# Transforming general practice: the redistribution of medical work in primary care

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**Abstract**    The paper focuses on the redistribution of medical work within primary health care teams. It reports the results of the analysis of interviews with general practitioners, practice nurses and managers, undertaken as part of an ethnographic study of primary care organisation and practice during a period of rapid organisational change. By examining the ways in which the respondents account for how work is being redefined and redistributed, we explore how current government policy and professional discourses combine to reconfigure both the identities of those who work in primary care and the nature of patienthood. In particular, we show how general practitioners are being reconfigured as medical specialists or consultants in ways that seem to depart radically from earlier claims that general practice is a distinctive field of social or biographical medicine. Within this new discourse medical work is distributed between doctors, nurses and unqualified staff in ways which make explicit the reduction of general practice work to sets of biomedical problems or tasks. At the same time, the devolution of much general practice work to less qualified and cheaper personnel is justified by drawing on a discourse of person-centred medicine.

**Keywords:** Primary care, professional identity, redistributing work, categorising patients, patient-centred care

## Introduction

The organisation of primary care in Britain has changed rapidly and radically over the past three decades. The work of the general practitioner (GP) has shifted towards the management of chronic disease, and general practice

itself has become organised through increasingly complex groups of doctors, practice nurses, administrative managers and support staff (Dowrick 1997). As we shall see, this process has been driven by the professions, as well as through government policy. In recent years these changes have become more rapid, and more radical. They have had important effects on the ways that primary care professionals have come to understand and organise their work. This paper aims to explore some of the effects of these changes in practice, and examines the way that they have led both to the reinterpretation and to the redistribution of work amongst primary care professionals, which in turn begins to reconfigure the identities of these professionals.

The paper begins with a discussion of the policy and professional context of contemporary general practice. We argue that this context produces a complex and frequently conflicting set of agendas for practitioners. Drawing on the idea of the 'constituting of classes' as a key organising device in the clinical domain (Latimer 1997), we discuss how practitioners settle some of this complexity through the production of hierarchies of appropriateness – of work, patients and personnel – that in turn produces a new distribution (and definition) of medical work.

We do this by presenting an analysis of the accounts of general practitioners, practice nurses and managers to illustrate how the redistribution of work itself produces a new kind of primary care organisation. Within this new organisation, attention moves away from the traditional claims of general practitioners to attend to the broader psychosocial correlates of ill health. Instead, it categorises patients on the basis of their biomedical problems and on the sets of tasks needed to accomplish their disposal. These tasks are distributed between primary care practitioners in ways that maintain old hierarchies of work and knowledge, as well as new economies of health care. At the same time, we show how, ironically, the new *active* management of primary care is justified by drawing on the traditional *moral* discourse of patient-centredness.

We conclude by discussing how the redistribution of primary health care work relates to wider changes in health services in a way that may signify fundamental shifts in the cultural and social significance of general *medical* practice as the most powerful component of primary care. We suggest that an unintended consequence of the increasingly active management of primary care is not just the effacement of the social. Rather, it is to encourage the actors to construct even more intense hierarchies of distinction, not just of themselves as professionals, but of patients and work.

## Actively managing general practice

The character of primary care has changed over the past three decades as general medical practice has shifted from a high level of relative autonomy to a much more closely defined linkage to the health care state. The external

influences on general practice are most clearly seen in the government policy reforms since the early 1990s. Since that time, government policy has emphasised the need to deliver a high-quality service that is accessible, flexible and efficient. These required qualities can be identified in the white papers of 1996 *Choice and opportunity. Primary Care: the future* and *Primary care: delivering the future* (Department of Health 1996a) and (Department of Health 1996b). They continue through the reforms of New Labour *The New NHS – Modern, Dependable* (Secretary of State 1997) and are present in the Government's recent White Paper *The NHS Plan* (Department of Health 2000). These reforms represent increasingly active management of an area of the National Health Service (NHS) that has hitherto been largely free of such constraints (Glendinning 1999). This has meant that, at a time when the scope of general practice is extending to include work previously carried out in hospitals, chronic disease management and health promotion, general practice has had to become increasingly efficient, transparent and accountable.

In parallel with the external policy agenda are influences that arise from within the profession itself. One of the most significant of these is the professional identity that general practice has aspired to since the early 1960s. This approach, which owes much to the work of Balint (1957), and is espoused by the profession's leaders such as the Royal College of General Practitioners, is based on a biographical approach to medical care (Armstrong 1979). Such an approach emphasises a patient-centred approach to the consultation. As a result the patient's narrative is given more value within the consultation, and the social and psychological context of the presenting problem is explored further than in a biomedical model. Bosanquet and Salisbury (1998) suggest that the move away from scientific, biomedical, and hospital-focused medicine allowed GPs from the 1960s onwards to develop a sense of identity and their own ideology that had previously been lacking. Dowrick *et al*. (1996) and May *et al*. (1996) have demonstrated that in reality general practice has frequently failed to meet the aspirations of biographical medicine. Despite this, it has remained an important ideology.

