Does the achievement of medical identity limit the ability of primary care practitioners to be patient-centred?
A qualitative study

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Abstract

Objective: To explore primary care practitioners approach to and management of menstrual disorders using a sociological perspective.

Methods: Semi-structured interviews of primary care practitioners with an iterative approach to recruitment and analysis informed by grounded theory.

Results: Two broad approaches to patient care were described—a biomedical approach, which concentrated on medical history taking and the search for disease, and a patient-as-person approach where a patient’s individual ideas and concerns were elicited. Practitioners believed they had a role in integrating these approaches. Activities intrinsic to the biomedical approach such as the performance of examinations, the ordering of tests and making decisions about biomedical aspects of care were however not available for shared decision-making. The exercise of these decisions by medical practitioners was necessary for them to achieve their professional identity.

Conclusion: While practitioners accepted the ideology of patient-centred care the biomedical approach had the advantage of providing practitioners with a professional identity, which protected their status in relation to patients and colleagues.

Practice implications: The adoption of shared decision-making by medically qualified primary care practitioners is limited by practitioners need to achieve their medical identity. At present, this identity does not involve significant sharing of power and responsibility. A shift in perception of medical identity is required before more shared decision-making is seen in practice.

1. Introduction

Primary care practitioners are increasingly encouraged to deliver patient-centred care and in particular to conduct patient-centred consultations [1,2]. Mead and Bower have described five distinct dimensions of ‘patient-centred’ care [3]. These are a biopsychosocial perspective; ‘patient-as-person’; sharing power and responsibility; the therapeutic alliance and ‘doctor-as-person’. The sharing of power and responsibility in relation to decision-making has been the focus of most recent research [4–7]. Elwyn et al. [8] argued, however, that patient involvement and empowerment in decision-making in primary care consultations was a distant fantasy. They argued that practitioners had learnt to explore biomedical and personal agendas but lacked the skills to provide patients with information and to share decisions with them. The framework of required competencies proposed by Elwyn and colleagues include: (1) problem definition, (2) explaining that legitimate choices exist, (3) portraying options and communicating risk and (4) conducting the decision process [9]. While shared decision-making (SDM) has been studied mainly in relation to decisions about treatment Elwyn and colleagues argue that there are opportunities for patients to be involved across the spectrum of decisions made in consultations. They argue that patients have legitimate perspectives on all decisions taken including screening, testing and treatment. The
authors developed a scale based on the competencies described and assessed SDM in routine primary care consultations. They found that practitioners did not involve patients to any great extent. Low rates of competency in involving the patient in decisions have also been found in the assessment of consultation skills using videoed consultations in the examination required for membership of the UK Royal College of General Practitioners [10].

The low level of SDM found in clinical practice contrasts with the emphasis given to this in education and policy. In addition to lack of skill, lack of adequate time and lack of an adequate evidence base with which to inform patients have been suggested as impediments to practitioners’ facilitating increased patient involvement in decisions [8]. Stevenson [11] also reported that practitioners suggested that patients varied both in their ability and their desire for SDM and expressed concern about how a practitioner could ensure decisions were really shared.

The assessment of practitioners’ skills in enhancing patient involvement is an example of consultation research within the clinical-observational domain [12]. Research is focussed on the activities of the participants in the consultation. These activities are understood as part of the doctor’s clinical method, and the doctor’s skills can be improved or changed by training. Bower et al. [12] conceptualised primary care consultation research as falling into four domains—clinical-observational, psychodynamic, social-psychological and sociological. These domains are described as perspectives on the consultation that have developed more or less independently, each using differing theoretical perspectives. The authors suggest that each domain can only provide a partial view of the consultation and consideration of other domains may provide alternative hypotheses. In the sociological domain, the consultation is conceived in terms of broad social processes such as power, rather than as a skills based interaction. The sociological domain is concerned with how the identities of the participants in the consultation are constructed. The construction of these identities involves self-presentation and negotiation and is generated via interaction [13]. In this domain, identity is not given but has to be claimed and demonstrated by the participants in their interaction. People are concerned to give the impression of themselves they want others to see [13]. The emphasis is not on how an activity is done but on what participants achieve through their activities.

