), I proposed to build on a growing body of similar work, intent on maintaining integrity of the stories, relating content without distortion and as complete in meaning as can be achieved (Isaac, 2011, Lahman et al., 2011, Rapport and Sparkes, 2009, Glesne, 1997).

Various poetic structures and terms have been applied to describe data in poetic form; poetic representation, poetic transcription, ethnopoetry, I-poems or simply poetry, each drawing on particular emphases and devices which capitalise on involving the reader in response to the intensity of the poem (Ohlen, 2003, Richardson, 1992). By focussing on particular narrative voices, this transformative writing aims to offer insights, to engage, to stimulate a reader's own interpretive work in response to suggested ideas and metaphors, and to make connection with the subjective experience of the narrator (Brady, 2010, Denzin and Lincoln, 2000, Saunders, 2003, Denzin, 1997a). Re-forming data into lines and stanzas, repeating the rhythms of speech, pauses and accentuation creates a reflexive space for the unsayable, encapsulating episodes of lives in a manner similar to how we remember and orientate ourselves to them (Ohlen, 2003, Saunders, 2003, Richardson, 1994). While

reducing the volume of material, this strategy aims to intensify the impact of the resulting extract (Maréchal and Linstead, 2010).

Selecting transcript for transformation into poems demands deep engagement with each interviewee's story and a feeling of enhanced understanding of their lived experience which can be both explorative and transformative (Glesne, 1997, Lahman et al., 2010). Material which aptly reveals aspects of importance for transferring knowledge and understanding takes precedence over data which might yield sensational but uninformative poems.

Unlike comparative examples skilfully demonstrated in Lahman's paper, my poems were not constructed to adhere to particular poetic forms though, as in all writing, an aesthetically acceptable effect was intended (Lahman et al., 2011). I preferred a technique often described as poetic representation in which lyric poems employ sound patterns, imagery and physical form to show how it *is* to feel something, to encapsulate the vividness of the episode or '*livedness'* of the narrated moment (Furman, 2006, Richardson, 1994). To facilitate visual engagement with poems and minimise disruption of surrounding text, longer poems are situated on pages facing my interpretive and explanatory comments, allowing readers to pause and dwell a little on the poems, to make connections or tease through their internal discursiveness (Smith, 2012).

The principal rules I adopted were to use the words spoken by the interviewees, to retain the order in which they were spoken and only rarely to adjust single word tense or ending to preserve the meaning of the phrase (thereby avoiding reader distraction due to clumsiness of original conversational-style grammar) (Glesne, 1997). Poems were created by removing those words which I believed not essential to the intended meaning, leaving those which maintained an authentic re-presentation of the sense, feeling, or message (Furman, 2006). I aimed to include only what was needed to convey a precise likeness in condensed volume and to achieve a poetic form in which participants could recognise themselves (Maréchal

and Linstead, 2010, Rath, 2012, Furman, 2006). On occasion strong words have remained undiluted to adequately express reactions and emotions. The ordering of phrases may flow jerkily, serving as a reminder that narrative recall can add layer on layer of remembered detail as the storyteller re-lives the story.

Formation of each poem adds a further dimension to understanding the data; to select which words were important to retain, I reflected on whether the extract remained cogent, whether the poem would convey new insights to an audience, whether contextual links remained undistorted and how this sat within my existing interpretive framework. Since no single interpretation in isolation can justifiably claim to be the only 'true' interpretation, interpretive credibility demands that I demonstrate a robust study design, an integral component of which is to make accessible the data which supports my reported findings as in extracts and poems included in later chapters.

3.11 Narrative legitimacy

My underpinning ontological and epistemological approaches recognise the incomplete, situated and temporally variable understandings gained by gathering and analysing narratives; they are individual constructions arising from recalled and interpreted events which may be expressed differently on another occasion or by a different witness (Riessman, 1993). To question validity of accounts by challenging the intrinsic authority of an individual's expression of perception, would run counter to my desire to privilege the account given by each participant (Skeggs, 2001). As noted earlier, Goffman described variations in how self-presentation may be affected by conscious or sub-conscious factors (Goffman, 1990) but privilege given to narrator's accounts ought not to diminish the rigour applied in research or to evade discussion of validity (Denzin and Lincoln, 2003, Silverman, 1993). Riessman's position on validation introduced four possible criteria for assessment; persuasiveness, correspondence, coherence and pragmatic use, but concluded that none brought adequate resolution (Riessman, 1993).

Of prime importance I propose that a firmly established understanding of applied theory and corresponding research methods with a reflexive stance prepare the ground for producing research findings which are fair explorations of the data and yield potentially trustworthy conclusions (Creswell and Miller, 2000). My orientation was primarily to conduct the process of gathering data with openness and emotional engagement, and to credit this material with inherent authenticity and subjective validity as though opening a portal to understanding an individual and their lived experience (Oakley, 2001, Creswell and Miller, 2000, Lincoln and Guba, 1985, Skeggs, 2001).

Multiple richly-detailed accounts which triangulate with each other and with researcher observations or as independently corroborated e.g. member checking by discussion of presented data, confirms a greater degree of general assent and probable reliability (Lofland, 2006, Lewis, 2009). Although returning to interviewees directly for useful responses proved problematic, poems presented orally or by poster elicited several responses in which other clinicians closely identified with the sentiments expressed thereby confirming elements of plausibility.

When discussing details of interpretation, Geertz recognised that the challenge for the outsider is to avoid being '*stranded in abstractions and smothered in jargon'* while an insider is in danger of finding themselves '*awash with immediacies'* and '*entangled in the vernacular'* (Geertz, 1973). Although much can be learned from what are prominent and obvious facts, the complexity of each informant cannot be ignored. Geertz advocated plural, multi-centred thinking, with overlaps and connections which are difficult to define, but use the same concepts or symbols employed in organising everyday life to unpack conceptual worlds as represented by those who inhabit them. In effect, he advised that understanding was best achieved not by looking behind the '*interfering glosses'* but by looking through

them. Whether this is more effectively achieved by an outsider entering a new social world or by an insider examining an intimately known one is further discussed below.

In practical terms, data in this research lies close to my own experience of workplaces, but also draws on my clinical experience of encouraging patients to describe how their health problems arise and my learned skills of looking for internal coherence or contradictions. Although different in many respects, exploration of an individual's concept of self as a person in their world seemed useful - through listening to the expression of their perceived inside (private thoughts, feelings) and outside (enacted and perceptible attributes) worlds. Inclusion of social arenas and organisational elements by which their professional world was defined, sets these observations in context. Discussion of doctors' narratives with academic supervisors, in Analysis Workshops and informally with medical and non-medical others expanded my consideration of alternative interpretations.

To some degree I have tested correspondence of my findings with clinical audiences and examined coherence through detailed discussion. On Riessman's remaining points, plausibility and the pragmatic use of my findings, eventual credence given to my findings would represent confirmation of acceptable credibility (Mishler, 1990).

3.12 Reflexive research; embedding my insider- researcher narrative

Having set out my theoretical approach and my shared background in training and professional work with participating doctors, I am ineluctably drawn to reflexivity. This has permeated both how I have sought out greater depth in understanding doctors' narratives and recognising my position - engaged in research of a social and professional world of which I am part (Etherington, 2004). I have not used my own stories to open deeper insight into the tales of others preferring to allow them to resonate with each other (Frank, 1995), but neither have I distanced myself from life experiences which I recognise and in many

respects may have shared; my interpretations cannot be completely separate from my own experience (Bourdieu, 1992).

Drawn from an exercise in which I set out my reflections in some detail, a task which I felt important to address before my thoughts became cluttered by collected data, the following extract summarises how I perceived my point of departure.

'"Perhaps YOU should be interviewed." she suggested. "Your participants are having a chance to tell you their stories, but yours remains untold...and the OUCH should get out there, with the rest...."

The prospect of an interview didn't much appeal. I had many arguments against attempting to mimic the narrative interviews with which I felt so comfortable as an interviewer. Besides, was there an OUCH in there? I wasn't so sure. The moment passed, but the idea smouldered. Perhaps I should at least try to set out how I thought about work, my motives, my reactions, turning points and the big moments – if only to review where I'd been.

Storying my journey from a four-year old with an inexplicable ambition to be a doctor, to a sixth former still determined to study medicine, I recognised that my burning desire then was to know how bodies worked; fixing them meant a little, understanding a whole person paradigm was not considered.

Transformative influences of medical school shaped without pain; I saw my future in the flexible and varied world of general practice and made my way there. Work and training brought contact with colleagues whose practices were influenced by Balint's[1] psychodynamic studies of consultations together with comprehensive structured teaching. High standards were expected in my training practice; professional attitudes, effective communication, making time to listen to really hear patients; self-regulated qualities designed to be inbuilt for an entire career.

As for other experiences - becoming a GP partner was an exciting time; a thrill of at last having my 'own' practice, a surgery building (partly) mine, management decisions (partly) mine and best of all patients could call me their doctor. A daily flutter of excitement accompanied driving up to my 'patch'; a socially deprived community with high levels of morbidity but down-to-earth attitudes and an appreciation of doctors who tried to listen.

Looking back, I feel sure my quest for knowledge for its own sake was sated in medical school, by graduation already less important than being a good doctor. In the context of work I assumed a new identity, but one which continued to evolve and centred around interactions with patients and keeping pace with the changing scene of general practice.

[1](Balint, 1957) SMS

Table 1 Framing my pre-fieldwork perspective

Leaving aside debate about precise definitions of a range of reflexivities and purposes of reflexivity in research (Lynch, 2000), I share Etherington's concept of regarding reflexivity as '*a means of constructing a bridge between research and practice',* so that through being informed about my starting points, my position in relation to interviewees and their stories, and how I examine my involvement, readers will better understand and be confident of my interpretations of data (Etherington, 2004).

Chapter 4

Starting out; narratives from early medical careers

> *'Graduating as a doctor is like opening a door to a long road leading to the noblest action that a human being can do for others…*' Fidel Castro, (quoted Murphy, 2008)

Bridging a transition between methodological considerations and presentation of research findings, four main purposes are served by this chapter;
Firstly to review the duties and responsibilities expected of junior doctors, secondly to illustrate how the nature of their job and their relationships with others were told in narratives, thirdly to consider what is revealed about early professional development in this group and finally to note how some moved into their chosen specialties.

Transition from the status of medical student to doctor which launches each generation into the workplace may pass almost unnoticed though it is sometimes marked by a ceremony (Veatch, 2002). For many participants, memories of work during their pre-registration year were their first topic as they took a chronological route to story their medical career. Recounted in old documentaries, fiction and dramas or witnessed first-hand by in-patients, tales the long hours of work expected of junior hospital doctors during 1980s remain in public consciousness and this group shared memories of taxing work schedules and internal rivalry but also of supportive camaraderie.

Narratives often contained detailed imagery, which emerging piece by piece, created an impression that the story-teller was surprised by the memories triggered by voicing a long-dormant incident. Bearing in mind that these events occurred in 1983-84, it is remarkable to note the detail with which specific events could be recalled, often with strong emotional

content and clear visualisation of the faces of those present. These vivid accounts accorded with identification of *'free associations'* in stories, recollections which prised open past events to reveal greater insight into the underlying processes and anxieties of the situations to which they referred (Hollway and Jefferson, 2000).

4.1 Duties expected of newly qualified doctors

It is worth noting that the position of pre-registration doctors often termed Junior House Officers (JHOs) was that of having qualified as a doctor after success in university examinations and permitted under provisional license from the GMC to practise medicine under supervised conditions. For the first time these new clinicians were personally responsible for their own clinical decisions. Senior colleagues could confirm or challenge decisions their following further assessment but, by thinking through presentation of cases, analysing results of investigations and monitoring the effects of treatments, juniors could gain valuable experience.

A range of duties fell to JHOs when for two periods of 6 months they were typically embedded in acute medical and surgical teams; initial assessment of patients referred for admission – recording a detailed general and focussed medical history, organising all appropriate initial investigations and presenting significant findings to others for confirmation and further evaluation. Practical tasks formed a major part of JHO work; receiving calls from GPs about new admissions, filling forms to request investigations, making phone calls to organise tests, to negotiate admissions to wards or book operations in theatre sessions, writing up detailed regimens for medication, recording findings and developments, chronological filing of paper copies of results in patient folders, preparing and administering intravenous medication and liaising with multiple colleagues. During surgical team posts JHOs were often required in operating theatres to assist a surgeon by holding instruments firmly in place though some also thoroughly enjoyed learning elementary surgical skills. It

was not unusual for JHOs to be expected to undertake technical skills after brief training – the adage being ‘See one, do one, teach one’ (Koehli, 1989).

Tales of badly treated overworked junior doctors was part of a pattern which had been in place for some time prior to 1983 and would continue despite voiced concern for the safety of patients and the health of medical staff (Greenhalgh, 1988, Durnford, 1988). Rotas were described according to the frequency with which doctors worked additional hours to cover ward duties and emergency admissions A ‘2 in 3’ rota for example denoted that in addition to five normal daytime hours of work per week the JHO was on duty during 2 of every 3 nights and weekends. Evening, night and weekend duties meant a total usually greater than 100 hours on duty per week, and in this case up to 125 hours, though diligent completion of ward duties could exceed official working time. It was generally not expected that the doctor should be awake and active during the entirety of each night when on-call, but sleep disturbances were commonplace and dependent on patient needs and support available from colleagues, and many doctors found it difficult to sleep in allocated rest rooms.

Long hours of work were a contentious area and one which frequently provoked comment from patients who noted the near-constant presence of the same doctor through several shift-changes of other staff. However, the presence of JHOs on wards and working closely with patients allowed them to follow patients’ progress closely and to become well acquainted those whose illness detained them for longer periods and to become thoroughly familiar with ward-based work.

Where doctors shared hospital-based residences fostering greater social contact, colleagues readily became friends and mutually supportive practices made everyone’s job easier. Strongly hierarchical and overtly competitive team behaviours however could have the opposite effect. Among medical staff, certain discourses prevailed and could influence juniors’ choice of post; e.g. that teaching hospital experience was seen as advantageous

since a good reference from a highly regarded consultant or professor was expected to carry more weight when competing for the next level of training posts.

Problems with stress, exhaustion, emotional distress and illness were identified in JHOs with concerns for their performance and their own health (Poulton et al., 1978, Firth-Cozens, 1987, Wilkinson et al., 1975, Spurgeon and Harrington, 1989) and added to pressure to reduce working time in advance of the EWTD of 1998-2009.

Early career progression

After one year of satisfactory supervised clinical training and having gained full GMC registration junior doctors were eligible to train for a specialist or general practice career. Significant numbers either chose not to commit to a pre-defined program or were unsuccessful in obtaining a place on the programme of their choice and were able to progress through other junior and middle-grade posts which contributed to training requirements before choosing a longer-term career. During these stages their eventual destination remained unclear – training requirements, examinations or other issues could become insurmountable obstacles. Hours of work remained high through subsequent training posts, particularly for hospital specialist trainees and this was a commonly cited reason for leaving medicine (Paice, 1997).

4.2 Enriched accounts conveyed through narratives

Bearing this in mind I considered how experienced clinicians recalled and reflected on their experiences just after qualification by analysing narrative components under two headings; characteristics of JHO posts, and characteristics of the people with whom they worked – though some overlap is inevitable.

4.2.1 Effects generated by work requirements

Onerous work

Narratives describing the extent of JHO duties, responsibilities and hours of work indicated that because they were often onerous and exhausting doctors withdrew from non-work activity. When on duty in the night, Richard resented being *'at the beck and call of all these people'* and it took little time for John to conclude that his preferred future would not involve on-call duties:

> *'I actually didn't want my job to dictate to my life…I was clearly going to start resenting the fact I was going to be on-call every night of the bloody year, weekends and stuff.'* John

Alice spoke of extensive periods of filing results and sorting records which ate into her off-duty evenings;

> *'I was there from like 7 in the morning till 7 at night, because I took the job really seriously'* Alice

Similarly Helen recalled *'I don't think I actually sniffed fresh air for 3 months'* and Stewart remembered that he did nothing '*except sleep, eat and work'* during his pre-registration teaching hospital surgical post.

When immediate work had been done and there might be a possibility of some rest, rooms provided were not conducive to sleep which in any case was likely to be interrupted;

> *'as a houseman you have to be in hospital to be on-call, and it was waking up in the night with your bleep going off, and having to sort of struggle out of bed and usually the heating would be too hot and it would be dry and dusty and trying to find a vein in someone whose veins didn't want to be found, trying to put a drip in or taking bloods, and I thought well the sooner I can sleep in my own bed … the better'* Richard

Doctors even experienced difficulty taking their entitled annual leave since;

'if you couldn't find a locum to cover your holiday, you didn't get a holiday' Helen

Stewart recognised that the effects of long periods in work harmed him in many respects;

> *'you don't socialise enough, you don't do enough sport, and you can kind of socialise by drinking too much at the weekend when you are off…I didn't like that sort of rut.'* Stewart

Impossible tasks

Certain duties were remembered as particularly difficult; Helen recalled traumatic consequences of difficulty meeting her surgical consultant's expectations in the operating theatre:

> *'when he made the neck incision it was your job as the house officer to stand there with two retractors in like that, and he covered your hands with a green cloth, and then when he took the green cloth off, after 1 ½ hours, if your hands weren't exactly in the same position as when he put the cloth on he would bollock you in front of everybody… And of course you never were in the same position because you couldn't see your hands to adjust them, terrible'* Helen

Job satisfaction

Completion of tasks could however be viewed positively; as Richard introduced his reflections on hospital junior posts, he did so against a background of acknowledging that he found practical, sorting-out tasks most rewarding. As a ward-based doctor his urge to *'make order out of chaos'* fitted well with routines of admitting patients, taking blood tests, making a working diagnosis and suggesting a treatment plan. Rather than a large teaching hospital, where there tended to be more hands enthusiastically grasping at opportunities to practise technically demanding procedures than there were patients requiring them, he located himself in smaller units where he could personally complete tasks with a greater degree of satisfaction, even enjoyment, experienced through doing more with and for patients. He relished testing his skills simply for amusement and challenge;

'that used to be quite fun actually… you would sort of take blood and it was a little lab in the middle where you could smear a blood slide and have a look at that, and do your own microscopy on cerebrospinal fluid. So we used to have a race; when we got a [case of] meningitis and we'd do the [test] and send it off to the lab and see if we could beat them to the diagnosis.' Richard

Self-awareness and choosing a post which matched his preferences allowed Richard to gain satisfaction and confidence; he had space to work on his own initiative, perform autonomously though within boundaries; although he struggled with night duties, he presented his early roles as more challenging and rewarding than stressful.

Hierarchical structures

New JHOs were generally less familiar with what they ought to be doing than nurses who had worked on the same ward for some time and they had not yet properly learned to communicate effectively with colleagues (Lingard et al., 2002). As has already become clear Helen felt herself at the bottom of an uncaring pile while George remembered

'*feeling that I was just going through a process then because I wasn't really making any diagnoses or decisions, I was just a tool in a machine'* George

He was aware that all around him others were competing to impress the consultant and to reach the top faster while he was limited to getting on with his never-ending pile of tasks;

'clerking people in at 5.30 in the morning who had been admitted at 11 o'clock and you had had been so busy you hadn't got round to it.' George

Yet Mary seemed undeterred by hospital work because of the support she felt from;

'having some structure around you, and actually having a structured day' Mary

Later perspectives on continuing hierarchies naturally indicated that these doctors had progressed to more senior positions from where the view was likely to be different.

A balance of autonomy and supervision

Of the accounts given, Mark seems to have most closely aligned himself from the outset with the prevailing teaching hospital ethos of career advancement which he negotiated with some success through his personal efforts to improve on existing treatment regimens. He relished delegated authority to modify existing medication when admitting patients for surgical procedures, for example by achieving better blood pressure control. Naturally his consultant was impressed and he remembered receiving praise for using his initiative. *'I loved that autonomy that chance to contribute, to make that difference'*. Faced with unsatisfactory measures to control side-effects of cancer treatments, he felt a need to try something different;

> *'I used to see patients terribly distressed and there was a standard [medication] they got … which didn't work in many cases and I remember saying to the ward sister, 'Ok we need to do something' and I basically…looked at all the options…and I was able to do it and the patients felt a lot better.'* Mark

Having researched the literature to identify alternative options and sufficiently supported and empowered to introduce newer drugs which proved more effective Mark's confidence was high but his most vivid recollection was of a prescribing error which occurred around the same time and which may have been avoided if a senior colleague had been more closely monitoring his work;

> *'I still remember her, I remember her face …she had one of the blood disorders. Vincristine [chemotherapy] was started on her and I had to work out the dose … but there was an error in the dose and she got slightly too much and as a result she got pins and needles and things... Now you know I still feel bad about it now. That's 27 or 26 years ago; I remember it now.'* Mark

Although ill-effects of the error were in this case somewhat limited, Mark suffered loss of sleep and severe disappointment in his performance; interestingly his choice of words

avoided first-person admission that it was his personal error though this was implied in his story. Safety systems were not well developed and Mark expressed regret at the absence of formal review or investigation; colleagues seemed to have little appetite for discussion of the incident. At this early stage he was already experiencing an uneasy balance between opportunities to act autonomously and inflexible working patterns, between sufficient space to make an error and close and restrictive supervision. His damaged self-image became a source of personal distress and his subsequent self-presentation indicated continued conflict between autonomy and regulatory or procedural control, between acceptance of the status quo and pushing for the highest possible standards of care.

Positive learning experiences

In general doctors expressed positive recollections of work which was consistent with their desire to put learned skills into practice through diagnostic work, treatment for patients and developing new practical skills – but they also encountered the darker side of medical error or of judging themselves as having failed to reach the highest standards.

For some, the ability to spend time in close contact with patients brought feelings of appreciation and positive feedback while others were so overwhelmed by the tasks to be done and demands to be met that they felt no personal pride, received no recognition and resorted to simple survival. The degree to which these outcomes were influenced by their choice of workplace or by personal attributes is not possible to confirm from this data though in general, the pressure of coping with an intense teaching hospital post appeared to generate fewer rewarding memories.

4.2.2 Influences of work colleagues and patients

Given that a considerable proportion of a junior doctor's life was spent at work, interactions with other staff and patients were of marked significance to experiences of the workplace and as such featured strongly in doctors' accounts.

Socialisation and support

Graham chose junior posts at District General Hospitals (DGHs) and smaller units, in teams with which he became familiar as a medical student or of which he had heard good reports and where he expected to work happily. His narrative was dominated by social interactions, by camaraderie between colleagues who readily supported each other and enjoyed spending time on ward-based activities. Since on-site doctors' accommodation units at both hospitals functioned as an off-duty venue for socialising, he regularly spent time there with colleagues who he regarded as friends. Learning was exciting. He was able to get to know all the patients under his care. When needed, support and expertise were available. Working 100 hours in the week was perfectly acceptable;

> *'You really did feel a valued member and it was kind of, not quite a holiday, but an experience, an expedition that you all did together…it was good fun, and you learned a lot and … because it wasn't a teaching hospital and you were a bit more independent, you could go and do things like insert chest drains and things like that, rather than have the middle grade doctors do it all, you could do it as a junior.'*
>
> Graham

With forward planning, Graham's choices facilitated higher levels of socialisation and autonomy and he was able to practice technical skills which proved useful later in his career.

Inspirational teachers

Exposure to the influence of a single inspirational teacher can steer entire careers; which for John was to immerse him in quite different specialist arena. His story was somewhat animated and clearly he expected everyone to remember a pathology teacher whose colourful demonstrations of knowledge had inspired him;

> *'BG was a very, very fantastic teacher, people used to sit there in awe… it was like wallpaper, you had all these stains…blue, red, pink, yellow… meetings where he would take the piss out of the clinicians for being crap you know, he put up all these things, 'Oh, [a clinician] got it wrong, I mean look at this you know, ha, ha' ..*

and everyone was 'Oh fantastic B'...he would put together a whole case about …all the organs that were going wrong. Fantastic.' John

Others stated their inspiration more mutely; for Jennie it was her GP trainer whose practice of spending time getting close to patients matched her own preferences and to which she attributed her career-long habit of getting *'very involved'* with patients. Stewart's trainer influenced him in several ways;

'I did a joint surgery with him on about my second day in and this girl made a big fuss …she wanted to see Dr S and wouldn't see anyone else. And she came in with a sore throat and went out with the pill … I had no idea that that happened…And generally his whole attitude… he was knowledgeable but very self-effacing … was interested in detail and that was one of the things that inspired me.' Stewart

Impressive clinical knowledge, an attitude towards patients which resonated with a young doctor, or a package of skills and attitudes, the various attributes of these inspirational teachers had proved durable.

Competitive strategies

Contrasting stories emerged from workplaces with more hierarchical structures; Alice found the academic competition there was *'just ruthless'* while George who was pushed to his limits trying to keep pace with work demands, recalled attitudes of colleagues only slightly more experienced than himself;

'..within that machine … were a couple of people in the middle of it who I just disliked because I thought they were snakey, challenging, hierarchical people who wanted to prove me wrong, who wanted to say to the consultant 'He's admitted [the patient], then he has done this and he has forgot to do that and thank goodness I rescued it and can I now get a foot on the ladder please?".' George

Here George sensed no patient-centred care; emphasis was on formulating a clever diagnosis and making your mark as a clinician worthy of recognition and promotion. He described those doctors as;

> *'a hideous group of people who were climbing up each other's backs…the hierarchy, the pecking order, the stress [of professional exams]… and all those things made them not nice people.'* George

His adopted mental attitude was to *'take the battering of it for that short lived period …and soldier on'*, but he felt that in doing so, in behaving as a '*tool in a machine'*, a sense of compassion was lost and he had encountered working practices which did not foster positive development of his clinical mentality; pressure and criticism forced him to adopt survival strategies.

Bullying

More serious for those who encountered it was bullying behaviour which had longer term consequences. Having chosen to work on the team of a consultant she had idolised as a medical student, Alice became *'the butt of his slagging and it was the job from hell'.* Not only was she expected to underpin the team by staying late to complete the most mundane duties, she found his attitude sarcastic and damaging to the extent that she declared herself almost broken by it and was driven to confronting him about how her opinion of him had changed because of his unreasonable (and unprofessional) behaviour.

A slight improvement appeared to follow this difficult conversation (and her tears) but she was later informed by other consultants that he was *'blocking references; and so he tried very hard ….to make sure I didn't get a job'.* Only after Alice removed him from her list of referees was she invited to interviews and able to progress – fortunate that other consultants had not closed ranks to support his actions. This entire episode came as quite a shock;

'...it really upset me that somebody could get such joy out of somebody working hard and picking holes in it, I think that was a revelation to me that people would behave like [that].' Alice

Expectations of fair and ethical behaviour were clearly breached leaving Alice in shocked disappointment with this senior consultant.

Unfairness also affected Helen who despite total commitment felt little support and regularly experienced overt and public criticism from her consultant. She felt humiliated by criticism if was she was not promptly present for a ward round and perceived senior nurses unresponsive when asked for support in caring for severely ill patients.

Oh it was terrible, it was a 2 in 3. [laughs] I didn't get, I don't think I actually sniffed fresh air for 3 months , absolutely dreadful in terms of bullying from nursing staff , bullying from consultants , no rest, exhaustion just shat on really it was horrible. Awful. Awful. And [I] remember one moment one day where I was crying in the treatment room , because I was making up the IVs and I was so tired and the pharmacist who was the only friendly person on the ward , saw I was upset , gave me a cuddle and came and bought me a box of jelly babies . [laughs].

Table 2 Transcript extract, Helen

The data extract above picks out a long-remembered moment when a peripheral team colleague witnessed her exhausted distress and with the smallest of gestures supported her determined but very real struggle to survive (and is shown in raw form for comparison with a later poem).

Relationships with patients

Although Jennie's narrative skated lightly over pre-registration hospital posts she returned to reflect on how she developed in her ability and preference for establishing close, longer-term relationships with patients and recalled how they expressed appreciation. She recalled chatting and making jokes with inpatients and being touched by their responses;

> *'...there was a lung cancer patient and I remember, in fact, I have still got it; he wrote poems about me'* Jennie

Not only did she spend time getting close to patients and their problems as a junior doctor, but the same pattern of empathic concern which was established then continued throughout her career.

Graham recalled how he and his colleagues used to divide their time between assisting in operating theatres and closer working with patients;

> *'You would go in and help them do the surgery bit, which was fun, but after a while the novelty wears off and you would rather be back on the wards, thinking and doing things, you know, for patients.'* Graham

Clearly Graham and his colleagues were less curtailed than some in how they organised their work, able to choose when to return to tasks which affected smooth running of patient care – and they made certain to enjoy both learning together and socialising in the on-site Doctor's Residence.

4.3 Transforming data presentation

Before moving on to later narratives, it is perhaps useful at this point to demonstrate how the transformation of a short data extract into poetic form allows the data increased openness and encourages reader engagement beyond the scope of verbatim data.

As described in Chapter 3, poems were formed from data which I felt of particular significance by reducing words I believed unnecessary to conveying the meaning of the

data. This transformation of Helen's data in Table 2 in which she spoke of difficult relationships on her ward, produced a more concise and powerful iteration in which her isolation and emotional distress appear in sharper relief.

Housedog

Terrible
didn't sniff fresh air for three months
bullying nursing staff
bullying consultants
no rest
exhaustion
just shat on really
awful
crying in the treatment room
making up the IVs

so tired

the pharmacist
only friendly person on the ward
gave me a cuddle
bought a box of jelly babies

Helen

In these few lines Helen's distress was evident; isolation, fatigue, imprisonment, and all the time trying to perform her duties. A single spark of humanity lingered in a simple kindness from a solitary person who offered support. In poetic form a reader is drawn closer to her emotional distress and, for those who have in some form been there, personal memories connect with her inescapable struggle.

Tools in a machine

I remember the on-call stuff;
classic stories
I was just going through a process
wasn't making any diagnoses or decisions
just a tool in a machine

Within that machine were people
I just disliked;
snakey, challenging, hierarchical people
who wanted to prove me wrong.
To say to the consultant
'He has done this and
he has forgotten to do that,
and thank goodness I rescued it
and can I now get a foot on the ladder, please?'

No patient-centred attitude;
it was about a diagnosis

And I was tired;
I used to stay on nights off
do all the clerking and the filing

People were falling off
with stresses and breakdown;
one ended up in a psychiatric hospital

George

From George's data this facing poem traced a similar process through aspects of his job and poor interactions with colleagues

• • •

Tools in a machine

• • •

The separation George felt from ruthlessly ambitious colleagues was abundantly clear and soon he was reduced to simply finding a way through. He was vulnerable, engaged in a game he did not wish to play and with people whose ambitious, doctor-centred approach he did not share. Recognising how severely it could impact on his own health, his options were limited.

By making a transition to poetic form, this section of data draws together the difficulties of both his job structure and negative consequences inflicted on him by the aggressive competitiveness of others. There is space for him to reflect that their style of medical practice appeared to focus on themselves and their brilliance leaving patients in the crossfire while they fought their way to eminence. This poem also has capacity to recognise casualties in the system; to register this without fine detail, appears sufficient.

When working and learning were fun

Six months there was good fun;
loose on the wards,
working with people you know
registrars that had taught us.

Living in the hospital
I would stay some nights because
there was a social thing to it.

It was fun, exciting,
learning a lot,
in an environment that you were comfortable with.

The surgeons let you get on with the medicine,
and you would call for help as you needed
You would help them do the surgery bit,
which was fun,
but the novelty wears off
and you would rather be back on the wards;
thinking and
doing things for patients

It wasn't too onerous;
by mid-afternoon you tidied things up,
could play pool.
Not too busy but you can rack up 100 hours

There really was a community,
camaraderie spirit.
Nights off, you would all go out together
You really did feel a valued member

It was an experience,
an expedition that you all did
together

It was good fun.
And you learned a lot
you were more independent
could do things
could do it as a junior

Graham

By contrast Graham's recollections were of positive experiences; fun engagement, supportive colleagues, friends on and off the wards;

• • •

When working and learning were fun

• • •

Socialisation and support marked Graham's carefully chosen posts, maximising a supportive camaraderie and friendship between colleagues and taking advantage of opportunities to acquire practical skills and exercise a degree of autonomy. The headline total of hours was tempered by an ability to have relaxing 'time-out' and the sheer joy of performing as a doctor after years of preparation. Use of verbatim quotes normally attempts to avoid undue repetition, but in a poem repetition, bounce and rhythm of the wonder of learning in a collegial and supportive environment lends an ongoing momentum to the piece. There remains a sense of endless possibilities, of his/their adventure, and of progress towards building a satisfying career.

Generating poems encouraged me to engage again with data and through presenting them to different audiences to hear the depth with which they were understood and realise how powerfully listeners reacted to expression of feelings or were reminded of past experiences and at times identified strongly with the narrator. For these reasons, poems continue to carry data throughout subsequent chapters often contributing a more rounded picture of what was important in the context of the quote. Since some data does not readily transfer to poetics and at times pertinent quotes are more appropriate, data is included in both forms.

4.4 *Neo-professional*; a provisional status

As discussed in section 2.9 many sources agree that a sense professional identity and understanding core characteristics inherent in medical professionalism undergo significant development from the point of qualification (Niemi, 1997, Weaver et al., 2011, Helmich et al., 2010). Stories revealed several examples during this period when doctors' developing professionalism was nurtured or challenged.

Hilton and Slotnick have termed young doctors as '*proto-professionals'*, but I propose a more fitting choice could be that of '*neo-professional'* (Hilton and Slotnick, 2005). At their graduation there may be variation in the degree to which individual doctors have progressed to firmer identity definition and embraced the duties, responsibilities and attitudes which are recognised as characteristics of medical professionalism (Kahn, 2013), but by obtaining a medical degree and entrance to the GMC register they are already correctly termed *'professionals'*.

Identifying this group as *neo-professionals* takes account of the learning processes which are in progress while the doctor enacts a professional role within limitations imposed by supervision. Cognisance can also be taken of their inexperience in enacting these roles, of vulnerability in hierarchical structures, and of a degree of malleability in what they will come to accept as normal practice and whether they may be at risk of adopting practices at variance with what they have been taught once these are observed (Cottingham et al., 2011). Indeed concern has been voiced that while medical educationalists have been teaching a bioethical based medical professionalism, an alternative sociologically favoured approach to adequately address relationships between clinical autonomy granted to the profession in expectation of returns such as altruism, morality and integrity, has been neglected (Cruess and Cruess, 2008). Once more rigid concepts have been established in a doctor's thinking and become tangled in complex notions of clinical mentality and a defence

of autonomy, unhelpful links between these concepts have been found more resistant to modification (Armstrong and Ogden, 2006).

As these experienced clinicians narrated their neo-professional experiences, they did so in knowledge of understandings of professionalism which have matured as their careers advanced. In their stories they demonstrated constraints of authority due to their lowly position. Clinical autonomy was limited and where granted could lead to contrasting positions of satisfaction with innovative work or distress through having had sufficient latitude to make an undetected error. Orientation towards caring for patients and skills to listen required more time than was available in some pressured posts. Socialising with likeminded colleagues contrasted with attrition of cut-throat competitiveness. Despite long hours of work their efforts could go unrecognised or receive unwarranted criticism and they encountered many instances when senior colleagues displayed behaviour which fell below standards to which they aspired.

4.5 Exploring early career trajectories

Onward transition from supervised dependence to independent practice transporting each neo-professional on a trajectory to become a mature professional has appeared, at least in the early stages, aided or impeded by factors such as inclusion, validation, affirmation and receiving feedback (Shiner and Howe, 2013). Construction of an independent self-identity and increased self-confidence occurred at variable rates and was influenced by support for ongoing learning and development through practice-based groups or mentoring for newly qualified GPs during a period when many personal and professional changes were occurring simultaneously (Rial and Scallan, 2013, Griffin et al., 2010).

It is worth pausing at this point to consider how doctors reflected on their progression from junior to senior positions, particularly with reference to two narratives shaped by particular obstacles.

When Henry's several applications resulted in a only one early interview he began to wonder if there could be an undetected problem though he had *'got membership, got some research… publications',* but he was reassured by his consultant that '*no it was just nothing, just was unlucky, good candidates'*. However through an accidental disclosure he was shocked to hear what he believed was clear evidence of a decision made prior to interviews – in keeping with rumours of preferential appointment. Unable to progress there, he simply relocated.

The cabal

It was run by a cabal,
people who decided
who was going to get jobs.

I remember
my consultant said,
Isn't it good that Dr X got the job.
I had to say,
I don't think the interview is until tomorrow.

Once, I got an interview,
didn't get the next,
didn't even get short listed.

I was told, No,
no it was nothing,
just unlucky,
good candidates,
whatever.
But I started casting my net more widely.

Henry

Gender bias- from the beginning

I said,
there has never been
a female anatomy demonstrator.
He said,
Don't worry I will pull some favours.
It was quite clear
they did not want a woman;
they were hostile,
perfunctorily went through the questions.
I got the job;
there was some sort of background sorting out.