In recent years two further confounding influences have emerged to challenge this aspirational model of practice. First, there is the requirement placed on primary care by UK government policy to increase access for patients (Department of Health 2000). Second, there is the competing imperative from within primary care to regulate patient demand. The issue of controlling patient demand is not new and predates the inception of the NHS (Bosanquet 1989). However as the field of practice in primary care widens, there is an increasing demand from within general practice to manage the workload (Rogers *et al*. 1999).

One effect of these different pressures is that GPs have delegated some kinds of clinical work to practice nurses. The delegation of work to nurses began in earnest in 1990 with changes to the GP contract that required them to take on new work in the form of health promotion and chronic disease management (Department of Health and Welsh Office 1989). The more

recent pressures, however, have resulted in the delegation not of new work, chronic disease management or health promotion, but of acute medical work, which has 'traditionally' been considered to be GP work. This has resulted in the construction of a more complex division of nursing labour and the development of an extended hierarchy of practice nurses, lower grade nurses and health care assistants.

From a policy and management perspective there is an attraction to transferring work from more expensive doctors to cheaper nurses (Richardson and Maynard 1995). However, within the increasingly managed environment of general practice this means doctors and nurses have to do more and more professional identity-work. Their place in the hierarchy can no longer be taken for granted – why should they do their job rather than someone who is less expensive (Jewell 2001)?

In what follows, we explore the ways in which those who work in primary care account for how they define and distribute clinical work. We explore, too, how this way of accounting helps them accomplish and settle some of this complexity. An essential theme here is how they constitute categories of patients and work in relation to a hierarchy of appropriateness. In the next section, we discuss the sociological literature on categorising.

## Categorisation of patients: the constituting of classes

Attempting to categorise patients according to their *appropriateness* is, as Rogers, Hassel, and Nicolaas (1999: 16) note, 'fraught with problems'. They highlight that in most of the literature the construction of an inappropriate use of services emerges from moral judgements made by GPs about patients' behaviour. The latter have been blamed for 'inappropriate' behaviour with terms such as 'trivia', 'heartsink' or 'difficult' being used by the GPs to characterise them. Studies in other settings have also emphasised the importance of moral judgements made by staff. In Jeffrey's (1979) study of accident and emergency departments he describes how staff classified patients according to their status as 'good or interesting' and 'bad or rubbish'. In Jeffrey's paper the moral character derives both from the patient's social identity and the perception by the casualty staff of whether they were medically interesting or not. Staff thus do their identity-work through their recognition of a patient's medical worthiness. Dingwall and Murray's (1983) analysis of work in an accident and emergency department again emphasises the important role that perceptions of moral worth play in categorising patients. However, they extend Jeffrey's work by including the influences on staff decision making brought about by the practical contingencies and social interactions within the accident department.

Our respondents also classify patients with judgemental terms such as 'trivia', 'heartsink' or 'difficult'. The terms used by respondents in their accounts may indeed attribute a moral character to patients, but the classification also

reflects the degree of expertise and knowledge needed to deal with the problems which patients present with. Those patients requiring the most expertise are the most valued. Thus the classification of patients is not just determined by organisational contingencies it is pivotal to accomplishing the hierarchical ordering of the practice. The hierarchical organisation of the work place is accomplished through practice staff's *differential* identity-work, which is in turn made possible by the ways in which patients are classified according to the expertise required to deal with their problems.

The complex nature of the decisions that nursing and medical staff make in allocating patients to certain categories is highlighted in studies on medical decision making. These studies suggest that the decisions are not based solely on biomedical or scientific factors (Silverman 1987, Berg 1992, Dodier 1994). Berg (1992) emphasises the diversity of elements such as time, organisation, knowledge of the patient and financial considerations that are interwoven into the decision-making process.

In contrast to the work cited above, which focuses on the effect that context has on decision making about individual patients, we draw on the observation that this decision making and categorisation not only assists practitioners in configuring their identities, but also plays a key role in producing and reproducing organisation[1]. Importantly, 'organisation' does not refer to a single entity, such as a general practice, but to different 'domains' of activity within the umbrella organisation. In particular we consider how, by constituting classes of work, patient and practitioner, the clinical domain is being transformed and reproduced in particular ways. The character of this domain is shifting and these shifts reflect the changing culture of the NHS. Primary care practice emerges as increasingly concerned with the managerial systems of efficiency rather than with people. Patients are categorised on the basis of the pathological complexity of their presenting complaint and who in the practice can most efficiently and cost effectively manage them. The realignment of general practice with this more biomedical approach, together with an emphasis on effectiveness and efficiency, indicates the erosion of the discourses that centre on the social character of both general medical practice and nursing. Both disciplines have consistently claimed, and still claim, to adhere to holistic views of the patient as an experiencing subject. This has, as we shall presently see, important implications for theories of an extended subjectifying gaze in health care practice, which rest on a view of a *discourse of the social* (see Armstrong 1983, Silverman 1993).

## Method

Our analysis draws on interviews with GPs, practice nurses and practice managers from nine general practices in the North West of England, undertaken as part of an ethnographic study of primary care organisation and

practice. The next stage of the study will crosscheck our interpretation of the respondents' accounts through participant observation of general practice work and organisation.