This paper reports on an interview study of primary health care practitioners about their approach to the management of menstrual disorders. The aim of the study was to explore practitioners’ management of these common disorders in primary care settings. Menstrual disorders are a common presentation in primary care but widespread variation in practice has been described. Menorrhagia, or heavy bleeding, is the most common reason for referral to gynaecologists and is considered a condition where patient-centred care is particularly appropriate. Serious pathology is rare and legitimate choices exist regarding management. The condition does however significantly impair quality of life [14]. The diagnosis is largely based on clinical history and the choices of treatment lie between doing nothing, taking medication or a number of surgical options. Guidelines for the initial treatment of heavy bleeding have been developed which suggest that unless there are symptoms suggestive of pathology investigations are not required, and that investigation and management should proceed according to individual patient need and request [15]. In the UK, referral to a gynaecologist at secondary care is required for surgical treatments but most investigations and oral treatments are available in primary care settings. Practitioners’ accounts indicated that many of the activities of the consultation could be understood as being important to the achievement of professional identity. The potential existed for the achievement of identity to conflict with sharing of power and responsibility in the consultation.

2. Method

The study was conducted in one inner city health authority area in the UK in 2000/2001. We used an iterative approach to recruitment and analysis, which was informed by grounded theory.

The aim of the study was to increase understanding of primary care practitioners’ approach to menstrual disorders. A purposeful sampling strategy was used to identify interviewees. Initial characteristics used for recruitment were gender, length of time qualified, qualification and type of practice. Nurses were included as previous research has indicated that women consult nurses for menstrual related problems [16]. In the early interviews, length of time qualified emerged as an important characteristic since practitioners’ approaches developed according to their experience of community practice. Subsequent sampling was directed to testing out the validity and scope of the emerging analysis. Practitioners were targeted according to their characteristics and were first sent an introductory letter, followed by a telephone call. Recruitment continued until categories were saturated. Twenty-two primary care professionals were interviewed and their characteristics are listed in Table 1. Formal ethical approval was not sought.

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<th>Table 1</th>
<th>Characteristics of interviewees</th>
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<td>General practitioners</td>
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<td>Principals 3 female, 7 male (3 single handed, 7 group practice)</td>
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<td>Nurses</td>
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as regulations in place at the time of the study did not require it. All interviewees were assured of anonymity in any reports or publication of the findings.

The interviews were conducted by NO’F; all were taped and transcribed. NO’F is a general practitioner by background who was working full time as a researcher at the time of the study. She was introduced as a researcher whose interest in this area had arisen when working clinically. A semi-structured schedule was used for the interviews. The subject of the interview was introduced as practitioners’ experience of treating menstrual disorders in practice. Topics asked of practitioners included whether they saw women with menstrual problems, their approach to those women and any difficulties they experienced in managing menstrual problems. Practitioners were encouraged to relate actual experiences of patient care and were free to raise any issues they considered important. Practitioners were prompted by the use of short descriptions of possible patient presentations e.g. what would your approach be if a woman said she had heavy periods? The interview scripts were professionally transcribed and NVivo used to organise the developing analysis [17]. Constant comparative analysis was used to develop categories and themes [18,19]. The analysis proceeded according to the steps described by Strauss and Corbin [19]. The data was initially fragmented and sentences and phrases examined individually to develop categories. These categories were reassembled via axial coding to develop core categories. The coding scheme was developed and agreed by discussion between the authors and the analysis conducted by NO’F. In keeping with grounded theory, we did not have a prior theoretical framework. Our aim was to develop a plausible relationship between concepts. As the analysis proceeded the developing codes were examined in relation to the research question and categories that appeared relevant were given priority in achieving saturation. Attention was then paid to the literature to explore how the hypotheses developing might be informed by existing theories [18].