I was the only female surgical SHO.
They didn't seem to notice,
never was an issue,
treated the same as the men,
all the operations.

The first woman to train in gynaeoncology;
that is when I started to really,
really meet people who were very anti-women.

A well-known, gynaeoncologist
made a terribly sexist remark to me;
'Women should be behind a kitchen sink not operating in gynaeoncology'.

One of my peers
said,
'How did you get that job?
You must have been sleeping with the professor.'

No one could believe it,
to this day I think I must have dreamt it

Liz

Liz's trajectory through traditionally male-dominated territory deserves mention because of the impact of prejudicial practices on career choices and personal development. She benefitted from early personal encouragement to follow her dreams despite knowing that historical access to surgical training did not match the cohort 56:46 male: female ratio and a popular training route had never admitted a woman;

• • •

Gender bias- from the beginning

• • •

Interview animosity must have tested Liz's nerve but personal backing from a senior surgeon had helped her to a platform from which to launch her career and early exam success proved her commitment and ability. Mixed attitudes followed, equality in surgery contrasted with an '*anti-women'* attitude in her final specialty. Immoderate verbal attacks left her incredulous and in no doubt that she was not universally accepted, but she persevered. Although her impressive academic performance, clinical abilities and high level of commitment denoted that Liz could be eligible for an elevated position, she rejected these and declared herself happiest working directly with patients and especially performing complex surgery. She felt no desire to take on a professorship or college office which could remove her from this work though from the outside, her self-imposed limits could be interpreted as an example of a glass ceiling effect.

Research examining status and career patterns of women physicians pointed to hindrances of family demands, sexism and stereotyping indicating how these interfered with *'professional socialising'* to develop informal contacts which supported career advancement;

women could not always engage if family responsibilities took precedence (Cain, 1995, Rantalaiho, 1986, Jonasson, 1993). Part of the negotiation of a maze of obstacles for Helen involved questions from prospective GP employers about her status as a single female with no children (yet) which made her feel a victim of prejudicial attitudes.

Among other employment irregularities Alice's experience demonstrated how advice from other consultants saved her from continuing damage due to a single consultant's undeserved poor reference; action which suggested they must have collectively believed that GMC advice on fairness and objectivity of references had not been observed.

4.6 Summary

This emerging picture of junior doctors in 1980s is more mixed than indicated by published research; together with narratives which focussed on a familiar scenario of damaging overwork, isolation, lack of respect and disappointment were others which recalled empowerment, growing confidence, autonomy and responsibility. Clearly there was a wide variation in the demands of posts and cultures operating within departments with an apparent distinction between high-status teaching hospital posts and DGHs where less pressure and greater collegiality were evident. In this group it was not possible to judge the relative importance of criteria informing doctors' choice of junior and training posts – I could not determine whether being attuned to the experience of predecessors or making a smart career move or simply being in the right place at an opportune moment was more serendipitous than calculated.

Threads from these earliest experiences flowed through subsequent narratives, emerging and fading according to changing circumstances and through more than 20 different specialties or sub-specialties. Doctors also spoke of active involvement in undergraduate and postgraduate educational programmes, managerial roles, clinical audit, academic responsibilities, clinical research, and as examiners for professional bodies. Because of the

natural divergence of training and working as doctors progressed, their daily routines and expectations allowed them to bring views from many angles, adding diversity while diluting uniformity.

Through narrating the influence of colleagues, patients and work teams and in a wider context of over-arching organisations, clinicians have provided detailed and personally meaningful accounts of 25 years working in the NHS. Awareness of their neo-professional roots and of the settings in which these stories were generated allows greater understanding of their significance as reflections on enacted professionalism.

Chapter 5

Ticking boxes; consequences for medical practice of increased use of information technology in the NHS

Investment in IT has facilitated data recording, transfer and processing at clinical and managerial levels of the NHS allowing managers to audit and evaluate information and respond to activity in the health economy with unprecedented comprehensiveness (Anderson et al., 2006). Headline targets; sub-optimal figures for waiting times, high costs per treatment unit, referral rates, duration of hospital admission, re-admission rates, super-bug infection rates – all drive management to demonstrate improvement.

As a result of ability to closely monitor trends and, empowered by evaluation of this information, managers initiate responses according to local and national policy decisions to modify or control clinical and administrative action (Yusuf and Kamal, 2012). This usually occurs as an interaction between clinicians and managers and though priorities and perspectives differ, participation is not voluntary. Managers, operating according to a management mentality, and clinicians, adhering to a clinical mentality, adopt different allegiances and show contrasting attitudes to responsibility, authority relationships and in their tolerance of ambiguity (Shortell and Kaluzny, 1997, Shortell et al., 1998).

Doctors delivering care can be monitored against externally determined standards; the most prominent of these being the general practice. Since its 2004 introduction, involvement by GPs with the Quality and Outcomes Framework (QOF) has been optional. However, funding arrangements are such that a significant proportion of available monies for general practice are linked to success with QOF achievement to an extent that non-involvement would be financially damaging (summarised in Appendix 10). (Roland, 2004).

However, for clinicians, new policies and priorities for data recording, audit and performance management, and altered relationships with NHS managers can produce tension between 'reflective practice' and actions which demand 'technical rationality' in problem-solving strategies or privileged measurable biomedical data over 'whole-person' care (Schön, 1983, Checkland et al., 2007). After setting out in 5.1 how GPs reported their preferred practices (specialists' preferences in 5.6), the remaining sections discuss consequences of technology-based processes and new working practices on everyday practice.

5.1 Principal valued characteristics of good general practice

Explanation of how performance management through use of IT may have interfered with what doctors wanted to achieve in work is necessarily prefaced by understanding their preferred working practices. I therefore explored how doctors expressed their personal definitions of being 'a good doctor' – an ideal which participants mentioned as their aspiration from graduation, as a continuing motivating factor, and which was incorporated in a sense of professional medical identity as expressed in these narratives. This background, together with similar extracts from specialists' data in 5.6, also informs subsequent chapters due to the overarching nature of themes, preferences and concepts. I have arranged presentation of this multivoiced data from GPs under four headings; diagnosis and treatment; continuing care; teamwork and management responsibilities; and personal aspects. Frequently comments demonstrated crossover between headings and included references to actions which fell short of their desired standards.

Diagnosis and treatment

GPs wanted to be able to make prompt diagnoses and to use learned skills directly when appropriate;

> *'I regarded myself, and I obviously still do, as a good GP who works very hard, who can spot things'* Mark

'[I] still enjoy a challenge when there is some weird or wonderful symptom going on' Richard

'*I really enjoy complex therapeutic problems which you get a lot of with the elderly… working out what drugs are going to be best because they have got heart failure, … diabetes, … peripheral vascular disease … trying to get the happy medium … get them feeling better and get the best out of their lives'* Helen

'I do minor ops and it's nice to sort of do that sort of thing and actually physically change somebody even if it's only a small way.' Richard

They also sought access to appropriate services, using expertise to choose from the options available though this was not always straightforward and sometimes they had to take further action;

'…prioritisation [before 2-week-wait clinics] was a bit informal and dependent on you as a GP - I saw a patient with rectal bleeding that I referred … he turned out to have bowel cancer …and I had written many letters to bring forward his appointment … and I think I should have done more with him' Mark

'If I think the system is not working well … I am not short to lift the phone and argue the point for people.' Alice

And after a patient had suffered many complications during several (re-)admissions under the care of different surgeons;

'in the end I wrote a personal letter to the consultant, the most senior consultant saying I would like a senior review of this patient.' Mark

In cases where blocks prevented what a GP considered as reasonable access they would act as an advocate for patients though this might risk damage to how they were regarded by specialist colleagues;

'I think good GPs make all the difference where you are advocates, for your patients, you ring people up…talk to the consultant, involve the patient.' Mark

'So I have stirred it up… I have played one hospital in L off another hospital to get the right outcome for the patient. And I have … been quite open that I am playing one hospital over the other and threatened to get a newspaper involved.' Alice

When curative treatment was not available, they spoke of continuing to work to make a difference for patients;

'I picked that one up, you know … I possibly did help them along the way or have picked it up early enough or whatever, I think I made a difference.' Jennie

'I see it…as a really great role that I can have as a GP and make a difference to people's lives' Helen

Continuing care

Several mentioned attempts to advise patients about healthier lifestyles though they did not always feel this was effective or that it ought to be a task expected of GPs;

'*I tell them they need to lose weight and if you don't lose weight you are going to get diabetes and high blood pressure and back ache. But … you never get anybody who says "You are dead right doctor I must do something about it".'* Richard

'What I should be dealing with is … drug therapy … but I am not going to follow someone around telling them what they should and shouldn't be eating.' Richard

Stewart indicated that he believed part of his role was to decrease patients' need for medical services;

'We…have a responsibility to make sure we don't make people too reliant on medical services all the time.' Stewart

Similarly, Mark voiced enthusiasm for working *with* patients;

'You always have to work in partnership … being on the side of patients and suggesting a set of options for patients; I think that is a very, very important thing.' Mark

Several spoke of taking time to build relationships which confirmed their innate sense of commitment and recognised the importance of meaningful two-way communication;

'…if they are really ill or genuinely needy or whatever…you just spend that little bit of extra time.' Jennie

'I like the relationships you get, and just the … sort of friend and counsellor feeling that I get out of it, and them to me, because sometimes you get such a lot back from older people who are have such a lot of wealthy experience.' Helen

'I think it's still a vocation to me you know, it still means a huge amount and it's that sort of patient care that still drives me.' Jennie

George also explained that social isolation increased the significance of consultations;

'I have got so many patients to whom I am the second most important person in their life.' George

After periods of personal illness, Helen perceived a change in her approach to patients;

'*I can really empathise with people who have got difficulties going on in their lives because I have had so many in the last 5 years or so … people who are perhaps feeling depressed or lonely, or struggling with stuff.'* Helen

She recognised that, at least in her experience;

'*Thoughts of compassion and stuff like that, have come more over time rather than what I thought of as a medical student, because I think you are just too young… because you have no experience of life you don't realise the importance of it.'* Helen

Getting to know patients well over a long period of time helped Jennie evaluate their situation better*;*

'…when you are treating your own patients you have got a memory of their needs and their thresholds and their needs.'

Since many health problems cannot be cured, GPs accepted a long-term role in helping patients and their families to cope with ongoing problems;

'A lot of it is, helping them to understand what they have got so they can live with it rather than being able to cure them particularly all these old people that there are these days.' Richard

'I take every opportunity to get involved in [palliative care] I find that very satisfying ...obviously you know these people for a long time … as things develop…I am not an expert in…palliative care, but I am interested … and I will try my best to look after [them] … and this works quite well…they like it.' Stewart

'My job here is to support people through difficult times…and to be there for them.' Alice

And Mark aimed to foster a culture amongst his staff such that without specific instructions they would know what he expected;

'…make the best decision you can that will support patients.' Mark

Teamwork and management responsibilities

Achievement of goals in general practice was recognised as a team-based activity and dependent on good communication, co-operation, stability and shared values.

'I have got a great team of girls that have been here a long time… if they weren't happy they would just get up and go.' Alice

'I still enjoy my work fantastically but that's because I am in an environment where it's controlled and you know, I basically set the culture, and you know it's very good.' Mark

Before joining a GP partnership, Mary used her observations during locum work to assess whether working routines created a congenial and inclusive environment;

'I used to mark them on whether they stopped for coffee, whether anyone talked to me… Very simple things.' Mary

Within GP teams, clinicians often proposed and implemented innovative projects and services involving other team members;

'I set up lots of services and protocols. We have…a good reputation for minor surgery.' Stewart

'I can always see things that could be done better …and it makes me want to change them' Helen

'…we went for our own [PMS contract] tender … and we won the bid.' Jennie

These new ideas could also involve engaging patients;

'Then the other thing is around patient enablement and encouragement, using these [decision-support] tools and then like finding new ways, new solutions.' Mark

Motivation of staff was essential to ensure attainment of performance standards with a range of team roles and inclusive management;

'We have had maximum QOF points, so we have worked at that but … we have a good secretarial team who sort that side of it out.' Stewart

'You can't rely on heroic doctors …you have to raise the standard throughout.' Mark

'I have got some authority although we try to be … democratic; I say "Well this is what I think, what do you think?" … if someone has a strong voice on it...we will give it a go.' Richard

When speaking about their hours at work, implied reasons for long working days included the volume of work to be done as 'normal' general practice or with additional roles, but also pressure to increase or maintain income;

'I probably came to work at 8 in the morning and didn't go home until 8 o'clock at night, and these were the days when [on-call duty] was every night and volumes of paperwork, and administration.' Alice

'…core general practice, training and minor surgery…I have been involved in a lot of the project management so is quite difficult…life is quite busy.' Stewart

'I just recognise that I have got a role which is to work and to earn money to look after my family.' George

Personal aspects

Various factors confirmed that as their career had progressed, GPs noted progressive personal development as evidenced by postgraduate examinations, appointments.

'I think passing the MRCGP first time round was quite a big thing for me.' Helen

'I did a medical rotation because I wanted to do the MRCP… because I set that as a personal goal, and also I think in those days …to be a proper doctor you had to prove yourself in some way.' Mark

'…becoming an examiner with the Royal College of General Practitioners has been a major thing for me, it's like coming of age…biggest career progression I have made…that's made a huge difference to me and my self-confidence as a doctor.' Helen

Other factors based on self-assessment or optional challenges indicated maturation of their clinical approach and confidence;

'…kids that were born the year I came here, are all coming in and telling me they are getting engaged and, I keep saying to people, "in my limited experience"; I am going to have to change that because it's not limited it's, it's extensive experience.' Alice

'*I am not really a very self-confident person, and probably the job has given me confidence.'* Mary

'I didn't do the MRCGP when I was a trainee so I embarked on it later …and I got involved in… membership by assessment. I felt I needed to do it basically to move on, and if I wanted to go into training…and I think I needed it myself, as well – professionally; I think I was getting stagnant.' Jennie

The majority of GPs were to some extent enthusiastically active in education and training of medical students and/or junior doctors, activities which they found stimulating and fulfilling;

'it gives me a buzz, makes me feel… like a real doctor, a real useful person for others, a useful resource, somebody with knowledge, somebody that can help, the helpful guide sort of thing… an affirmation of my abilities really.' Helen

'I have been involved in lots of training with registrars, registrars in difficulty…really anything educational…students from university…6th form students…done careers and motivation days, and I have always kept up the education.' Stewart

'teaching gives me a high; it's just being with young students and going back to basics again, you know teaching examination…back to basic clinical skills which sometimes you lose sight of.' Jennie

'..my first batch qualified last year so it's quite nice to watch them through and when I can, I also help in their OSCE examination.' Jennie

Maintaining a healthy or at least an acceptable work-life balance was often discussed, though some doubted whether they had achieved this and wondered if other doctors had done so more successfully. Helen's period of depressive illness had made her particularly attentive to her own mental health and the risk of inducing stress through overwork;

'If I ever start feeling like I am going downhill I will stop whatever … makes me feel like I am going downhill, so I am very wary of overloading myself… if it doesn't make me feel good I am not doing it.' Helen

'The reason why I actually took the partnership was because I felt as a salaried doctor you aren't in control of your own life.' Mary

Juggling time for work and family commitments had also proved challenging;

'I keep trying to check myself and make sure I have got the right work-life balance and all those clichés and I am very grateful for the amount of money that I earn.' George

'I was playing tennis about 4 times a week …and now I don't do that and I think genuinely that I carry a bit more stress.' George

'I was full time and I have always been…from the day I started. …I had a maternity locum who … did me 12 weeks … and I just said "I will come back" …there was no sort of thinking about it … I have also brought kids into work, and put them on the sofa…downstairs with a blanket and phone next to them and "Ring me upstairs if you get sick.".' Jennie

To be regarded as 'a good doctor' by peers, patients or specialists was important and on occasion brought tangible appreciation;

'I have a good relationship with secondary care...don't have any problems; think I am quite well regarded.' Alice

'*I want to be liked, and appreciated and I want to always get it right, and that is not possible...I like it when…I feel that I have done well and the patients have appreciated it.'* George

'The thing that I feel I have been most successful in in my life, has been my job, so for me to fail at that, my sort of gauge of my success is very inherently kind of mixed up in my success in life, the two are pretty close.' Alice

'I have had patients that have done pictures and poems and … dropped them in…all the thank you cards, the bouquets of flowers … it's like the old general practice, …actually - we were almost part of their lives.' Jennie

Unprimed by prior discussion of Freidson's analytical categories of medical professionalism, several of the above quotes demonstrated clinicians' engagement with notions of authority, autonomy, self-regulation, clinical mentality (including moral and ethical practice), the influence of socialisation and sense of a professional identity (Freidson, 1988). Narratives revealed aspects of how they aspired to enact medical professionalism.

Of the principal goals listed by these GPs none were reported to be actively enhanced by technology or dependent on in-consultation use of IT and only a limited proportion sat comfortably with criteria selected for inclusion in performance measurement.

5.2 General effects on GP work of performance measurement through IT

In addition to QOF clinical targets, significant financial rewards were also linked to specified managerial or administrative tasks and feedback reports from patients about their opinion of GP services provided to them. In the poem below, Stewart explained his view of how the QOF and linked incentives have impacted on his sense of working as a professional. He has struggled to wholeheartedly embrace all the recommended actions across a spectrum of chronic clinical conditions in which achievement is recorded as numerical values of test results, evidence of prescribing specific drugs and advice given to patients.

It's number crunching

I didn't see the evidence;
was just doing that because
if I didn't
I would be looked upon
as a bad doctor
and be paid less.

Resented;
because we don't like being told what to do
didn't give room for techniques I am keen on

If we send somebody to a nurse
we get paid for it
but if we do it ourselves
we don't get paid a penny
Irritates me
Political correctness

Stewart

Playing the game

We are very friendly with the PCT
volunteer to do all the enhanced services
a lot of the pilots

I just play the game
they know we play the game

We have an army
a good secretarial team
who sort it out
finish the fine detail

Stewart

Although through commitment to continuing personal learning as an active GP educator he could not be accused of failing to update his knowledge, Stewart remained unconvinced by statistical evidence which claimed benefit from the use of certain medications in primary prevention of disease. He was not alone in this view but it did not fit with NICE guidelines (Goldacre, 2009). He could not resist pressure to conform; finding his view devalued and facing the prospect of a further insult through reduced income, Stewart felt forced to comply with the issued guidance, meet all the requirements to tick the boxes and thereby qualify for payment.

Stewart's use of techniques or treatments which he had found effective was inhibited by conforming to externally generated protocols, it ran counter to independent thinking and clashed with his clinical mentality (Freidson, 1988). Where multiple health problems co-existed, these infinite variations could not be accommodated in a standard protocol – general guidance could not be tailored to fit individual complex problems. Substantial links to income diminished his autonomy – to maintain income he had to play by the rules which might mean passing tasks to team members despite believing he could personally execute them more effectively. However, having set aside his preferred methods on one level he discovered there was another arena in which he could operate; he played a game.

● ● ●

Playing the game

● ● ●

Stewart had adapted to engage with the agenda of his employing body (a Primary Care Trust), to give them the returns they wanted in exchange for financial rewards. Debate about whether or not these services represented best value for NHS spending, appeared disregarded by both GPs and PCTs; questioning the detail did not fit with the dominant agenda for either party.

Standards of medical care have traditionally been set and maintained by a combination of the expert opinion of senior clinicians and directly observed benefits of treatment together with scientific understanding of beneficial mechanisms (Howick, 2011). As indicated above, a new emphasis on documentation of individual tasks, including biophysical parameter checks, insisted these be recorded throughout the NHS as proof of compliance with guideline-driven plans of action. They were designed to confirm that adequate assessment had been carried out, that detailed investigations were performed prior to, if necessary, setting a patient on a 'care-pathway' which facilitated access to appropriate services. Instead of remaining a matter of clinical judgement, individual decisions increasingly referred back to this process and correct recording of this information could be key to funding or for acceptance of a referral.

It seems inconceivable that a change of data recording of this magnitude could occur without impacting on daily NHS activities and no surprise that it was prominent in many GP interviews. Doctors participating in this study worked during the introduction of IT systems and many compared their recent observations to a less technologically - dominated era.

5.3 The effects on consultations of recording care in General Practice

The changing nature of GP records

As this cohort transferred from hospital posts to general practice (1984 - onwards), most practices in the UK were writing consultation records on 4" x 6" cards which could be held in chronological order. Of necessity, notes were brief, bundled with results and hospital letters and ideally available for reference and updating when patients attended. However, it became evident that computerised records were the smartest way to advance and initial computerisation was boosted by funding through linking up with pharmaceutical companies, though practices later sought a proportion of funding from their PCT or equivalent organisation; early uptake of IT was not universal and usage varied widely.

Rolling forward to the current situation, all practices now depend heavily on customised IT systems for multiple tasks; initial registration of patients, booking appointments, complete (and GP-GP transferable) consultation records, prescribing medication including regular monthly prescribing (repeat prescribing), links to hospital letters and laboratory reports and a vast range of audit functions for disease prevalence, chronic disease management purposes and administrative tasks. Because the 2004 GP contract required IT-recorded information to link clinical performance criteria with payment this immediately increased the priority of efficient use of IT in everyday practice.

5.3.1 The effects of increased use of IT during GP consultations

Although fewer choices are available between alternative GP computing systems, increased complexity and capacity of IT processing and software packages now support features such as risk calculation on the basis of patient data but depend on regularly updated data; blood pressure, biochemistry, smoking habits etc. and prompts are shown as on-screen reminders about outstanding screening tests, overdue medication reviews, and a host of other targets particularly for patients whose chronic illness is relevant for QOF targets. This can mean that as a patient enters a consulting room the doctor is partially distracted by an array of tasks and issues which have no immediate relevance to the reason the patient is attending and since he/she is unaware of the screen ‘alerts’ this can lead to communication difficulties through scenarios like those in Table 3.

Doctor fails to immediately focus on the patient's problem, Doctor misses vital initial cues Patient mistakenly believes he/she has been heard Doctor probes only part of the story for more detail Partial picture of the problem emerges Questions and actions triggered by the on-screen reminders are misunderstood by the patient as relevant to the presenting problem Flitting between issues results in unsatisfactory resolution and mis-matched ideas of the consultation The presenting problem/s may be side-lined by a clinician diverting attention to the outstanding data issues which, although they may merit attention, are not the patient's priority Patients may be suspicious of inaccuracy or fear incomplete understanding of their problems due to limitations of the computer record and their inability to interrogate its contents (Pearce et al., 2009, Greatbatch et al., 1995, Booth et al., 2004, Pearce et al., 2008)

Table 3 Consequences of computer use during consultations

Introduction of another entity into consultations has been 'problematized' through analysis of shifts in the dynamic between patient and doctor; while many elements in the above table could arise for other reasons they were more prevalent when a computer was in use. Among GPs I interviewed, a number indicated first-hand awareness of interference by the 'active' presence of a computer and voiced several effects on consultations.

Less attention for the patient

Richard explained his view;

> *'I certainly find now that I am spending more time looking at the screen and typing things in now and that doesn't appeal to me, as a doctor, as to be what I should be primarily doing.'* Richard

Diverting attention from face-to-face direct communication between doctor and patient was not in keeping with how he believed he should conduct consultations, did not fit with his view

of ideal medical practice; it was an added factor which distracted his attention by providing information which may appear irrelevant or by demanding that new data be recorded. Tasks not included as facets of his medical identity were distancing him from the sort of doctor he wanted to be.

Stress induced by an urge to record everything while a patient is present

Further, Richard reported that pressure to enter information worked against the quality of interaction in a consultation which he could otherwise achieve and robbed him of the satisfaction.

> *'I don't think it's actually making me a better doctor, in fact it's probably making me more crotchety because I feel I have to do it'* Richard

Richard recognised that his preference was always to do a practical task, to complete tasks, perform an organising task which resolved a 'messy' situation. The constant challenge of a data-hungry IT system caused him discomfort until all that needed to be done had been done yet afforded him little satisfaction. This may in part be because recording the task did not resolve the patient's problem, nor did it allow him to enact the 'doctor/healer' role which he sought and having satisfied all the box-ticking requirements on one occasion, he knew that by the next time the patient attended more data would be required. His desire to complete tasks made him conscientious about entering information, but time spent doing so led to longer consultations, falling behind with appointments and finishing work later than Richard felt reasonable, and all the while pressured by *'just trying to stop yourself running too far behind schedule'.*

Keeping up with the computer

No GPs mentioned the near-seamless access now available to the data necessary to support medical care; results, BP readings, hospital letters, and medications prescribed etc. Instead, they spoke of a need to 'feed' the system with data;

'[previously] it was pre-computerised, so the pace was different…[now] a lot of it is recording data, computer recording of data, and good data isn't it, that is about the biggest thing, essentially punching buttons on the day in front of the patient, it's getting that quality data in' Jennie

'*people keep (adding) more boxes, so what I want to do is actually reduce the number of boxes to tick, rather than work harder to fill them all in. I am having to sort of work harder just to keep going'* Richard

During training, these GPs used short written records as described above, only relevant information was entered and no coding or specific measurements were mandatory meaning that communication with and assessment of a patient could occupy the majority of face-to-face encounters.

5.4 Impact of additional tasks to established working practices

In addition to clinical aspects of primary care additional dimensions entered consultations which extended responsibilities of doctors and were predominately mediated through IT. These affected how consultations were conducted and decisions were negotiated, doctors perceived an expectation that they must incorporate them into daily practice. These required doctors to simultaneously or serially deliberate on the impact of their actions or recommendations on a number of different levels, or frames, as represented by Dodier in his sociological analysis of medical judgment (Dodier, 1994).

Building on Goffman's frame analysis concepts, Dodier identified three principle frames; a **clinical frame** (symptoms, examination and investigative findings), a **solicitude frame** (embracing an understanding of a patient's situation, an intimate negotiation of what can or must be done for this person and taking into account how the outcome can be justified to outside bodies) and a **psychological frame** (of seeing behind the surface).

In research amongst occupational physicians, Dodier observed no difficulty in their shifting from one frame to another as part of routine interactions, though each frame differed from the others in the relationship established by the doctor between the subjective (felt/reported) symptoms and objective (clinically demonstrable) accompanying signs. It remained the duty of each assessing doctor to make a judgement on the balance of evidence presented and taking into account the idiosyncratic elements in the reactions, motivations and consequences for the individual patient. He added a fourth framing concept, an **autonomy frame** to represent sharing the therapeutic decision-making process with the patient or acquiescence with patient preferences; an idea somewhat removed from the authoritative physician figure of Foucauldian thinking (Foucault, 1963, Dodier and Barbot, 2008). For occupational physicians, as for NHS GPs, the necessity of working in multiple frames added to the complexity of the task expected on each occasion.

Prominent new frames included:

- The patient's presenting problem/s, as subjectively experienced symptoms etc., which may be presented with greater complexity as patients conducted internet searches and used other sources to personally check out their concerns
- Lifestyle issues to be addressed (smoking, alcohol, dietary intake, exercise, mental health) and data recorded for QOF and other targets.
- Examination findings and further investigations; might require cross-checking against NICE guidelines, disease-specific protocols or local care pathways
- Treatment needs; prescribing guidance, relative cost of suitable medication, individual tailoring of treatment.
- Prescribing incentives and budgets which were externally evaluated or compared
- Referral procedures; available (unrestricted) referral routes, patient choice of services, locally determined pre-referral criteria (e.g. blood tests, x-rays etc.); referral management processes have been developed to monitor and increase GP accountability for referral decisions.

Substantial proportions of funding linked to compliance means that doctors cannot easily afford to ignore this aspect of medical practice, yet if each frame were aligned with their espoused aspirations, then these shared objectives ought also to be evident in their concepts of 'good practice'.

What measures quality in medical practice?

Bearing in mind doctors' concepts of being 'a good doctor' and limitations on how many tasks from different frames could simultaneously be accommodated, requirements of performance measurement came as an un-matched additional burden in the workplace, altering the course of consultations (Chew-Graham et al., 2013). This could therefore be viewed as impacting negatively on work patterns by demanding time and attention from the doctor but also by diluting or conflicting with his/her sense of providing adequate holistic care for patients.

At its introduction, attention was drawn to a scientific evidence basis for criteria chosen for clinical measurement under QOF with documentation collating evidence of the clinical impact of inaugural targets. On the strength of this evidence the QOF could be viewed as reinforcing best medical practice with expected improvement in health outcomes for patients - though monitoring quantitative measures produced a partial picture and might not correlate with what doctors or patients valued most (N.H.S. Confederation and British Medical Association, 2003b, Lipman, 2006).

As a single-handed practitioner Alice viewed her QOF scores (and high ratings on prescribing indicators) as evidence of providing a quality service. Her practice scores became part of the body of information available to those monitoring her practice when unavoidable circumstances left her unable to confidently deliver continuing care. However, she recognised that this was in large part due to the efforts of her team since she was periodically absent from the practice;

'QOF is a team target … delivered by a team of people and I can't take the credit for achieving that completely on my own … I have got a good team who do it… with me' Alice

As new standards were added and some of the supposedly strong evidence called into question by further research, this caused uncertainty about the effectiveness of recommended clinical management; some doctors expressed their own doubts about the clinical usefulness of the evolving QOF (Tracy et al., 2003, Willis, 2009). Reticence about the purpose of achieving the full range of QOF standards led to a degree of ambivalence or frank disagreement as in these examples:

'I suppose we ought to be doing things where there is an evidence base that it's actually doing some good. And some - you know you are not going to find out if someone has got hypertension and reduce the risk of stroke unless you measure it, so to encourage people to start measuring blood pressures is a good thing' Richard

'they keep squeezing in stuff and they keep making it harder, and then it starts to feel that way [immoral] … so its glory days are well and truly diminishing in my view' George

With a constantly-changing evidence base and diverse ideas about credibility attached to the quality of emerging evidence by established clinical experts – including suspicion of potential conflicts of interest by sponsoring pharmaceutical companies, keeping clinicians in agreement on 'best practice' is a shifting goal for which NICE attempts to provide guidance (Goldacre, 2009).

It matters more because of linked payments

Frustration resulted from ongoing efforts to keep recorded data in a form which was recognised for assessment purposes; Jennie reported examining records to detect omissions;

'…medication review isn't ticked…although they have been reviewed, they are on the right amount of medication, they have had their bloods done…' Jennie

In other words, full medical care had been delivered but the computer record for specific codes did not confirm it and this record would be counted as failing to achieve the standards required – a case of doing everything apart from what triggered payment.

In Jennie's practice, shortly after the introduction of the QOF and while continuing to work towards improving target achievement, they suddenly found themselves without a Practice Manager to lead and co-ordinate the team's efforts. As Senior Partner, she felt responsible for improving income by investing extra time and taking on tasks beyond her expertise to extensively audit and review records to improve figures.

She admitted that she set about this *'without thinking about it properly and planning it',* attributing her attitude to having trained in a culture of '*just getting on'* with what needed to be done. In consequence she heavily overloaded herself and faced a serious complaint from a member of staff who had likewise felt over-stretched by her actions during this time. Jennie's reflections indicated that she was re-thinking whether her overwork in an unfamiliar area had been the best course of action;

'maybe I shouldn't have taken it all on … because there are prices to pay for everything isn't there really and that was the price … [it] was a completely new field to me and I just didn't, wasn't aware of what the rules of the game there are, or anything really.' Jennie

What are you doing the job for?

Certain times
the balance of expenses and income
was becoming more and more tricky
you think
what are you doing this job for
when the expenses are going to be so huge
when you think of the number of hours
for the QOF
and just generally
because of the nature of the job
the way that the hours are just chewed up
the rewards are getting less
and less

You have got to think again
Is the stress more than it's worth
at times
really?

Jennie

The issue of having all clinicians fully engaged with properly entering data came into sharper focus with QOF requirements when one of Jennie's colleagues remained reluctant to do his share – a problem which had not been resolved. Her misgivings mounted when she led the practice to an expensive purpose-built surgery and questioned her reasons for carrying on despite financial concerns;

• • •

What are you doing the job for?

• • •

New facilities must be paid for but increasing profitability through working even harder was an unattractive option – her metaphor of '*chewed up'* time hints at recognition of regret that precious, finite time was too quickly slipping from her control and for scant rewards.

Takes the joy out of the exploration of the patient's illness/problems

Because of his preferred working style, Richard was frustrated by the demands conveyed through the IT system;

> *'I always feel the pressure to do all these things and tick the boxes and get everything done, because…I like to get it all done so I can say "sorted".'* Richard

Previously he loved to spend time with patients investigating the cause of their problems and helping them to resolve them. Now his appointments ran over time increasing stress levels while his enjoyment of investigating unusual cases or exploring knowledge must wait until later; after his list of things to do had stopped growing he could relax, delve into cases to

better understand them and increase his knowledge, communicate with colleagues and be comfortable;

> *'The time I find I am most relaxed is not doing surgery [consultations] … it's after everybody has gone home and I can sit and think and … I can do a dictation, type a letter up or have a look at somebody's blood results and look on Google about what their illness is, and I think oh that's interesting.'* Richard

Richard's thoughts about how long he may continue in work were linked to this increasing pressure and diminished satisfaction. Although he had anticipated continuing to work until aged 65, he had started to consider earlier retirement and reflected that many older doctors had already done this.

Enjoyment of work had also reduced for Mark leading him to become disenchanted;

> *'I think you know it's like you have got to enjoy your work, got to look forward to going into work.'* Mark
>
> *'Occasionally it does seem like it's an impossible job …most of us feel like that … you are…doing your best and you haven't got the support, or you get criticised.'* Mark

Mark sensed a mismatch between what he believed delivered best care to patients and what was expected from him and troubled by managing uncertainty in isolation;

> *Everything falls on you here…you are left… but it's a big responsibility.'* Mark
>
> *'We don't seem to be in control of you know the kind of what good is and how we could make it good, better and you know lead to better standards you know.'* Mark
>
> *'I [have] got another 10 / 15 years of that, everyone seems to be developing tighter and tighter criteria reasons for declining [referrals].'* Mark

Despite his best efforts, a combination of trying to achieve high standards with limited resources, inability to define good standards according to criteria, he believed worthy of achieving, yet knowing that he frequently bore final responsibility and would readily be

criticised; all these drained enjoyment and enthusiasm as he considered continuing with this until he could reasonably retire.

Compliance with recommendations to avoid being considered a bad doctor

Aligning contemporary medical practice with the recommendations of Evidence Based Medicine (EBM) re-defines good medical practice in terms which include appropriate use of diagnostic tests, efficient use of specialist departments and restrictions applied to prescribed medication. Emphasis can focus on empirical evidence as a superior form of knowledge though others have argued for greater inclusion of other forms of knowing such as experiential evidence and patient and professional values (Tonelli, 2001). As EBM advice is regularly revised in the light of new publications, each reiteration cannot itself be held to have been unalterably dependable though it may have been the best advice then available.

Articles in the lay and medical press have questioned the validity of presented evidence with allegations of bias in favour of pharmaceutical companies who part-sponsored new research and such questioning can affect clinicians' opinions (Goldacre, 2009, Schott et al., 2010). When doctors lost faith in the value of what they had to do, sometimes they only did it because of incentives or to maintain a good reputation. For example, Richard said;

> *'There are a number of things which I think, well, I know I am ticking the box, because if we don't tick the box we don't get the points.'* Richard
>
> *'…you could fall behind the evidence base and say I know that I want your cholesterol to be below 5 but actually that's quite good for you.'* George
>
> *'there are a lot of, dichotomies aren't there about things; like when do you stop prescribing statin for instance, and I think it hasn't been addressed and I have got patients … still on statins in their 80s when there is no real evidence it will make any difference.'* Stewart

Stewart's practice employed *'an army'* of staff to ensure that all available points were achieved but he resented the implication that because he could not agree with all the recommended actions of the QOF he would be branded as a bad doctor. Like others, his preferences were not always rewarded under the QOF since they lay in developing relationships with patients, empowering them to make healthy lifestyle choices and developing services which would be more effective in helping and supporting them; hence his attitude supported tactical responses like playing a PCT-led game for mutual benefit.

