

**A CASE FOR DIALOGIC PRACTICE:  
A RECONCEPTUALISATION OF 'INAPPROPRIATE' DEMAND  
FOR AND ORGANISATION OF OUT OF HOURS GENERAL  
PRACTICE SERVICES FOR CHILDREN UNDER FIVE**

**A thesis submitted for the degree of Doctor of Philosophy**

**by**

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**July 2000**

## ABSTRACT

The recent expansion of general practitioner (GP) out of hours cooperatives indicates that many British GPs see this as the solution to managing out of hours work, particularly the 'problem' of 'inappropriate' demand. This thesis investigates the highly contentious subject of 'inappropriateness' of demand for out of hours GP services for children under five, and develops a methodology that allows for a reconceptualisation of the issues involved based on the beliefs, assumptions and practices of all those concerned, rather than locating the 'problem' within the province of parents alone, or within the doctor-patient relationship as a bounded system.

Using a predominantly sociological and anthropological conceptual framework, the thesis draws on a synthesis of views and practice, bringing those of professionals and parents together with fieldwork observations based in the primary care centre setting. It suggests that contrary to talk about management of the 'problem' in technical, bureaucratic and medical terms, this becomes a moral issue in practice. Scientific or organisational imperatives disguise largely moral proscriptions and examples illustrate ways in which moral and emotional dimensions embedded within these social relations can conflict with particular forms of rationality. The analysis shows how organisational initiatives that fail to take account of such moral frameworks can produce unexpected and unintended consequences. The thesis illustrates the value of what is described as a dialogic process, taking account of the fluidity between voices, layers of time and space, and interchange between researcher, participants, and future audiences.

The play of these issues in the rapid and extensive growth of cooperatives is discussed in the wider context of the rhetoric of consumerism and shifts in interprofessional practices and relationships. Negotiation of 'appropriate' supply of and demand for out of hours services has had a major impact on government initiatives for primary care as a whole. Thus key elements in the formation of cooperatives, originally targeted at a more narrow conceptualisation of problems, can be seen as expressing a deeper impetus for change, and serving as vehicles for more fundamental and rapid development.

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## **ACKNOWLEDGEMENTS**

Research and writing are dialogic processes, and this thesis is a result of the social relations I have been a part of for the past four years. I am therefore glad to have the opportunity to thank some of the people who have been especially helpful to me along the way.

First, my husband Peter Kamlish and son Nicholas have provided me with inspiration, motivation and a great deal of love and understanding, for which the words 'thank you' seem totally inadequate. I hope this work will prove worthy of their many sacrifices. Thanks to my mother Ione for her care and all I have learned by her example.

I would like to say an enormous thank you to my supervisor Ian Robinson, who has been a source of help, encouragement and friendship, and has created the supportive and stimulating environment at Brunel University which I have so much enjoyed.

I am very grateful to those parents, children, nurses and general practitioners who shared their consultations and experiences with me. In particular, David Lloyd has greatly facilitated the study with his boundless enthusiasm. Thank you also to Paul Wallace for his interest and assistance.

My special thanks go to Jane Sandall and Clare Williams for all of their ideas, counsel and lifting my spirits when my confidence flagged, and I owe Clare an extra thank you for a superb editing job.

I would also like to express my thanks to Ronnie Frankenberg, Adam Kuper and many other colleagues at Brunel University for their sage and challenging advice. A special thank you to Helen Harland for making our fieldwork extra fun.

In the field of medical sociology there are even more thanks due, but particularly to Gareth Williams for his detailed comments on part of chapter three; Mike Bury, Mary Ann Elston and Jonathan Gabe, who welcomed me into the world of medical sociology; and Penri Griffiths, who made sociology a riveting subject for me as an undergraduate and whose lessons have not been forgotten.

Finally, I am grateful to the London NHS Executive R&D, previously North Thames, for their generous financial support, without which I would have been unable to undertake this work.

## Introduction

What is healthcare? Is it the application of technical and scientific theory and practice to the cure and prevention of disease, or attention and response to illness and suffering in a broader sense, or something that draws on all of these things, or something more? The meaning of healthcare is shaped by and shapes the organisation of care; that is, it is constituted through the interaction of the people who engage with each other in the pursuit of providing and receiving it. An important part of that process is the negotiation of who is entitled to care from which others, and in what circumstances. This thesis investigates constructions of demand for out of hours general practitioner (GP) care, and in particular the concept of 'inappropriateness' of such demand and its function in the mobilisation of changes in the organisation of GP services.

Out of hours work for general practitioners has been a long-standing subject of contention in the medical literature, and between NHS policy makers and GPs, especially in the last ten years. A number of factors have been identified as contributing to the problem. However, existing research on what has been largely conceptualised as 'inappropriate demand' for out of hours services has so far been unsuccessful in producing a 'solution', and appears to have created further barriers to the resolution of the problems. I argue that this situation has arisen because researchers have rarely begun to question the assumptions on which this conceptualisation rests, so the twin aims of this research have been to use social science perspectives to develop an innovative theoretical framework as well as methodological approach within which both assumptions and practices can be examined.

During the first phase of my study, I reviewed the existing published literature, and had meetings with and interviewed key health professionals and academics in general practice to try to understand how the 'problem' of out of hours GP care was constructed. As a result of this work, a series of connected fundamental issues and problems unfolded, such as the reported widespread low morale, and difficulties in recruitment of GPs; the changing contractual status of general practice; and new forms of the organisation of out of hours care - notably primary care centres run by GP co-ops. In contrast little

published research existed which represented the views and experiences of healthcare users of out of hours care. The implications of these issues are examined in chapter one.

The topic of appropriateness of demand, more commonly referred to just as 'inappropriateness', has intrigued me because it touches upon many issues in medical sociology that I had explored in my Master's degree in medical sociology, and my subsequent experiences in research on childhood and becoming a parent. Some of these issues are: the relations between medical practitioners and people who consult them; how organisational practices are shaped by and influence changes in these relations; how symptoms are understood and may or may not be perceived as warranting attention; how the roles people play in both their healthcare relationships and their broader lives are constructed, and how such roles enable or constrain particular kinds of interactions and behaviours. I saw 'inappropriateness' as a point amid a number of intersecting processes and trajectories, which, because of its contentiousness, would gain from analysis through a judicious mixture of interactionist, constructionist, conflict or critical perspectives. It would also gain from drawing on a wide range of social science literature to consider how best to reconceptualise the issues. This largely theoretical background to the thesis is developed in chapter two.

I came to the view that to make a worthwhile contribution to this debate, my study should not be undertaken on the basis of essentialised, isolated categories previously hypothesised to be self-evidently material to inappropriateness, as in, for example, research which has described the statistical relationship between socio-demographic characteristics of parents of children under five and their demand for out of hours services. Thus a main aim of the research has been to develop an innovative methodological approach to seek to understand the complexity of issues in the area of out of hours care. In this context, as Williams and Popay (1994:109) argue, qualitative methods are particularly suitable in 'circumstances where the definition of the problems is potentially contested'. Therefore I formed an ethnographic research strategy derived from sociology and anthropology designed to capture the experiences of both healthcare professionals and users of health care services; to understand different interpretations of events and explore alternative conceptualisations; and in particular to pay close attention to the contexts in which parents and health professionals operate and interact. In

addition to this, I saw that this arena of service provision was undergoing rapid change as a result of both government legislation and what could be seen as more 'internal' professional moves to improve working conditions for GPs. I therefore also adopted an emphasis on process, to take account of the dynamic aspects of change and development.

A fundamental methodological issue underpinning my approach was that because of the contentiousness of the concept of 'inappropriateness', I thought it important to try not to make prior judgements about the definition or legitimacy of this term. I also want to make clear from the outset that none of the parties involved in my analysis are homogenous in their views or experiences. Therefore, whilst the issue of inappropriateness remained the central focus of my enquiry, instead of starting from the existing categories and conceptualisations, I have worked backwards from them, exploring the contexts, expectations, beliefs and practices of people involved in out of hours consultations. Through such an approach it is possible to understand and reconceptualise current interactions between people as well as their past connotations and future consequences. My approach is thus less characterised by an emphasis on categories of 'inappropriateness', or inappropriate users, and more on an emphasis on the processes by which such terms come into being in a specific context. These methodological issues are addressed in chapters three and four, and an introduction to the research settings and participants is given in chapter four.

It is clear that the out of hours 'problem' has in the past been seen primarily, and often simply as one of managing patient demand, whereas the methods I have employed make it evident that it is important to analyse the roles, behaviours and beliefs of many parties engaged in this arena, whose actions have equivalent, parallel effects on each other. Patients', nurses' and doctors' views are mutually reinforced and constituted in this process. Therefore in my analysis I have had not only to take account of the parties involved, but particularly the negotiations between them, and the processes and contexts by and in which they operate. The perspectives of GPs and nurses in the study are presented and analysed in chapter five, and those of the 'users' (patients and their parents) in chapter six. The views of professionals and patients are important, and the organisation of the material in this way allows for easier comparison with previous research. However, in their restriction to 'category based' views, previous studies, such

as more traditional sociological studies of lay beliefs, have proved inadequate to explain what happens in practice, and especially users' experience over time. Therefore in chapter seven I present an account and analysis of my observations of interactions between GPs, nurses, parents and children, producing in chapters five, six and seven (taken together) a synthesis of views and practice.

Cooperatively run primary care centres such as the one in which I conducted my fieldwork are seen by many doctors as a far more effective way of managing out of hours work than previous systems of being on call, or arranging for deputies to cover out of hours calls individually or for group practices. However, this new cooperative 'solution' simply provides another context in which practice and its rationale continue to be negotiated and constituted. It follows that my intention was not just to assess whether the cooperative is a successful solution in simple terms, such as restricting numbers of home visits made by GPs, because such an approach would not do justice to the fundamental complexity of how and why out of hours care may be considered problematic. In this thesis I have used key features of the processes, contexts and content of these negotiations within alternative conceptual frameworks, in order to illuminate and offer important insights into organisational practices in primary care and what GPs have regarded as the problem of inappropriate demand.

## Chapter One

### **'PROBLEMATIC' DEMAND IN GENERAL PRACTICE: SETTING THE SCENE**

#### **1.1 The idea of 'inappropriateness': the background to a 'problem' in general practice**

##### **a) The crisis in GP morale and recruitment: 'inappropriateness' of demand and conditions of out of hours work highlighted as major factors**

At the time of my initial research for this study, family doctors were threatening to take 'industrial action over the issue of pay for night work', and dissatisfaction with the out of hours aspect of GPs' work had grown to the point where 72.6% of GPs wished to drop out of hours work (Pennington 1995:16). Night calls and interruption of family and social life by telephone calls have been cited as particularly responsible for rising stress levels (Cooper, Rout and Faragher 1989, Sutherland and Cooper 1992). Further reported reasons for low morale and a crisis in recruitment include general overload of work; visits taking more time than surgery based consultations and therefore taking time away from other patients; being tired the next day and fearful of making mistakes or having poor judgement (Ilfie and Haug 1991); perceived danger of home visits in unsafe environments (Hobbs 1991); and the belief that a high proportion of out of hours calls are medically unnecessary and therefore an abuse of the system (Hallam 1994, Lambeth, Southwark & Lewisham Out of Hours Project 1995).

Although GPs complain of a growing burden due to rising patient expectations, including 'inappropriate' forms of demand (Salisbury 1993), explanations of how increasing demand arises are complex. To take one example, in the five year period after the 1990 GP contract was introduced, the number of night visits doubled. Baker, Klein and Carter (1994) connect this to the fact that the new contract gave a disincentive to using deputising services (GPs received a much higher fee if they did their own visits: £45.85 vs. £15 for a deputy visit). Moreover, they found that post-1990, 'the increase in night

visiting stimulated by the new contract occurred unevenly: the sharpest increases were in the very affluent authorities', and that in the very deprived areas, more visits were carried out by deputies than in affluent areas (1994:70).

This point illustrates how statistics on out of hours activity can be variously interpreted. Higher visiting rates in affluent areas could be regarded as evidence of a particularly demanding population, or, in the light of the 1990 contract incentives, as an effect of GP preferences for particular conditions of work.

This also demonstrates how matters of payment overlap with issues of who decides whether a visit is necessary and who is responsible for the outcome. Between 1984 and 1994, deputising services were required to make a visit to any patient who requested one (Salisbury 1997:183), although GPs who delegated the care of their patients in this way were accountable for deputies' actions. Patients who were reluctant previously to make such demands of their own GP may have become accustomed to the situation, post-1984, where a deputising service came out without resistance, even if GPs could still admonish patients for using the service 'unnecessarily'. As a consequence, patients may have gained the impression that a much lower threshold of concern was seen as a legitimate spur to seeking an out of hours visit.

Following a survey by the British Medical Association's General Medical Services Committee (GMSC) in 1992, which identified out of hours work (being on call, taking phone calls, and making visits) as the most major source of job-related stress for GPs, and negotiations between the BMA and Department of Health, important changes to the GP contract were introduced. The 1994 Terms of Service allowed GPs to delegate responsibility to deputising doctors if registered as principals on a Family Health Services Authority list, and GPs gained the final say as to the type (and location) of response required by any request for a visit. This was followed in 1995 by a financial package which included a replacement of the two-tier fee-for-service with a new formula eliminating the incentive to use deputies and providing development funds for new solutions to the out of hours problem, such as the increasing use of telephones as a means of communicating with patients, and the setting up of co-ops and Emergency Primary Care Centres.

Despite these developments, in February 1996 the GMSC identified the rise in both GPs' dissatisfaction (which doubled in 1994/95), and patient demand for out of hours services as contributing to a deepening general practice 'workforce crisis', calling for an urgent resolution of the out of hours issue (BMA 1996).

The issue of out of hours work is therefore extremely serious for GPs, and if it continues to affect recruitment, will ultimately threaten the functioning of the National Health Service as it has been constituted since 1948. However, the ways in which such notions as inappropriateness are constructed are highly and significantly problematic.

b) Children under five identified as both frequent and more 'inappropriate' users; parents taken off lists and 'labelled'; BMA campaign to stop people calling GPs out of hours

Children under five are reported in numerous studies to represent a large proportion of, and the most frequent users of out of hours services (Hallam 1994, Cragg *et al* 1994). Existing research has indicated that between 25% and 33% of out of hours calls relate to children under five (Dale 1995). Perceptions of the 'inappropriateness' of out of hours calls vary from between 5% to 59% of workload (Hallam 1994). Small children are seen by many GPs as mobile (or portable) in almost all cases, and therefore especially suitable for bringing to the primary care centre rather than receiving a visit. Parents who demand home visits, call out of hours too frequently, or for 'inappropriate' reasons, have been routinely admonished or taken off the list by some GPs, or put on a rotation between a number of GPs<sup>1</sup>.

As part of a deal to appease the increasing discontent of GPs and threatened industrial action, the Chairman of the GMSC, Dr Ian Bogle, and the Secretary of State for Health, Stephen Dorrell, jointly launched the Doctor Patient Partnership (DPP) in February 1996

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<sup>1</sup> Health visitor in Harrow, private communication

to encourage the appropriate use of NHS general medical services by publicising out of hours initiatives and educating the public to use GP services responsibly. (DPP, 1997a)

In March 1997 the DPP launched their campaign 'Enjoying Easter' which advised patients to be prepared for treating minor illnesses themselves and reminding people only to call a doctor for urgent problems, because of 'limited GP services... remember the doctor probably has a family too' (DPP 1997b). The leaflet for patients, and the accompanying poster, featured a rather sad looking stuffed toy rabbit with a plaster on its paw, with the caption 'Enjoying Easter. Puffers, pills and plasters. Don't run out over Easter.' (DPP 1997b). In their advice to GPs, they suggested GPs should

Encourage mothers not to bring their children to the surgery for a check before leaving on holiday. If the child is not ill, there is no reason for an appointment. (DPP 1997c)

This statement incorporates three themes that appear throughout much of the literature. First, mothers and children are singled out as a special category of patients for whom GPs need an access strategy. Second is the idea of 'checking' whether there is anything wrong (see section on this below), a concept which greatly irritates some GPs, and often leads to the third characteristic idea contained in the second sentence. By stating 'If the child is not ill, there is no reason for an appointment' as if it should be obvious, the inference is patronisingly made that mothers consult inappropriately, leaving out any other possible logical reason for needing reassurance or a professional opinion on the state of a child's health.

The DPP's corresponding advice to GPs contained suggestions about managing their own practice arrangements so as, for example, to reduce routine appointments to allow for last minute consultations before the weekend, and to plan ahead to obviate the need for repeat prescriptions at that time. However the general formulation of these issues was in terms of putting in place a concerted range of measures designed to curtail patients' 'inappropriate' demands.

In the event, the campaign had to be abandoned after complaints from healthcare organisations and unions objecting to the confusing messages it contained, and in

particular the effect it would have on the old problem of demand being lobbed back and forth between GPs and A&E departments (Walker 1997). Some of the press literature resorted to the use of 'atrocious stories' (Stimson and Webb 1975) to illustrate patients' misuse of out of hours services. For example, in an article on the campaign which cited criticisms from the Patients Association and Community Practitioners and Health Visitors Association, the following typical counter argument was offered:

Out of hours calls have increased fivefold over the past 20 years as patients have increasingly used the service for routine demands. Doctors have reported receiving calls from patients who needed an aspirin for a headache. (Laurance 1997)

One of the troubles with formulating the 'problem' in terms of inappropriate demand is that parents are working with different kinds of pressures, expectations and types of judgement to GPs, and in some respects (but importantly, not all), different forms of knowledge. Policy which appears best for the profession but does not sufficiently account for this, and instead is based on falsely negative characterisation of parents, especially mothers, seems not to have been very effective. When such educative attempts fail (O'Dowd and Linden 1997), it is not simply a question of an inability or unwillingness of patients to comply. In interviews with 120 patients about their response to the initial DPP education campaign in 1996, Shipman and Dale (1997) found that participants indicated that if decisions about what is urgent are to be medically based, the public cannot be expected to make such judgements, particularly where children are involved:

people's needs are varied and unpredictable and likely to be dictated by the context surrounding their illness. While for some minor illness may appear identifiable, it would seem unreasonable to expect all patients to be able to assess what might require urgent help and what might wait until the following morning. (1997: pp. 16-17)

In summary, despite the evidence of problems in the working conditions of general practice as a whole that are unsatisfactory to GPs but also partly of their own making, it is the 24 hour commitment that gets particular focus, along with the 'unreasonable' behaviour of patients on behalf of their children. However, the issue of what constitutes legitimate or appropriate demands is seen very differently from parents' perspective.

c) Parents in a 'no win' situation

Mothers are particularly subject to the moral imperative of providing 'appropriate' mothering, whereby their self-esteem is intricately bound to the child's well-being: the decision to seek outside help lays them open to scrutiny and thus a threat to self-esteem, in addition to the fear of wasting a 'busy' doctor's time (Cunningham-Burley and Maclean 1991:36). Mothers' sensitivity to symptoms and signs of illness are part of what 'constitutes an important criterion of the provision of 'proper care', by which others judge mothers and hence mothers judge themselves' (Brannen *et al* 1994:90).

The pressure for parents in caring for an ill child can be immense. If a child is crying continuously, vomiting, and perhaps feeling very hot, he or she needs undivided attention. However, parents (usually mothers) may be balancing the needs of other members of the family, facing a night without sleep and possibly a day of work ahead, feeling little control over symptoms which are not easy to interpret or assess (Kai 1996a), and knowing that at this time, their child is completely dependent on their decisions whether to act or not, from whom and when to get help. New parents who have no previous experience of caring for babies who are ill may be especially likely to be labelled 'anxious' if they call a doctor essentially for reassurance. Yet acting responsibly as a mother often means having the emotional and physical engagement to act on signs of illness which can then lead to such charges of 'irrationality' (Silverman 1987). From within the medical perspective, it has (somewhat unusually) been asserted that parents concerns can be seen in the context of a 'rational' framework of beliefs partly (if sometimes erroneously) based on professional advice, some of which is inconsistent (Kai 1996b). This perspective leaves unquestioned the assumption that purely 'medical criteria' are the only legitimate basis from which to judge appropriateness of demand (Hopton, Hogg and McKee 1996:994).

Parents' instincts in situations involving concern for their child's health are often to rule out all the worst things that could be wrong with their child (e.g. currently people are especially frightened of meningitis) or to seek reassurance about the seriousness of symptoms. In seeking to eliminate possible diagnoses requiring urgent action, they have

been said to act more like A&E nurses than GPs, who work within a framework which assumes that most cases are fairly benign, on the basis that in the majority of cases, illnesses in children are self-limiting and not as serious as parents fear. Parents tend to want to be 'on the safe side' since it is not possible to be sure there is nothing seriously wrong without a 'proper diagnosis' (Green and Dale 1990). A related point is that parents have to decide prospectively whether their contact will turn out to be deemed appropriate, whereas the medical judgement is made retrospectively (Calman 1997).

A lot of symptoms which are distressing to children and parents are not deemed to constitute a 'medical emergency'. Some GPs argue that most cases can be dealt with by giving telephone reassurance and advice, because a history can be given over the phone, and if more tests are required, the patient should be taken to hospital. However, sometimes parents need a professional to actually see and examine the child in order to be assured that the problem has been properly assessed, and they have not thought the problem warranted a trip to the A&E department. In addition, parents may not always have the means of getting to a *primary care centre* at night, e.g. if they are also ill, or don't have a car, or there is no one to leave the other children with (Cragg *et al* 1994, Horobin and McIntosh 1983), or the child is vomiting and crying. But these problems are often written off as 'social' and therefore not in accord with the medical criteria for assessing need. A recent suggested set of guidelines on the criteria for out of hours visits submitted for adoption by the National Association of GP Cooperatives illustrates the lack of appreciation some GPs have for the circumstances and pressures many parents face:

The old wives tale that it is unwise to take a child out with a fever is blatantly untrue. It may well be that these children are not indeed fit to travel by bus, or walk, but car transport is sensible and always available from friends, relatives or taxi firms. (NAGPC, 1995)

Similarly, the point has been made that if a parent decided to go to A&E, they would find transport, and that some parents, especially in London, choose to go straight to A&E because they know that more specialised expertise and back-up diagnostic equipment will be available. Parents can find themselves caught up in long-standing disagreements

between A&E departments and GPs about which is the most appropriate service provider (Walker 1997), being told by each service that they should have used the other.

Parents have thus sometimes felt as though they were in a 'no win' situation, admonished for using a service inappropriately, yet knowing they would be held accountable, and would probably at least partially blame themselves for failing to act on symptoms in time if it turned out their child was seriously ill. The reassurance parents seek is therefore often about whether they are right to be concerned, in addition to the actual cause for worry.

## **1.2 Current research on the 'problem' of 'inappropriate' demand**

### **a) Characteristics of parents and consulting behaviour; research on parents' views**

A substantial amount of research has been carried out to identify the demographic and psychosocial characteristics of higher-consulting parents - usually mothers (Iliffe and Haug 1991), focusing on new parents, older mothers, socio-economically deprived (Livingstone, Jewell and Robson 1989) and unemployed parents, those without a car or telephone, Asian parents, parents living in 'privileged areas' with high expectations (Pitts and Whitby 1990), anxious mothers (Leach *et al* 1993), and young single mothers (Riddell 1980).

Most of the literature on demand for primary care, including out of hours care, focuses on the characteristics of parents and their consulting behaviour, and locates causes of 'inappropriate' demand in a combination of these factors. An exception is Campion and Gabriel's (1985) study of 113 mothers with young children, which used a range of methods including contact recording by GPs, health diaries, and vignettes that described common symptoms which they showed to the mothers and 72 GPs. They found that significant disease was the strongest predictor of help seeking, with mothers' anxiety, number of children, and mothers' level of education also statistically significant. However, using the vignettes they found that the doctors responded to the question of how they would ideally react significantly more in favour of consulting than the mothers. Summarising the study as a whole, they argue that:

The tendency for doctors to attribute consultation for 'trivial' childhood problems to 'maternal anxiety' may be correct in so far as we have shown that anxiety is correlated with consulting, but to make a general judgement that such anxiety is inappropriate or abnormal cannot be justified... mothers should be regarded as competent actors, making rational decisions about their children's health. We... would argue that of the two possible deviations in utilisation, under consulting due to lack of information, or lack of concern, is far more important than the over-consulting for trivia noted by Cartwright and Anderson [1981]. (1985:329)

Watson (1991) differentiates between inappropriate use and the poor uptake, or lack of appropriate use of services that some groups make. In a longitudinal study of the use of primary care by mothers of infants in the first year of life living in East London, she found that Bengali women experienced the worst socioeconomic circumstances, and their babies had correspondingly high rates of illness, consulting their GPs and A&E departments more often than indigenous or English-speaking immigrant women. However, they also made more use of preventive services than the other mothers.

Campbell and Roland's (1996) review of the literature on why people (of all ages) consult the doctor reflects the structured basis of most of the literature, focusing on socioeconomic and demographic factors, the influence of family and social networks, and psychological theories such as the Health Belief Model. They offer a conceptual framework which incorporates these in terms of steps on a pathway from an individual's experience of illness up to the point of contact with medical care, and only briefly refer to issues such as people's faith that general practitioners' actions will be beneficial, belief that doctors will be unsympathetic, or service providers' promotion of self-care. Interactions between patients and healthcare providers, and the way that these feed back into pathways to consulting, do not feature in their model, reflecting the comparative absence of this approach in the literature.

The process of decision-making from parents' and children's point of view has been relatively neglected (Lambeth, Southwark and Lewisham Out of Hours Project 1995), but there are a few papers I would like to discuss in some detail. Hopton, Hogg and McKee's (1996) qualitative study based in Edinburgh on patients' accounts of calling the doctor out of hours in one general practice found that patients tended toward a focus on

symptoms, but instead of limiting their decision-making to medical criteria, they put these in the context of

a range of other factors that led to the call, including their feelings, concerns about specific illnesses, their responsibility for others, and... past experiences with health services that were important in explaining... their general approach to using services (1996:991).

Summarising their findings, Hogg (1997) states that whereas models of daytime primary care emphasise family circumstances and psychosocial aspects of illness, debates about out of hours care assume a different professional model of rational decision making based narrowly on symptoms and treatments:

Health professionals are encouraged to take a holistic approach to patients during office hours. But patients should not be expected to become simply a list of symptoms and signs out of hours, shedding the accompanying problems we try to understand at more convenient times. (Hogg 1997:51)

Cunningham-Burley and Maclean's (1991) research on mother's perceptions of health and illness and their decision-making behaviour used unstructured interviews and health diaries to gain information on children's mundane and everyday illness and the ways in which mothers almost always observed and treated these without seeking medical advice. They argue that seen in this context, consulting a GP represents an infrequent response to illness. In everyday life, the mothers showed confidence in recognising subtle changes in behaviour and deviations from their children's normal state, but not when interacting with general practitioners. In contrast with the vocabulary they used when talking about pharmacists and health visitors,

It seemed to be the doctor-patient relationship, in particular, which could result in a mother saying she "felt stupid". This has to be understood in the context within which women mother, and deal with health and illness. (Cunningham-Burley and Maclean 1991:35)

The context they refer to is one in which notions of normality are culturally produced, derived 'from peers, professionals, parents, the media and 'what we all know about children and mothering'' (Cunningham-Burley and Maclean 1991:32). Although their data is purely drawn from interviews with mothers and the health diaries, they make

points about the women's relationships with medical practitioners that I would like to address.

The first is that they position mothers as being 'vulnerable to feelings of being stupid or silly, which could easily be reinforced if their concerns were not dealt with sensitively' (Cunningham-Burley and Maclean 1991:35), and seem to be offering a view of women as relatively powerless within a given system. Following on from this, they leave unexplained the processes through which GPs and medicine as a body of knowledge and practice, or indeed parents, can be understood as creating, or perpetuating the conditions under which women come to feel this way, and in particular refer to doctors simply reinforcing existing vulnerabilities. It is as if we can regard these as fixed social facts, rather than looking at the processes in which these relations are produced and/or reproduced. In researching mothers' perceptions and experiences of dealing with their children's illnesses and in referring to their encounters with medical personnel, they seem to operate within taken for granted categories such as society, culture, and normality, rather than seeing these perceptions and experiences as arising not just within a 'cultural context' but within a range of particular processes in a number of contexts.

I should stress here that Cunningham-Burley and Maclean's intended focus is on how children's health and illness is managed in the home, and perceived as 'normal' within everyday life, in contrast with the majority of research in this field which, as I have said above, tends to describe consulting behaviour in terms of structural factors. However, bringing in the concept of normality as a cultural product raises many questions about the processes by which normality is produced. In a similar way, they state:

The mothers' accounts of their views on their doctors, and on whether they should consult, were also dominated by the theme of not wanting to bother the doctor and of not wasting his time. *This provides further understanding of the wider cultural context within which mothers make their decisions.* Again, this is tied to the problem of distinguishing trivial from serious problems, and to the different relevances of doctors and mothers. Some were concerned that they might be consulting inappropriately, thus 'bothering the doctor'... Again, the general practitioners themselves may not have intentionally given any indication that they thought their time had been wasted, but this shows how important it is to consider the way the mothers might be interpreting what is going on, and what concerns and vulnerabilities they bring to the interaction... The mothers' views on their

interactions with general practitioners may be grounded in both a *general sense* of what they thought doctors do, feel and say, and perhaps a personal experience or particular episode where the mother felt she had been made to feel that she had consulted inappropriately. (Cunningham-Burley and Maclean 1991:36-7, my italics)

Thus we are presented with a 'wider cultural context' which is held accountable for making mothers vulnerable to interpreting interactions with doctors in certain ways. Although they refer to the possible relevance of previous experiences, this is in terms of 'a general sense' and how they felt they had been made to feel. That is, there is little sense of women's agency outside of the home, either in themselves or in others they interact with. Instead, the catch-all of culture is referred to in explaining how and where such notions as 'bothering the doctor' arise and can be located. Although Cunningham-Burley (elsewhere) states 'Health and illness then must be seen as process and practice, rather than abstract concepts' (1990:92) the focus on process and practice in this study seems to be bounded within the home environment, and culture used as an abstract concept, even though the influence of 'outside' interactions upon these practices within the home is strongly implicated.

My point here is that in Cunningham-Burley and Maclean's seeking to describe mothers' decision-making and perceptions of health and illness solely within the home, they nevertheless make reference to key influences, such as the attitudes and behaviour of GPs, outside of this context, which seem to be taken for granted and rather fixed in nature. This is not to deny at all the validity of their representation of women's experience, which is in accord with many other reports: nevertheless, it seems to me these influences have to be explored further in the contexts where women interact with them. In other words, these taken for granted issues should also be paid attention in terms of process and practice in the same way the authors have stated the case for, and explored the work of health care in the home.

At the same time as not accepting at face value the construction of the 'problem' of inappropriate demand, it seems to me important not to accept uncritically the location of the 'problem' in parents' behaviour. In the same volume as the chapter just reviewed appears, Curren argues that research as well as practice may be racist if

it fails to examine the cultural underpinnings of health care practice itself; it may implicitly assume that white patients have *no* culture or that health care in Britain is 'culturally free' (1991:51)

and Mayall shows how mothers and health visitors hold contrasting perspectives and ideologies of child care (1991:53). These studies highlight the need to avoid adopting uncritically the professional definition of a problem when that problem arises interactionally, and in particular, locating problems only in 'users'.

Literature on consulting behaviour limited to specific situations may say more about those particular conditions than about patients themselves, e.g. Cragg, Campbell and Roland's (1994) research on the characteristics of those attending and declining to attend out of hours primary care centres. They found that people were reluctant to travel to the primary care centres (PCCs): only 20% agreed to attend, although attendances for children under five tended to be higher. Satisfaction with the service was high, but several patients said that choice of attending should be in their control, and that they would still expect to be able to have a home visit.

It is worth considering the particular circumstances in which this study was carried out bearing in mind the rapid change in out of hours provision even since 1994. All five of the primary care centres were run by a commercial deputising service, rather than a GP cooperative, and other research has established people are relatively less happy with deputies than GPs from their own practice (McKinley *et al* 1997). All of the PCCs were newly opened, functioning for between two months and one year, so most patients were using them for the first time, and would have been expecting a home visit. The PCC was run by a deputising service and switchboard staff did not attempt to persuade patients to attend in the way that those working in GP cooperatives are in a position to do. Finally, as was the case with other deputising services, duty doctors were not allowed to give advice over the telephone unless the patient specifically asked for it. All of these factors could help explain the low attendance rate, and it remains to be seen how patients will respond to PCCs run by local GPs, especially once new systems have been in place for some time, and people become accustomed, in particular, to receiving advice over the telephone.

b) Managerial attempts to alter parents' behaviour: the 'education' approach and triage as a means of managing inappropriate demand

A notable characteristic of the literature in general is that it is GP rather than patient-driven, and that the policy message tends toward the simple view that the GP-defined problem of 'inappropriate' demand can be addressed by efforts to change patients behaviour through better 'education'.

In two papers reporting on qualitative research on what worries parents and their information needs when their preschool children are acutely ill, Kai (1996a, 1996b) refers to the limitations of an education approach to parents in addressing the issue of rising demands for out of hours care. In interviews and focus groups, he sought parents' accounts of their difficulties and experiences in coping with ill young children, and their information needs. From these accounts he developed, in the first paper (Kai 1996a), a model of perceived threat and personal control in parents' management of their ill children in the context of pressures to protect their child from harm. This 'context' is mentioned briefly and not expanded upon more than referring to the parents' 'socio-economically disadvantaged backgrounds' (1996a:984) and media campaigns about meningitis.

In the second paper (Kai 1996b) he identified parents' difficulties in coping with acute illness in their preschool children, including:

- parents feeling disempowered because of their experiences with professionals in which they encountered inadequate information sharing and inconsistent behaviour
- making sense of their child's illness
- advice which left them feeling confused, uncertain and uninformed
- disparity between their own expectations and beliefs and professionals' behaviour.

Parents' knowledge was based on deviation from their child's normal state: uncertainty about the cause and seriousness of illnesses led them to seek a diagnosis and further information. However, they reported feeling excluded by the process of professional assessment, and dissatisfied with labels such as 'virus' because it did not offer a sense of being in control or define what was wrong. Variation in doctors' prescription of

antibiotics frustrated their attempts to make sense of the illness and learn for the future, although sometimes, a prescription for antibiotics helped parents to feel they were actively treating their child and therefore felt less helpless, more able to cope, and made them feel their concerns had been taken seriously by the doctor. There was a strong desire to share responsibility for assessment with a professional, but in seeking information they lacked confidence or felt uncomfortable in making their real concerns clear. They were conscious of time pressures on doctors and had experienced being made to feel stupid, or being in a 'no win' situation about the correct time to consult.

Kai then focuses on parents' expressed needs for specific and detailed advice about viral illness, how over the counter medicines and antibiotics work, the nature of rashes, how to assess severity, when to seek advice, prevention, longer term implications of illness and treatment, accessible forms of information free of jargon but including technical information, and illustrated booklets with photographs or videos.

The papers illustrate, I think, the problems in using qualitative methods without actually leaving the medical model of research. While he succeeds in producing illuminating information, the focus is narrowly restricted to physical symptoms and a 'control' or 'management' approach to abnormal signs and behaviour. The premise of the second paper, to determine parents' information needs, indicates the prior orientation towards the aim of education rather than the possibility of an unforeseen outcome from the parents' accounts. The tendency of parents to express some of their needs in ways to which this approach can be applied reflects, as Kai himself states, the context of the research in which women from 'disadvantaged' backgrounds select out of their public accounts material which they judge would be unacceptable to a male, middle-class health professional. On this basis he accepts that 'discussion may have been biased towards medical rather than lay concepts' (1996a:985).

Although Kai acknowledges the importance of extra-medical and contextual factors in parents' decision-making, and emphasises the need to clarify concerns with parents and treat lay knowledge seriously, it as if these are 'barriers' to effective communication, which, when overcome, will allow doctors, after all, to educate their patients and thereby change their behaviour. In his consideration that

Parents' understandable desire to pursue an active course of management may reflect not only erroneous beliefs about viral illness and treatment but also frustration at feeling unable to maintain control of their child's illness (1996b: 989)

it is as if there is only one 'correct' way to view and treat viral illness, that it is obvious that the doctor's role in the situation has primarily to do with aiding parents' control, and that the desire to act in such ways arises in a sense apart from social processes which encompass not only parents' motivations but also his own medical training. Thus I think the limitation to medical concepts is more a fundamental feature of his research since even if he asked for them, he doesn't analyse or report parents' views on other topics. For example, what was the GP's role other than giving information and writing prescriptions; what happens between parents, their children and others before and after what parents characterised as frustrating and confusing encounters; and what made them think of doing all the things they did about the child's illness, of which going to their GP was only one course of action?

His recommendation for consistency as if a blanket standard could be set reflects trends in health care management to routinise practice, but at the same time he states that 'Labelling an illness as viral may not be helpful unless a parent's beliefs and understanding are explored and discussed with appropriate explanation' (1996:989). He also points out the inevitable uncertainties in diagnosis and treatment, and tensions that arise in both parents and professionals in tolerating and sharing uncertainty. It seems to me there is a fundamental contradiction between his concluding recommendations for standardising practice and information and the recognition that a process of dialogue between doctor and patient is essential to avoid the pitfalls of previous attempts at 'education'. Imparting more sophisticated medical knowledge in a more sensitive way to parents, even if this research suggests this is what they are asking for (and it is arguable that they might ask for something else in a different context), is likely to suffer the same limited success (if by success we mean a reduction in demand) as previous attempts. As Blaxter (1995) argues, this type of research needs to focus less on the transmission of information from doctors to patients, and more on questions of asymmetry in doctor/patient relationships.

A further point on the futility of 'education' solutions is made in a paper by Green and Dale (1990) on initiatives to reduce the rates of 'inappropriate' attenders at A&E Departments, including notices, leaflets and media publicity campaigns, which have not produced significant effects for a number of reasons. They argue:

Differences may exist between lay and professional definitions of 'appropriateness'; it is to ameliorate this mis-match that the development of guidelines has been advocated. The results of our survey, though, suggest that even for experienced A&E staff the boundary between the 'appropriate' and 'inappropriate' use of A&E services is often unclear...Decision-making, whether by nurses assessing the appropriateness of A&E attendance, or by patients choosing where to seek care, is likely to be influenced by a complex interplay of both overt and more subtle cues, reflecting social, cultural and individual circumstances. General guidelines for the public based on the broad features of illness or injury will inevitably fail comprehensively to address all the processes involved in decision-making, and so it is unclear whether such guidelines could influence the lay person who is responding to a specific health problem'. (1990:160)

These comments arise from the considerable research Jeremy Dale and colleagues have undertaken from King's College, Dept. of General Practice & Primary Care, including a long-term project called Lambeth, Southwark & Lewisham (LSL) Out of Hours Project, which looked chiefly at the inter-agency aspects in providing out of hours care. One of the issues behind the research was that historically, demand which had been squeezed in one location often reappeared in another. There is consequently a corresponding literature on 'appropriateness' of attendance at A&E departments, and the use of triage as a means of controlling demand. Patients' experiences of access to both services may therefore vary temporally, geographically and in ways which reflect the local state of play between GPs and A&E departments.