The interviews took place between August 2000 and June 2001. They were conducted by HCJ (who is a general practitioner) and all the respondents were aware of his professional identity[2]. All the interviews were conducted on the practice premises in a private room, without interruption. The interviews varied in duration from 29 minutes to one hour and 10 minutes (mean duration 47 minutes). The sampling of the practices was purposive in an attempt to include a representative spread of practices based on epidemiological data supplied by the health authority. The factors chosen were socioeconomic, practice location and practice size. In addition at least one practice was selected from each Primary Care Group[3] in the health authority, and the sample included a Personal Medical Services (PMS) pilot site[4]. Three of the practices that were approached declined to take part. In each practice an attempt was made to interview a GP, a practice nurse, and a practice manager, however in one practice two practice nurses were interviewed and in another only the GP was interviewed. A total of 26 semi-structured interviews were carried out. This number was not fixed in advance, but was guided by the sampling strategy and the judgement, based on the analysis of the data, of the point at which 'category saturation' was achieved.

An initial topic guide for the semi-structured interviews was developed following the literature review and was piloted in three preliminary interviews. The interview style was open to avoid leading the respondents in their answers and to minimise the effect of the interviewer's (HCJ) opinions. All the interviews were recorded on audiocassette and later transcribed. The analysis of the data proceeded simultaneously with data collection and through this iterative process the interview topic guide was refined. The data were initially categorised with assistance of WinMax software and the constant comparative method was used during the coding process to continually develop the categories. Subsequent analysis drew on the technique of discourse analysis (Silverman 1993). Importantly, the analysis follows Silverman in treating the interview data not as a version of reality, but as 'compelling narratives' which 'provide access to how people account for both their troubles and their good fortune' (1993: 114).

## A hierarchy of appropriateness

Analysis of interview transcripts revealed precisely the kinds of 'constituting of classes' that we described in the introduction to the paper. Through a discourse of categorising and allocating patients, the practitioners and managers constitute classes of patients based on their definitions of *appropriateness*. The respondents' discourses construct a hierarchy of appropriateness in which different patients and problems are attributed different professional

values. This is seen most clearly in how requests for same-day appointments are managed:

> GP (General practitioner) 7: I think for us [Triage][5] means helping people to access the service that is most appropriate for their need and so, it works simply by most of the patients who want something that day, whether that be a sick note or a visit or an appointment, or 'I've got sticky eyes and can I have a prescription for it?' speaking to one of the triage nurses. They are both now, I think, very skilled at directing people to resources.

In this example the GP used the term 'access' in a way that was subtly different from its use in the managerialist rhetoric of policy. He refers to it not in terms of making it easier for patients to be seen by offering more appointments, but as a term that refers to the mechanism through which patients are constituted as members of categories. The allocation of resources to them depends not on a moral judgement of their *appropriateness*, but on the level of expertise needed to manage them. This categorisation allows those working in primary care to accomplish the transformation of the patient's problem into a problem with an *organisational* solution (Berg 1992). However, it goes further than the individual patient by operating to organise the division of domains of clinical work:

> M (Practice Manager) 6: I think it's the medical problems that require the doctor to be there, looking at the complexity of the problems that present and not the stuff that N [The triage nurse] gets rid of which is 'I've got a cold'. She says well yes you won't feel better for two or three more days whatever. You know, (*laugh*) sorry but you won't, you know and the doctor won't give you anything for it (*laugh*).

The absence of an appropriate biomedical label – 'I've got a cold' or in the example above 'I've got sticky eyes' – works to reduce the importance of certain conditions, and allows practitioners to delegate responsibility and work downwards through the professional hierarchy of the practice. The problem here is disposed of by placing it in an area of the clinical domain that belongs to those with the least expertise, which includes the patients themselves. This resonates with studies revealing the delegation of 'social' work in hospital medicine to nurses (eg. Latimer 1997, May 1992).

Increasingly, practices are introducing nurse triage to 'manage' patients' requests for same-day appointment. Where this is in place it makes categorisation explicit through the construction of protocols and agreements about the hierarchy of appropriateness. The process of categorisation is expressed by this triage nurse's analogy:

> PN (Practice Nurse) 7: I'm trying to, you know, in some way sort out the wheat from the chaff.

The 'wheat' applies to those patients whose presenting problems are given such priority that they will be allocated a GP appointment that day and the 'chaff' applies to all the others who will either not be seen at all or be seen by a nurse. The hierarchy of appropriateness is predicated on, and helps reproduce, a hierarchy of expertise. The nurses in the practice below have the expertise to manage 'cystitis', a 'sore throat' or a 'small skin rash', but 'bad chests' are referred to the GPs not because they are necessarily more serious (although they might be), but because the nurses in this practice are not trained in the auscultation of chests:

> M2:   Everybody has allocated slots, you see, after the triage, so the nurse takes a call for someone with cystitis, or sore throat, a small skin rash, something like that, she will put that into her slot whereas before it would have gone onto the emergency doctors.
>
> HCJ:  Right.
>
> M2:   So now, hopefully only the people with bad chests, or, you know, things that the nurses can't deal with will go into the emergency doctor's slot.

Even in those practices without nurse triage, patients are categorised by reception staff:

> PN3:  They [reception staff] say is it anything to do with ear, nose and throat, or rash, or a child or whatever, so they've sort of picked out the things that they think I'm good at, and they put them for me, and they don't get it that wrong, you know. When I started I used to get, you know, I got the occasional bleeding in early pregnancy and things which I don't see as appropriate. So now I don't get those.