5.5 Effects on medical practice of other initiatives, targets and incentives

Referrals management

To maintain budgetary control, the volume of referrals to hospital specialists has come under increasing scrutiny. Measures introduced included curtailment of inter-consultant referrals and scrutiny of GP referrals under local policies (LMCs of Berkshire Buckinghamshire & Oxfordshire, 2012). This involved peer review of the adequacy of information supplied in referral letters, completion of any advised pre-referral tests and suitability of patients for the requested referral. During interviews this process was quite new but gaining momentum with increasing pressure on the health economy. Jennie was involved in examining referrals made by colleagues and in developing a process of more active management of referrals including direct feedback to referring GPs of information on which to reflect and consider modifying future actions – which caused her some discomfort;

> *'..it's leading to a level where we will be looking at referral letters and thinking is this appropriate?…and we were talking about giving feedback to GPs and how do you feedback to your colleagues?'* Jennie

Restraints on hospital specialists making referrals to each other (unless certain circumstances applied) have prompted letters to GPs requesting that such a referral be made. On receiving these, a GP can decide whether to simply agree with the recommended

No

You want to refer someone but
they don't meet the criteria
they say, No

No clear plan,
No clear leadership
No one in overall charge
No over-sight
No kind of challenge and leading the change
No clear pathway

No, it's not sustainable

Mark

referral or to personally evaluate the problem and respond after discussion with the patient. The system was proposed to reduce unnecessary inter-consultant referrals and the demands on secondary care, though also with implications for funding. Where referral remained necessary, the diversion delayed treatment for the patient at unknown 'cost' and increased GP workload – neither of which was factored into any calculation; rather than cost-saving this exercise facilitated a different funding arrangement. Richard related his experience with these as feeling *'like a clerk'.* He generally preferred to see the patient to make his own assessment since some problems (perhaps unknown to the consultant) could be adequately managed in primary care; in these cases net costs might well be reduced.

Absent joined-up thinking by his PCT left Mark unimpressed when at the same time as notifying him of an excellent patient feedback survey with no recognition or congratulation, they also informed him that his prescribing and referral levels were too high. They did not acknowledge any potential relationship between high patient satisfaction and his use of medication or referrals which the GPs had considered appropriate. Mark spoke of difficulty he had experienced when his referrals were declined because of a minor deficiency in clinically insignificant details or given lower priority than he deemed appropriate because the patient did not precisely fit criteria chosen for priority appointments.

• • •

No

• • •

Increasingly entrenched attitudes in the NHS were, in Mark's view, hampering patient care; his chance encounter with a consultant newly-arrived from overseas (and who by implication

remained uninitiated in NHS procedures) proved '*so refreshing'* when he immediately recognised a potentially serious problem and by-passed obstacles to arrange an urgent assessment.

Mark sought high standards for his own work and expected the same from others and was dismayed by multiple, recurring and unresolved errors and omissions which emanated from hospital departments. He had seen patient care compromised due to lack of prompt action to initiate treatment and knew that a sequence of adverse circumstances led to another patient suffering progressively worse complications while her care was passed from one team to another with no comprehensive clinically-authoritative voice to take the necessary action. A specially created forum to deal with hospital deficiencies blamed continuing difficulties on rapid staff turnover and failed to effect solutions, yet Mark maintained a belief that doctors should not evade responsibility but act as leaders when consulting and with colleagues.

Referral pathways

To prioritise care of patients with symptoms suggestive of cancer, a 1997 Government White Paper proposed a more clearly defined referral pathway; through which a first specialist appointment would occur within 2 weeks of GP referral (Department of Health, 1997). Implementation in all main specialties was scheduled by the end of 2000 with guidelines to filter appropriate referral cases but this had not always achieved intended beneficial outcomes. In her oncology clinic, Liz encountered many non-cancer patients for whom she had little to offer (poem overleaf);

● ● ●

Wrong patient, wrong clinic, wrong outcome

● ● ●

Wrong patient, wrong clinic, wrong outcome

I am afraid
a few GPs
seem to make anything
fit the two-week wait criteria
a very bad thing to do

all we can do is
send it back

we check
and say that's fine
that is all
we do not have time
I cannot sort it out

I find that
very, very unsatisfactory,
very unsatisfactory

Just saying,
"it's not cancer
you have a problem that needs sorting
but I just can't do it,
I haven't got the time
I don't do that operation"

Liz

Her role in this clinic was primarily to detect or exclude the presence of cancer. As a highly specialised surgeon in gynaeoncology, she no longer participated in non-cancer gynaecology clinics, nor did she perform procedures which would not be appropriate in her field. So when a patient attended her clinic whose problems did not 'fit' the conditions she could deal with, she was blocked; her available solutions did not meet the needs of the patient with unsatisfactory outcomes for both parties.

Many reasons could account for why patients appeared in the wrong clinic or why GPs struggled to access specialist services, and additional complex factors were added when the referral decision involved negotiation of choices with a patient. Fear of missing something important might push doctors (and patients) towards seeking a specialist opinion as an urgent priority or a GP may wish to avoid retrospective criticism or potential litigation by taking prompt and decisive action (Furedi, 2012). Alternatively a doctor could selectively elicit a medical history to fit the guidelines for referral rather than make a more balanced, objective evaluation which would lead to continued GP-based care compatible with an acceptable level of uncertainty as was expected in general practice (Haslam, 2003). Since symptoms and conditions from an infinite range cannot easily be contained in patient pathways, permutations which had no 'natural' pathway demanded flexibility and improvisation; a referral sent to the correct clinic could be re-directed due to a misunderstanding or misinterpretation arising during administrative allocation.

The limited scope of this research does not permit full exploration of the balance of effects of the 2-week wait criteria or the addition of pre-referral guidance for other clinics. Opinions expressed in these narratives suggested that existing service designs could benefit from modification – perhaps starting with a forum where generalists and specialists negotiated from a basis of understanding the position of each other.

However, George reflected on decreased social or professional interdisciplinary contact between GPs and hospital consultants; he had previously kept in social contact with a range of local consultants, regularly discussed cases informally and felt better placed to choose the most appropriate specialist to contact when necessary. His involvement with a hospital-based committee helped facilitate these interactions also but when a new process for referrals (Choose and Book) removed his ability to choose a specific consultant, these benefits had diminished.

Similarly, Mary related how whereas previously she frequently discussed cases with consultants by phone, she could not recall having done so for some time, though Liz spoke positively of regularly receiving calls from a small number of 'interested GPs'. A general impression of increased distance between primary and secondary care would support expressed concerns of decreased co-operation.

Prescribing incentives

To support clinicians with the increasing challenge of keeping abreast of the volume and pace of change in clinical knowledge, two organisations were established in the UK. The National Institute for Health and Clinical Excellence (NICE) set up in 1999 and The Scottish Intercollegiate Guidelines Network (SIGN) develop clinical guidelines. The stated purpose of NICE was to provide;

> '*independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation'* (NICE, 2013)

Local health-providing and funding organisations (i.e. Primary Care Trusts and Health Boards) examined NICE and SIGN resources and took an active interest in modifying prescribing practices. They offered support to those GPs practices willing to have Prescribing Advisors evaluate and advise on their prescribing and funding incentives encouraged GPs to prescribe medications deemed more cost-effective under NICE/SIGN

guidance. Doctors could choose from a short-list of available targets on which to focus and were rewarded according to how they performed on achieving these goals. Monies gained through these changes must, in accordance with the rules, be invested in other forms of care or service provision rather than be made available as profitable income. While interviews revealed that some doctors cherished the idea of prescribing freedom as established in 1948, many recognised that demonstrable cost-effectiveness was a more realistic choice and engaged enthusiastically. Alice revealed her competitive approach by proudly topping the charts in her area and had worked hard to maintain that position;

> *'we have a locality pharmacist and I did make a deal with her that I would be the highest generic prescriber across X and she thought I was kidding, and of course I am the highest generic prescribing doctor in X… I have it under control.'* Alice

Richard also spoke of maintaining low prescribing costs where possible;

> *'I am quite keen on that because … if you are going to prescribe something you might as well prescribe the best value for money and … I am swayed by the argument that they are all pretty much of a much-ness all the drugs in a particular group and no matter what the drug reps say, they'll do pretty much the same thing.'* Richard

Where no measurable difference justified extra cost, Richard was happy to select cheaper options regardless of pharmaceutical advertising. On the other hand, he described difficulty in which he found himself as a consistently low-cost prescriber in that it became progressively more difficult to drive costs downwards from a low level; because there were few changes he could make, he would like to have been rewarded for maintaining cost-effective prescribing.

5.6 Prominent factors in specialists' narratives

Analysis of the limited data available from specialists drew out a perspective of enactment of professional roles which differed from that of GPs. My examination of how narratives from

consultants in psychiatry, gynaeoncology, histopathology and anaesthesiology with chronic pain expressed this is organised below under the same broad categories; diagnosis and treatment; continuing care; teamwork and management responsibilities; and personal aspects.

Diagnosis and treatment

Similar to GPs, consultants spoke of being well-prepared, competent and ready to perform tasks which could help patients;

> *'the skill is [to] spot the rectal cancer in amongst all the rubbish during the day… 95% of the stuff is just routine and then bang, oh, something will come in and you have got to spot it.*' John
>
> *'…it's very hands on practical, very satisfying in that respect, very interesting in terms of lots of different things that you were challenged with, and you could see outcomes fairly short term.*' Graham
>
> *'I was going to have to stitch an episiotomy… [I] asked the registrars…"Can you teach me how to suture an episiotomy"…I got the surgeons to teach me how to do an appendectomy.'* Liz

Whereas GPs related how they struggled to obtain services for patients, consultants explained how they would discuss possible options with patients and help them make a choice, even trying several treatments in hope of benefit;

> *'…my mind is just whirling around saying well it could be that, and we need to do that, and you know this investigation and then following that patient through, operating on them and getting them better.'* Liz
>
> *'…drug and alcohol users have more of a choice, it just makes it a bit more optimistic to work with…you can always feel it might be their 29th detox but this might be the one that matters.*' Henry

'You can come up with quite a lot of interventions that can make a big difference to them …we do get people come through and grab it and that is quite gratifying … and satisfying.' Henry

Continuing care

Comparatively less data dealt with ongoing care though a sense of doing the best possible job in difficult circumstances reflected how consultants aimed to minimise problems and achieve improvement and were aware of and affected by wider implications for patients;

'Although we had done our very best for that lady …we just weren't advanced at that stage and … I think it blew something in her head. … I felt sorry for the baby … I can't imagine that it started off life in a very good situation.' Liz

'There is a chronic long term problem [on] which you are at best … going to have some marginal impact but not total cure… the stress of chronic pain is kind of an insidious ongoing kind of stress, the patient keeps coming back…you are running out of ideas… seeing someone…deteriorating in front of you… that's kind of very unpleasant to watch.' Graham

When decisions were unclear, Liz preferred to share this with patients and if things went wrong she built stronger relationships with them by talking openly and directly;

'I think I am very open and honest with people now and I think I tell them it can go wrong and if it has gone wrong, I tell them it has gone wrong.' Liz

Teamwork and management responsibilities

Unlike GPs, consultants had always worked in managed environments and become personally involved with how clinical care and local teams were managed. John spent several years as a clinical manager through a period of re-structuring which incurred;

'…a lot of friction, a lot of hassle, a lot of…unhappiness from colleagues, difficulty in trying to get the Trust to recognise the problems and sort of move forward.' John

Later, when he found that his thinking was '*at odds with the management*' and felt unsupported, he decided to stand down.

Contacts with managers to reconfigure services did not proceed smoothly when Henry found himself in disagreement with managerial assumptions about how medical staff might react to challenges to established working patterns;

> *'We have got a manager who has come from a non-stat sector and her ideas of what you can do with medical jobs in particular is quite fanciful; we have had a few run-ins about,No, you can't just tell doctors they are now on a rota and by the way that rota includes going to the prison in the evening 5 – 8 o'clock.*' Henry

As lead consultant in setting up a new service, Liz developed a leadership style in which she tried to draw team members into the process;

> '*I have built up the service but I have done it sort of, in a roundabout way, without sort of being majorly thought of as a manager and being inclusive.'* Liz

Graham spoke of networking to build together a multidisciplinary team – *'a framework of other people working in similar areas'*

Involving team members could mean encouraging their active participation in team discussions which could be *'full and frank'* but generally led to constructive outcomes;

> *'I feel everybody knows their patients and we all present [our own cases] and I always involved them in every decision.'* Liz

Supportive working was a particular strength of Henry's Mental Health teams;

> *'I think all the teams I have worked with have valued me …same as I have enjoyed them. I like team working…smallish team, quite a big area, people work hard, and you're flexible… people are working for each other.'* Henry

Personal aspects

On more personal aspects of work, consultants spoke of their success with research publications, postgraduate qualifications, prominence in their specialist field and generally feeling valued as an expert;

> *'I have been able to build up more research and expertise predominantly in chronic pain…I need to be involved from an intellectual point of view…involved in the writing up and interpretation and publication.'* Graham
>
> *'I wrote my MD … at that point you could get your MD by pulling together your publications.*' John
>
> *'…not blowing my trumpet too much…I have a national reputation for GI pathology.'* John

With success came opportunities – to be the first woman to break into a highly specialised developing field or sought-after to participate in pharmaceutical research or simply to appear more credible with colleagues;

> *'they worded everything so basically they had to appoint me, in fact in the end I was the only person interviewed for the job, because the job spec was so narrow.*' Liz
>
> *'…nowadays companies come earlier and we are involved in the actual design of studies as well, so that's helped having a track record in that side of things.'* Graham
>
> *'To be able to speak with other colleagues … not just [with] an anaesthetic hat on but … as an 'out in the real world seeing patients'…so I think it empowers me as an anaesthetist to be able to do that with my colleagues.*' Graham

Although all had participated in education and training of junior colleagues, data indicated a lesser degree of committed enthusiasm than amongst GPs. Liz spoke of spending a lot of time trying to enthuse students about her specialty but recalled how senior colleagues had left her under-supervised;

'There were many … times that I think I was left [operating in theatre] when I shouldn't have been left. So I never leave my trainees now.' Liz

Graham's post included a significant teaching commitment but he was also involved in speaking with doctors who had failed specialist postgraduate exams.

'You guide then in a gentle way …and you can see some people very intent on getting it and it's, it's cracking them …I am terribly empathetic towards them' Graham

Although the duties of formal supervision could be onerous, Henry still believed it worthwhile;

'the amount of work to educationally supervise an SPR and the paperwork and all of the assessments all takes a huge amount of time, none of which is necessarily timetabled … don't get me wrong I value them coming here, … but you know it can get you down.' Henry

Consultants reflected on how they had tried to gain some control over their working arrangements. From an early stage John had restricted his patterns of work;

'I can pick out the priority stuff and get that done, and push the rest aside and just play catch-up later, it is a job which if you want it to be can be office hours.' John

When discussing her new contract 'Job Plan', Liz, who admitted she couldn't not work and was passionate about patients and doing the best for them, aimed to include something of advantage to herself;

'If they are going to do this to me I want something out of this, and I negotiated that Wednesday morning is my CME session that can be taken at home, and I just don't work Wednesday afternoons.'* Liz

Henry admitted that he had already explored his options on early retirement;

'I think I might be able to retire at 53, but I don't know, so I need to find that out and I don't know if I want to.' Henry

*Continuing Medical Education

Inter-consultant relationships seemed important; recognition of a higher profile for histopathologists had boosted John's sense of clinical acceptance;

'We are the experts of the tumour, we are the cancer doctor, we are holders of the tissue, examiner and interpreters of the tissue and we also, in our role have to now understand a lot more of the molecular.' John

While Graham spoke of focussing on developing his research connections by obtaining prestigious grant support, Henry explained his view that;

'You have to be seen to put yourself about a bit and get your face known.' Henry

References were made to periods of exhausting work which came close to causing Liz to abandon specialist training while by making himself available Henry found that;

'I had constantly people sat at the side of the office waiting to see me, squeeze them in...So I have always done long hours.' Henry

He contrasted this with his visits to a private hospital when he was warmly greeted;

'How are you doctor, always doctor, would you like a cup of tea, we will get you the patient … and treated you with respect and were nice'. Henry

It is in the above context of how this particular group of specialists regarded their preferred practices and professional roles that I considered changes in what was expected from them and the reactions these produced.

5.7 New working practices affecting specialist care

Although a relatively limited range and depth of data was gathered from hospital specialists in this study, firm impressions emerged of similarly changing and challenging new practices based on monitoring performance.

Guidelines in cancer care

The 1995 Calman-Hine report on provision of cancer services in the United Kingdom proposed restructuring cancer services to achieve a more equitable level of access to high

levels of expertise throughout the country. As explained in detail by John who was familiar with the situation before and after implementation of the guidelines it involved;

> *'setting up of this idea of multi-disciplinary teams to deal with cancer for … every specific [anatomical] site, so … the breast team, the GI team, and the key members of that team, clinician, surgeon, radiologist, oncologist and pathologist.'* John

Multidisciplinary teams (MDTs) were formed to discuss and oversee everything; provision of prompt appointments, rigorous and timely reporting of a tissue diagnosis, ensure clinicians' understanding of the most efficacious treatment options and oncology support services. For John and his pathologist colleagues, this altered their patterns of work and transformed how they felt as integral parts of clinical teams. He reported that the trend, through the 1990s;

> *'was to bring us… out of the lab, more into the clinical team picture which has been very good for pathology and pathologists; made us feel a lot more involved and also people can understand the key role of pathologists*' John

John appeared more than content with the team's expectation that a tissue sample be reported quickly, that the report conformed to a '*standardised, prescribed report- style and content'* to make it more universally useful and for the first time he felt personally involved and appreciated as the *'expert of the tumour'*, empowered to contribute to patient management. Involvement of the Royal College of Pathologists in setting out expected criteria and local audits contributed to achievement of the required standards.

As a nationally recognised and experienced pathologist, John participated in implementing these changes and expressed his delight at the new standing which pathologists enjoyed amongst clinical colleagues. Keeping up with the standards required had presented no obstacles or unwelcome challenges and he happily used networks with colleagues to facilitate delivery of results. It is perhaps unlikely that, given the task of improving cancer care for patients, the writers of the Calman-Hine Report actively considered the knock-on effects of this more prominent role on the morale of pathologists, but this was primarily how it was narratively represented.

When the Report's recommendations were to be put in place, Liz's gynaeoncology department was already implementing the principal elements. We have already discussed how she believed that many patients inappropriately found their way to her clinic leading to her complaint that *'only 15% of 2 week waits are cancer*.' Clearly in spite of attempts to direct only high-risk cases to cancer diagnosis clinics it seemed many patients who attended had a gynaecological problem but not a malignant one. For these, a referral to a benign gynaecology clinic would have been completely appropriate and Liz stated that, due to a high proportion being diverted to the 2-week wait cancer clinics, benign clinic appointments were in low demand – her 'benign' gynaecological colleagues appeared to be under much less pressure.

Comparative figures available on 'conversion rates' i.e. the percentage of patients attending two-week wait clinics who are found to have cancer, revealed that Liz's department was in fact experiencing a slightly higher rate than the 13.5-14.3% in some gynaecology clinics (Twomey, 2006). Her major problem arose because her skills were only suited to cancer treatment allowing her no facility to manage benign conditions. Designers of cancer care pathways may not have anticipated that a gynaeoncologist would consider a conversion rate of this level unacceptably low or predicted the delays and frustration re-referral would provoke.

Similarly, full consideration of how GPs would behave when interpreting the significance of ill-defined symptoms which could suggest cancer would be difficult to accommodate when designing a new referral route. Comments reported from the consultation process had largely focussed on issues of capacity in specialist clinics and pathology services and on a dialogue about referral criteria, together with ensuring that sufficient resources would follow initial diagnosis (Department of Health, 2000).

Recording pre-operative procedures in operating theatre suites

Graham found his anaesthetic work placed him at the interface between care delivered on the ward and what followed in theatre and was responsible for oversight of the patient until fit for ward-level observations. He spoke of discovering from records that prescribed pre-medication had not been administered by nursing staff prior to transfer to the theatre suite, and his need to check through detail of all aspects of pre-operative management. In his experience with well-trained and professional teams he believed that this had been dealt with efficiently and thoroughly but new regulations had recently generated an additional layer of paperwork;

> *'we have had imposed in the UK sort of a surgical brief…to formalise the whole process. So the whole team sit in the coffee room before the day starts, running through the list, what are the potential problems, what are the requirements...and then before each patient is operated on, they are anaesthetised on the table, again, there is a surgical pause, running through confirming the name, the site of operation, the antibiotics going in. So that's all done now, but it's done to us in the theatre'* Graham

He asserted that, for well-run teams, this formalisation and the time spent filling out documentation or in formal discussion was unnecessary and felt like an unwelcome imposition on the team. While conceding that some '*subsets'* which he described as *'shoddy hospitals that weren't doing anything'* had improved through implementation of the surgical brief, he remained convinced that it was better to have an *'inbuilt'* expectation of good practice than an externally imposed system with documents to be completed, his preference was to maintain standards by universally good practices and self-regulation. Since it is impossible to document each minute aspect of patient care, perhaps this move towards concentrating on certain documented aspects could militate against global professional attention which protects staff and patients from unforeseen risks.

5.8 Summary

Experience-grounded narratives following introduction of QOF and other targets, rules or incentivised criteria provided evidence of their effects on how doctors worked with patients, how their professionalism was challenged through curtailment of clinical autonomy and by countering their sense of professional identity.

Introduction of the QOF placed greater pressure on both clinician and patient to gain tighter control of biophysical parameters in specific areas of chronic disease management which demanded detailed monitoring and focussed interventions and shared decisions. Multiple objectives superimposed on GP consultations altered how doctors addressed issues brought by patients and lowered GPs satisfaction in how they had responded to patients' expectations. Indications that doctors tended to overrun appointment times may confirm that they attempted to address items on both agendas but comparative observational studies of behaviour would be required to exclude confounding factors.

Standards of care for long-term conditions included in QOF (2004) which were already improving before implementation showed greater relative improvements in regions of social deprivation while conditions not attracting QOF payments fared less well and evidence suggested that higher than predicted QOF achievement implied prioritisation of this by practice teams (Gubb and Li, 2008, Roland, 2006, Elovainio, 2010). In keeping with feelings of deprofessionalisation in these interviews, concerns were expressed elsewhere about a diminution in professional identity of doctors who responded to external regimentation and the lure of payments rather than employing interpersonal skills and responding to patients' needs (Heath et al., 2007, Heath, 2012, Lester et al., 2013).

Adaptive strategies reported here resembled observations elsewhere and depending on existing personnel or situations could stimulate re-creation of hierarchies and boundaries to fit new team relationships (Grant et al., 2009). The wider effects of limitations on referrals to specialists appeared less thoroughly documented - perhaps because evidence was not yet

available or due to variable progress and non-uniform processes throughout the NHS. Links between clinical decisions and costs are important not only where doctors retain professional authority but where funding is managed by an insurance body or state controlled (Millman, 1977). Although GPs were shown to have poor knowledge of prescribing costs, rewards for alteration of prescribing behaviour reduced costs across a wide range of dissimilar practices and among interviewees seemed unproblematic (Bateman et al., 1996, Ryan et al., 1990).

Doctors in this study expressed comfort with an honest response to patients including citing cost-effectiveness as the primary reason for changing medication or not recommending referral to a specialist. Specialist claims that GPs might make symptoms 'fit' a pattern for referral which did not jeopardise targets were not corroborated by GP narratives in this group but elsewhere decisions with financial incentives or penalties were shown to affect clinical choices (Lundin, 2000).

It is not difficult to imagine, and anecdotally true, that patients can view decisions which affect doctors' income with suspicion – as has been prominent in public media and controversy about how financial incentives might modify clinical judgement where this is not backed by clearly demonstrated reasoning, ultimately threatens trust in doctor-patient relationships. It appeared that a widening gap of understanding alternative perspectives existed between GPs and hospital consultants; general satisfaction with co-operative work of 1999 contrasted with recent poor quality of interaction or communication (Marshall, 1999, Etesse et al., 2010, Martinussen, 2013). From both sides came admissions of less direct contact and subtle differences between how GPs and consultants spoke of their own enactments of professionalism suggested that these perspectives would merit investigation beyond this study.

Chapter 6

Inflicted narratives; consequences of team working in the NHS

"We trained hard, but it seemed every time we were beginning to form up into teams, we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing, and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralization" From Petronii Arbitri Satyricon AD 66. Attributed to Roman general, Gaius Petronus,

Against an historical background of clearly defined and hierarchical medical teams, movement in primary care and hospital settings of the NHS has been towards organising a multidisciplinary workforce into integrated teams (Wise et al., 1974, Bate, 2000, Brown, 2007). To improve services, this policy-driven shift has been analysed for effectiveness in delivering a holistic services to patients, with team organisation demonstrated to support safer working practices and to reduce stress levels for members who otherwise felt vulnerable (Junor et al., 1994, Jefferies and Chan, 2004, Firth-Cozens, 2001). Analysis of total costs including medication and use of other services, suggested that team management could deliver services of comparable quality with lower expenditure (Borrill et al., 2000b, Zimmer et al., 1990).

My focus in this research was not to duplicate work which examined implementation of multidisciplinary teams, or to investigate their effectiveness, but to understand how working within teams affected the working lives of doctors. Presentation of narratives relevant to teamwork is preceded by brief consideration of the nature and practices of team working in general terms and with particular reference to health care.

6.1 Situating team working in the NHS, negotiations to deliver services

Among the NHS workforce are models of group activity which may defined, analysed, modified or explained in terms of leadership balance and shared or individually held goals and relative accountability (Feltham, 2010, Katzenbach and Smith, 1993). Strength of leadership and focus with shared goals and joint accountability have been designated as characteristic of '*team'* structure but functionally looser *'work groups'* co-exist and in both cases internal relationships determine how they perform. I believe precise definitions are not crucial for my discussion of working relationships revealed in these narratives and propose to use terms which best mirror the manner in which doctors spoke of their relationships with immediate work colleagues.

Measurement of team performance in economically productive companies explored the use of technical and social integration through Self-Regulating Work Groups (SRWGs) proposing that smaller units would prove more productive (Pearce and Ravlin, 1987). Continuing challenge and future uncertainty stimulated SRWGs by feeding into a need for a group to justify its on-going existence or viability (Susman, 1970), while a shared drive to survive and progress appeared to reduce absenteeism and staff turnover as each member felt accountable to the group (Pearce and Ravlin, 1987).

Status differences between leaders and other members could inhibit problem solving which, though augmented by the heterogeneous skills of a mixed membership, was inhibited by internal communication difficulties (Doyle, 1971). Setting specific goals and accurate feedback increased cohesiveness and studies demonstrated positive performance outcomes such as increased job satisfaction, decreased absenteeism, fewer workplace accidents and lower turnover rates (Koch, 1979, Aquilano, 1977, Trist et al., 1977). A concept of SRWGs comprised of individuals with different skills, complementary roles and specified objectives clearly mirrors many NHS work teams where flexible and committed staff have demonstrated an ability to overcome lack of training (Molyneux, 2001) and more creative

future models of multidisciplinary working have been advocated (Carter et al., 2003). Team working brings implications for training and monitoring performance with greater success linked to commitment to clear objectives (Poulton and West, 1999),

However, performance success of a team need not be dependent on or related to positive experiences on a personal level (Alexander et al., 1996). On an individual level, factors which influence how team work is experienced depend on relationships between members of the team how they operate in everyday situations; key aspects of which are summarised below:

- A work group is one of the psychologically relevant reference groups for most individuals
- Acceptance by and co-operative interaction with at least one reference group is preferred by most people
- Group members must assist the group's leader for effective leadership and maintenance of the functions of the group to achieve optimum group effectiveness
- Unresolved conflict and suppressed feelings militate against problem-solving, personal growth and job satisfaction
- In practice, levels of trust, support and cooperation are generally at lower levels than desirable or necessary for best outcomes
- For many attitudinal and motivational problems, the solutions lie in the group's interpersonal dynamics

(Susman, 1970)

Table 4 Features of Self-Regulating Work Groups

In an extensive literature examining the nature and effects of teamwork in health care, multiple perspectives reflected different experiences, including primary and specialist care,

medical and nursing experience, co-operation and productivity, breaking cultural barriers, leadership and communication (Aquilano, 1977, Hall, 2005, Mickan and Rodger, 2005, Leggat, 2007, Taggart et al., 2009, Kunzle et al., 2010, Brown et al., 2011, Horwitz et al., 2011, Leonard and Frankel, 2011). In everyday practice, NHS employees give direction and implement delivery of local health care services by working within managed frameworks and allocated budgets. Individuals who trained as doctors, nurses and allied clinical professions, join multi-professional teams to share tasks of co-ordinating patient care interacting with hospital or primary care management. Obstacles which constrain effective team development include suspicion about motives, unshared objectives, status differences and other inter-professional barriers (Borrill et al., 2000a). Like clinical teams, management organisations are themselves managed and monitored according to the performance of people and facilities under their direction (Goddard et al., 1999, Amaratunga et al., 2002, Conrad and Guven Uslu, 2011).

New initiatives may be launched with new teams but many form from established but evolving structures, responding according to local conditions, to fulfil their mission under direction of management or to meet demands placed on them by patients' needs (Vize et al., 2008, Nason, 1984). Measurements of success may attract additional payments (e.g. QOF) or failure lead to imposed penalties (e.g. waiting times breaches and poor information reporting) (Hughes et al., 2011). Consequences of these factors on team dynamics are dependent on intra-team relationships and how their culture of values and norms guides members in relating to each other and influences relationships with external others, e.g. patients, managers (Mickan and Rodger, 2000). A consensus approach or team-based ethos may underpin agreed activity and the manner in which members collaborate, a process interrupted by acknowledged or unrecognised dissonance. Team roles are often designated according to relative professional expertise and relevant experience.

6.1.1 A narrative picture of team working

Although empirically based in industry, Susman's findings resonated deeply with those I interviewed from medical teams and the patterns of their evidence resembled theoretical models proposed by Goffman (Goffman, 1990). His comprehensive analysis of induction of new members, internal divisions or cliques, responses to external challenge, maintaining team performance or repairing a mis-performance, loyalty, codes of conduct and team 'secrets', public and hidden behaviours – all of these appeared among multiple facets which he described as a team's '*dramaturgical cooperation'* and were evident in participants' narratives about team experiences.

There appeared no clear distinction between team issues from general practice and hospital settings; several stories recalled by GPs referred to a stage in their career when they were working in hospitals or employed in salaried posts in general practice and therefore under the direction of managers. In hospital settings, senior consultants spoke of some degree of autonomy in regulating their managed workplaces while GP partners exercised considerable influence over their work arrangements though all were contingent on the dynamics of a GP partnership (as a legally-recognised group normally operating under a Partnership Agreement) to which they belonged.

Broad similarities across the spectrum of primary-secondary-tertiary care conveyed an impression that team experiences were primarily determined by the nature of the tasks and the organisational structures in place rather than due to a particular clinical designation. I will therefore introduce all teamwork-related elements according emerging insights of team functions or operations rather than separate them according to the specific settings in which they occurred.

Organisation of doctors' reflections on team working is loosely split according to whether the accounts focussed mostly on overarching structural elements, on interpersonal dynamics

between team members, or on characteristics pertaining to the individual narrator which matches the pattern of Clarke's three mapping areas, and also framed Mickan and Rodger's overview of characteristics of effective teamwork on which I have drawn when exploring this area (Clarke, 2005, Mickan and Rodger, 2000). Stories frequently drew together aspects of all three components, weaving them into a representation of remembered experience; each area produced issues which determined, or were determined by, what happened in another and inseparable from reactions induced in an individual.

6.2 Locating teams within organisational structures; teams with purpose

Within an overarching organisational framework teams can be designed and orientated for specific individual and collective purposes;

Team purpose
A team may exist to provide a specific service to patients or to other teams. Where their remit is clearly defined, work is limited within those boundaries and individuals know where their responsibilities begin and end (Kirkman and Benson, 1999, West and Poulton, 1997).
Resources
Available resources are regulated by management decisions on budgets, and subject to competitive tendering for services (West and Poulton, 1997).
Roles in relation to others
Success demands that the team recognises different roles within its structure. Where specific specialised skills are necessary, team members must bring these skills, or acquire them, or delegate the task elsewhere (Blechert et al., 1987, Maple, 1987).
Specific designated tasks
Where tasks necessary to meet management expectations are open to little modification, innovation or deviation from what is expected must be justified (Sundstrom et al., 1990, Firth-Cozens, 1998)

Table 5 Key aspects of organisational impact on teams

Changes in team availability

When changes occurred in how services were organised, this impacted on the availability of team members to provide adequate cover for duties expected of them. Clinical team members were considered responsible for different tasks depending on their stage of training and acquired expertise. During Liz's progression towards provision of a subspecialist surgical service, she had occupied posts of increasing responsibility as her training progressed from;

> *'Pretty awful being a registrar in obs and gynae …one in 3 on-call… 6,000 deliveries …basically up most of the night and then you would just work the next day.'* Liz

Her working week was predictable and fully occupied;

> *'I always knew that I would be on labour ward on a Monday morning and a Friday afternoon. And, in between time there were certain theatre lists I went to and clinics and basically every session you had something on.'* Liz

There was little room for flexibility, absence would be obvious and would be questioned. A rigid hierarchy meant that juniors felt pressure to meet expectations of a consultant whose reference would assist their career progression.

Relationships between junior staff sharing the same wards, and between doctors of different experience but attached to the same consultant team, determined the level of practical support available and affected the quality of teaching and learning exchanged through case discussion. Liz and her colleagues simply got on with the hard hours allocated to them; *'...didn't complain, I thought that is just how life was.'* Progression to Senior Registrar meant being treated differently and new ability to delegate tasks to others;

> *'there was more leeway … it wasn't quite so onerous, you could delegate a bit more and send people off to do things…consultants were starting to treat you …much more like a colleague.'* Liz

Changed work patterns

I used to do four and a half lists a week,
but I had junior backup,
I could rely on people to know if there was a problem.
We used to get a huge number of people through,
but it was a team effort

Now, I do two lists a week;
a lot less people through,
but I have to check on those people every day,
simple postoperative checks for complications;
no one else would pick it up.
Sometimes you just despair

Patients wait for a bed;
sitting all day.
Nurses flying around;
speaking to bed managers.

Liz

However, having established herself as a consultant, those familiar stable and hierarchical working teams had been disrupted (due to EWTD, training programmes and part-time working) and there was no longer a stable and predictable basis for her clinical team:

• • •

Changed work patterns

• • •

Several organisational-level changes had altered the ways in which Liz worked. The breakup of a clearly defined consultant-and-juniors medical team produced significant knock-on effects (Carter et al., 2003). Difficulty recruiting junior staff of high quality meant she personally made herself available to oversee tasks on the ward. Where previously she had felt able to trust junior team members to do routine checks, by default it fell to her to carry out duties which lay far beneath her skill level. Unable to be in two places simultaneously she had not performed as many operations. Difficulty finding beds for newly admitted patients had anecdotally been a longstanding headache – but still was perceived to occupy time and attention from nursing staff who should be expected to be performing nursing duties. On the basis of this short extract it could be said that the NHS was achieving reduced value for money by allowing a situation where clinical staff were not working to their most skilled level, and in doing so were likely to share her '*despair'* at the waste of their skilled resources – a double failure on best performance and job satisfaction.

Distance between managers and clinicians

Studies revealed that workers involved in decisions which governed how they worked were likely to prove more productive and proactive than if excluded, experienced greater job

Not listening

This is not good;
Network
Work to your strengths
See who you have,
what their needs are.

Why don't you ask us,
What is important to the way you work?
Can we shift the service around to keep you on board,
motivated,
keep you in this area,
not piss you off and
so unhappy that you are going to think about moving.

Nobody does that;
no one is coming.
Management has turned out very poor,
it should and could be better.

John

satisfaction, higher levels of commitment to the team and achieved better delivery of services to clients (Kirkman and Benson, 1999). However, managerial direction which differed from preferences of clinical team members, or placed constraints on resources which curtailed activity could produce a team which struggled to engage fully and function effectively in accordance with management objectives (Kapral, 2011).

Ideas John had produced to streamline processing of pathology specimens despite resistance from some colleagues offered opportunities for managers to increase cost-effectiveness without reducing quality, but they did not seem ready to implement the changes he proposed:

● ● ●

Not listening

● ● ●

With a handful of consultant pathologist colleagues, administrative and technical staff, John worked in inauspicious surroundings at a small hospital on the fringes of an urban sprawl close to a vast, modern and expensive PFI-funded laboratory. Due to management difficulties, they chose not to relocate to the new facility, preferring to remain in relative isolation in an old laboratory from which they could continue to foster national networking relationships and retain more control over their methods of working. Their actions were intended to ensure a situation where; *'we will make sure we enjoy our jobs, and it works well'.* This nucleus of histopathologists had withdrawn from active engagement with colleagues in management roles, but took great pride in delivering a first-rate service to their local hospital and on request, sharing their expertise nationally through expert interpretation of difficult histological material. John found these close colleagues like-minded, respected

their abilities, and worked with them to develop new working practices with potential to reduce the cost of pathology services.

Unable to sustain a continuous battle with management structures which they found unwilling to change established working practices which would bring significant economic savings, a new cohesion developed between these doctors. External conflict was keenly felt, and expressed in terms of '*fight', 'siege',* and *'battle'.* John reflected that their position may look poor, but in the interests of self-preservation they saw no alternative. Although attempts to change working practices locally had failed, they had not conceded defeat but taken that debate to national level while auditing their own introduced changes to provide supportive evidence.