Apart from education, the other main effort to manage out of hours demand has been in the form of nurse triage and advice. One of the areas of work of the LSL Out of Hours Project was on the development of nurse triage decision support software, and Dale, Crouch and Lloyd (1998) carried out a study on the first 10,188 calls taken by Nightdoc<sup>2</sup> triage nurses within the first six months of Nightdoc being set up, and in particular the

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<sup>2</sup> the pseudonym I adopted for the cooperative that participated in my study

nurses' use of the computerised decision support system (TAS) developed at King's College. The study looked at how the call outcome varied between nurses and according to the symptoms, age and sex of the patient. Dale, Crouch and Lloyd (1998) describe the most common symptoms and the range of variation between nurses in their decisions about how to respond to calls. They acknowledged that because nurses, like GPs, vary in their performance at managing telephone consultations, continued training is envisaged to make their decisions more consistent.

The authors make a number of claims which I would like to examine here. First, they take (the low number of) complaints received about triage nurse contact as a proxy for patient satisfaction/acceptance of the system. In the light of the highly problematic nature of interpreting reported satisfaction, and especially over-positive reports (Sitzia and Wood 1997), this seems a totally inadequate proxy. Nightdoc have also carried out a telephone survey to gauge acceptance of the new system which I think will unfortunately reproduce the common pitfalls in researching satisfaction. As it stands, analysis of four complaints by itself does not justify their view that the service appears to be highly acceptable to patients.

Another claim made is to do with the merits of consistency of advice. It would appear that demonstrating the utility of TAS in providing a means of auditing the performance of triage nurses, partly in an attempt to make their advice more consistent, is the main goal of the research. However, I would argue that Green and Dale's (1990) comments on the difficulties of producing guidelines 'to address all the processes involved in decision-making' (1990:160) would also apply here. In fact, at two nurse triage training days I attended, there was considerable questioning of how uniform nurses' advice should be expected to be, citing exceptions and individual cases that needed judgement at the time and could not easily have been predicted or covered in general guidelines.

This raises the further issue of how consistent GPs themselves are in their practices and advice given to patients. The formation of the co-op makes apparent such differences in ways that are both new and of a larger scope than has previously been the case. In devolving the initial decision-making to triage nurses, these differences are not resolved, but simply add to the already existing variations between nurses, and between nurses and

GPs. It is asking a lot of any software to be able to overcome this fundamental problem, but more importantly, to date I am not aware of any research which addresses this aspect of the great shift to cooperatively run out of hours care.

In relation to the reported lack of agreement between GPs about the services they provide (Whitfield and Bucks 1988), and how such guidelines could be agreed upon, a similar debate has been rehearsed between GPs, paediatricians, nurses and health visitors for many years on the use of a scoring system (Baby Check) to help new mothers judge the seriousness of symptoms in their young babies to decide if they should call the doctor. The debate has included the opinion that better information would cut down on 'trivial' use of GP services, but concern has been expressed that checklists should not be regarded as a replacement for babies being seen. Researchers at the University of Glasgow recently undertook a randomised controlled trial of the effect of distributing Baby Check to newly delivered mothers on the use of health services in the first six months of their babies' lives, and found that use of the Baby Check booklet resulted in 'no change in parents' use of general practitioner services for their babies in the first six months of life' (Thomson *et al* 1999). This prompted the editorial comment (Jewell 1999) that it is probably not worthwhile aiming to reduce consultation rates for this vulnerable age group, and instead it may empower parents to identify serious symptoms and consult GPs more effectively. Apart from demonstrating that the design of the study did not allow for explanations about the meaning of the consistent consultation rate, i.e. that perhaps some people decided not to go as a result of using the booklet, but others had gone when they might not have before, the study illustrates the challenges I have made earlier to the education approach at the mass information level.

c) Examining the organisational context; triage systems, telephone advice, formation of co-ops; relief of stress and low morale of GPs

In comparison to the literature identifying and labelling individual behaviour, and advocating education of patients, there is less literature which examines actions of professionals and organisational imperatives in relation to demand (McKinley 1972). As Hallam (1994) argued:

Plans to extend the “Help Us to Help You” campaign to educate patients would benefit from examining possible relations between demand and daytime surgery hours, waiting times for appointments, and time allowed for appointments. If more appropriate use of out of hours services is to be encouraged these factors ... will require further investigation. (1994:252)

In her 1994 review of published work on out of hours primary care, Hallam suggests further that although the 24 hour commitment has been a special focus of complaints about general practice as a profession in the UK, the problems are not likely to be solved by a simple reduction in hours:

this aspect of their workload contributes disproportionately to feelings of stress, fatigue, and fear of violence... Opposition by general practitioners to the 24 hour contract is unlikely to be solely the result of the amount of time spent on call... most general practitioners have considerably reduced the on call component of their workload. Instead, 24 hour responsibility seems to be unacceptable because of the increased workload and stress during daytime. Thus, changes in the method of delivering out of hours care that further reduce the hours worked on call but do nothing to address the problems of general stress and dissatisfaction may be only partially successful in persuading general practitioners to retain 24 hour responsibility. (Hallam 1994:250-251)

There is also very little research that substantiates the purported link between the ills of general practice as a whole and the inappropriateness of out of hours demand. To the contrary, Green (1996) reports that single-handed GPs found the 24 hour commitment less stressful than their colleagues in group practices, and that evidence suggests they did far more on call work than group practice based GPs, but perceived the amount as low. This was because they constructed the meaning of out of hours work differently, perceiving their time as a continuous responsibility rather than dividing it into periods of surgery, on call and free time. They also found it easier to deal with patients by telephone since they had ongoing, first-hand knowledge of them and their histories, and operated a policy of availability, seeing themselves as part of the local community. These arrangements and attitudes created a context in which the issue of inappropriateness was given far less attention, and was not a focus of stress. In these and other ways, single-handed GPs viewed continuous responsibility as a source of pride rather than a burden (Green 1996:89). Those in group practices who saw their community as their professional colleagues tended to speak more negatively of people in the locality of the practice. Inappropriate demand was partly constructed by the boundaries which they put

in place to separate their free time off from working time, and themselves from the 'community'. These findings resonate with those of Sandall in relation to the ways midwives in the community handled out of hours work in contrast to the hospital based system (Sandall 1998).

Further factors in the organisation of general practice that have been investigated as contributing towards rising demand for out of hours services include short consultation times and limited daytime availability, limited awareness of psycho-social problems, and poor communication and education skills (Usherwood 1985, Salisbury 1993, Iliffe and Haug 1991).

The use of the telephone in general practice has changed substantially in the last twenty years, and it is interesting to note how these changes fit into the picture of the current radical reorganisation of out of hours arrangements. Apart from telephoning to make appointments and requesting a home visit, patients have increasingly been able to speak to a GP over the telephone instead of meeting face-to-face, although a further consultation at the surgery or at home may be the outcome. This has been seen as an effective means of managing GPs' workload, especially out of hours, but also during surgery hours as a way of avoiding the need for both surgery appointment time and out of hours contact (Virji 1992).

In a study of GPs' views of patient access by telephone, Hallam (1992) noted key themes in the GPs' responses, including the importance of prior knowledge of the patient and/or caller, which helped determine the caller's reliability in reporting symptoms; agreement on particular symptoms or categories of patient where telephone advice was inappropriate, e.g. any illness in a young child; and the operation of a fail-safe policy whereby if any element of doubt existed, the decision to see a patient would be taken unless it was positively safe not to, rather than positively necessary that they did see them. Similarly, it was noted in a study of nurse telephone triage in Wiltshire (SWOOP 1997) that the practice policy dictated that all calls for children under one year should automatically be referred to the GP. Taken together, these themes would seem to indicate that it would be unlikely that GPs then would be happy to use the telephone

alone for queries about children under five unless they had ongoing knowledge of the child and parents, and were certain the symptoms were not serious.

Hallam (1993) also sought the views of patients on access to GPs by telephone and found that although a high percentage of patients reported being satisfied with the help they received from the doctor, there were difficulties in getting through on the telephone and patients were more likely to be dissatisfied if they were questioned by the receptionist before being put through. Hallam comments that

the need to convince receptionists of their need to speak to a doctor may have contributed to the high proportion of patients claiming their call represented an emergency, an assessment which was apparently not always shared by the practice. (1993:334)

Nagle *et al* (1992) reported a high level of patient satisfaction with telephone consultations, although the GPs in the study were less happy and 26.3% of the patients in the study said they would have preferred a face-to-face consultation. It is interesting to note that in this study, 58.8% of the patients were known to the doctor and patients' records were also given to the doctor for each call. There was also a significant difference between patients' and GPs' report of the consultation, with 42.8% of patients saying the doctor had given them reassurance, but only 26.4% of GPs saying they had given reassurance. In contrast to Nagle's research, Salisbury (1997) found that patients were likely to be dissatisfied with telephone advice (provided by a deputy or the GP cooperative) in comparison to face-to-face contact.

It seems overall that patients appreciate being able to consult their GP by telephone, and that this can be a useful way for GPs to manage their work, although Salisbury's (1997) findings suggest more evidence is needed on the possibility that patients' preference is for face-to-face contact. The conditions under which telephone advice succeeds stress the GP's knowledge of the patient and fairly unhindered or direct access rather than too restrictive screening through a receptionist. In the very short time since these reports were published, out of hours care has undergone radical change, making these conditions increasingly less common. Patients contacting out of hours GP services now are more likely to encounter call handlers and triage nurses, and only if it is deemed necessary, one

of the doctors from a large number belonging to the cooperative, who will probably have no knowledge of them or access to any records. Twenty-four hour responsibility is still part of the GP's contract, but the days when patients had a 'personal doctor' in the sense that single-handed GPs have manifested are almost gone. As one foresighted patient put it:

With all respect, would there be a great temptation to direct patients to the advice line rather than make surgery appointments or home visits? (Nagle *et al* 1992:192)

The suggestion that it would be 'tempting' not to have face-to-face contacts with patients, and the preliminary remark 'with all respect', infer that this patient regards these moves as some kind of transgression. In the past there was concordance that personal care was a core characteristic of general practice, and this was stated explicitly in 1969 by the Royal College of General Practitioners and restated in 1996 by the General Medical Services Committee of the British Medical Association and the Department of Health (Baker 1997:831). Personal care does not necessarily mean a personal relationship in terms of intimacy or friendship, but it suggests ongoing individual knowledge and continuous responsibility for patients, which has implications for organisation of the service. The evidence suggests that continuity of care (see next chapter), though not a guarantee of good communication, is an important prerequisite to the development of relationships between doctors and patients in which personal care is more likely to take place, and that although some patients may prefer choice and immediate access to adhering to a personal list system, there is, as Baker argues:

substantial evidence about the importance of continuity in influencing patient satisfaction and other aspects of outcome. Higher levels of continuity are consistently associated with higher levels of satisfaction amongst groups of patients. Furthermore, being able to see the same doctor has been rated by patients among the more important features of general practice. (Baker 1997:831)

Freeman and Hjortdahl (1997) distinguish between longitudinal and personal continuity, suggesting that longitudinal continuity may not be as important as the nature and quality of contacts they wish to imply by the term personal continuity. The former requires care from one doctor over an extended time span, but the latter could include coordinated care from a primary care team as long as the principle of continuity of carer is balanced

with willingness on the part of patients to wait for their chosen practitioner, acceptance of referral within a team for special skills, and supportive practice arrangements. Their critique of a simple adoption of longitudinal continuity reflects the changes in the expectations and characteristics of the contemporary general practice workforce, many of whom, increasingly women, wish to work part time and not to commit themselves to a lifetime in one community.

Two unusual solutions to the stress of out of hours work appeared in the literature which run counter to the prevailing trend of setting up GP cooperatives. One was tried by a six partner practice who reorganised their schedule to cut down on the number of hours worked each week, but opened the surgery for longer hours, staying open during weekday evenings until midnight. Demand shifted to less than half the rate during the hours between midnight and 7am, and increased between 10pm and midnight. Although the GPs did more work during evening surgery than they did when on-call during the same period under the previous arrangements, they found it less stressful because they were 'at the surgery and... geared up to work and not sitting at home hoping nobody will call' (Cooper 1992). The second solution was in the form of a cooperative with the difference that it offered ambulance transport to the centre for people without cars or who could not afford a taxi. Telephone advice was also offered only by GPs because, although they considered nurse triage, they felt their patients were more satisfied when they spoke to a doctor. In this way they had arrived at a home visiting rate of 6.5%, attendance rate of 33.5%, and telephone advice rate of 60% (Marshall 1997).

All of the evidence confirms that primary care is undergoing radical change, and that great experimentation is taking place with the organisation of general practice, including out of hours care. As others have argued (Hallam 1994, Hallam 1997) it is important that these innovations, e.g. GP cooperatively run primary care centres, are carefully and sensitively observed and analysed to ensure that they achieve change where it has been needed but do not lose what is most valued by both users and providers.

d) Investigating the idea that more information will bring the respective parties and their interests together in relation to demand for primary care

The idea that more information about parents could help align the interests of users and providers is the premise of 'Child Health Matters', a collection (referred to above) edited by Wyke and Hewison (1991), which includes chapters on studies which seek to understand the perspectives of parents on health and consulting GPs and other health services. In their introduction they state:

... a gap exists between the needs and characteristics of service users, and the functions and characteristics of a health service as seen by its providers. We believe that it is in everyone's interests to reduce this gap as much as possible - to bridge the information gap. Service users would be more satisfied with the service they received, and providers would be more satisfied with their jobs. It would also, of course, be more efficient of everyone's time and energy if the service were even more appropriate to clients' needs. (1991:2)

This idea is echoed more generally in the literature, with the implication that if health professionals and 'consumers' only understood each other better, communication would improve and hence produce a more successful outcome. Better communication is often advocated at the end of discussions about how people perceive interactions to have been unsuccessful. This assumes that if health professionals and patients achieved better communication and understood each other better, they would act differently towards each other, and/or their interests could be made more complementary to each other. Alternative possibilities are that people may already 'understand' each other fairly well, but simply have different interests which are not so easily reconciled, or that by understanding each other better, the differences in their interests would become more entrenched. Another is that people do not usually judge each other on the other's own terms, e.g. what patients regard as the qualities of a 'good doctor' may not be the qualities doctors themselves believe are most important (Roberts 1985: 13).

### 1.3 Conclusion

I have shown how demand for out of hours primary care has become the focus of a great deal of controversy, new legislation and organisational change in recent years. The crisis in GP morale and recruitment has found expression in complaints about patients and what is regarded as their excessive and inappropriate demand. Particular patient groups, forms and times of requests for help and advice have been singled out as producing especially problematic out of hours healthcare demand. Children under five represent a large proportion of users of out of hours services, and the nature of help-seeking for this group has been particularly criticised by GPs.

The great discontent felt by GPs, as represented in national campaigns and the literature, covers many aspects of their work but focuses sharply on out of hours work and the characteristics of the demand and expectation for services. At the same time, although parents' experiences have been relatively under-represented, there is evidence that attempts at limiting access and stressing 'education' meet with some resistance or are themselves inappropriate. The approach commonly taken in health services research restricts the conceptualisation of GPs' problems in relation to the management of demand, to issues of clinical need, and GPs' own organisational needs and concerns (Rogers and Elliott 1997). Furthermore, arrangements for out of hours care are undergoing very rapid change, taking this kind of conceptualisation as the starting point for bringing in measures to control demand and change patients' behaviour. Yet social science based research indicates that measures using, for example, the educational approach within a relatively narrow medical framework have had little success, and highlights the need to look beyond the medical definition of need to recognise both 'lay' perspectives, and the contextual, processual and relational aspects of utilisation.

In their extensive review, 'Primary Care: Understanding Health Need and Demand', Rogers and Elliott (1997) set out what they see as the implications for future research arising from the existing literature, and their summary headings are as follows:

1. Research on the formulation of demand and use of services should be based on the use of a social process model

2. Incorporating lay understandings and past experience of services with subsequent primary care use
3. Mapping the relationship between self- and informal care and type of primary care
4. Assessing the influence of social networks and context on primary health care use
5. Research on use needs to be integrated with research on professional practice, quality and structure of primary care. (1997:55-57)

These 'social' aspects cannot be sectioned off somehow as if, once understood sufficiently, they could after all then be pressed into service in pursuit of the unchanged aim of reconfiguring demand. In looking at the literature all together, there is a need for a fundamental reconceptualisation in terms of a variety of interests converging around healthcare for children in particular circumstances, without prejudging what are the 'problems' or locating them in any one set of actors. Although the literature reviewed in this chapter seems to lead to a recognition of the need to look beyond, for example, existing categories and characteristics of demand, it still seems bounded and over-structured in certain ways, and so doesn't go far enough in allowing for process and rapidly changing contexts. The challenge is to work out a way of considering these issues of process and change, instead of configuring the problem in existing, largely static and categorical terms. To help develop a theoretical framework which allows for a more relational conceptualisation of these issues, chapter two draws on the wider social science literature.

## **Chapter Two**

### **RECLAIMING RELATIONAL GROUND: A SOCIAL SCIENCE FRAMEWORK FOR RECONCEPTUALISING DEMAND**

Although out-of-hours care represents only a small proportion of all primary care workload, it is the point at which the tensions between patients and professional expectations are felt most acutely. The challenges and difficulties have led to a period of intense innovation and experimentation. These developments may prove influential well beyond out-of-hours care, leading to a re-evaluation of core values in general practice, changes in relationships between local practices, the reconsideration of the place of a GP as an independent contractor in an integrated health service and, most importantly, a change in the nature of the relationship between patients and their doctors. (Salisbury 1999:181)

Salisbury's comments are in accord with my arguments in chapter one, that questions around demand for out of hours GP care, and the concept of 'inappropriateness' of demand in particular, lie within a web of issues that need to be addressed in order to understand the context in which various interested parties contest its meaning. I concluded that many existing studies focus on partial views and 'bounded' situations, and argued that a more processual and socially contextualised approach looking beyond technical and medical frameworks is needed to see how a range of players operate and interact with each other over a longer period of time.

The argument which structures this chapter is that, as Salisbury says, the importance of recent initiatives in the development of out of hours general practice services is far broader than that single topic. It involves the fundamental re-evaluation of GPs' relationships with their patients, with other healthcare workers, and their own professional values. This has taken place in the context of a shift in emphasis during the 1990s 'Towards a primary care-led NHS' (Dept. of Health 1994), which has seen an incremental rise in the status of nurses, such that the term 'primary care' is used increasingly in place of 'general practice'. Another switch has been that of 'consumers' for 'patients': but does the political rhetoric about what 'consumers' want adequately

express the experiences of parents who must negotiate construction of the appropriateness of demand as guardians of their children's welfare and thereby users of the healthcare system? And does it accord with what GPs feel they can best provide? Are there moral and emotional aspects of the production of health that are shared by all health 'producers', including doctors, nurses, parents and children? To what extent do all of those involved in healthcare operate according to moral constructions of one another?

It becomes clear when trying to understand such complex phenomena from the ground up that what is true of the 'applied' literature can also be said of the wider social science literatures this topic touches on. An attempt must therefore be made to integrate what may initially appear to be somewhat disparate sources. My overall aim in this chapter is to bring these together to bear on the key issues, including those identified and implicated in Salisbury's statement. As well as considering how these ideas offer possible ways of illuminating and reconceptualising the problems as presented in the medical and health services literature, I will also pay attention to the ways in which they have been generated through research, so that this chapter also acts as a bridge between the previous and next chapter, addressing methodology.

The material that follows is grouped together into six areas to reflect the strands outlined above. The first of these critically reviews the literature on doctor-patient relationships and the concept of continuity of care. The second deals with professional and organisational aspects of general practice and nursing, focusing on the concept of professional autonomy. The third section examines the literature on communication and discourse in medical consultations, paying attention to the methodologies used in research on these topics. The fourth section addresses literature on 'consumerism', and 'configuring the user', which I draw on to reconceptualise the processes of recent change in the organisation of primary care in the UK. The last two sections introduce some of the social science literature on parenting and emotional labour.

## 2.1 The 'doctor-patient relationship' and 'continuity of care'

The provision of personal, primary, and continuing care to patients in the context of an ongoing doctor-patient relationship was always regarded as an essential characteristic of general practice in the UK. (Morrell 1998:18)

Morrell's comments, in the introduction to a volume tracing the political and professional development of general practice under the NHS from 1948 to 1997, reflect the widespread belief reported throughout similar publications that the personal and continuous doctor-patient relationship is a cornerstone of the National Health Service. Yet in the same volume, Horder (1998) concludes

Erosion of the tradition of personal care is now a real danger, and its preservation is one of the great challenges we face in these times of uncertainty and confusion over the future direction of the NHS and of general practice within it. (1998: 284)

As Salisbury's comments opening this chapter indicate, the current changes in out of hours GP services have the potential to bring with them important transformations in the social relations between patients and their doctors. Previous assumptions about continuity as a fundamental aspect of the GP-patient relationship are problematic in the current circumstances because the recent changes in out of hours primary care, including the huge and rapid growth in GP cooperatives, make it increasingly unlikely that GPs will see their own patients, or those belonging to their group practice, out of hours. This situation has broader implications for core values in general practice because it is just one effect in a trajectory of change away from the model of personal care. The cooperative I studied was at the forefront of the development of nurse triage and advice, along with the technology used for this function, which has subsequently evolved further into what at present is an additional service, NHS Direct. Whereas many GPs were happy to join the cooperative as a way of relieving their 24 hour responsibility for patients, some GPs see NHS Direct and now walk-in centres as moves which lead general practice too far away from their core value of continuity and too far towards fragmentation of care. The following accounts and analyses of communication will be used to open up the conceptual basis on which we can consider, as Salisbury (1999) suggests, how this trajectory of change might transform the nature of doctor-patient relationships in general practice 'in hours' as well as out of hours.

a) Theories on the doctor-patient relationship

The doctor-patient relationship can be analysed in a number of ways, and it can be seen in most of the literature that there is an assumption of continuity in the relationship. Gerhardt (1989) provides a useful scheme of four paradigms in medical sociology. The *structural-functionalist* paradigm is represented by Parsons's (1951) 'sick role' and 'systems' theory. The doctor and patient each play a role, with complementary rights and obligations, within a shared value system. The social control aspect of the relationship inheres in its unconscious interrelations, and the mechanism of identification (Figlio 1987; Gerhardt 1987). The sick role is a positively motivated form of deviance, which Parsons regards as a breaking down of the adult's socialised ability to repress needs (e.g. dependency, passivity, irresponsibility) which conflict with the obligations and constraints of their work and family roles. Treatment entails aspects of psychotherapeutic techniques aimed at reversing the patient's retreat from adult functioning. Although this perspective has been widely criticised for neglecting conflict, it can still be applied to such issues as sickness certification for benefit and insurance purposes, with fragmentation of care extending the existing possibilities for breakdown of communication between doctors and patients.

Szasz and Hollender (1956) also use a 'functionalist' approach, identifying three types of doctor-patient interaction: activity-passivity (minimal interaction, doctor active and patient passive: severe injuries, coma, surgery); guidance-cooperation (closest to Parsons); and mutual participation (psychotherapy, chronic illness). An important point is that the types depend on the stage of treatment (e.g. after surgery a patient may be required to take active part in recovery). In line with criticisms of Parsons and functionalism, Tuckett (1976) states that Szasz and Hollender's scheme 'unwittingly perpetuates the 'rational' or 'normatively-based' model of doctor-patient interaction' (1976:201), and neglects conflict (see conflict-theories, below). It is interesting that Szasz's later work made him well known for arguing against coercion in any form of treatment, but especially in relation to mental illness (Szasz, 1961).

In the *interactionist* paradigm (negotiation, symbolic interactionism, labelling theory and anti-psychiatry) the social control element of the relationship lies in the doctor's ability to 'label' a person with his diagnosis (Freidson 1970, Gerhardt 1987), but the consultation is characterised as negotiation, carried out through rituals and bargaining, (Davis 1979, Goffman 1963, Robinson 1988, Jobling 1977) and the stress is more on the agency of the patient. Negotiation is less likely in acute situations and may address the (possibly conflicting) goals of treatment; involve the need for a patient to keep pressing for their condition to be taken seriously, or the use of technology to support the doctor's diagnosis. Interactionist approaches can be useful in examining how the doctor-patient relationship is negotiated differently by different players, with some patients being more successful than others, and some doctors being more willing than others to form a negotiative relationship. Fragmentation of care provides a different set of opportunities for patients to negotiate care because some people will find it more difficult to do this outside of an ongoing relationship, and others will be able to take advantage of more complex possibilities.

*Phenomenological* studies (ethnomethodology and conversational analysis) observe how rules such as the ideal of 'normal forms' of illness (Gerhardt 1989) are expressed in language, gesture and narrative (Berger and Luckman 1966, Garfinkel 1967, Williams 1984b, Habermas 1984, Silverman 1987). The emphasis is on the role of communication in the doctor-patient relationship, especially if it fails. This perspective allows for analysis of changes in the construction of rules and norms, and contested meanings, practices and beliefs, all of which are relevant in a time of such dramatic shifts in the healthcare system.

*Conflict-theories* (e.g. social constructionism and politics of health) point to the power imbalances which give rise to inherent conflict in, for example, the doctor-patient relationship (Freidson 1975) but also in the wider social and political context (Doyal 1979, Ingleby 1980) which determines some aspects of the nature of such encounters. Lukes (1974), in his three-dimensional analysis of power, argues that conflict is often not out in the open (Scheff 1968, Stimson and Webb 1975). 'Treatment' is conceived of less in terms of individual solutions, stressing instead legislative action and public health measures which are aimed at prevention; and the doctor-patient relationship is analysed

in terms of the respective class positions of the two parties, or the clash between professional and lay perspectives (Freidson, 1975).

Conflict theorists are particularly critical of functionalism. For example, in relation to Szasz and Hollender (1956), Freidson (1970) points out relationship types in which the doctor is not completely in charge: patient guidance, doctor co-operation; patient active, doctor passive; mutual non-cooperation; mutual passivity. Cartwright (1974) observes that patients often try to assert their own diagnosis, and suggest their own treatment. Another criticism of the 'sick role' model is that it represents a type of relationship which doctors wish to create, but does not acknowledge conflicts such as the 'double bind' situation whereby the patient is expected to make a mature judgement about when to consult the doctor, but then to defer to the doctor's authority (Bloor and Horobin 1975). Stimson and Webb (1976) found that many patients 'reconstruct' their encounter with the doctor through stories which make them appear more active than the researchers judged they really were.

Stacey (1976) questions the adequacy of the traditional doctor-patient model, embodied in the DHSS (1972) statement that doctors are primarily accountable to patients. Doctors usually work as part of a team, so that patients may benefit from a number of people's knowledge and skill, whom they may never see. Similarly, GPs may feel entitled to information about the treatment of 'their' patients when they refer them to a consultant. Stacey contends that the actions of both doctors and patients must be seen 'in the context of collective actions and interactions in the health service' (1976:196). This is part of her argument that patients should be seen as co-producers of health rather than the subjects of medical care. Of the perspectives presented so far, Stacey's is the least wedded to the assumption of both continuity and boundedness of the relationship between doctor and patient.

Armstrong refers to the idea of 'idiographic' medicine (1982:15), a focus on the whole person and biography, analysing its potential for surveillance as a form of individualised control. Armstrong (1987) also develops Foucault's (1973) notion of the doctor's 'clinical gaze' and the confessional nature of the consultation, defining the patient as an 'object of social consciousness' (1987:70), constituted by medicine, medical sociology,

and wider social processes. The creation of the social body as subject followed the development of medical and political ‘technologies’ during the early half of the 20th century which moved the ‘gaze’ in hospital medicine more powerfully to the patient’s body and inside the body; while the ‘gaze’ in general practice came to rest more on the temporal elements of illness and spaces between bodies, the chief technology being the survey (1983b:73-78).

Another element which, Armstrong argues, the emergence of this technology engendered was a new preoccupation with distinctions and conflation between normal health states and sickness, leading in the post-war years to complaints about general practice being overwhelmed by ‘trivia’ (1983:79). However, Morrell (1998:2) points to the introduction of the National Health Service as the trigger for the many complaints contained in the medical journals about ‘inappropriate demands for care particularly out of hours’, and ‘unrealistic expectations of patients’. The delivery of healthcare free at the point of delivery (with many GPs only participating under duress), which unleashed a previously under-presented amount of demand, was as important in generating a preoccupation with distinctions between normality and sickness as the increased visibility of sickness revealed by the survey. This suggests that in the analysis of my data, the process of change in relationships between GPs and patients needs to be viewed not only on a meta level in terms of discourse constituting the ‘patient-as-person’, but also from a sociopolitically inter-constitutive perspective at more of an intermediate level. In this way, we can ask both how the wider social discourse on childrearing and healthcare constitutes parents, and how changes in the organisation of the NHS inter-relates with changes in how people come to make use of it.

Returning to the notion of ‘idiographic’ medicine in which the ‘gaze’ extends to the ‘whole person’, and thereby constituting patients as psychological subjects and social objects, Silverman (1987) takes up the ideas of Foucault (1981) and Armstrong (1983b) in his critique of ‘patient-centred’ medicine as espoused by Balint (1964), Byrne and Long (1976), and Mishler (1984). Balint’s (1957) ideas have been characterised as ‘the doctor as drug’, i.e. that the doctor’s powers, presence and personality in themselves are therapeutic. By developing listening skills, the doctor can pick up ‘flashes’ (Balint and Norrell 1973) of information from the patient, even in consultations of only a few

minutes. Although Balint's aim was to 'develop a technique for psycho-therapeutically influencing the patient', it was important that this should be in a form 'which is germane to general practice, not an importation' (1973:148). Balint argued that by developing a relationship in which emotional facts about a patient are acknowledged by the doctor, the patient is less likely to present symptoms which appear to have no biological explanation, and which may be an unconscious means of bringing painful feelings to attention. Hillier (1987) makes a connection between Balint's ideas and Weber's (trans.1978) concept of 'charismatic' forms of legitimated authority, so that the patient is drawn to 'the doctor as drug' as much as, one could argue, they are constituted as a subject of medicine.

Byrne and Long (1976) suggested similarly advocating a 'patient-centred' rather than 'doctor-centred' medicine, but pointed out that doctors were not trained in the skills necessary for this kind of consultation, and Tuckett *et al* (1985) make elaborate suggestions for, as well as insightful analysis of the barriers to doctor-patient consultations becoming more like 'meetings between experts' based on genuine dialogue. However, Silverman sees problems inherent in such approaches and asks how we can know whether such psychotherapeutic communication is intrinsically valuable or simply another 'historically-located form of sense-production', just one of a number of 'publicly available ways of speaking' (1987:195). He cites Mishler's (1984) argument that systematic methods are needed to study how conversationalists themselves make sense of and structure medical interviews as a particular form of discourse (1987:195), but adds Arney and Bergen's (1984) Foucault inspired argument that the discourse has now incorporated these reforms to the extent that medicine now 'incites' rather than allows patients to speak. He also warned, as Mishler acknowledged, of the problem of essentialism in the conceptualisation of separate categories for 'the voice of medicine' and 'the voice of the lifeworld', and promoted instead an emphasis on the relation between voices.

Silverman's critique is very valuable, yet sometimes his focus on discursive forms seems to lack sufficient contextualisation. Although his studies focus on hospital medicine and do not assume continuity as heavily as other studies, he does not explore how communication in the hospital setting relates to other forms of healthcare, as in Stacey's perspective. Also, it is as if the only space between voices he is interested in are those

which relate to the medical matters at hand. Both Armstrong (1983b) and Silverman (1987) address the role of the social sciences in 'discovering' the human 'subject', which has been hand-in-hand with medicine (Silverman 1987:202). But if Silverman's interest is primarily on the subject as constituted by a focus on medically related discourse, it seems to me Armstrong's subject is only of interest as far as it inter-relates to discourses of power. He states that the 'whole person' is a multi-dimensional being constituted by a series of smaller discourses (1983b:110), but the discourses he deals with are at a meta level. I adopt a position somewhere between these two theoretical approaches: attending to the spaces between voices but more widely around them as well, i.e. not only those related to the medical 'gaze'; but perhaps making more modest claims and analysing my data in terms of more local discourses of power than Armstrong's meta-analysis engages in.

The relevance and inter-penetration of the settings in which doctors and patients meet and their wider social contexts extends beyond those relating to the medical aspects of their business with each other, and this view will inform my analysis. This was touched upon by Helman (1981) in distinguishing between the public domain, in which consultation, treatment and prescription take place, and in which the doctor's power is symbolised in various ways (the office, clinic, technology); and the private domain, where compliance with the treatment (e.g. ingestion of medication) and self-care within the home is a manifestation of the patient's autonomy. Helman found that tranquillisers could function as a symbol for the continuity of the doctor's concern, representing the doctor's presence in the private domain. This might be a factor in long term 'habits' where the drug itself is no longer thought to be effective. Repeat prescriptions can also be used as a means of regulating but also keeping active the contact between patient and doctor. As a doctor in Cartwright's (1974) study said, 'It offers her a regular and legitimate occasion to come and see me - gives some structure to her life and she feels someone is bothering' (1974:18), but perhaps the significance of such arrangements is more two-way than that, as Gothill and Armstrong imply in their discussion of the doctor herself as 'an embodied and vulnerable individual' (1999:1).

To turn to the narrower focus on the 'human environment', the involvement of parents in the relationship between doctors and child patients is obviously instrumental (Strong

1979; Silverman 1987), not only for the child but the future health of the parents (Friedman *et al* 1963); which may then, in turn, have direct effects on the child's recovery (Skipper and Leonard 1968). Laing (1961, 1971) regarded the family 'nexus' as a crucial concept in the treatment of his patients diagnosed as schizophrenic, but GPs, especially, have to weigh up an individual patient's needs against the needs of the rest of the family, and indeed other patients (e.g. the problem of viral resistance to antibiotics at a community level), so that it is not a simple thing determining who is 'the patient'.

The studies I have reviewed illustrate the close scrutiny which the doctor-patient relationship has received from medical sociologists, and the assumption that this relationship in general practice is a long-term one. They make the point that patients' needs of doctors are hugely variable, and are often in conflict with medical objectives, but they also constitute a challenge to simple versions of medical dominance. I have suggested some ways in which we can open up the conceptualisation of patients' relationships to doctors, including paying attention to questions of agency, conflict and constructions of normality; to who produces health and who are the 'patients'; to spaces between and around voices rather than focusing on the doctor and patient as a bounded couple; and to wider processes of change as important factors in the evolutions of such relationships.

b) Continuity of care

Continuity of care is a complex issue in which assumptions about its definition and intrinsic value need to be questioned. Freeman has examined linked issues such as the value of 'personal' versus 'longitudinal' doctor patient relationships (Freeman and Richards 1994, Freeman and Hjortdahl 1997), the importance to doctors of continuity of care (1985), and whether personal continuity can be compatible with patient choice of doctor (Freeman and Richards, 1993), but takes the view that the evidence on the benefits of personal continuity of care remains elusive. Some of this elusiveness may be attributable to confining the concepts within a medical framework, and concepts of value may have to be addressed at a more theoretical level and in a broader context as discussed above. The issues are raised in policy literature in terms of contradictions and trade-offs. Peer equal and younger patients may be less likely to want a 'personal' style

of relationship with their GP, but might still want continuity so that medical decisions are informed by application of knowledge from the past. Patients might want the expertise of a particular doctor, whether or not there is a good relationship. People want different things from different sources depending on the circumstances (Malbon, Jenkins and Gillam 1999:11), e.g. parents of young children often need quicker access but need continuity as well to pick up on the meaning of longer term illness patterns, but people with conditions which require a high level of medical expertise may be willing to wait for an appointment with someone they will only see once.

Typical subjects in the social science and health-related journals, some of which originate more from health services research than general practice, are evaluations of patient satisfaction with different levels of continuity in delivering care; compliance under such alternative models; practice arrangements and ways in which this impedes or promotes continuity; whether long-term knowledge of patients helps doctors make better diagnoses or leaves them vulnerable to missing things a fresh eye would pick up; and the pros and cons for patients of being able/forced to always see the same doctor. Almost no studies look at the wider context of which the consultation is only a small part, and I suspect that continuity of care is only one manifestation of a much wider set of problems that can never be resolved by assuming continuity of care to be the core issue.

Medical sociology literature on the doctor patient relationship in general practice has tended to reflect the assumption of continuity of care as either a defining or a desirable characteristic of general practice, although Jefferys & Sachs (1983) extended the focus of study to include wider organisational, professional, social and political contexts. Cartwright and Anderson (1981) quote the RCGP 1977 definition of the role of general practitioners, which stresses continuity of care, the longer term social needs of patients, prolonged contact and so on. But they also make a link between complaints about 'inappropriate' demand and the meaning for practitioners themselves of continuous, personal relationships:

For doctors to regard a high proportion [of consultations] in this light [as trivial, inappropriate or unnecessary] suggests a degree of alienation from patients and their problems; a low proportion, a degree of identification.... It was found that to some extent doctors' feelings about 'triviality' seemed to be of their own

making... In 1977 as in 1964 [their previous study] there were a number of indications that doctors' attitudes and practices were associated with their perceptions about trivialities. In the later study doctors estimating a high proportion of consultations as trivial carried out fewer procedures themselves, were more likely to use a deputizing service, and were less likely to be trainers or members of the Royal College of Practitioners, than their colleagues who regarded a smaller proportion of consultations as trivial. In addition patients were rather more critical of doctors who thought a lot of their consultations were trivial, for not taking time, and for hurrying them... Our study indicates that... general practitioners are retreating from more intimate contacts with their patients. (1981:183-186)

The narrow focus on continuity of care, taking my argument through here, could be seen as a product of the medical and social science preoccupation with the creation of an individual subject. Continuity of care assumes the value of the doctor's longitudinal recognition of and work with a patient's subjective experience. Those who perceive a threat to this core value in general practice tend to put their concern in terms of questions about whether patients value 'choice' and 'easy access' over the continuous personal relationship, because these are contradictory outcomes as general practice is currently organised.