Once again certain conditions and patients are downgraded, in this case a rash or a child, whereas others, such as vaginal bleeding, are upgraded. Again this hierarchy is dependent on a preconfigured categorisation of the practitioners' level of expertise either constructed by the practitioners themselves or in the example above based on the receptionists' perception. By constituting classes of patients and work through a discourse of clinical expertise and knowledge, practitioners and managers are able to accomplish more than the organisation of the 'patient's journey' through the organisation. They are able both to strengthen and to develop the professional hierarchies that exist within the organisation. In the example below, the GP envisages an expansion of both the medical and nursing hierarchies with the introduction of new grades of practitioner:

> GP7:  I think there's going to be a need for a hierarchy in primary care because there will be different levels of experience and competence which will become more apparent in the next five to 10 years. . . .

> I think that the difficult complex problems will end up coming to the GP whereas other things will be dealt with by a range of workers who might be nurses. I see health care assistants coming into general practice much more because of the shortage of nursing too, in the same way as we have in hospitals. And a lot of the problems will be filtered out perhaps before they come to the consultant in primary care, as they will become I think.

At a time when the ownership of some of the 'medical work' is being transferred to nurses, this type of account reinforces the identity of the GP as the person at the top of the hierarchy. It also achieves something else. It begins to move the GP towards an identity that is *the consultant in primary care*, within a hierarchy that resembles that found in hospitals. The GP is thus elevated to become a biomedical specialist and at the same time the nursing role is being extended and segregated. An unintended consequence of this is the way in which patients are being configured in these discourses: not as persons, located in social space and time. Rather, they are reduced to their condition or to the tasks that are required in order to dispose of them. In other words, this discursive shift accomplishes the kind of biomedical reduction of the patient's identity to a pathological label that both general practice and nursing have historically resisted most strongly.

This GP makes it clear that it is the GPs who are deciding which type of work and patients are valued enough to be appropriate for GP care:

> GP3:   Triage is going to take certain patients out of the system. For the GPs, again it's one of those things we'll pass on the things we don't want. So perhaps things are going to go down the line in that way, some of the minor ailments may be, although what's a minor ailment, but generally coughs and colds and sore throats and things will be dealt with by nurses?

By delegating those patient-clinician interactions that have low levels of indeterminacy to nurses, the GPs are able to maintain their dominant position in the professional power relations that exist within a general practice (Johnson 1972). However, by asking 'what's a minor ailment?' this GP also introduces an element of doubt into the discourse of categorisation, and it is to this that we shall now turn.

### Reconfiguring professional identities

So far, we have observed that by constituting classes of patients and work through the discourse of 'appropriateness' professionals and managers are able to organise both the clinical domain and the professional hierarchy within the practice. We will now explore further how the identities of both

nurses and GPs are being reconfigured and the challenges that this presents to these two professional groups.

The need for general practice to respond to government policy by demonstrating increased efficiency and accountability has been described above. When a patient is allocated to a nurse or a doctor, resources are being distributed and these resources are not of equal value. Within this climate of increasingly active management it is necessary to show that 'best value' is being achieved from the available resources. The consequence of this is that the identities of different practitioners are themselves catego-rised into a hierarchy of *value*. This practice manager provides an example of this:

> M6:   When I first came, I'd got two G Grades doing absolutely anything and everything. Now from my background I think that's dreadful. I think that's a dreadful waste of resource because here we have well trained, expert ladies who basically were putting on dressings or giving travel vaccs [vaccinations].

The manager places professional roles and skills in the frame of cost-effectiveness, when she asserts that having G grade nurses 'putting on dress-ing or giving travel vaccs' is a waste of an expensive G-grade nurse. This work could be done by someone with less expertise and knowledge, and so there would be a cost saving. This kind of discursive move also reinforces the move *up* the professional hierarchy of the G grade nurse. In whichever direction the move is made, the effect is the same: any notion of a nurse-patient relationship as a space for exploration or discretion is completely effaced. In this technocratic model of nursing roles, the sole object of the nurse-patient encounter is the completion of a task, the need for which is decided elsewhere.

Similar examples of managing resources by delegating 'minor ailment[s]' from GPs to nurses have been given above. In terms of managerial 'efficiency' and 'cost effectiveness' this may appear to be an appropriate development. However, it excludes or ignores those aspects of clinician–patient interaction that are not easily measured. Within this managerial dis-course, patients are identified by their biomedical diagnosis in ways that efface the social and psychological aspects that are defined as important by biographical or social medicine. Respondents' accounts suggest that they are aware of the tension between their identities as configured through a mana-gerial discourse and as configured through the patient-centred discourse of their professions. By asking 'what's a minor ailment?' the GP above high-lights one of the dilemmas faced by doctors in categorising their work in this way. As their professional identity is reconfigured and enhanced in the move to 'specialist GPs' or 'consultant GPs', so the tendency to move away from working within a biographical model towards a more biomedical model becomes more likely:

GP3:   So every now and then you kind of get this realisation, you think, so that was what it was all about. I suppose that's my concern about unloading the minor stuff. It's this question of when people say, oh this trivial student stuff, you know, that could be off-loaded to someone else. I am very often the one that will turn round and say, well actually maybe it's not trivial, or it might be trivial but shouldn't we be dealing with something else. And I quote, your kind of, your Neighbour and your Balint.