John's disillusionment with local managers had its roots not only in lack of contact and meaningful dialogue, but based on his previous involvement in management at a high level where he gained experience of steering through substantial changes and engaging others in this process. Having stepped up to take on a management role as Head of Department in a lab attached to a teaching hospital (1990s), John was wedged between two distinct cultures; an academically orientated university department and a service-driven clinical ethos.

As lead consultant during efforts to merge these departments, John's was the door on which irate colleagues would knock. Much friction accompanied unravelling traditional contracts and former working patterns, a process in which he tried to encourage others by example - he arranged to transfer his own contract *'because that defined better I felt what I was actually doing'.* But he struggled with his colleagues' unhappiness and had difficulty *'trying to get the trust to recognise the problems and … move forward'*. He finally realised that insufficient backing from senior managers created a near-impossible situation. A few years and several twists later, John and others working in a DGH laboratory were isolated from

those appointed as their managers. He was highly critical of the calibre and performance of current managers;

> *'They are just not good; just not up to the job… not forward thinking, engaging people. Unfortunately they end up fire-fighting, all they can do is trouble shoot and fire-fight, and they don't have either the time, the energy but also sadly I think in many cases the ability. There [is] not the standard of managers available to the NHS to be able to construct and effect change'* John

One of the short-comings John saw in management was that non-clinical managers appeared unable to resist pressure from consultants who *'rule the roost'* and maintained the upper hand when additional cost-cutting measures were debated. This resulted in protection of the interests of consultants to the detriment of other groups, blocked development had, in his view, led to lost opportunities for economically sustainable development of NHS pathology services.

Criticism of managers is nothing new in the workplace; what separated this from general criticism was that John believed he had identified an innovative method of working which had been successfully introduced in other places but which he had been unable to persuade local managerial colleagues would be generally beneficial. The scheme involved transferring skilled preparatory tasks from consultants to highly trained laboratory staff allowing increased time for consultants to employ their higher-level diagnostic skills and therefore, in theory, work more profitably. Private laboratory managers readily embraced this as a logical progression yet somewhere in negotiations between NHS consultants and managers there remained insurmountable obstacles to changed working practices; issues of professional authority and relative power appeared balanced in favour of consultants. Faced with difficulties over external issues John's team maintained isolation through partial detachment and increased loyalty to each other. As obliquely hinted in the poem above, his disgust with inactivity of his local managers and their complete lack of engagement, was at risk of making

him resign. He was aware that they may not be upset to see him go – a factor which could contribute to his dogged reticence to leave.

Roles in relation to other team members

Led by the Hippocratic Oath and as reiterated in GMC guidance, NHS doctors are expected, above all, to put the interests of their patients first, regarding it their duty to work within current knowledge and the availability of resources to deliver health care services. Devastating effects may result when a team or team members are unprepared for an emergency situation as occurred when lack of cohesion, co-ordination and support placed Helen in one of the most difficult situations of her clinical experience as she fought to resuscitate a severely ill patient. Although she intended to follow a surgical career, she was still an inexperienced SHO in a small unit which did not normally receive acute surgical emergencies. Visual memory of the incident and her isolation remained clear;

> *'... [the patient] was shocked and desperately ill, and I phoned up the surgical SHO … saying "I need an urgent transfer over" I needed somebody to come and help me to do this. "Oh just resuscitate the patient and send them over in an ambulance".'* Helen

Ideally her supervising consultant would have been available but alone and responsible, she recalled her mental picture of a patient *'lying on a trolley and drip up, and ashen'*, and her own feelings *'I was frightened; frightened, worried, anxious, frustrated, inadequate. Awful'.* Devastated by self-blame, she later recognised symptoms similar to post-traumatic stress disorder which troubled her for several years. In unusual circumstances and with breakdown of the structures which should have directly assisted her, a sense of having comprehensively failed this patient (who subsequently died) left Helen in great distress: unable to sleep, unable to move on, unable to realise that this was not her fault. Her professional knowledge and clinical abilities were simply inadequate for the situation she encountered; she was left exposed by a series of circumstances beyond her control, lacking skills or authority to effect solutions to the crisis. Helen subsequently rejected a surgical

career, training instead for general practice; how much this incident contributed to her decision is difficult to assess.

Unshared priorities, unsupported by resources

Resources to support medical practitioners proved lacking for Alice after her only GP partner was fatally stabbed during an unprecedented incident and her world fell apart. These two doctors had been working together to transform an organisational '*mess'* into an effective primary care service, when suddenly she was plunged into a nightmare situation where she and her staff were severely traumatised. The immediate response of her local primary care organisation was to ask if she would be returning to work at the beginning of the following week. Rather than support, she discovered they would continue to make things difficult for her by refusing to treat the case as *'exceptional'* and therefore not releasing emergency short-term funding to support locum costs. Alice had no available escape route, no time off to adjust or make plans;

> *'…there was no visit from primary care; there was no offer of medical input to help you do your job'* Alice

By the time an offer of psychological help reached her she had been through the '*immediate aftermath'* which for several months meant working 12 hours daily and with no help for additional duties or administration on which she observed; *'and the health board thought that was ok.'.* Her coping strategies failed and gradually her work pattern slipped into irregular periods of unplanned absence during which her remaining team stuck to their tasks, supported patients and delivered good quality care. Although she continued to feel let down by a system which could have responded differently, she and her loyal team have survived.

As Alice faced pressure from press intrusion and from patients who inevitably continued to require medical services, her fiercest criticism was directed at the Health Board which only sought to ensure health services were in place for the patients with apparent disregard for the welfare of the remaining GP. Their narrow priority for provision of continuing care for

patients had overlooked compassion for damaged staff; it was assumed that a normal service would be deliverable regardless of the circumstances. This managerial perspective collided with Alice's subjective reality, lack of insight and understanding prefaced years of reactive illness and distress. Repercussions of the incident continued – Alice believed that if she should hear of any similar situation she would be among the first and loudest to campaign, on behalf of colleagues, for a proper package of support to be immediately made available through tapping into NHS resources and removing inappropriate pressure.

Cohesive cooperation

Although it is important to enhance team performance by using all available skills, practical difficulties arise about who should be responsible for which action when role boundaries are blurred because members originate from different backgrounds; different points of emphasis can lead to intra-team division on priority setting (Ivey et al., 1988, Hall, 2005). Sundstrom's study of the effectiveness of work teams identified diversity as a hazard to be negotiated, while Firth-Cozens indicated that conflict and inconsistency impacted more severely on overall target achievement during periods of economic rationalisation (Sundstrom et al., 1990, Firth-Cozens, 1998). To assign specific targets often aided team cohesion in pursuit of these goals, but increased satisfaction having achieved them was not guaranteed (Koch, 1979). Hackman noted that, in health care, rather than arising as a collection of interdependent team members, teams which formed as a 'pool of talent' did not automatically lead to effective working (Hackman, 1990).

Graham spoke of his work in anaesthetics as being part a strong multidisciplinary team who had high inbuilt standards, accustomed to carrying out their jobs almost without thinking.

> *'anaesthesia is … [a] very controlled environment, small group, highly professional skilled people, you get on and do things and then you are finished at the end of the day'* Graham

These team members were not simply trained to do a job, they had engaged with the job to be done and, regardless of whether anybody was looking, they enacted a work ethic which demanded consistently high standards. Team members depended on each other to perform well. In operating theatre anaesthesia margins were tight, objectives clearly defined and a complex series of tasks was completed within a few hours. Graham's reflections that his teams were highly motivated and well drilled in their roles hinted that, in keeping with those described by Künzle et al, shared leadership contributed to their effectiveness (Kunzle et al., 2010). It was on a basis of smooth team function that Graham indicated he did not welcome the recent introduction of a process of formal briefing and additional documentation though evidence suggested this improved outcomes (Leonard et al., 2004). Strength and thoroughness within his team convinced him these regulations were an unnecessary burden but he was compelled to adopt them.

Multiple team membership

It is not unusual for health care team members to be integrated into more than one team and as a senior GP partner for several years, Jennie was 'finding' team membership in several places. Throughout her career many challenges caused major disruption and team changes brought particular problems. She ventured outside her immediate workplace to fashion a series of side - teams by developing a portfolio-style career. Colleagues had been found in her diverse roles;

> Medical students, who attended for undergraduate teaching and whose success filled her with pride
>
> External medical colleagues, who shared a workgroup while preparing for quality recognition of the RCGP's Membership by Assessment
>
> Practice Nurses who proved indispensable as their roles in general practice evolved
>
> A Nurse Practitioner who collaborated to replace a closing branch surgery with something new and different; realising that '*it's very much about tendering and*

private providers coming in' they successfully braved a tendering process in which they were novice players.

Clinical colleagues (including non-doctors) involved in examining the appropriateness of GP referrals

Her neighbouring GP colleague; traditionally their practices had been competitive but she began *'crossing the barrier'* to share ideas.

These multiple roles drew Jennie into several functionally-different teams in which she gave, shared and followed leadership. As a generalist, her overview of medical care benefitted from a wide range of consultations and communications. As an educator, she was reminded of the sequential learning needed to equip students for an undetermined career. Examination of referral letters from GP colleagues informed her of relative thresholds which prompted specialist interventions. In her core role as senior partner, she felt pressure to take on considerable additional administrative work in the absence of a manager. Her facility for socialisation and working across boundaries appeared to support the diversity of her roles as she reacted to new agendas and priorities.

Stability; the team is not a talking-point

In general practice, smaller and more stable teams have continued to exist, though with widespread team expansion and attitudinal changes, a traditional hierarchy is now less visible; power and responsibility tend to be more democratically shared (Brown, 2007). Two GPs who had little to say on teamwork in their partnership appeared comfortable in stable teams which functioned smoothly in the background. They recognised elements of interpersonal differences which were well tolerated, of leadership through discussion and flexibility, and both sensed sufficient freedom to work in accordance with their individual preferences and had underlying confidence in the abilities of their colleagues.

6.3 What makes teams tick; integration of members' attributes to achieve team goals

Negotiations between team members proved of key importance to doctors participating in this study as demonstrated by the volume of narrative, emotive language and pivotal incidents which turned on success or difficulty of internal team interactions and at the interface between teams and management structures. Processes generally required for team members to function well together include; coordination, interpersonal communication, team cohesion, decision making strategies, conflict management, social relationships, performance feedback, and early detection of difficulties (Sundstrom et al., 1990, Mickan and Rodger, 2005). Cross-disciplinary composition breaches general recommendations that team design should minimise internal status differences with a balance of homogeneity and heterogeneity though historical analysis of teams in industry suggested that mixing skills allowed increased scope for taking advantage of skill transfer (Hackman, 1990, Aquilano, 1977, Pearce and Ravlin, 1987). Three prominent aspects determined by team members are shown in Table 6.

Leadership (and lines of accountability)

Often leadership follows assumed superior knowledge of the clinical speciality without regard for experience of leadership or the skills required (Leonard and Frankel, 2011).

Culture, ethos

Often members carry with them cultural norms acquired during training or in contact with other influences. For multidisciplinary teams this can lead to a mismatch of expectations (Hall, 2005, Sundstrom et al., 1990).

Membership choices

Inclusions are generally based on requirements expected of the team, and may be open to modification by those in a position to effect changes in group composition (Hackman, 1990).

Table 6 Principal areas of importance in intra-team relationships

Leadership, team ethos and membership choices appear interwoven in multidisciplinary team working since each is dependent on the other and in turn affect how effectively the team can function. Health service managers believed that embedded knowledge of organisational policies, self-awareness, knowledge of management together with a balance of personality traits, strong commitment to collaboration and high performance, and skills in communication and conflict management offered optimum health team outcomes (Leggat, 2007). While acknowledging that managers' views of preferred qualities may differ from clinicians' preferred orientations, Leggat's work also noted that greater success was achieved through team members understanding '*the values, climate and culture underlying effective interpersonal and teamwork relationships'*.

Analysis of teamwork experiences informed Mickan and Rodgers of six major characteristics of effective teams, of which half depended on team processes; leadership, communication and cohesion (Mickan and Rodger, 2000). Salas et al summarised several team studies before listing a '*big five'* preferred characteristics; leadership, mutual performance monitoring, backup behaviour, adaptability and team orientation (Salas et al., 2008). Failure of efficient inter-professional communication in clinical settings has been blamed as a leading cause of patient harm, since doctors were trained to focus on communicating concise headlines with a rapid transition to the main message while nursing colleagues typically employed broad narratives to convey a bigger picture (Leonard and Frankel, 2011). In critical situations, communication broke down because one party did not realise that their manner of communicating details had not adequately transferred understanding of the gravity of the problem. Perceived status differences created an additional obstacle to effective communication (Leonard et al., 2004).

I may have been stubborn…

It can be very wearing
that constant managing of risk,
with more and more responsibility.

You have been told;
if you haven't done a proper risk assessment,
or asked the right questions,
and something happens
you are for the high jump;
the coroner's court.

So, dealing with that stress,
and reached the decision,
then having to fight with the nurses;
just another barrier.

At the end of the day,
if push came to shove;
I am sorry
I am the consultant and they are coming in
I am not taking the chance

These pointless, counterproductive, time-wasting arguments
that occasionally would get quite heated
You would have to think-
ridiculous
All and sundry felt a right to an opinion
no matter how unqualified

It's my neck on the block at the end of the day,
that is what they pay me for

I may have been stubborn
standing up and saying,
Well no,
I am sorry,
I am not discharging this patient

I didn't have many suicides
Luck?
or through caution?
I am not sure.

Henry

Different perspectives of risk

Approaching complex decisions from different angles meant that Henry's perspective was unshared by others. As responsible psychiatrist his over-riding priorities drew him into conflict with well-intentioned others;

• • •

I may have been stubborn…

• • •

Henry recalled his hospital-based psychiatric training as a series of battles with other staff where it seemed everyone felt entitled to challenge the authority of his clinical decisions. Far from deferring to his specialist psychiatric training, non-clinical staff and nurses with psychiatric training would engage in lengthy debates expressing strongly held opinions about what should happen with individual patients. He felt duty-bound to defend decisions he had made only after deliberating carefully on available evidence.

If a patient breached ward rules for inpatient behaviour (e.g. by using illegal drugs or alcohol), ward staff would argue that he/she should be summarily discharged in accordance with the rules. However, where this action carried an unacceptably high risk of further serious harm (e.g. the patient may be mentally unstable and at risk of harming self or others), Henry felt duty-bound to insist, against open opposition, that enforcing ward rules must remain a secondary consideration to primary concern for the overall well-being of a patient. He would remind them that, should anything untoward occur, it would be his judgement, not theirs, which would be questioned by a coroner; in the final analysis his decision carried, but relationships were not comfortable. While he acknowledged that useful supplementary information could be contributed by a nursing assistant who had spent time

Shaping the culture for the team

We have the staff we need,
we have the equipment,
we have nice colour carpets,
nice wall art,
premises that we own

Everybody knows the number one priority
is quality

We are on the side of patients,
we set the direction,
and have flexibility.

We manage a small general practice,
independent contractor status allows that.

Leadership from doctors,
the owners, because
if they set the right culture then
everyone follows.

We hand pick the staff,
turnover is extremely low.
Everybody knows that
I trust them and say,
Just make the best decision
that will support patients.

So we will see people,
we will go the extra mile,
we will coordinate care,
we will chase things up,
it's the classic general practice function.

Mark

talking with a patient, these *'pointless, counter-productive, time wasting arguments'* did not encourage him to continue working in hospital teams. Later narratives from his community-based work in addictions which involved a great deal of team-based care produced contrasting narratives of cohesive teamwork.

Shaping team culture and ethos

Leadership skills have not traditionally been part of medical training despite an apparent assumption that clinical experience may naturally foster development of leaders, and clinical priorities have been found to limit time available for team leadership development and liaison (Wake-Dyster, 2001). However, progressively more complex responses to policy shifts have demanded greater organisational capacity to mount an effective team response (Taggart et al., 2009).

As owner/employer/senior clinician, Mark was clear about how he aimed to inspire his team.

• • •

Shaping the culture for the team

• • •

From Mark's description of routine work you could question whether profound changes in NHS services have affected his close-knit team at all. It sounds idyllic - could almost be mistaken for a well-appointed urban reincarnation of Sassall's 1960s Forest of Dean practice (Berger, 1967). Instead, Mark's 21st century practice served patients from diverse ethnic backgrounds in an inner-city location; characteristics not normally associated with good health outcomes or relaxed working conditions but his ethos was clear. He was involved with a system drawing attention to poor performance seen in hospital care: *'…we have a*

reporting system where we can report poor quality incidents of care.', and for medical students; '*I do one [module] around quality, measuring quality, improving quality, evidence… early diagnosis'.* Unsurprisingly he concluded that anyone in his family would be unequivocal; '*I think they will say that I am interested in quality and standards… and have ambitions for that.'*

Negotiated internal team management to avoid managerial interference

Ideally, a multidisciplinary team (MDT) in gynaeoncology receives, assesses, discusses, implements treatment and reviews cases with relatively little external clinical or managerial input. Autonomy within a framework of targets was carefully managed by an MDT team which took shape under Liz's leadership. During development as a highly structured unit with a mixture of staff skills and working within recommendations of the 1993 Calman-Hine Report, personnel changes threatened continuance of a cohesive team approach.

As an inclusive team leader (a position she held largely by default through being the senior clinician), Liz was content for experienced nursing colleagues to speak out in defence of the team ethos which was jeopardised when a new consultant sought to adopt a position contrary to promptly providing treatment. It suited her, even within the privacy of the team, to avoid an inter-consultant confrontation which could have proved damaging; she emphasised the principles which enabled them to maintain a high quality of service by maintaining their core unity of purpose;

> *'I work in … a team with some quite strong women who are specialist nurses, and they usually sort of say, " well you can't do that, you know, we are all working in this certain direction and you can't do that" and we all sort of get behind them and then it sort of, seems to go away.'* Liz

An MDT team must not only keep pace with the through-put of new and returning cases but do so within specified periods of time from referral to avoid breaching target waiting times.

Flexibility was necessary and a discussion between staff which revealed reluctance to work in the most expeditious manner led to *'full and frank discussions'.* Occasionally, when there was no clearly 'correct' treatment choice, divisions based on clinical judgement within the team could be difficult to resolve but only rarely did this result in continuing bad feeling - though she recalled once where;

> *'there was a lot of discussion, and it was quite difficult, but it was… resolved; everybody is speaking to each other'* Liz

Since her preference was not to give singular leadership, her facilitation of contributions from valued and experienced staff led to joint decisions and good progress without prolonging divisions - which may be viewed as an effective adaptation to managing the existing team structure. Failure to achieve targets which would inevitably lead to external managers becoming involved with the team was seen as a worst-case scenario, one best avoided by internal cohesion and cooperation.

Clinical and educational consequences of disassembly of former clinical teams

In contrast to MDT coordination, Liz's reflections on her clinical team revealed deeply troubling malfunction, an arrangement ill-equipped to provide effective inpatient management through dependable and coordinated actions of a range of skilled staff. On moving between posts after short periods (usually four to six months), junior doctors expect a short period of training and increased supervision. After this they should undertake an appropriate level of self-organisation to fulfil their responsibilities within a new clinical team. In recent years, this progression to effective working practice for Liz's teams was limited by two factors; altered working hours and doctors whose clinical skills appeared sub-standard.

Introduction of EWTD-compliant working patterns led to disintegration of Liz's former team; attendance of junior doctors was repeatedly reduced to the extent that she became unable to depend on anyone to be regularly present for routine duties or to discuss cases and gain educative experience;

About how we train people nowadays.

I am very, very worried.
I have two on our team;
they never follow patients through,
never on the ward round ,
not in theatre with me,
they hardly come to my clinic.

So
these two people,
that I am supposed to be educationally supervising
in six months, I might see four or five times.

It is very difficult to train them,
to take them through a structured way.

Liz

'*they never seem to be able to follow patients through, like they are never able to be on the ward round every day, sometimes somebody from a completely different team does the pre-operative assessment clinic, they may be not in theatre with me, they hardly come to my clinic*'. Liz

After junior doctors failed to perform requested assessments of inpatients on other wards, she no longer trusted them to undertake these tasks but did them herself. Stating that *'most of our juniors wouldn't know an ill patient if it hit them in the eye',* she revealed how she was unimpressed by the clinical acumen of many locums employed to fill gaps created by recruitment difficulties. As a result she worked closely with specialist nurses who had to a large degree taken the place of absent junior medical staff. Filling gaps was reflected in the timetable of Liz's new contract but, aside from frustration at under-utilising her skills, a decreased level of teaching and learning due to reduced contact with the junior doctors, heightened her concerns about the calibre and quality of future clinicians.

In the above-mentioned woes of patchy recruitment to gynaecology and frequent employment of locum doctors, Liz was responsible for teaching and monitoring doctors who were nominally are linked to her 'team' but she felt uneasy about the adequacy of training and evaluation:

• • •

About how we train people nowadays.

• • •

Benign but too big

We now have people in consultant jobs
who cannot do a big benign gynae operation.
Never been taught to do it.

We have a new consultant,
first big operation
landed up for us to discuss
We had to say
'We are too busy,
we cannot do this case;
it's over to you

I don't know what this girl will do

It is a real problem.
We are not training people;
hours is a big thing,
not working in teams anymore.
It's very difficult to train them.

Worries me if I ever need a gynae operation
Who would you…?

Liz

The task of completing assessment forms (format similar to that of GP training programme; (RCGP, 2013b)) served to highlight her limited ability to confidently confirm their work as satisfactory. Brief contact fed serious concerns about progress; poor clinical skills, non-attendance, unsound decision making, and failure to take appropriate responsibility. A recently appointed fully accredited gynaecology consultant who encountered a case which exposed her lack of confident operating skills had approached Liz's oncology team for assistance because she felt inadequately prepared for the complexity of the task:

• • •

Benign but too big

• • •

Although a study of recently appointed consultants reported that the clinical skills learned during training had, broadly speaking, prepared them well for taking on a consultant post, this incident compounded Liz's concerns (Morrow et al., 2012). The study revealed that new consultants perceived relative weakness in components of training which developed their ability to participate in the organisation of health care but not affecting performance of general clinical duties. Perhaps it was the new consultant's difficulty handling this case from an organisational point of view which allowed it to come to Liz's attention. Deeper concerns, however, also rose from reports of changes in higher professional exams. Recalling her own as a testing experience, Liz was clear that in her remit as a college examiner her instructions were to aim to ensure that candidates were '*safe'*, meeting '*minimal'* standards rather than demonstrating a comprehensive knowledge of the specialty.

Vulnerability of team cohesion

Health care teams' experiences of intra-team conflict frequently arose from differences related to role boundaries (i.e. whose role covered which activities/duties), scope of practice (i.e. the extent of activity which each member was sufficiently trained to do as part of their role), and accountability (i.e. who carried ultimate responsibility for service delivery) (Brown et al., 2011). Differences of understanding, expectations and opinions, which needed to be addressed to iron out such issues, were often constrained by lack of time and opportunities for extended team members to meet and talk. Workload, physical space, fears of causing emotional upset and lack of motivation to confront the problems, became barriers to resolution. Ability to negotiate through such difficulties could make or break teams.

Detailed analysis of shared leadership, which permitted utilising different styles of leadership within teams, indicated that such sharing increased the range of leadership skills available and promoted more effective functions, including conflict resolution and decision making (Bergman et al., 2012). Limited success in engaging interdisciplinary team members in shared performance feedback has been linked to an unequal reflection of the roles of members from different disciplines; which may be exhibited as difficulty allocating praise, reward or extra payments accrued through payment for performance; e.g. to calculate whose labour was most productive, or essential to delivering this achievement. Until indicators of performance which embraced input from different disciplinary groups became more comprehensively defined, further improvement of outcomes through more seamless team integration was deemed unlikely (Johnston et al., 2011).

Henry's involvement with community Mental Health teams generated positive stories of how members worked well together;

> *'really good staff, good laugh, they did their job, they were incredibly politically incorrect, and filthy jokes, sexist jokes all that sort of thing, which made life quite bearable, but you know you knuckle down and you saw the patients'* Henry

A combination of personnel changes and the team manager's sickness absence plunged that team into *'a complete crisis, external consultants coming in to try and sort the team out.'* Having survived and returned to a functional unit, they faced further uncertainty when a consultation document advising that a quarter of the team should be made redundant; his wary tone not only hinted at difficulties ahead for the team but concern for his own position;

> *[I] have never felt as insecure in my job as I have in the last year…you thought, NHS consultant, job for life…but…they are absolutely tightening everything down, and I am not even sure that there is going to be much in the way part time jobs around and that is…it's not quite unsettling it's actually very unsettling…; at 48 how attractive am I going to be?'* Henry

Unhappy partnerships

While it can be difficult to explain why some GP partnerships exist as stable teams which function well in contrast to others in constant change or conflict, anecdotal and research evidence suggested that many GP partnerships exhibited dysfunctional characteristics much of the time, though the nature of the difficulty varied (Smith, 2002a, Cembrowicz, 2005).

Helen's first partnership was never comfortable. She declared them a group of *'strange people'* who did not communicate well; messages from the senior partner were relayed to her via a member of staff, unannounced meetings took place without her prior knowledge, and the partnership was rife with bartering and brinkmanship. Essential matters, such as fair sharing of workload and income, remained contentious. Helen felt she was excluded from decision-making but expected to work unreasonably hard to fill the shoes of the experienced GP she had replaced. Before the end of her probationary period, they simply asked her to leave, stating merely that *'our solicitor has advised us not to tell you why'*.

Feeling shattered, she convinced herself it had not been a good place to work and moved to another partnership where the senior partner gave effective leadership; he was supportive and implemented some her ideas making her believe she could contribute positively. A

Team talk

The thing that
really crystallised
was

one night
we discussed it,
worked it all out
we all stood in a line
down the middle of the room.
then
we had to give our opinion on something;

you either took

a step to the left
or a step to the right.
I ended up over there,
the other three ended up over there.

And that said it all really

Helen

leadership vacuum developed on his retirement. A new partner arrived who *'seemed quite nice to start with',* but unfortunately Helen and he *'clashed terribly, completely opposite characters'*. The new senior partner suggested they all participate in a commercially available programme to identify personality traits and work preferences built on individual completion of a long questionnaire. Each doctor's score reflected their reported strengths in four categories. Although intended to facilitate discussion and understanding of selves and other team members, the result of the profiling was a graphic illustration of the starkness of Helen's position; her preferences took her in the opposite direction to everyone else;

• • •

Team talk

• • •

Limited background information did not convey sufficient understanding to sense whether these differences could have been resolved with the help of skilled programme facilitators, or even whether undisclosed motives had intended to exacerbate the situation to terminate an unhappy alliance. Confirmation of her complete isolation in this exercise illustrated and underlined Helen's dissimilarity; already as the only GP trainer, her requirement of protected time for teaching and supporting the trainee doctor was contentious.

Differences increased further when she chose not to work outside normal hours yet those who did so (for additional personal payment) continued to benefit from reduced hours which were not available for her. Disagreement turned to resentment while Helen slid into a clinical depression. In the power struggle which followed, she judged the senior partner ineffectual, her junior colleague undermining and finally she handed in her notice. Theories about

whether the best interests of such a group would have been better served by supportive recognition or could have been avoided through earlier intervention remained untested.

Disharmony in a partnership team

Even within established and continuing partnerships, relationships may be complicated; Stewart found himself senior partner where, unlike her colleagues, one doctor did not unreservedly participate in ad-hoc extra duties, but took time out in lieu. She was also noticeably absent more frequently and for longer due to sickness. Her 'minimum-necessary' commitment was recognised throughout the team and compounded by reticence to invest in further development of practice property. Her failure to adequately cover agreed duties for Stewart when he was occupied with educational or other duties, caused friction and a tone of disharmony remained. Team members covertly devised plans to dilute her negative influence by bringing in additional doctors. In her absence, they made jokes about less conventional strategies and **'***had a sweep stake…about how long she would take off…with hysterectomy.'* However the team had continued to function despite a dominant sub-group colluding against a colleague.

Finding a 'safe' team

Away from partnership worries, Helen found a rewarding niche in leadership of a local GP Trainers' group where she established herself as an effective and popular leader. Beginning as a nucleus, initially of female trainers, the group formed to exchange ideas, share in mutual support and to mix socially. Aware that this group valued her leadership and that her reputation there was strong, she was fiercely defensive of her standing as the group grew. When a former colleague, whose previous actions had terminally undermined her, looked set to join the group she felt compelled to privately, but explicitly, request that her long-term friends protect her interests should things develop which might again compromise her position. Her sense of vulnerability reflected a damaged and fragile confidence, but she demonstrated great determination to retain this positive role. In her reflections on these

difficulties Helen recognised her repeated attempts to become established as the sort of doctor she aspired to be. Repeatedly thwarted by incompatibilities, her career shifted from one place to another, constantly searching for likeminded colleagues who were prepared to work with her strengths without magnifying differences in style or approach.

Narratives in earlier chapters echoed and added emphasis to these stories. Camaraderie in learning situations recounted by Graham provided 'fun' as his cohort of junior doctors proved cohesive and created a mutually supportive environment which helped everyone to thrive. Positive feelings of being *'valued'* built self-esteem and confidence which fed future professional development. In specialist training Graham had unexpected difficulty passing his final professional exams; repeated attempts and disappointment with soul-searching analysis of his failures preceded his eventual success. Although senior colleagues were supportive, he was close to considering an alternative future. It is perhaps significant that, having formed strong links with colleagues and laid down positive feelings in relation to work, those aspects may have helped keep him on track to a successful and fulfilling career.

Insufficient data over a wider range of practices or hospital teams prevents development of generalised theories as to how and why some professional work teams function well while others lurch from one crisis to another. Multiple personal or attitudinal characteristics introduced by several individuals, unclear evolution of roles or duties, weak leadership, disputed goals, or externally imposed change of priorities appear among factors which must be considered influential. Mutual support and understanding combined with new challenges can create a stimulating working environment but, without cooperative action, what may begin as stimulating team development can become challenging or threatening and seem less attractive.

6.4 Individuals as effective team members

As a basic unit of performance in many organisations, teams must bring together sufficient members with the necessary experience, attributes and perspectives since, without their input, structures, mission statements, definitions of roles and principles of accountability cannot function effectively (Katzenbach and Smith, 1993). Advantageous member characteristics included: self-knowledge, trust (or lack of trust), commitment, flexibility, awareness of own boundaries, motivation and sensitivity; all of these attributes facilitated effective interactions (Mickan and Rodger, 2000, Ivey et al., 1988, Mickan and Rodger, 2005, Salas et al., 2008).

Cognitive ability exerted an impact on individual tasks while emotional competence was positively associated with team performance, attitudes and the emergence of effective leadership (Offermann et al., 2004). Use of personality testing was shown to contribute indirectly to increased team effectiveness by sensitising those who had undertaken it to traits of colleagues, which in turn fostered better team interaction (Varvel et al., 2004).

Currently appointments in the NHS must be made with a view to transparency and fairness with subsequent inclusiveness necessary to engage clinicians in co-operative action by avoiding feelings of isolation or difference (Hunt, 2007, MGMA, 2011). Although separation from watchful colleagues raised concern about development of practices which were not conducive to good health care, evidence from singlehanded GP performance demonstrated that this need not be the case (Hippisley-Cox et al., 2001). Writers generally agreed that training programmes tended not to prepare healthcare staff for team working as this was expected to be learned ‘on the job’ (Leggat, 2007, Leonard et al., 2004). Improvement of defective communication between nursing and medical staff which built on patterns of structured communication in a manner used by flight crews, demonstrated superior outcomes by alerting staff to unsafe situations where prompt action was necessary and thereby reducing medical errors and inclusion of specific training for nursing students

promoted better general communication between team members (Leonard and Frankel, 2011, Snyder, 1981). Similarly, despite misgivings discussed earlier, it was shown that introduction of formal pre-operative procedures during which all angles of a proposed operation were discussed by the team, reduced errors in theatre and increased intra-team understanding (Leonard et al., 2004). Apart from these examples, little evidence emerged of structured pre-qualification or early career training available to develop team-work skills.

Although many employment models co-exist in general practice, when this cohort of doctors first became GPs from 1987 onwards, employment models as GP partners or as an assistant 'with a view to partnership' were most prevalent. Sequential changes, not least through alterations to funding arrangements, have transformed the GP scene to a mixed pattern of employment (Merry, 2007). Doctors may be GP partners with shared ownership of the premises in which they work or partners who work in rented premises. In both cases, a core group frequently forms a profit-sharing partnership with responsibility for managerial direction. Practices often employ 'salaried' doctors whose work tends to focus on a clinical commitment; these posts may be short term or used as a stepping stone to eventual partnership. Partnership agreements and contracts normally spell out the duties expected and obligations to be fulfilled by both doctor and partnership.

Narrative accounts described how specific characteristics of team members and the reactions of team members to these characteristics brought additional complexity to team dynamics. Several of the stories of this chapter have referred to inter-personal differences which impacted on team behaviour; the account below emerged late in the interview having been omitted during an earlier partial account of working in that practice.

A culmination

He never answered,
he would be aggressive

He never came to meetings
used to run late
didn't do prescriptions
appalling at writing referrals
but not open to suggestions

He wasn't writing down his consultations
just wasn't functioning as a doctor.

It was difficult to shop him
who was there to go to?
The PCT didn't take much notice
To totally shop him-
the situation would have been unbearable
but you couldn't help him either

So it came to a head
when even the practice manager
was putting on me
dumped a pile on my desk

Totally overwhelmed
unheard and unsupported,
driven to a slanging match;
'can't take it any more',
the final straw.
I was gone

I lost my job;
my choice.
If I had stayed,
covering up,
trying to work round him,
keep the boat afloat…

I don't feel as though I could have lived with myself

What seems to come out of this is;
you are on your own

Mary

Working alongside a dysfunctional doctor – immediate and knock-on effects

Inter-personal discord as a result of unconventional and (arguably) unacceptable working practices became evident for Mary when her salaried colleague persisted with behaviours at work which were not conducive to effective patient care or good working relationships.

• • •

A culmination

• • •

In this first 'proper' GP job as a salaried GP, Mary worked closely with her practice manager to address many new requirements of the 2004 GP contract. Although this was not strictly expected of her in a salaried position, lack of active medical leadership (no on-site GP partner) made it necessary and tasks included the appointment and training of nurses as well as administrative processes. She found this stimulating and welcomed a sense of having influence over her working arrangements.

At one point she was offered a partnership, but this did not subsequently materialise. Instead another doctor *'muscled in'* but conducted his work in way she described as *'dysfunctional'.* His shortcomings resembled the definition of an *'unacceptable'* doctor in GMC publications; failure to record consultations, failure to record medication, failure to promptly refer patients when required. His overall failure to function included poor attendance at doctors' meetings when significant failings could be discussed in a non-threatening manner (General Medical Council, 2006).

Since he regularly allowed appointments to seriously over-run, many patients remained unseen for long periods and were dissatisfied. Yet he was not open to suggestions about how he might work more effectively as a member of the medical team. Although like him a salaried doctor, Mary had, in the absence of clear leadership, been functioning at an elevated managerial level. Speaking to local primary care managers about her colleague brought no resolution; had she evoked a supportive response from the PCT, it may have been possible to resolve it differently.

When eventually Mary sensed that the same practice manager with whom she had previously worked constructively was no longer supporting her efforts to *'keep the boat afloat'* she felt she had exhausted all available options (short of formally reporting him to the GMC with a risk of unknown repercussions) and resigned. Despite mounting concern about his work she did not explain why she had not directly reported his deficiencies to the GMC other than to imply that to '*totally shop'* him would have left her in a difficult position. Finding herself unsupported and under immense pressure due to indefensibly poor practice was more than she could tolerate; non-engagement of her 'dysfunctional' colleague had defied all attempts to make progress; from her position of limited power she felt no alternative option remained other than to leave rather than remain open to the risk of being damaged by association.

Suddenly unemployed, Mary experienced many different GP settings as a locum doctor using these to ascertain team and workplace characteristics which she most valued. Her single most important requirement was that the doctors should take daily time-out to meet and talk regardless of how busy or pressured they might feel. Eventually she found a close-knit team who shared her desire to have protected team-time (a carefully synchronised morning coffee-break). This helped build relationships while they shared tasks, discussed cases or any important developments, and '*usually fight over visits … because it's nice to get out'*. Secure in this partnership she felt certain she could at any time negotiate to adjust

her workload and considered herself integral to decisions and general management of the team. Finally she had achieved career fulfilment with acceptable authority, autonomy and supportive colleagues.

References to colleagues in previously mentioned narratives highlighted how their behaviour affected their immediate colleagues and impacted on the work environment – e.g. George's bitter encounter with '*snakey*' career-focussed doctors who appeared ruthlessly ready to snatch any and every possible opportunity to highlight their clinical abilities including denigrating colleagues. Similarly Helen and Alice's experiences of unsupportive and bullying behaviour profoundly affected their early careers. Inspirational characters also generated powerful influences whether through depth of knowledge or by instilling a sense of empathic engagement with the lives of patients. These illustrated that proximity and shared professional space inherent in teamwork meant that success or failure of cooperative actions affected how a team could operate and any deficits within a team would also affect the entire group.