I referred in the previous chapter to the concepts of continuity of care, longitudinal and personal care, and at the beginning of this section to Morrell (1998) and Horder's (1998) comments that although up to now the personal and continuous doctor-patient relationship has been regarded as a cornerstone of the National Health Service, this tradition is now under threat. The possibility of continuous direct and personal contact with a 'family doctor' has been regarded as a 'core value' in general practice, but has also been a key aspect of the organisation of the National Health Service since it was set up in 1948, because of its access and gatekeeping functions. The NHS as a whole is perceived by many people, professional and public, as an important political asset of the UK, as suggested by the announcement of substantial increases in funding for the NHS in the March 2000 Budget at a time when Tony Blair's government is experiencing a decline in support, so the reorganisation of such an important element of the NHS usually generates great attention in the medical journals but little public debate.

Recent initiatives such as NHS Direct and walk-in centres have the potential for routinisation and virtual 'industrialisation' of medical care out of hours, and to fragment access, care and the integrity of the registered list. Although these new services are promoted as a political response to consumer demand for easier and quicker access, choice and convenience, they also threaten the future of continuity of care in the GP-patient relationship. This contradiction lies at the heart of much of the medical research on this topic.

Later in the thesis my analysis of the ethnographic data will examine how the concepts in play in the current changes in the provision of primary care - e.g. continuity of care, choice, convenience - were regarded by both primary care professionals and users of out of hours services who participated in my research. If we question the emphasis on continuity of care as a manifestation central to constituting the doctor-patient relationship as a bounded situation, and look instead at the patient's experience and/or the doctor's experience and/or their relationship to each other as situated within a wider series of discourses or broader set of contexts, does that mean that the personal doctor-patient relationship will no longer be regarded as valuable? This will be explored in the analysis of my ethnographic data.

In this section I have challenged the notion of the doctor-patient relationship arising from or existing in a bounded space, and this raises the question of how much it is seen as a priority for patients. What patients suffer from is situated within their life as a whole, including series of discourses but also more mundane material conditions. What they want are things which doctors and their treatments can sometimes provide - a listening ear, information, explanations, company, relief of symptoms, more control over their body and their lives - but if GPs do not offer these things, will patients choose or be forced to find them elsewhere by other means?

## **2.2 Professional autonomy and organisational aspects of general practice and nursing**

In my review of the 'applied' literature in chapter one I referred to the importance for GPs in formulating new strategies for managing out of hours demand. A key initiative

has been to develop the role of nurses to include triage and advice to stand alone without patients having contact with GPs. This raises opportunities for the 'professionalisation' of nurses, and implications for the changing role of general practitioners. In this section I will introduce some of the debates around these issues, focusing on the concept of autonomy.

Jefferys and Sachs (1983) studied the effects on both patients and GPs of organisational changes in provision of general practice, following government actions for over a decade from the mid 1960s designed to encourage the setting up of group practices and health centres, partly to provide relief from the out of hours commitment. This was alongside initiatives including promotion of integration with local health authority health workers; introduction of direct access to hospital-based diagnostic services instead of going through specialists; and enhancement of the professional status of GPs in relation to hospital doctors by initiating financial incentives for taking part in continuing professional education. All of these measures were undertaken as part of a policy of promoting the role of general practice in containing growing health service costs, at a time when it was not an attractive career option compared to hospital based medicine (1983:3-6).

There are striking similarities with the situation today, in which the policy of promoting a primary care led NHS has met with a crisis in recruitment of GP principals as well as primary care nurses. The research questions formulated by Jefferys and Sachs could equally be used to highlight many of the implications of the contemporary changes in general practice addressed in this thesis. Replacing the words primary care centre or Primary Care Group for health centre or general practice unit, one could ask:

Would young doctors choose positively to enter general practice in sufficient numbers?... What tasks would doctors delegate to other health workers? How would doctors react, if, for example, the nurses employed in or attached to their practices were to demand a greater share in decision-making relating to patient care and perhaps even some autonomy in their clinical work within the general practice unit? Would doctors ... take to working in groups with other doctors?... What of the acceptability of the Health Centre idea to patients? Would they find it less easy to consult the doctor of their choice at a time of their own choosing? Would they resent nurses and others undertaking work once performed for them by doctors? (1983:7)

The promotion of nurses to more autonomous roles in out of hours primary care must be understood as part of a much wider move in this direction for nursing as a whole.

The Cumberlege report, or 'Neighbourhood Nursing - A Focus for Care' (DHSS 1986) made a number of proposals to extend the role of nurses in the community. An important development was the introduction of 'nurse practitioners' with advanced skills based on the American model. In America, Richman (1987) argued:

Doctors made little protest about the breaching of their medical domain, partly because nurse practitioners concentrated on the doctors' non-favoured clients, the chronic, the aged, rural dwellers and the poor. (1987:111)

Nurse practitioners were envisaged in the Cumberlege report to become part of a primary healthcare team, to be managed by the neighbourhood nursing manager but responsible to the general practitioner(s) for carrying out agreed medical protocols (1986:32). The emphasis was on continuing care (rather than cure for acute conditions), initial diagnosis and treatment of minor illnesses, and health promotion.

Calnan and Gabe (1991) suggest that the proposal that nurse practitioners should give prescriptions 'challenges the [medical] profession's monopoly of certain skills' (1991:152) and therefore autonomy. However, nurses will only be able to prescribe from a 'limited list', in restricted circumstances<sup>1</sup>. 'The Report of the Advisory Group on Nurse Prescribing' (Dept. of Health 1989) stipulates that 'no nurse without defined post-basic training should be empowered to prescribe under any circumstances' (Carlisle 1990a:17).

Austin (1979) has argued in favour of the extension of nurses' role<sup>2</sup> and the development of nurse practitioners, but points clearly to the problems involved: encroachment on the

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<sup>1</sup> including 'dressings, ointments and medical sprays...[and] within strictly agreed limits to vary the timing and dosage and use of alternative pain relief agents for patients who have been diagnosed by general practitioners as terminally ill and in pain.' (DHSS 1986, pages 33-34)

<sup>2</sup> into 'activities normally undertaken by a doctor but which may be performed by nurses with appropriate training and competence' (The Extending Role of the Nurse PL/CNO, 1989)

work province of health visitors and community nurses; challenges to existing inter-professional and professional-client relationships; and the need to

develop a knowledge-base to underpin the claim of independent practitioner... For *independent* practitioner she must become...a practitioner who exercises clinical judgement within an area of healthcare expertise which stands alongside, but remains independent of, medical expertise. (1979:150)

All of these proposals hinge on reforms in training set out in 'Project 2000', in which three general factors underlying the need for radical change are indicated:

demographic changes... cost-effectiveness and value for money... [and the] government policy... shift towards the community provision of healthcare and increased emphasis on the prevention of ill-health. (UKCC 1987:3)

The strategy covered a new division of labour and new arrangements for training. An 'advanced practice' level, with a 'pioneering role' was envisaged in the UKCC 'Post-registration and Practice Project (PREPP) Discussion Paper' (1990). Pashley and Henry (1990), both academics, were in 1990 optimistic that by the year 2000 graduate status for most nurses would make the profession self-regulating and autonomous, and argued for equality between the nursing and medical professions to be achieved through the new education programme (p.46). The problem with these remarks (as well as Austin's - above) is that nurses cannot become 'equal' to doctors, or 'independent' from medicine, if the word 'profession' is used in existing sociological terms.

It is clear that the word 'profession' is used in a different sense in the nursing literature (e.g. references to 'professionalism' in conceptualising good standards) to that of sociology, which tends to refer to the medical profession as the archetypal 'profession'. Up until the 1960s, conceptions of 'profession' rested on Durkheimian notions of the social function of 'service', altruistic commitment to social responsibility and public welfare, for example trait and functionalist theories (Parsons 1951; and Goode 1960). This position has been challenged for adopting uncritically the personal service and ethical images presented from within the professions (Hughes 1958), which help to underpin and legitimise the privileges of professional status; and for its lack of a concept

of power, or historical analysis (Johnson 1972) of the conditions in which the power struggles involved in the process of professionalisation take place (Saks 1983).

An 'anti-professional' (Halmos 1973), critical perspective, which corresponds with an anti-functionalist trend within sociology as a whole, incorporates two main strands, the neo-Weberian and Marxist theoretical frameworks. In the British context, Elston (1991) summarises these frameworks in terms of their view of medicine as:

the paradigmatic profession, a publicly mandated and state-backed monopolistic supplier of a valued service, exercising autonomy in the workplace and collegiate control over recruitment, training and the regulation of members' conduct... subordinating other occupations in the health division of labour. (1991:58)

Freidson (1988) stresses the occupational nature of professions, using medicine as an example of a dominant profession. Some of his central themes are autonomy over work and self-regulation; medicine's control over the work of 'paramedicals', including nurses; hierarchies within paramedical occupations, and their claims to 'professionalism'; and institutional power based on claims of expertise. His use of the term 'professional autonomy' resonates with Weber's conception of authority as legitimated power:

the autonomy of the consulting profession... is an officially created *organized autonomy*... not merely freedom from the competition or regulation of other workers, but... freedom to regulate other occupations... By its position in the division of labour we can designate it as a *dominant profession*. (1988:369)

Yet when discussing the problem of keeping women in nursing, he argues that it is the conflict between work and marriage and family that makes women leave. He argues that attempts by leaders of nursing in the USA to emphasise the professional qualities of the occupation, in order to create a stronger commitment, will not solve this problem, and that a better solution would be to change the 'organization of the job so as to accommodate to the demands of marriage and family.' (1988:55). This point is echoed by Sandall (1998) in her study of the professional difficulties in implementing government policy to promote choice, control and continuity of care for women in the organisation of midwifery, particularly in relation to out of hours work. Freidson concludes that nursing is 'an incompletely closed occupation in a state of change', the practice of which 'is ultimately

contingent on the judgement of a superordinate profession and so cannot constitute the basis for autonomy' (1988:66). Freidson doesn't make links between his two 'diagnoses', but some feminist writers (see below) have pointed out the thread of patriarchy which runs through both of the situations Freidson describes.

Light and Levine (1988) have criticised Freidson for continuing to emphasise 'control over subordinate health workers and the power of licensure' (1988:13) in the face of various substantial threats to the medical profession, including the ideology of 'consumerism'. However, in America, battles over licensing of lay-midwives illustrate the continuing power of the medical profession to restrict other health workers' right to practice autonomously (Annandale 1989), and in the UK, despite growing 'consumer' demands for homebirths attended by midwives, the vast majority of deliveries are still in hospital. Donnison (1988), commenting on the UK, claims that even though

the midwife is the senior person present in 76% of all deliveries, she has, in many cases, especially in consultant units, declined to little more than a handmaiden of the obstetrician and a minder of his machines. (1988:203)

Parry and Parry (1976) focus on the Weberian concept of occupational closure and the ability of the professions to dominate the market for services, but, in contrast to Freidson, rely far more on the class dimension, and professionalism as an ideological strategy, to explain the medical profession's success against other

professional colleagues who are formally equal. This is the basis for professional control over education, markets for service and organisations over which a profession may achieve dominance. (1976:162)

Parry and Parry also contend that 'sexual divisions in society must be treated as a structural factor which is of equal importance with social class' (1976: 162).

In his earlier work, Johnson (1972) introduces the concept of a profession being 'a means of controlling an occupation' (1972:45), rather than a description of the intrinsic nature of a particular occupation. 'Collegiate control' is exercised in those systems where, as a corporate body, the producer defines the needs of the consumer and the way in which these needs are catered for. It is this type, he contends, which best exemplifies

the autonomous professions. In the collegiate system, self-regulation (including recruitment) by the profession has meant that it has been possible for the medical profession to reproduce its class, gender and race dominance over other health workers, and claims of expertise can be made without outside scrutiny. Other occupations then have to compete in an ideological struggle for professional status.

Recent developments such as the granting of authority to nurses to prescribe from a limited list of drugs, and the expansion of nurse practitioner, triage and advice roles, mean that nurses have started to push at the boundaries of professional autonomy. In 1986, the UKCC advisory paper on 'Administration of Medicines', referring to the exercise of professional judgement, talked about a combination of knowledge and experience, but retained the importance of checking with the patient's doctor. Increasingly, there are areas of nursing work which are more autonomous even though the overall position of nursing in relation to medicine is still not one of equals.

Doyal (1979) draws on Marxist and feminist theory in discussing the subordinate role of women in the health division of labour as a reflection of their place in the wider social structure. The hierarchical structure in the health services

reflects and also reinforces the division of labour in the wider society, emphasising the differential allocation of status, power and income on the basis of class, sex and race. (1979:43)

Doyal argues that the social relationships involved in the production of medical practice both inform and reproduce capitalist and 'scientific medicine' ideologies. The costs of labour-intensive sectors have been kept down by the use of female and migrant workers. Entry to medical schools, and career progression once qualified, has until recently been restricted in favour of white, middle and upper middle-class men, though this situation is changing especially in general practice (Allen 1992:4) where the ratio of women to men trainees is now more like 50:50.

Gamarnikow (1978) and Ehrenreich and English (1976) also draw on feminist theory to focus on nursing as the prime example of the patriarchal (occupational) subordination and exploitation of women. The function of nurses is determined within the dominant

ideology that the female personality is ideally suited to the 'mothering' role in nursing in the same way that domestic labour is regarded as 'naturally' women's work.

Gamarnikow argues that the division of medical work is a reproduction of the patriarchal family ideology in which the wife submits to the husband's authority. According to Salvage and Smith (2000), this can no longer be assumed, because of the feminisation of the medical profession, but Davies (2000) is more cautious:

Individually nurses and doctors may strive to overcome such lingering stereotypes of their professions but there is a weight of tradition - and a tradition of gender thinking - to contend with... The tales nurses and doctors tell about the other when they are 'among friends' suggest there is still some way to go. (2000:27)

Nurses' complaints about their lack of occupational control form an important part of their socialisation and informal organisation, articulating the 'structural hiatus between their skill and their lack of autonomy within the medical bureaucracy of the modern hospital' (Turner, 1987:153). Turner (1987) observes that the functions of these complaints include the creation of solidarity within the nursing workforce against the dominance of the medical profession and authority of the hospital hierarchy, and release of tension and frustration. This 'safety valve' function acts symbolically and conservatively, because it allows symbolic rebellion to take place instead of formally organised or effective conflict which might bring about actual changes in the nature or practice of nursing work.<sup>3</sup>

The changes now being introduced, which arguably have not been brought about in this way but more for cost-cutting and recruitment reasons, have the capacity to shift this pattern because nurses will gain more autonomy over certain tasks. NHS Direct, walk-in centres and the developing role of 'nurse practitioner' hold out the possibility of new autonomy for nurses to undertake examinations, tests, diagnoses, write prescriptions and make referrals. In the past few years there have been several published studies indicating that nurses are performing certain, limited tasks in general practice as well as or better than GPs, and at the 1999 annual conference of the Association of University

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<sup>3</sup> Turner compares this to Goffman's (1961) depiction of the symbolic expressions of rebellion found in 'total institutions'.

Departments of General Practice, it was apparent that 'primary care' was fast becoming a more appropriate term than 'general practice'. For example, nurses seeing 'extras' in general practice (Kinnersley *et al* 2000), patients who requested same day appointments (Venning *et al* 2000), and those presenting with minor medical conditions (Shum *et al* 2000) all achieved acceptable results compared to GPs on a number of measures such as rates of prescription, reduction of symptoms at two weeks, patient satisfaction and costs. Some of the rise in studies of this kind must be attributed to the higher levels of training in research nurses now undergo as part of Project 2000.

As Davies (2000) suggested, there is resistance on both sides to change, and this is illustrated by the following quote from a letter in the joint BMJ/Nursing Times edition focusing on the changing roles and relationships between doctors and nurses:

The ability to distinguish self-limiting illness from serious illness and the opportunity to build a rapport with patients by seeing them through a variety of illnesses over many years are key skills of GPs. If nurses take over the supposedly trivial, what will happen to the doctor-patient relationship?

I am not necessarily opposed to nurse practitioners. They may produce the best primary care in the new century. At the other extreme, the introduction of nurse practitioners could undermine general practice as a profession, remove patients' right to see a doctor without consulting a nurse first, promote inequality and allow non-medically qualified people to practise as doctors. (Alcolado 2000:29)

Melia (1987) showed that students and 'rank and file' nurses expressed a preference for technical, doctor-devolved work, which they regarded as 'prestigious', allowing them to enjoy the reflected glory of the dominant medical profession. She argues that nurses' only hope of becoming 'professionals' is to achieve a look-alike status without the power of the traditional professions. This taking of work from above in the hope of rising in status (Hughes 1971) can be seen, Melia argues, as succumbing to medical dominance, but she also argues that nurses are a heterogeneous group, and sees this as a major difficulty to be overcome if their needs are to be represented at governmental level. The 'education segment' aspires towards professional status, while the 'service segment' is motivated by altruism. Attempts have been made in the recent proposals to address both goals: 'Project 2000' emphasises 'educationally determined' training for student nurses; while the Cumberlege report and PREPP stress the practice orientation of further

training. However, the differences appear to persist, and Fletcher argues that nurses are losing their personal touch:

As the vocation of nursing has evolved into a profession, we seem to have lost fundamental values. Nursing now focuses less on patients and more on acquiring knowledge and skills to further its status... Professionalisation in itself will not guarantee improved patient care. (2000:29)

Witz (1990)<sup>4</sup> regards the generic concept of profession as a gendered one, and proposes 'professional projects' as an alternative conceptualisation in which to discuss the relationship between patriarchy and professions<sup>5</sup>. In this model, Witz stresses both the class and gender relations of professional dominance and subordination, within the structural and historical parameters of patriarchal capitalism. She distinguishes between exclusionary, demarcationary, inclusionary and dual strategies of closure. The exclusionary and demarcationary tactics of the medical profession (characterised by the downwards exercise of power and the process of subordination) have been challenged by nurses and midwives, 'who engaged in dual closure strategies as they both resisted medical men's demarcationary strategies and strove themselves to secure a degree of exclusionary closure' (1990:679). The dual closure strategy involves the upwards exercise of power as a form of usurpation, and downwards in the form of exclusion.

Witz convincingly demonstrates her model by applying it to the history of midwifery, and the campaign for a state-sponsored system of nurse-registration as female professional projects. The concept of 'professional projects' is taken up by Sandall (1998) to analyse the problems for midwifery in promoting continuity of care rhetorically as part of their claim for occupational autonomy over the organisation of their work. Midwives who gained job satisfaction from seeing families through the childbearing process needed to work flexible hours, but this form of work organisation is difficult for midwives with young children, reflecting gender issues in adopting the professional project model.

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<sup>4</sup> drawing on neo-Weberian, neo-Marxist, and feminist theories

<sup>5</sup> 'Professional projects are essentially labour market strategies which aim for an occupational monopoly over the provision of certain skills and competencies in a market for services. They consist of strategic courses of action which take the form of occupational closure strategies and which employ distinctive tactical means in pursuit of the strategic aim or goal of closure.' (Witz 1990:675)

These concerns have parallels for general practitioners, including the growing numbers of women GPs, who may support the principles of continuity of care but not the implications for practice, and the issues for single versus group practices were similarly examined by Green (1996).

It is possible to see a push from within nursing to become more of a 'profession' in generic sociological terms, but there is still a tendency to cite 'professionalism' as an occupational and ideological goal. The problem is that by emphasising such concepts as 'professionalism' and 'continuity of care', attention is drawn away from the structural factors which bear directly on the barriers nurses have in advancing their occupational status, the main ones being class and gender. The claim of 'professionalism' both obscures and makes more palatable the subordinate position nurses occupy in relation to the dominant medical profession (Freidson 1988:70), and therefore holds nurses back even though it is used as an important basis for their occupational status.

I think Witz's model best explains developments such as the extension of nurses' role and the introduction of 'nurse practitioners' as inclusionary strategies, because it allows for the concept of process in the relationship between the medical profession and nursing, not seeing either in fixed positions. Debates about deprofessionalisation and proletarianisation of medicine; the fact that more women are becoming doctors; and the current changes in nursing practice and training, indicate that the relationship will continue to be a shifting one. It does not seem likely that nursing will become totally independent from or equal to the medical profession, or become a profession in the generic sociological sense. Nevertheless, nurses can be seen as engaging in a continuing professional project, and it will be interesting to see whether the development of new roles for nurses such as nurse triage and advice, NHS Direct and nurse led walk-in centres prove to be important steps in challenging existing professional boundaries.

These issues are highly relevant to my study because they are part of the dynamic context in which definitions of appropriateness of demand are negotiated. What may have been seen as trivial by GPs who want to change their working conditions may be argued to be the very stuff of general practice by those GPs who hold on to continuity of care as a core value. But if nurse practitioners and other nurses in the new roles including out of

hours care continue in their professional project to take such work from general practice, they may find themselves caught between two camps in general practice, and helping to reformulate the work as 'primary care'. Patients with 'trivial' medical problems may be welcomed by the new nurse practitioners, even if some GPs feel this disrupts their longer term relationships. These debates form important background to understanding the innovative work being carried on in nurse triage at the cooperative's primary care centre where my study was based, and the possibilities now being negotiated by parents in accessing care 'appropriately'.

### **2.3 Communication and discourse in medical consultations**

In chapter one I challenged the assumption that many of the problems of 'inappropriate demand' could be solved by better communication and 'education' of health service users, and concluded that a more contextual and processual approach is needed to appreciate how elements such as communication fit in to the bigger picture of how healthcare is constructed. In this chapter so far I have argued that it is important to break out from the confines of looking narrowly at the doctor-patient relationship and to situate understandings of these within wider social discourses, particularly when the organisation of out of hours care is at the centre of such dynamic change. I turn now to similar problems in much of the existing research on communication, because the authors tend rarely to make connections between the ways in which consultations are situated within wider social processes, and how these interpenetrate the communication between doctors and their patients.

The preface to Stimson and Webb's (1975) landmark book on general practice consultations opens:

'Going to See the Doctor' is a sociological analysis of the process of consultation with the general practitioner. The major emphasis is on the way in which the consultation process is managed as a social activity. It has been called *process* because in addition to presenting an analysis of the face-to-face contact of patient and doctor, attention is paid to what, for the patient, goes on before and after the consultation itself. (Stimson and Webb 1975:vii)

In the intervening 25 years since this was written, much has happened in social science that could be used to develop Stimson and Webb's emphasis on process and to try to capture the processual nature of communication and its wider context. However, the literature seems still predominantly to be confined to such issues as doctors' problems in putting across medical information, how poor communication leads to low patient satisfaction, less successful outcomes and inappropriate use of services.

Locker (1986) argues that communication plays a key role throughout the medical system, but especially between doctor and patient, and indicates that this will increase as the prevalence of chronic illness grows. The doctor's role becomes one of assisting patients and their families to adjust to and manage such conditions, by giving information, advice and support, as much as, or often instead of biological treatment. Again, however, work in the 1970s such as Cartwright's still constitutes a challenge to such rather straightforward views. Cartwright and O'Brien (1976) found that 'working-class patients may be more diffident about expressing criticism, and also possibly less articulate about their difficulties in communication' (1976:85), and that doctors were more satisfied with their consultations with working-class patients, who were seen for fewer minutes than middle-class patients. Doctors could influence consultation rates if they thought patients were presenting 'trivial' complaints (Dunnell and Cartwright 1972), and patients were less likely to consult doctors who seemed busy or uninterested (Cartwright, Hockey and Anderson 1973).

Kincey *et al* (1975) found that patients who were satisfied with the information given to them by their GPs reported a higher rate of compliance with the doctor's advice. However, in a study which began as an attempt to identify the characteristics of patients who defaulted from taking prescribed drugs, Stimson (1974) argued that similar studies were 'posed from the point of view of doctors and not necessarily patients' (1974:102), and when viewed from the patient's perspective, including the social context of drug use, there are good reasons for not always doing what the doctor says. The culture from which patients receive information about health is as important as the doctor's advice, because in the end it is for patients to decide what is best for their health, even if they are then seen as a 'defaulter'. Mishler (1984) has also noted that, often, the term 'non-

compliance is used in a way that makes it equivalent to deviance...from the unquestioned norms and values of medicine' (1984:50).

Korsch and Negrete's (1972) study linked compliance with mother's satisfaction with doctors in a paediatric clinic. They found that only 17% of those who were 'highly dissatisfied' complied with the doctor's advice, whereas 53% of mothers who were 'highly satisfied' carried out the doctor's instructions. The mothers reported most dissatisfaction with doctors who were unfriendly; who failed to understand their concerns; and who did not give the mothers enough information about their child's disorder, which they regarded as very important. In Fitzpatrick *et al*'s (1983) study of the management of headaches, patients who felt the doctor failed to go deeply enough into the history and context of their symptoms thought that the explanations and diagnosis the doctor offered could be inaccurate. This was a critical factor in whether patients were satisfied with the consultations, and Fitzpatrick *et al* observe a direct association between these factors and the outcome of treatment.

Pill and Stott (1982) take a slightly different approach to communication in their criticism of assumptions that all patients share a belief in individual responsibility for health. They argue that attempts at health education should take into account their findings that socio-economic status indicators such as education and housing tenure co-existed in their sample with the desire to make positive changes in health related behaviours. This lends weight to the hypothesis that a large sector of society is hampered in following officially, medically recommended 'lifestyle' choices because of poor circumstances, and has implications for GPs interested in better communication in service of health 'education'.

Britten *et al* (2000) comment in their paper on 'misunderstandings' in prescribing decisions in general practice that

Most of the research about patients' preferences and expectations has been carried out at the population level using methods such as questionnaire surveys and focus groups. A consistent finding over the years has been patients' preferences for doctors who listen and encourage them to discuss all their problems. As patients' expectations are often context specific what is needed is

research within the consultation to determine whether or not patients' preferences are being articulated and listened to. (2000:484)

The study on which this paper reports was funded by the Department of Health under the aim of improving doctor-patient communication. It takes up the idea of process by collecting data from consultations and interviews before and after consultations with both GPs and patients, but the processes of communication and context are limited to those relevant to the consultation. Another point is that the concept of misunderstanding is employed more in the interests of 'compliance', or 'concordance', than in the interest of communication which might admit more unwieldy realms of patient problems.

Similarly, Howie *et al* (1999) report on their study of quality of care in general practice with 'enablement' as their outcome measure. They found that over 50% of patients had a mixture of social and/or psychological reasons for consultation, and conclude that longer consultations and greater continuity of care lead to higher scores on their 'enablement' score. However, the study was a cross sectional survey of 25,994 consultations, so that further elaboration than the category 'social problems' was obviously not feasible.

A very sophisticated and substantial research project on medical communication was undertaken by Tuckett *et al*, who found that patients were not given the opportunity or encouragement to make an equal contribution in consultations:

This level of communication failure seems to have been the result of the ethos prevalent in consultations which devalued the patient's contribution and so prevented an exchange of views. The ethos is part of an old stereotype of the patient which... blames failures of communication on the patient and his ignorance. (1985:178)

Many of the doctors in their study displayed a

'gut' anxiety about allowing patients to develop their theories: it threatened their sense of being a doctor and 'in charge'. When they tried to encourage patients to talk about their diagnostic and therapeutic theories they seemed to find it very difficult to listen to what they heard. They would often become uncomfortable about the passing of time and become very fidgety. They seemed to find the looseness and uncertainty of the resulting situation almost unbearable... It seems

to us that the wish to avoid the discomfort of being passive and the lack of training in holding the anxiety of 'not knowing' were powerful influences behind some of the difficulties the doctors were having and also behind many of their assumptions and theories. (1985:202-3)

These problems were compounded by patients' reluctance to speak assertively (explained by a number of factors stemming from experience), yet their overall finding was that consultations were most successful if the advice given was *keyed into* a sharing of the patients ideas and understanding of what their symptoms were (or were not) likely to be caused by, based on a view of patients as experts on their own experiences of healthcare. The authors found that their suggestions to doctors in their study were met with 'arguments to justify doing anything but having a dialogue with their patients' (1985:213). This study opens up a number of important and fruitful avenues for analysis, particularly on how reluctance to hear patients' case for concern and to key further discussion into this contributes to a poor consultation outcome, and how the results of such failures in communication tend to be blamed on patients. One drawback is that like the other papers reviewed here, it illustrates the continuing tendency of research on this topic to be confined to the consultation or processes only directly related to it.

Taking a different approach, in his discussion about analytic frameworks and methodology for addressing interview data, Silverman (1987) explains that he and his co-researcher Baruch

adopted an approach derived from Margaret Voysey's (1975) work on the families of handicapped children. Voysey noted how what such families said was to be seen less as a direct picture of unmediated 'feelings' and more as an expression of an 'official morality' about parenting. Similarly, Baruch (1981) discovered that parents were telling him moral tales which painted a picture of valiant struggles against adversity. Stories of 'atrocities' were told about the lack of early detection of the heart condition, despite parents' sense that 'something was wrong'... There were powerful cultural forms at work in these stories... (1987:12-13)

In this way, links are made between doctor-patient communication and discourses which overlap between medicine and cultural forms of moral judgement. Baruch took up Webb and Stimson's (1976) idea of 'atrocious stories' to examine parents' accounts as 'demonstrations of adequate parenthood' which are 'accomplished by appeals to standards of the everyday world which parents assume are shared by the interviewer'

(1981:276-277). This seems to me a fruitful way of accessing something of the spaces not only between doctors, patients and interviewers, but the spaces around them.

The wider social context of moral discourses of parenting will be taken up at the end of this chapter, and will serve to introduce perspectives which emphasise the situated nature of the negotiation of appropriate demand. The importance of attending to such wider discourses will inform my data analysis, and in the following chapter I will explain how I have tried to integrate this approach within a view of communicative interaction as part of a 'dialogic' process.

## **2.4 Consumerism and 'configuring the user'**

### **a) Consumers and consumerism**

In this section I discuss how conceptualisation of demand can be related to sociological theories on the wider discourses of managerialism, consumerism, and routinisation, and specifically how the concept of 'configuring the user' can be applied to situate sociopolitically the new forms of out of hours primary care. Many of the changes now being introduced regarding out of hours healthcare, which as I have argued have profound implications for general practice/primary care more widely, are justified with an assumption that rising general healthcare expectations are combined with people's experience of extended business opening times to create 'consumer' demand for 'choice' and easy access in out of hours GP services. I think it is important to question here such assumptions inherent in the use of the concept of and political discourse around the word 'consumerism'.

Anthropologists Shore and Wright (1997) 'define discourses as configurations of ideas which provide threads from which ideologies are woven', and 'a key concern is who has the 'power to define'' (1997:18). Drawing on the work of Raymond Williams (1976), they argue that 'certain 'keywords' undergo shifts in use and meaning', and that 'changes in the meaning of a keyword invariably entailed changes in its 'habitual grouping', thus 'keywords accumulate meanings historically' (pp.18-19). They state:

When such keywords succeed, not only in competitions within the ‘political field’ (Bourdieu 1991), but also in attracting mass popular support, we term them ‘mobilizing metaphors’ (Wright 1993). Mobilizing metaphors become the centre of a cluster of keywords whose meaning extend and shift while previous associations with other words are dropped. Their mobilizing effect lies in their capacity to connect with, and appropriate, the positive meanings and legitimacy derived from other key symbols of government such as ‘nation’, ‘country’, ‘democracy’, ‘public interest and the rule of law’. (1997:20)

The language of policy, they go on to argue, provides a lens for exploring not only how political systems work at the level of discourse and power, but also how governments attempt to manufacture consent, by ‘naturalizing’ a particular ideology as common sense (p.24). The keyword ‘consumer’ constructs whole populations as a new kind of ‘citizen’, and profoundly reshapes the citizen’s constructions of the ‘self’ (p.24). Thus policy can be seen as

a form of power which works upon the individual’s sense of *self*... new norms of conduct - often actively engineered and promoted by government and organizations - come to be adopted and internalized by individuals. The focus here is on how ‘techniques of the self’ work to produce new subjects of power. (p.29)

Another aspect of this process is the use of ‘expert’ knowledge to encourage the self-regulation of subjects, and here they cite Dreyfus and Rabinow’s (1982) argument that

political technologies advance by taking what is essentially a political problem, removing it from the realm of political discourse, and recasting it in the neutral language of science (1982:196).

Taking all of these suggestions together, I propose as a central theme in this thesis that we have experienced in the UK attempts by successive governments to replace the keyword ‘patient’ with ‘consumer’; to group this together with other keywords such as ‘individual’, ‘access’ and ‘choice’; and to shift the meaning of ‘consumer’ up to the level of a ‘mobilizing metaphor’. The implication of this for access to healthcare is that citizens should construct themselves as independent of state provision by taking responsibility for their own health and buying into the ideology of individual choice and

instant access. Further, notions such as ‘appropriateness’ of access and demand are promoted as judgements of what is *medically* legitimate rather than politically expedient.

My sense is that we have not yet been converted. Of course some people will take the ‘carrot’, but I argue that most are unaware of the ‘stick’, the contradictions that arise when a service such as GP out of hours provision is pressed to provide ‘choice’ and ‘access’ (NHS Direct and walk-in centres in addition to primary care centres) at the same time as ‘continuity of care’, a concept which many practitioners and patients still hold as valuable and associate with treating people as ‘individuals’. Such contradictions will be a main focus of my analysis.

The wider social trend towards the belief in the science of management over the art of human relations can be seen in ‘managerialism’, and medicine has not escaped this. Although a consumerist model of involving patients in the planning and evaluation of healthcare can be traced back to the role of organisations like the Patients’ Association and MIND and other self-help groups (Tait and Graham-Jones 1998:238), the Griffiths report (Griffiths 1983), seized upon by Margaret Thatcher’s government to promote managerialism in the NHS, and John Major’s government’s Patient’s Charter (1991) were heavily instrumental in promoting the politically associated axioms of ‘value for money’ and ‘patient choice’. These ideals dominated policy throughout the Conservative’s 18 years in power, but of especial importance to GPs was the 1990 Contract (Health Departments of Great Britain 1989), which encapsulated the objectives of guaranteeing value for money and greater consumer satisfaction and choice (Webster 1998:41-42), to be followed in 1991 by the introduction of the internal market and fundholding (since abandoned).

All of these developments underscored a government imposed and largely medical profession opposed market mentality which created consumers out of patients, and did not evaporate with the incoming (New) Labour government in 1997. GPs’ comments in medical ‘freesheets’ such as ‘Pulse’ and ‘Doctor’, and in the e-mail discussion list ‘GP-UK’ frequently refer to assumptions that patients want a 24-hour service just like 24-hour pizza delivery or telephone banking, and these are lumped together with their perception of demand as spiralling out of control. The response to the notion of growing

consumerist demand has been a tendency towards the routinisation and virtual 'industrialisation' of medical care. As Ritzer (1996) argues from the North American context:

Perhaps the best example of the increasing efficiency of medical practice in the United States and of the pervasive influence of McDonaldization is the growth of walk-in/ walk-out surgical or emergency centers. These so-called 'McDoctors' or 'Docs-in-a-Box' service patients who want medical problems handled with maximum efficiency. Each center handles only a limited number of minor problems, but with great dispatch. Although the patient with a laceration cannot be stitched as efficiently as a customer in search of a hamburger can be served, many of the same principles shape the two operations... 'Docs-in-a-Box' can also be more efficient than private doctors' offices because they are not structured to permit the kind of personal (and therefore inefficient) attention patients expect from their private physicians. (1996:43-44)

The potential for copying this kind of response can be seen in the example of routinisation as the basis of the system of nurse triage advice used at the cooperative's primary care centre that I studied and NHS Direct, and the consumerist assumptions behind the newly introduced walk-in centres. Although many of these ideas and even the technology employed in using them have been imported from the USA and Canada, the initiatives to do so had different and separate origins within the UK and I will return to this later.

An example of the consumerist assumption in the medical literature can be seen in Gwyn and Elwyn's (1999) analysis of a consultation between a GP and parents of a young child who want antibiotics to treat a viral disorder. They argue that 'shared decision making' is inherently problematic in such situations, partly because 'consumerism... is changing clinical practice' (1999:437). In making this statement, the authors acknowledge they have drawn on Lupton (1997) and Laine and Davidoff (1996), whose arguments come from USA and Australian contexts, but I think more care is needed when applying such views to (I assume) a South Wales context, where I think we do not (yet?) have quite the same sociopolitical orientation to the market. Stimson and Webb's (1975) study, based in the same area twenty years ago, pointed to ways in which organization of medical care influenced how much patients could contribute to the outcome of consultations with GPs. Like Gwyn and Elwyn, they also found that shared decision-making was inherently

problematic, but for the opposite reason, i.e. that patients had so little relative power. Thus although the two studies point to a lack of what Gwyn and Elwyn term 'equipoise', Gwyn and Elwyn attribute this (without going into further explanation) to 'consumerism', implying that in the intervening 24 years there has been a complete change in the relationship between doctors and patients, brought about by new patient attitudes.

Can this really be the case, or is it more a question of inaccurate terminology? Haug and Lavin's (1983) book 'Consumerism in Medicine: Challenging Physician Authority' provides an illuminating clue to the problem, as I see it, with importing this particular term, and perhaps the ideology behind it as well. Throughout the book, Haug and Lavin conflate the concept of 'consumerism' with 'challenging physician authority'. This stems from their observations in the USA of a number of social developments dating back from the 1960s including rising expectations of the rights and benefits of citizenship; anti-authoritarian attitudes and behaviours dramatically expressed in relation to American involvement in the Vietnam War; the student movement questioning academic authority; anti-credentialism; and the promotion of equal rights for 'Blacks' and women (1983:17-18). All of these I recognise, having lived there at the time, but I would argue that their absolute equation of such challenges to authority with 'consumerism' is a misconception. Challenging authority can take many forms: assertiveness, mutual negotiation on other terms than purely economic ones, a search for alternatives to traditional medicine, boycotts and so on. Even in capitalism-dominated USA, many of the people involved in such movements maintained (and have retained) an orientation that could better be described as 'anti-consumerism' than consumerism; an anti-materialist, anti-consumption 'alternative' culture which has been the thrust behind much of the alternative healthcare movement and political activity around environmental issues. Those who embrace 'consumerism' may not be as fundamentally challenging of authority (including medicine) even if they are militant about their 'consumer rights'.

Attitudes towards medicine in the USA arise in relation to a very different economic and political system of healthcare to that of the UK, but even if could be argued that the two systems are showing signs of future convergence, I would argue that there are still salient barriers to an emergence of radical British challenges to medical authority that Haug and

Lavin would attribute to consumerism. This is evidenced in the British literature which reports widespread reluctance on the part of patients to 'bother' the doctor, to 'shop around' amongst traditional healthcare providers, to 'go privately' for regular GP advice and treatment, or other behaviours which might indicate a consumerist orientation. Elston (1991) and Calnan and Gabe (1991), within their critiques of the 'deprofessionalisation thesis', also make the argument that recent challenges to medical authority within the UK health system cannot be equated with a conversion to the ideology of consumerism.