3. Results

The analysis developed a number of core categories. The nature of menstrual problems and the importance of gender in the interaction have been described in another paper [20]. Practitioners had two main approaches to women with menstrual disorders; a biomedical approach and an approach that we have called patient-as-person, which emphasised patient individuality. These categories are described here under the label of the clinical task. Practitioners’ assertion of their medical identity to their patients and to their medical colleagues was a further category. Identity and practice were linked as the exercise of the biomedical approach was a necessary part of the display of medical identity. We are using the term medical identity to describe the particular professional identity that the medically qualified practitioners sought. From a sociological perspective this identity has to be expressed and demonstrated in interaction.

3.1. The clinical task

When asked about their approach to women who presented with menstrual problems, practitioners described a traditional clinical method of history taking, followed by examination and investigation. Within the activities of the consultations, two broad orientations were revealed. These were a biomedical approach and a patient-orientated approach. The biomedical approach consisted of attention to the biomedical model of disease, to skills learned in medical training and to concepts of diagnosis, disease and cure. The patient-orientated approach primarily involved a patient-as-person approach. This included exploring the individual patient’s agenda and needs and the importance of allowing the patient to tell their story. A patient-orientated approach was not however necessarily truly patient-centred. Many practitioners were guided by their assumptions about what the patient might want, rather than guided by discussion with individual patients about what they wanted.

3.1.1. The biomedical approach

In the biomedical approach, the purpose of exploring the patient’s complaint was to allow categorisation of symptoms. Broad categorisation was initially into those likely to have major pathology. Clinicians sought out symptoms not related to menstruation itself and more indicative to them of pathology, such as post-coital bleeding. In their accounts, practitioners reported asking about symptoms such as pain and bleeding and described patients’ problems using biomedical terms like menorrhagia and dysmenorrhoea. However, categorisations into either serious or not serious problem and the use of contextual factors such as age or ethnicity were commonly used as grouping factors and had more importance in directing categorisation than symptoms per se.

‘I think yeah at the moment they’re in little boxes, because I sort of define them according to their age’

(GP5, Female qualified 6 years)

Grouping in this way represented an alternative to standard medical categorisations which practitioners found unhelpful in their assessment of patients [20]. Categorisation was integral to the role of a doctor, allowing the patient’s complaint to be repackaged. The act of categorisation was a characteristic of medical practice. The organisation of patient symptoms was a positive experience for the clinician.

‘I think the knowledge brings something really satisfying, there’s this whole rag bag of things, and so to me the knowledge and discipline that you get say in a gynae clinic, it actually does bring some sort of, you can differentiate what
is going on, I know it’s false, it’s sort of a construction, but it does allow me to feel as if I am doing something useful’

(GP2, Male qualified 9 years)

The categorisation made by clinicians when exploring a patient’s complaint as described above provided a hypothesis and guided subsequent activity. Practitioners were at times confused by their lack of ability to diagnose and treat disease in patients with menstrual complaints. Their biomedical orientation presumed disease as a basis for the patient’s complaint. When disease was not found practitioners doubted their own knowledge and found the uncertainty difficult to cope with.

‘I suppose I know, I mean I’ve looked it up and I’m sure my knowledge base is okay. It’s just a question of the unsurety of, after all of that, is there actually something more? Is there something I’m missing? You know, is there an answer? Maybe it’s just the training that we have, there is a cure to everything and there actually isn’t’.

(GP3, Female qualified 8 years)

3.1.2. The patient-as-person

The patient-as-person approach involved the exploration of the patient’s complaint with two main objectives. The first was to uncover patient wishes and concerns; the second was to allow the patient to be heard. That patients came with underlying fears about, for example, cancer and fertility was assumed by all clinicians. Most of the interviewees reported asking about the specific concerns of individual patients, and also sought to understand the cultural meaning of menstruation that patients brought with them. However, some practitioners reported never asking about patient concerns. These practitioners were more likely to be male and older. There was however explicit recognition of the psychosocial aspects of menstrual problems.