6.4.1 Partial stories

When describing teams in which they have worked, narrators could only report how interactions, relationships and consequences appeared from a single viewpoint; additional comments could be reflective or conjectural and important for how they remembered and shared the accounts. By accessing the narrative of only one person in a team, my evaluations were restricted, leaving wider perspectives open to interpretation based on limited information and subject to assumptions based on my background experience of similar situations.

It could be proposed that poor performance in one area of work may be due to greater effort in another which is unseen or less-valued by colleagues. For example, while recognising the difficulties experienced by Mary when her colleague's actions led to obvious deficits and

inconvenience, the picture remains incomplete without his story or those of others with whom he worked; patients with whom he spent extended periods using Cognitive Behavioural Therapy techniques may have greatly appreciated those skills.

A different approach to work demonstrated by Helen's separation from her colleagues seemed natural and right to her but set her apart in her partnership; she did not however voice criticism of their clinical work or abilities, merely that their perspectives were incompatible; production of ideas and their implementation can require different aptitudes.
In both cases irreconcilable differences, whether of working practices or strategies, led to resignations to escape uncomfortable situations. In Stewart's practice, joint planning behind the scenes by the majority effectively side-lined a partner whose attitude seemed fundamentally different from how others dealt with extra commitments; it would be most interesting to have her views on inter-partner relationships.

Despite the modest reach of this study, interviews displayed wide diversity in positions held by doctors at different times and in different teams. Figure 6 illustrates a range of such statements, indicating opposing or complementary positions in which the doctors have found themselves or created for others.

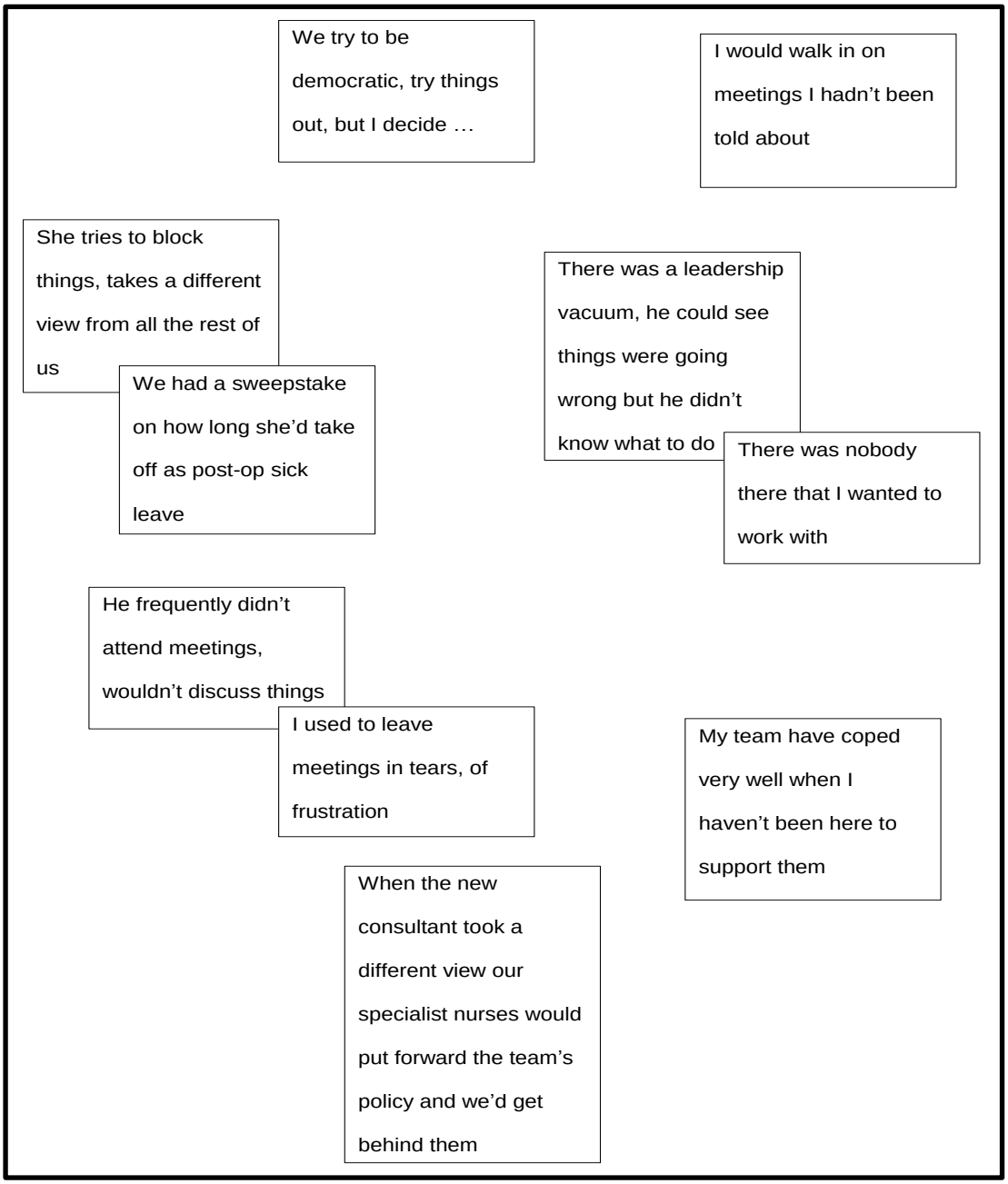

Figure 4 Contrasting views of team member relationships

Although doctors had not received formal training in how to work in teams, their weight of talk about teams as places in which to work with others, to manage relationships of power, to negotiate responsibility and to feel secure, accepted and valued indicated that they adopted a range of strategies to function as team members. Reflecting on their stories, I sensed that some felt more comfortable than others in teams and some seemed able to manage team negotiations more successfully than others. Those who reported episodes

which were globally less satisfying tended during those same periods to lack stable team membership.

6.5 Summary

Participants spoke at length about relationships within teams of which they have been part at various stages in their careers involving work teams of varying composition, clarity of purpose, stability and cohesion. Much of the strength of team work was derived from the strength of the relationships which were established between members who shared a common purpose and were highly motivated to see their team succeed. Quality and style of leadership varied widely with positive experiences occurring when this operated in a focussed or singular manner. Shared accountability helped cohesion, shared humour discharged frustration but on occasion cohesion was strengthened at the expense of an isolated team member who was not fully part of a core group.

Some teams were able survive frank discussion of difficulties while for others the starkness of difference became a terminal event. Communication between members has not here been demonstrated as a significant problem though some negotiation was necessary to negotiate a resolution when priority actions had not been unanimously agreed. Establishment of team training components in medical education to achieve safer patient outcomes and training to educate teams about processes have been advocated and appropriate tools developed (Salas et al., 2008, Weaver et al., 2010). Incorporation of appropriate training in team working improved understanding of commonly arising difficulties and may facilitate smoother transitions into more effective team working, however, the only account which described how a team attempted to address disharmony, found that this exercise served only to highlight fundamental differences.

Several doctors experienced difficulty due to external influences from structures and policies determined at political and national or local organisational levels. Distant decisions were not

seen to have direct relevance or to be suited to local services. Mostly clinicians reacted to these with a grudging compliance, in recognition that it would be easier to modify practice to comply and take advantage of any accruing benefits than to deal with the consequences of resisting.

Although these doctors reflected little on their own qualities as effective team members, they readily identified colleagues whose attributes led to poor team functioning including complete breakdown of relationships. Findings substantially echo principal points summarised by Susman and Goffman's observations of team interactions. Whether formal or less formal, multidisciplinary or homogenous, work teams were represented as psychologically important and featured prominently in talk about work. Clinicians spoke more positively of teams where leadership was shared and preferred retention of autonomy. Doctors who were thoroughly integrated could thrive, while for any non-integrated members the pressure of exclusion often precipitated departure.

Focus on interpersonal dynamics as a root cause of many difficulties was however not the message of several accounts where blame was instead attributed to external influences beyond the control or modification of team members – akin to *objectivation* of the organisation which denied their agentic influence; the organisational structure being presented itself as an object which interfered with independent action (Lofland, 2006).

Having explored narratives on working with colleagues, the following chapter examines reflections on deeper personal feelings, considers interpretations of medical identity and the motivations, actions and responses which emanate from an inner perspective.

Chapter 7

'I am a doctor…that is who I am'; consequences of a sense of medical identity

"Doctors?" said Ron, looking startled. "Those Muggle nutters that cut people up?"
(Rowling, 2004)

By tradition, selection based on academic success in science subjects preceded entry to medical school training where students, as individual products of their past, were equipped with new knowledge, skills and attitudes as they continued to develop personally and professionally (Collins et al., 1995). Diversity encountered within medicine and during interviews confirmed that doctors did not automatically assume a universal medical identity, and even through training at the same university they did not metamorphose into a pre-destined uniform category of physician.

7.1 Medical identity; a culturally acquired and situated identity

Becker's idea of a formed medical identity emphasised certain priorities learned by medical students as they gained medical experience and clinical responsibility, supported a notion of development of culturally acquired attitudes and resonated with Parson's proposal that early training was influential in developing professional behaviour (Becker, 1977, Parsons, 1951). However, Freidson argued that acquisition of recognisable medical professional characteristics occurred later as the complexity and uncertainty inherent in clinical situations exerted greater influence on shaping emerging physicians – conferring greater importance on development as 'neo-professionals' (Freidson, 1975, Lorber, 1975).

Freidson's analysis of professional thinking informed description of a concept of clinical mentality, which he believed to consist of an amalgam of ideas around which doctors developed professional identity and which guided professional practice. Features of clinical

mentality included a service orientation, a sense of moral and ethical responsibility for patients and for 'the profession', a 'clinical mind' orientated towards action to achieve results and tending to privilege clinical experience over book knowledge.

Yet Friedson seemed dissatisfied with available data to understand the development of clinical mentality. He was unconvinced of the generalizability of limited studies believing that while external manifestations of professional attitudes and behaviours were open to scrutiny, knowledge of inner thoughts and intentions, particularly of everyday doctors rather than spokespersons or academic doctors, were less accessible – in keeping with Goffman's front-stage and back-stage presentations (Goffman, 1990).

Internalisation of medical culture, which Digby proposed facilitative for construction of a sense professional identity, was viewed as contingent on multiple influences operating in medical circles and in society (Digby, 2007). Expression of identity, and specifically of medical identity, must therefore involve not merely an appreciation of self but of culturally determined constructs within which medical identity exists. It follows that recognisable medical identities which differ temporally and across cultures, will be subject to the influences of political, sociocultural and economic factors (Tallis, 2006). These combine to dictate the space available for individual interpretations and expressions of medical identities which Maynard analysed on a number of conceptual levels;

> Self; as the person experiencing identity
>
> Personhood; as an extension to include aspects of social being in relation to close others
>
> Ethnic in this case *medical* identity; where focus rests on an individual's relation to an ethnic (medical) group.
>
> (Maynard, 2007)

To distinguish between these aspects of identity in analytical terms does not necessarily assist in gaining greater understanding of the whole. In the narrated accounts I have studied, individual doctors spoke of facets of their identity as a continuum; components of their identity, medical and non-medical, appeared mutually interdependent. In the same moment they were doctors, counsellors, employers, parents, teachers and active members of their communities, with different attributes and modes of expression accompanying each role – as is not only normal human behaviour but has been judged supportive of psychological well-being (Thoits, 1983). In this context it is worth remembering that doctors are constrained by the fact that , despite evidence that they may wish it otherwise, GMC regulatory powers apply to a doctor's general conduct in addition to their professional activities (General Medical Council, 2011, General Medical Council, 2006).

Just as investigation through narratives revealed evidence of the effects of organisational-level requirements and the dynamics of interpersonal relationships in teams and with colleagues, narratives also allowed exploration of how doctors saw themselves, how they reflected on medical identity, motivation, aspirations and how they functioned as medical professionals (Mishler, 1986). As a sense of medical identity developed socially or culturally, doctors took on a medical identity with public exhibition of some characteristics while supressing others (Goffman, 1990). An attitude of self-effacement which Maynard observed tending to replace deep reflection on medical identity among busy doctors, was consistent with narratives gathered in the early or unsettled stages of these research interviews - 'private' self being eclipsed by 'public' dimensions of experience (Maynard, 2007).

7.2 Reflections on being a doctor

Having spoken to a tiny proportion of NHS doctors my research-based sense of how it felt to be a doctor was restricted to this group, yet each of their narratives revealed facets of a picture which though incomplete might point to converging ideas. Research which

What does work mean?

It’s probably what defines me

I live to work,
would fear for how I would be if you took that from me
in the wound down, highly deprived, high unemployment town

I wouldn’t like to be sitting in an academic practice
pulling my hair out if folk came in with printouts from the internet

Give me your ordinary down to earth person any day;
I have got a job to do here,
to support people through difficult times,
challenging events in their life.
To be there for them
whatever they need from me.
My job is not to sit here in judgement;
it's to journey with them.

If I can do that, it’s a job well done.

Alice

seeks multiple voices or multiple lenses through which to examine lived experience through narratives fleshes out greater complexity than previously uncovered and can bring together reflections and which appear diverse (Penn and Frankfurt, 1994, Tin, 2006). Yet as Johnson and Moneysmith argued;

> *'Constructing a multivoiced argument is not like a war but a dance of contrasting yet connected voices*.' (Johnson and Moneysmith, 2005, p:6)

In response to my questions posed in Section 3.4; questions of being, feeling, thinking, coping, adjusting and interacting (p108) this chapter explores how doctors expressed a sense of how it felt to live on their side of the consulting desk, experiencing being a doctor and dealing with backroom matters. Unprompted by questions about their sense of identity or thoughts how it felt to be a doctor, several interviewees nonetheless reflected on their deep connections with what work meant and an intrinsic self-identification as a doctor.

• • •

What does work mean?

• • •

It seemed clear that working in challenging places need not be a negative experience; a high proportion of Alice's patients suffered morbidity and mortality levels well in excess of more affluent areas, but they needed her support. And, having survived an extended period of her own difficulties after a tragic incident at her surgery, she needed them too. Many had also been deeply affected by the incident; they had all worked through it together. The compact was clear; they brought their troubles and she listened. She remained realistic, knowing that the nature of their dis-ease was such that not all could be cured even with best available treatments; some must be endured.

Still special

I have still got one chap
that brought this Aloe Vera plant.

He brought me a rose called Superstar
the first day I took on my partnership,
with a vase and a rose
because he is a gardener.

He came in two Thursdays ago.
We were shut.
I was doing some paperwork.
He was going to leave it at the counter
and he saw me
and brought this in.

He is about eighty five years old and
he brought that Aloe Vera plant,
dropped it in
just like that.

There was a little note with it;
from your aged patient Mr A

So it's sweet
isn't it?
Still special
isn't it?

Jennie

Her commitment to her community was high; everybody knew who she was and most were aware of the incident which rocked her to the core. Knowing this, they expected her to understand and to skilfully steer them forward. Alice was aware that, perhaps as a consequence of exceptional circumstances in the shared trauma of a premature loss of her GP partner and the close relationships she established with patients, she was 'lucky' to hear them compliment her work and appreciate her close involvement in their lives;

> *'I have a wonderful relationship with the majority of the folk… Very few people come in here and I don't know them, or who their parents are, … it's almost like old fashioned general practice … if they have got difficulty remembering where their roots are, I can usually fill the gaps in for them.'* Alice

Though at times struggling through her own problems, she would not consider moving away; her memories could not be erased by distance and support flowing back from patients would be missed.

Jennie reflected on changes in society, including fewer expressions of appreciation or gifts, then told this story in which I sensed an event that touched her deeply and resonated with an impression from several participants that their greatest reward was positive feedback from those they were able to support;

● ● ●

Still special

● ● ●

A simple gift from an elderly patient handed over in person to an appreciated doctor acted as a reminder of closeness which can grow in doctor-patient relationships, a thoughtful gesture towards reciprocity in that relationship.

George recognised that occasionally he was the third most important person in the lives of several regularly seen patients, as close as family members. Helen spoke of how, as she became '*older and wiser'* and recovered from a difficult period with her own health, she felt more able to '*really listen'*, to treat people with kindness as well as professional skills.

Several doctors spoke of indecision or tension between the demands of work and of spending quality time with family. Jennie admitted that she felt a '*backlash'* from having too often been absent from the school gate or school events or had brought her own sick children to rest in a room at the surgery while she consulted as normal. Stewart's involvement had been central to multiple projects within his practice; he led on education and training, team recruitment and team building, managing team conflict, developing PBC, setting up protocols for a minor surgery service, premises development, and innovative development of a project to enhance care for the elderly – which raised two questions. Firstly, if this was a fair representation of his roles, were his partners equally active in management portfolios? And secondly, assuming that he continued to see patients, when did he find time to make progress in all these areas? His narrative conveyed a sense of keeping himself right at the heart of things, always aware of what was happening and preparing for the next strategic advances wherever they might appear.

By contrast, Mary's balanced approach and flexible work schedule allowed her devote sufficient time to family needs. This restricted her choices but ultimately, when she achieved the status of a part-time GP partner she felt she had achieved all her goals; professionally and personally fulfilled, she was happy to have avoided destructive stresses.

A doctor's dilemma

Yesterday,
my forty-ninth birthday
I worked until eight-thirty in the evening
A big mistake
I thought I would
soldier it,
get on with it;
but I was just pissed off

I went home,
thought;
I am going to just give them it for once
let them know how hard my life is

I got in the door
My wife had been very smart,
had the six year old
with a cake and candle
smiling at me
I blew it
That was it

I just had to be nice from there on
Extended hours is a pain
We could live comfortably
doing seven sessions
but greed
and having that money
keeps you working

It's a great shame
because you end up spending
what you don't need to spend
it's hard
it's a shame
I need to be disciplined
think about trimming down another session

I have got plenty of stuff I can enjoy
I used to have a tennis lesson
I will again
I pick up from school
kick around with the kids
that's what you should do

George

In a less contented place, George was acutely aware of a mismatch between what he wished for and what he did;

• • •

A doctor's dilemma

• • •

Switching between inner voices, weighing up what really mattered, this was a frank and I believed honest depiction of George's thinking after a long and intense working day. Rather than medical dilemmas, he debated unresolved conflict over work commitments, responsibilities to provide adequately for a growing family, and expectation of recognition for his arduous schedule; but acknowledged that, perhaps it need not be that way. He had choices. His '*shame'* at entrapment by greed and habitual spending seemed too fixed to escape - redressing the balance only a distant aspiration. In this, his experience was far removed from many of the elderly and ill patients with whom he met regularly, but though he worked conscientiously as their doctor, his achieved status, employment and earning power set him apart from their lives. His need to address his own issues could be postponed to another day.

As was confirmed by analytical construction of Positional maps (PMs), much coherence was added to individual accounts by demonstrating how core values and principles underpinned each doctor's position in relation to work, society, patients and colleagues – awareness of how they perceived themselves and how they liked to work not only added coherence to their accounts but could frequently have been used as a reliable predictor of their reactions and responses.

7.3 Medical identity; an enacted identity

While some favour stratification of identity on conceptual levels of a sense of self, of personhood in society or as linked into a group, I question whether splitting the pillars on which identity is constructed might not become more problematic than enlightening. I prefer an approach suggested by Mol of exploring identity as it is *enacted*, an entire spectrum of identity including a sense of self, of relations within an inner circle, of a role expected by a wider public and how responsibilities are achieved (Mol, 2003). An enactment paradigm accords with Garfinkel's analysis of human activity; primarily based on practical out-workings or observable interactions rather than on cognitive processes themselves (Garfinkel, 1967).

Overlooking that my expressed and intended focus was on the experience of work, collected narrative accounts offered insights into a contemporary medical identity as doctors related how they acted as individuals and in conjunction with others to perform the role of physician. Interdependent relationships with patients allowed them to enact a role of physician, respect from colleagues meant their specialist or generalist role continued unchallenged. Each individual depended on a group or team for support and to achieve shared objectives. Although Goffman preferred to consider his distant view as a superior lens through which to view the presence of a curtain between front and back stage arenas, others considered that no such backstage entity existed, no curtains concealed a deeper core identity. Instead, Butler proposed that each identity was constituted by the elements of actions on whatever stage they acted (Butler, 1990).

Doctors through medical school education and professional training must acquire knowledge not simply of how to understand and modify biophysical processes in the human body, but to recognise and participate in a complex pattern of communication and behaviours. This prepares them for interactions with a public conditioned to accept and expect certain standards of professional behaviour. In doctors' conversations I observed tropes; for

example, typical patterns of behaviour reportedly enacted as they consulted with patients for the first time as opposed to behaviours reserved for frequently seen patients with whom they had already shared in a long and difficult journey. Built on previous meetings, those doctor-patient relationships had been negotiated to allow both parties to interact in ways which would previously have been uncomfortable or unacceptable. Likewise when speaking of team dynamics, patterns of behaviour differed depending on whether they felt secure in constructive and supportive teams, or were struggling with dysfunctional situations, where uncertainty or distrust dominated.

7.4 Identity in action

Asked to speak about their experience of work rather than a request to give account of themselves *per se*, talk of a sense of identity in doctors' narratives was often not explicitly addressed but inferred throughout. For each participant the PM area was thickly populated with categories and extracted comments; numerous links across all map areas assigned connections between causes and effects, between principles and actions.

Individual preferences reflected in their responses to situations were influenced by personal guiding principles, motives or drivers. For each doctor these dictated how they preferred to operate in the workplace and ultimately shaped their careers. Interwoven and contingent, three loose headings helped organise recurring unprompted expressions of identity in personal narratives; guiding principles, personal values or motivation, and adaptive strategies.

7.4.1 Guiding principles influencing attitudes and choices

Personal performance – trying to get it right

For several interviewed doctors becoming a doctor was a serious concern; the over-riding necessity of academic success meant taking a serious attitude to course assessments – as George quickly discovered;

I was worried

I had a resit in first year
that reminded me
it was possible to fail.

There was always
a challenge;
I was average,
never the thickest, never the brightest
I could get by
Good at passing tests
then forgetting everything

But never had that confidence,
that swagger,
that some lads had.

George

• • •

I was worried

• • •

Few entrants failed to complete the course, but graduation led to further learning and assessments and to working with patients where a positive attitude to diligence and applying knowledge was encouraged and required to impress and make progress. Reviewing his academic success, George recalled his early resit as a warning, one which didn't quite fit with his preferred view of his ability to learn sufficiently well to pass tests even if he forgot it promptly afterwards. An obvious implication could be that he simply failed to prepare properly and having learned from the error he reported no continuing academic difficulty. He had no problem considering himself of average intelligence among his peers, but felt '*intimidated by them'* - by their greater confidence – unable to comfortably behave as one of '*those lads'*. Yet as he reflected that having '*tested…and looked at the other specialities',* by the time of his graduation; '*I thought I was going to be the doctor I am today actually.'*

Similar feelings arose when he was offered a partnership before completing his VTS; '

> *'I was following the class act…they were really testing me to see whether …I could be anything close to this doc who everyone thought was the bees knees… a bit of a flash act, having been a GP for 15 years…he was a challenge to follow'* George

George made no early pretence of masquerading as his predecessor, feeling he had '…*won the prize without actually entering the competition'* he described his strategy; *'quickly I carved my own place in there.'*

When a junior doctor caring for patients undergoing chemotherapy, Mark's inner motivation for making improvements for patients in every possible situation drove him to search for new drug regimens to relieve their distressing side-effects; in addition to achieving his objective,

his efforts were publicly rewarded; *'…on the ward round Mr W, people saying "Oh well, that's very good well done".'* Similarly Liz recalled how she always wanted to be well prepared; prior to transferring to a new post she learned to perform new surgical techniques so she could fully engage in unfamiliar operative procedures knowing that an urgent call to her consultant could evoke a negative response;

> *'You couldn't have phoned Miss M and said "I can't do an appendix"- she would have said "Don't be stupid girl, get the registrar or the surgeon, I am not coming.""* Liz

Several doctors expressed their deep desire to perform well; to spot a diagnosis early, to meet targets successfully, or recognise an abnormality which could easily slip past unnoticed. Self-blame and self-questioning fuelled counter narratives when failure or error occurred – inability to predict the course of illness became a reason to examine performance and ponder whether different actions might have altered the outcome.

Work-life balance

Achieving goals in work, particularly when long working days were already demanding, presented challenge to the notion of maintaining a healthy work-life balance and was a concern voiced by many doctors. This topic, which stole into final reflections in most interviews, may have revealed an attempt at rationalisation; perhaps their need to justify continuing in an imperfect job, or explain why dissatisfaction drove towards new or unachieved goals. Alice and Helen's difficult circumstances contributed to illness and absence. Others had been able to take a more measured career path and seemed well satisfied.

Equilibrium

I have been quite happy
worked as much as I wanted
haven't felt too stressed
been able to bring up my children
be at home as much as I needed

I have been happy most of my career
A lot has got to do with home;
if I am emotionally stable and happy
then my job will be.
You have to feel on top and stable
to deal with other people's problems
in a rational way

It hit me some time ago
that actually I am a doctor,
that is who I am and
if I…
if I didn't go to work I wouldn't be anyone.

Now that I have made it,
I could give it up.

Mary

● ● ●

Equilibrium

● ● ●

Mary spoke of a balance of work and home time which matched her preferences, yet sandwiched between layers describing a sense of detachment from her medical identity, she asserted her realisation of a deep identification of herself as a doctor and her need to acknowledge the importance of work in her sense of who she was. At the core of her ability to deal with problems presented by patients, she claimed a stable personal life was an essential base; having her own emotional needs grounded in her family she felt able to take a rational approach to patients' problems without becoming destabilised.

Having been totally absorbed in work for most of her career, Liz described how just a few years earlier she had returned to a much-loved leisure activity which had been excluded from her busy life;

> *'So I went along … within 4 seconds…I thought what the hell have I been doing with my life…part of the reason I negotiated Wednesdays off is that …[it] has become a big thing for me… I sort of come back.'* Liz

Only a newly defined consultant contract permitted to Liz return with immediate regret at having been absent for so long.

Based on Stewart's expectation of working hard and his involvement in non-clinical roles he maintained a full schedule; *'I work 9 sessions where most people work 8*.' Yet witnessing his high commitment may have been partly responsible for unanticipated consequences; although Stewart grew up in a family with '*lots of medical relatives'* his own household '*would think I probably work too hard…but I think that's a general thing…none of them are going to be doctors.'*

What does work mean?

It is everything,
it's really important.
I think it's great,
I think it's a privilege,
I mean, it's good we get paid for it
I feel very privileged.

I am quite sensible about it,
I am defined by other things as well but,
interested in quality and standards
and have ambitions for that.

Mark

While Richard dreamt of having more time to think, reflect, plan – perhaps see '*9 patients in…2 ½ hours',* or working 6 sessions a week, he acknowledged that was currently an impractical proposition. Stepping away from work commitments was viewed by many on the horizon but not something for which they yet had firm plans.

Satisfying aspects of careers

Elements of work which brought satisfaction revealed further principles underpinning how doctors felt about work. Helen viewed the traumas of her career as part of her journey as an experiential learner, '*no experience is ever wasted'* was her epitaph on the demise of her surgical dreams though she needed a short break before moving on.

A balance between single and brief patient contacts to provide anaesthesia and repeated follow-up appointments to review patients with chronic pain enhanced Graham's career; he felt more fulfilled by experiencing both forms of practice and noted;

> '…w*orking in chronic pain … you could change people's quality of life with successful treatment.'* Graham

Contrasting with Richard's assessment that his vocation had become a job, Mark's comments reflected the intensity with which he still engaged in medical work.

● ● ●

What does work mean?

● ● ●

Mark's alignment was firmly in the direction of quality; his efforts drove for the best that could be achieved, and while he acknowledged his need of non-medical down-time and a life outside doctoring, priorities which impelled him seem tough to resist – payment for the privilege of doing his work was a welcome bonus.

I decided not to be a surgeon

On a ward round,
general surgery with Mr W,
who was a bit up himself
Just going round
chucking out from the day before

Stopped at the 35 year old lady's bed,
a breast biopsy.
He said, Oh yes, Mrs whatever,
yes,
erm… the section did show cancer,
erm… back next week for a mastectomy.

Move on to the next bed

And at that point I thought,
Oh shit,
I can't do that
can't do that.
That was the moment I decided

The sheer callousness.
The look on the woman's face.

Staff nurse
drew curtains and stayed
I had to go on.
I wanted to go sit
with the patient.

She had gone by the end of the ward round.
A complete bastard
and didn't think there was anything wrong with it.

I thought;
I wouldn't be like that
I can't work in that environment

Helen

7.4.2 Personal values and motivation

Focus on patient care

High on Helen's list of priorities was being the sort of doctor who listened and cared, and she felt increasingly able to achieve this as a result of life experiences as her career progressed.

> *'I really listen. Sometimes that's all I do… and try and make them feel like they are not on their own really…I want to treat people with love and kindness, and …I think that makes a big difference.'* Helen

Helen graphically described a seminal moment which drove her away from intended surgical training.

• • •

I decided not to be a surgeon

• • •

The detail of Helen's account painted such a vivid mental picture that after hearing it and later mulling over her data I could almost have been there. This narrative was powerful in transcript and transformed into poetic form I found it became more intense, evoking images from scraps of memory; it was as if I was observing and sensing the impact of a scene which marked changed life-courses for this patient and for Helen's career;

A posse of white coats moves from one bedside to the next. Led by Mr W, pin-stripe suited, a man of few words. Anxiously waiting for news, a young woman observes a ward-round routine. Stop, speak, pass on. Her turn has come; what will the great man say? Cancer. She hears nothing more. A sweet nurse screens her from the world, comforting, holds her hand.

Every instinct tears at Helen's coat-tails. How could he do that? How can he be so devoid of feeling, callous, uncaring? She too wants to slip behind the curtain, do what she can to soothe, explain, to distance herself from association with everything he represents.

This is the last straw; a sign that surgery is not the place for Helen's career.'

Analytical image reconstruction SMS

Among Helen's favourite general practice patients were elderly folk with multiple limitations for which medication was often recommended but who struggled to optimise the balance between beneficial and detrimental effects. Experienced and confident, she felt able to approach with them with compassion, building relationships, '*trying to get the happy medium… get them feeling better and get the best out of their lives'.* Others spoke of sharing this holistic approach, spending time, guiding rather than controlling decisions, working with care for how patients wished to be treated.

Personal ambition, seeking to meet challenges

For some doctors, the existence of a qualitative measure presented an irresistible target – perfectionism and competiveness urged maximum effort personally and from their team. This has already been discussed as an effect of QOF targets but was evident too in Mary's elation at *'I finally made it, I'm a partner'*, her ecstasy at the realisation so fresh I wondered whether she had even considered it to be her ambition before it happened.

Where is the buzz?

I am still like a wee lassie
I send somebody to hospital
and phone up
I want to know how they are getting on
That kind of adrenaline rush
YES!
I got that diagnosis right
I still get a kick out of that
the buzz of knowing that you have done a good job

Alice

No longer needing evidence from research portfolios to advance their established careers, Liz and Graham continued research activities to improve patient care though Graham recognised this as a significant drain on his leisure time – part of his construct of taking a different approach to his career involved compromise;

> *'I would have tried to get more handle on time management, at an earlier stage, have a better work life balance you know, that's always a struggle between the two.'*
>
> Graham

Alice spoke of unquenched enthusiasm, she had not yet had enough of rising to challenges, but was still applying her skills and expertise to help patients and make a good impression;

● ● ●

Where is the buzz?

● ● ●

Perhaps as a single-handed practitioner, and one under surveillance by the GMC for health reasons, Alice may have felt greater pressure to monitor her performance, to seek evidence of 'getting it right' – but her narrative related this as a joyful curiosity, as wanting reassurance for the pleasure of knowing she was on the right track with a suspected diagnosis. Her constructed narrative suggested that in spite of many knocks, she had never grown out of early naivety; she still revelled in her ability to do a good job.

7.4.3 Adaptive strategies

Individuals finding themselves in difficult situations drew on personal beliefs, principles and preferences, and on their abilities to develop strategies for responding to new challenges – in keeping with the attributes of effective teams (Salas et al., 2008). Although options could be limited, doctors recalled several instances demonstrating effective adaptation and

Putting it in writing

We are supposed to do
Significant Events
on various things.

So, you say,
'Oh we can make that a significant event',
though you wouldn't have normally have brought it up
because it's routine work.

In the old days,
you would probably talk about it over coffee.
Which is what we do,
then write down our coffee talk as a significant event.

Mary

illustrating insight into techniques which supported their own well-being; such as Richard's post-interview conversation about negotiating a way around problems rather than engaging in full-blown confrontation as he had seen preferred by a colleague.

A simple adaptation

In response to QOF and GP revalidation requirements to document their discussion of 'significant events', Mary's practice team simply adjusted their established practice of talking about such matters during a coffee break by creating documents to log as evidence.

• • •

Putting it in writing

• • •

These 'significant event' discussions could be about any incident or concern which the team discussed in order to reduce risk of recurrence or to promote better practices and where doctors did not regularly meet and talk through glitches and errors this requirement could act to give impetus to establishing better practices through communication. For Mary's partners only simple strategic adaptation was needed as they capitalised on pre-existing good practice – made easier by building on established regular contact between doctors.

Moving on

Stewart generally approached PCT initiatives as opportunities to be exploited, but when working for an independent OOH services provider was confronted by more conflicts and inconveniences than he was prepared to tolerate.

Getting out of Out of Hours

I stopped, distressed.
I didn't like going to patients triaged six hours before,
and upset

Everything is target based
and lacks common sense.
Somebody peeping over my shoulder,
criticising.

'This one shouldn't be a visit '
A five year old child
three other children,
single parent
or partner has been drinking
worried the child might have bronchiolitis,

They just rode rough-shod over it,
and are expanding all over the place.

Stewart

• • •

Getting out of Out of Hours

• • •

In spite of his wishing to participate in OOH services, the delays and inflexibility built into this service drove Stewart away. Their processes meant a visiting doctor reached an already irritated patient who had been waiting for several hours. He felt scrutinised and censured for making an effort to considerately respond to patients. Instead of sharing their inflexible view that an ill child should attend the treatment centre regardless of the family or home situation, he wanted to make allowances, to understand the context, to respond to their real concerns.

Career adjustments were similarly made by others when uncomfortable circumstances resisted modification. As indicated in Chapter 6, a climate of unimaginative management led to John's disengagement and his creation of an escape route should he wish to resign. He cited several occasions on which he adjusted his position in relation to management before explaining his isolated stance;

> *'…we are here if anyone wants to speak to us, give advice, you know we will help but we all stepped away from that, and we will make sure we enjoy our jobs…we will continue to provide as good a service as we can to this trust.'* John

Holding everything together

When Jennie's practice manager suddenly departed, and in part because of financial pressures as indicated earlier (section 5.4), she felt personally responsible for undertaking audits and other tasks to earn QOF points and to do general administrative duties in addition

The risk of doing it all

I just did it
without thinking.
'As senior partner, I have got to.'
I had been trained in a
'just-get-on-with-it' culture

We had a receptionist
who did some jobs,
then left and
complained that
we had overloaded her;
threatened to go to employment tribunal

That came as a back lash.
Then I thought;
'I was stupid,
I shouldn't have done it.'

There are prices to pay.
Insurance covered legal costs
but the experience of it all;
personal insult,
mental stress,
worrying,
no control,
more stressful than everything else

Jennie

to her usual clinical work. She adopted a response she had learned early in her career of simply digging in and getting on with everything.

• • •

The risk of doing it all

• • •

While Jennie survived her period of extra duties without being destroyed, threats from a member of staff to take the practice to an employment tribunal because of the difficulty this had created for her caused Jennie immense stress from slight to her character and worry of having to negotiate a tribunal hearing. It struck her with greater force by being something beyond her control and she concluded that by acting to personally make up deficits in areas with which she was not familiar, she had stirred up more difficulties than expected.

Improvement of procedures and protocols were reported in several narratives; Henry encountered unsafe practices in a prison health unit for which he became responsible; lack of contracted cover arrangements meant that in addition to absence of proper protocols those doctors who usually attended *'…wouldn't come and do anything in our unit - that really left us high and dry at weekends.*' As a member of multiple committees representing his colleagues, his specialty and liaising with managers, Henry was fighting to preserve his own job and the service he had established but with *'no spare in the system*' he was *'having to find ways of doing more with less',* and with *'no slack to cover holiday'.* Use of non-medical prescribers *'because they are cheaper than doctors'* troubled him somewhat; in his experience prescribing training produced nurse prescribers reluctant to take full responsibility and he quoted a nursing colleague: *'I had no idea how complex it was…I don't want to take these risks, I don't want to be doing this'*.

Celebrate the good

It's a great profession
(these are not fashionable things to say)
there is a lot of good you can do,
but we don't seem to be in control of what good is
and how we could make it better,
lead to better standards.