My point is to emphasise the distinction between 'consumerism' and challenges to medical authority in other forms, because I think the former is used as a misconceived shorthand for the latter. This is not to overlook, however, the political use of the appeal to voters of such notions as 'choice', 'value for money', and 'easy access', as I have argued above, although I think many people are finding the rhetoric less tangible in their own experience. Harrison *et al* (1992) argue that 'since the late 1980s Conservative ministers have laid great rhetorical emphasis on 'consumer choice' in the public service sector' (p.136), but

as many commentators have pointed out, Conservative consumerism has tended to be of a very particular and somewhat limited type (e.g. Pollitt, 1988). It has not, for example, had much truck with the idea of extending the legal rights of public service consumers... Conservative consumerism has been found focused mainly on providing the individual public service user with more information about services and more 'choice', where choice is conceived largely in terms of the opportunity of 'exit', especially exit to private sector alternatives... In cultural terms it seems probable... that the NHS will continue to operate a Fordist, provider-dominated mode of service delivery for a good while yet. Consumer views may well be collected much more assiduously than in the past, but mainly in the managerially-malleable form of the survey questionnaire. (1992:136-138)

Allsop argues that government policies on prevention of disease have shifted from those based on prevention on the public scale to those which focus on individual behaviour, lifestyle and risk-taking, with the government's role being seen as promoting health in individuals via information and education (Allsop 1984:178). This approach, which co-exists with a managerialist trend, has been criticised for ignoring the wider social structural causes and solutions to disease, and this debate, Allsop argues, is unlikely to

be resolved when the British population as a whole, in comparison at least to North Americans, tends to be more apathetic and fatalistic towards health issues (p. 186). In relation to the Thatcher government's attempted shift towards individual responsibility for health by introducing the notion of consumerism into the healthcare discourse, describing health service users as consumers in the language of the economic market, Allsop points out:

The assumption is that there is a product 'health services' which are produced and available on demand or need, in the case of the NHS without price, to be consumed by health service users. (1984:197)

However, Allsop (1984:198-199) challenges the notions of both active and passive versions of the 'users as consumers' argument. Users of the health service cannot be termed 'consumers' because they cannot build up expertise when few of their illness episodes are exactly the same, the 'product' is so varied, and they are not in a position to judge the technical competence of doctors or hospitals, even if they can make choices, usually on 'hotel' or other aspect of care.

An alternative view, in line with Stacey (1976) and others, is that patients, carers, and children all play a part with other health workers in producing health within and outside of institutional settings. They are producers of recovery and health, rather than consumers of the 'product' healthcare. I see this more as an interactionist perspective, allowing for recognition of conflicts and asymmetry, than a functionalist one with more harmonious assumptions. It acknowledges that most healthcare takes place outside of medical settings altogether, and that patients, or parents, are experts about their own (or their children's) bodies in the everyday sense, which includes care for a lot of 'normal' illnesses.

Hogg (1999:158) makes an important argument linking what she terms persistent and sometimes contradictory myths about the function of healthcare, infinite demand and patients as consumers. Although the NHS is a powerful symbol of the governments' care for its citizens, users have always had a very limited role in forming policy. She states that beliefs in scientific certainty and medical progress blind us to the real harm that healthcare can do, and to the economic, environmental and political causes of illness.

We want to believe because we need to have hope, but there are also profits to be made from drugs, new techniques and research. She challenges the myth that demand is infinite and resources are finite, which fuels managerialist attempts to control costs. Instead, she argues that 'much health care is finite... In addition, the amount of resources that are available to spend on health care is a political decision and a question of priorities' (p.166). Demand is created for many reasons, including medical advances and interests in using them, and commercial interests in providing products and services. Harking back to Titmuss (1969:67), she attacks the myth of the patient as consumer along similar lines to Allsop (1984, see above). Apart from the difficulty in defining who the consumer is,

medical care is uncertain and unpredictable; many consumers do not desire it, do not know they need it, and cannot know in advance what it would cost them... They must rely on the supplier to tell them if they have been well served... and the producer discourages comparisons... Medical producers have the power to select their consumers... they can even sell forcible internment... (1999:169-170)

Hogg is also sceptical about the notion of patients as 'partners' with the government, professionals, and pharmaceutical companies, because of the unequal risks for patients in such 'partnerships', the tendency of such myths to gloss over conflicts of interest and power, and inequality in access to resources and decision making. The myth of the patient as consumer does not guarantee users more power, and the focus on individual rights detracts from attention that might be turned towards health services being made more democratic and accountable (p.173). Altogether,

these myths encourage us to equate health with health care - which creates new markets and a demand for more health care and more 'cures'. While we may consume health care, this may not give us health... These myths all divert attention away from inequalities in health among different groups in the community that have increased since the 1980s. Reducing poverty and unemployment, providing better housing or improving the environment are likely to achieve better health for the nation than will health care. (1999:173-174)

For the purposes of my immediate arguments, I re-state my position, which is to challenge existing assumptions, e.g. that parents' 'abuse' of GP services can be identified as a symptom of 'consumerism'. As an alternative to the assumption that patients have created a consumerist form of demand, I would argue that they have been configured as

consumers in a context where healthcare is becoming increasingly depersonalised. The notions of choice and patient power are more evident in terms of their function within the rhetoric of consumerism than in practice.

b) Configuring the user

Earlier in this chapter I referred to theories on the moral constitution of doctor patient communication and medical discourse and these are relevant to the following discussion on 'configuring the user'. This concept will be helpful in analysing the processes by which people are constructed in various ways but especially in relation to the technology of the nurse triage and advice process I observed at the primary care centre. Using this perspective to examine the effects on parents of being configured, and configuring themselves, as appropriate users is not just a semantic exercise: it is a way of tracing the interactional processes that have a material effect on the outcome of these telephone consultations. The implications from how this technology operated at the primary care centre also have a direct link to the development of NHS Direct.

The concept of 'configuring the user' was developed in Woolgar's ethnographic work (1991) participating in the development of a computer to make an anti-essentialist argument about the relationship between people and technology (Grint and Woolgar, 1997). Machines, according to this view, cannot be understood as separate entities from their social construction and interpretive context. This argument seeks to invalidate the notion of the 'impact' of technology on its 'users', since "the technology' is the machine's relations with its users' (1997:93). Instead we can investigate how the technical/non-technical dichotomy is constructed and sustained in practice. Woolgar's ethnographic work focuses on ways in which the design of the machine entailed simultaneous work to configure (i.e. 'define, enable and constrain') the user to make the desired sense of the machine and appropriate demands of it. The producers of the machine contribute to a definition of the user and establish parameters for their actions (p.73), which

involves boundary work. The user's character, capacity and possible future actions are structured and defined in relation to the machine (...) Insiders [in the company] know the machine, whereas users have a configured relationship to it,

such that only certain forms of access/use are encouraged. (...) More generally, of course, the more significant this boundary, the more likely will be the prevalence of this kind of separatist talk.

It is in this light that we might best understand the occurrence of 'atrocious stories' (...) Whereas many of the company members engaged in the exchange of such atrocious stories, it was also possible to identify liberals who were willing to speak up for the user: 'Users can't help the way they behave; they just need to be educated to understand what we are trying to achieve here'.

(...)although the processes of technological development can be described in terms of the social construction of technology, their importance is in the ways they create and sustain the boundaries and dichotomies which we subsequently come to take as a natural feature of our relations with the technology. The import of these developmental processes is that users are configured to respond to the technology in sanctionably appropriate ways. (pp.92-93)

As Woolgar argues, ideas of appropriateness of demand are incorporated into the development of the apparatus, by which is meant not the material technology in isolation but the whole nexus of telephone, computer and software, and the people who interact with these things. We could include in this conceptualisation Dreyfus and Rabinow's (1982) observation (referred to above) that 'expert' knowledge can be employed as a form in which political 'technologies' are recast to advance the self-regulation of subjects. Thus a form of medical language is incorporated in the triage and advice technology such that interaction with it demands that the user configures problems within particular parameters, but these are defined more to serve the political ends of saving on GP time than offering the users a response based on their own perceived needs.

In talking about 'users' we might assume we only mean callers (parents, patients or other carers), reasoning that they are constructed as 'outside' of the technology which includes the triage nurse, who in this formulation is 'part of the machine'. In this scenario, parents have to learn how to interact with both the medical diagnostic environment and the triage 'technology'. But if the technology is constituted by the relations between the machines and people who use it, then we could say triage nurses are users as well as callers, because the 'technology' has been developed with particular 'appropriate' uses in mind, that is to allow patient demand for GP services to be processed and partly re-directed to nurses to cut down GPs' out of hours workload. It is the means by which GPs can let go of some of their authority and control as a trade off for improvements to their quality of life, but authority and control are divested only up to a certain point. In

this sense the triage and advice software assists nurses to act in place of GPs but constrains them from developing a fully authoritative and autonomous role.

This compares to the way in which Prout (1996), who (like Woolgar) draws on actor network theory and argues the use of metered dose inhalers (MDIs) can

be thought of as 'standing in' for biomedical control of the therapeutic substance by encoding the ability to meter a dose. This, however, entails a trade-off between, on the one hand, patient access and, on the other, medical control of therapeutic substances. (p.206)

In Prout's (1996) analysis of the MDI actor network, he asks what are the assumptions the MDI's designers make about its human users, whether and how these assumptions are encoded in the technology, and how these change over time. The MDI creates and demands particular competencies from its users which do not occur 'naturally' (1996:208). Users can be characterised as failing in their technique, or committing errors deemed bizarre, and the response to this is surveillance of users' practices and subsequent attempts at education, with some of the work of monitoring, checking and advice delegated to less expensive staff such as nurses (1996:209-211).

These ideas on configuring the user, or patient as consumer, resonate with Ritzer's (1996:105-106) discussion on how 'McDonaldization' entails controlling the customers. Users of fast-food restaurants move customers through the system in the manner desired by the management. They know when and where to line up, how to make a correct order, where to consume the food, where to put the trash, because they have come to understand the unwritten rules. Security personnel ensure that diners do not linger or use the restaurant in other inappropriate ways, and even the chairs are designed to make it uncomfortable to stay too long. In constructing patients as consumers who value convenience over continuity, are we heading this way? And are triage and advice nurses users or part of the machine?

## 2.5 Parenting and motherhood

I have referred earlier to the importance of contextualising parents' interactions with GPs and nurses within the wider social context of moral discourses; to my objections to users of healthcare services being equated with 'consumers', and to the attributes assumed under such categories, and these points are relevant to this section. I also continue with the theme of 'mobilizing metaphors' to examine the way ideas of 'the mother', metaphors and understandings of the roles of women as mothers, and of women and men as parents enter into and constitute relationships with other healthcare workers. I will address some key issues which arise from wider social perspectives on experiences of parenting, but which interact with the construction of parents as legitimate negotiators of the healthcare system on behalf of their children. Some of the literature speaks of women rather than parents, arguing that women continue to carry out the main share of childcare and healthcare. However, I refer to mothers or women, rather than parents, only if it seems more accurate in relation to particular points, or if only women participated in a study.

Williams (1998) summarises aspects of caring for children on a number of dimensions, including emotional labour (see following section), physical labour, organising care, sentient activity, active sensibility and developmental activity. Of particular interest here are the skills employed in the sentient activity and active sensibility required of parents and mothers in particular (Mason 1996). Activities such as noticing, interpreting and providing for the needs of children involve both feelings and work, woven together in the time consuming and sometimes exhausting, but often unnoticed daily round. Williams argues further that such activities carry a symbolic, moral value within an 'ideology of competence' (Anderson and Elfert 1989:742) which constitutes responsibility for the health and well-being of their children as intrinsic to women's role. These concepts would appear to be directly applicable to parents' healthcare activities.

In a similar vein, Olin Lauritzen's (1997) study of mother's accounts of attending to the bodily signs and reactions of their young babies reveals how

the embodied images of child health are intertwined with the mothers' presentations of themselves as responsible for the health of their children and as 'worthy' parents. (1997:436)

The work of constant monitoring of various bodily and social states, being 'in charge', and showing determination and devotion in the face of fatigue are all part of the mothers' moral self-presentation, relating in a similar way to the concept of an ideology of competence. Mothers talked in terms of potential threats to what has been conceptualised as the baby's 'unfinished' body: worries that there might be something 'wrong' with their baby, threats to their survival or to their thriving, and threats from illnesses. These worries brought them into contact with a range of people for advice:

Typically, several professionals are consulted when a baby is ill, and the mothers describe how they react to the different pieces of professional diagnostic reasoning and advice in terms of how the medical advice fits in with their own observations of the child. Throughout it all, the mother describes herself as being in charge, trying one thing after the other, not giving up even if it is all very tiring and she feels miserable. Again, the image is one of a parent who has to give her all to the baby, however demanding this might be. (1997:450)

These comments illustrate how mothers use medical advice as only one resource in their healthcare work, so that their 'worthiness' depends on constructions of motherhood arising in a much wider context of sentient activity and active sensibility.

Litt (1997) warns against simplistic assumptions that women have been 'victims' of medical dominance via 'scientific' models of motherhood drawing on psychological and child health expertise. In an analysis of the experiences of three women raising children in Philadelphia in the 1930s and 1940s, she found that the women differed in their uptake (or resistance to) 'scientific' practices advocated by medical professionals in ways which served to emphasise, rather than diminish their class and ethnic social positions. She argues for a more inter-constitutive relationship between conceptions of motherhood and medicalization because:

the processes through which medical authority made its way into mothers' households was not a neutral, progressive march of science... medicalization articulated and even depended on an interlocking series of gender, racial, ethnic, and social-class divisions and practices already in place, which cast the meaning of medicalization and how it was used. (1997:299)

In this light, rather than assuming all women simply by virtue of being female experience motherhood in the same way, we can consider how such issues as the use of public or private healthcare, or the rejection or acceptance of medically authorised childcare practices can function in relation to other ways in which women can be seen as separate from, and to differentiate themselves from each other.

Jefferys (1998:129-130) commenting on the way in which the social-class divide pervaded general practice in her childhood, recalls how when her family visited the doctor, they entered the house through the front door and waited to see him in a well-furnished sitting room. Her mother did not hesitate to call him to their own house if the children were unwell. Panel patients, working-class men who received medical care through compulsory National Health Insurance payments, used a side entrance and waited in the passageway. Their wives and children were not included in the insurance so were not entitled to any free treatment, advice or medicine.

One can imagine the meaningful glances cast by the different classes of women at each other as they approached the house to enter through separate doors. This sort of arrangement echoed many other similar ones which helped to construct class distinctions between families. Childcare practices, like housing and education, served to identify 'what sort of people' one's neighbours and acquaintances were. In a more contemporary sense, issues about medicalized versus 'natural' childbirth, the case for and against immunisation, the use of homeopathic and other 'complementary' healthcare are all part of the discourse on parenting which co-exists with other discourses that define 'what sort of people' we are.

I have referred earlier in this chapter to what Silverman (1987) and Baruch (1981) termed moral versions of parenthood, or 'dilemmas of discourse rooted in a profoundly moral universe' (Silverman 1987:263), concepts which help to analyse how interactions between parents and healthcare professionals are socially constituted and situated. Smart (1996) applies Foucault's notion of normalising discourse to deconstruct the institutionalised standards of 'good motherhood'. She refers to ideals which have become fixed policies, and are then applied through health visitors, doctors and others

who work with mothers and children. Standards are set (but change like fashions) on such practices as how often to feed infants, whether to breastfeed or use formula, where and in what position infants should sleep. Smart sees these rules

in Foucaultian terms as the calibrations of good motherhood... The significance for Foucault of normalizing discourses is the way in which degrees of adherence to the rules are secured by the stigmas and impositions placed upon those who disregard them. (1996:46)

In the late 20th century, Smart argues, we saw the increase in ways mothers were deemed to have failed at mothering, with new dimensions for expertise and failure, even in the precise ways and forms mothers show love for their children, with middle and upper class mothers no longer protected from scrutiny. The real targets for such judgement, however, remain working-class mothers and particularly unmarried 'lone' mothers, with an assumption that the boundary between good and bad mothers continues to be equated with that between the married and unmarried. Tracing the historical development of policy on lone motherhood enshrined in law and government commissioned reports, she points to the 1970s as a high discursive point in creating the possibility of economically independent and autonomous lone mothers. However, further shifts, culminating in the reconstitution of fatherhood with the Child Support Act 1991, and debates around the use of reproductive technology, have led her to conclude that the single mother is once again seen as 'the source of almost all social ills' (p.56). The assumption that social problems and therefore higher demand are associated with single motherhood was evident in the applied literature reported in chapter one (e.g. Riddell 1980).

Taking a feminist but rather different approach, Stacey (1988) makes the following points

all members of a society are actively involved in health production and maintenance work... everyone is potentially involved in health work as a patient and that patient is a health worker... more people than the socially recognized healers are health workers. (1988:7)

In this light I will now turn to work on sociologies of emotions, without limiting a consideration of such work to any one group of people, but recognising that as one aspect of healthcare, any member of society can be involved in emotion work.

## **2.6 Sociology of emotions**

The subject of emotions in parents' role of bringing up children and caring for their health has largely been constructed from a mixture of psychological theories and research and cultural assumptions similar to those about 'motherhood', but has more recently been re-examined in the light of sociological theories on emotion (Hochschild 1989). Until recently, the development and application of these theories to medical work and other forms of healthcare has been relatively neglected<sup>6</sup>.

In this thesis I propose that emotions are not only a central component of the production of health undertaken by doctors, nurses, parents and children, but are also an important factor in how people's roles are defined, and how their roles relate to each other. This in turn feeds back into what sort of demands are seen as appropriate to make of people in particular roles. *These issues are therefore relevant to all of the other themes already* addressed in this chapter, including the fundamental implications of recent changes in the organisation of out of hours care for general practice and primary care more generally.

### a) An overview of sociological theories of emotions

The diversity of perspectives discussed in this section reflects that of the 'sociological macrocosm' (Kemper 1990). The grouping together of these approaches under the banner of the sociology of emotions provides an opportunity to bring a variety of insights to bear on processes whereby internal feelings and perceptions interact with aspects of the social structure in the subjective experience of health and illness, and in the roles and interactions between doctors, nurses, parents and patients.

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<sup>6</sup> see Ehrlich 1991, in which this field is reviewed in more detail

It is important to recognise that 20th century Western medicine, outside of psychoanalysis, has been dominated by a view of emotions as separable from the main business of science (Williams and Bendelow 1996), although in general practice, Balint's ideas provide an exception to this generalisation. Good (1994) argues, however, that 'despite [the] materialist shaping of illness by clinical medicine, moral and 'soteriological' issues (that is, those referring to suffering and salvation) are fused with the medical and at times erupt as the central issues of medical practice' (p.67). These concepts can be used to challenge a view of medicine which encourages the treatment of patients in material, scientific terms, and a belief in the technical as the means of taming the soteriological, while parents' experiences of children's illness episodes are seen more in soteriological terms. An alternative, reflecting Good's comments, is that children, parents and family members look to doctors and nurses to respond in both modes, and that 'lay' people also operate in a less 'split' fashion. In addition, although the soteriological side of medical work may be undervalued, even rejected by many, the excitement and passion in medicine often occurs precisely when the rational, technical aspects intervene in events which literally embody the most emotional and dramatic aspects of life. In some ways it could be argued that there has been a splitting off of emotion work from the science of medicine, but it is not a true split: both sides are present.

Connotations of irrationality, loss of control, and distorted perception (or at the least, subjectivity) are often attached to the idea of emotions (Hochschild 1983), whereas much of social science, for similar, parallel reasons to medicine, has been concerned with the objective study of social order (Stacey and Homans 1978). This has been challenged, argues Olesen (1990), by the 'ascendancy of the subjective in sectors of American sociology, thanks in part to the impact of feminist thought which stresses lived experience and attentiveness to subjectivity' (1990:12).

Organismic models of emotion (e.g. Darwin 1872; the early Freud) defined emotions in terms of biological bases and processes; while interactionists (e.g. Goffman 1967) have tended towards descriptive accounts of the outcome of social interaction in terms of cognition, behaviour and gestures related to their social settings (Hochschild 1983).

Collins (1975) addresses macro level themes of social order, conflict and stratification, but argues that social order depends on solidarity and moral commitment (Durkheim 1912), achieved through micro level 'interaction rituals' (Goffman 1967) which produce a unifying common mood. Collins (1990) argues that, in addition to the structural and cognitive aspects given emphasis in Weber's concept of legitimate power and Marx's analysis of class mobilisation and conflict, one must acknowledge an emotional part. The outcome of interaction rituals is 'emotional energy': at the high end of the continuum this produces confidence, enthusiasm, and solidarity, while at the low end one feels drained, depressed, and alienated from the group. Group moral solidarity can generate both altruistic acts and righteous anger. Symbolic rituals of the group enforce cognitions, which in turn give rise to emotional energy, even when we are not actually interacting with anyone from the group.

It is in this way that society gets inside the individual's mind... They are pumped up with emotional energy because of a successful interaction; this energy gets attached to ideas, and thinking those ideas allows these individuals to feel a renewed surge of socially-based emotions. (1990:34)

Scheff (1990) uses a similar micro-macro approach to an analysis of social control using a shame and pride continuum, extending his earlier work (1966) on the sociology of mental illness in which he saw symptoms as violations of social norms, dependent on societal reaction and role-playing. On the micro level, the experience of approval or disapproval is monitored cognitively and emotionally, so that people check their position, and are checked by others, as they navigate their way through social encounters. This process has the cumulative effect, on the macro level, of providing the basis for social conformity, and thus social order. Pride and shame are seen as the most important ones influencing social life (Darwin 1872; McDougall 1908; Cooley 1922), the balance between them being defined as a level of self-esteem.<sup>7</sup> The low visibility of pride and shame as directly expressed emotion in social life is explained in terms of the recursiveness of unacknowledged emotions, i.e. emotions acting back on themselves.

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<sup>7</sup> This seems reminiscent of the religious concept of determining whether one is in a state of grace or sin.

The importance of the 'expressive body' as the common ground for the sociology of emotions and health and illness is emphasised by Freund (1990) in his exploration of the existential-phenomenological perspective. He argues that the task of the two sub-disciplines of the sociology of emotions and health and illness is to

show how this active, expressive and experiencing body relates to historically shaped, socially organised systems of human activity. Sociology thus needs to redefine the body, mind-body, subjectivity and bodily activity in relationship to the macro-micro social milieu (1990:456).

Hochschild (1975, 1979, 1983, 1989, 1990) sets out a sociology of emotions as 'a body of work that articulates the links between cultural ideas, structural arrangement and... feelings' (1990:117) based on an interactionist model which derives much from Goffman and Freud<sup>8</sup>. According to Hochschild, the

emotion-management perspective fosters attention to how people try to feel, not, as for Goffman, how people try to appear to feel. It leads us to attend to how people consciously feel and not, as for Freud, how people feel unconsciously (1979:560).

Two of Hochschild's key concepts are 'emotion work' and 'feeling rules'. Emotions function like a 'sense', or 'signal' (Freud 1915), communicating information to the self about where we stand in relation to both outer and inner events, in the context of culturally accepted perspectives and expectations about the world. Feeling rules are integral to 'emotional culture', they tell us what is appropriate in a given social context, 'what is owed in gestures of exchange between people' (1983:76).

'Emotion work' involves the effort of 'trying to feel', and making gifts of such feelings and displays (of respect, affection, etc.). This often requires forms of acting, whether 'surface acting', 'deep acting' or 'method acting', not only to control or suppress emotion, but to evoke or shape feelings. Emotion work is necessary when there is a discrepancy between the society's, or the self's, feeling rules and what we actually feel at a given time. Emotions must then be managed, so that they conform to the feeling rules.

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<sup>8</sup> see appendix A of 'The Managed Heart' 1983

When this is done as part of a wage earning activity, Hochschild uses the term 'emotional labour'.

Hochschild's main focus is on the commodification of emotional labour in capitalist society. Her study of the emotional labour of airline flight attendants<sup>9</sup> describes how the appearance of a smile is not enough: to do the job properly involves achieving in oneself feelings of warmth and enjoyment. This is essential to the manufacture of the product - passenger contentment. But this type of labour is not restricted to the capitalist system, or even to the public domain. Hochschild points out that similar uses of feelings are taken for granted, for example, in the theatre and psychotherapy, as well as in private life<sup>10</sup>. It is the exploitation of these skills, and the inequitable distribution of rewards in terms of money, authority, status, honour and well-being, which causes concern (Hochschild 1983).

The theme of emotional labour is central to James' (1989) discussion of the expression of feelings as 'a central problem of capital and paid work' (1989:15). She argues that, as a commodity, emotional labour is poorly paid and largely unrecognised, yet it is a significant part of 'the social reproduction of labour power and social relations of production' (1989:15). Taking a Marxist-feminist perspective, she draws (*inter alia*) on the work of Heller (1979) and Elias (1978). Like Heller (1979), James rejects the division between feelings and reason in twentieth century thought, and asserts that the personality is 'split' because of dominant forces in the social structure which determine and reproduce, via norms, those feelings, intentions and behaviour which are acceptable. She relates this to the concept of the 'civilising process', by which society becomes increasingly regulated and constrained (Elias 1978).

People in higher status positions expect more importance to be attached to their feelings, while lower status people expect to have their feelings discounted or discredited. This contributes to the situation in which women, whose position is lower status, specialise in overcoming anger and aggression, i.e. in 'being nice', whereas men's emotion work

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<sup>9</sup> 'The Managed Heart' 1983

<sup>10</sup> 'The Second Shift' 1989: Hochschild's research on the emotion work of two-job couples

involves controlling fear and vulnerability, and the use of aggression. The different commercial use of men's and women's emotions means that the emotional capacities from which they are most likely to become estranged are also gender related. As a result, gendered jobs, such as 'flight attending [are] one sort of job for a woman and another sort of job for a man' (Hochschild 1983:171).

b) Emotion and the doctor-patient relationship

The doctor-patient relationship is potentially charged with emotion for everyone involved. The consultation may involve reporting frightening symptoms, which give rise to fears about the diagnosis, the outcome of disease and/or treatment, or 'biographical disruption' (Bury 1982). Touching various parts of the body as well as discussing certain diseases may be physically uncomfortable and socially 'taboo'. In this particular social situation, however, we assume that the doctor's professional status provides us with assurances that their behaviour will be constrained within ritual and conventional limits, and that the patient will play their role within equally established boundaries. Lupton (1996) argues that

trust relations in the doctor-patient relationship are always characterised by ambivalence, uncertainty, anxiety and a sense of risk because this relationship involves a high level of vulnerability and dependency. (p.167)

The process of dealing with such ambivalence entails the management of both the doctor's and patient's emotions, with each participant trying to produce the 'right' emotions for, and in, the other according to feeling and expression 'rules'.

The 'sick role' model of this relationship includes the idea that professionals adopt an 'affective neutrality', or a 'detached concern' (Lief and Fox 1963) for patients, but Smith and Kleinman (1989) argue that in our society, an unemotional persona is associated with authority, therefore 'affective neutrality reinforces professionals' power and keeps clients from challenging them' (1989:56). In a study of the issue of physical intimacy inherent in medicine, Smith and Kleinman (1989) observe how medical students learn to manage the emotions to which this aspect of their training gives rise. In the medical school they studied, there are no formal courses in the medical curriculum which offer

guidance in the management of emotions such as disgust, attraction or embarrassment, and discussion of 'unprofessional feelings' is 'taboo'. However, students learn a number of strategies from the medical school culture and their clinical experience. These include

transforming the patient or the procedure into an analytic object or event, accentuating the comfortable feelings that come from learning and practising 'real medicine', blaming patients, empathizing with patients, joking, and avoiding sensitive contact.' (1989:57)

The students learn that emotions are 'unprofessional' because they sense the 'unwritten rules' about affective neutrality. They are guided by disapproval and approval, which they pick up from teachers and other students. From Hochschild's perspective, they have to undertake a form of 'deep acting', e.g. thinking about cadavers 'as if' they are not real people.

Fox (1975) observes that uncertainty in medical students reflects their awareness of gaps in medical knowledge and their own inexperience, but that they are particularly prone to frustration when the underlying causes of a patient's symptoms are thought to be of emotional or environment origin, because the students are more powerless in relation to these factors. This sometimes results in doctors blaming patients for their illness, e.g. inferring that the patient is neurotic (especially if female). These features of uncertainty partially explain the use of regularised procedures, including a managerial or systems approach to the doctor-patient relationship (Arney and Bergen 1984), which has in the past sometimes been justified in terms of protecting the patient from anxiety (Davis 1960). For example Scheff (1968) noted the use of 'rules of thumb' in the informal medical subculture, and McIntosh (1976) described the 'rule' of not disclosing a diagnosis of cancer unless absolutely necessary, using uncertainty, in this case, as a way of protecting doctors from the distressing reactions of patients. Another tactic is to discourage patients from making direct expressions of anxiety, and to encourage short-term optimism (Comaroff and Maguire, 1981). All of these 'feeling and expression rules' necessitate and facilitate the adoption of strategies for emotion management.

Conventions vary according to the social context. For example, a television documentary series 'The Doctor'<sup>11</sup> gave an insight into the life of a rural GP who devoted a lot of time and concern to his patients in a way that would not be expected in an inner city practice or more routine hospital clinic, with a more transient population and fewer chances for the doctor to get to know patients outside of the medical setting. In one programme, the doctor emerged from a very long home visit visibly shaken, not by the patient's physical state but by her social and emotional circumstances, resonating with Berger and Mohr's (1967) portrayal of 'A Fortunate Man'. This was a clear example of emotion work which involved the gift of time and care in a situation where there was nothing else the doctor could offer. Programmes of this kind also play a part in shaping the cultural expectations we have of doctors as part of the 'agenda setting role' (Karpf 1988) of the media, e.g. reproducing appropriate feeling and expression rules for doctors and patients.

In the manner of Goffman's essay on 'Embarrassment and social organization' (1956), Heath (1988, 1989) describes the micro-interaction of the medical examination using conversational and video tape analysis. He argues that bodily expressions of embarrassment and pain are 'thoroughly embedded in the social organisation of participation in face-to-face interaction' (1989:113). The patient accomplishes avoidance of embarrassment by turning to one side during the examination, slightly lowering the eyelids, looking into the middle-distance:

The middle-distance orientation allows patients to cope with the contradictory demands of the physical examination. In turning away patients can render their body for inspection and become insensitive to the operations performed by the doctor; temporarily transforming themselves from a fully fledged participant into an object of test and inspection... The middle-distance orientation also keeps self-consciousness and embarrassment at bay. (1988:149-159)

I have referred above to medical students' beliefs that expression of strong emotions is 'unprofessional'. Peschel and Peschel's account of 'When a Doctor Hates a Patient' (1986) is therefore somehow refreshingly human. Referring to a particularly obnoxious patient who spit at and bit staff, Peschel and Peschel comment:

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<sup>11</sup> 'The Doctor', directed by Jeremy Mills, broadcast on BBC 1, beginning 23 July 1991

My natural urges were to choke her to death... Over the year, I had to minister to [her] about four times. Each time was an indescribable ordeal of exercising patience and self-control. I had to constantly smother my rage to maintain an objective approach to her medical problems...As professionals, the doctors and nurses refused to let personal feelings interfere with the proper medical management of her case. But each one of us must have been secretly imagining her murder. (Peschel and Peschel 1986:118)

c) Emotional labour and nursing

In this section I will focus on nursing work as an example of gendered emotional labour to highlight some of the contradictions in the status of emotional labour in nursing, and the implications these have for nurses' present and future work.

Strauss *et al* (1985) argued that 'sentimental work' in the social organisation of medical work involves 'taken for granted' rules of courteous behaviour, and composure and biographical work to facilitate the management of a patient's 'illness trajectory'. When these forms of sentimental work are lacking or transgressed, nurses are often left to do 'rectification work' or 'picking up the pieces'. Although their account of sentimental work is very detailed, it is rather normative and descriptive, offering little theoretical analysis of the gender division of labour in medical work, or the split between 'rational' science and 'irrational' emotions in the modern context of the high value placed on high-technology medicine (James 1989).

In his study of nursing the dying, Field (1989) found that a tendency for nurses to avoid 'involvement' with the patients was associated with high turnover wards, whereas in a ward with more terminally-ill and long-stay patients, nurses were expected to get 'involved' with patients. Many of these nurses described the emotional aspects of the work as rewarding, and an important factor in job satisfaction (Field 1989). Strauss and Glaser (1975) also report that nurses frequently get drawn into the emotional work involved in the process of helping the patient come to terms with death: 'The patient typically initiates the 'death talk'; the nurse tends to listen, to assent, to be sympathetic, to reassure. The nurse may even cry with a patient' (1975:260).

However, one nurse in Field's (1989) study remarked:

It's people's relatives that give me the hardest time emotionally. It's the most devastating blow that anybody can receive and you've got to inflict it on somebody. (1989:88)

This comment is interesting because the nurse seems to accept her position as a legitimate target on which the relative can take out their emotions. She describes the impact of grief on the relative as a 'blow', which has to be inflicted, in turn, on *somebody* else. Hochschild and Freund's concept of 'status shields' seems relevant here, because if the nurse had higher status, she might have been more able to resist the relatives' use of her as an emotional punching bag. An important point made by Smith (1991) is that in contrast to Hochschild's flight attendants, student nurses acquired the authority, as they reached higher levels in the hierarchy, to avoid, or withdraw emotional labour from certain patients. At the beginning of training, nurses were more vulnerable, not having the 'status shields' of more senior staff.

Caring is described by James (1987) as having three component parts: emotional labour, physical labour and organisation. In the household, emotional work is fitted in around the organisation and carrying out of other tasks. The flexibility this entails enables emotional work to be done in a way which allows responsiveness to the timing and needs of others to be taken into account, but also enables both emotion work and organisation to be done 'invisibly'. Emotional labour is often low-paid, low status, unrecognised, and done by women as part of another job or task, yet the 'invisibility' of this work belies its value and centrality to many types of work.

Melia (1987) found that routinization of care work was sometimes preferred by student nurses because it reduced anxiety and uncertainty, but they were also socialised to regard physical rather than emotional labour as 'real work'. There was an 'unwritten rule' that even when there was a lull in the work, it was 'more acceptable to try to 'look busy' than to demonstrate a lack of work by talking with the patients' (1987:21).

Salvage (1990) argues that the assumptions in the 'new nursing ideology' (which includes a model of patient-nurse partnership) are inconsistent because

'psychotherapeutic' relationships are entered into by 'contract', whereas many patients are more interested in efficient nursing skills than in getting 'involved' with nurses (Melia 1987). Strong (1979) likened this perspective to customers being willing to forego the personal touch of the grocer for the lower prices of the supermarket. I would argue, however, that there remain unresolved questions over the image of nursing as a 'caring profession', and that in some cases its construction as a gendered occupation means that the emotion work of nurses is seen as secondary to the 'real work' of nursing. It will be interesting to see whether this changes in the future reconstitution of primary care, in which I think it possible that emotion work may become an issue over which general practitioners and nurses vie for jurisdiction.

Such a discussion cannot today avoid the imperative to reflect on its own position in the 'discourse'. For example, we could ask: does the modern tendency to polarise emotion and control in any way explain the focus on *management* of emotion even within the sociology of emotions? Does the sociology of emotions in the context of the sociology of health and illness assist in the new form of social control and surveillance (Foucault 1969, 1973, 1978; Armstrong, 1983a, 1983b, 1984), respond to the 'incitement to discourse' (Arney and Bergen 1984), or articulate the relationship between discourses (Silverman 1987). James and Gabe (1996:10) regard the related question of 'whether, and in what ways, such studies of emotion may contribute to new moralities of emotions' as an open one.

In the analysis of my data I will draw on theories from the sociology of emotions to illuminate an important dimension of the constitution of health production experiences of and social relations between doctors, nurses, parents and children.

## **2.7 Conclusion**

In chapter one I concluded that problems for GPs in relation to their out of hours commitment have been looked at chiefly from technical and organisational perspectives to be solved by bureaucratic means conceptualised within a medical framework. I argued that this perspective fails to recognise or understand a whole range of issues to do with the social relations constituting healthcare. The purpose of this chapter has been

to bring together a range of social science literature to open up the topic of demand for out of hours healthcare for reconceptualisation of the issues in these terms.

In addressing such themes as communication and the moral and emotional components of parenting and professional behaviours, I have shown that these issues are embedded within broader debates about who we are and how we constitute each other relationally. These include gendered assumptions about women's role as mothers as well as forms of work undertaken by nurses. They also tend to neglect the everyday work we all engage in, including emotional labour, to produce our own and others' health.

I observed that continuity of care is presented as being in opposition to consumer choice and convenient access, because the organisation of out of hours care has been such that they have seemed impossible to achieve simultaneously. However, it is important to challenge the consumerist assumptions behind this rhetoric, because the implications of current innovations such as fragmentation of care and loss of personal continuity between doctors and patients, especially for particular user groups, have not been publicly debated. Another problem I have addressed is that continuity of care is usually assumed to be part of a bounded doctor-patient relationship, which also, and increasingly, needs to be questioned. I have also discussed the implications of the revolution in arrangements for out of hours care for inter and intra-occupational debates around autonomy and the professional and organisational changes in general practice and primary care.

Much of the existing research addressing patients' experiences uses limited outcomes such as 'satisfaction' or 'enablement', but such measures are usually quite inadequate for getting at the values of qualities like continuity of care, for patients but equally for professionals. In attempting pragmatically to measure something more tangible than 'values', but working within the confines of the medical framework, they do not seem to me to address issues at the appropriate conceptual level. Values must be seen in the light of a range of issues in their everyday and taken for granted contexts to be able to assess their relative importance, and of course, the values of different players may be in conflict.

I have brought together a diverse body of literature to bear on these issues, reflecting the equally diverse range of implications grouped around the central focus of out of hours care. My engagement with the literature in chapters one and two together constitutes a challenge to the notion of patients as consumers, assumptions about the role of mothers and parents, and the splitting off of emotions from medical science, and provides the theoretical framework which I have drawn on in the analysis of my data and reconceptualisation of demand for out of hours healthcare. Finally, in this chapter I have also addressed some methodological issues in approaching research on communication as one aspect of the social relations involved in healthcare, and in the next chapter I now turn to a fuller discussion of these matters.

## Chapter Three

### REFRAMING INVESTIGATIONAL METHODS: INNOVATIVE ROUTES TO DIALOGUE

The literature suggests that the kinds of research methods most commonly used in researching ‘appropriateness’ of demand, e.g. cross sectional designs, questionnaires, and structured interviews, rest on *a priori* assumptions about the contexts in which people act, and attribute motivations to psychological or structural factors, or abstract concepts such as ‘culture’. They tend to follow from the definition of problems in terms which assume the intention of changing the behaviour of patients or specific organisational tools (e.g. phone and appointment systems), and do not account for the complexity of situations in which the appropriateness of demand is seen as contentious, for example, the triage process. With these methods categories are sectioned off in order to investigate possible correlations between structural factors e.g. socioeconomic and demographic variables, but this approach can lead to static and disjointed views of what I will argue are far more fluid processes.