In referring back to two key proponents of 'person-centred' general practice, Balint (1957) and Neighbour (1987), this doctor points to those ideological influences that have configured his 'traditional' identity as a GP. In his account he relates how he will use the discourse of biographical medicine to 'remind' him that different interpretations are still possible, although the organisation of his work is shifting them out of view. This move suggests that person-centred or biographical medicine is still an available ground upon which to base accounts, but one that is becoming marginal. The question arises as to when practitioners draw on this discourse: when is it used to justify a move? We return to this issue below.

Of course, there has always been some distance between the rhetoric of biographical medicine as espoused by the profession's leaders and the reality of general practice with all its conflicting demands (Dowrick *et al*. 1996, May *et al*. 1996). The same conflict between professional aspiration and practical achievement is to be found in nursing (Melia 1987, Davies 1995). In the everyday practice, GPs have always tended to practise within a more biomedical framework than the ideological construction of the profession has suggested. A discourse of categorisation that configures GPs as specialists, responsible only for complex cases, strengthens this tendency. Moreover, some practitioners, such as the GP above, seem to be aware that possibilities for a more diverse general practice are shrinking.

The nurses too seem to be aware that a managerial discourse of 'skillmix' challenges their professional identity, which shares much common ground with GPs. The nurses' accounts emphasise the traditional nursing values of 'understanding the full circumstances of a patient' and the importance of the emotional and personal relationships that they have with patients (Davies 1995), rather than efficiency and cost effectiveness:

HCJ:   What do you think about the change? [The introduction of triage and skillmix of her job]
PN6:   I don't like it. I miss the treatment room. I miss that contact. To me that was nursing, and I do miss that.
HCJ:   What bit of it do you miss?
PN6:   Whether it's something that's familiar to me. You know I'm a nurse, it's nursing to me and triage is sort of nurse cum receptionist cum doctor. It's sort of between the three. I can see the

> need for it and I can see the value of triage, I just don't get any job
> satisfaction from it. Not like I did with nursing. I chose to be a
> nurse and I feel as though. . .

This nurse appears to suggest that the need to deliver the managerial agenda
has moved her away from what, in her view, her identity as a nurse should
be. Indeed some nurses, in particular those who practise at the top of the
nursing hierarchy as nurse clinicians or nurse practitioners, appear to have
separated themselves from this notion of nursing's identity:

> M7:   I think if you talk to them [The nurse clinicians in the
>       practice], they don't see themselves as nurses. And they're very
>       clear that they are a clinician in respect that they've moved
>       on from the hands-on nursing. They've moved on from that and
>       they're more into diagnosing, which nurses are not trained
>       to do.

By developing the expertise of 'diagnosing', they have extended the degree
of discretion that is granted to them. In doing so they have delegated
responsibility for their nursing work to less qualified practitioners and
moved into an 'hybrid' area of clinical practice that is no longer solely
medical, but is not traditional nursing either. The managerial discourses
of efficiency and cost effectiveness call for the reconfiguring of GPs' and
nurses' identities and the redistribution of general practice work. Crucially,
the effect is to move the focus of general practice work to the biomedical
aspects of a patient's problem and redistribute responsibility for the patient's
narrative to those with the least expertise.

The delegation of responsibility in this way challenges the professional
identities of GPs and nurses, but allows resources to be managed 'effect-
ively'. Therefore the constituting of classes, of work and patients, not only
serves to organise the clinical domain and reconfigure the GPs' and nurses'
identities within a strengthened and expanded hierarchy, it helps to deliver
the external policy agenda.

Respondents' accounts, however, also show how this delegation of
responsibility is itself complicated by patients with certain complex
problems. These occasions illuminate how GPs, practice nurses and man-
agers draw on a discourse of the social or person-centred medicine to
justify the need for *greater*, not lesser, expertise. There are two categories
of patients whose needs and the character of their problems appear to put
a stop on them being subjected to the 'processes of disposal' already
described. The discourse about the care of these patients is one of per-
sonal relationships and continuity, not delegation. The first group consists
of those patients with mental health problems. These patients are considered
to be 'complex' and requiring the care of a GP who knows them, rather than
a nurse:

GP10:   I think we have an above-average incidence of people with depression and I think most of these people feel like they have failed. If you have to go to someone to tell them, 'I've made a total mess of my life'. I don't think it's particularly nice to tell that five times in a row, in five different appointments, to five different people. So I think that is certainly where it can be valuable to have one person to relate to.

The 'one person to relate to' was thought, by both a highly-qualified nurse clinician and the manager in the practice, to be the doctor. There seems to be a distinction made between those patients who may or may not have underlying psycho-social problems but who present with other medical problems, and those patients with an unambiguous psychiatric diagnosis. Patients are thought more likely to disclose their problems to a nurse, but once their psychiatric status is acknowledged they become 'complex', and therefore require management by the doctor:

PN7:   I think I work in perhaps a slightly more emotional level [Than a doctor] does. . . . I think the patients realise that and I think they think this is somebody I can spill it all to. So they might spill it to me in 20 minutes and give one minute of that to the doctor.