‘If they come for menorrhagia there are a few things might be worrying, depending on their age, are they going through change, have they got a cancer, what about their sex life and all that in personal relationship. They are worried; they go ... not again today. All right, I don’t make it a point to ask that. I don’t think I will ever ask directly, but it might be better, I’m sure sometimes, they must be worried. And perhaps might be the expense, day in, day out, but I will never ask them’

(GP10, Male qualified 26 years)

There was consensus however among other clinicians that an exploration of the patient’s complaint was seen to be important in itself, as a means of allowing the patient to be heard and to be considered an individual. Although the importance of allowing the patient to be heard was noted by clinicians of both genders, female practitioners also often identified with their patients and expressed sympathy for them. Clinicians perceived that they had been chosen by the patient, and had an individual perspective to bring to the interaction.

‘I think I see myself, when they come in to see a female GP they’re looking for your personal side on it as well, so for me to put it into a general box, I think they might find it a bit insulting’

(GP3, Female qualified 8 years)

Investigations and referral were done at the instigation of the patient. Ultrasound scans were viewed as particularly powerful in reassuring patients although generally not necessary for diagnosis. A scan rendered visible the internal organs involved in menstruation. This was useful in the education of patients.

‘and I think the scan is often for the patient to know that yes they’ve got fibroids, just where they are, and so that they can actually feel it’s tangible for them as well’

(GP12, Female qualified 30 years)

However, practitioners also made assumptions about what it was patients would want. Female practitioners in particular considered what they would want for themselves. And I know that you don’t have to scan a lot of them, but I tend to scan them, because I think if it was me, I’d want to be scanned.

(GP5, Female qualified 6 years)

The practitioner above who felt that a scan made fibroids tangible for patients discussed her own feelings about the intangibility of internal organs.

And I mean, I know with myself, when I was young I thought, ‘Well I don’t know, perhaps I have periods, but do I really have a uterus? I’ve never seen it.’ And actually for a patient to see what’s inside them, is actually I think very helpful.

(GP12, Female qualified 30 years)

In general, the biomedical approach and patient-as-person approach were not recounted in opposition to each other. The single-handed practitioners, all of whom were men, gave primarily biomedical accounts. They did not deny the patient-orientated approach, but delegated the communication aspects to their nurses. The majority of other doctors felt that their role was to integrate these approaches and they could be accorded equal importance. GP12, for example, discussed the need to remember extremely rare biological causes of menstrual problems, and the importance of exploring specific cultural health beliefs.

‘I’ve never seen a sarcoma in spite of all the fibroids, but if one’s read about it they sort of haunt you’

‘and even I’ve found amongst our African patients particularly, even a sort of magical level, there’s still a lot
of magic around and people worry about curses being put on them and bleeding to death through a curse, and there’s all these things to unravel’

(GP12, Female qualified 30 years)

Practitioners were explicit in attempting to provide a particular experience for patients and practitioners differentiated their role as general practitioners from that of the specialist services. This was described by one male general practitioner (GP4) as ‘a bit more gentle, a more conversational experience’ than patients would experience in a hospital setting. The community gynaecologist interviewed saw her practice as similar to that of GPs. She had chosen to work in the community as she felt this setting would allow her to integrate attention to the individual patient and her gynaecological skills.

3.2. Maintaining medical identity

Practitioners’ expression of the importance of orientation to the individual patient and of their role in integrating this approach primarily concerned the ‘patient-as-person’ aspect of patient-centredness. Their accounts did not include examples of sharing of power and responsibility. Many of the activities that took place in the consultation allowed the practitioners to act in accordance with their perception of their medical role. Decisions about primarily biomedical aspects such as examination, investigation and referral were recounted as being the responsibility of the clinician. They were not necessarily available for discussion between doctor and patient, but were required by the clinician to display their medical identity to patients and colleagues.