It became apparent to me that what are seen as intractable problems are made more so by research methods which seem to deny the interactive complexity and dynamic nature of this topic, so an approach needed to be adopted which would allow a more holistic view of ongoing and constantly evolving processes. Therefore in this chapter, to explain my methodology, I critique the literature in and propose development of two key areas: the dialogic process of *producing* and *analysing* ethnographic research material.

My overall position is to advocate understanding the social world in a *relational* and *interpretive* way. In the first section, on approaches to ethnography, I argue this case in two senses: in appreciating how parties appeared and were perceived by each other, but also in terms of my own positioning to them as a researcher or observer-participant. Although these can be conceptualised as two kinds of dialogue, they are in practice both part of one ongoing process. In contrast to the scientific approach in which the researcher distances herself and compresses the social world to construct and focus upon

particular objects, this approach stresses the researcher as a subject positioned in a field of other subjects. Rather than gathering a collection of monologues, the world is seen as a complex and ever-changing set of relationships from within which one can try to capture processes of dialogue.

The practical aims of the fieldwork, which will be described in more detail in the next chapter, were to observe and describe the talk and activities of as many people as I could include around the focus of one primary care centre (PCC) and to a lesser extent the larger GP cooperative which ran the PCC. I also had many conversations outside of the main research setting with people involved in caring for children and providing out of hours services, and participated in the e-mail discussion list GP-UK. The main forms of data are notes and tape-recordings from participant observation, informal conversations, and unstructured interviewing; recordings of telephone conversations between triage nurses, doctors and parents; and general 'fieldnotes'.

Because the products of the flexible ethnographic approach which I set out in the first half of this chapter are unlike more conventional sociological or health services research material, this leads to a discussion in the second section on dialogic analysis, in which I set out an interpretive framework that allows for the retention of multiple voices and ways to make sense of them. I discuss the limitations of some previous work on narrative and discourse analysis and develop a synthesis of ideas. Whereas the meaning of narratives has often been understood in terms of single or linear stories, I interpret them as potentially multiple, polyphonic and between parties, thus reframing both narrative and this research approach as dialogic processes.

### **3.1 Approaches to ethnography**

The research methods I used I would describe as ethnographic in the sociological sense, and informed by anthropology; that is, most anthropologists would not regard my study as an ethnography, but I would argue that what I have gained from my exposure to anthropology means that I have worked in ways that differ epistemologically from the ways in which many sociologists use ethnographic methods, and in this section I will try to illustrate this.

Although I think it is important in this chapter to refer to the substantial differences between sociological ethnographic research and anthropological ethnography, it has been argued that ethnography is itself a category which it does not pay to try to make too fixed (Stewart 1998). This is because describing ethnography either as a method or as a 'product' of research fails to represent the range of nuances in methodology included in either anthropological or sociological 'ethnography'.

a) Contrast between ethnography and grounded theory

It may be germane first to consider Stewart's distinction, in his description of 'the ethnographer's method' (1998), between grounded theory, which he claims is the almost taken for granted analytical framework for sociological qualitative but non-ethnographic research, and (predominantly anthropological) ethnography. They are similar because they 'both use comparable processes of generating understanding with iterative comparisons of data and theory' (1998:8 [referring to Agar 1986]); and because ethnographic theory is also 'grounded', in that ethnographers give priority to context in interpretation of their observations (1998:9). However, in ethnography the focus is more on description than theory-driven analysis or interpretation; and in grounded theory, priority is given to generating concepts more than depicting context.

To illustrate this point I review Coyle's (1999) paper 'Exploring the meaning of 'dissatisfaction' with health care: the importance of 'personal identity threat'. Following on from her critique of the validity of the concept of patient satisfaction, she argues that

'dissatisfaction' should be investigated in a way which examines both the vague undifferentiated negative emotions initially felt, and the more stable negative interpretations which crystallise over time... dissatisfaction is best seen as 'transformation' (which is changeable, subjective, reactive and fluid)... The task therefore, for further research is to develop, or adopt, a methodology which is capable of exploring the complexity of this social phenomenon. (1999: 100)

Coyle goes on to describe in detail her methodology which is informed by grounded theory. As Stewart (1998) suggests and she states, this allowed for close attention to the context of her respondents' narratives. However, the data is immediately analysed and

coded into abstract categories such as ‘dehumanisation’ and ‘stereotyping’. She refers to using a technique (the ‘explanatory matrix’) advocated by Strauss and Corbin (1990) which addresses ‘causal conditions, intervening conditions, context, process and consequences’ (Coyle 1999:104), and goes on to say that the aim of organising categories by this technique is ‘to identify a ‘core variable’ which has the greatest power’ (Coyle 1999:104). In her study, she refers to this core variable as a new concept called ‘personal identity threat’.

It seems to me that Coyle’s grounded theory approach thwarts some of her more interesting previously stated intentions, because rather than depicting processes of change and fluidity as she indicated, it produces somewhat static categories. An additional factor is that the sample consists solely of users of healthcare, so that any sense of the interactional context of their experiences is necessarily from one viewpoint.

To take two specific examples, earlier in the article she points out that satisfaction and dissatisfaction can co-exist, such as when people are unhappy with aspects of care, but accept mitigating circumstances, or that their goals are outside the duty of the provider. However, in her discussion of the data, there are no findings which reflect this kind of ambiguity. Another interesting theoretical idea she raises initially is the changing quality of dissatisfaction (transformation), yet, again, she does not appear to have captured this sense of process within her categorical descriptions. In her conclusion, she suggests that ‘measures of personal identity threat, or the extent of ‘humanity’ in health care’ could be developed, ‘which could add to or supplement existing measures of satisfaction with health care’ (Coyle 1999:118). So although I think she has succeeded in her development of categories which reflect the complexity of how people might experience and express ‘dissatisfaction’ by breaking this down into a greater number of categories, I would argue that she has not sufficiently represented or depicted the more interactive, emergent, ambiguous and processual aspects of people’s experiences.

#### b) Critiques of ethnography

The ‘problems’ with ethnography, in contrast with grounded theory, have been debated at length - notably by Hammersley (1990a, 1990b), who encapsulates many of the

arguments in his discussion of the criticisms and defences of ethnography that have been rehearsed by social scientists since the 1920s with the development of case study research at the Chicago School of Sociology and community studies in the USA and UK, stemming from origins in anthropological ethnography. Hammersley identifies two categories in the debates: criticisms of ethnography for not being 'scientific' enough, or for being too scientific. These debates emphasise issues of objectivity, validity, generalisability and replicability.

An elaborate discussion of these issues is provided by Lett (1997), who argues against forms of humanist anthropology, as advocated by interpretive anthropologists (whom he equates with post-modernists), which reject science because, in his view, they fail to operate according to the fundamental principles of rational inquiry. I take issue with Lett's argument (which relates to similar ones in sociology) first because I think he unhelpfully polarises the debate into two extreme positions; and secondly because while conceding the impossibility of achieving absolute 'objectivity' when pursuing the aims of science, adopting this position in the case of interpretive anthropology is seen as extreme relativity and morally evil. He argues that the aims of science rest on the assumption that there exists an ultimate logical and objective reality, and only our imperfection denies us its apprehension:

...objectivity is an unattainable ideal... As human beings we can only concern ourselves with the reality that we can perceive or infer; we can only concern ourselves with those phenomena that impinge upon our lives, however directly or indirectly... Furthermore, our perception of objective reality is obviously constrained by our humanity. It is limited by the nature and range of our sensory organs and by the ability of our minds to devise instruments to extend those limits. Our perception of reality is never purely passive but is always a process of active interpretation filtered through the myriad biases of our cultural contexts and personal histories... What we know is inextricably linked not only to our perceptual and cognitive abilities but to our interests and goals as well... However... science also proceeds on the assumption that objective reality exists independent of human capacities and concerns'. (1997:44-45)

By contrast, he supports those who find interpretive anthropologists guilty of 'evil and immoral' epistemological relativism, because:

If you start with the premise that objective descriptions of human affairs are unattainable, then it is impossible to derive sound moral judgements about human activity. Interpretive anthropologists need to recognize that premise for the venomous snake that it is. (1997:102)

To elaborate on the two problems I see with Lett's position, first, it seems he is saying that because science is pursued on the premise that there is one ultimate objective truth, we can ignore the fact that the 'reality' of scientific work (as he describes it) is much more like how interpretive anthropologists describe it. This strikes me as resembling his argument about the closed logic of religious belief: no inconsistencies can dissuade the believer. Lett states that it is possible to prove a synthetic proposition true or false on the basis of experience, even if it is impracticable ever to obtain sufficient evidence. To say that we must *believe* that objective reality is only knowable through science, despite his arguments that it exists but can never be proven, can never be falsified, is always vulnerable to new knowledge, and can only be known through the imperfect human practice of science (therefore, unknowable in practice), seems to me more an emotive than a synthetic proposition, and even in those terms, Lett follows Popper's (1959) claim that 'no synthetic proposition can ever be demonstrated to be absolutely true' (Lett 1997:37). Whether or not objective truth is impossible, if we follow the kind of reasoning and logic that Lett presents, this must, technically, always remain only a possibility, however strong the evidence.

The logic of rational inquiry in science, he argues, demands that we look out for ways our propositions might be falsified and thus detract from any assertions we make, but we can *allow* that (for example) negative synthetic propositions 'can be falsified beyond any *practical* possibility of error' (1997:39), i.e. we can accept negative propositions (e.g. Santa Claus doesn't exist) as if they were objectively true on the basis of a reasonably small possibility of error. This is where I think he unhelpfully polarises two positions, since many anthropologists and sociologists have arrived at ways of *practically* demonstrating the validity of their findings (see below) which do not conform to the ultimate rules of physical science, but then, by his account, neither does science itself. Postmodern anthropologists may not attempt to do this, but other anthropologists (and sociologists) have arrived at workable solutions to this problem.

The second problem is one which has been rehearsed with as much vehemence in sociological as anthropological circles: it seems to me that arguments for epistemological validity are conflated with those concerning *moral* validity. That is, the view that there are multiple ways of seeing and experiencing the world is equated with moral relativity. In my view, to take the former position does not necessarily imply the latter one. Moral judgements about the relative merits of different perspectives are not prejudiced by admitting that multiple interpretations are possible. To restate Lett's position:

I cannot state this point too emphatically: an anthropology that was *not* based on reason would be both intellectually indefensible and morally irresponsible... any legitimate set of humanistic values must be founded upon a bedrock of objective knowledge, because reason is also the only reliable means we have of distinguishing between right and wrong. (1997:18-19)

Obviously reason is central to epistemological problems, the extent to which *how* we go about research can be said to be a 'valid' way of seeking knowledge. But this does not determine what is 'right and wrong' in the sense that research carried out according to reason proves an irrefutable reality: that is an *ontological* question which is not answered sufficiently, for me, by believing that science delivers truth. Reason and logic can lead to flawed conclusions, *because* knowledge can only ever be partial.

Nor does it determine what is 'right and wrong' in the moral sense: that is a separate question. Because something is logically correct or thought to be true by a process of reason does not make it morally right. The ability to make sound moral judgements depends on an *a priori* moral code which can then be applied or adapted to situations according the most plausible information available. Courts of law could not operate otherwise, and also could not operate if they could only act on irrefutable facts. The point, made throughout his argument, that science is not capable of delivering these either (and at the same time claiming that critics of science construct as a straw argument the notion that science can do so), is all forgotten when he makes such polarised claims as in the following statement:

By refusing to make unequivocal determinations of objective fact, interpretive anthropology renders itself incapable of making sound moral judgments... It is

possible to determine whether or not a moral judgment is defensible by evaluating the *consequences* of that judgment. (1997:101-102)

The idea that the consequences of judgements should be subject to different moral evaluation than the original judgements does not seem to me satisfying, it merely brings in another debate: whether the ends justify the means. Ultimately, such arguments can never be resolved, but Lett's solution to these problems is to try to resolve yet another irresolvable old chestnut, the nature/nurture debate, when he proposes:

that the human mind is a complex set of specific problem-solving mechanisms that evolved as adaptations to particular problems encountered during human evolution (1997:129)

By closer adherence to scientific methods, he claims, we can pursue the agenda implied by this statement and thus enjoy the greater successes of the physical in contrast to his examples from the social sciences. My answer to this is to be wary of successes, and their comforts, based on (what are by his own argument) less solid knowledge than many scientists will admit.

I have considered Lett's arguments at length here because I think the consequences (imagined or not) of this highly polarised view are of concern (in one form or another) to many people working in the social sciences, and have an impact on the stance one takes methodologically. As I have implied, I think many people *have* addressed them (e.g. Grint and Woolgar 1997; Wolcott 1995) and arrived at methods which take them seriously and are as 'more or less' successful as science can claim if applied to appropriate issues. I take the (unoriginal) position that social life in comparison to the physical world is less amenable to the logic of ('hard') science and is more convincingly understood or explored through interactionist and interpretive methods, but in using the latter term I do not mean postmodernism in the extreme (although arguably caricatured) form to which Lett and other critics refer.

In my view some of the ideas which have arisen in addressing the 'postmodern condition' have been overworked and overextended in their application to social science. Connor (1989) traces how concepts of postmodernism were originally developed as a set of

arguments in relation chiefly to architectural, literary and cultural studies, but have become crystallised within and across a number of disciplines (p 6). For example, he notes that although Lyotard's (1979) characterisation of the postmodern condition

revolves around the function of narrative within scientific discourse and knowledge[, h]is interest is not so much in scientific knowledge and procedures as such, as in the forms by which such knowledge and procedures gain or claim legitimacy. (Connor 1989:28)

For me, this provides for a sufficiently interesting and worthwhile project, and is the orientation I have taken in this study. I will have to leave to Lyotard's many, more informed, critics postulations about the ultimate philosophical consequences of (to take as one main example) his 'incredulity' towards metanarratives.

c) Looking for the unexpected

A feature of my study was that hypotheses about possible theoretical outcomes, structural explanations and indeed, conceptualisation of the phenomenon of 'appropriateness' itself were suspended during the fieldwork rather than 'front end loaded' as would be the case in more conventional sociological research, and even more so in health service research (HSR), whatever the particular methods employed, although I would say that HSR is dominated by the 'scientific method'. My original research design, discussed more fully below, was based on the existing applied literature, and it incorporated hypothesised links between demographic and organisational characteristics of GPs, and demographic and consulting variations of families. It also carried through some of the assumptions about what has been referred to in the literature as the out of hours 'problem', particularly its location in consulting patterns, or parents' behaviour. In my revised strategy I tried to bracket off these tentative hypotheses and pre-existing categories as much as possible in order to observe what people actually say and do, and to be able eventually to formulate new conceptions which, again, I hoped would be more closely tied to their originating contexts and processes.

This seems to me to be an important epistemological issue, since even working ethnographically, one can in effect find what one was looking for if the end product

envisaged for research is to be able to represent the data in terms of a particular structural focus, for example gender, race or class. One might go as far as to say that in the field it cannot be assumed that one's own epistemology will work with what is there, and in many ways this is indeed what I found, which contributed to the development of my methodology as outlined in this chapter.

Adopting this approach meant that many unexpected findings could be incorporated in my ongoing understanding of a dynamic context rather than being seen as disrupting a carefully worked out plan. Openness to the unexpected was both in relation to unfolding events and in a more fundamental sense. First, it meant that the changing nature of the research subject was tackled in a positive way by approaching the fieldwork in terms of looking at processes rather than static categories, for example seeing (and hearing) communication in a consultation as a process informed by both the past and future, rather than successful or unsuccessful as if one could describe that moment as a separated off 'outcome'. One of the ways in which I tried to capture a sense of process was to follow the route of families through from the original phone conversation with the triage nurse, observation of their consultation with the GP, and a follow up interview in their home. Thus each of these cases could be looked at in terms of changes in the way seeking medical help was negotiated, understood and (re)constructed. Another was by following the development of the cooperative, and the ways in which their views on legitimacy and meeting of demands were made manifest and reconstituted in the practices and organisation of the service they provide.

The second sense in which openness to the unexpected emerged as a fundamental principle of my research was in trying to suspend my own common sense and knowledge about children's health, doctor's practices, and ideas about the assumptions people make in their interactions. Proposing an 'anthropology of the present', Shore and Wright (1997) argue that the task

is to unsettle and dislodge the certainties and orthodoxies that govern the present. This is not simply a question of 'exoticizing the familiar'. Rather, it involves detaching and repositioning oneself sufficiently far enough from the norms and categories of thought that give security and meaning to the moral universe of one's

society in order to interrogate the supposed natural or axiomatic 'order of things'.  
(1997:17)

Here Shore and Wright acknowledge the difficulty of

standing outside one's own conceptual schemas... The problem is... how to become aware of the historical contingency and inventedness of our taken-for-granted present. (1997:17)

Shore and Wright (following Burchell 1993) advocate a Foucauldian approach of examining the historically conditioned constitution of the subject and a consideration of the possibilities of an alternatively constituted subject and relation to self. I take this, together with their formulation of the 'historical contingency and inventedness' of the taken-for-granted present, to suggest a more fluid interpretation of what the present is, i.e. that although we talk of operating at particular points in chronological time, we are simultaneously operating from past and future orientations, in the same way that we can say at any one time we may simultaneously be holding different selves.

Goffman's (1974) use of the terms 'frame' (drawing on James, 1950; and Schutz, 1962) and 'laminations' are helpful here: the idea that 'definitions of a situation are built up in accordance with principles of organization which govern events - at least social ones - and our subjective involvement in them' (1974:10-11), and that 'any more or less protracted strip of everyday, literal activity seen as such by all its participants is likely to contain differently framed episodes, these having different realm statuses' (1974: 560-561). Transformations of the subjective status of framed episodes, or 'laminations', are in theory unlimited, but the opposite is also considered possible if not very likely to continue for long: 'often effort will have had to be exerted to ensure even this. The absence of laminations is to be seen, then, as something worth seeing' (1974:565).

Another problem with ethnography is what Hastrup refers to as 'the violence inherent in fieldwork' (1992:122). She argues that violence arises because ethnography involves an ultimately hierarchical relationship to informants in that in any scientific discourse the questions are unsolicited and may be intrusive, and the many voices of respondents are subsumed by the author writing ethnography. Very similar debates have been rehearsed

in sociology, for example by those who claim reflexivity as a central part of feminist methodology. As Hastrup puts it, fieldwork involves challenges to the boundaries of self and other: the informant speaks 'not from the centre of their world but from the liminal space of the cultural encounter' (1992:121). Ethnography represents the reality created between self and other(s), so that the authorial status of ethnography is necessarily reflexive. The ethnographer tries to see her interpretation in relation to those in the field she engages with. Taking further Geertz's notion of culture as webs of significance man has spun for himself (Geertz 1973:5) Wright (1994) suggests that people have more than different understandings of situations and actions. Different people have

different structural power and personal ability to impose their meanings on events so as to make their interpretation definitive and thereby accrue very material outcomes. It is this political process, a contest to assert definitive interpretations which produce material outcomes, that is the key to anthropological understandings of culture, of relevance to organization studies. (1994:23)

Thus the project of ethnography poses the challenge of how to work with historical contingency and inventedness in terms of possibilities (without taking an extreme relativist position) of multiple histories, multiple contingencies, and multiple inventions or perceptions of history and self existing at any one point in time, including the effort to impose particular interpretations or meanings of events on others.

Although one can endeavour to be open to the unexpected, one cannot, of course, set out with the benefit of hindsight, and this highlights (at least) one aspect of my fieldwork that I would have wished to give more attention to, which I only appreciate more fully now that I have done some analysis. Although I took fieldnotes and made extensive use of tape recording, I might have had more to draw on for my analysis had I made more successful attempts to note what I saw people doing and the objects used - not in order to offer these as evidential claims to a scientifically observable reality, but to give me more material on this dimension for interpretation than speech alone can provide. However, no amount of copious recording would solve (and could even add to) the fundamental problems of textual or narrative attempts to represent our interpretations of social life, and to consider some of these issues I will turn now to problems of the analysis of research material.

### 3.2 Forms of analysis: from monologues to dialogic process

In particular forms of qualitative analysis there is often an overemphasis on text and the spoken word which leaves the data strangely decontextualised. Certain forms of narrative and conversation analysis, for example, seem to privilege extracts of conversation as if speech in quoted text form represents a fixed truth or reality. This is not to deny the value of work using this approach, and I have drawn on Silverman's (1987) work as a good example in the previous chapter. There are also some important and useful ideas incorporated in ethnomethodology, for example 'indexicality', the contextuality of meaning which is taken for granted in everyday conversations (Garfinkel 1967), and the work that goes on in filling in these background assumptions. Nor is it to overlook the issues of textual construction addressed by Atkinson (1990). Again, however, Shore and Wright's (1997) comments suggest to me the need for a more elaborate interpretation of the present which would try to address not only its historical contingency but its future connotations; not only how the present has been (multiply) invented by the people one observes, but also by the observer; not only the taken-for-granted things people *say*, but the things they *do* and the things they use to do them. Thus by comparison the use of text can seem rather limited unless there is some attempt to situate it in this sense, i.e. to delineate the relevance of what is said with the context of what went before and may be yet to come, and with what possible simultaneous meanings text may co-exist.

#### a) Discourse analysis

Some of these points can be illustrated using the example of Gwyn and Elwyn's (1999) advocacy of discourse analysis in their investigation of a situation in general practice in which 'shared decision making' is inherently problematic, the case of demand for antibiotics to treat viral disorders. The article uses the case of two non-native speaking parents bringing their small son to a GP with tonsillitis. As will be seen later, this was a very common subject for consultation that came up in my study. Their overall claim is that power differentials between doctors and patients make shared decision making a limited option, and I would agree with this point. However, another conclusion of the

paper is to promote the use of discourse analysis as ‘an appropriate method for examining the rhetorical strategies employed by both doctors and patients in arriving at a shared, or even a partially-shared decision’ (1999:447), and I will focus here on some limitations in using this method alone in their interpretation of the encounter.

The problems as I see it are not so much in using discourse analysis *per se* (which I also use in my study as will be seen later), as they are to do with using it in isolation; in particular, not addressing sufficiently the context outside of the immediate situation of the consultation. I have referred in chapter two to the assumptions in this paper regarding the wider sociopolitical context. In terms of the more local context, it seems to me that Gwyn and Elwyn underestimate the doctor’s failure to elicit sufficient of the family’s social issues because they regard the father’s mentioning of his other son’s history as an exploration of existing knowledge. For example, they overlook the importance of the father’s stress on saving time the boy is to spend suffering by using antibiotics; and equally the doctor’s subtle confirmation of this interpretation, and the father’s subsequent mention of their moral responsibility as parents. Thus their analysis perhaps inadvertently colludes with the doctor’s narrower agenda of whether antibiotics are appropriate medically, rather than appreciating the fuller context from which the parents are coming from. The reader can merely speculate because we only have the text of the consultation to go by.

A further factor is that the parents’ dialogue with each other was in another language during key moments which influenced the outcome of the consultation, and this should have alerted them to the possibility of misinterpretation. At one point, the father says, significantly I would have thought, ‘it is too difficult to explain’. Despite the transcription stating that the mother keeps up a quiet and insistent input in her own language via the father, the authors’ only interpretation of the parents’ acceptance of the GP’s arguments against antibiotics is that the mother has overturned his choice of antibiotics, a ‘potentially face-threatening outcome’. But since she is speaking in another language, how do they know this is what transpired? An alternative is that the mother remains adamant that she wants antibiotics, but the father realises he is going to have to back down in the face of the doctor’s resistance. Thus his qualification that he will agree not to have antibiotics ‘this time’ may, as the authors argue, be a face-saving manoeuvre

on his part, but not so much as a result of embarrassment in front of the doctor that, as they assume, his wife has sided against him with the doctor, but that, in spite of his wife's pressure, he is having to back down against the doctor and has had to take a stand against his wife. Again, we cannot know, because we don't know what the couple say to each other in their own language.

Finally, suppose another alternative (and there could be others) is that both the father and mother have realised they are going to get nowhere with the GP so they are both backing down, but have in mind a future strategy or other factors to consider, which have not been discussed, in case their son is still suffering after some further time. Perhaps these involve other people in their family, friends and acquaintances who have a powerful part to play in their decision as to how to act in the consultation. Equally, the GP is responsible and accountable to others outside of the immediate setting and may have a range of strategies which can be brought into play in relation to these various people and institutions. These possibilities illustrate the limitations of the authors' model of decision making, which focuses only on those present and on the consultation situation. They acknowledge the problem of 'the plurality of value systems' (1999:440), but do not engage in further discussion of how this could be addressed methodologically. For instance, they take no account of 'significant others' who may not be in the consultation but have an influence on all of the players; or the consideration of past and possible future effects and consequences which may be as important as the immediate decision.

For all of these reasons I take issue with the authors' conclusion on the appropriateness of using a discourse analytic approach as the single method to examine the rhetorical strategies employed in such instances, because the authors' analysis rests purely on the consultation as a 'sealed unit' and is flawed by having insufficient contextual and longer-term process information, making it particularly vulnerable to the researchers' own assumptions, such as their introductory comment on the influence of consumerism, and possible misinterpretations. I would argue therefore that a study design which allows for some attempt at confirmation or exploration of findings with people and influences (sociopolitical, professional, and so on) involved in consultations outside of the situation to check interpretations is important.

A promising development for the contextualised analysis of transactions between the parties involved in out of hours healthcare is provided by the burgeoning literature on narratives. Narratives and narrative analysis imply attention to issues of continuity, context and linkage between those elements which have been treated in a far more circumscribed and limited way in discourse analysis. As will be noted later in this chapter, narratives provide a clear entree into issues of dialogue and process which form the heart of the framework of this thesis. Thus I now turn to a brief review of key issues in the development and application of narratives in healthcare settings.

b) A dialogue with 'narrative reconstruction'

The use of 'narrative theory' has become established practice in the analysis of qualitative data, particularly interview material. Although the historical antecedents are possible to trace (Bell 1999), a key concept in its application to research in medical sociology was that of 'narrative reconstruction'. This is most frequently referred to citing Gareth Williams' (1984b) paper 'The Genesis of Chronic Illness: Narrative reconstruction', arising from his PhD thesis (1984a). In the thesis Williams argues:

... if, in some fundamental way, an individual is a social being with a biographical identity, and if the prime sociological importance of chronic illness is the disruption of biography, then an individual's account of the origin of that illness in terms of putative causes can perhaps more profitably be read as an attempt to establish points of reference between body, self and society and to reconstruct a sense of order from the fragmentation produced by chronic illness. This imaginative endeavour is what I call narrative reconstruction.

Within this narrative reconstruction, the problem becomes one not of establishing the cause of the disease in a 'clinical' sense, but rather of reconstructing the unfolding process of their lives in such a way that a genesis of the illness can be given a sensible place within it. If lay accounts are read in this way, the whole problem of lay beliefs becomes different because they are given their proper context rather than being lifted out and fitted to the researcher's preconceived notions. The distinction between 'internal' and 'external' causal factors in lay accounts comes to be seen as rather artificial because the whole narrative reconstruction in which 'causes' are points of reference constitutes an attempt to bring together the whole of the person's life in a unified way. Once you begin to read the accounts in this way the whole nature of their complexity changes from one of formal sophistication to one of socio-structural embeddedness. (1984a:132-3)

In the paper he defines narrative reconstruction as:

... part of a quest to determine the associations between body, self and society and to unify past, present and future in a cohesive story. (1984b:367)

In citing this work, many people have referred to the aspects relating to the concept of biographical disruption (Bury 1982) of chronic illness, focusing less on illness as fragmenting a person's former relationship between body, self and society, and more on narrative reconstruction as an attempt to reconfigure these temporally to make a unified and cohesive story. For my part, I would like to state at the outset my appreciation of this work, and perhaps particularly what might be considered the less celebrated strand, his emphasis on how narratives reflect the situatedness of the person within a nexus of body, self and society. Yet in drawing on Williams' form of analysis to develop my own methodology, I have found it helpful to graft in material with which I have more recently become acquainted.

I think it fair to say that at the time the thesis was written, the work of Bury, Williams, and other medical sociologists, drawing attention to the *experience* of chronic illness, and giving voice to people with chronic illnesses rather than writing about them from an academic or medical point of view, was an innovative and important stance. Located in space and time between the diminution of 'critical' sociology and the rise of interest in deconstructionist and 'postmodern' theorists, it also coincided with medical sociology becoming an established part of the medical education curriculum. Writing now some sixteen years later, it is inevitable that the field has developed with new concepts and empirical work, so that theoretical revisions can be made of earlier work that could not have been made at the time because we were not then saturated with the concepts used in later work. In relation to Williams' work, my purpose is not so much to critique it but to view it in an 'archaeological' sense (Frankenberg 1989), to look at how some subsequent ideas and perspectives have overlaid it and produced different permutations, and to suggest some possible developments I have tried to use in the analysis of the material in this thesis. As I hope to show, I regard Williams' work on narrative as forming a peak in the terrain, which though overlain subsequently, remains a landmark.

Bell's (1999) review of the literature about the experience of illness and narrative focuses on two topics of research: 'how illness affects identity and ways in which 'local' contexts shape experience and its analysis' (p.1), reflecting the development of questions within the wider discipline of sociology concerning the meaning and production of knowledge and how the 'self' is constituted. Included in the range of approaches to writing about narrative in the late 1990s are recognition of a plurality of 'truths' in narratives; the importance of historical and cultural context; the multiple ways in which narrative projects may be embedded and constituted; and a view of the 'self' as a processual, reflexive, emergent phenomenon. As a major development since the early 1980s, questions are asked more routinely now about the ways in which the researcher influences the telling of stories, the re-telling of and selection of them out of bigger data sets. I take the position of many of the writers Bell (1999) refers to that data within the narrative research tradition is relationally and contextually constituted, that the researcher cannot but influence the process, and that the question of the effects of this process is therefore a matter for reflexive analysis.

These arguments have led us to the point where 'reflexivity' has a much wider scope than an exercise in analysing what might have been the effects the researcher had on the 'subject', e.g. the effects of the class or gender of the interviewer, which led some feminists to proclaim the virtues of feminists interviewing other women on some issues (Oakley 1981). Reflexivity now entails an expanded awareness of a more interactional and contextualised relationship between researchers and research respondents, one effect of which is to change the language used to describe people as participants, respondents or co-researchers, rather than 'subjects'.

#### *Temporal and moral aspects of narrative accounts*

Bringing these developments to bear on a consideration of Williams' work, one can consider the possible ways in which the paper (1984b), and particularly the moral and temporal elements of his arguments, can be seen in a different light. First, I suspect that much of the high regard for the paper, which I share, stems from recognition of Williams' facility to bring to his analysis an especially informed and empathic *moral* framework, which emphasises the social relations within which narratives are embedded.

Secondly, it seems to me that the content of the particular accounts presented, and the selection of them for this influential paper, reflect the author's concern to convey the impact of chronic illness as biographical disruption (Bury 1982), that is as a *linear narrative*.

To begin with, I would like to examine here what he has himself referred to as the viewpoint from which he has read the accounts:

In confronting the experience of chronic illness, then, like any unusual or disturbing experience, Musil's narrative thread - 'when that had happened, then this happened' - becomes *questionable*. The individual's narrative has to be reconstructed both in order to understand the illness in terms of past social experience and to reaffirm the impression that life has a course and the self has a purpose or *telos*. It is from this viewpoint that I have read the 'causes' to which my respondents refer... (1984b:179)

While I would agree that in the experience of illness, and not just chronic illness (Frank, 1995), relationships between events and their meanings become questionable, I would also question whether an individual *has to* reconstruct their narrative in such a way as to reaffirm or create an impression that there is a course to their life inseparable from their sense of *self* and *purpose* in the eschatological sense that the word *telos* implies<sup>1</sup>. This seems to me to be taking a particular and profoundly moral stance, which may only represent the experience of illness for some and not all people. If I can take these elements separately I hope to demonstrate how the relationship between them need not necessarily be tightly bound or configured in quite the way Williams has argued, using the theme of 'blame' as an example.

### *Narratives as blame explanations*

Following my assumption that the researcher and respondent co-produce research data, I am led to ask, to what end would people perceive his asking why they thought they got arthritis, as opposed, for example, to asking what was their experience of the illness? Within their talk of the origins, causes, or as Williams puts it, the 'genesis' of their

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<sup>1</sup> I am acutely aware that the word *telos* is freighted with meanings accumulated over centuries of scholarship, and that I am not equipped to deal with it adequately. However, I think the particular way in which I question it in this context is valid and I am grateful to Ronald Weitzman for advice on this.

illness, I would suggest that his research participants' accounts, situated within cultural processes as all research must be, would most probably have reflected to a greater or lesser extent particular cultural assumptions about *blame*: who or what is to blame for this experience? Some alternative possibilities for the play of this concept in the constitution of his interviews in this way are suggested by Douglas' (1992) essay on 'Risk and Blame', in which she sets out a theoretical relationship between the conceptualisation of blame and wider cultural processes:

...in all places at all times the universe is moralized and politicized. Disasters that befoul the air and soil and poison the water are generally turned to political account: someone already unpopular is going to be blamed for it... The questions start with how people explain misfortune.... Communities tend to be organized on one or another dominant form of explanation. (p.5)

Douglas proposes three types of blame explanation:

- 1) moralistic: in which the community is exhorted to obey the laws or else suffer the same fate as the blamed person. Communities which accept this as the dominant form of explanation are organised very differently from those that do not blame the victim.
- 2) individualistic: looking after one's own interests, individual competition and calls for compensation
- 3) blaming an outside enemy

These three types of blaming influence the system of justice. Or rather, the influence goes both ways, the blaming and the system of justice together are symptoms of the way the society is organized... the stronger the solidarity of a community, the more readily will natural disasters be coded as signs of reprehensible behaviour. Every death and *most illnesses will give scope for defining blameworthiness*. (1992:6, my italics)

Of the different types of blaming system that we can find in tribal society, the one we are in now is almost ready to treat every death as chargeable to someone's account, every accident as caused by someone's criminal negligence, every sickness a threatened prosecution. Whose fault? is the first question. Then, what action? Which means, what damages? what compensation? what restitution? (1992:15-16)

If different types of culture, based upon kinds of organisational structures, generate different patterns of blame organisation, in what ways can we interpret the organisation and construction of stories about the 'genesis' of illness as a reflection of the cultural

processes of the constitution of blame in the teller's life? I should point out here that I am not arguing that Douglas' framework is a better one than any other, or that I agree with it entirely. For example, I think people can operate within more than one framework at a time. The point I am making is that Douglas' framework poses some alternative versions of the relationship between people's stories and their moral content and thereby some worthwhile questions to consider.

There is much in Williams' later discussion of his interview material in 'Chronic illness and the pursuit of virtue in everyday life' (1993) to suggest his own position in this respect. Here he analyses a case to demonstrate the moral discourse of one woman as being offered in the hope of displaying virtue (through cleanliness in spite of a declining physical ability to achieve this) within an increasingly individualistic political climate. In relation to this particular case but as an example of considering alternative frameworks, I suggest that avoiding blame and pursuing virtue are subtly but importantly distinct concepts. One could argue that these categories are more fluid and interconnected, so that one could say the pursuit of virtue is sometimes a way of avoiding blame. I think, though, that there is a distinction: avoiding blame seems to me much more an action within Douglas' first category of a moralistic blaming framework, in which she argues the blamed person is deemed to have sinned, and 'purification rituals are called for' (p.5)<sup>2</sup>. Displays of virtue as cited in Williams' account would seem to fit more into an appeal to, perhaps even signify a 'buying into', a more individualistic framework, but within Douglas' individualistic framework of blame people are characterised as looking out for their own interests, and not caring so much about moralistic evaluations of others as they are for their own compensation in a system of competition. It seems to me from the case story he presents in the more recent article that his respondent may be anxious to avoid blame, and therefore more concerned with others' view of her as breaking purity taboos than seeing herself as buying into an individualistic framework of competition (although she could be seen by others in this way even if she did not see herself in this way). As I pointed out earlier, people could operate in more than one framework at a time, e.g. she could be conforming to a desired image of the independent person who

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<sup>2</sup> I am grateful to Clare Williams (no relation to GW!) for pointing out the important distinction between avoiding being blamed for sin and recognising or accepting that one has sinned.

looks out for herself and is not a burden on anyone (in keeping with an individualistic framework) at the same time as carrying what might be thought of as ‘baggage’ from the past, perhaps an upbringing which stressed cleanliness within a moralistic framework. One would have to look into more detail about what it was about cleanliness that was good: was it good because dirtiness was associated with poverty, and therefore, being a burden; or was it that dirt was associated with illness; or could her narrative claim to cleanliness have been to avoid the negative judgement of the interviewer, and so on?

I draw attention to these distinctions not to refute Williams’ interpretations, but in considering that there may be alternative ones, to suggest the possibility that the concept of narrative reconstruction is inherently situated within a more particular moral framework than it may appear to be. That is, I think the presentation of narrative reconstruction as ‘a framework for teleological explanation’ (1984b:179) conflates interpretation of phenomena in terms of their possible causes or origins, and interpretation of phenomena in teleological terms. There is an important link between the two of *meaning*, but it is a particular kind of meaning, an implication (which I do not dispute may well have been the case for his respondents) that people are impelled to make a meaningful connection between events in terms of an *ultimate* purpose or moral judgement, a position which I’m sure many people would disagree with when talking about their own experience. It may therefore reflect some of his respondents’ experience, but I would argue it is not a template we can impose methodologically.

### *The temporality of narratives*

To turn my emphasis more to the temporal element, Douglas also points out that perceptions of risk of blame depend on time-span, and that

Our understanding of the time-span depends to some extent on features of the social structure. [For example] Economists are aware that the organization of the firm affects perception of the long term. Individuals have a much shorter term to their expectations than firms. (1992:18)

Further to the moral construction, then, is the temporal organisation of stories according to moral frameworks. Williams claims that the production of a cohesive story is an ordering of the elements of body, self and society *temporally* in a meaningful way. This

can be reviewed in the light of Ezzy's (2000) recent work on the teleological nature of human understanding of the temporal aspects of illness narratives, building on Davies' (1997) three forms of temporal orientation: living in the future, living in the empty present, and living with a philosophy of the present; and Frank's (1995) identification of three types of narrative: restitution narratives, chaos narratives, and quest narratives. The difference between the two analyses, argues Ezzy, is in their temporal orientation. Ezzy argues that:

In one sense the chaos narrative and the restitution narrative, or living in the future and living in the empty present, all share the same temporal orientation and moral framework. They all share a Kantian understanding of morality in which there is assumed to be one right way to live a life, that follows a clear linear narrative of control and mastery of the future. The Aristotelian ethics of Greek tragedy contrasts sharply with these assumptions. The 'quest' narrative and 'living with a philosophy of the present' can be reread within this Aristotelian framework that emphasises the polyphonic nature of these narratives and uncertain and finite nature of the human condition. (Ezzy, 2000: 607)

I think this is another useful set of ideas with which we can re-examine Williams work, because the temporal nature of the narratives in Williams' work were oriented predominantly to the past and present, focusing as he was on the 'genesis' of the illness. Ezzy refers to more recent work that has emphasised the importance of imagined, hoped for, or lost futures in the construction of the present, and Robinson (1998) has argued that narratives sometimes contain 'remembered futures', 'imagined pasts', and 'grieving for lost futures'. These ways of thinking have led me to try to attend to the temporal aspects of people's accounts with an expanded awareness to the ways I had previously thought of narrative analysis.