In some countries,
switch the TV on -
always a doctor's story;
they have invented this new device,
the sense of pioneering spirit -
doctors have made a big difference.

You switch the TV on here -
people have died in hospital,
dirty hospitals,
doctors suspended or
under staffed, over worked
cut backs in research and
crisis in everything.

There's a champagne quality to work abroad,
enthusiasm.
I have seen it here
but less now
We have got to
rediscover that pioneering spirit,
I think that is important.

Mark

Mark approached hospital colleagues about disjointed care or ill-advised prescribing but added; *'we report lots but nothing ever changes'*. His reflection on his NHS experience was tinged with a sense of what it *ought to* be; *'This should be joyful work…that's why we are doing it'.* Too often he felt that high demands and high expectations rendered his job impossible and he regretted his inability to influence criteria which defined 'good' practice;

• • •

Celebrate the good

• • •

Hospital acquired infections, staff shortages, flawed culture – all attract widespread publicity and many failings of the NHS have been translated into recommendations of the recent Francis Report (NHS Confederation, 2013). Prominence of what is viewed as great, beneficial and positive in medical innovation can be seen headlining fundraising events for medical charities (e.g. Cancer Research UK) but many press headlines have focussed on negative aspects of health and social care, including criticism of the bodies responsible for monitoring standards (Ali et al., 2001, Glasper, 2013).

7.4.4 Challenged identities; when things go wrong

As formal complaints against GPs have increased it has been noted that facing complaints can affect clinicians as emotional reactions. Through damaging doctors confidence this can lead to defensive practices and challenge aspects of their professional identity (Jain and Ogden, 1999). Even in the absence of a complaint doctors have become distressed and carried negative effects into their personal and professional lives as a result of believing that patients have suffered adverse effects under their care (Aasland and Forde, 2005).

Unfortunate events

One young lad.
I was called to see him,
hardly breathing
then he arrested.
Paramedics came and
were trying to get oxygen.

He survived but
brain damaged
and virtually blind.

I wondered,
was anything more I could have done?
Whether I should have acted a little bit quicker?
It was just ‘my God what am I going to do?’
I didn’t have anything with me

On the way to his house,
the police pulled me over.
‘Your brake light is out, and
Blow in this bag’
Five minutes delayed;
whether that made any difference
I don’t know.

Richard

Two narratives describing poor outcomes illustrated how these GPs recalled such incidents with reduced clinical confidence and self-questioning. This was how Richard remembered an evening call to a young asthmatic patient.

• • •

Unfortunate events

• • •

This emergency call did not come with a special tag to indicate particular urgency or unpredictability. Limited equipment and few opportunities to utilise resuscitation skills in real situations reduced the likelihood of a good outcome. Richard felt exposed, inadequate, he recalled the obstacles and wondered if it could have been different. A broken light, a breathalyser test – he continued to ask himself if those delays could have been crucial. His habitually detailed notes of the event were scrutinised but in the end he faced no sanctions apart from his self-questioning and knowledge that his patient was irreparably damaged.

Jennie recalled a PCT panel investigation after she recommended an unwell patient go directly to hospital rather than wait for a home visit; although she continued to believe that her triage of his case was a good decision, after his death in hospital his family complained that she had not attended to personally assess him. Yet more disruption and multiple concerns occurred during several months when Jennie was the last doctor to see another patient whose death the coroner was investigating;

A coroner's inquest

A young girl, a drug addict
I had visited.
She later developed pneumonia
and died.
I had to give witness;
that was quite traumatic.

I'd seen her regularly and
she looked no different
just a normal routine call.
She didn't look as ill as obviously she was.
Died so quickly soon after;
I was shocked.

I had prepared myself and
the medical defence union
because I was scared,
they had brought solicitors from London

I remember shouting from relatives in the dock;
that was hard.
Jennie

Again there was nothing that Jennie could recall distinctive about this case; she visited to assess and treated in her usual manner. Lawyers defended her actions in court but nothing prevented months of fear or shielded her from shouts of angry relatives. Her confidence was battered; for some time she practiced with exaggerated caution.

7.5 Medical identity – a shared experience

In keeping with Strauss's concept of a shared social world, I found many reflections, concepts and ways of speaking about medical work resonated with my own passage through developing my professional identity (Strauss, 1978). Despite the uniqueness of

Close the door

Force the door.
I cannot finish this chapter
for the lurid image which
occupies the space and
will not pass.

See, his ruddy smiling face, who
never leaves without a smile, a joke,
a bit of banter.
But now, so sudden,
like spring snow
vanished into rivulets

and he has gone.

Blighted life could not consume his
refusal to be beaten,
while I prepared to care
to a distant end,
a long-haul journey
interrupted,
closing the door.

A cruel blow; with it
my job has fallen
to a stranger offering
no smile, no remedy.
I would have held your hand and
uttered words…
I know not if
by accident
or by your own design
you kept this death from my door.

SMS

each story, similarities allowed my ready identification with this group and I recorded some personal perspectives before beginning to interview others (Chapter 3).

While this thesis is not intended to showcase my own experiences, total self-subtraction is impossible making recognition of their influence an important calibrating task. When I returned to previous notes, reading these with an analytical eye to apply the same processes as I had applied to each narrated account I found this facilitated deeper understanding of my own reasoning and reactions and revealed new insights about my sense of medical identity, clinical mentality and motivation.

For some time prior to this research, writing has helped me to 'process' my thoughts, to reflect and honour what has happened in my workplaces and I include here a single poem penned after the sudden death of a long-term patient who often opened my consulting room door. Although medical care could offer little lasting improvement for his many problems, he seemed to draw benefit from consultations but I wondered what lay ahead for him and how we might negotiate this together. Then, without warning, I returned from a short break to find he was gone.

** ** **

Close the door

** ** **

Managing my own reactions was made a little easier by putting it into words, in a similar fashion to interviewed doctors who spoke of managing risk by sharing decisions with colleagues. Through looking analytically at this writing I grasped the nature and magnitude

of a change which had occurred somewhere between beginning medical school and this event; my early thirst for scientific knowledge had been superseded by compassion, humanity, even disappointment that I was unable to make a greater contribution at the conclusion of our relationship – or a feeling that, in different ways, we had both been cheated by circumstances beyond our control.

I have been fortunate to share work with colleagues whose commitment is to looking after whole persons, who understand that what is discussed in the consulting room is a small slice of troubled lives. In recognising the effects of pressure from many sources which currently forces our attention in multiple directions and which I feel are poorly aligned with caring for patients, I believe I have identified my own '*OUCH'* of working in the NHS.

7.6 Summary

Just as single-person narratives yielded partial stories of group interactions, exploration of narrative accounts produced incomplete understanding of views, attitudes and sense of self. However, evidence pointed to deeper facets which assisted or blocked responses to challenging situations, and when mapped alongside a greater picture of experiences at work, demonstrated coherence or revealed dissonance – these being evident as connections crossing Situational Mapping complexes.

Many doctors spoke of their development as a mature clinician in terms of exhibiting a mellowed, more patient and understanding attitude. Some reflected that personal illness contributed to deeper empathy, challenges faced due to parental illness also influenced attitudes. A process of change occurring during clinical practice concurred with Freidson's proposal that the demands of encountering a variety of problems, and preference for interventions made on a pragmatic basis, represented strong features of professional development.

Transition from the status of non-doctor to doctor characterised only one of many possible life-time transitions made by doctors where sets of meanings which placed self in a social world altered with time or circumstances (Cast, 2004, Fullinwider-Bush and Jacobvitz, 1993). Reflecting more deeply on experience during interviews was occasionally noted as a tipping point between discourses, a conspicuous transition, as if a mask slipped from the face of a less-paraded self. The tone of the interview became darker as a doctor voiced concern for future medical care, concern for young doctors entering an uncertain profession, or for their own 'happy ending' as retirement approached.

The next chapter features narratives about external or enacted evidence of doctors' practices which emerged after less-controversial topics had been discussed, and which revealed responses of clinicians to rules and directed practices. These are considered as products of how clinicians believed it was appropriate or acceptable for them to respond.

Chapter 8

'Trust me, I'm a doctor'; a basis for confidence in the NHS?

"Ever since 1983, when we first started asking the public's view of who they trust, more people have said they trust doctors than any other profession or occupation, and they remain so today. It just goes to show how much faith the public place in doctors. It will be interesting to see if the public's trust in doctors is maintained following the proposed changes to their role in the reforms of the NHS." Sir Robert Worcester, Founder of MORI. June 2011

Despite widely publicised instances of medical failures, gross negligence and even criminal activity, doctors have continued to occupy top position in a major public poll of most trusted professions in the UK (Ipsos MORI Veracity Index, 2011). Such trust may in part be founded on wishful sentiment, or could be maintained by positive personal contact with the NHS or medical profession. This chapter examines narratives for insights into clinicians' self-regulatory practices where transparency and rigour could confirm a sound basis for public confidence.

8.1 A basis for ethical and moral behaviour in medicine

Both the ancient Hippocratic Oath and guidance from the GMC which were intended for members of the profession rather than the public, advocated conscientious attention to clinical care and a positive disposition towards the welfare of patients as normative expectations of physicians. In the Oath, doctors pledged to apply ability and judgement to do work which was for the benefit of patients, to maintain confidentiality, to act with propriety in relationships with patients and, respecting teachers, to support the teaching of others. Modern GMC monitoring of medical professionals is founded on guidance circulated to registered doctors on the duties expected of registered practitioners (General Medical

Council, 2006, General Medical Council, 2003). Advisory guidance may be sub-divided as duties linked to working practices or interactions with patients and summarised as follows:-

Working practices	**Dealing with patients**
prioritise care of patients	treat patients with respect
promote good health	maintain proper confidentiality
provide a good standard of practice which is up to date	work in partnership with patients
recognise limits of competence	listen and respond to concerns and preferences
work constructively with colleagues; teaching, training, appraisals and references should be skilful and honest	communicate desired information effectively
be honest and open and act with integrity	respect patient's decisions
act if you believe that you or a colleague may be putting patients at risk	support self-care
you are personally accountable for your professional practice and must always be prepared to justify your decisions and actions	
never discriminate unfairly against patients or colleagues	
never abuse your patients' trust in you or the public's trust in the profession.	

Table 7 Summary of expected standards, based on GMC guidelines

(General Medical Council, 2006)

Doctors are expected to be aware of and compliant with GMC advice provided in booklets which set out underlying principles as guidance and as a basis for individual responsibility for locally-based or case-specific interpretation. Since interpretive variation increases

potential for inconsistency when applied to work practices, behaviours and responsibilities and could result in different outcomes from similar situations, Medical Royal Colleges and faculties were encouraged to develop more specific guidance for doctors working in each specialty (Palmer et al., 2002).

Although suitable for circulating a consensus of interpretation, not all aspects of practice can be anticipated for detailed comment implying that doctors must be prepared to defend and justify their own decisions. A wealth of diverse texts attest to the importance of moral and ethical dimensions of behaviour and conduct in medical work, but for the purposes of this chapter I am chiefly concerned with how narratives indicated doctors' boundaries of interpretation regarding moral and ethical standards. Dealing with perceptions or suspicions of deviant behaviour constitutes a sensitive area which has occasionally surfaced in correspondence or articles from authors who preferred to remain unidentified (BMJ unattributed, 2009, BMJ unattributed, 2008). Promised anonymity and established rapport in these research interviews supported a notion that stories could emerge which may indicate departure from what might be expected of practising doctors, or concerns about such deviations.

8.2 Framing ethical behaviours in the workplace

While ethical debate around morally contested areas such as end-of-life care, organ transplantation and genetic manipulation hold prominent positions in sociological considerations of bioethics there remains a vast range of less visible medical work which operates in a moral/ethical framework where application of philosophical ideas meets 'hard cases' (Dimond and Hughes, 2013). Everyday situations for the doctors participating in these interviews generated narratives in more general areas - such as information sharing, informed consent, moral engagement with management objectives and transparency of standards of performance.

Studies which explored how doctors enacted morally or ethically judged decisions confirmed doctors' commitment to supporting patients' right of access to necessary information by adherence to a duty to inform patients and the principle of informed consent (Miyaji, 1993). However Miyaji also observed that, in practice, physicians tended to retain control of what information was shared through selective or flexible interpretation of those principles and sought to justify this decision rather than to relinquish control over information transfer.

When considering moral engagement, greater compliance with ethical standards of behaviour was demonstrated when workers were active participants in designing work goals; they had less opportunity to dissociate themselves from targets which were agreed, less latitude for rationalisations or moral justifications they might make (Barsky, 2011). Given a task which may prove impossible to achieve, he noted that employees used overstated excuse-making to keep their organisation or themselves out of trouble. Barsky found that, if included in goal-setting, they exhibited less displacement of responsibility by actions such as; claims that false exaggeration was normal, or that management expected an unethical action, or that the fault lay with excessive pressure from management, or simply that an individual's action in the organisation could not be blamed for overall failure. Moral disengagement provided a means by which individuals with a high degree of cognitive complexity could construct moral justifications for deceptive behaviours while retaining internal coherence by making flexible interpretation of what constituted acceptable behaviour.

For Ashforth and Anand, three pillars supported corruption in business organisations, viz. institutionalisation, rationalisation and socialisation and could be mapped onto patterns of behaviour as described above (Ashforth and Anand, 2003). Unethical practices were perceived as a matter of routine, taught to and taken on by new staff without thought for their impropriety, or in some manner legitimised in the thinking of individuals. In each case actions were viewed as normal, expected or necessary for success.

To evaluate narratives of significant moral or ethical content I have drawn on references to workplace behaviours characterised by actual or potentially misleading interactions where the fullest available level of information was not communicated between individuals or groups. A five-level taxonomy of *deceptive acts* described by O'Hair and Cody was further developed by Hoppin in the context of doctor-patient communication. Classification divided these acts of deceptions into; lies, evasion, overstatement, concealment and collusion providing a framework which facilitated structured evaluation of actions (O'Hair and Cody, 1994, Hoppin, 2011). Working definitions, such as those assimilated from multiple sources by Hoppin, suggested a range of terms which best correlated with narrated sentiments.

8.3 Narrative reflections on ethical aspects of managed medical practice

With these categories in mind, I examined mechanisms apparent behind a doctor's opinion or chosen behaviour, considering how these responses flowed from an individual's moral judgement or ethical viewpoint. Participants spoke of how they reacted in situations where full and frank disclosure of medically informed knowledge was resisted or where they were aware of a deficiency which remained undetected or unchallenged and demonstrated participants' sensitivity to these issues for patients, colleagues or managers. Of particular interest were their responses in those instances when moral or ethical boundaries were unclear. Each definition below is adapted from Hoppin (Hoppin, 2011).

Lies

> *Lies; defined as direct fabrication with an intention to create a false belief which is contrary to available facts.*

In certain situations doctors came under pressure to lie, or to give information in a way which deliberately misrepresented the truth. In this example, Liz, a gynaeoncologist, faced criticism from family members for telling the truth.

An elderly grandmother was the main carer for her 11 year old grandson who had Down's syndrome. She attended a clinic when recurrence of cervical cancer had reached a terminal

Breaking the news, breaking the rules?

So I went in
with the specialist nurse
to see the patient.
She asked
what was going on
and what I thought.

I told her.

The daughters say
she never spoke another word;
went out the clinic and
died three days later.

Liz

stage with no possible effective treatment. Two daughters accompanied her and, while she escorted to an examination room, they informed Liz that she should not tell their mother any bad news.

• • •

Breaking the news, breaking the rules?

• • •

Wider family issues including ongoing care of a young dependent may well have affected the strength of the reaction which followed. These daughters demanded a meeting with Liz because *'they didn't want me telling people this ever again and I had done a very wrong thing'*. In short, they asserted that telling their mother about the extent of her illness had *'killed her'*. These aggrieved ladies remained steadfastly convinced that Liz had been wrong to respond truthfully to their mother, and insisted that she should never repeat this action. Liz had acted according to her established principles;

> *'I have always tried to involve everybody with the decision, but if somebody has asked me directly, and she did, I have always tried to be honest with them…in …quite a kind way… In my opinion she quite clearly wanted to know.'* Liz

No agreement could be reached between them; the family continued to believe that disclosure had hastened their mother's demise, blaming the doctor – despite knowing that her illness had progressed to a terminal stage. Meanwhile the doctor believed it would have been wrong to answer a patient's direct question with a lie and reflected on how she would address future situations when families wished to control information shared with their relative. Liz continued to believe that she had done the right thing by her patient in spite of the unpleasantness of their reaction and a difficult meeting, but she modified her response to

family requests for secrecy. She started to pre-empt possible dissent by setting out her case in advance;

> *'I have been asked by other relatives not to [tell the truth], and I have said to them, "What do you expect me to do if I am asked directly?" … then put my case; "If I am asked directly I am not prepared to lie…now I may put it gently, and I may put it somewhat vaguely so they can then go on from that, if they definitely want to know, but I will not lie." '* Liz

Reflection on this difficult event induced Liz to put pressure back on relatives whose stance was to prevent disclosure, to face up to how she would feel obliged to respond if questioned directly. Emphasising her perceived duty to be honest, her declared position proved workable, yet in doing so she risked imposing an openness with which family members felt uncomfortable and to which they may have struggled to adjust. For Liz, her duty to be honest exceeded her willingness to dishonestly conceal the truth.

Nobody in these interviews gave any indication of having lied or felt that it was necessary to lie to patients, colleagues or management. It was impossible to know whether this represented a true pattern of behaviour amongst participants or merely marked a boundary of what they were willing to divulge.

Evasion

> *Evasion; defined as use of ambiguity, equivocation, understatement, diversionary tactics*

Liz's decision about giving honest opinions to patients in *'a kind way'* and *'somewhat vaguely'* in the above example could be labelled an evasive response. Patients who detected an evasive strategy and chose to pursue it could ask supplementary questions, pushing a clinician to give a more complete explanation. Hoppin's work indicated that many medical practitioners asserted that evasion was justifiable as a more benevolent response to patients, and that as a substitute for explaining the truth in its entirety, served as a time -

Call yourself a doctor

It's the dishonesty

the professional challenge;

that patients would trust

the woman in Holland and Barrett's

who has a white coat

and has worked there for two months

more than they would trust me

after many years,

many degrees.

George

saving device (Hoppin, 2011). However, little data in my study fitted this category, which is not to imply that clinicians may not be engaging in it but could suggest that they had no moral issues in doing so and therefore did not find it problematical or worthy of mention.

Overstatement

Overstatement; defined as exaggeration, magnification of facts or data, embellishment, self-promotion

George's orientation towards a scientific basis for modern medicine allowed no quarter for patients who sought his acquiescence when they chose alternative sources of help in the form of complementary practitioners. Feedback from family and friends made him realise that his reaction against these practices appeared somewhat extreme, but he remained unable to control his reactions to perceived '*dishonesty'*.

● ● ●

Call yourself a doctor

● ● ●

While George cited '*dishonesty'* of non-medically qualified persons adopting the title '*Doctor'* as his major concern, the tone of his outrage hinted rather at a zealous protective reaction to defend his own conventional qualifications against threatened undermining of his professional authority through superior knowledge. Much '*biting my lip'* was needed when patients reported improvement from alternative medicine, but he admitted having a periodic *'rant'* on the matter which was not well received by colleagues or friends with more open views. He claimed to be frank and open with patients about the limitations of traditional medicine when making a confident diagnosis and recommending treatment indicating his acceptance that this should not be over-estimated, but his antipathy to alternative medicine was palpable.

I self-reported

I thought they needed to know
there were problems with my health,
as a single-handed practitioner.

I have conditions
on my fitness to practice,
which is fine;
I don't have a problem with that.

I think all I am saying is
I need to be watched for a while
to make sure I am OK.

They have done that,
haven't made my life difficult,
haven't made my practice difficult,
haven't intruded on me
haven't asked me to do anything off the wall
or jumping through hoops.

I found them
understanding
supportive.

Psychiatrists every 3 or 4 months
submit a report to GMC

You have no secrets when GMC is involved,
You don't have the same confidentiality rights as any other patient

Alice

Concealment

Concealment; defined as not disclosing, hiding or disguising something, including feelings

As with evasion, concealment was not prominent in the data as a pattern of deceitful behaviour in relation to patients. Concern regarding the standards of training through which junior doctors now progress to senior positions, which is largely concealed from public gaze, has drawn much internal attention and debate and is discussed separately later in this chapter.

For Alice, whose health and coping strategies were severely damaged and stretched beyond her capacity to continue normal commitments, concealment was not her choice; she was sufficiently concerned in her precarious situation as a struggling single-handed GP, to report herself to the GMC so that she would be externally supervised. She explained this as an attempt to prevent reaching a situation where her medical practice could deteriorate so severely that she might be responsible for clinical errors which would both damage patients and further impair her ability to function as a person and a physician.

• • •

I self-reported

• • •

Alice's case was somewhat unusual in that despite her difficulties with illness there was no evidence of poor performance; healthy QOF figures and engagement in prescribing initiatives provided supportive evidence that, when she well enough to be at work, she provided an effective service to patients – with the support of a team who carried on working when she was absent. She regarded sacrifice of her privacy and normal professional freedoms an acceptable price for the comfort of supportive monitoring. Likening the process

to using stabilisers on a bicycle, she remained wary of the risk of making an error and was uncertain of when she would regain sufficient confidence to feel she could again function fully independently.

Her account differed from anecdotal suggestions that involvement with the GMC necessarily entailed obstructive or punitive measures which militated against rehabilitation of a doctor at the centre of a case. Perhaps it is unsurprising that few publications could be traced reflecting accusations against GMC procedures; a private doctor's online web page which carried reflections on her GMC hearing and a whistleblower's blog being examples of few available sources (Myhill, 2010, Pal, 2013). No other participants added stories of GMC contacts; hushed, almost reverential tones tended to accompany mention of it together with a sense of having been lucky enough never to have first-hand experience of GMC deliberations.

Collusion

> *Collusion; occurring when a deceiver and target cooperate in allowing a deception to succeed.*

Clear differentiation between concealment and collusion demands knowledge of conscious awareness of both involved parties and therefore judgement based on unilateral interviews is at best uncertain. As doctors and managers worked together to devise and implement new performance monitoring systems, these were presented as providing assurances of quality and patient safety. However, in the view of clinicians some of these did not measure up to the standards claimed for them. Limited information prevented judgement of how aware managers were of discrepancies between what was understood and accepted by both parties and no external objective assessment was available. Collusive behaviour could potentially be a convenient mode of framing actions in response to those situations, as indicated in the following narratives linked to performance measurement.

Quality assessments in histopathology were carried out on a number of occasions during each year to test reporting accuracy. Batches of microscope slides were sent to consultant histopathologists for each of the tissue groups for which they regularly provided histological reports in order to detect any consultants who were unable to reach a correct diagnosis and whose daily practice could not therefore be quality assured. They were not expected to confer on their findings before submitting reports on these 'test' slides. John reported that the degree of difficulty or complexity of slides was not high, implying this test could only detect very low levels of diagnostic skill. However, he and his consultant colleagues encouraged managers' acceptance of these External Quality Assurance (EQA) schemes as a valid test of adequate standards within the NHS.

> *'So it actually isn't testing very much but … to the government it looks as if it's testing, but not really.'* John

Rather than speak of his concerns in a manner which indicated that he would prefer to be more open and honest regarding the dubious value of this EQA test, he proceeded to justify this stance based on two factors;

Firstly, in practice consultants expected to liaise with colleagues on a daily or frequent basis about slides which presented any diagnostic uncertainty (an action confirmed when his colleague requested a second opinion during our office interview). Occasionally slides would be sent to colleagues regarded as experts in particular tissue types; utilising a highly-valued system of pathology networks.

Secondly, if a significantly more rigorous testing process was implemented, a risk that many consultants could fail the test would so deplete remaining manpower that the NHS Pathology service could not cope with workload demands and the entire service could collapse.

Whose side am I on?

They are not really
testing under performers.
They shape themselves up
to look like they are,
and we can tell managers
they are,
but they are not,
they are not.

But then again,
why should they?
You don't actually want
huge numbers
of under performers;
what the hell
do you do about that?

And anyway, it's not testing
how you are working in practice;
you don't look down and not really
understand what you are looking at
and just write something anyway,
get it off your desk …

You ask colleagues.

John

A further test of histological practice was examined by the *'cancer police'* whose visit confirmed that mandatory EQA tests had been completed successfully and the local NHS Trust was expected to provide evidence that all required actions were in place and any alerts on performance were properly addressed. If those responsible for assessments harboured doubts about the standard of the tests then the situation as described could represent collusion, if not, histopathologists must have been effectively concealing their own misgivings.

• • •

Whose side am I on?

• • •

Since John was a nationally recognised expert in his sub-specialist field, it could be argued that his personal high standards gave him unrealistic expectations of his colleagues; by others' estimation the tests may have been appropriately challenging. Justification of his position hinged on his perceived mismatch between the test and routine practice and a predicted unsustainability of the pathology service should too many consultants fail to reach a higher standard. Although arising from dissonant reasoning, both arguments offered sufficient support to satisfy his sense of duty so he took no further action. In view of other battles with local management, this may have appeared a contest worth avoiding particularly if he felt morally able to defend his position.

Regulatory security

Regulation changes for opioid prescription and administration introduced post-Shipman created new rules which made correct documentation of the use of opiates more difficult and

Operation opioid; fallout after Shipman

All the regulations
have no bearing at all
to practice in theatre
with opioids.

If someone was intent
on killing,
they could still do it.

We do all this hoop jumping
just to show the process,
a sort of PR thing
to show the system has changed.

We have documentation
so it can never happen again.

But it could.
I could kill someone tomorrow
and I am no less able to do that
than ten years ago,
before Shipman.

So you feel
there is more attention to process
than actual substance.

Graham

provided for more rigorous inspection. To a large degree GPs ceased handling these directly, but Graham indicated that they remained widely used in anaesthetic practice and he believed that it would still be possible, or even easy, to use them inappropriately implying no effective new safeguards for patients;

• • •

Operation opioid; fallout after Shipman

• • •

Graham's evaluation suggested that impracticalities inherent in legislating against every possible harmful action in everyday practice supported an argument that training processes and assessments should be sufficiently sensitive and discriminating to detect anyone who could intentionally or through foreseeable poor performance put patients or colleagues at risk. Since attempts to monitor medical practice could never account for every conceivable situation, he advocated a robust process to take decisive action to remove dangerous doctors from opportunities to cause harm. However, in his own experience he perceived increasingly lax early career supervision and wider evidence of problems from alcohol and non-prescribed drug use among medical staff suggested reasons for concern in this area (Marshall, 2008, Fowlie, 1999, Gossop et al., 2001).

Mutual benefit

As indicated earlier, Stewart lacked confidence in scientific evidence behind some clinical interventions rewarded under the QOF. Presented with in a system where payment followed results for specific working practices and achievements, he was prepared to abandon moral high ground and developed close working relationships with his paymasters at the PCT. While irked that they would only play according to specific rules, he opted not to stubbornly resist but worked with the agenda the PCT had been asked to follow or policies they had

The other thing the contract did for me and my career

We had a mysterious red book
my senior partner
my chaotic practice manager
used to cook up this red book.
We never knew where we were with money
He and she ran the practice
out of this red book.
A classic case of
'We have always done it like this'
A classic case of
a nightmare
and very poorly run.

Everything happened at once;
the contract came,
a new efficient, young practice manager
I said
'It's my time to do it'.

So
the contract
with all that QOF stuff,
was so clear about how you earned your money
and what you did it for
and you could fall behind the evidence base
and say
'I know that I want your cholesterol to be below 5
but actually that's quite good for you'

So it didn't feel immoral

George

adopted to meet their own targets. It became a game of mutual convenience. Nurse-led smoking cessation activity felt limiting (and against the grain of his preferred practice), but it paid. His narrative claimed a collusive relationship but he added moral justification for practicing in a manner with which he was not completely comfortable by indicating that the majority of his work was of high quality and listed his involvement in training and development initiatives. Although Stewart denied financial motivation, issues surrounding income generation crept into his interview at several points; e.g. an entrepreneurial project development saw him train his practice nurse to perform minor surgery which attracted additional income through financial incentives for avoiding referral to more expensive secondary care resources - an innovative scheme which his PCT was proud to support.

The empowerment of change

Transformation of George's position within his practice stemmed from introduction of the 2004 contract; it was the mechanism through which he took control within his partnership.

• • •

The other thing the contract did for me and my career

• • •

Suddenly, the old regime vanished to be replaced with a transparent new system. Senior members of the team lost their advantage of accumulated knowledge and experience, and moved aside. The entire team structure changed and a new administration began; George could now understand which activities earned income and could plan accordingly. On the clinical front, asking patients to alter lifestyles or take preventive medication knowing that this improved his income felt uncomfortable, but discomfort (or guilt) was rapidly justified by embracing *'evidence*' which argued that it would be *'good for'* them in the end. This seemed

to soothe his ethical misgivings though elsewhere it has remained an active debate (de Zulueta, 2008, Heath, 2011, Kramer, 2012).

8.4 Consequences of discordance between clinicians and managers

In addition to discontent at doctors' perceptions of the calibre and performance of managers (section 6.2.), further stories demonstrated reasons behind disharmony and distance which existed between clinicians and managers.

Different priorities in primary care

By drawing on personal experience from professional contacts but also having watched a relative rise through the ranks of NHS management, George's dual view made sweeping generalisations; vehement criticism flowed with the fluency of a well-practised tirade.

Two-bit managers

Primary Care Trusts
make me angry.

All they are doing is protecting their own jobs;
Chief Exec, financial director,
whatever the hell it is.

They know that if
they keep in budget, they tick their boxes,
write the right papers,
make the right mission statements,
they will get a pat on the back from above

George

George had little respect for doctors who long ago left clinical practice to work within PCT management; '*doctors that haven't practiced good quality clinical medicine for 20 years… not respected by any of their medical colleagues'.* Wave after wave of newly appointed

So you want to be an NHS Chief Executive

He left school with five O levels
to be a lab technician.
Got raced up through the ranks,
got himself on an NHS MBA course then
fast tracked up that ladder,
and then he was Chief Executive.

He had the biggest debt in the country
They said
'You're sacked.
You're gagged.
We will enhance your pension'

Two years later,
back to become Chief Exec,
paid twice as much because
he was employed by an agency.

George

liaison officers had arrived to promise a '*breath of fresh air'* but he failed to see any patient care benefit. He suspected their motives; believed that, from lower ranked positions to senior level, they were motivated to protect their jobs and advance their careers by performing well with specific objectives. His lack of respect spilled out in highly evocative language, patronising statements insensitively following each other in hurried succession. While his style of expressing these views was direct and uncompromising his sentiments were not unique (Davies and Harrison, 2003, Davies et al., 2003). Perhaps he felt he could be less restrained because his immediate audience might empathise and because by observing the career of someone known to him, he claimed inside knowledge of NHS management.

• • •

So you want to be an NHS Chief Executive

• • •

Scepticism about the ability of management personnel and a general anti-management attitude linked Davies' findings to the particulars of this story revealing barriers which can interfere with cooperative service delivery in a national institution. From a modest educational base George watched a relative progress to Chief Executive (CE), then from sacked and gagged CE he returned to even greater financial rewards; this was George's inside story on NHS management. Distortions and apparent injustices which accompanied powerful positions did not impress him; they caused resentment and intrigue. Concluding his tale, this doctor wanted to see more appropriate use of power in NHS management, he wanted effective management to improve weak areas in primary care;

> *'I … feel that there are quite a number of GPs who need to have … supervised practice, and this softly, softly approach - PCTs can't get a handle on it'* George

Having earlier advocated abolition of a layer of management, he sought tougher enforcement of high standards; he declared he would welcome effective managerial intervention but he saw no prospect of effective action from many managers he had encountered.

Disengagement from hospital management

In secondary care John's experience of negotiating with managers, whom he judged incapable of making innovative cost-effective decisions, provided further evidence of the absence of managerial characteristics preferred by clinicians. Having criticised their lack of engagement he also viewed them bereft of ideas;

> *'…they just revert to the mechanisms that they see will be effective … cut the secretarial staff, cut the lab staff, squeeze those elements because those are the only elements in the budget they can tackle to make their savings.*' John

John and his consultant colleagues, in a bunker-like small lab, did not doubt that their situation looked isolated and bleak. He was aware that they could be criticised for opting out of mainstream involvement but John's prior management experience strengthened his resolve not to relinquish the moral high ground. In order to survive, he and his colleagues chose to retain the degree of autonomy they had established; tucked away from the limelight they enjoyed great camaraderie and much pride in the service they delivered. He despaired at recurring loss of staff who supported the pathology service, who were modestly paid but whose contribution allowed more highly trained specialists to do specialist tasks; instead of seeking new ways to work more efficiently each wave of cost-cutting pared away at the periphery instead of grappling with the thorough overhaul of working practices which was required.

Medical students

I don’t get any sense of excitement
that they are going to solve problems.
Individually they are brilliant,
extremely patient centred,
fantastic.

But thinking
‘I can’t do this
because the system won’t allow it’

There is no challenge and
leading the change.

Mark

8.5 Responsibilities for training doctors

Two thirds of interviewees participated in training future doctors and for some a significant portion of their narratives was devoted to their concerns about current medical training, though unfortunately full exploration of this theme lies beyond the limits of this work. As previously discussed, the effects of a dynamic, inspirational teacher can profoundly influence junior doctors; in these stories of practical everyday encounters with junior colleagues, the narrators' sense of a duty to teach a rising generation of doctors was hindered or obstructed to a troubling degree.

Medical student teaching; a new generation

While Richard was quite impressed by the demeanour of medical students who briefly visited his practice, Mark, who was involved in teaching course modules, was more concerned by what they lacked;

• • •

Medical students

• • •

Perhaps he asked too much, but clearly Mark expected more from medical students than simply to perform well with patients; he expected them to demonstrate the sort of problem-solving skills and inclination towards clinical leadership which he felt were needed to implement positive changes. As the poem overleaf suggests, he was looking for a new generation to push beyond the limitations of existing boundaries;

• • •

No more heroes

• • •

No more heroes

Excellence is dead,
you are not allowed to flourish or
be strong anymore.

Nowadays
if I prescribed a different regime,
I would be shouted down;
This doctor is working outside the guidelines
he is an outlier.

To succeed
you have to assimilate and
be embedded in the system.

Mark

Consistent with his personal philosophy, Mark drove for improvement through innovation, through sharing ideas, through pushing at closed doors to achieve the best care for patients. He was irritated by those who hid behind guidelines as an excuse for not doing more to help patients, who were too willing to accept obstacles instead of trying to overcome them. The negative implication of labelling a doctor who did something different and innovative as an '*outlier'* and therefore in need of close observation or censure did not sit well with him; he wanted excellent doctoring to lead the way. From his GP perspective, he believed that recent changes to qualifications necessary to enter general practice had raised the standard of new entrants, though still he waited for new heroes in clinical leadership. Instead he observed a prevailing tendency to merge with the pack, to accept mediocrity because that matched better with everyone else.

Postgraduate training; fit for purpose

Although GPs seemed relatively content with GP training programmes, stories from hospital specialties suggested reduced confidence that new training programmes (MMC) would produce fully prepared consultants and questioned whether middle grade staff training properly equipped doctors for crucial roles (Khan, 2012). The Tooke Report recommended flexibility, aspirations to excellence and consultation about changes to mechanisms and requirements governing specialist training, and increased emphasis on evidence of training outcomes (Independent Inquiry into Modernising Medical Careers, 2008).

Conflicting findings emerged from research into objective changes such as the effects on patient care of EWTD restrictions on working hours, alterations to team structures with fewer onsite senior doctors and juniors often unavailable for training events. Comparable figures pre-MMC were said to be unobtainable or indicated that no consistent effects had been detected by objective measurement of professional performance or standards of patient care (Goddard et al., 2010, Moonesinghe et al., 2011). Liz and Graham spoke at length about serious concerns in each of their departments.

The breath of fresh air trainee

There are one or two;
so bright,
on the ball,
so lively.
They get into the thick of it
and get experience.

One came last year;
she managed to be always on the ward round
every morning
even if she was geared up to do other things.

It was just so amazing, that
in this higgledy piggledy rota
she could make sure
she was there to go round with me.

It was like the old days;
she just organised everything.
I would say,
This lady needs such and such,
and she would sort that out.
Always,
'I will do that.
Yes, don't worry,
I will do it.'

Such a breath of fresh air
She will do very, very well.

Liz

Foundation training and junior posts; a mixed picture

Against a background of recurring recruitment difficulty in obstetrics and gynaecology, doctors from non-UK universities have brought different ideas and attitudes but often failed to impress Liz with their abilities. Only rarely has she glimpsed enthusiasm and eagerness which proved that it was still possible to achieve high standards of work.