Many practitioners reported that it was often clear from a patient’s history that pathology was unlikely. Clinicians judged however that an explanation by the doctor based on clinical judgement alone would not be considered adequate by the patient.

‘If you sit them in a chair and say ‘there’s nothing wrong with you, I can tell you that basically sitting here’, it’s not very reassuring to the patient, I mean you can’t explain that you can tell from just their history’

(GP3, Female qualified 8 years)

The choice to visit a general practitioner was also perceived to be a specific choice by the patient for a biomedical approach. The performance of tests was what the role of a doctor demanded.

Q: ‘why do the battery (of tests) if you don’t expect to find anything?’

GP: ‘Well I suppose partly because you’re told to do it, you’re socialised to do it as a medical student venture, this is what doctors do, so you want to be a doctor, don’t you, and your instinct it to just say, well let’s just keep an eye on it, your feeling is if you do that, people won’t see you as being a doctor, which is why it’s a dilemma, and whether it helps or hinders the patient I’m not sure’

(GP4, Male qualified 13 years)

While it was the role of the doctor to investigate, it was also the role of the doctor to protect the patient. Many practitioners used a consultation for menstrual problems as an opportunity to do other preventative measures that patients might otherwise forget such as smears. This was presented as an example of good practice.

‘Like I say, I remember they used to say to us, “If you have somebody who hasn’t had a smear, do it. Don’t send them off and tell them to come back or go somewhere else.”’ And I do feel, and there’s always a feeling, that I’m left with the feeling that if I didn’t do one there and then, that they would do the same thing, they’d let it slip again’.

(GP7, Female qualified 7 years)

Practitioners did not share the lack of sensitivity or specificity of tests with patients and were reluctant to raise the issue of more uncommon but potentially serious causes of problems.

Well this is the dilemma, yeah. If I’m referring them I say, “Look, you know, I think we should just see what this is. Sometimes you can have a little growth in there giving you a problem.” But it is a dilemma to say within five minutes of seeing somebody, who comes in with a bit of bleeding to say, “Well we’ve got to make sure you don’t have a cancer”. Is it fair to traumatise them, when they’re probably going to end up totally normal, you know?

(GP4, Male qualified 13 years)

Making judgements in this way and taking responsibility differentiated general practitioners from their practice nurses. General practitioners discounted nurses’ abilities to deal with problems like menstrual disorders. It was recognised that nurses could increase ease of access for patients, did actually see women with these complaints and sometimes organised investigations but doctors expressed doubt as to whether practice nurses could adequately deal with such complex problems. This could be expressed as a technical issue in terms of a nurse’s ability to do an internal examination.

‘I used to worry that, in a sense, was a smear done by a nurse different than a smear done by a doctor, which by definition included something that you might call a vaginal examination’

(GP9, Male qualified 33 years)

A more important distinction was between the training doctors and nurses received. Doctors considered the training of nurses to be more orientated to the application of protocols, and menstrual disorders were not considered appropriate for this approach. Menstrual disorders might be indicative of other gynaecological or
medical problems, and general practitioners had the knowledge required to deal with this. The ability to make judgments that came with the medical training was perceived as important.

‘I think, you know, in the literature that you read, you hear that nurse practitioners are very good at dealing with minor complaints and things like that. I’m not saying that they can’t do any of that other stuff, the longer and more difficult stuff, it’s just that our training is such that it can be quite complex. That’s what we’ve been trained to do, complex stuff, and some of these menstrual irregularities aren’t barn door, you have to go into them and you have to, maybe then they could refer to a doctor, I don’t know’

(GP5, Female qualified 6 years)

‘And I think that for something that’s more complex non-procedure, I think it should be GPs doing that’.

(GP2, Male qualified 9 years)

This view of an appropriate division of responsibilities was respected by the practice nurses. Although technically the nurses could order blood tests and scans most would not do this and advised women to consult a medical practitioner. One nurse who had done further training in regard to women’s health and did occasionally organise scans emphasised the arrangement for supervision organised within her practice. She also differentiated her activities from what other nurses could and should do.