Williams comments on the three narrative reconstructions presented in the paper that:

These accounts all speak of illness experience at one moment in time. Their pasts were the pasts of those presents in which they were interviewed, and I have no evidence for or against the proposition that their image of the past would have been substantially different in other presents. (1984b)

I think an interesting question we might ask now is how they were shaped in his *presence*, and, as an important development of the tradition of narrative analysis which

he helped to form, we can recognise more fully, for example, the possible futures that may be part of people's accounts of both the present and the past told in the present.

In the context of the research for this thesis on constructions of demand for GP services, parents' accounts had different purposes, only one of which was to help me understand their part of the story of how their use of the out of hours GP service for their children could be constituted as legitimate. This involved their interactions with many other people, and focused on their role as carers responsible for their children's health and well-being. In these accounts, as will be seen later, temporal and moral themes from past experiences had implications for the future. Remembered futures could influence interpretations of the past, and the purpose of constructions of the present for their effect on both the past and present were also entwined with and within a variety of moral agendas.

### *The 'linear self'*

I turn now to the assumed marriage of two concepts which I would argue may be quite separate or not present at all in people's accounts of their lives. These are first the role of agency within a *linear* temporal conception of life, that is the perception of a sequence or timing of events in one's life in terms of being individually influenced or controlled (even if only in theory, leaving open the possibility of blame for failure), and secondly the conceptualisation of the *status of one's self* in similar terms. I think here that the position of Williams' work is far from what could be termed a kind of self-help, changing one's life and self at will philosophy (Williams 1989), because he has rooted people's narratives so firmly within their social context, yet it can still be asked how much one should assume people's *joint* conceptualisation of these two ideas. In previous research following up the long term effects of living in care, I interviewed women who had lived in children's homes, who were now in their mid-thirties. It seemed to myself and my colleagues on the study that many of these women had great difficulty in thinking in these terms, which is not at all to say that they displayed fatalistic tendencies. The interviews were 'semi-structured', but some people had the greatest difficulty in configuring their memories in anything like a linear fashion, and the experience of several of the interviewees was that we were trying to force their recollections into a framework

which was quite artificial to them. It was also clear that many of the participants had ideas about themselves at the time of the interview or at earlier times which seemed unconnected to the concept of shaping who they were or had become in any significant way. For many of respondents I interviewed, their self concept seemed to have been particularly influenced by their relationships with men, especially when they were younger. These aspects of their accounts were analysed by some members of the research team in terms of the concept of 'planning' (Quinton and Rutter 1988) and the interpretation was that those who were unable to think strategically in terms of a particular view of desirable life goals were unable to plan for their future and often suffered the consequences of lack of education and early pregnancies. Yet women's own accounts of their lives stressed such values as whether or not the men in their lives were 'good providers'. Many of them were happy that they had had children, but as to how much control they had over which men they might have children with, or how many, there hung a large and open question. This could be interpreted in terms of these women seeing their route through life as more by chance than design, or in terms of valuing having children over the timing of them or the choice of the children's father. Whichever might have been the case, they certainly had great difficulty in, but also didn't seem to express a great need to engage in a construction of their lives teleologically.

In my interviews with parents in my current work, it seemed to me that their careers as parents were also often not tied into a linear temporality or individualistically conceptualised sense of self. Their comments described more usually a hopping about between episodes grouped together by similarities of experience, for example kinds of illness episodes that seemed comparable across different children, or at different times in one child's life, or their own life. Their sense of themselves as parents also seemed to be orientated within a concept of responding within a moral nexus of relationships with people and with orientations to past and future selves, for example talking about how adjusting to the demands of parenthood could be a 'shock', or not being able to imagine being without their children if anything happened to them. Although in this sense I recognise the idea of 'grieving for lost futures' (Robinson 1998), it seems possible that people can have pictures of themselves as they imagine they could be in the future without having a self concept of directing the course of events to create that future in the

way that concepts such as ‘planning’ seem to imply, or necessarily to have a sense of order about why things had turned out as they had.

These elements of my argument have led me to question the idea that people are compelled to create narratives which unify concepts of self with a linear temporality, and to wonder if they might stem from the medical framework from which much of the work in the narrative analysis tradition in sociology has been associated, understandably since the focus of this earlier work was on chronic illness. Indeed, one might argue that it is stretching the points made in Williams’ work too far to be applying it in such a far reaching way as I am trying to do. Perhaps we should also read more into Williams’ phrase that people are attempting ‘to reaffirm the *impression* that life has a course and the self has a purpose’, that is that although they may try, they may not always be successful in imposing order out of chaos. I stress again, in an archaeological sense, that at the time, opening up the possibilities for relationships between meanings and causes of illness in challenge to the domination of positivist models was a profoundly important contribution and a radical breaking out of restrictions, so much so that perhaps my arguments appear to take for granted the groundwork that makes such a dialogue possible. Nevertheless, in the hope that I am not too far off the mark, I will now discuss some alternative ways of developing the concept of narratives that I have used in this thesis.

c) Fragile and polyphonic narratives

In his work on the impact of arthritis, which was also conducted in Manchester in the late 1970s, Bury (1988) stressed the *fragility* of the meanings of people’s relationships with others; and the ways in which arthritis put the possible meanings of these relationships and the consequent effects on their future selves at risk, so that re-establishment, perhaps the renegotiation of the meanings of relationships becomes perpetual. Added to this, as Robinson (1990:1175) has argued, the trajectories of personal, social and biomedical narratives may be substantially different, and the reference points may be at variance. One could go beyond this and say that narratives, as constructed stories, are always to some extent an attempt to create out of one’s experience a story in familiar and acceptable cultural forms, such that they are in a sense

always a kind of 'fiction'. This is not to say they are not 'true', because sometimes it is only through fiction that certain kinds of truth can be expressed, but this is because one is, in the telling, displaying something about how one's experiences have come to be culturally formed and with particular audiences in mind, rather than that there is only one true sequence of events involving one self. Thus the idea of telling a story which accounts for how much or how little one has been able to achieve culturally acceptable goals is itself an artefact of a particular cultural context in which particular goals are seen as desirable.

The construction of *a* story about illness is bound to be a problematic endeavour, either for the person whose life is directly involved, or the researcher acting as co-constructor. It may be helpful at this point to consider Ezzy's alternative conceptualisation of narratives, and in particular the idea of 'polyphonic' narratives, developed in the context of his research with people living with AIDS and HIV:

The term 'polyphonic' literally means 'many voiced'. Polyphonic narratives are characterised by overlaid, interwoven and often contradictory stories and values. They are 'many voiced' in the sense that they explicitly contain a variety of different and often contradictory goals, values temporal assumptions and attitudes. While all narratives contain contradictory elements, polyphonic narratives embrace many of the contradictions and tensions in their accounts rather than suppressing them....

In polyphonic tragic narratives the uncertainty of prognosis is embraced as allowing a focus on quality of life in the present... is integrated into a more general uncertainty about the future, where investments are still made in the future, but goals are more abstract and gratification more oriented toward the present.

The authors of polyphonic tragic narratives emphasise that the future cannot be controlled completely. An individual's actions do have consequences for the future, but life is also unpredictable, shaped by events beyond human control. Acceptance that the future cannot be controlled does not lead to despair, or a sense of powerlessness. The future is not completely uncontrollable, but simply less amenable to control...

The polyphonic nature of these narratives was also underlined by the recognition of the way other people's actions shaped the respondent's experience. Concomitant with an acceptance that one's own life may be influenced by forces beyond one's own life is a recognition that other people's lives may be affected by one's own actions...

Polyphonic illness narratives provide a different form of temporal unity that explicitly incorporates fragmentation, discontinuity and contradiction... In linear narratives, ontological security is sustained through a unified consistent narrative that develops progressively from the present into an ever improving future. In contrast, polyphonic narratives provide ontological security through a form of transcendent hope that emphasises wholeness in the present and relation to a person's community... (Ezzy 2000:613-616)

In Ezzy's research, he claims that 'polyphonic illness narratives provide a more robust cognitive framework that allows a person greater flexibility to adapt to an uncertain future' (p. 616) which ultimately may contribute to a more positive and liberated feeling about their lives than is likely with the more precarious nature of linear narratives.

In this narrative framework, we can see the elements of recent work as cited in Bell's (1999) review, notably the recognition of multiple voices that may reflect contradictory goals, values and temporal assumptions; the possibility of forces outside of an individual's control shaping their life course; but an emphasis on the interactive and constitutive nature of experience. Ezzy, like Williams, adheres to the idea of some kind of temporal orchestration, to continue Ezzy's use of the analogous term polyphonic. Further, he argues for the possibility of a wholeness espousing not only 'fragmentation, discontinuity and contradiction' but also in 'relation to a person's community'. This seems to me to stretch the idea of transcendent hope to an unrealistic extent. It begs the question, to what extent can disharmony achieve polyphony rather than cacophony<sup>3</sup>?

d) Chronotopic narratives

The notions of orchestration and polyphony were used by Bakhtin (1981) in a different context - literary scholarship on narrative - but they are worth considering here because I think his use of temporality solves some of the problems as I see them in Ezzy's use of the term polyphonic, as well as overcoming some of the limitations I have discussed in relation to other work on narratives. They need to be understood in relation to his use of the concept of 'chronotopes' and the significance of chronotopes in understanding their meaning for literary narratives. For Bakhtin, the chronotope expresses:

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<sup>3</sup> I am grateful to Ian Robinson for alerting me to this point.

the intrinsic connectedness of temporal and spatial relationships that are artistically expressed in literature... the inseparability of space and time... In the literary artistic chronotope, spatial and temporal indicators are fused into one carefully thought-out, concrete whole. Time, as it were, thickens, takes on flesh, becomes artistically visible; likewise, space becomes charged and responsive to the movements of time, plot and history. This intersection of axes and fusion of indicators characterizes the artistic chronotope. (1981:84)

Chronotopes define genres of literature and 'to a significant degree the image of man in literature as well' (p.85). They also define 'a literary work's artistic unity in relationship to an actual reality' (p.243), and are always 'colored by emotions and values' (p.243). Basic types of chronotope in ancient times included the 'adventure novel of ordeal' (p.86), the 'adventure novel of everyday life' (p.111), and the 'biographical or autobiographical novel' (p.130). Within these basic types Bakhtin refers to minor chronotopes like 'the encounter' or 'the road', in which space and time are fused, giving rise to rich metaphors such as the imagery of the road as 'the course of a life' (p.244). We might ask, as does Bakhtin:

What is the significance of all these chronotopes? What is most obvious is their meaning for *narrative*. They are the organizing centres for the fundamental narrative events of the novel. The chronotope is the place where the knots of narrative are tied and untied. It can be said without qualification that to them belongs the meaning that shapes narrative.

We cannot help but be strongly impressed by the *representational* importance of the chronotope. Time becomes, in effect, palpable and visible; the chronotope makes narrative events concrete, makes them take on flesh, causes blood to flow in their veins. An event can be communicated, it becomes information, one can give precise data on the place and time of its occurrence. But the event does not become a figure. It is precisely the chronotope that provides the ground essential for the showing-forth, the representability of events. (p. 250, italics in the text)

Two more important points must be made here: first minor chronotopes can interact and contradict each other. Secondly, we as readers or listeners enter into a dialogical relationship with these interactions, a constant interaction between meanings, and our worlds too are chronotopic (p.252), thus the concept of the 'polyphonic novel' as 'unfinalized and infinite dialogue' (1986:152). These ideas stress the uniqueness of meaning according to time and space, and therefore the primacy of context over text<sup>4</sup>,

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<sup>4</sup> see p. 428, in the glossary provided by Holquist, the editor of the 1981 translation

but in a continuing dialogical sense: the context is constitutive of and by the narrative in a never ending process.

There is neither a first nor a last word and there are no limits to the dialogic context (it extends into the boundless past and the boundless future). Even *past* meanings, that is, those born in the dialogue of past centuries, can never be stable (finalized, ended once and for all) - they will always change (be renewed) in the process of subsequent, future development of the dialogue. At any moment in the development of the dialogue there are immense, boundless masses of forgotten contextual meanings, but at certain moments of the dialogue's subsequent development along the way they are recalled and invigorated in renewed form (in a new context). Nothing is absolutely dead: every meaning will have its homecoming festival. (1986:170, italics in the text)

I hope this excursion into Bakhtin's ideas explains how I envisage the analysis of narrative in ways that avoid the imposition of a temporally unified telos where there may not be one, in contrast to what I have argued is an orientation to linear narratives inherent in the concepts of biographical disruption and narrative reconstruction, so that in a sense I am harking back to and trying to expand on Bury's point to say that meanings are perpetually at risk. Williams suggested that:

The trouble is that sometimes the 'orderly sequence of facts' gets broken up. It cannot be sustained against the chaos and, for a time at least, the life-course is lost... From such a situation narrative may have to be given some radical surgery and reconstructed so as to account for present disruptions. (1984b:178)

In re-examining Williams' formulation of narrative reconstruction I have suggested that particular moral and temporal orientations cannot but have contributed to the narratives produced with his respondents. Although he points out in relation to studies which contain typically unexamined standards of concepts such as 'adjustment' to chronic illness, that such approaches 'tend towards moral judgement in scientific guise' (1984a:14), perhaps we are all, practitioners as well as researchers, open to the charge of insufficient reflexivity. Williams' statement could stand as a leitmotif for the whole of this thesis, i.e. the construction of appropriateness of demand tends towards moral judgement but is presented, and to a large extent perceived by those who undertake it, in the guise of organisational and medical imperatives. At the same time, by the nature of the enterprise, the kind of work I am engaged in presents me with the opportunity to produce similar results. It seems to me therefore that an awareness of alternative moral

and temporal orientations is equally important not only in reconceptualising issues of medical practice, but also in carrying out research in such a way that co-production of narratives with participants in research, and the subsequent analysis of interview talk, might produce a more robust framework from which to create not 'radical surgery' but a more dialogic - I hesitate to say more reflexive - kind of understanding.

### **3.3 Conclusion: Research as a dialogic process**

In this chapter I have set out the development of methodology used in my research. In discussing some of the debates about ethnography I have tried to steer my own course between sociological and anthropological approaches, addressing some of the problems but also highlighting insights from experienced ethnographers that I have found particularly helpful. This discussion has emphasised an openness to unexpected findings, suspension of my own 'conceptual schemas', and reflexive attention to the liminal space between myself as a researcher and those who participated with me.

I have also considered in a similar way approaches to narrative or discourse analysis, indicating the importance of attending to moral, temporal and relational contexts when interpreting ethnographic and narrative data. In challenging the notion of linear narratives, I have argued for an opening up of the possibilities suggested by adopting a dialogic approach to the analysis of narrative and ethnographic material.

The following chapter continues the narrative of this research. Because I have adopted a situated approach, positioning myself as part of a dialogic process, it is particularly important to ground my account contextually, and therefore it will act as a bridge to ground the empirical work that follows. If this chapter can be described chronotopically as a methodological quest narrative, in the next chapter I will go back to the beginning again to tell another, co-existing story, 'an adventure of everyday life' in which encounters on the road 'take on flesh'.

## Chapter Four

### RESEARCH PROCESSES IN THE FIELD

In this chapter I continue my account of how I developed an innovative methodology to apply to this topic 'in the field'. Following a review of the medical and health services literature, I formulated this as one of the aims of the research and it was an ongoing process. As Silverman (1987) argues:

A much-repeated complaint about research reports is that they are too polished. They read as if researching were just a matter of going from A to B, a direct path without diversions or doubling back from cul-de-sacs. As we all know, this is a gross misrepresentation of how most research is done, particularly qualitative sociological research [...] It conceals the cognitive, temporal and political processes through which a relationship was constructed with the parties in the setting, and how sense was read into (what came to count as) data. (1987:1)

Part of that construction, in the case of my research, was that I was funded by NHS R&D, which could be taken to carry implicit assumptions that a more typical health service research approach would be taken. However, in chapter two I argued that different methods would be needed to be able to reconceptualise the long-standing issues that have so far been regarded as the 'problem' of 'inappropriate' out of hours demand for GP services. Additionally, working in an academic environment which has strengths in medical sociology and medical anthropology has meant I have been able to work across some boundaries between sociology and anthropology, and in particular to develop my own understanding of the use of ethnographic methods, discussed in chapter three. Thus, having made the case in both senses for different ways of dealing with my topic, I will in the first part of this chapter set out my thinking and the processes behind how the research strategy developed as part of the fieldwork. In the second half I will go on to set the scene for the following three empirical chapters by giving a description of the study settings, an introduction to the research participants, and details of the kinds of data generated by the research.

#### **4.1 Pilot phase and initial study plan**

The original design of this project was based on ideas derived from the existing literature but before a full critical review and pilot exercise were undertaken, and conformed to typically accepted practices in health services research. It was hypothesised that differences in daytime practice arrangements and structural factors, and in perspectives between GPs and parents, might help to explain variations in what was referred to as 'inappropriate' demand for out of hours GP services. My initial plans included construction of a sampling frame of GPs from 200 training practices working with the Department of Primary Care and Population Sciences, Royal Free Hospital School of Medicine, representing a broad range of demographic variation, fundholding status and out of hours arrangements. Methods included use of questionnaires, interviews, consensus groups, vignettes and health belief scenarios to determine how factors such as parents' and children's perceptions of urgency, needs for reassurance, diagnosis, advice and treatment, demographic characteristics and decision-making processes differentiated between high and low user groups.

In the pilot phase, interviews lasting between one and two hours each were carried out with five general practitioners in March and April 1997. One of the GPs runs a single-handed, rurally located practice but belongs to a cooperative for out of hours services; one works full-time in an urban group practice; and the other three combine urban group-practice work and/or research and/or teaching. The interviews included piloting of the draft questionnaire and then a broad discussion of the issues around out of hours calls for children under five. We also considered the research strategy and the GPs made suggestions about the methods and settings I could employ to illuminate the topic of how 'appropriateness' is constructed by GPs and parents.

In addition to these interviews I had telephone conversations throughout this period with staff in three North London health authorities in an attempt to get demographic and practice details about GPs to use in constructing a sampling frame, and information on ethics committees and permission for access to GPs and patients; meetings with researchers who had worked, or were working on studies closely related to mine; other

researchers who were helpful in discussing the research methods; and a GP who has had experience of the structural organisation of GPs at national level.

Many of the comments made during these interviews and meetings confirmed points made in the literature in chapter one, so I will focus here mainly on points I had not encountered previously, and those pertaining to revision of the research strategy.

While discussing the questionnaire items about GPs' list size and number of children on their list, I became aware that group practice-based GPs are often unclear without consulting the records, or would be unwilling to take the time to look up, exactly how many patients they have on their individual list, but can more easily give the practice list size. Numbers of children on the list are also not easily recalled. A possible reason for focusing on the practice list size as opposed to an individual GP's list size was offered to me by a member of staff at one of the health authorities I contacted. This was that if the individual GP's list size is known, their per capita salary can be worked out, which means they may not be willing for that information to be given out to a researcher unless it is anonymised. However, this view is probably wrong in most cases, because it is exceptional for a partner's income to be directly related to their personal list size. Shares of the total income are specified in the partnership agreement. Nevertheless, another factor was that the Health Authorities were, at the time of the piloting work, individually responsible for such data rather than the Region, so that it was collected slightly differently and by different sorts of staff in each authority. This made it difficult to obtain the same data to compare across the different Health Authorities to be included in my sample.

In the initial strategy, I hypothesised that the mode of out of hours cover offered by GPs could influence demand or how it was constructed. However, in discussing the questionnaire items about modes of out of hours cover with GPs, it became clear that there was no clearly demarcated set of modes. GPs reported differing definitions of out of hours, sometimes including daytime visits outside of surgery opening times, or excluding Saturday morning surgeries. Arrangements for working during these times could also be complicated. For example, there could be a practice rota for an afternoon when the surgery is closed, deputies employed only up to midnight, or only after

midnight, GPs on call for part of the time, or the practice could belong to a cooperative open until midnight or all night. Some cooperatives used a deputising service after a certain hour, some asked their member GPs to work sessions to cover the whole out of hours period, and some covered the whole period at the base but use deputies for home visits. It also became clear in my further examination of the literature and advice from the Health Authorities, as well as my other sources, that a high proportion of GPs were joining, or likely to join cooperatives. This was partly because some pioneering cooperatives seemed to offer a way out of the out of hours problems for GPs, and because of government funding to encourage GPs to set them up. All these factors suggested to me that my original sampling frame was likely to prove problematic both in practical terms and in the usefulness of practice arrangements as an explanatory variable.

Moreover, the effects of different ‘messages’ to patients (‘training’ as some GPs have put it) may not persist when the structure changes, a point made by a cooperative member GP who claimed that the initial starting point of the GPs who joined the cooperative, i.e. their previous organisational mode of out of hours cover, did not differentiate patient demand in the cooperative setting. Some ‘old-fashioned’, single-handed GPs’ patients used the cooperative less than they had used their GP, whereas some patients from ‘good’, modern practices used the cooperative more than expected. Similarly, a group practice GP commented that in her two years since joining an old-fashioned, continuity of care approach group practice, she had been part of a drive to change the practice ‘culture’, which included the other GPs, reception staff, and patients, resulting in acceptance that a GP would no longer automatically visit a patient on demand.

Another issue raised was that there was no common understanding of what the terms ‘inappropriate’ or ‘appropriate’ mean. Indeed, it is a topic that has been debated for decades, often in the context of accident and emergency services, and in discussing the apparent see-saw relationship between A&E departments and GPs in relation to out of hours care demand, with no consensus as a result. ‘Appropriateness’ has been used in the positive sense of making the best use of resources, so that it becomes an ideal to be worked towards (O’Neill, 1994), including reduction of ‘inappropriate’ demand. ‘Inappropriateness’ has been used to describe the provision of service rather than the

demand, i.e. that some GPs, typically described as older, old-fashioned, single-handed, and having a commitment to continuity of care, induce in their patients a reliance on them, freedom to call out of hours and expectation of home visits, which is seen as 'inappropriate' by younger, efficiency-oriented GPs. So although I was initially interested in how the concept of 'inappropriateness' is used differently by GPs and 'users' or parents, it became clear that it is a term without a common meaning amongst health care professionals.

Following on from this, I recognised that identification of high and low levels of inappropriate demand would also pose problems, since if there is no consensus on 'inappropriateness', there is no agreed basis for these categories and therefore these terms have relatively subjective meanings. This suggests that finding out what GPs regard as 'inappropriate' as well as high and low levels of demand would have to be seen as another research objective, rather than using such terms as a starting point.

Talking to GPs also helped clarify my research focus in that I think one element of out of hours work now being considered for radical change in terms of legitimate demand is home visiting, rather than 'inappropriate' demand attracting equal sanctions across the range of responses requested. The GPs I spoke to didn't object to the idea that parents should have access to advice in some form (preferably telephone) 24 hours a day, but this was probably contingent on a situation where this no longer means personally making home visits or being on call nearly as often as in the past: for one cooperative it is only one session every two months<sup>1</sup>. It seemed to me therefore that I could try to address home visiting as a distinct issue, from the point of view of both GPs and parents.

In view of my pilot stage findings, I considered that a sampling strategy based on the organisational mode of out of hours cover (i.e. whether single-handed, group practice rota, deputies etc.) might turn out to be redundant. The propensity of parents to request out of hours help might be associated less with the organisational mode of cover, and more with the prevailing 'message' about the legitimacy of calls, whatever the

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<sup>1</sup> The major exception to this is rural GPs in very isolated practices such as in Scotland (see Gillies and Ross, 1997) where it is difficult to see how cooperatives could operate, and it is hard to recruit locums and deputies. However, that is not an issue I can feasibly address in this project.

organisational mode of cover was in the practice at any particular time. In other words, what was differentiating them in the past may have been the message coming from the surgery about what was a legitimate call, whatever their mode of out of hours cover. Another possibility was that it might be that parents' behaviour changes in line with what is 'allowed', but that their own construction of what is appropriate does not, so that underlying conflicts of interest remain unchanged.

A more fundamental issue was that I began to see that the construction of the 'problem' of 'inappropriate' demand as located in parents' behaviour was reproduced in the managerial approach of reducing demand or somehow changing its nature, rather than finding out by what processes GPs offer a service but then deem the people it is for to be using it inappropriately. The idea of looking at 'high' and 'low' consulting families would therefore imply an uncritical acceptance that 'high' consulting behaviour was problematic.

These examples illustrate the benefits of the pilot exercise because it can be seen that my assumptions about how practices could be classified for the questionnaire, based on the existing literature, would have led me to collect data on a more narrow basis in comparison to the approach I subsequently adopted. I concluded that my original sampling strategy would have been difficult to achieve, with little to gain from the effort. More importantly, the research would have to take a more exploratory approach if it was to avoid simply reproducing existing constructions which located the problem in parents' behaviour and attitudes.

#### **4.2 Development of the research strategy**

In view of the above findings, I considered that contested constructions of the 'appropriateness' of requests for medical help out of hours for children under five should remain the focus of this project. However, because of the myriad ways in which GPs have offered their services, in terms of the organisational mode of out of hours cover (i.e. whether single-handed, group practice rota, cooperatives and/or deputies etc.); the rapidly changing context of the burgeoning of cooperatives and primary care centres; and my developing understanding of some of the ways in which the variation in how out

of hours services are offered may reflect constructions of appropriateness, it seemed unlikely that an initial sampling strategy based on organisational modes of cover would be feasible or meaningful.

Taking a more fundamentally questioning stance to the issue of appropriateness meant that I should focus less on structural arrangements and more on the processes of influence that particular constructions demonstrate, e.g. the process by which a practice's previous 'allowance' of what were appropriate circumstances in which to seek advice may have influenced parents' construction of acceptable consulting behaviour. The exploratory interviews with GPs and parents should be much more broadly based (see appendix 1 for list of themes).

The piloting process also yielded an offer to site my research at a large and growing cooperative within the London region. Nightdoc is part of a larger GP cooperative group that has been open since September 1996 and was established with 120 GPs as members. It is located in a mixed density urban area with a socially mixed, multiethnic population. The larger GP cooperative has primary care centres at four locations and now has over 450 members. At the time of my observations, Nightdoc had its own receptionists and triage nurses on site. Triage nurses operated the computerised decision support protocol (TAS) developed by Lambeth, Southwark & Lewisham Out of Hours Project. Nightdoc used a deputising service for all visiting, and all calls after midnight. GPs belonging to Nightdoc worked in a variety of ways during the daytime: single-handed, group practice-based, part-time and full-time.

The results of my pilot work and proposal of taking up the Nightdoc offer were discussed at the Brunel medical/social anthropology postgraduate students' seminar and those colleagues, together with my supervisors, helped illuminate for me possibilities for refocusing the conceptual basis of the study, and using a more ethnographic and deconstructionist epistemological approach. The research strategy was revised to take advantage of the opportunity to study at close hand the rapidly changing out of hours scene in general practice. My reading of the literature and discussions with GPs indicated that cooperatives were fast becoming 'state of the art' and would soon be the mode of

out of hours cover for the great majority of GPs, at least in urban areas of England like the area in which my study was based.

A more ethnographic approach was adopted with Nightdoc as the main case study, starting with an initial period of observation of the triage process and general orientation in their primary care centre. After obtaining permission from patients and GPs, I planned to observe surgery consultations in the primary care centre, and to build up mini-case studies based on the process of advice-seeking for individual children, consisting in each case of the tape recorded nurse triage telephone call, possibly an interview with the triage nurse, interview with the Nightdoc GP (to be fitted in between patients, after the GPs finished their surgery based session, or at another time), or in the case of visits, with deputies. Finally, follow-up interviews with parents, their children if possible, and other people who influenced the decision to make the call would be undertaken at their home.

The observations were planned to take place at different times: weekdays, weekends, early evenings, late at night, and during two time periods - summer and winter. A further possibility was to do some observations with the deputising service using the same case study design, i.e. include the initial telephone call and follow up at a later time with parents at home.

Both GPs and patients would be asked about other experiences they had had within the preceding year, i.e. comparing the previous out of hours arrangements to the cooperative system, and patients would be asked about any other type of practice they may have used in that time for an additional source of comparison.

An advantage of this strategy was the fact that as a 'lone researcher', I would be able to compare my findings alongside other research taking place on Nightdoc as well as the data being collected as part of their ongoing evaluation programme. Permission to base the study at Nightdoc was granted in consultation with two of Nightdoc's GPs who comprised the Nightdoc Research Board, and formal Ethics Committee permission was obtained from the appropriate local Research Ethics Committee.

A further development during this stage of the research was that I undertook to supervise the work of a student, Helen Harland, reading anthropology and psychology in the Human Sciences department where I was also based. The work placement consisted of two elements negotiated and agreed between myself, Helen and her supervisor. First, she carried out a review on the psychology literature on stress and burnout, which we thought might be a useful adjunct to the theories I was mainly interested in, and yet would provide her with a separate sphere of work. Secondly, she would gain some fieldwork expertise by accompanying me on observations, and she did this on four occasions. The results of her work are written up in her dissertation (Harland 1998), but some points which she addresses will be noted here because our discussions about them further informed the research.

The main concept I asked Helen to focus on was Maslach's (1982) theory of burnout, the second dimension of which is 'depersonalization', described as a coping mechanism in which clients are regarded as objects and experienced as requiring less emotional energy than when dealt with on a more subjective basis. The theory links up in some ways with work in the sociology of emotions referred to in chapter three. In particular, depersonalization relates to Hochschild's (1983) description of alienation in relation to the commodification of emotional labour, and to Smith and Kleinman's (1989) study of the professional socialisation within medical training which encourages the objectification of patients. Looking at the literature on stress and GPs using this model of burnout, Helen found that burnout was associated with large list size and number of partners; blurring of boundaries between home and work including time boundaries; and contrary to burnout theory, there was a trend indicating it was as, if not more, prevalent in younger doctors. These findings help to explain the lack of newly qualified GPs willing to become principals in general practice, choosing other options which allow for a more bounded work commitment.

In the rest of this chapter I will describe how the research plans described so far materialised, how the data was produced, and some other forms the research took in following the moving target of processes involved in health production in this context.

### **4.3 My role in the study:**

My role changed in the different circumstances involved in undertaking the research, and over time. Because I am not a general practitioner, any other kind of medical doctor, or nurse, I generally adopted a 'naive researcher' stance when talking with and observing people at Nightdoc. If participants took the lead and checked with me how much I was following their line of talk, I responded accordingly, but I thought it was interesting to see what kinds of things were important for them to find out about me and what I knew.

When I was with parents, I made it clear to them that I was not medically qualified, that I was a medical sociologist from Brunel University, and, if the conversation seemed to call for it, that I was a parent. Being a parent may have placed me nearer to their position than I might have been perceived if I was a medically or academically qualified non-parent. On some occasions I was asked about aspects of my life as a parent which I was happy to respond to, because it seemed to put us a little more in the situation of any two parents sharing common experiences and I did not wish to give the impression of being a researcher seeing participants as 'subjects'; and because otherwise people could imagine a number of things about me (and probably did in any case, for example that I was a medical student, which they sometimes asked) that might have influenced what they told me but would not have been revealed unless we had talked about the research relationship in those terms.

I told all participants I was a researcher paid by the health authority to study out of hours services for children under five and the new GP cooperative arrangements, that I was independent of the cooperative and its GPs, and that I was interested in both GPs' and parents' views. The resulting discussions may have been equally influenced by this information, and I felt obliged to explain my position clearly for the reasons above but also in the interests of informed consent (Alderson, 1995). While people would in any event have their own interpretations of our discussions, I felt the relationship between us was not of central focus as it was, for example, in Oakley's (1992) social support research. Nevertheless, I saw the communication (involving more than speech) between us as mutually constituted, and therefore the ways in which this process differed across the range of contacts I made were interesting points for analysis. The same could be said

for the research situations themselves, in that each occasion, observation or interview, was shaped by the particular events which occurred and people present.

For some of the observation sessions I was accompanied by a Brunel work placement student, Helen Harland. I was uncertain how this was going to affect participants and was slightly apprehensive about keeping control of the effects of our presence especially as we had not worked together on a field project before, and the success of the fieldwork was crucial to my ongoing study. I tackled this by having discussions with her prior to doing any sessions in which I made explicit my concerns, and in the event she provided another dimension to the observations which was very helpful.

Hastrup, drawing on Dwyer (1977) argues:

To a large extent it is fieldwork itself which generates the events, that are then portrayed as facts. Fieldwork is confrontation and dialogue between two parties involved in the joint creation of otherness and selfness (Hastrup 1992:12).

The extent to which I felt myself to be like the people I was with, or 'other' was very fluid. At the beginning of the research I was inclined to be rather sceptical of the political and economic arguments made by many GPs, and their claims about parents' behaviour. Later on I became more appreciative of both the pros and cons of general practice, and more sympathetic to GPs. Sometimes I felt an easy affinity with parents, GPs, nurses and receptionists, and at other times I felt there was a wide gap between our experiences, but I very rarely felt that my 'role' had dropped completely. This was simply because however frank I thought participants were with me, and however empathetic I felt about them, in each case our meetings were initiated by me and primarily served my purposes in my role as a researcher, even if the research or the discussions also served theirs in a number of different ways. I was particularly conscious of the interests of my key informants in findings which could be used to support their ideas for the development of primary care. This caused me some anxiety but was useful at the same time because it was part of their enthusiasm for the study.

The issue of confidentiality was addressed in the following ways. Nothing that was observed by myself or Helen Harland was ever described or recounted to anyone other

than my supervisors or in an academic context, with no identifying names or facts being given. The tapes and transcripts are kept securely and anyone who has transcribed tapes has been under strict instructions to keep the information confidential. Comments made by GPs about colleagues or patients were not repeated to other colleagues or patients, and no one will be identified by name or detail in publications or conference papers. In one case a mother told me in detail about the physical and sexual abuse of her children by a childminder, which I had not asked about, but she wanted to talk about. At the end of our interview we discussed and agreed on how this information was to be handled.

The question of feedback and dissemination of findings to participants is an ongoing one. Two parents said they would like to know the results of the study and I have kept a note of this with the consent forms. I am still in touch with some of the GPs and Nightdoc will receive copies of papers in due course.

#### **4.4 Negotiation of access**

Nightdoc Primary Care Centre was offered to me as a research site by the main entrepreneur in setting up the cooperative, who is also a GP trainer at the local hospital postgraduate medical centre. Subsequent negotiation was with the cooperative's academic research advisor who is a GP member of another branch of the cooperative and an academic at a nearby department of primary care.

My initial contact came about when I was working on the original proposal for this project. I had been given the name of a GP by a former health visitor who had worked in her practice. This GP suggested that her husband (also a GP) would be the best person to speak to because he was so involved in organisation and training in general practice, and would be enthusiastic about research. I therefore interviewed him at his surgery and found him to be very helpful and amenable.

I decided to make contact with this GP again as part of the initial fieldwork when I interviewed five GPs as part of the piloting process and tried out a questionnaire I had intended to use (but subsequently abandoned). During this interview he told me about his many ideas and plans for the GP cooperative Nightdoc, which had only been going

for about six months, including the intention of developing its research activities. He was keen on my involvement with this aspect of Nightdoc and came up with the idea of my using its first established site as a good place to meet a broad variety of GPs, sit in on consultations, listen to the tape-recorded triage telephone calls, and have access to other data already being collected for their own purposes and with other research concurrently being carried out. After some consideration of this change in strategy and consultation with my supervisor, I decided to take this offer up, and it was then negotiated formally through the Nightdoc Research Committee and the main Nightdoc Board. The necessary permissions were also obtained from the local research ethics committee, including permission for Helen to accompany me on observations.

#### **4.5 The cooperative**

In this section I will provide organisational information on the cooperative I studied to give a background to the structural context of my study.

The National Association of GP Cooperatives (NAGPC) defines a GP cooperative as ‘a non-profit making organisation entirely and equally owned by, and mostly medically staffed by, the GP principals in the area in which it operates’, its primary purpose being ‘to cover the out of hours commitments of its members’ (Reynolds 1995). Member cooperatives are all non-profit making, non-shareholding primary care organisations.

GP cooperatives have been set up to alleviate some of the problems GPs have had in providing 24 hours a day patient services, especially ‘out of hours’ (in this usage usually referring to the time between close of surgery in the early evening to start of morning surgery, and all weekend). The variety of forms of GP cooperative reflects their members’ focus on alleviating particular difficulties, according to their preferences and needs, and the location and demographic characteristics of their patients. For example, some cooperatives have been most concerned with cutting costs, so they cover all their own calls and visits, and do not employ deputising services; while others do not wish to make home visits, so provide services at a primary care centre (PCC), but employ a deputising service for home visits.

Since the revision in 1995 of the GP contract terms and conditions which allowed GPs to decide whether and where to respond to out of hours calls, the number of GP cooperatives has increased at an exponential rate. From only a handful in existence during the 1980s, mostly in the north of England (NAGPC 2000), the number has risen from 124 registered with the National Association of GP Cooperatives in 1996 (Jessop *et al* 1997) to 290 in 2000, representing two thirds of all GPs (NAGPC 2000). Put another way, in 1988 there were approximately 500 GPs in cooperatives, whereas by 1998 this number increased to 22,000 (Hallam and Reynolds 1999:63). The main reasons for this 'boom' included both the widespread dissatisfaction GPs reported with the conditions of their 24 hour responsibility for patient care, and with their financial remuneration (see chapter one), and the introduction in 1995 of an out of hours development fund (Hallam and Reynolds 1999:66).

Nightdoc is a GP cooperative formed in September 1996 to cover the out of hours calls for patients of approximately 150 GPs in a densely populated suburban area within a large English city. It is essentially a 'worker cooperative' (Birchall 1997), and its members are GPs. The branch of the cooperative I studied is part of a larger organisation run by a board comprised of members from each of four member branches. At the time of my study, managers of the other sites each carried additional special areas of responsibility (e.g. Marketing, Staff Training). Initially the cooperative opened a Primary Care Centre located within a local general hospital. By October 1997 it had four sites, and was negotiating for another site to be opened.