• • •

The breath of fresh air trainee

• • •

The mystery of how one trainee managed to be present, functioning effectively, learning and supporting care of patients while others were almost anonymously absent, raised more questions than my research can answer; perhaps root causes could lie in training, or ability, or possibly these occasional super-doctors simply disregarded the EWTD to do a better job or to more effectively advance their career.

Anaesthetic training – fragmented supervision

In early anaesthetic training and supervision formerly close links between junior and senior staff broke down as reduction in hours and a disjointed rota meant that a trainee spent short periods in multiple places with little opportunity to develop a sound mentoring relationship as Graham and his contemporaries had done. Because documentary evidence must confirm their progress, meetings took place and forms were completed, but only on the basis of what was known and shared. Consequently a significant proportion of the work done by a junior stayed outside personal observation of the supervisor who completed the documentation. Unless a senior colleague who had witnessed an issue of concern contacted the supervisor,

it could pass unnoticed, undocumented and uncorrected. When trainees were officially 'off-duty' they often missed teaching sessions and no questions would be asked if they did not attend local or regional training meetings. These views were consistent with reports that juniors believed they had insufficient time devoted to training during working hours - some spent un-scheduled hours at work to compensate for this deficit. Reports were also received of insufficient educational supervision suggesting that trainees recognised inherent deficiencies (Khan, 2012).

8.6 Summary

Cultural modifiers in workplaces have been shown to affect attitudes to deception with the result that certain forms of deception are regarded as less acceptable than others (Dunleavy et al., 2010, Sims, 2002). Doctors acting to protect colleagues at the expense of optimum patient benefit or adoption of working practices which used resources to benefit the interests of the organisation were observed in Millman's study and more recently it was alleged that senior doctors seemed '*untouchable'* (Millman, 1977, Wilmshurst, 2013). The point at which clinicians have a duty to take action about imperfect practice remains both difficult, topical and under recurring scrutiny as specific situations arise and the general terms of GMC publications are applied (Irvine, 1997b, General Medical Council, 2006).

Discussing the likely fate of *whistleblowers',* Bolsin et al. termed this a *'traumatic undertaking and not one to be recommended'* and admitted scant evidence that such disclosures were ethically sound, backed by moral and legal justifications or devised to improve patient outcomes (Bolsin et al., 2011). Although several years have passed since a Chief Medical Officer declared his intention to introduce a Duty of Candour, so far none has been introduced though debate continues and further changes have been proposed (Donaldson, 2003). Complex legal and ethical arguments surround how patients can best be protected and how doctors ought to judge individual decisions (Hough, 2010).

In narrating their experiences doctors clearly described principles which they believed central to good medical practices though at times these caused difficulty through being unshared by others or working against how other bodies wished to operate. In some cases they were prepared not to expose deficiencies in performance measurement despite believing that it was sub-standard. They were also prepared to participate in activities whose effectiveness or efficacy they doubted – particularly when financial incentives were available. Concern about standards of training and supervision of junior doctors as expressed by two consultants is insufficient evidence on which to evaluate a spectrum of postgraduate specialist training but suggested that further investigation could uncover further disquiet.

Many potential points of tension exist between an NHS need for qualified operators to deliver health services and the operators who provide that service while remaining sustainable providers, as individuals or provider organisations. Once regulations are in place defining levels of performance and payment it should not cause surprise that GPs and consultants, who are both strategically alert and enterprising, seize opportunities to deliver those services and find arguments to justify their actions. Given that workers in other disciplines responded to enactments of power which diminished their autonomy, threatened their social identity and brought perceived injustice with some form of resistance, perhaps we should also expect that some form of resistance meet radical re-drawing of the medical profession (Lawrence and Robinson, 2007).

Since forms of resistance by medical staff are constrained by explicit regulations, cultural norms and internal principles there are limited options for NHS staff who feel alienated by changes made without meaningful consultation or participation in design, or in the absence of general active support. On the above evidence it seems that moral disengagement could be judged by some doctors in some contexts as an acceptable form of deviant behavioural response (Barsky, 2011).

Chapter 9

Discussion and conclusions; contemporary doctoring for a modern NHS

'We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time'
T.S. Eliot: Four Quartets, *Little Gidding*

My purpose here is to review aspects of medical practice about which doctors volunteered insights, indicating how these impacted on everyday working practices, how relationships within teams and with patients were negotiated, and their reflections on professionalism; authority, autonomy, self-regulation, clinical mentality and technologies in medicine. These findings inform an emerging impression of a profession which is seeking to clarify its role in contemporary settings, to understand how to respond to challenges and to make sustainable transitions.

9.1 My purpose in collecting perspectives of working in the NHS

In this exploration of experiences of doctors' work in the NHS I sought to compare accounts of expert witnesses providing a range of perspectives, opinions and ideas about NHS activity. I hoped to discover their views on the nature of work environments, expected working practices and gain a sense of how they regarded themselves as doctors. I have outlined how changes in society, re-organisation within the NHS, advances in managed medical care and modifications to medical training programmes combined to create a workplace quite different to that of the mid 1980s.

However, listing aspects of change serves only as an initial frame within which more far-reaching motivational drivers and practical consequences affect patients, public and NHS workers, and as a clinician, I too have experienced evolutionary change in delivery of health care and participated in many informal discussions about improvements and obstacles. These accounts confirm that changes which may be necessary to improve local performance, service delivery, or cost effectiveness, can lead to unforeseen effects at another point in a large organisation with complicated relationships between different departments.

Clearly it would be impossible to collect, much less to rigorously analyse, in-depth interviews from all active clinicians, but potential distortion by peering through the lens of a single doctor or single specialty is reduced by having obtained first-hand biographical narrative accounts from a group of ordinary doctors, working in diverse places and in a range of specialist fields. Acknowledging my locus on a spectrum between having access to the totality of experience and situated individual perspective, I have sought to maximise understanding through data richness and sensitivity in analysis. Variety and recurring themes which populated narratives, offered assurance that, despite limited resources, gathering accounts which spoke about self-selected topics in a characteristically reflective manner and through relating working selves, generated new perspectives on a hidden world.

9.2 Management-directed working practices

Financial constraints in health care

With budgetary constraints, increasing patient demands and pressure on health care providers Klein observed that making consultants and GPs accountable for budgets put clinical autonomy under pressure (Day and Klein, 1991). The managed market introduced after the new NHS Plan was seen by some as an interference with a clinical ideal and negatively viewed by public and professionals (Department of Health Great Britain, 2000a,

Learmonth, 1997, Pattison and McKeown, 2010). Rather than solely meeting patients' medical needs, as global recession and cost-adjusted reductions occurred, doctors were expected to save money while improving health outcomes (Ham, 2009). This was to be achieved through more efficient purchasing of goods and services, administrative rationalisation, and improved use of IT; increased productivity to be demonstrated by delivering more without additional resources (Mulley, 2010).

As the use of information technology to monitor everything related to health care and spending patterns supplies an ever increasing volume of information about medical activity, statistical analysis can be applied in a manner not previously possible. With this information, health service managers monitor and can seek to influence spending on medical interventions; doctors are asked to consider the cost implications of their clinical recommendations e.g. GP practices are given designated budgets for prescribing costs and incentivised to contain spending within these boundaries. GP referrals to secondary care are monitored and assessed against other local and national figures with encouragement to internally examine these and discuss how they could be decreased.

Hospital consultants also come under pressure to justify spending and seek to reduce costs e.g. by earlier handing over of prescribing responsibility to GPs and by dealing with a higher proportion of operations and procedures as day-case events. Despite contested definitions underpinning NICE calculations and recommendations, these standards are commonly (even deferentially) accepted as making prudent use of funds (Appleby et al., 2009, Spence, 2013).

Financial implications widen the scope of each consultation to consider not simply the best medical advice for this patient now, but what might be the most cost effective method of dealing with this patient in the longer term. This multiplies frames competing for a doctor's attention during each consultation with knock-on effects for the use of time, and can be an

unhelpful distraction from the primary purpose of providing care (Davies, 2006, Dodier, 1994). Supplying doctors with information about costs of medication, hospital treatments and consultations intended to make them modify their decisions can only be useful if there are cost-effective and acceptably efficacious alternatives – it has been shown that clinicians' knowledge of costs has been poor with some rejecting cost-saving choices as unethical or a non-clinical decision (Fowkes, 1985, Ryan et al., 1992). In many cases, particularly where the final outcome remains in doubt, the balance of costs is projected on uncertain evidence and as relative costs of pharmaceuticals alter, the balance of costs also changes. Narratives often returned to cost effectiveness as a contentious topic; a sense of squeezing more and more from dwindling resources, ill-conceived cost-cutting decisions did not sit comfortably with doctors' aspirations to provide high quality health care.

Limitation of access to services

Policies put in place to restrict access to specific health services bring conflict into a consultation where an individual patient's access to resources is balanced against available funds. This gained sharper focus as Practice Based Commissioning (2005) was scheduled to be followed soon after completion of fieldwork, by greater emphasis on GP leadership through Clinical Commissioning Groups (Davies, 2006). For those GPs in the study who readily acted as knowledgeable advocates for patients denied services, challenging future decisions may be characterised by a different dynamic as GP colleagues will be more closely involved in making decisions about what constitutes an 'exceptional' case.

Sometimes doctors noted that criteria which must be in place before a patient could be seen in an outpatient clinic excluded patients whose pattern of illness was unusual or had been inadequately documented; policies to regularise patient pathways or clinic activities effectively blocked access. However, such obstacles could be circumvented by ensuring that referral criteria were met even if this required a misrepresentation of the patient's problems.

Unhelpful outcomes from well-intentioned but ill-fitting patient pathways were confirmed by accounts from both primary and secondary care sources.

Medicine by protocols and guidelines

Mixed reactions accompanied rising prominence of evidence based medicine (EBM) as a scientific basis for the development of protocols, guidelines or algorithms as advisory tools for clinical actions. Although not mandatory, established protocols are difficult to disregard; for some they represented an agreed series of definitions and practices supporting clinicians towards 'best' management decisions (Sackett et al., 1996). Rejecting a notion of '*cookbook*' medicine, Sackett emphasised that '*individual clinical expertise and patients' choice'* are necessary partners in the application of EBM. Others questioned the usefulness of EBM for patients who could never have been included in research trials because of co-existing problems, age or preferences (Bensing, 2000), while use of EBM as a means of reducing clinical uncertainty for clinicians permitted junior doctors comfort that their recommendations were not without backing but they became heavily dependent on technology for ongoing access to established protocols (Timmermans and Angell, 2001). Full use of protocols by health organisations may however fail to limit costs due to their tendency to advocate 'gold standard' management in terms of diagnostic certainty and treatment efficacy (Sackett et al., 1996).

As previously indicated Calman-Hine recommendations for processing, reporting and decision-making in cancer diagnosis and treatment, formally laid down timescales and standardised how surgeons, histopathologists and oncologists should deal with new cases. With clarified roles, histopathologists became increasingly included in clinical management since it was their expertise on the tumour which informed treatment options as a support towards improving outcomes.

Doctors engaging with protocol-based practices to improve or standardise patient care or to increase patient safety encountered particular difficulty when matching elderly patients' needs with treatment recommendations suggesting that sensitive negotiation was necessary; dissonance between protocol recommendations and patient preferences are further discussed below.

Performance related payments

As the most comprehensive payment-for-performance scheme, the GP-based QOF has attracted greatest attention to examine its effectiveness as an incentive for clinical action and to evaluate detrimental effects. Although confirming better control of hypertension and a reduction in health inequalities, early results have been regarded with some caution as multiple non-QOF factors may have boosted observed improvements (Doran and Fullwood, 2007). Several risks proposed as by-products of incentivised payments included; inappropriate treatment recommendations, relative neglect of tasks not measured or not attracting payment, fragmentation of care, and 'gaming' (a practice of making figures appear better by actions ranging from exploiting loopholes to fraudulent activity) (Doran and Fullwood, 2007, Kramer, 2012, Gubb, 2009).

Sweeping changes which accompanied introduction of QOF in the 2004 contract meant that incentivised payments to GPs provided a significant proportion of income and therefore assumed greater importance. Superior QOF scores could be viewed as evidence of good medical care since many initial QOF targets were in accord with generally accepted standards (Steel et al., 2007). However the use of surrogate biophysical measures rather than long-term clinical outcomes in general populations raised general questions about the effects on patient-centeredness of improving cost-effectiveness by incentivisation in health care (Starfield, 2008).

Participants in the study reported ardent participation in the 2004 QOF but criticised later inclusions as less in tune with their clinical aspirations. Not all GPs were convinced of a robust basis for additional standards leading to an equivocal attitude; a feeling that some recommended actions remained insufficiently proven to warrant inclusion for QOF payments. Debated evidence for the efficacy of audited clinical management squeezed clinicians into an uncomfortable place; where the validity of an action which was financially rewarding for the clinician could be questioned, doctors who doubted the evidence or questioned the morality of advocating potentially harmful treatments or preventative medications, must measure their discomfort against underlying ethical principles. In hospital practice pressure to manage targeted goals of patient care expeditiously in order to avoid closer management attention may not always allow specialists to operate in the areas of their greatest strengths.

9.3 Defining interactions between NHS staff

Relationships with colleagues

As indicated in Chapter 6, many narratives were anchored by influences of team working which operated by setting a local context and as source of support or stress. Effectiveness of team training for delivery of health care has been shown to benefit from strategies to improve communication together with matching training to the specific needs of a team's situation (Buljac-Samardzic et al., 2010). While this generational cohort of doctors did not as undergraduates undertake training designed to prepare them for teamwork or leadership, evidence indicated that some had acquired these skills while others, despite being aware of the dynamics of such situations, had not achieved the same effectiveness. Simple tactics of 'divide and rule', or of silent waiting until other strong voices led the argument of which they approved, were employed to good effect. Teams or colleagues were in general mutually supportive, an audience for shared 'black' humour, even a hidden locus for challenging accepted norms or politically incorrect ideas.

Narrative accounts produced evidence of a sense of 'passing on' a valued profession to the next generation, of striving to maintain knowledge and skill to a high level. Concern was voiced about slipping standards on the grounds that at one professional examination testing for excellence had been replaced by checking for competence, yet another examination was judged to have raised the standard required. Training programmes in recent years (post-MMC) placed emphasis on documented achievement in a minimum set of standards or tasks and were likewise criticised for accepting a 'safe' standard of clinical practice but not encouraging doctors to reach for excellence. Team fragmentation was blamed for disruption of mentoring and disjointed tutoring in specialist skills of anaesthesia, and training in surgical technical skills and decision-making appeared deficient.

Not all doctors welcomed expertise in colleagues from other disciplines; nurses who chose not to undertake on-going responsibility after training to be nurse prescribers tallied with expressed disbelief that their short period of training could provide adequate preparation.
Missing from these accounts were perspectives of un-interviewed members of teams; unvoiced alternative narratives from which dysfunctional or successful teamwork could be more comprehensively studied.

Relationships with patients

Although changes in society and wider access to health-related knowledge had been identified in reviews of altered dynamics in medical consultations, stories of interactions with patients did not reveal this as a problem. When seeking health services, patients may be better informed and more inclined to actively participate in decisions affecting their health yet current constraints have increased tensions for doctors choosing to follow treatment guidelines rather than fully address patient preferences (Solomon et al., 2012). Since EBM is disease-orientated rather than patient-orientated, and often based on trials under carefully controlled conditions, it can correlate poorly with patient-centred practice; a biophysical model contrasting with a biopsychosocial model (Bensing, 2000). Doctors who prefer to

adopt roles as medical scientists may be better attuned to delivering EBM advice taking little account of patients' unique health profiles or preferences, in contrast to doctors who function chiefly as care-givers. Most interviewees expressed feeling responsible for working with patients towards diagnoses, guiding them to effective treatments and felt strongly that they should continue to listen attentively to patients and support those whose problems could not be cured - though this aspect of doctoring had not been considered worthy of incentives. As Starfield observed;

> '*No system of quality assessment addresses the adequacy of recognition of the patient's problem'* (Starfield, 2008, p:693)

Interface with management

It could be argued by medical staff that a primary purpose of management in the NHS ought to focus on how structures, procedures or equipment can best facilitate the effective roles of delivering health care, yet hostility and incomprehension between managers and health professionals with confusion about roles and functions has contributed to poor relationships (McCartney et al., 1993).

NHS management is tasked to achieve government policy objectives, develop service design, deliver services to improve health outcomes, oversee clinical governance, satisfy service users, limit future costs through promoting healthier lifestyles – and to achieve this within budgetary constraints. In the challenge of managing human resources for maximum engagement and efficiency, there are reasons to believe that engagement of clinicians in shared objectives contributes to effective and efficient working (Clark, 2012). Attitudes to NHS managers among interviewed doctors were universally negative; disengagement resulted from physical separation and different ideas about how to effect changes, lack of respect as new managers were introduced resulted from previous disappointment and suspicion that a fresh face would not be accompanied by fresh ideas. It remains to be seen whether greater involvement in service design and delivery through Clinical Commissioning

Groups leads to an era of partnership as non-clinical and clinical managers combine expertise and experience to deliver the patient-focused high quality care which Clark proposed.

9.4 Doctors on being doctors

Professional autonomy versus constraints

Medical narratives often returned to perceived limitations due to external factors; insufficient time to fully address patients' problems, absence of effective colleagues whose work should smoothly support patient care, obstacles to specialist services, perceived ineffectual leadership from management or clinicians. As juniors, some felt ill-treated in an undervalued role while others thrived in less competitive settings. Opportunities to re-shape treatment, or spend longer periods talking to patients contributed to a sense of enacting the role of a useful doctor, empowerment by medical qualification was utilised to make improvements which matched their aspirations and brought particular satisfaction when patients expressed appreciation.

As indicated above, constraints implicit in an increasingly managed health service were wide-ranging; referral pathways were devised and implemented, drug formularies listed, formal work schedules included in consultant contracts, and NICE guidance, protocols and algorithms multiplied. Reduced flexibility in training programmes impacted on choices available and team dynamics, while documentation of '*learning activities'* became *bona fide* proof of progress. To deviate from current medical practice or established programmes became more difficult and increased medical indemnity costs served as a reminder of vulnerability and a perception of public expectation that doctors ought never to make mistakes (Daly et al., 2009).

Later career stories revealed how doctors recognised internal limitations; they spoke wistfully of difficulties finding a balance between work to which they felt highly committed and time to be off-duty. An array of additional tasks, which was a frequently perceived outcome of re-organisation, required more effort than seemed worthwhile. Under pressure from competing agendas, doctors made business-effective decisions by deciding to concentrate efforts on narrow but achievable improvements or on those which improved group income, status or best fitted their shared ethos. Work-related problems, which caused absence through ill-health, drew attention to doctors' need to monitor their own health and not to allow a damaging excess of work. In response to illness among medical practitioners, comprehensive services for over-stressed or sick doctors and new training modules on how to consult effectively with health professionals have been made available and formal discussion of personal health issues takes place during annual appraisal (Firth-Cozens, 2003, Oxley, 2004, Knight, 2012).

Practices which support preferred enactment of a medical identity

Tensions between identity, ideals and the realities of lived experience in work and society were evident as narratives linked experience of work with personal factors. An other-ness; family life, leisure activities, even an active interest in medical education and training, was identified and distinction made between co-existing working and non-working identities. With this came new definitions, new '*versions*' or alternative perspectives of self, sometimes related and coherent but also contrary (Goodman, 1978). This was visible as tension between being present at the school gate or committed to running a medical practice, or bringing a sick child to the workplace where switching between consultations and parental caring would appear to maintain 'normal service', less obvious attitudes or moods could be carried home with potential effects on relationships.

Though being a doctor began as a desire for understanding, diagnosing and prescribing some healing regime, that pure clinical frame lost its primacy for several interviewees as

other frames were established in contemporary doctor-patient interactions (Dodier, 1994). Several spoke of dealing with an *administrative* frame which demanded completion of paperwork or computer records; detailed clinical information, requests for investigations, responses to electronically communicated results and letters generated at clinics or external sources. Although this caused irritation, among studies which analysed inter-professional communications for content, promptness and format, little recent evidence could be found to evaluate professional time necessary to produce or act on information received (Hughes, 1991, Closs, 1997).

A *financial* frame was thrust into consultations by reminders of medication costs and restrictions placed on available (i.e. funded) procedures. No longer was it an achievable goal to do everything that could be done for every patient; referral management scrutinised the necessity for referral and the quality of pre-referral preparation received increasing attention. Profitability or earning potential impacted on consultations; computer screens displayed reminders of boxes to be ticked to attract additional payments for information which would not directly benefit patient or physician but were likely to distract. More serious consequences of screen-directed step-wise responses may be an implicit invitation for clinicians to stop thinking about practising medicine but simply respond to IT generated prompts (Heath, 2011).

Several competing frames in addition to clinical, solicitude, psychological and autonomy frames described by Dodier demand a balancing negotiation between conflicting priorities with a risk that although all receive attention no frame is satisfactorily addressed' no frame is satisfactorily addressed. Incompatible priorities, incomplete tasks, tensions between patients' and personal interests, dissatisfaction at being unable to excel in all performance areas, uncertainty as to which frame should be prioritised and exhaustion through trying to achieve perfection, all these exacerbate job stress, decrease job satisfaction and are linked

to intentions to leave work (Simoens et al., 2002, Macleod et al., 2007, Branthwaite and Ross, 1988, Sibbald et al., 2003).

Expected practices, which may not have an identifiable origin or justification, have entered consultations and background activity; patterns of behaviour which have become acceptable norms within health care and are manifested in specific habits, patterns of speech, gestures or even physical movements around a building (Law, 1994). All aspects of work practices come under this influence; styles of speaking, drawing up rotas, 'giving' a paper prescription, booking appointments, whistle blowing, staying at work when unwell, taking work home, referring to guidelines when a patient is present.

While on superficial examination, it may appear that a doctor acts in a distinct and clearly demarcated clinically-orientated world, closer inspection uncovers separation of individual actions into a number of different arenas, each with different motivating actors, different priorities and different effects. Boundary crossing or switching between frames may appear seamless but at times cognitive somersaults become evident because of abrupt leaps from one topic or issue to another; as when a doctor asks questions which bear no relation to a patient's presented problem.

Individually variable preferences and abilities between the interviewed clinicians determined their relative affinity for tasks which must be performed or roles adopted when performing them. Several continued to be enthused by regular contact with patients; embracing opportunities to listen to patients, learn useful skills, make early diagnoses, and advise appropriate treatment choices. Although not preferred, doctors accepted that additional duties necessarily accompanied core tasks; these included ensuring informed choices which permitted patients to accept or reject professional advice, and integrating with team members as colleagues.

As a consequence of structural or organisational changes new obligatory roles emerged; e.g. expectation of clinical leadership with increasing experience and supporting development of medical and non-medical colleagues. Clark proposed that stable leadership from clinicians is a characteristic of effective health organisations…and his re-definition of a 'good doctor' included their roles as good managers and leaders (Clark, 2012). External processes or requirements demanded that someone, by volunteering or by appointment, must attend meetings to represent their department or advise on clinical aspects of service delivery – tasks which some interviewees undertook more readily than others. Roles which nobody wished to have imposed upon them were also identified; clinical duties for which they felt ill prepared, duties which breached personally held beliefs or principles, and tasks which compromised time and attention available for patient care.

In general, narrated evidence suggested that underlying personal traits and a doctor's sense of who they were or wanted to be had a vital influence on how they responded to each role or requirement and how they felt about work as a consequence. A wide range of careers and diversity of working practices in medicine allowed many to choose compatible posts but some remained partially unfulfilled.

Strategies and career intentions

Interviewees shared thoughts about future plans which accorded well with background literature linking job satisfaction to proposed retirement intentions (Simoens et al., 2002, Taylor et al., 2008, Evans et al., 2002, Sibbald et al., 2003). Some indicated clear intent to opt for retirement as early as they felt it financially viable, others envisaged working reduced hours for an interim period while another viewed contractual instability as an imminent threat to his position. Through their reactions came a sense of straining to survive for long enough to make a dignified exit, of plans to disconnect though still several years short of eligibility for a full pension.

To cope with intensity, complexity and changing expectations, doctors had devised many strategies;

Team building; associating with a group of 'like-minded people' who could negotiate their way together through difficult issues provided a supportive workplace, as did employment of 'hand-picked staff' who shared an established ethos. Incorporating skill-mix widened the range of options available since, as indicated previously, attributes of leadership and negotiation did not necessarily accompany medical qualification.

Campaigning for improvements; developing quality standards, involvement in medical education, informative public media presentations, setting up service improvements, trials of more efficient ways of working; all of these occurred as doctors engaged with wider communities. An active role was undertaken in advocacy on behalf of patients or personal representation made in support of legitimate grievances about poor care or advice.

Selective adoption of evidence; if doctors preferred a negotiated, patient-centred approach more than unquestioning acceptance of recommendations of EBM they sometimes chose to discuss a balance of benefit vs. harm with patients more openly and to guide them towards empowered choices.

Selective acquiescence occurred in response to imperfect assessments or regulations, doctors played a 'game' of making money while boosting PCT priorities and thereby gaining their approval. Individuals also declined continued involvement in an organisation whose working practices they found unacceptable (e.g. private provider of OOH services).

Change in career plans; when intended career plans went awry, a change of plan has usually been a viable option within medicine. It was possible to step away if progression through professional exams became a block, or if attitudes or aptitudes did not fit, or if a team proved dysfunctional, or an individual colleague was persistently under-performing.

Doctors could then opt for a role with achievable requirements, or join a new team or link up with a supportive network of more compatible colleagues. Opening doors which were formerly restricted had depended on support of senior colleagues to break into a traditionally male-dominated training programme, but exclusion from a local 'cabal' was blamed for blocked progress.

Selective commitments within an employment contract allowed clinicians to selectively undertake or avoid specific responsibilities and payments which were seen as advantageous to the doctor though not necessarily beneficial to global NHS activity (Maynard and Bloor, 2004, Geue et al., 2009, Whalley et al., 2008b). Preferences included opting-out of OOH work, participation in fund-holding activity, negotiated consultant timetables for NHS and private work and involvement with management to develop services in their locality. If engagement with managers proved too difficult, clinicians withdrew to concentrate on clinical work or switched to other objectives.

Private medical work – was characterised by a contrastingly helpful attitude from staff and was open to a few participants. Belief that private services could be more efficiently run encouraged entrepreneurial involvement outside the influence of NHS managerial attitudes.

In summary, strategies used by doctors proved a fascinating and diverse area for study since each clinician entered with a unique background of multiple factors which collided or coalesced with others and primed them to respond with different approaches in the workplace. Each brought personal opinions on the relative importance of specific aspects of work and had their own view of what was appropriate in clinical and administrative management of the patient; their own developed clinical mentality. Interviewing this group gathered together much information about how doctors liked to work, though often in the negative as they explained how they did not like to work.

Primarily doctors liked to have autonomy, ability to maintain control of workload and to direct their efforts into care which they felt best helped patients. They worked with care pathways for patients requiring specialist investigation or treatment, but needed these to be sufficiently flexible to accept non-standard cases, yet balanced by not directing inappropriate cases at specialist clinics. They required clarity in what they should do for optimal clinical benefit but they also needed time and space to apply experienced judgement where choices between treatments were unclear.

Cohesive teams were an essential feature of effective workplaces and, when goals were shared, clinicians and others could implement good practices. Doctors particularly valued opportunities to discuss cases and procedures with empathetic peers knowing that this non-adversarial approach could be mutually beneficial. Thorough preparation through appropriate training when moving to a new post or changing roles enabled doctors to rapidly become useful members of teams.

9.5 Limitations and prospective sites for further exploration

Limited resources have prevented more extensive exploration of professionals' worlds on a number of counts;

By selecting as participants only those who have continued in an NHS career for 25 years I have excluded those who chose other options or were unable to continue.

Unable to exhaustively describe the totality of medical experience or to claim that these participants necessarily form a representative sample, to adopt purposive sampling across additional specialties for comparative work would necessitate a much larger study.

Similarly, while this cohort study inevitably gathered data from a group where concurrent personal and professional maturation and career progression could be expected to colour the data, new dimensions would be added if a similar investigation included

cohorts of more and less-experienced clinicians since experiences and reflections linked to a particular generational perspective cannot be assumed to be shared universally.

My impression from personal contacts with more recently qualified graduates suggests that other cohorts' perceptions could produce alternative viewpoints built on changing patterns of training and altered expectations. Extension of the study to recent graduates, would add greater confidence when configuring ideas about how the lives of medical professionals are evolving and how well prepared doctors are for work situations they will occupy. Inclusion of doctors who failed to progress or left NHS employment would open a further dimension, exploring whether they moved on to more satisfying careers or regretted their need to reframe expectations.

Scope for future work in relation to ideas of preferred working practices might usefully examine why certain tasks are negatively regarded or viewed as presenting difficulty, particularly where that task is widely considered essential or a core element of modern medical practice. Perhaps greater understanding of underlying factors of misaligned perspectives of doctors and managers could yield more constructive outcomes as NHS services and requirements continue to change. In a similar manner, it could be proposed that selection, teaching and training of future doctors would benefit from being informed by these findings to assist with future-proofing against difficulties with recruitment, retention, low morale and sub-optimal performance through attitudes less suited to NHS work.

I have sought to identify how individuals described themselves as people and as doctors, to discover how they linked their preferences to underlying principles, how they explained chosen career pathways, how they accounted for relationships with colleagues, patients and management and how they justified contentious decisions. In particular I wished to observe how they made multiple connections between many conflicting factors to construct a coherent biographical narrative. Having found marked similarities across in this group

regardless of their final career choice, I believe the influences on work experience may not depend heavily on a particular career path.

Narrative accounts, which as discussed earlier are by nature provisional, uncertain and open to interpretation, were my primary sources of knowledge alongside ethnographically informed analysis, checking findings with medical non-participants and comparison with published and un-published reflections of medical work. Taken together, these strengthened the foundations on which general conclusions were constructed. An observational study of everyday consultations, meetings, practical procedures, and everyday conversations with colleagues would facilitate an ethnographic update on NHS practices. Informed by multiple observations key factors such as observer background knowledge, trust and depth of reflective communication could contribute further to interpretive analysis.

Making this exploratory study I attempted to avoid eliciting only expected findings by probing behind stories and observations (Paillet, 2013). In stories recalling work as junior doctors I elicited tales of fun, camaraderie and engagement in contrast with publicised counter-narratives of overworked overstretched and under-supported juniors. Similarly rather than senior doctors reporting clinical autonomy they described frustrations of isolation, lack of influence, working below their skill-levels and distanced from patients by management duties such as; tendering, budget setting and personnel management. Where it might be expected that professionals united to prioritise patient care, narratives revealed bickering, competitiveness, brinkmanship, deceit or collusion, focus on remunerated tasks, and replacement of a sense of vocation by merely doing a job. All-knowing confidence was tempered by searching for best solutions in a tangle of unclear choices, yet information on these many uncomfortable exposures of sub-optimal practices appeared lacking in prior research.

9.6 What are the implications of these findings for a 21st Century NHS and its stakeholders?

Although investigation of lived experience of a professional group may hold intrinsic interest, linking new perspectives to demonstrate how these contribute to a constructive discussion of an accessible, viable and appreciated NHS assumes greater importance when troubled headlines are a dominant theme. I propose to address four pivotal questions which I believe span key areas of debate:

First, if the NHS exists to serve patients, what do patients want from doctors?

Despite rhetorical statements that patients are at the centre of health care, it appears these words do not translate to actions when an attitude of 'We know what is best for you' prevails (Bensing et al., 2011). Doctors, trained by doctors, may forget how it feels to be a non-medical patient leading to assumptions about what matters most to patients as they approach consultations.

Asked to guess what a 'good patient' wants from his doctor, clinicians produced a five-item wish list; all important questions answered in understandable terms, ability to determine own level of participation in decision, option of full access to health record, right to a second opinion without prejudice, and ability to communicate with health care provider outwith consultations (Jadad et al., 2003). By contrast, from patient representatives primary requirements were; time, eye contact, partnership, communication, and appointments (Boland, 1995, Stone, 2003).

Investigation of consultation dynamics revealed a complex interplay of factors determined by both doctor and patient and the nature of illness under discussion (Street Jr et al., 2005), though analysis of patients' written agendas revealed that most patients had a specific requirement of a consultation; many sought an explanation of something, about half requested treatment, while slightly fewer wanted investigations which may or may not be

appropriate (McKinley and Middleton, 1999). Failure to adequately address patient-generated concerns resulted in dissatisfaction, while doctors who approached with medically-generated agendas could achieve better outcomes through understanding and inclusive negotiation (Middleton, 1989).

Detailed observations from an international patient group confirmed the importance of listening attentively, showing empathy and personal attention as they produced suggested tips for both doctors and patients to modify behaviour before, during and after the consultation (Bensing et al., 2011). Although this study cannot evaluate how effectively doctors have aligned their practice with patient agendas, it seemed clear that patients continued to desire broadly similar qualities from doctors over an extended period of time; new technologies may alter how information is shared, but personalised clinical encounters remained top priority.

Secondly, since doctors occupy key roles in health care, what does the NHS want from doctors?

Wide diversity of professional roles within the NHS makes an all-encompassing list of what is required from doctors imprecise and unhelpful; online advice from NHS Careers proposed aptitudes which may match with practising medicine such as *'concern for people', 'an enquiring mind', 'ability to handle pressure', 'patience',* and *'decisiveness'* (NHS, 2013). As discussed earlier, training programmes for doctors have altered under MMC with an emphasis on documentation of training events attended, skills acquired and an annual review with a senior colleague. Annual appraisal and revalidation activity is in place for established clinicians and GMC regulations define the qualities of an excellent doctor (General Medical Council, 2012, General Medical Council, 2006). During fieldwork, clinicians were poised to expect greater involvement in management through Clinical Commissioning but reflected on interactions with management as a generally less-valued activity; preparation of competitive tenders meant losing team members, cost-cutting did not match

clinical priorities or patients' needs; management influences appeared to re-focus medical activity to meet management agendas but lessened provision for of personalised medical care.

Proposals that guidelines should normally direct how 'cases' are dealt with implies that a doctor could become simply a purveyor of a battery of tests to establish a diagnosis for standardised treatment rather than an experienced clinician thinking through and negotiating individualised care with a patient (Heath, 2011).

Financial incentives/disincentives attached to clinical decisions also raised ethical questions;

- Would or should a doctor continue to seek 'best' negotiated treatment for a patient which may reduce their earned income?
- Could a patient continue to fully trust a doctor engaged in incentivised practices?
- Could centrally approved guidelines (influenced by political or pharmaceutical interests) be sufficiently independent to inform of best known medical evidence?
- Might micromanagement according to state-driven priorities erode professionalism losing a sense of balanced advice tailored to each individual patient?

  (Kramer, 2012, de Zulueta, 2008, McDonald et al., 2007)

The extent to which these issues affect doctor-patient relationships remains a sensitive area which may be increasingly exposed with proposed publication of medical incomes (BMA, 2013).

Thirdly, in view of changes in how health care is planned, prioritised and delivered, should we consider re-shaping medical professionalism?

If a new sort of professionalism is required by the public or necessary to function in harmony with political priorities, then doctors who work under NHS contracts need to be aware of potential conflicts and adjust how they practice. Under current arrangements, perceived pressure urges doctors to refer to a generalised 'evidence base' rather than depend on training, pragmatism, clinical judgement or experience; a patient-centred approach is considered secondary to generalised solutions, constraints on individual care of less importance than population management. On available evidence, this is not what patients prefer or what doctors find satisfying.

Since the health of professionalism cannot be maintained without due attention to ethical practices with regard to self-regulation, implementing ethical practices – regulating selves and colleagues' work within a professionally controlled system implies accountability to other professionals (e.g. in appraisals). Whether or not self-regulatory practices are adequate lies beyond the scope of this thesis; what was evident from narratives was a growing sense of being monitored, audited and evaluated. Traditionally, GMC-defined principles were open to interpretation allowing doctors to make personal judgements in support of difficult decisions – but as a greater body of 'evidence' is collected from clinical practice, might this make it more difficult for doctors to act outside usual limits or less reluctant to take patients' idiosyncrasies, opinions or preferences into account? If doctors' internal controls (i.e. self-regulation) proved ineffective, Freidson proposed that external controls could be expected but with the proviso that;

> '*a truly adequate system for controlling a service to human beings must be able to control the spirit in which performance is given, the stance toward work'* (Freidson, 1975, p:252)

Yet the point at which doctors judge decisions ethically acceptable seems unclear and responses to concerns they raised have not been helpful. Interviews confirmed that training and early clinical experience shaped how doctors developed professional values. They continued to enjoy interactions with patients, liked to spot abnormalities and achieve positive results. For some an emphasis on delivering a better all-round service to patients became a driving force towards provision of innovative and cost-effective practices. Across the interviews, there was much discussion of maintaining levels of performance or achieving targets, which in most cases triggered a fairly pragmatic response from clinicians but with consequences for how they organised work patterns, feeling fulfilled when they succeeded as healers and helpers.