‘It’s having done my advanced course in family planning, that was quite significant because, you know, the learning outcomes were sort of sent round and they’ve known, and they’ve also known that I’ve maintained my skills. I have some sort of clinical supervision, informal sort of clinical supervision, with two of the partners, two of the female partners, over these issues. So yes, it’s attached to me rather than . . . yeah, because I’m me’.

(Nurse practitioner 1)

While the demonstration of appropriate medical behaviour distinguished general practitioners from nurses, the display of appropriate medical behaviour was important for general practitioners relationships to hospital specialists. General practitioners’ identity in relation to their hospital colleagues was precarious. Although generally confident of their own medical knowledge and of their distinctive role, doctors justified their clinical practice in relation to the practice of specialists. The practice of specialists appeared as a gold standard, deviation from which had to be explained. Many had heard criticism or had themselves been critical of general practitioners during their hospital careers. As GPs themselves they now felt misunderstood and defended their practice by explaining how it differed from hospital medicine. Guidelines were cited as an example of the lack of understanding of general practice by others. Guidelines for example suggest that women in their 40s with abnormal bleeding should be referred. GPs were dismissive of this reflecting on the selective nature of the population seen by specialists.

‘I vaguely think that I looked at those (guidelines) and thought, ugh, they wouldn’t be able to cope with this. They’re never going to cope with that, they obviously don’t know really the size of the problem I imagine actually

(GP8, Female qualified 26 years)

Referral presented the opportunity for practitioners to present their expertise to their colleagues.

Practitioners were proactive in defending their medical identity in the face of anticipated criticism. The range of investigation performed on patients prior to referral was often chosen so that the practitioner could be seen to conform to what a consultant would expect. A complete evaluation in primary care would not allow the general practitioner’s treatment to be impugned.

GP: you just think in case I’ve missed and I refer them and get an angry letter back saying, ‘You didn’t even do swabs and actually the swab’s . . .’

Q: Have you had angry letters back saying you didn’t even do swabs?

GP: No, that’s because I tend to do them before, but maybe before, you know, I don’t know, maybe it’s my own perception of it. I suppose I expect a full examination or I suppose they would expect a full examination before seeing the patient, so I put myself in their shoes and think, ‘Well everything’s been done.’

(GP3, Female qualified 8 years)

Older practitioners had a more secure view of their role and its place in relation to secondary care. These practitioners were less likely to be so influenced by the potential perception of their hospital colleagues and saw the specialist as a provider of additional knowledge that could be accessed when required.

‘I think that my philosophy is that people should be handled in primary care, I think they should be investigated appropriately in primary care, and I think when they are referred it should be for opinions’

(GP9, Male qualified 33 years)

4. Discussion and conclusion

4.1. Discussion

The clinical task identified by this group of medically qualified practitioners encompasses both a biomedical and a patient-orientated approach. While a minority expressed either lack of interest or inappropriate skill in eliciting women’s concerns and views, all practitioners referred to
communication in their account of how they managed women with menstrual complaints. Despite the stated importance of patients' perspectives, some clinicians were however making assumptions about patients' concerns and wishes rather than eliciting those of individual patients. In these accounts, there was little evidence of the sharing of responsibility. Moreover, doctors' explanations for their activities in the consultation indicate a perception that the doctor's role is to be responsible, to protect patients from their own lack of responsibility and the concerns that may be raised by medical uncertainty. Some activities such as the ability to examine, investigate and refer also provided doctors with a means to display their medical identity to patients, to differentiate themselves from nursing colleagues and to claim comparable status with other medically qualified practitioners. This medical identity provides the practitioner with status both in the medical and social world.