Nightdoc was set up in the form of a limited company which receives joining fees from GPs, and payments from member GPs for each patient contact. In 1997 this was on a scale rising upwards from telephone advice by nurse (£6.50), to PCC consultation with Nightdoc GP (£13.00), to home visit by deputy GP (£26.00 up to 10 pm, £47.25 after 10 pm). GPs were given a reduction from their Nightdoc bill of £22.00 per hour for each of the sessions they do (minimum once every two months). There was a one-off joining fee of £300, and they had to make a deposit of their out of hours development money (c. £1,400), some of which was returned to them throughout the year depending on how much of it was used by Nightdoc for capital expenditure.

Members of Nightdoc had to work only one out of hours shift every two months, didn't do any home visits, and didn't work after midnight. All home visits were made by a commercial deputising service, which also covered all calls after midnight until the GPs' next morning surgeries. In addition to these factors, Nightdoc offered a great reduction in the number of consultations GPs were directly responsible for. Around 54% of calls made to Nightdoc in 1997 were dealt with by other people: the greatest number by Nightdoc triage nurses giving advice (38%), and 16% being dealt with in some other way than the caller seeing a cooperative member GP, i.e. sent to A&E, told to ring 999, given a home visit by a deputy (Dale, Crouch and Lloyd 1998).

Nightdoc employed receptionists to take incoming calls, arrange for ambulances to take patients to A&E, and to liaise with other agencies on behalf of patients and GPs. The other key employees of Nightdoc were triage nurses, who carry out the initial telephone consultation with patients/parents to ascertain what was required. The options were a home visit, an appointment at the PCC, telephone advice from the nurse, or a referral to A&E. Triage nurses have legal responsibility for the advice they give to patients and are insured through their professional body, the Royal College of Nursing, against litigation. Nightdoc's structure put the financial costs to GPs as a high priority, thus nurses were asked to adhere to the drive to keep responses to the lowest possible cost option. Some triage nurses were more inclined to send out deputies for home visits, and some to get patients/parents to accept more telephone advice. They were assisted in this task by the TAS (telephone advice system) software which provides suggested questions, responses and related advice guidelines, and simultaneously documents the nurses clinical assessment and advice. The 'call report' was given to the GP if a patient attended the PCC for an appointment; and for all outcomes, was faxed through to the patient's own GP.

Nightdoc was the biggest and longest running of the larger cooperative's sites. It was envisaged that in the future, triage calls for the whole group would be made from a central site, so that the other branches would only need a doctor and receptionist to function, and indeed this has since come to fruition.

The form of this GP cooperative reflects their members' first main aim, which was to alleviate the stress of working unsocial hours as a top priority. The wish of the majority of its members to reduce dramatically their out of hours commitment and not to make home visits meant that the cooperative did not save their members as much money as some other types of GP cooperative who cover all their own calls and visits. Instead, they employed deputising services for all home visits and all call responses after midnight. They have used the advantage of joining together in such a large group of GPs to negotiate lower rates from the deputising service, so they save members some money in this way. However, one GP reported that as an overall comparison, joining the cooperative is a more expensive option than their previous arrangement of covering the out of hours service between three partners and employing a deputising service after midnight.<sup>2</sup>

A second aim was that they regarded the demand from patients for home visits in general as excessive and in many cases inappropriate. To address this, they adopted a policy of assessing carefully the best outcome for all contacts, and 'converting' - whenever possible and acceptable to patients - requests for home visits into the outcome of a consultation at the PCC or telephone advice. To achieve this they installed the TAS software and trained triage nurses in its use, and have actively promoted this policy, e.g. at nurse training days. In contrast to other GP cooperatives, who use GPs to answer calls and give telephone advice, Nightdoc is heavily reliant on the work of the triage nurses to handle approximately 50% of incoming calls. GPs on duty can also give telephone advice, and at the time of my study were expected to do some of this work if there was sufficient time between seeing patients.

The third aim of Nightdoc was to achieve a high standard in quality of care. This can be broken down into the factors continuity, clinical quality, and quality of care afforded by GPs being less fatigued and generally less stressed. To take the last of these first, I think all the GPs I interviewed were unanimous that the great reduction of out of hours work would achieve this aim, and this was the cooperative's main claim for success in rapidly

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<sup>2</sup> The cooperative eventually took on their own home visiting and dispensed with the services of the commercial deputy service.

attracting so many members. On the aim of continuity of care there was less consensus, which is unsurprising given the complexity of this concept. Some of them thought the most desirable level and form of continuity of care was for patients to be seen out of hours by a GP from their own practice, and joined the cooperative with reservations on this point. Others said that the cooperative provided an improvement in continuity of care for those GPs who previously made more extensive use of deputising services, because Nightdoc uses local GPs (at least for the PCC based consultations) who are more likely to be known amongst themselves; the system of feedback was more sophisticated, reliable and gave more detail, and the cooperative structure allowed GPs to follow up call reports very easily if required. This was linked to quality of clinical care, because in addition to knowing what treatment and advice patients were given, GPs on duty at Nightdoc could if necessary check with a patient's own GP if there was essential medical information needed before deciding on treatment or advice.

#### **4.6 Introduction to the settings and participants**

Hastrup (1992) refers to *place* and *space* as analogous to what Geertz (1973) called 'thick' and 'thin' descriptions. As introduced by Michel de Certeau (1988), *place* is 'the order of distribution and of relations between elements of whatever kind; it is an instantaneous configuration of positions' (Hastrup 1992:11), whereas *space* occurs as the effect produced by the operations that orient it, situate it, temporalize it, and make it function in a polyvalent unity of conflictual programs or contractual proximities' (de Certeau 1988:117). Therefore 'A space is constantly transformed by successive contexts and has nothing of the stability that characterises a place' (Hastrup 1992:11); 'Space is a practised place' (de Certeau 1988:117). Hastrup contends that visual anthropology, and films in particular, 'generally focus on the forms and places of life. Due to the apparent materiality of these features they have been perceived as accurate records of ethnographic reality' (Hastrup 1992:13). Rather than rank visual and textual representations of ethnography in terms of different degrees of accuracy, she argues that 'they display different *kinds* of accuracy, related to the different anchorages of their authority: in place or space' (Hastrup 1992:14). In the observation sessions, I found it helpful to attend to these two concepts of place and space, as a way of broadening out

my attention beyond the words spoken between people. This approach follows from my earlier discussion of an ethnographic approach that emphasises context as much as text.

The main setting for my study was a primary care centre (PCC) run by the GP cooperative Nightdoc. The branch where I based my study was the biggest and longest running of the Nightdoc sites. At the time I was there, it was located in a general hospital in a suite of rooms used during the daytime for an outpatient clinic. It had a room for the receptionists, a room for the triage nurses, two rooms for GP consultations, a mini-lab room with a sink and cupboards, a staff toilet, an office, a curtained-off area with a bed, and out of public view, a small kitchen.

The PCC was reached via the same entrance as the Accident & Emergency Department, but was on a different floor and people had to follow signs to Nightdoc to find it. The door to the suite of rooms was locked, partly because at night this part of the hospital was otherwise fairly deserted, and partly because there was a policy that people could only come to Nightdoc if they had telephoned first and gone through the triage process to determine what kind of attention they would receive. The receptionists' room was immediately next to this entrance door, so they could hear the buzzer and let people in. The waiting area was on the opposite side of the door and people could see into the receptionists' and nurses' rooms unless the doors were closed.

The receptionists' room was often overcrowded and busy. It already had the furniture in place for its use in the day time as a consulting room, and each evening extra equipment had to be brought out from a cupboard and installed in the room, including the telephones, two computers, printer/fax machine, paperwork and files. There were usually two receptionists there, sometimes a supervisor or branch manager, and the nurses and GPs had to come in and out as well. The phone rang almost continually, and the receptionists were usually either on the phone, speaking to patients, nurses or GPs, or sorting out the paperwork. For each call, they had to obtain the patient's name, date of birth, name of own GP, and general complaint, and the caller's telephone number. The caller was then routed through to the triage nurse, or sometimes to the GP on duty, or (as in most cases) the caller was told a triage nurse would call them back. Once the nurse had spoken to the caller, a call report was produced for each contact and handed

to the GP if the patient was coming in. The receptionists then had to fax all the call reports through to the patient's own GP, with the cooperative GP's handwritten notes added at the bottom if the patient was seen at the PCC. Privacy was hard to achieve because the room was too crowded and busy much of the time to have the door shut, and this meant that people in the waiting area could hear most of what the receptionists said on the phone. A similar problem occurred with the triage nurses, some of whom did not want to close their door but this was more often because they felt cut off in their room by themselves.

The waiting room had about seven chairs along the wall opposite the receptionists' and nurses' rooms. There was a toy box in the corner and table with some magazines on it in the middle of the area. At the end of the waiting area furthest from the entrance door was a single toilet for the staff and a sink immediately outside it which the staff could use to wash their hands in addition to the sink in the mini-lab room. In addition to the lack of privacy staff had in using the sink, use of the toilet itself was easily overheard.

Sometimes there were too many people waiting for them all to sit down. Patients usually had someone with them, and often there were three or four people accompanying them. On busy nights, and on the weekends, they were seen within about 15 minutes, so there were not too many people waiting there, but sometimes people drifted around in the corridor or went downstairs to make phone calls or go to the patients' toilets reached by the corridor outside. The overall impression I had at these times was that the premises were a little cramped and busy, but people could be seen fairly quickly and could also see that the doctor was busy.

The kitchen, located out of sight and earshot from patients and people accompanying them, afforded the staff with their only 'backstage' space. On one fairly quiet evening, one of the doctors had been talking to me in the consultation room with the tape recorder on when we decided to go into the kitchen to make ourselves a drink. It was remarkable how her demeanour was transformed with this subtle change in location. She became more informal, revealing personal details about colleagues in her practice, using swear words and a more colloquial turn of phrase. This was in marked contrast to her manner with patients, and even with me but in the other room and with the tape recorder on. In a sense the research also had a 'backstage' because I could go into the office

when no one else was there, the kitchen, or other areas of that part of the hospital, to be by myself and write notes, have a break or think about how to deal with a situation, or go with Helen to talk about how the observation was going and exchange comments and ideas.

On some occasions, especially between around 10 and 11 pm, there was a lull in activity and not many people were there. At these quieter times the staff were able to chat a bit more to each other and these conversations were very interesting. The place outside their rooms was then used as a meeting space for staff outside of their more confined and separated off working areas. When patients were in the waiting area, the space was not shared between staff and patients but functioned more as a boundary for the separate groups. It could be used in yet another way, to stage the presentation of educational messages, and this will be discussed in chapter seven. When no patients were in the waiting area, it became temporarily a different, more shared, neutral, staff space, with staff drifting out and having informal conversations. As soon as patients came into the waiting area again, staff were more careful about what was said outside of their rooms. On one of the quieter times I was talking to a triage nurse outside her room and the GP joined in the conversation, eventually offering her work at his surgery. Sometimes nurses asked what the GP had thought about a particular case and they compared what they had picked up from their own contact with the person. The atmosphere seemed to me to be geared mostly to the personality of the GP on duty for that session, and less so to the nurses. I saw some of the receptionists for several observations and they seemed to adapt to whoever was on duty, sometimes telling me that a particular person liked things to be done in a certain way, or that someone was helpful about taking some of the calls or good to work with because the nurses could consult them and get feedback.

The consulting rooms were just big enough for an examination couch, square stainless steel trolley holding some basic medical equipment and GP's case, a small desk and chair for the doctor, and two chairs for patients. During observation sessions I squeezed another small chair for myself into the corner next to the head of the couch and the trolley. I put the information sheets either on the desk or the lower shelf of the trolley, the tape recorder on a ledge just under the desk top, and put my bags in the office. During both summer and winter observations it was very hot and stuffy in the room if the

door was closed, but doctors had different views about whether the door should be open or not. It would not be difficult to overhear what was said in the consulting rooms from the waiting area, so that whether the door was open or not affected how much privacy there was in the room. Sometimes the GP had the door open all the time, but closed it at times for privacy, e.g. when a patient had to remove clothes to be examined, or when they wanted to take a telephone call. Some GPs had the door closed most of the time.

The suite of rooms was used during the day for an outpatients clinic, and this caused considerable tension between the day clinic staff and Nightdoc staff. I would often notice messages taped on the office fax machine or on the walls to the effect that Nightdoc staff should not use any of the clinic's equipment or paper, and should put every last chair back in place before they left. These messages became quite hostile at one point. Over the Christmas period a series of events seemed to epitomise these problems. The following paragraph is taken from my observation notes written in February 1998:

Arrive at Nightdoc at about 7pm, to find the software engineer in the office looking at the computer equipment that *inter alia* is supposed to be able to store and retrieve all the tape recorded telephone calls. We have a long conversation during which he shows me how the calls need to be tagged if they get chopped up into sections, and he ascertains what it is I am trying to retrieve. He has heard about me and tries to be helpful and suggest ways that we could get the tapes done, e.g. if Nightdoc get him in to do a training session, he will use my job as an exercise in tagging. It transpires that not only have the tapes been wiped for a period of 4 weeks up to January 16 or thereabouts, but he came in today because the software company have been monitoring the machine from their office and saw that it has been switched off by someone today. He is trying to find out who is switching it off and why. It seems to him that no one is monitoring when the tape gets full, so that instead of the tape being changed at least once a week, when it is full up, it just gets left and recordings are lost. The hard disc stores recordings as a 'buffer' when the tape runs out, but if the new tape is not put in in time, the older recordings 'drop off' to make space for the new ones. Because over those four weeks over Christmas no one checked the machine and the tape had finished, no recordings have been stored. It is made more difficult by the fact that the software should be run with a colour monitor. There is a scale which turns to red when the tape needs changing, but as they have a black and white monitor, the scale warning is useless.

Another piece of information was that a buzzer or beeper was going off when the new tape was needed, and my guess is that the daytime office staff didn't know what to do about it, were annoyed by the noise, and simply turned off the computer.

A number of issues were involved in this episode in addition to the tension caused by sharing premises. It raised questions about people doing their jobs properly, whether equipment was working correctly, whether people had been given sufficient training, and the possibility that the tape recording had been sabotaged, and if so, by whom. It was also a situation in which my presence as a researcher was material to the outcome, because it was partly my repeated requests for tape recordings - which the cooperative had committed themselves to providing for me but were also necessary for them to keep as medico-legal documents - that alerted them to their own problems. In these circumstances, and in consultation with my supervisor, I decided that this had become a sensitive issue in which further requests would amount to an intervention in the cooperative's organisational procedures. I stopped pursuing this for the time being, even though it substantially compromised my research design because many of the recordings of triage conversations relating to observations were missing (see further details in section 4.8).

#### **4.7 Observation sessions**

Observations were arranged during two periods: August and September 1997 and January to March 1998. This was planned to allow me to see how the primary care centre operated during summer, because it suited my overall timetable to start at that time; and winter, as a contrast, and because there is usually a greater demand relating to upper respiratory infections in children in winter months, one of the most common reasons for contact in this age group. I also wanted to have a gap between the two time periods to reflect on what I had observed and consult my supervisors about how I was proceeding, and to allow me to finish interviewing parents from the first observation sessions before starting on the second round.

Twelve of the observation sessions took place on evenings from about 6.30pm until midnight, and two were on weekends, one a bank holiday. I had planned to carry out at

least twenty observations, but in March 1998 I had to stop after 14 observations because I became ill<sup>3</sup> and could not return to work until the end of June. For each session I made the following arrangements. The GPs working on particular sessions were identified by consulting the administrative staff person responsible for coordinating the rota. Each GP was sent an information sheet (see appendix 5) about the study and a covering letter to say I would be contacting them by telephone to discuss the research and to ask if I could sit in on their consultations. It was usually necessary to make many phone calls to the practices to speak to GPs, and it then turned out that several of them had changed their arrangements and would not be at the PCC during the relevant session. None of the GPs refused my request outright, but in two cases we agreed not to go ahead: one GP was already bringing a registrar, one was about to retire.

For the first few sessions I also wrote to the nurses on the rota, but this was less successful because I found that the letters hadn't been forwarded, or the nurses had changed their shifts. When I spoke to nurses who had received letters, they appeared not to think it had been necessary. The cooperative was new and they were not in a set routine yet, they were getting used to the triage software, many of the nurses were new to the job, and there was a lot of settling in and supervision going on. I had also been introduced at a triage study day and some of them remembered me from that occasion. Perhaps for these reasons, they gave me the impression that they were quite accepting of having me around, but also, in sharp contrast to the GPs, I was aware that they may have felt they were not in a position to refuse observation. Therefore, I made a point of arriving before the PCC was open to patients in time to introduce myself, give them an information sheet, talk over how I would work, and answer any questions they wanted to ask.

At each session, after speaking to the nurses and receptionists, I put up notices for patients and placed information sheets on the waiting room table. When the GP(s) arrived, I introduced myself and asked if there were any further issues they wanted to talk about. I set up the tape machine and discussed with them how I would use it, where

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<sup>3</sup> I had contracted a virus normally associated with childhood, probably as a result of the consultation observations. The virus has more serious effects in adults, and this meant I could not undertake any further fieldwork.

I would sit, and how I wanted patients/parents to be given an opportunity to see GPs without my presence. Most of the GPs adopted the procedure used in their surgeries for students and researchers sitting in, which was to go to the waiting room, call the patient's name, and tell them outside the consulting room that there was someone doing research and ask if they would mind if I sat in with them. Although I recognise this is not ideal, I did feel that the notices and information sheets emphasised that people should feel free to tell either the receptionists or the GP if they felt uncomfortable in any way with being observed. I don't recall ever being asked to go out, although I went out without being asked to several times, e.g. if there were other people there with the patient and there would not be room for all of us, or if I felt examination procedures or topics might be embarrassing for people in my presence. On one occasion the GP asked me to stay, even though I was about to leave, because he wanted a chaperone.

On the occasions when Helen Harland accompanied me, if there were two GPs on duty we sat in the different consultation rooms, and sometimes swapped over later. If there was only one GP, Helen observed the triage nurse while I sat with the GP, or we took it in turns to sit with the GP. Sometimes there were long periods of time with no patients to be seen when we both sat and talked with GPs. Half way through each session we both went outside and discussed what we were observing and how to carry out the second half. These were very useful brief meetings, when we were both able to benefit from a different perspective or interpretation, be alerted to something the other noticed, or piece together information.

#### **4.8 Nurse triage and advice**

The nurse triage and telephone advice was an important element in the observations because it was at this point that parents made the initial presentation of their concern to Nightdoc<sup>4</sup>. The purpose of the triage process is to establish the best type and location of response to callers, and the nurse and caller together achieve this according to their own knowledge of health care, the patient's history, and the ethos of the cooperative. Each

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<sup>4</sup> See the full text of my discourse analysis of a nurse triage/parent telephone call, appendix 2.

caller to the cooperative (except in clearly acute emergencies when a receptionist could phone, or advise the caller to phone for an ambulance) spoke to the triage nurse and sometimes to GPs either to be directed to another source of help or to be given advice directly over the telephone. The main options for further help were to come in to the PCC to be seen by the GP on duty, to wait until their own GP's next surgery, to go to the Accident & Emergency Department, or to receive a home visit from a GP deputising for Nightdoc.

I observed triage nurses at work by sitting in with them and watching them operate the computer operated telephone advice software package (TAS). Despite the difficulties described earlier, the cooperative eventually produced a sample of triage recordings involving the same triage nurses I observed, so that I was able to hear their conversations with callers. It was also possible to talk to triage nurses informally during many of the sessions, and sometimes they came into the GP's room to discuss particular calls or concerns.

In my original study design, I planned to retrieve the tape recordings of all telephone triage conversations about children under five for the evenings I was observing at the PCC, so that I could build up case studies of particular children with the telephone call, observation in the PCC, and an interview with parents at home. Collection of all three types of data was only possible for seven cases, due to the problems with tape recording of telephone calls as referred to above. However, in the cases where it was possible, this proved to be a productive design, and analysis based on this data is discussed in chapter seven. In addition I had seven cases where I had a tape recording of the triage call and had observed the family in the GP consultation.

There were study/training days arranged by Nightdoc for triage nurses and I attended two of these. Speakers were invited to talk about how to deal with specific symptoms or categories of health problems likely to come up in their work, e.g. respiratory problems in children. There were also group discussions and opportunities to talk informally during breaks and I was able to get a lot of comments from triage nurses on these occasions without formally interviewing them.

#### **4.9 The consultation observations**

Observations were carried out during 14 separate sessions, five in summer and nine in winter. During these sessions 17 GPs were observed<sup>5</sup>. Each session lasted between five and six hours. Only one session was not tape-recorded, and for some sessions the tape recorder was switched off for some of the time, e.g. if it stopped in the middle of a consultation, or when I was taking a break, or when we were talking to people outside the room where it was set up. Most of this material has been transcribed fully, some of it in note form. Transcription was far more difficult for the observations than interviews, because different voices come and go and are not always introduced, the sound quality often fails, and there are many comments made which relate to actions that would not be easy to interpret out of context, so it proved unsuccessful to give them to a transcriber who had not been there. I also took notes during observations and wrote up my immediate impressions of the session as soon as possible afterwards.

During observations in periods when there were no patients I often had long discussions with the GPs which were more like interviews. When GPs were seeing patients, I didn't initiate any talk between us or with patients, only responding if they addressed me, although I did smile at people when they came into the room. At the end of consultations for children under five, I handed parents an information sheet and asked them to look at it later because I hoped to be contacting them. While I was observing I took notes continually, partly because I wasn't sure what might end up being useful information so I just wrote down anything that I could see, hear, or smell, or whatever I was thinking or feeling that seemed interesting; and partly so that I could remain outside the circle of eye contact between GPs, patients and parents. It seemed to be reassuring to GPs to be told before patients came that I would not interact with patients at all unless asked questions. My overt note-taking was therefore partly for their benefit. On one occasion a GP had agreed to the observation on the telephone, but was then somewhat concerned about ethical issues when we arrived. We discussed these at length, and continued with the observation, but at times when there were no patients he simply did paperwork or worked on his laptop. At these times I just wrote notes for myself, so that

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<sup>5</sup> See the full transcript of an observation session in appendix 3.

if he wanted to talk he could, but it was uncomfortable for me just to sit there not talking to each other and I was glad to have something to do. At the end of the evening he spoke quite freely with me, so perhaps the strategy paid off.

#### **4.10 The home-based interviews**

Interviews (n=16) with parents were held in their homes in all cases<sup>6</sup>. The information sheets for parents stated that I might contact them soon after their attendance at the PCC to talk about taking part in the study, and I telephoned parents to discuss this further and make arrangements if they were willing to participate. Telephone numbers were recorded on the call reports, so after each session I made a list of all parents who had attended with a child under five and attempted to contact them. In many cases it was not possible to make contact because there was no reply, or messages on answering machines were not answered. In some cases parents didn't have time available for an interview, or were not interested in taking part. In one case a father spent over an hour on the phone talking to me about why it was not a good time to interview his wife but gave me some very interesting information, and several others gave more brief comments over the telephone.

The interviews were arranged at a time to suit parents as much as possible. Sometimes their children were at home which made it more difficult to sustain a conversation, but it was interesting to see parents together with their child, both of them usually feeling better than when they were at the PCC. I saw both parents for three interviews, only the father on one occasion, seeing mothers only for the remaining 12 interviews. I also met some grandparents and other children in the families. The interviews lasted between 40 minutes and three hours, with most taking about an hour. On each occasion I talked about the study again, even if we had discussed it on the phone, and asked for any questions before giving parents a consent form (see appendix 5), which was filled in and signed and a copy given to parents together with another information sheet (see appendix 5), before proceeding. All of the family interviews were tape recorded with parents'

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<sup>6</sup> See the full transcript of an interview with parents included in appendix 4.

permission. Eleven of these tape recordings have been transcribed verbatim, and notes were made after listening to the remaining five.

#### **4.11 Other sources of information and summary**

In addition to the above research processes, I attended the cooperative's annual general meeting, facilitated a discussion group with the mothers attending a health visitor's clinic; had numerous meetings with members of the Nightdoc Research Board; attended an RCGP study day on out of hours issues, and listened in on the GP-UK e-mail discussion list for over one year. As well as giving me valuable information, these sources of data usually also provided me with opportunities to learn more about how different people in various roles interacted with each other.

In this chapter I have recounted how my research methodology was further conceptualised, developed and carried out once I was 'in the field'. In this process I formulated a way of working which suited the aims of the research to develop an innovative way of opening up a contested issue for reconceptualisation; follow the moving target of rapid changes in the organisation of out of hours GP services; and attend to a wider context than the bounded situation of the doctor patient consultation or the 'satisfaction' scores of any one party. I have also introduced the setting and participants involved in my study, and set out the kinds of data they produced with me. In the following three chapters, I will present the views of these research participants, my observations of them, their behaviour and interactions, and my analysis of all of these. This begins the second half of the thesis, in which many other voices will join me in the narrative and the dialogue.

## Chapter Five

### GP AND NURSE PERSPECTIVES

In this and the next chapter, I present separately the perspectives of GPs and nurses and the views of the ‘users’ of the primary care centre. The division of the data in this way was chosen because chapters five and six can be compared more easily with other work which seeks the views of either healthcare workers or users. In chapter seven I present the interactions and processes I observed between all of these research participants. This constitutes an innovative approach in comparison to more conventional approaches to this topic and highlights the insights yielded in contrast to ‘one-sided’ designs.

It might be argued nevertheless that my choice of presentation creates as much as it reflects differences of view between these groups of people<sup>1</sup>, so I have tried to point out the instances where there is a lack of consensus within categories of people, and to indicate where some views and/or experiences seem to be more common between them. Equally, all of the data should be seen in terms of the relational context in which they were created, including the different kinds of exchange I had with people in each setting.

To support the stylistic device just outlined, in chapters five and six I only report from data generated when people were talking with me and not from their interactions with each other. Most of my interviews with GPs were conducted before, after and in between consultations with patients, so that the conversation sometimes picked up on the circumstances of patients we had just seen. Comments from nurses were gathered similarly in between phone calls, during breaks, and at the end of sessions; as well as at the study days.

General practitioners were asked during observations and interviews (including pilot interviews) for descriptions of their lives and work, and their views about patients’ needs, behaviour and attitudes. Most of these comments were derived from their

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<sup>1</sup> As an alternative possibility, if I were to talk to a similar group of people from a particular geographical location we could have produced data in which parents, triage nurses and GPs were all represented and united by their political views, e.g. on the development of A&E services for their area, in opposition to another group in the same area but with different political views.

experiences before joining the cooperative, since it had only recently been formed, and they are important because they form the background to how GPs in this study constructed their opinions on inappropriate demand. It can then be seen later in the chapter how joining the cooperative had changed their personal and working lives, including relationships with other members of the primary care team, as well as adding a new dimension to how they assessed the appropriateness of demand.

GPs are identified by a study number as a way of preserving confidentiality. Biographical and work history details will not be included in the majority of cases because most GPs wished to have their statements anonymised. Although this constraint may seem to hinder a fuller understanding of their position, it is doubtful that their views would have been given without such assurances. Where personal information seems important and clearly does not make individual GPs identifiable, it will be included. The letters 'K' and 'H' in transcripts of dialogue indicate myself or Helen Harland, GPs in the cooperative are referred to as 'Dr', and GPs interviewed in the pilot phase have a 'GPP' identification at the end of quotes.

## **5.1 The stress of being 'on-call'**

All of the GPs had had experience of being 'on-call' under previous out of hours arrangements, and this took a great variety of forms, reflecting the diversity found in the literature. Some were working rotas with partners, taking calls and making visits throughout the out of hours period right up to joining the cooperative, but most used deputising services such as Healthcall for home visits, and all services from late evening until an hour or so before surgery opening time. Some of them had also worked for deputising agencies.

All of the GPs described being on-call as stressful in one way or another. There was the stress of waiting for the phone to ring, however infrequently this turned out to be. The possibility of the phone or bleep going meant they could never be completely relaxed or absorbed in what they were doing. For many GPs this was inextricable from whether they felt the call was an emergency or not, which involved most importantly the timing and the nature of the complaint:

'Well the hateful thing about the on-call system is that you're at the beck and call of Uncle Tom Cobble and all, I mean, 'you're on call, I just thought I'd phone and ask, can I have a repeat prescription?' or 'I haven't had time during the week to do this', and they're just phoning you the whole time, so the calls have been passed through to you, so your time according to the patient is dedicated to them. This is not an emergency service, you're on call. There's no correlate as far as they are concerned with your time and this being an emergency, so there you would be with your family, girlfriend, boyfriend, or other - your time's not your own, you can't do anything because the poxy bleep or phone or whatever may go off, and it might be for a load of old cack or it might be for something really tasty from a medical point of view, you don't know. So you can't relax, so you can be with your family, but not, because you can't really participate and do anything, because you can't, because you are on-call, so you can't be a normal human being, you are an on-call human being.' (GP 05)

A GP who had done his own out of hours work until joining the cooperative believed his ability to sleep through the night had been permanently damaged:

'Until I qualified I used to sleep very well. I've never slept well since. I never, well I say never, virtually never have 8 hours undisturbed sleep... it ruined my sleep, I'm sure it's that, and I get patients come and say to me I can't sleep, I wake up every morning at 6 o'clock, and I say lucky you.' (GP 04)

The effect of being on call on GPs' family lives was also raised, with the worst effects reported by mothers who worked long and unsociable hours when their children were small. GP 17 recalled the nightmare of having the bleep go off when she was in the park with her two young children and having to find a phone box. Another GP whose children are now grown up said:

'None of them have done medicine, because they could just see how hard I worked going out at night, and going out at weekends, it just used to drive me insane.' (GP 03)

On call work affected GPs' families, and in one GP's view this in turn affected his own personality:

H: Did it affect your family as well, I mean  
Dr: It was horrible  
H: Did you get complaints?  
Dr: Yeah it was horrible  
H: How often were you on call?  
Dr: Not... I mean it would be one in three, could have been worse, but when someone was away it was one in two, and you know it's not conducive to normal

functioning, either as part of the family or as a human being, in my opinion. That's why so many doctors are strange, or maybe they're strange and that's why they go into that kind of work where it facilitates them being strange...' (GP 05)

These comments indicate an alienation from his emotional self as suggested by Hochschild (1983). As he said in his earlier quote, 'you can't be a normal human being, you are an on-call human being'. They also support the findings of studies referred to in chapter four (Harland 1998) which associated blurring of boundaries between home and work with burnout, particularly time boundaries, and time will be discussed further below.

Concern was expressed by some of the more senior GPs who had also been trainers that GP registrars are no longer being trained in how to provide an out of hours service other than in cooperatives, and that these younger GPs would not become partners in practices that did not belong to a cooperative. An important and interesting correlate with this is that GPs who were experienced in out of hours work, especially in single-handed or husband and wife practices, claimed that they practised in surgery times in ways which obviated the need for much of the kinds of contact they were coming across in the cooperative (see sections 5.9 and 5.11). The view that GPs would not develop an understanding of, or skills in such daytime practices if they were no longer expected to do their own on-call work was supported by one of the younger doctors, and a registrar, who had only worked in general practice under the cooperative system. They said that doing their on-call on their own would be utterly unacceptable and impossible in terms of their long-term future career. This compares to a similar situation in midwifery (Sandall 1998), in which those midwives who had always worked in a hospital team could not imagine working on-call in the community. Another view was that out of hours work could be developed as a medical specialty.

## **5.2 Special skills and conditions required for telephone consultations**

A common problem was that although most GPs felt immediately prior to joining the cooperative that they were much less willing, and not always expected to make home visits out of hours, they were instead providing telephone advice. Yet many said they had not been trained in how to do this, and this was another factor which made being on

call more stressful than surgery consultations. Telephone consultations require special skills in triage, taking a history and making initial diagnoses without being able to see or touch the patient. The importance of *seeing* patients was referred to most notably in relation to infants and rashes.

‘Dr: Any child who, if a parent says a child is unwell I won’t talk to them about it, I want them down the surgery. I don’t want to talk about their ill health, I want to see the child in order to make sure that the child is well.  
K: So you don’t take any telephone calls from patients?  
Dr: Rarely, rarely. I find it’s totally and utterly hopeless. The information is either garbled, they only take out of it what they want, you give advice, they get it wrong. It’s easier to see them and just ensure there isn’t a problem. ‘Well, he’s got a bit of a temperature’. What does that mean? ‘He just doesn’t look right, he’s got some neck stiffness’. Well is that a stiff neck or is that meningitic? Well there’s no point in talking about it. I don’t see why I should go out to see that. Bring the kid down. If the child needs a jab of penicillin I’ve got everything down in the surgery, you know, I am trained as a technician and that is what I do, I am a technician. So I don’t see why I should go out in some bloody ill-lit place where I can’t do anything and no one is there to help me, no chance.’ (GP 05)

GPs said that in the past, they were more confident about giving telephone advice when they knew the patients - or parents - fairly well, which even if not always the case then, would be less likely in their work for the cooperative. In addition, they would often ask for patients to come into the next available surgery, so that giving telephone advice was always joined with the option to phone again if concerned, or to follow up the call by having the patient seen as soon as possible.

### **5.3 GPs’ experience of demand for home visits**

The question arose before they joined the cooperative as to where to see patients out of hours: in patients’ homes by making a visit, in the GP’s own home, or at the surgery. Visits were almost universally disliked, on the grounds of appropriateness of requests and inconvenience to the doctor. The aversion was not so much to home visits *per se*, because they could actually prove very useful in understanding patients in their own environment and family context. One GP even remarked that

‘In some ways getting up in the middle of the night, there’s something almost refreshing about it.... if you look at the actual act of going out, the roads are

clear, it was very fresh out, they're usually very worried people who call you out in the middle of the night. You know if you actually feel that you're doing something that they're grateful for, then perhaps it's more worthwhile than some of the other visits, so there were definite plusses to it, but in the context of a family life and a home- uh, and a GP's work life, I didn't like it.' (GP 11)

The strongest objections were to the circumstances surrounding making the visit: having to go out in the night, when it was dark, to unknown addresses, possibly unsafe areas, and having to get up from bed, and most of the GPs I spoke to were no longer working on call after around 11.00 pm. Some of them did not switch their home phone through to Nightdoc until then because it was cheaper for them to answer their own telephone calls, and if the patient needed a home visit or PCC consultation, they could ring through to the Nightdoc telephone number. Patients' homes were often regarded as providing unfavourable conditions in which to examine patients, including noise from children, dogs, televisions; poor lighting; no examination couch or equipment to undertake simple tests; and lack of special equipment found in the surgery for treatment. In addition, opening up the surgery could be problematic, especially for women GPs:

'For most of my career I've worked in a very large rota and that- I just can't tell you how you felt when the Saturday and Sunday approached, where on a Sunday you might, apart from those that you dealt with in the surgery and dealt with on the phone, you might go out to 20 visits and it was to strangers in areas you didn't know and of course in the winter in the dark, and just finding houses, the whole thing was a nightmare. [and later in same session] ... one of the things I wasn't very enthusiastic about doing was opening up the surgery at night. My partners did, but I've heard that in fact for a woman alone it's more dangerous to be alone in a building with patients than it is to be in their house, and so if I was going to be alone with them I'd rather not open up the surgery and be entirely alone in a building with drugs and possessions and things so I would always go to them anyhow.' (GP 03)

Safety issues relating to home visits were raised both by women GPs and by male GPs about their female GP partners or wives with whom they were in a GP partnership. GP 07 had once been mugged at gunpoint in New York, so always took her husband out with her on home visits. Now that they have children, she is glad she doesn't have to do visits at night because he would have to stay home with the children. The gender difference in feelings about out of hours work were not only attributable to safety concerns. GP 14 is in partnership with his wife, and always used to do the out of hours work for all of their patients. She refuses to do any cooperative sessions, but he

reasoned (in a humorous tone of voice) that it was easier for him to do out of hours visits or cooperative sessions than doing childcare, cooking and housework, and he thought most husband and wife teams were probably the same.

GPs reported a variety of practice policies on home visits prior to joining the cooperative. Some saw the offer of a home visit as 'doing a favour', especially now that they were able to justify the decision more narrowly on medical terms. They resented patients who seemed to think it was their right to have a home visit out of hours.

'Because they don't pay us, whatever we are doing for people, we feel like we are doing them a favour, particularly if you go and visit them at home. I always feel that if I visit people at home, that I'm doing them a favour. And I'm sure they don't see it that way.' (GP 03)

Some GPs had a blanket rule not to visit children because they believed parents could bring them to the surgery, if necessary out of hours. Other GPs had a policy always to see infants, or felt more obliged to visit, for example when they felt uncomfortable giving phone advice, did not want to open the surgery, were put under pressure from third party sources (one cited a meningitis advice organisation), or were anxious about official complaints. GPs reported differences between themselves and partners over how many out of hours calls should result in home visits, some saying that they often found it easier to go out and see people than try to make a judgement over the phone. GP 05 claimed not to worry about missing real emergencies, or upsetting patients, and almost never made home visits, whereas one of his partners was the opposite. Older people who were bedbound or terminally ill were seen by most GPs as more 'deserving' of home visits, but long term medical management issues were not welcomed out of hours. Most of the GPs commented that it was much easier to gauge these decisions when they knew the patients. When they worked on a large rota, it was much more difficult.

Demand for home visits was the main issue that was cited in relation to rebukes for inappropriateness, and taking patients off a registered list. GP 12 said that if new patients demand a visit because that is what they've had before, and he regards it as inappropriate, he will tell them the next time they come for an appointment not to do it again: 'they will only do it once'. This GP commented that the previous system,

whereby it was in the interests of commercial deputising services to visit on demand, gave patients easy access to home visits and encouraged demand.