This again accomplishes the shift between nursing and medicine, but in a more conventional way; the nurse's professional identity is framed in terms of communication and compassion. It also implies a separate, perhaps less person-centred, identity for the doctor. There is a managerial position evident too; the *cheaper* nurse has more time than the *expensive* doctor does. By filtering out the patient's narrative at a lower level in the hierarchy the managerial goal of increased cost-effectiveness is achieved.

The second group of patients whose care remains the responsibility of the GP is those with a terminal illness. Again continuity and personal knowledge of the patient by those involved in her care is emphasised:

GP8:   [Giving her views on who should have a home visit] I think sort of terminal patients, and that side of things, you know, you have to do it, it's a way forwards and I actually think it's very important. I mean it generates quite a bond with the patient and the family to do so.

and:

PN5:   I think when we're doing terminal care and things like that, I think D. [the GP] is very good with that. He does have time then. But they [GPs] don't spend the time that we do with patients. They don't listen.

The psycho-social aspects of the patients' care in patients with a terminal illness are not delegated to nurses, but are shared. What appears to set the terminally ill and psychologically distressed apart from the broad mass of patients is that, while biomedicine is not absent from their care, it is the junior partner to the social and psychological. Moreover, these patients are considered 'complex' requiring high levels of discretion in their management. By retaining the discourse of the social in these instances, GPs are able to construct an identity that links them morally and ethically to their traditional identity as a 'family doctor', while at the same time maintaining their status in the organisational hierarchy. Again, it is the GP who delegates control of discretion and indeterminacy.

## Reconstructing patient-hood

A managerial discourse of redistribution organised around the hierarchy of appropriateness that we have described, not only reconfigures patients as objects of a clinical procedure such as 'dressings' or 'taking blood', or as biomedical diseases such as 'cystitis' or 'a rash', but also functions to reconstruct the requirements of patient-hood. Within this hierarchy of appropriateness some patients do not meet the criteria of patient-hood. Responsibility for the care of these patients is delegated back to the patients themselves. These patients are taken 'out of the system' (see GP3 above). The effect of such an approach is to reduce the importance of the patient's narrative and runs counter to the 'rediscovering [of] the patient' that today's patient-centred general practice aspires to (May and Mead 1999). The patient becomes less of a person and more of a biomedical diagnosis to be managed in the system. We can see this in the next excerpt from a nurse's account, in which effacement of the patient is illustrated. The patient disappears to be replaced by a computer number with a biomedical problem:

PN6:   I just use computer numbers [When carrying out telephone triage], so therefore names don't sink in that much, so when you see them again you don't know who they are. Because even when I go into the doctors and say Mrs so and so wants a prescription for cystitis, well it's not Mrs so and so, it's a computer number.

The dominance of the managerial discourse is not complete. Some respondents appear concerned that overly managing the system might cause the 'patient as a person' to disappear:

M2:   We've moved on from the old cosy doctor sitting there with his cup of tea, chatting away and a quick look at whatever the problem was and or just in and out with a prescription. We've got the opportunity to improve things now but I think we must be very

careful not to lose sight of what the patient is there for. That they're still patients and the doctor's still a person and we must not let the computer and the technology and the need to do things ready for audit interfere with the relationship between the doctor and the patient.

This manager justifies the *new* system by configuring the *old* way as technically deficient, and by implication, dangerous. The cosy chat, but no examination, is out. She centres the doctor-patient relationship as the most important aspect of general practice. However, this is a new kind of doctor and a new kind of encounter. The doctor is reconfigured, not as a free agent or the centre of discretion, who reaches for the prescription pad after a chat, but as a medical consultant, a disciplined subject, who examines the patient. The doctor is located in (and by) the technologies of efficiency and transparency – the computer and the audit. Although the doctor-patient relationship remains key to general practice, it has become a mechanism through which technically competent and externally accountable bio, not social, medicine is performed. The patient is reconfigured as an object of a clinical-managerial surveillance.

The tension that exists between the managerial discourse of managing demand, controlling access and maximising efficiency, and the professional discourse, is ever present. Without some organisation, the professional values of patient-centred care and an emphasis on the psycho-social cannot be achieved. The manager (M2) above points out this balancing act, but another perspective comes from the one practice in this study that had no appointment system and offered uncontrolled access. There is a clear sense of a system dangerously out of control:

GP6:   Now when you say seeing, I mean that's pretty much probably all you're doing. I mean, don't get me wrong, some of that could just be a sick note or, a lot of it I feel by that stage is just triaging in itself. You're just literally, child comes in, it's meningitis exclusion and you're literally going through things as quickly as possible.

In this system in which access was controlled by the patients the clinicians were unable to practise anywhere close to the aspirations of biographical medicine. The GP goes on to say:

GP6:   I think this practice is unusual, because of where it is personal care's quite a luxury, you know, I think in lots of ways we are at the sort of coal face, if you like.

This example perhaps suggests that a discourse in which management either dominates or is absent results in the effacement of the patient as a person. In both cases the patient is reduced to a biomedical diagnosis.