The findings of this interview study are based on accounts provided by a small sample of practitioners without any direct evidence of what occurs in their consultations. Respondents in studies of clinical practice may feel that their own practice is being assessed [21]. Practitioners are managing their identity in the interview situation as well as in the consultation. The accounts from practitioners are likely to reflect the current views of how practitioners should behave. Given the current emphasis on patient-centredness the degree of involvement described may overestimate patient involvement. The results are however consistent with those studies that have directly examined practitioner behaviour [9,10]. The interviewer in this study was known to most of the interviewees as a clinician. There is some evidence that when this occurs interviewees provide more personal accounts of their attitudes and their behaviour in clinical practice. Respondents appear to feel safe enough with a fellow professional to provide a more private account than they would otherwise [21]. Influences in clinical care are complex. We are not suggesting that the only influence on practitioners' actions was their need to assert their identity. Practitioners do need to make diagnoses and rule out major pathology. It is the manner in which they carry out these activities that allows them to achieve a particular identity.

The medical practitioners interviewed in this study used their biomedical approach to identify themselves as doctors. Many practitioners also perceived that patients were asking for such an approach when consulting them. This may create difficulties for doctors in the exercise of patient-centredness, particularly in relation to the sharing of power and responsibility. The difficulties in translating SDM into practice may lie not in absence of skills or knowledge but in the understanding by practitioners and patients of what constitutes appropriate medical behaviour. Despite the increasing emphasis on patient-centredness the trend in this data was for younger interviewees to be relatively more paternalistic, to endeavour to distinguish themselves more clearly from their nursing colleagues and to establish themselves as competent in the eyes of hospital professionals. This approach may be related to their more recent entry to the profession and their need to claim a professional identity for themselves but the identity they are aspiring to does not allow for substantial SDM. Primary care practitioners may have a particular dilemma. They do not have the more obvious markers of medical status that are seen in secondary care such as white coats, a hospital setting and access to high technology. While these practitioners clearly expressed a commitment to addressing the patient as an individual, they also required a means to achieve their medical identity. The ability to take responsibility and form judgements and the conduct of medical investigations allows them to do this.

Norris [22] considers that practitioners' explanations for their actions and their comments on other professionals are strategies through which they claim their professional identity. There is marked similarity between the strategies described by the medically qualified practitioners in Norris' study of professionals treating musculo-skeletal problems and the accounts provided by medical practitioners reported here. Both studies report views that non-medical occupations such as nurses are limited by their inability to diagnose and surgeons are limited by their inability to do anything other than operate. Norris [22] points out that the strategies available to professionals to distinguish them from other professionals are dependent on the repertoire of what they can provide. In primary care, medical practitioners can be distinguished by their ability to apply biomedicine. The importance of the biomedical to the identity of general practitioners has also been expressed in a study addressing work distribution in the current UK primary care system [23]. The authors report that primary care professionals need to do an ever increasing amount of identity work to justify their position in the primary care hierarchy. The place of the general practitioner was expressed both by general practitioners and other members of the primary care team as increasingly that of a biomedical specialist able to exercise a high degree of clinical discretion.

4.2. Conclusion

The addition of a sociological analysis of the consultation in the terms described by Bower et al. [12] provides an additional perspective on the current low level of SDM observed in practice. This study suggests that primary care professionals’ management of complaints is influenced by their structural position in the medical division of labour and their need to maintain that position. Medical practitioners in primary care may accept the ideology of patient-centredness but currently require the exercise of the biomedical approach to achieve their professional identity.

4.3. Implications for practice

There is an increasing literature that suggests that patient-centredness improves patient outcomes [24]. Commentators
do recognise that the adoption of shared decision-making may change the role of the clinician, but concentrate on skills training and development of decision aids to improve the doctor–patient interaction [25,26]. Such an approach underestimates the power of medical socialisation and the need for all practitioners to do identity work [27]. The adoption of the sharing of power and responsibility will require a shift in the perception of what makes a good doctor.

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References

[22] Norris P. How ‘we’ are different from ‘them’: occupational boundary maintenance in the treatment of musculo-skeletal problems. Sociol Health Ill 2001;23:24–43.