The 2005 RCP Working Party Report confirmed that modern professionals found it difficult to define how they perceived characteristics of professionalism, but readily recognised their absence (Royal College of Physicians, 2005). The report considered professionalism to be comprised of a '*set of values, behaviours and relationships'* and identified it as the characteristic which '*lies at the heart of being a good doctor'* and the basis for *'the trust that the public has in doctors'*. In this evaluation of medical professionalism a vocational commitment to integrity, compassion, continuous improvement, and partnership working with patients and colleagues were non-negotiable components.

Recognising that not everything fits neatly into the examining lenses of league table ratings and ticking of boxes, the RCP report proposed the development of relationships with managers which would facilitate effective provision of health services - an outcome contingent on inherent accountability within the medical profession in tandem with a multi-level corporate responsibility – ideas reiterated by the recent Berwick Report (The National Advisory Group on the Safety of Patients in England, 2013). Due attention to education of junior doctors in medical leadership is implied in this objective, an objective which some

believe essential to support future streamlining while maintaining quality in commissioning within the NHS (Brown et al., 2012).

In arguing a case for better understanding of development of characteristics of professionalism, Nicholson et al. proposed that a key requirement of a good doctor lay in being able to make a judgement in the face of uncertainty (Nicholson and Raval, 2009). Up-to-date knowledge and skill form the basis for this judgement, but tacit knowledge gained through experience is also necessary. This complex decision-making is characterised by sound professional judgement and actions depicted by the *'practical wisdom'* of mature practitioners and was mentioned or implied by interviewed doctors as a valued benefit of many years of medical practice.

Fourthly, whose agenda takes precedence when re-considering how doctors work?
Reversing gaze from a professional perspective to that of a (generic) patient points towards previously listed priorities. Rather than value highly technical competencies, patients want a doctor who works to understand them on a personal level and can provide reliable guidance on health issues, supported by skills of listening, sorting problems and who will offer consistent availability (Boland, 1995). Reducing health inequalities through realistic evaluation in consultation with a trusted GP of the balance of risks and benefits available from treatment, moves towards meeting WHO objectives of achieving equity and reducing possibilities for premature death, disability and disease. Those who form close relationships with patients are empowered to support them in strategic life decisions and will have greater influence on patients' perceptions of health.

Despite recent recommendations and exhortations from the Francis and Berwick reports, few of the above preferences appear to match established NHS priorities. Further, the introduction of audits, guidelines, regulations etc. have done little to enhance the doctor-patient consultation and much to get in the way. Incentives increase the likelihood of neglect

of other less-scrutinised areas and important patient-centred priorities are unrewarded. Provision for patient safety through newly imposed rules may not achieve improvement since there is no substitute for constant comprehensive internal and peer-accountable regulation of the activities of doctors. In the words of Sir Cyril Chantler; *'medicine used to be simple, ineffective and relatively safe, now it's complex, effective and potentially dangerous'* (quoted by G Catto (Catto, 2007)). The duties of a clinician to maintain sufficient depth and breadth of focus demands adequate training, support and continuing commitment to standards which cannot be exhaustively or objectively measured; recommendations of culture change and transparency are immense in both conceptual and practical implications (The National Advisory Group on the Safety of Patients in England, 2013, NHS Confederation, 2013).

9.6.1 Implications for major stakeholders

Public

While it may be tempting to view the general UK public as current or potential patients, disparity of health experience and inequality of access to services allow specific sectors of society to relate less closely to the status of 'patient' than others and remains problematic despite actions to reduce the gap (Mackenbach, 2012). Having less personal involvement in contentious funding and moral issues, these individuals may differ on what they believe it is fair and reasonable to expect from a taxation-funded NHS. Objective debate requires understanding of relative risks, possibilities and costs and tends to become contentious as 'experts' disagree on interpretation of detailed evidence (Genazzani, 2002, Reeves et al., 2005). This research adds little to that debate; doctors have expressed mixed views on what NHS funds ought to support and reported advocacy when decisions penalised individual cases. At best, a more rounded knowledge of the balances and professional responsibilities

involved in medical practice may increase general understanding of multifactorial decision-making.

Patients

Given clear indications that patients continue to trust and prefer personal engagement with their medical advisors, it seems important to observe that NHS doctors are concerned that increasingly managed health care may damage personalised encounters. Since different approaches to consultations are appreciated by different patients, growing uniformity through greater application of protocols and guidelines may reduce meaningful interactions; doctors motivated by biophysical targets may be more readily distracted from attentiveness to patients' priorities. Clinicians' relationships with patients operate through a permitted professional authority but diminished professional autonomy through restricted patient pathways, treatments, access to services etc. limit how clinicians can manage cases. Fear of censure by acting outside expected norms, while sometimes appropriately protective, may inhibit doctors developing innovative approaches.

NHS managers

As indicated earlier, fundamentally different perspectives jeopardise constructive working relationships between clinicians and non-clinical managers; poor awareness of motivational drivers of another group can inhibit constructive dialogue or facilitate engagement for effective solutions (Clark, 2012). Frank views expressed by doctors in this study may not make comfortable reading for NHS managers but represent strongly held views based on real-life cases, though they are unlikely to appear in management journals and at odds with reports of managers perceptions of doctors (Snow, 2013). Shifting dynamics and professional drivers of relationships between doctors and managers would merit deeper exploration.

Political bodies

Political influence cannot be removed from the NHS while funding is drawn from public sources; formal and informal links supply information relevant to policy development. Perhaps greater questions still need to be asked of the roles of companies who develop ground-breaking medical technologies and new pharmaceutical products which may influence political priorities.

Medical educators and students

Medical schools have altered selection processes to increase evaluation of students' attitudes at entry and discourses around professional behaviour are more prominent. However, it is not easy for prospective students to form impressions of how their career may progress or what challenges they will most relish. I believe that Chapter 4 confirms that neo-professionals who encounter positive and inspirational influences carry those with them as they progress; those who experience damaging episodes may not fully escape their detrimental effects. Bearing in mind high levels of professional support recently requested by junior doctors from the BMA, awareness of possible pitfalls and of how to maximise their chances of career satisfaction may help reduce casualties (Peters, 2011).

Doctors

Based on conversations with many colleagues, I suspect that little data in this thesis is new or surprising to established doctors; nuances may differ from one specialist area to another but the general picture is familiar. Responses to the issues raised for patient care have been mixed and motivation necessary to influence responses to unwelcome change appeared patchy within this group. Their tendency to look forward to retirement may in part explain personal disengagement; a useful addition could emerge from further investigation to gauge the orientation of younger cohorts whose interests affected to a greater degree.

9.7 Conclusions

The stories told in these interviews portrayed a professional group who were aware of changes in their position in society, in relationships with health service managers, with patients and amongst colleagues. Analysis of their stories confirmed them as individuals with underlying values, motives and ambitions whose working practices and relationships were affected by this complex combination of factors. They have indicated how they preferentially enacted an interpretation of a 'good doctor' but regularly encountered difficulties, particularly with growing micromanagement.

In progressive changes in health service systems and clinical practices, I believe an emerging fresh turn in the sociology of contemporary medical practice awaits elucidation. Organisational structures have changed the manner in which medical services are directed by government and detailed information is made available through IT to health service managers who direct practical interventions and set priorities. Within many work situations, teams of doctors merge more closely with other health service personnel whose training is not aligned with medical training and who may retain conflicting or complementary priorities in dealing with patients which demands good communication and appropriate adaptability.

The compact with patients has been altered by increasing access to information and more open questioning of traditionally authoritative voices. Social pressure to be more actively involved in decisions affecting health, yet a relative lack of balanced debate about how limited funds should be spread in provision of services, leads to tensions and dissatisfaction. Concepts of professionalism appear to have altered; prestige and trustworthiness of past generations of doctors resulted from claims of realities based on scientific evidence, yet flawed and incomplete understandings of illness, medical interventions and the complex interplay between mind and body are demonstrated by contradictory new guidance, misleading new evidence and emerging links between psychological and physical health (Shojania et al., 2007, Ioannidis, 2005, Kroenke, 2003).

Key traditional characteristics of professional status are progressively diminished as an ability to act autonomously is curtailed by policies, departmental guidelines and budgetary restrictions. Innovative developments must be made with full consideration of possible consequences and in a defensible manner. When colleagues' performance is deemed to be poor this may be remedied only when objectively judged standards are breached while, in practice, absolute standards of performance are not easily determined.

On a personal level, doctors who recognised their own limitations and the factors which continued to motivate their work reflected negatively on what they perceived as less committed work behaviours exhibited by some junior colleagues. Without necessarily being convinced by improvements promised by newly introduced audit of care systems and specific treatment recommendations, they nonetheless responded to targets by achieving them. They tended to only selectively expose assessment standards which represented sub-optimal performance, and aimed to effect strategies to survive in the workplace.

Research such as this offers the beginnings of an empirical grounding for new understandings of contemporary professionalism and of the nature of medical practice. As examples of ordinary medical practitioners whose invitation to participate was based solely on their membership of a university cohort, I believe they together presented a balanced though incomplete picture of the spectrum of experience in NHS work during recent years. I have argued that by allowing them to choose the subject matter and emphasis of their narratives they have been enabled to focus on issues of greatest individual significance, interest or concern. Returning with accessible poetic representations of stories to medical audiences revealed reassuring levels of self-recognition and no dissonance.

It is in the interests of patients that doctors remain accessible and trusted professionals; an objective which Freidson encouraged by suggesting that doctors must persuade society, politicians, managers, patients…and everyone, that '*the fate of patients is tied to the fate of*

their doctors' (Freidson, 1970). If by not dwelling on selfish self-interest, today's practitioners can demonstrate that the best way to build a strong and responsive NHS is to maintain a motivated, thinking, ethically responsible and forward-looking workforce, they may retain or regain a role of professional responsibility and limited autonomy in working for the welfare of patients.

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Appendices

Appendix 1 NHS Timeline

		APPENDIX 1 NHS TIMELINE	
Year	Career stage	Prominent NHS-related changes, events or activity	UK Government
1948		NHS established	
1976		Health Services Act; attempt to phase out 'pay-beds' and to achieve full time, 'no-private practice' consultants	
1979		Depressed economy. Pressure to limit public spending. NHS cuts and efficiency savings	Conservative government elected
1980		Health Services Act; reversed the flow of restrictions on private practice	
1983	Graduation	Griffiths NHS Management Inquiry and Mental Health Act	2nd consecutive Conservative govt.
1984	Full registration	Warnock Report on Human Fertilisation and Embryology. Implementation of general management function, Limited List prescribing	
1985		Enthoven's Review of the NHS, WHO targeted Health for All	
1986		BSE crisis. Project 2000. Primary Health Care Green Paper. Cumberledge Report on community nursing	
1987	First GP posts	Promoting Better Health White Paper. Achieving a Balance (re medical manpower). Financial crisis in NHS	3rd consecutive Conservative govt.
1988		Community Care, an agenda for action. Nurse regrading via Project 2000 agreed	
1989		Working for Patients (NHS Reforms). General management in FPCs. Caring for People	
1990		New GP Contract. Societal changes casting patients as consumers with GPs as service providers	
1991		GP Fundholding First Wave	
1992		NHS Patient Charter Clinical Standards Advisory group.	4th consecutive Conservative govt.
1993		Plans for re-validation of doctors. The Health of the Nation. Tomlinson Report (London Health Services)	
1994		Reduction in number of Health Regions from 14 to 8	
1995		GP OOH dispute. Policy document - Renewing the NHS. Restructuring of the internal market	
1997		NHS Primary Care Act	Labour, government elected
1998		A First Class Service, Green Paper. Bristol cardiac surgery criticised. Information for Health strategy. NHS direct	
		Independent inquiry into Inequalities in Health. European Working Time Directive initiated	
1999		Clinical Governance systems emerged to improve quality and accountability. NICE established	Scottish and Welsh Assembly elections
		Abolition of GP fundholding. Nursing staff shortages. Saving Lives:Our Healthier Nation White Paper	
2000		Shipman murders uncovered. The NHS Plan White Paper. Walk-in centres. NHS- private sector concordat	
		Reforming the Mental Health Act White Paper	
2001		Organ Retention Report. Health and Social Care Act, Shifting the Balance of Power. Hospital star ratings	2nd consecutive Labour govt.
		Wanless preliminary report on NHS finance	
2002		NHS Reform and Health Care Professions Act. SHAs replaced HAs	
		PCTs took over commissioning. Funding increased. Wanless Review. NHS Foundation Trusts proposed	
2003		National Service Framework for Diabetes. GPs and Consultants new contracts agreed. Agenda for Change launched	
		Building on the Best; a patient choice agenda	
2004		Payment by Results. 1st Wave Founation Trusts. NHS Improvement Plan. Choosing Health White Paper	
		Healthcare Commission. Modernising Medical Careers. GP 2004 Contract implemented (including QOF)	
2005		Creating a Patient-led NHS	3rd consecutive Labour govt.
2006		Star/league tables abolished. Our Health, Our Care Our Say White paper. Shift to design services around patients	
		Best Research for Best Health, a new national health research strategy. SHAs and PCTs reduced in number	
2007		Framework for Action, Lord Darzi. Reduced rise in annual funding	
2008		Regional (Darzi) reviews. Final report High Quality Care for all	
2009		NHS constitution. Mid-Staffordshire Hospital report on poor care	
		Care Quality Commission took over from Healthcare Commission	
	Interviews began	European Working Time Directive implementation completed	
2010	Interviews completed	Equity and Excellence, liberating the NHS. Healthy Lives, Healthy People - public health White Paper	Coalition government elected

Appendix 2 Open request to participants and response sheet

[address]

6th March 2009

Dear

An exploration of the narrated experience of doctors in a changing NHS

As someone who, like you, graduated from Xxxxx Medical School in 1983 with an MBChB, I'm writing to request your participation in a research project which I am undertaking as part of a research PhD in the Faculty of Medicine at the University of Liverpool.

In the 25+ years since we qualified the NHS has changed in many respects and I would like to collect your stories of how you have experienced change in the NHS and whether this has impacted on your working life. To achieve this, I am attempting to contact as many as possible of our year group with this same invitation.

If you are interested in taking part in the research, I'd like to arrange to visit you for a one hour interview, at a place and time convenient for you.

You can be assured that all our interactions will be dealt with in the strictest confidence before during and after the project, in accordance with outlines submitted in obtaining the necessary ethics and research governance approval.

The enclosed information describes the plan in more detail and I will happily answer any further questions you may have. If you could please use the SAE provided to return the enclosed response sheet to let me know whether or not you wish to take part, I will respond quickly to the positive replies.

I hope to hear from you soon.

Best wishes

Sharon Spooner

Sharon Spooner, PhD student, Health and Community Research Unit, Thompson Yates Building, Quadrangle, Brownlow Hill, Liverpool, L69 3GB, Tel 0151 794 5503

An exploration of the narrated experience of doctors in a changing NHS

From _____

I am/am not interested in finding out more about participating in this research project

Preferred contact address_____

_____

_____

_____

_____

Preferred email address _____

Telephone contact if preferred_____

Send to

Sharon Spooner
PhD student
Health and Community Research Unit
Thompson Yates Building
Quadrangle
Brownlow Hill
Liverpool L69 3GB Tel 0151 794 5503

Appendix 3 Research Participant Information Sheet

Title **An exploration of the narrated experience of doctors in a changing NHS**

You are invited to take part in a research study which is part of my PhD and focuses on your experiences as an NHS doctor.

In order to fully appreciate the background to this research you should read the following information before making a decision about your involvement.

1. What is the purpose of this research?

I want to explore the experience of NHS doctors through the eyes of clinicians who have worked through periods of immense change throughout their NHS career. I believe that quick questionnaires have a limited ability to reflect the range of doctors' experiences and this qualitative study forms the basis for my research PhD.

2. Why have I been chosen?

I will be recruiting graduates from Xxxxxx University Medical School in 1983. I do this to select a cohort who now have considerable working experience and who appreciate the importance of research in influencing their work situation now and for maintaining an effective NHS in the future. Collecting stories such as yours is vital to this research.

3. What will happen if I take part in this research?

a. Phase 1

You will be committing to one or two face-to-face interviews which will be audio-recorded, at a venue convenient for you where there is sufficient privacy for you to talk freely and quiet enough for audio-recording to be successful. I expect interviews to last from 30 minutes to 1 hour normally. This is dependent on the time you can make available. The choice of whether to conduct the interview in one session or by arranging a second interview will depend on the arrangements which best suit the participant and a shared view that it appears worthwhile to continue as further data remains available for exploration.

b. After the interview I will review the material and may request clarification from you, probably by email, of any points where I find myself unsure of your intended meaning.

c. Phase 2 OPTIONAL

Following the interviews (or if no interview can be arranged) I will invite you to write about your thoughts around how it is/has been for you working in the NHS particularly in view of the changes you experience.

4. What will be done with the findings?

I will analyse the data I collect through recognised qualitative methodology and incorporate my interpretation in my thesis. A short report will also be available to summarise my findings. This will be widely circulated in academic and medical circles.

5. Is there a benefit or cost to me by taking part?

You should make a considered decision regarding your participation since the process of thinking through issues can be challenging and it is possible that this may de-stabilise your views. However it should not be forgotten that in finding a means by which to express your working life an increased sense of perspective can be a very positive result.

6. What happens after the research is completed?

I expect to complete my entire data gathering from each participant within a 2-4 month period with the aim of causing minimum disruption. However, as I need to continue with my own part-time clinical work, I will not be able to interview everyone immediately but will spread the interviews over a 12-15 month period arranging to meet some participants earlier in the study than others. This means that, for some participants active involvement may not begin until late 2009 or into 2010.

7. Will my contributions be anonymous and confidential?

Your input will be linked to a pseudonym and nobody apart from myself will be able to identify any individual contribution. Any major identifying characteristics will be dealt with to avoid any chance of loss of anonymity.

8. If I agree to participate can I withdraw if I change my mind or circumstances change?

You are under no obligation to participate and you may withdraw at any time without offering a reason.

9. Who can I contact for further details?

Contact me for any further information through the address, telephone number below or more rapidly by email

10. What do I need to do to participate?

To participate please fill out the enclosed response form and return as soon as possible. If you require further information I will be happy to make contact with you at your request. After you have been fully informed I will request your written consent before proceeding further.

Sharon Spooner PhD student
Health and Community Research Unit
Thompson Yates Building
Quadrangle
Brownlow Hill
Liverpool
L69 3GB

Tel 0151 794 5503

Appendix 4 Consent Form

CONSENT FORM

Title of Research Project: An exploration of the narrated experience of doctors in a changing NHS

Researcher(s): **Sharon M Spooner**

	Please initial box
1. I confirm that I have read and have understood the information sheet dated [DATE] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.	☐
3. I am aware that interviews in this study will be recorded and transcribed, and that unattributed quotes from the interviews or written contributions may be used verbatim in reporting on the research.	☐
4. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	☐
5. I agree to take part in the above study.	☐

_____	_____	_____
Participant Name	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

The contact details of lead Researcher (Principal Investigator) are:

Sharon Spooner
PhD student, Health and Community Research Unit
Thompson Yates Building
Quadrangle
Brownlow Hill
Liverpool
L69 3GB
Tel 0151 794 5503

Appendix 5 Research Ethical Committee Approval

South Staffordshire Local Research Ethics Committee
Mellor House
Corporation Street
Stafford
ST16 3SR

Telephone: 01785 221119
Facsimile: 01785 221279

04 March 2009

Mrs S. M. Spooner
Xxxxxxx
Xxxxxx
Xxxxxx
XX XXX

Dear Mrs Spooner

Full title of study: **An exploration of the narrated experience of doctors in a changing NHS**
REC reference number: **09/H1203/1**

Thank you for your letter received on 6th February 2009, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*	
Proposed Notice for Alumni Newsletter		05 December 2008	
Sources of support for Doctors		05 December 2008	
Reflective Writing Guidelines Phase 2	1	05 December 2008	
CV of Supervisor		05 December 2008	
Response document	1	05 December 2008	
Participant Consent Form	1	05 December 2008	
Participant Information Sheet	1	05 December 2008	
Letter of invitation to participant	1	05 December 2008	
Interview Schedules/Topic Guides	Phase 1 V1	05 December 2008	
Peer Review		05 December 2008	
Covering Letter		05 December 2008	
Protocol	1	05 December 2008	
Investigator CV		05 December 2008	
Application		05 December 2008	
Response to Request for Further Information		03 February 2009	
Participant Consent Form	2	22 January 2009	
Participant Information Sheet	2	22 January 2009	
Letter of invitation to participant	2	19 January 2009	
Protocol	2	03 February 2009	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review –guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

09/H1203/1	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Professor Tim Reynolds
Chair

Email: sandra.halden@ssh-tr.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Miss S Fletcher, Research Governance Officer, Foresight Building, 3 Brownlow Street, Liverpool, L69 3GL*
Ms N Marriott, R&D Officer, Stoke on Trent PCT

Appendix 6 Topic suggestions

Topics which may provide interesting starting points at Phase 1 interview

Clinical responsibilities
Clinical contact in surgery/clinic
Professional judgement/ professional identity
Managing expectations and delivery of care
Working relationships
Variety in case-load
Tell me about your clinical responsibilities, are they much the same now as when you started in this post?
Has your own view of what you are achieving or aiming to achieve changed?
Do you feel the pressures are different now?
How is your team-working?

Related issues
Clinical needs of patients
Maintaining identity/ self esteem
Patient charter influence
Expectations by others of your role
Media/ publicity/ complaints etc.
Supportive structures
Has your ability to respond to clinical need changed?
Have your objectives changed or been forced to change?
Do you feel change has made you more pressured or more supported?

Working hours
Organisational NHS changes
Treatment priorities
Availability of funding
Work/ life balance
Flexibility/ control over workload
Payment structure
How have changes in working hours affected you?
Can you influence decisions to direct funding for the benefit or your patients?
Are you happy with the priorities as presented to you?

Multiple roles, multiple relationships
Clinical governance, appraisal, re-validation etc.
Clinical supervision
Role of management
Tell me about your various roles and what they mean to you
How do you view the trend towards a regular appraisal process?
Have you protected time for updating your knowledge, teaching etc.?

Working environment
Physical space
Supplies of essential equipment and other resources
Accountability for efficient working
Does anything limit what you can achieve for patients or colleagues at work more or less than previously?

Administration

Hospital referrals and paperwork/ letters to GPs
Practice administration/ Hospital management roles
Are you communicating well across specialties and between primary and secondary/tertiary care environments?
Has the proportion of time absorbed by paperwork changed?

Work: home interface and social life
Demands of your job on family life/social life
Are you content with the balance you can achieve now; is it better or worse than a few years ago?

Adapted from

Cooper CL, Rout U, Faragher B. Mental health, job satisfaction, and job stress among general practitioners. *Br Med J* 1989; **298:** 366–370. and

Warr P, Cook J, Wall T. Scales for the measurement of some work attitudes and aspects of psychological well-being. *J Occupat Psychol* 1979; **52:** 129–148.

Appendix 7 Proposed interview questions

CRQ		What can be discovered by means of narrative inquiry about the working experience of NHS doctors through a 25 year period of change?	
TQ 1		Can doctors illustrate their experience with stories and examples?	
		Question	Purpose/ To elicit response about:-
	IQ1	Can you tell me about your work as a doctor? Can you tell me about your medical career, starting 1983?	Biographic story Positioning Building rapport Catching-up on progress
	IQ2	Thinking back around the time you graduated, can you tell me about your ambitions/aspirations then?	Aspirations Aims Expectation of self
TQ2		How prominent in their narratives are stories relating to changing situations/systems/ practices?	
	IQ3	Can you tell me about any pivotal moments or events which you feel really shaped your career?	Incidents Inspiration Disappointments Imposed blocks/changes Success/failure stories Identify pivotal points
	IQ4	Explore feeling re any such experiences	Reflexive thinking Self-recognition Self-justification Blame allocation Enjoyment stories Explored personal principles
	IQ5	Are there patterns or circumstances which have been particularly important to you?	Imposed blocks/changes
	IQ6	Can you tell me about times when you have had to adapt to change or facilitate change?	Empowerment/subjugation
	IQ7	Can you tell me about any time when you remember working in a way which would undermine changes which were intended by others?	Subversion Imposition of own ideas Difficulty in teamwork/adapting to new situations
TQ3		How have work experiences affected them in terms of career choices and professional satisfaction	
	IQ8	Can you tell me in what respect your career developed most successfully? Explore if other respects should be voiced too	Success stories Achievements
	IQ9	Can you tell me what has assisted in your achievements or which worked against success? Explore how this happened?	Awareness of others and their role in career Opinions
	IQ10	Can you think of an example of an event that shows up whatever it is that centrally motivates you in your work?	Motivating factors Awareness of relative failure

	IQ11	In what ways do you feel able to influence how you work now?	Ownership of changes Management roles Career development
	IQ12	Can you tell me about any moments/instances when you felt like leaving the NHS/your particular job?	Satisfaction lows Emotional investment
TQ4		Do they see any changes in their own value systems and aspirations over time?	
	IQ13	Can you tell me about any specific ways in which you have been affected by changes in your work role/roles? Or Are there any roles which have changed for you and changed how you see work? Or Has anything changed about your role which has significantly affected your work?	Job/role changes Impact of change
	IQ14	Can you recall specific situations in which you have reacted or conducted yourself differently as compared with how you might have done several years ago?	Changing expectations Changing roles Maturity
	IQ15	Which aspects of your work do you enjoy most/least? Explore aspects mentioned	Why do this job? What make them tick?
	IQ16	Can you tell me about an incident which gave you a real buzz?	Hearing the buzz Enthusiasm Commitment Vocation
	IQ17	Can you tell me about any experiences which rocked you?	Coping with disaster Negative experiences Support structures?
	IQ 18	Is there anything you wish you had done differently in your career? And lead on to the story...	Regrets

Appendix 8 Probing questions – iterative interview development

When you graduated, **what sort of doctor did you think you would be**?

Can you tell me about any **pivotal moments or events** which you feel really shaped your career?
Can you tell me in what respect your career developed most successfully?

Can you tell me about any moments/instances when you **felt like leaving** the NHS/your particular job?

Can you think of an example of an event that shows up whatever it is that **centrally motivates** you in your work?

Can you tell me about an **incident which gave you a real buzz**?

Can you tell me about any **experiences which rocked you**?

What can you remember of your feelings?

What did you want to do at the time?

What reasons did you believe lay behind x

What did you **tell other people** about x?

How do you interpret what was going on?

You say you felt x, **just what kind of feeling** was that?

Having been where you've been and seen what you've seen, is there anything that **causes you concern for the future**?

If I was to **ask your friends and family** about what work was for you, what do you imagine they would say?

What would you like to see as the **'happy ending** 'to your professional career?

Is there anything **you wish you had done differently** in your career?

How did it feel?

Appendix 9 Participants' backgrounds and career trajectories

To safeguard confidentiality, additional information about the backgrounds and career trajectories of participants is in composite form which indicates their career paths and allows general comparison of their profiles with national data. Specific details of postgraduate qualifications career progression was not consistent with my methodology and only discussed if they mentioned it or if essential for my understanding of their narrative. My summary of their careers is therefore partial and intended to be indicative only.

As noted in Chapter 4, one year as pre-registration JHOs preceded further training, programmed or self-organised. The broad range of posts participants spontaneously mentioned are shown in Table A1 though time spent there was mostly unspecified;

Accident and emergency	Paediatrics
Anaesthetics	Pathology
Elderly care	Prison Medical Service
General medicine	Psychiatry
General surgery	Psychogeriatrics
Gynae-oncology	Public health
Obstetrics and gynaecology	Substance abuse
Oncology	Transplant surgery

Table A1 Specialties mentioned by one or more participants

Of the eight participating GPs, I was aware some initially undertaken specialist training; General Medicine (2), Surgery (1), Surgery and Public Health (1), Anaesthetics (1). Reasons were not always offered for their eventual choice of GP work though one rejected surgery after failing exams and becoming disenchanted, two admitted choosing general practice because they could avoid further exams (having failed in anaesthetics and general medicine).

Table A2 provides comparative socio-demographic information for interviewed doctors and NHS England statistics. The proportion of GPs:specialists included was above the national but matched the proportion of R&D approved positive respondents.

Table A2 Socio-demographic comparison of participants with NHS England statistics 2010 (headcount methodology)

ID	Gender; and Full- or Part-time	GP/Specialty	Area	Proportion of 50-54 age band in local workforce	Proportion of males in 50-54 group in speciality (NHS England statistics)	Managerial role	Medical educator	Research active	Medical family
						Y = yes N = none disclosed			
A	M; F/T	GP	Yorkshire & Humber	17%	62%	Y	N	N	N
B	M; F/T	GP	Yorkshire & Humber	17%	62%	Y	Y	N	Y
C	F; P/T	GP	East Midlands	17%	62%	N	Y	N	N
D	M; F/T	GP	East Midlands	17%	62%	Y	Y	N	N
E	M; F/T	GP	South East Coast	18%	62%	Y	Y	N	Y
F	F; F/T	GP	South East Coast	18%	62%	Y	Y	N	N
G	F; P/T	GP	South West	20%	62%	Y	N	N	N
H	F; F/T	GP	NHS Scotland	Not accessible	62%	Y	N	N	N
I	M; F/T	Anaesthetics	NHS Scotland	Not accessible	70%	N	Y	Y	N
J	F; F/T	Gynaecology	East Midlands	20%	60%	Y	Y	Y	N
K	M; F/T	Histopathology	West Midlands	18%	66%	Y	N	Y	N
L	M; F/T	Psychiatry	South Central	17%	56%	Y	Y	Y	N

Sources of information; http://www.cfwi.org.uk, http://www.hscic.gov.uk/home, personal communication with HSCIC and personal details disclosed during interviews. By estimation, all participants were included in 50-54 age-band.

Progress to GP Partnerships varied; one was approached before he had completed his VTS, six seemed in their first practice, two spent time in development posts or as salaried GPs; one had twice for short periods been a partner before leaving abruptly and returning to salaried work while the other later found a longer-term partnership. Two GPs have reduced workload or been absent due to ill health, and one for family commitments. Six GPs were working full-time, though some was non-clinical.

Each of the consultants appeared to have made a firm early decision to enter their specialty though while one performed excellently at every stage another required several attempts at his final professional exam. Progress through training was mostly smooth though there were difficulties for two doctors due to suspected or voiced discrimination. All have been working full-time (or more) and one took on significant management responsibilities for a significant period. All of them reported considerable changes in their roles and duties as hospital policies and funding availability varied. All consultants have been involved with training junior doctors; two became examiners for their specialist colleges.

The list of additional roles and appointments below includes items which were mentioned during interviews to indicate the scope of their interests and experience.

Appraisal for other doctors	Prescribing Committee Member
Audit committee work	Private medical work/business development
Commercially funded research	Research Council funded clinical research
Committee work; multiple areas	Roles in Quality Assurance
Examiners for Royal Colleges	Teaching medical students
Leadership of a Royal College	Tendering for services (Foundation Trust)
Lecturing, undergraduates/postgraduates	Training GPs
Management roles	Training junior doctors in a specialist area
PCT project leadership	

Table A3 Range of roles and appointments disclosed during interviews

Appendix 10 Quality and Outcomes Framework; a summary

Introduction of the OQF signalled a fundamental shift in the activities by GPs could boost their income and because of the influence it continues to have on general practice consultations, merits more detailed explanation.

The QOF arrived at the same time as ultimate responsibility for 24 hour care transferred to local primary care providing organisations rather than a compulsory part of the GP contract. Opting out of providing 'out-of-hours' cover meant reduced income but the QOF offered a substantial optional boost to offset this if the practice could demonstrate the required achievements. Points earned under QOF fell into three main categories; organisational, patient experience and clinical.

Organisational indicators required GPs to produce evidence about compliance with pre-determined standards of;

Records and information about patients (legible, full and with basic medical data)

Information for patients (clear details on who to contact and how to access GP services)

Education and training (as appropriate for all staff, reviews of significant events, appraisal and personal learning plans)

Practice management (e.g. procedures for IT back-up, staff employment practices, protocols for links to social services and for child protection purposes, infection control measures)

Medicines management (recording all prescriptions, procedures for re-issue of regular prescribed items, proper storage of emergency drugs and meetings with a prescribing advisor)

The **Patient Experience** section of QOF dealt with average consultation duration and required an annual approved survey be carried out allowing a proportion of patients to report their levels of satisfaction with access to GPs and the care they received. The doctors must

also show that this survey had been discussed internally and with the Patient Participation Group (PPG) or a non-executive director of the primary care organisation (PCO)
Each section of the above areas allowed the practice to accrue points on completion.

However, the greatest impact from the QOF for most GPs, Practice Nurses and patients centred on **Clinical Indicators**. For each of 10 conditions included in the 2004 QOF, the practice must create a disease register; a data set of all registered patients with that condition. For these patients, specific monitoring information must be recorded on the IT system at set intervals, using specific codes. Each subsection of disease management areas was allocated a number of points. While some points could be earned for simply recording a measurement or that a check had been carried out, a greater proportion of points required that recorded quantitative data must meet target levels for a specific percentage of patients between minimum and maximum thresholds to achieve a proportion of the maximum points available for that parameter

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Additional Services such as cervical screening, child health surveillance, maternity and contraceptive services fell under another section of the QOF and practices could choose to include a range of Directed Enhanced Services such as minor surgery, childhood and influenza immunisations together with National Enhanced Services to include anticoagulation monitoring, intra-partum care, minor injuries services and more specialised services for homeless patients, alcohol and drug misusers, patients with multiple sclerosis and others. This extensive list allowed GPs with an interest in these areas to profitably develop services according to local need.
Out of a total of 1050 points the Clinical Indicators accounted for 550, Organisational 184, Patient Experience 100, and Additional Services 36 with a further 180 from an Access bonus and based on calculations of Holistic Care and Quality Practice.
Clinical indicators were transferred electronically for analysis and once the system was fully operational practices could easily monitor progress. Those starting from a high level of IT

usage or who invested more heavily by employing staff to review patients or manage the data could more rapidly improve on these scores. Fine-tuning clinical management required the engagement of GPs and PNs and their ability to persuade patients to attend reviews and take advised medication or alter health-related behaviour. IT systems provided reminders to clinical staff of any criteria which remained unachieved and could potentially be discussed in each new consultation. Regular audits could be used to monitor whether the highest targets and therefore maximum income could be achieved by the end of the QOF year.

Subsequent revisions of the QOF added to the list of diseases included and shifted the balance of points which could be gained from each area but largely retained the initial structure.

Additional details available in; NHS Confederation and British Medical Association 2003, New GMS contract 2003: investing in general practice, London, BMA/NHS Confederation.

Appendix 11 Research Outcomes; Papers presented and publication

Publication

Identity, Ideals and the Inevitable; Stories of experienced doctors which reveal personal perspectives behind professional actors in *The Many Facets of Storytelling; Global Reflections on Narrative Complexity* Edited by Melanie Rohse, Jennifer Jean Infanti, Nina Sabnani and Mahesh Nivargi and published at http://www.inter-disciplinary.net/publishing/id-press/ 2013 ISBN 978-1-84888-166-2

Papers presented

1. Public Lives, Private Lives: New Research Across the Disciplines, Postgraduate Research Conference University of Liverpool 2nd June 2010

2. RCGP Midlands Faculty Annual Faculty Research Meeting, North Staffordshire Medical Institute, Newcastle under Lyme 10th June 2010

3. Salford Postgraduate Annual Research Conference (SPARC) June 2010

4. Poster presentation of poetic data, Annual RCGP Conference, Liverpool October 2011

5. Social Science from a medical perspective…in 5 minutes, at launch event for Social Sciences Collaborative in Health and Medicine, University of Liverpool 24th January 2012

6. Identity, Ideals and the Inevitable; Stories of experienced doctors which reveal personal perspectives behind professional actors. Storytelling: Global reflections on narrative, Prague, 14th May 2012

7. Poster presentation of poems. Ethnography Workshop for PGRs, Liverpool 29th August 2012

8. A poetic representation of contemporary medical practice. BSA Medical Sociology Conference, Leicester 5th Sept 2012,

9. 'This should be joyful work': The Poetic Representation of Modern Medical Careers. International Congress of Qualitative Inquiry University of Illinois at Urbana-Champaign 17th May 2013

10. Excellence is dead: Poetic representation of personal narratives from contemporary medical practice Creative Intentions Symposium; Emerging Sociological Research from the NWDTC Institutions, University of Manchester 25th June 2013

11. 'This should be joyful work'; Poetic representation of personal narratives from contemporary medical practice. The RCGP & University of Birmingham Department of Primary Care Annual Research & Innovation Symposium, Birmingham 27th June 2013

12. Developing data; making sense of it all with Situational Analysis, BSA Medical Sociology Conference, York, 12th September 2013

13. 'This should be joyful work'; Poetic representation of personal narratives from contemporary medical practice. Annual RCGP Conference, Harrogate 3rd October 2013