## The discourse of justification

It is clear from what has been described above that the respondents' accounts offer a justification for the organisational changes that are redistributing patients, particularly those who present for 'same-day' appointments, to the different types of practitioner within the practice. The discourse of justification co-opts patient-centredness in the service of the managerial to construct appropriateness *for* patients:

> PN8:   I mean my personal view of triage is that I'm not preventing this patient from seeing the doctor. What I'm doing is I'm looking at triaging them and getting them to the most appropriate form of care.

This nurse does not see herself as a barrier, but in reality she is preventing certain 'inappropriate' patients from seeing the doctor, or in some cases being seen at all. Once patient demand is regulated in this way patient-centredness can be deployed to depict an organisation in which those patients who gain access get given more time with clinicians and biographical, patient-centred, care can thrive:

> GP6:   So, instead of always saying well we can only deal with one problem at the moment, can we get you back next week for the next one, and so on, we may actually have an opportunity to look at the whole issues and sort them out in one go. It may take quarter of an hour or 20 minutes, but that's more than we've, you know had up until now.

Anticipating the introduction of triage and a reduction in the number of patients he will see, this GP suggests that 'whole issues' can be sorted out. This might mean that within a longer consultation it might be possible for him to deal more effectively with complex biomedical problems, enhancing his new professional identity as a biomedical GP specialist. Alternatively, lengthening the consultation time might allow him to explore beyond the patient's presenting problem into the realm of the psycho-social. In other words, he might be more able to achieve the aspiration of biographical patient care.

   In the same way that increasing the time available to GPs might enhance their identity as practitioners of biographical medicine or as biomedical GP consultants, so the redistribution of patients from doctors to nurses is justified in a way that suggests two interpretations. As has been described above the redistribution tends to be framed within a managerial discourse. As a result patients are allocated on the basis of their biomedical condition to those practitioners with the 'appropriate' level of expertise and knowledge.

The biomedical emphasis within this discourse devalues the social and psychological components of patients' problems. However, within the discourse of justification an alternative patient-centred construction also appears. By redistributing patients to nurses, who are widely, but not necessarily correctly, viewed as being able to communicate more effectively with patients than GPs, there is potential to improve the quality of the patient-clinician relationship. Nurses are assumed to communicate better with patients because they tend to spend more time with them and they are perceived to be less intimidating than GPs:

> PN8:   They're a lot more relaxed with us. Some patients, you know, are fine going to see a GP. But a lot of patients, I would say, feel nervous. They see the GP as this person sat on a pedestal and a lot of patients come in and when they realise they can see us with acute illnesses 'Oh I can talk to you so much easier'.

This nurse is reinforcing her professional identity, which is framed in terms of patient advocacy and communication and which is, as we saw earlier, separated and in these areas superior to that of the GP.

## Conclusion

Our theme has been how primary care practitioners and managers construct a hierarchy of appropriateness, both of patients and of work. Specifically, drawing on Latimer's (1997) notion of the constituting of classes, we have examined how the respondents characterise, and classify, different aspects of primary care work and patients. To do this we explored how the priorities that form the basis of this hierarchy of appropriateness are constructed. We have shown that these priorities are predicated on the degree of clinical discretion that is extended to a particular team member. For example, clinical practices that demand low levels of discretion, but require practical skills, such as taking blood, are delegated to the least qualified practitioners. In contrast, those that demand the highest level of discretion, such as making a differential diagnosis, remain with the more highly qualified nurse clinicians and the GPs. Doctors retain the power to decide levels of discretion and so to define the division of labour.

Through their accounts of how work is redistributed between different kinds of health care professionals, GPs, practice nurses and managers are able to reinforce old hierarchies of knowledge and expertise, particularly those between doctors and nurses, and invent new ones between different kinds of nurse and different kinds of GP. Importantly, as they reinforce and develop their professional identities, a new kind of character for the general practitioner is beginning to appear. The general practitioner role is becoming reconfigured by those working in general practice as a 'biomedical specialist'

or 'consultant', rather than the more traditional, biographically-framed, 'family doctor'. A similar process, but at a more advanced stage, is shown to be occurring within practice nursing. The generic, practice nurse role is disappearing and is being replaced by a segmented hierarchy, with nurse clinicians and practitioners at the top and health care assistants at the bottom.

In addition, we have shown that as a result of this reconfiguration of nursing and medical roles a 'hybrid' form of general practice emerges, which is distributed between nurses and doctors. The nature of this work is not fixed and can be performed by both doctors and nurses, depending on the qualifications and expertise that the individuals possess. Crucially, it does not depend on whether they are medically or nursing qualified. In the past this type of work would have been automatically medical work, but this is no longer the case. However, by reconfiguring themselves as 'specialists' or 'consultant' GPs can, with the exception of this negotiable area of 'hybrid' work, retain control of those interactions with patients in which there is a high level of indeterminacy. GPs are therefore able to maintain their high professional status within the organisation and sustain a hierarchical difference between themselves and nurses.

At the same time that constructing a hierarchy of appropriateness assists GPs and practice nurses to reconfigure their identities, it also organises the clinical domain and so the patient's interaction with the practice. This offers one solution to the competing influences of government policy, which strives to increase access to primary care (Department of Health 2000), and the desire of those working within general practice to manage patient demand. Patients are categorised according to the hierarchy of priorities set by the practice. As a result, different classes of patient are constituted, which determine the routes that patients take through the system. Patients are thus disposed of according to an extended hierarchy of expertise. Those patients with the most complex problems are allocated to those practitioners with the most expertise and knowledge.

There is a third consequence of this constituting of classes. Because the hierarchy of expertise is also a hierarchy of resources, constituting classes of work, patient and professional also assists those working in primary care to deliver the external policy agenda. Those with the least expertise are the least expensive. Therefore, allocating patients to this hierarchy not only organises the clinical domain, but also delivers the management and external policy requirements of efficiency and cost effectiveness.

From within this discourse of categorisation a new sort of primary care is revealed, in which the 'traditional' identities of GPs and nurses are changing, and in which the notion of patient-hood is also changing. The development of 'consultant' or 'specialist' appears to threaten the biographical identity that GPs currently aspire to. The adoption of a biographical or patient-centred medicine from the 1960s onwards has formulated a particular kind of clinical gaze that includes the patient's social and emotional life

(Armstrong 1979). By constructing categories of patients and their problems and then disposing of these across a hierarchy of health care professionals, it is possible that the clinical gaze is changing.

As those professionals, both GPs and those nurses who are higher up the hierarchy, increasingly focus on the biomedical and complex they begin to develop a clinical gaze that is both narrowed and shared. So it is not just the traditional identity of GPs that is threatened, but also that of nurses; especially the most highly qualified ones. As they increasingly focus on biomedical problems and begin to work like doctors, by making diagnoses, for example, so their identity, which traditionally is configured through the discourse of holism and personal care, is further challenged.

In the discourse of general practice there appears to be a retreat from an interest in patients-as-persons in favour of a rhetoric of improving through-put. The increasing use of nurse triage to manage patient requests for same-day appointments is the ultimate expression of the categorisation process. The discourse of triage redefines patient-hood and prevents certain 'patients' from gaining access to the system at all. Those patients who are permitted into the system are then allocated to a hierarchy of appropriateness, based predominantly on their biomedical not psycho-social needs.

These accounts appear to suggest an effacement of the social relations that have previously underpinned medical work in general practice. We want to suggest that this reflects how increasingly people are thrown back on themselves, as individuals who make individual choices, rather than as subjects of professional power and knowledge. Furthermore, if a concern with patients-as-persons is being squeezed out of the discourse of general medical practice, then this has implications for what is known as social medicine. For some theorists, social medicine is connected to particular forms of governing: the discourse of the social which extends medical power to all areas of people's biographical and social lives (Armstrong 1983, Silverman 1987).

It seems that GPs increasingly are no longer configuring themselves or being configured as concerned with people's conduct, with them as psycho-social beings, only with them as biomedical problems (with some exceptions, such as the mentally ill and the dying). A government policy agenda that strives to apply increasingly active managerial values to the NHS encourages this retreat by GPs to a more purist biomedical space. Within this space GPs can perform 'evidenced-based medicine' (EBM Working Group 1992), and their performance can be more easily measured. Responsibility for the care of patients outside this biomedical space is delegated to others, including patients themselves. However, this change also implies the erosion of an older ethical discourse, shared by doctors and nurses in general practice, in which the patient is an 'individual' who is cared for as a 'whole'. If this discourse is drowned out by biomedical and managerial ones the result will be a different type of general practice – more efficient, but less personal.

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## Notes

1    One of us (Latimer 1997, Latimer 2000) has developed an analysis of the 'constituting of classes' that builds on earlier studies of medical decision-making: in particular Berg (1992), Dodier (1994), and Silverman (1987). Her key departure from this body of work is the move away from individual patient-clinician contacts to examine how through 'constituting classes' of patients the decision-making process allows the practitioners to configure their own identities, organise the multiple clinical domains within their organisation and address the needs of the external policy agenda.

2    We do not discuss here the implications of this for the practice of data collection, or the ways in which respondents framed their accounts. We do recognise that it *has* affected the latter, and in an empirical study Chew-Graham, May and Perry (2002) have described some of the ways that general practitioner respondents in qualitative studies describe these effects and attribute specific professional identities to medically qualified interviewers. Clearly, were a social scientist to have conducted the interviews, this would also have affected the ways that accounts were framed and focused.

3    Primary Care Groups are groups of local healthcare and social care professionals who together with patient and Health Authority representatives take devolved responsibility for the healthcare needs of their local community. (http://www.doh.gov.uk/pricare/pcgs.htm)

4    Under the NHS (Primary Care) Act 1997 an alternative contractual arrangement for providing primary care services in the UK was established as a pilot scheme. These are called 'Personal medical services' (PMS) pilots. (http://www.doh.gov.uk/pricare/pca.htm)

5    At the time of the study many of the practices were introducing 'nurse triage'. Although the process of 'nurse triage' varied in the practices under study it had the following consistent features. Patients who contact the practice requesting a

'same-day' appointment are directed by the receptionist to the triage nurse. The nurse then speaks to the patient, usually by telephoning her/him back at an arranged time, and offers a range of solutions to the patient's problem. These solutions range from advice on self-care, an appointment with a nurse, a 'routine' appointment with a doctor or a 'same-day' appointment with a doctor.

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