However, several of the GPs, in making a distinction between the needs and convenience of patients, claimed further that patients had developed a consumerist orientation towards GPs. Their comments echoed those of other GPs as reported in the medical journals and press, and my pilot and observation interviews. The following quotes also include one from the e-mail discussion list, GP-UK:

‘I think it’s along with the fact that you can get 24 hour banking and 24 hour everything else, it’s the 24 hour society... and so I think that patients were thinking that out of hours were normal hours.’ (GP 02)

‘Certainly there’s one doctor I know, who’s very good indeed, and he really does say to the patient, ‘It is inappropriate to call a doctor about this, this is not an emergency, this is inappropriate use of the service.’ Now, I don’t know if he’s had complaints lodged against him, but what he is saying is absolutely reasonable. But our patients are not reasonable. This is a consumer organisation, the NHS these days.’ (GPP 02)

‘I think parents have a right to 24 hour medical help, ok, but what I find very irritating about on-call is that it is a patient driven thing, ‘I want you to come and visit me.’ You can’t get anybody else in the world to come out to you. You can’t your bank manager to come out to you, you can’t get a solicitor to come out and visit you. Doctors are the only people that you can say, you know, and ‘I’m going to sue you if you don’t’, irrespective of the fact that you’ve got toothache, you know, you can make me come and see you because you’ve got toothache by holding a legal threat over me. Medically, it’s nonsense... from an efficiency, doctor efficiency time, it’s rubbish, it doesn’t make any sense that way, from a medical point of view it is rubbish. It’s not a medical judgement being made, it’s a patient driven thing. ‘I’ve decided I’m so sick I want to see you and you’re going to come and see me.’” (GPP 04)

‘I was delighted when the local Tesco’s decided it was no longer viable to stay open all night. Patients already have a tendency to think along the lines of, ‘If the shops are open why isn’t everything else’. Don’t get me wrong, I do believe we are there to serve the patients. But it is not in anyone’s best interests to have 24 hour full services... Children who can always ask a parent how to spell a word may never learn to use a dictionary. Patients who have immediate access to doctors may never learn to think for themselves. Why should we work all hours so other people don’t have to put themselves out - for what actually is their problem?’ (GPUK3)

In these quotes there is a conflation between what are seen as inappropriate uses of out of hours services and a purported consumerist attitude, although analytically it is possible to separate out views on inappropriate use of the service on medical grounds, and what is felt to be inappropriate about the *way* in which the demand is made. The theme of dependency appears as it does in my discussion of the social problems assumption (see below), and it is particularly interesting in the last quote how the GP talks about patients as both consumers *and* dependent, which doesn't fit in with the rhetoric about consumers being in control. Patients who insisted on home visits were also likely to be characterised morally as unreasonable, a nuisance, and just plain demanding: 'it's a patient driven thing.'

#### 5.4 Time as a boundary, commodity, or signifier of value

Talk about time was dominated by three themes: time as a symbolic boundary (Green, 1996); time as a commodity (demanded by 'consumers'); and time as a signifier of value. The following quote is typical of GPs who talked about patients not using their services at the right time:

'If it's an unnecessary call I do tell them that the service is not *free*, and they could have seen me during the weekdays. I saw one of my own patients here just now, 7.30pm. *Cystitis*, since morning. I said, 'what were you doing today...', I mean I'm sure she could have been seen in my surgery this evening, no problem. So, these are the people who *upset the routine*. I mean, I don't mind attending their emergency, but something which can wait until tomorrow or which could have been sorted out today...' (GP 14, my emphasis)

This quote draws on the merging of three factors in making judgements about what is 'necessary': evaluation using medical criteria, evaluation of the timing of demands in relation to the GP's time boundaries (her 'routine'), and in relation to the monetary value of the GP's time. There appears to be a notional distinction between what is reasonable in the day time but unnecessary at night purely on the grounds of timing. GP 12 said that the same kind of request for advice or even a home visit that would be easy to deal with during the day would feel worse at night because of his own resentment about the interruption to his evening, emphasising the emotional content (resentment) in evaluation of the necessity of the patient's problem being dealt with at a particular time.

Evaluation of the necessity of calls was typically made in terms of the medical aspects of the case, less often in terms of the doctor's openly expressed need for boundaries, although some GPs did express an appreciation of patients' own reasons for using services at times regarded as 'inappropriate'.

Some doctors talked in terms of patients who intruded into doctors' bounded time and taking something from them which was worse because it was in their 'own time'. This was linked to resentment stemming from a belief expressed by many GPs that people in what they saw as comparable professions (accountancy, law) would be compensated financially for contact in their 'own' time:

'With other people, business is such that you know any contact usually means money, whereas in my line of work it was aggravation, because someone wants something from me, not what I could provide them with, well from their point of view it was, but from mine they just wanted something from me, in my time.'  
(GP 05)

A related point is that one person's 'saving' time may be another person's 'wasting' time. A parent anxious to get a prescription for their child on a Saturday morning in the belief that their child will be better in time to go to school on Monday may be seen by the GP as wasting time set aside for emergencies only. One GP referred to the 'the Friday cusp', the surge of appointments requested by patients or parents who consulted about symptoms which were not too serious at that point but might develop over the weekend. What patients might have regarded as a prudent way of avoiding bothering the GP over the weekend was seen as creating an inconvenient number of 'trivial' consultations.

Frankenberg (1988) points out that whereas patients' experience of medicine is characterised by waiting, the time of hospital consultants is held as sacred, with 'symbolic value above and beyond his scarcity value' (p.119). The disruption of the consultant's boundaries of day and night, private and public space and time made possible technically through beeps and now mobile phones mark his (or her) special status as one who is licensed 'to cross, even to penetrate, the boundaries between the embodied self and the self-in-the-world' (p.123). But in this respect power and status derive from the choice made by such elevated people to forego privilege. For GPs, the tradition of noblesse oblige has never been quite on par with hospital consultants and

such as it exists, is on the wane. The 24 hour commitment has become an oppressive contractual requirement rather than an obligation associated with assured high rank.

Underlying the quotes and many other comments made to me during the fieldwork is the issue that many GPs have been pushing for an end to 24 hour contractual responsibility, hence the development of cooperatives. GP principals have been able to delegate their duties for a long time, and have been given a yearly allowance and fees for patients seen between 10pm and 8 am (Hallam and Reynolds 1999:14) yet the views expressed as in the quotes above reveal the contentiousness of the situation. Clearly one could argue that since GPs are paid on a contractual basis for 24 hour responsibility and are compensated financially, then patients are not demanding GP's 'own time'. However, if they feel they are not paid adequately, and do not enjoy the rewards of status and high esteem, this is where evaluations of demand come in: how much is that problem worth the amount being given for compensation? Would any amount of remuneration be enough when the effects of not having time of one's 'own' are so intolerable? How did GPs cope with this aspect of their lives in the past and why are they not able to now? In all of these questions time signifies joint meanings relating to commodification, boundaries, and time as a signifier of value beyond simple financial compensation.

### **5.5 Appropriateness/ inappropriateness of supply and demand for out of hours healthcare**

The acceptability or otherwise of working on-call or making home visits was usually qualified in terms of the perceived appropriateness of patients' requests for help, and again this was conceived mostly in terms of timing and the medical nature of the problem, yet it was difficult to elicit *positive* criteria for appropriateness. When asked for definitions or examples of appropriate circumstances in which to ask for out of hours help, some of these were if a patient is concerned and feels they can't wait till next surgery time to see a doctor; if a patient thinks something is wrong with them that is life threatening; or if they think they will be materially worse off by waiting for a next available surgery consultation. Some GPs thought appropriateness is to be judged purely on medical grounds; some on medical and social criteria; and one said it is not what the GP thinks but what the patient believes they need that must be paramount. There was a

wide range of opinion about how much of their work was ‘appropriate’: GP 09 thought that only about 5% of consultations are absolutely necessary, and that 60% of them are ‘crap’; whereas others felt that if patients are concerned enough to consult, it is better to provide reassurance than miss the few real emergencies by putting people off.

The inappropriateness of demand was more readily discussed. Some GPs had very strong feelings about patients’ behaviour, telling ‘atrocious stories’ (see chapter seven) about how patients had abused the system, were ignorant about the workings of their own body, or consulted about what GPs regarded as trivial matters, referred to as ‘rubbish’, ‘crap’, ‘a load of old cack’. Some GPs actively addressed the behaviour of patients with a ‘track record’ of consulting inappropriately, including making them go elsewhere:

‘I can remember one family where we just told them to change doctors because their expectations were different from ours. I mean people feel that strongly about it now [their right to have home visits]. You know we had on two separate occasions a ding dong with this woman who wanted us to go to her block of flats at night and she had one child and transport and the child had whatever sort of minor viral children get, so we said to them...’ (GP 03).

‘If the patient kept coming up [to the PCC] we would give them a warning and then they would be removed you know. I think it is about £7 or £8 looking after patients for a year and it costs £12 to come here so...’ (GP 04)

On the other hand, it was not always patients who came in for criticism. Some GPs regarded their colleagues’ behaviour as giving the wrong educational messages and thereby encouraging inappropriate demand. Prescribing antibiotics for minor or self-limiting sore throats, coughs and flu was widely and strongly condemned as bad practice based on the latest evidence by many GPs. If patients were given antibiotics for such symptoms, their belief that antibiotic treatment was required would be reinforced and they would demand it in future. This was a source of great frustration to some GPs, who felt that their efforts to ‘educate’ patients away from the use of antibiotics were undermined by other GPs acting inappropriately. Yet organisational and cost factors overrode these considerations for some GPs because their priority was to reduce demand for out of hours services. As GP 14 admitted: ‘I sometimes tend to overtreat, but I do not want them to get in touch with the emergency doctors.’

It was of great concern for some GPs that the cooperative allowed people an alternative source of treatment that might go against what they would receive from their own GP. In an important departure from the previous system, membership of cooperatives, with their opportunities for more collective communication and working, is making the differences in practice and beliefs of GPs more visible to each other. Having other GPs and triage nurses give possibly conflicting advice, and patients becoming confused or being able to play the system as a result, was one of the causes for reticence for many GPs in joining the cooperative. There was a certain degree of mistrust that colleagues might not practice the same way, although other GPs from local practices were preferred over deputies. GP 17 said she thought that triage nurses working with the protocol are probably better than other GPs and deputies, because the advice is organised and follows cooperative guidelines. GP 02, commenting on how many of the patients he had seen at the PCC that (weekend) morning could have waited until the next day, said:

‘They all could have waited, in as much as there’s nothing that I could have sent into hospital today, all the children could have waited, but on the other hand the factors that brought them up here were actually quite interesting. I mean, I don’t want to be critical of my fellow GPs, but that asthmatic child was just easy peasy to deal with, and should have been dealt with at the first consultation. Rather than saying ‘oh I’ll get you an appointment at the hospital’ for mild asthma, it’s ridiculous .... That was a doctor factor that brought that child up to [the PCC].... And then the boy with the eye was interesting too, again, he might have waited until the next day, but because his doctor has said ‘you might have a low white count, or something serious’, that had triggered it off. So it isn’t just patients’ beliefs and patient factors that bring people up inappropriately to a primary care centre, when they don’t need to, but it’s also what the doctor does to the patient that brings them up as well.’

Appropriateness therefore applies to supply as well as demand factors (see further discussion in the section below on continuity of care), and highlights important changes in organisational features of general practice.

## **5.6 Attributes of demand and demanders**

In addition to comments on the appropriateness of demand, GPs expressed a variety of opinions about other qualities of demand, and demanders, starting with the view that demands for out of hours attention were constant and continually rising. Patients were seen as wanting instant help and cures, and incapable of or unwilling to fit in with the

system by using it appropriately and waiting when necessary. Some of the blame for rising demand was cast on a general shift in society towards consumerism, as referred to above. Another object of blame was the media:

- ‘Dr: By and large the perception is that the GP can do anything and everything nowadays, which is a wrong one.  
K: What sort of thing do you have in mind?  
Dr: Like if you’ve got a social problem or other problem, a housing problem, they don’t go anywhere else but ask the GP first...everywhere, they put the GP in the front line, and GPs get fed up with this to be honest.  
K: And do you feel that that has increased?  
Dr: Yeah that has increased, the communication from various sources.  
K: Do you have any feeling about why that might be?  
Dr: Because the patients’ expectations have been increased, and it’s easy for them to just say, look, go to your GP and he’ll sort it out. The media, the radio, television, newspapers, they have to fill up the spaces, they have to write pages, radio has to make it interesting and television has to make it interesting, and a medical subject is something people want to listen about, so that has made things worse, to be honest, to some extent.’ (GP 14)

This extract also illustrates a widespread set of assumptions I came across in GPs which could be seen as forming a breakdown of society, or social problems theory. The thread of the theory is that GPs are being relied on inappropriately for advice on social and trivial medical matters, and that in the past this would have been provided from within the ‘extended family’ or from ‘the community’. In this assumption one can see both an identification of what is inappropriate, and an explanation, that people should, but no longer rely on their family for help rather than outside resources.

‘I mean the whole set up is because of the social and cultural needs in this country. You will find that, I mean if you look at say 20, 30 years ago, not many people will come to the doctor, because the mother is there, mother knows what to do for the child. If the daughter, if the mother thinks there is something wrong with the child, they ask their mother, ‘Mum, what’s wrong with my daughter or son?’ That sort of help was available, that’s number one. Number two, they always think twice if it’s going to cost them to see the doctor. Now, the situation has changed completely. Now, the family unit is, it’s only husband, wife, children, or single mother and children. Especially in an inner city cooperative or practice like here, you will find there are a lot of, lots and lots of single mothers, lots and lots of people who are on benefits, and it doesn’t cost them anything to get the doctor out. What the, the grandparents of the children were doing is being done by the GPs at the present moment in time. Lots and lots of things. See for example, a child has got diarrhoea - so what? You don’t go to a doctor the minute a child has got diarrhoea. Or you don’t go to a doctor the minute a child has got a blocked nose or sneeze. In those days, the grandmother used to

say, 'No, just leave it, give only water, or don't give milk. You wait for a day or two, or maybe 24 hours, usually it settles down.' But now that type of support is not available. (GP 12)

Clearly there are certain kinds of people implicated here more than others, and the notion of dependency is inferred. 'Dependency' is not just the result of a lack of family:

'The one prescription I told you I gave, that I might normally have not given, was somebody, presumably must be slightly less well off, who wanted paracetamol on the NHS, and so the less affluent people, there are two things, first of all they want what ever's going free, and secondly they are ignorant and dependent - some of them - that's a terrible generalisation, but they can be, they are not knowledgeable and very dependent on authority to tell them what to do in given situations.' (GP 03)

'The lower the social class, the more dependent they are on the GP. They use GPs because it's free. They're insecure, no confidence, lower intelligence. They can't assess the problem, they don't know about symptoms. 70% of calls are for self-limiting or minor illness. GPs in the shires don't have all this hassle. People who are working won't take time off to treat themselves. It's cheaper to buy something than spend time. The higher social classes can't afford to take time off. Rich patients, self-employed, business people won't waste time, they'll treat themselves.' (GP 12)

Looking at the two quotes from GP 12 (one immediately above and the other two quotes back), parents/patients are represented as no longer using the advice of older relatives for two reasons: because they are not available and because the doctor is 'free'. But these attributes are in turn associated with a third, the interpretation of such behaviour as 'dependent'. The assumption that relatives are no longer available to ask is seamlessly linked with a view of single mothers and people on benefits being inclined to see a doctor because it 'doesn't cost them a penny'. But what starts out as an apparently two pronged conceptualisation of the problem turns out to be dominated by the overriding message: if medical care is free at the point of delivery, people will continue to use it *even if* they could look after themselves, or ask relatives for advice, because such behaviour is a manifestation of a dependent attitude. In the current climate of individual responsibility and self care, this has clearly negative moral connotations. In another context, for example in trying to encourage young pregnant women to make more use of antenatal care, similar behaviour might be construed as appropriate compliance with medical care instead of listening to 'old wives tales'.

Some families were seen as 'lots of trouble', because of the nature of their health behaviours, or because they were more prone to illness and therefore made frequent demands. In the following quote, rather than seeing the family in terms of social support, having a large and close family was instead seen as the cause of such problems:

'Dr - ...it's all too convenient for some of my patients, and I tend to find that it's the same families, week in, month out [...] The [ethnic group] will just use it for anything, I mean, they've got endless social problems, they are very fond of each other, so whenever they fall out, they all fall ill! But, er, they've got a lot of children, of course, um, they've always got ear infections, chest infections...

K - Right, so, is it inappropriate, what they call you about, or is it just that they call you a lot?

Dr - It's the same - my wife is the practice manager here, and she sees all the [cooperative] slips, and she says it's the same old names that keep cropping up all the time.' (GPP 02)

If having no family support can be as much a problem as having too close a family, so can having too much rather than too little money:

'Classic, precious [town name] patient, [town name] is very upmarket and affluent, there's a way about them, they try and make everything personalised. I've been observing the rich in action here, they want to feel that the whole world is doing them a personal service... We have an even more upmarket area [area name], well the GPs in [area name] have joined [Nightdoc] because their lives were being made a complete nightmare, and even though it's 10 miles away, even the fact they would have to accept that they would have to pay lots more for visits, they felt it was worth joining just to get away from the constant demand from the rich.' (GP 02)

According to the social problems theory, whether people are rich or poor, from close families or not, the demand is inappropriate because it is *social* in nature rather than medical, a kind of reverse logic to the current calls for health policy to address social inequalities. Although the following comments were in relation to the demand for visiting and not specifically for medical treatment, the same thinking applies:

'My attitude is if a child needs to be visited, it's got to be so sick that it probably ought to be in a car to the hospital, you know, and if they're well enough to run around there have got to be bloody good reasons why I can't, why the child can't come down to the surgery, which will be social: 20 other children, no transport, you know. It won't be a medical reason why the child can't be brought down, because anything under five can be picked up and carried, so you know, the mobility of a sick child is far greater than a 90 year old granny, it's a completely different reason why they can't come down, it will be social: no car, um, or other

children, can't leave them. There's a good argument to say that you can get them all dressed and bring them down as well, you know, there's lots of reasons why.' (GPP 04)

Another stereotype that arises in the social problems theory is demonstrated in the following extract. This GP and I had engaged in an impromptu role play during our interview, in which I put forward a hypothetical case where a mother was worried about a young child with a high temperature lasting over four days:

'It may be inappropriate but you can be educational and reassuring, or there are others where you actually just have to confront them with the fact they're liberty takers. Now a new mother will not present her 4 or 5 year old like that unless they have got a social problem of some sort and they're actually, the child's the symptom carrier. If it's a new mother who is very anxious and neurotic and hasn't got very much in the way of family support etc [...] you can still be reassuring, say yes I understand, it must be difficult not having uh, you know, uh, living up the 14th floor and you know, uh, ex-partner kicks the shit out of you and doesn't support you and all that stuff. So you can be supportive and there are others who come because they have run out of Calpol and I'm sorry that's like having a plaster in the house, Calpol, with a child.' (GP 05)

Although many of the GPs were more tolerant of parental anxiety, especially in relation to babies, the anxious/neurotic/ignorant mother featured in several of my conversations with GPs. Mothers used the service inappropriately because they were 'useless', 'hadn't got a clue', with single mothers on benefits, isolated mothers, and first time mothers cited in particular. By contrast, GP 07 admitted that she had actually called out a GP herself to see her child on a Saturday night, and said that having her own children had definitely changed her attitude towards parents of young children.

Most GPs in my study thought that older people were more careful about the demands they made, and more appreciative of what doctors did for them and of the effect of their demands on doctors. The relatives of older people came in for criticism, and several GPs referred to a syndrome whereby grown-up children living far away but visiting on the weekend would phone out of hours demanding that something be done for their ageing parent. GPs were particularly cynical about the immediacy of attention demanded, because the visiting relative had only just become aware of the changing status of a long-standing condition, so that again, it was the timing as much as the nature of the request to which GPs objected.

Returning to the 'social problems theory', GPs also had theories about the ways demand could be changed through financial means. Several GPs thought that only fees would reduce demand, because as long as people did not have to pay at the point of delivery, they would regard the service as 'free', and those on very low incomes would take advantage of anything free such as getting a prescription for children's paracetamol rather than buying it from the chemist. Some GPs thought that the cooperative would increase demand for similar reasons. Making access to advice easier would open the floodgates simply because if there was no charge, people would have no other restraint.

### **5.7 Pay, conditions, and business aspects of general practice**

Pay was a major and politically topical issue for GPs, and inextricable for some from feeling that the stressful nature of out of hours work made it insufficiently rewarded to make it worthwhile. Older GPs commented that when they trained, out of hours work was seen as 'part of the job', not necessarily a good part of it, but accepted under the terms of 24 hour responsibility for patients, whereas GPs now are unwilling to accept these terms and would refuse to do out of hours work unless it was in a cooperative situation. Younger GPs were seen by older GPs as being more militant on out of hours work, but at the same time more 'mollycoddled' as a result of their training. In their comments to me, younger GPs seemed to feel most strongly that their training was wasted or their time inadequately remunerated. They were more likely to make comparisons with other professionals, arguing that hospital consultants, lawyers and accountants were better paid and that no other professional person was expected to be accessible to their clients 24 hours a day. This lack of a barrier seemed to be a symbol of less prestige, in comparison for example to doctors in hospital medicine, for whom GPs act as gatekeepers.

GPs seemed to feel entitled to high pay, although they differed in how they expressed the implications of this. For example, GP 09 spoke at length and bitterly about the pay and conditions of life as a GP. He felt unrewarded - coming from the top 1% in his public school, he felt he should be in the top income bracket. He felt controlled by his patients, whose expectations were ever rising, while his faith in medicine was ever waning. He

compared himself to a hospital consultant, and complained that ‘£50,000 per annum is no big deal, BMW salesmen get that.’ He regarded the BMA as toothless because they weren’t prepared to back strike action, and allowed GPs to be pushed around by the government. After some time I put it to him that many people, given the option, would enjoy the employment security, salary and autonomy of a GP, and in response he conceded that he does indeed have job security, a good pension and a less dangerous job than some: ‘you’ve pulled me up short there’. My point was not made to remonstrate with him, but to get a sense of how far his perception of entitlement and comparison included more ordinary people, such as his patients, which it clearly did not. By contrast, although not proposing to earn any less personally, GP 03 said:

‘When I think about how much my patients earn, then obviously I know I’m very privileged, and we don’t have the ups and downs...’

GPs could suffer from isolation, even if they were in partnerships, because they didn’t always feel they could discuss problems. In Helen Harland’s research on burnout for this study, she found that GPs in the UK who suffer from the experience of stress or other health problems do not appear to make use of support services offered by their professional organisations. This is due to lack of trust, fears over confidentiality and the possibility that future employability could be called into question (Harland 1998, Silvester *et al* 1994, McKeivitt *et al* 1996). Concern over reputation was apparent in subtle ways, such as being careful not to criticise other doctors overtly, and yet not entirely to trust how other GPs might treat a GP’s ‘own’ patients. In one practice, each of the partners happened to be included in my study, and each of them asked me what the other partners had said about them or what I knew about the other partners.

Sometimes partners had religious differences which caused problems: for example, one GP said she always saw women wanting emergency contraception because her partners were very religious and regarded it as a form of abortion. Some partners refused to work at certain times for religious reasons, so having a partner with another faith meant they could cover on-call times for each other. Some practices had experienced conflict over whether to join the cooperative for financial reasons but also in terms of the impact on continuity of care. One GP in a husband and wife practice had always done the out of

hours work for both of them, and was still doing his wife's share of out of hours sessions at the cooperative.

One of the business aspects of general practice most commented on was the comparison between using deputising services (and one in particular that was used by the majority of GPs in the area) and joining the cooperative in terms of costs. Many of the GPs felt that the deputising service was 'only interested in the money', that they had been 'ripped off' by them, and preferred the cooperative structure. One GP, however, had reservations about how much control he was able to exert over the use of the cooperative. Prior to joining the cooperative, he would take phone calls until late in the evening, and only get deputies to do home visits, but now he was being charged for phone visits, telephone advice and home visits<sup>2</sup>.

Charges for cooperative services, including joining fees and use of development funds, were the subject of fierce debate at the annual general meeting of the cooperative which I attended. Although most GPs had resented the financial terms of the previous deputising service system, they were some who were nevertheless critical of the cooperative on the matter of how much it cost them to belong. However, it is difficult to make easy comparisons or talk in terms of cost-benefit trade-offs because cooperative membership is on a completely different footing and involves them in complex relationships of ownership in financial terms but also of agreed practices and ethos. There was a notable divide between those GPs who seemed to want to relate to the cooperative as if in negotiations with a deputising service, and those who wanted to embrace the cooperative ethos and take on responsibility for its development more as insiders. An interesting point in the meeting for me was when one of the leading GPs, at a moment when a great deal of conflict along these lines was apparent, used the appeal of talking about inappropriate users and their cost to GPs to unite the audience.

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<sup>2</sup> Interestingly, at the time of my study, home visits were still being done by the deputising service he had used before, but home visits are now carried out by the cooperative. In my original plan for the cooperative ethnography, I had included the possibility of accompanying some deputies on home visits. However, in the event this became a very sensitive issue as the cooperative began negotiations to take on home visits, and thereby dispense with the deputising services, and thus I decided not to pursue this.

## 5.8 GPs' experiences of out of hours work since joining the cooperative

GPs almost unanimously reported a huge quality of life improvement since joining the cooperative. The biggest benefits were having more time to spend on family and social life, reduction of the continual stress of being on-call even coming from quite large rotas, and not having to do home visits. Other benefits included being able to treat medicine 'like a job' instead of it dominating their life, the positive associations with the idea of belonging to a cooperative movement, reduction of isolation, and better feedback from the call report system. The cost issues, as discussed above, were acknowledged by most GPs, but were given greater priority over these benefits for a minority. On the whole, the cooperative seemed to be the long-awaited solution to a major problem in general practice.

The majority of GPs expressed enthusiasm and relief to have been delivered of what they saw as the enormous burden of out of hours work under the old system, but there were a few who looked ahead and had concerns for the future. In her analysis of the development of cooperatives across England, Hallam and Henthorne (1999) warn that the benefits of cooperatives as reported by my informants are indeed vulnerable in the longer term. That is, the time that I observed the cooperative can be seen as its 'honeymoon' period, with demand containable and GPs enjoying a greatly reduced out of hours commitment. However this has been followed, in the cooperatives that Hallam and Henthorne studied, by a gradual but substantial increase, so that GPs may find they have to put in more time and money to meet demand, and this would significantly reduce the benefits they were enjoying in the first 18 months.

A difficulty in trying to interpret my data in relation to studies such as Hallam's is that there are already major changes being introduced which entirely change the context, amounting to a shift from out of hours *general practice* to out of hours *primary care*. It remains to be seen what the impact of NHS Direct and walk-in centres, the two main developments, will be, but those feared by my informants mainly focused on the themes of increasing demand and loss of continuity of care (see section below).

## **5.9 Out of hours healthcare: Emergency work or part of general practice?**

Closely linked to the distinction between general practice and primary care, with the latter incorporating a broader range of health care professions including nursing and pharmacy, is the conceptual splitting off of 'real medicine' or 'real doctoring' from the more 'holistic' aspects of general practice, i.e. dealing with the emotional, moral and suffering, or soteriological (Good 1994) dimensions of patients' experience. This has classically led to a division of labour between medics and nurses, and relates to the system of triage which separates out the latter as appropriate work for nurses, leaving the GP free to do the 'real' doctoring. It can also be seen in terms of how doctors define what constitutes appropriate out of hours work in terms of 'emergencies' rather than general practice.

In my interviews with GPs the separation of 'real' medicine from more socially oriented health care work, could be represented as a continuum with 'real' medicine at one end and 'personal care' at the other, with some people balanced across these two positions. A possible model is that of one trajectory of GPs' professional self-concept using this continuum transposed with one representing their conceptualisation of work boundaries (Green 1996). Those who expressed a socially oriented professional self-concept seemed more willing to accept 24 hr general practice responsibility for patients, and valued continuity of care as part of their work. In contrast, others talked about their work in more technical and 'boundaried' terms, with limitations on place of, and hours given to work and on how much they were prepared to take on of the patient's social circumstances.

Some of the GPs at the cooperative I studied assumed that because they were seeing patients at the PCC who had already been 'screened' by the triage system, they were less likely to see people presenting 'trivial' symptoms. This meant that they viewed the cooperative arrangement as providing more of a chance of doing 'real' medicine, also referred to as more 'interesting', 'tasty', and 'fun'. The following extract helps to explain this by implying that using one's medical skills is exciting compared to the more mundane aspects of consultations:

‘You actually feel quite excited if somebody’s ill, because it’s so boring, in a way. I mean, I like seeing people, and it’s nice to discuss them and most of the people I see I like very much [...] But you know, it is quite exciting to see somebody, especially if you get it right [...] and if you’ve done the right thing [...], got the diagnosis as quickly as possible, despite the fact that you’ve got the most terrible expectations for that person’s future health, it was still quite a pleasant experience for the doctor.’ (GP 03)

There was some tendency for those who indicated a preference for work that could be characterised as ‘real’ medicine also to express a job-oriented professional self-concept, to stress the out of hours service as an emergency service, and to talk about patients abusing the system. In contrast, those who conveyed a more social orientation, seemed to see the out of hours service more as an extension of general practice. This has implications for how GPs with different views see the current changes in and future of out of hours services (see chapter seven).

GP 05, who described himself as a technician and displayed a ‘real medicine’ orientation, made this comment about the issue of seeing children on an emergency basis:

‘We have a wonderful policy. Do you want to be seen? Come down now. Now, if it’s not an emergency they get a bollocking.’ (GP 05)

One of the pilot interview GPs, who worked in another cooperative where doctors took all the calls, also illustrates an orientation to ‘real’ medicine:

‘I find [giving telephone advice] extraordinarily boring in terms of work because it’s very non-medical. Most of my work is giving advice on the phone, and it’s repetitive, I mean when the flu epidemic came round, we probably took 50 or 60 phone calls in the space of , you know, in our shift, which meant you were on the phone continuously, and you were just saying the same thing over and over again, you know, it really, five years of medical training, ten years of being a doctor after that, to just stand on the phone for seven hours and tell people to take paracetamol or, you know, drink a lot, I mean it’s just not good use of my time, you know, and I’m being paid a lot of money to do it, but it’s stupid, you could pay someone lower down the medical ladder to do the same thing, and have the doctor just there if it doesn’t work, and that’s my argument to be honest.’ (GPP 04)

A sharply contrasting view to the last two examples was that of another pilot interview GP (GPP 02), who had previously worked in a larger practice, but decided to go into practice on his own because he wanted to work in a different way. He joined his local

cooperative after working for three years as a single-handed practitioner and covering his own out of hours service. He regarded this period as the most satisfying in his career, because his practice was based on knowing his patients and offering a personal service. When he had sole responsibility, he had greater control over what was happening and his knowledge of patients was an advantage in making decisions and keeping track of people's progress. He said that a lot of GPs get burnt out, so he tried to run things in such a way that he could go on indefinitely, for example giving people 15 minute appointments so that both he and patients were under less pressure. Knowing patients meant that out of hours work was much easier because he knew their history and how they usually behaved, and in turn, his patients were either reluctant to bother him or more willing to accept telephone advice until the next morning. His overall approach could be characterised as seeing his out of hours work as integral to his practice, and he still answered the telephone on many evenings. He used the cooperative as a cheaper way of providing patients with a service than employing locums when he needed to have a weekend off or holidays, and it had improved his family life greatly to be able to do this more often.

The orientation which stressed knowing patients well was adopted by several GPs as a way of practising which made life easier, for example because it made diagnosis easier and avoided the need for out of hours contact. Those with the opposite orientation thought that this way of practising would make life intolerable because it would be pandering to patients' uncontrolled demands.

### **5.10 Knowledge, education and diagnosis**

A view commonly held by GPs, and a central ethos of the cooperative, was that 'education' of patients would lead to an understanding of what are appropriate circumstances in which to consult GPs out of hours, and therefore a reduction in demand. This reflects the influence of models of general practice such as that proposed by Stott and Davis (1979), in which the principle of

'modification of help-seeking behaviour... embodies the assumption that each consultation may in some way influence the patient's future help-seeking

behaviour and that recognition of this fact should lead to better patient care... a practice policy to stop prescribing for minor ailments coupled to a programme of patient education will lead to a lower demand for medical care for such illnesses.' (1979:203)

This position was encapsulated in the following comment made by one of the GP leaders of Nightdoc about what he hoped would be the effect on patients of the cooperative's emphasis on education:

'And the next time it happens, they might not call the doctor. And that's the crucial thing, is that, it's the long game we're playing here, so that every person we see, we are educating, so that the next time it happens they might just be able to do it themselves.' (GP 02)

Thus the concepts of education and triage are employed as central features in the cooperative's strategy to reduce demand for out of hours care. The aim of education is to make patients self-reliant, obviating the need to consult GPs over what are seen as trivial medical matters.

The view that people don't want to use, or don't have, adequate medical knowledge is linked to the idea that they lack family and community networks from whom to learn about health care, and to dependency arguments (see above). On the other hand, GPs were sometimes fairly dismissive of the kinds of knowledge parents offered, for example comparison with or knowledge of another child, or information they had found in child health care books.

Issues of demand arising from knowledge or lack of knowledge were both represented and were linked to the idea of the loss of family networks. Some GPs claimed that patients lacked knowledge because they no longer had the benefit of older or more experienced people to call upon (see above). Another view was that people had erroneous or irrelevant ideas based on family health beliefs.

Some of the GPs had tried giving information leaflets to patients when they first registered with the practice, and sometimes when they felt people were making inappropriate demands. Others thought that such measures don't work, and that the only form of education patients would understand, in terms of using services appropriately at

the right times, would be to charge fees. One GP referred to how his patients are 'trained' when they join his practice, by making them aware of the costs incurred by using the out of hours service.

An interesting message that many GPs wanted to convey to patients was that there is 'no magic wand', that the doctor often has nothing to offer except common sense healthcare advice about how to make people comfortable, and reassurance. This seemed to me another example of how 'real' medicine is seen as something different from the routine work GPs do. GPs with this orientation could feel that it was a waste of everyone's time for patients to come in with symptoms for which there was no prescription or medical intervention needed. A more common 'package' was to explain why antibiotics should not be prescribed and putting an emphasis on 'self care', so that the patient would go home with the message not to come again with similar symptoms but to look after themselves:

Dr: One of the great educators is to examine the child and do nothing.

K: How does that work?

Dr: Well I think if you go and do a home visit on somebody who's got a concern, you see them and examine them thoroughly, and you give advice but you don't give a prescription, I think that's a good message.

K: What does the-

Dr: I think it's an educational message that if you get your child in the same situation again, that's what the advice is, what you need to carry out, perhaps next time you'll just do the advice without calling the doctor, whereas if you go and see a child with a bit of a temperature and a runny nose who's got a cold, feverish cold, and you give them an antibiotic, you're giving them the message, 'I was quite right to call out the doctor, my child needed an antibiotic, I'm going to go to the doctor next time.'

(GP 11)

Diagnosis was a central (inter)action of the consultations (see chapter seven), and several GPs expressed anxiety about getting it right, particularly over the telephone. The most common example given was diagnosis of rashes, which were regarded as useless to describe and necessitated being seen. Most GPs felt that very young children generally needed to be seen, because GPs claimed they could tell a 'sick' child as soon as they saw one, but I was not aware of the cooperative having a policy in favour of this. They felt they couldn't go by the carer's description, and had experienced going out to see a child

described as very unwell who appeared to be fine, but also, more worryingly, deciding to see a child whom the parents thought was not too bad who was clearly very ill.

Management of the risk of making mistakes differed in style amongst the GPs. Some took the view that you have to take decisions and stick to them, but be able to justify your actions. Others would not take any chances and before joining the cooperative, had high home visiting rates. Somewhere between these views was the argument that diagnosis required the use of logic *and* intuition, listening for clues from the patients or parents, and taking a careful history, and this called for skill and judgement developed over time. Some GPs felt that one of the problems with younger GPs was that they had never experienced being on-call for a significant amount of time, and had been 'mollycoddled'. They were seen as incapable of making decisions because they had only worked in team environments.

In the cooperative setting, it was stressed that an important part of the GP's job is to redirect patients as quickly as possible to casualty and other wards when necessary, not to 'sit on' patients. This was presumably for the benefit of patients as well as the efficiency of the PCC, and was facilitated by the fact that in this cooperative, the PCC was on the same site as a general hospital. On one particularly dramatic occasion, the paediatrician was summoned to the PCC from the hospital.

Although some GPs thought that it was a waste of time seeing people who needed no treatment, most of them recognised the value of reassurance (see chapter seven) and the need to rule out major illness when symptoms could not be understood. However, diagnosis was not always satisfactory to patients without further action, and in these situations further investigation or treatment that was not strictly appropriate was sometimes offered. One GP (GP 13) referred to this as the difference between 'textbook medicine' and how things work out in practice.

### **5.11 Doctor-patient relationships and continuity of care**

In section 5.9 I argued that the distinction between out of hours work as an emergency service and part of general practice could be seen as illustrative of two contrasting

orientations in general practitioners. This can be seen in the way GPs talked about the issue of continuity of care. The following two GPs, interviewed in my pilot study, have been referred to in section 5.9 as representing opposite extremes on the 'real medicine'/personal care continuum, and the subject of continuity of care brought out their different orientations in a similar way. To some extent this reflects their ages and the fact that they work in very different settings, although equally, they have to a large extent chosen working environments that reflect their orientations. The first is a young woman GP working in a large group practice in a densely populated mixed social area:

'I think people are learning, because I mean initially it was all this crap about, 'oh no, doctors have to do their own on-call, and continuity of care', and crap crap crap, and all the old people were really hanging on grimly to the tradition of being a doctor and looking after everybody, and now that cooperatives are up and running and people are being shown that first of all, you don't have to visit everybody who asks for a visit, you can do an awful lot of it on the phone, in fact 70% of patients are more than happy for you to talk to them on the phone. I would say that in the paediatric area, probably it's more like 80 or 90% of the calls just need some advice, they just need a bit of hand-holding and a bit of advice, or they can come down to the centre, you know.' (GPP 04)

The second, middle-aged male, GP (GPP 02) works in a semi-rural town. He had found that working in a group practice involved a lot of administrative time and liaising with partners and other members of staff that cut into time with patients, and that it was harder to get to know patients so well. For these reasons he decided to practice single-handedly, and for the first three years he did all his own out of hours work himself. His waiting room was more like the lounge of a country inn, in contrast to a modern health centre, with an atmosphere of cosy attentiveness. He thought that fear of complaints was an important factor in professional behaviour, and was responded to by many GPs by being over cautious, e.g. sending people into hospital for tests, whereas his philosophy was to insure himself by making the relationship more personal:

'I personally feel the best protection [against complaints] is actually not giving the impression that you don't actually care, or that you despise them, then you're in serious trouble. And unfortunately, the way general practice has gone for the last 15 or 20 years has actually begun to alienate the patient, you know, the formalisation of general practice and, you know, the days where patients would play practical jokes on the doctors, and vice versa, long gone.'

(GPP 02)

The issue of continuity of care reflected this general distinction in orientation amongst the GPs in my study generally, with the more technically-orientated GPs regarding continuity of care in the sense of having a personal relationship as an outmoded, old-fashioned concept, a 'fable'; while those with a more social orientation assumed that a personal relationship was best for both doctors and patients. Those who support the notion of continuity of care valued the role of the personal doctor and knowledge of patients and families, which they found contributed invaluable to the quality of advice they could give and saved a lot of time and expense. This was particularly true for single-handed or husband and wife partnerships. Loss of continuity of care was seen by this group as a whole very much as reported in the literature: a threat to a core value of general practice and to a key means by which GPs derive satisfaction from their work.

Those who were less wedded to the idea of continuity of care tended to be more concerned with what they regarded as the intolerable effects of rising, and they would argue, largely inappropriate demand on GP services. They saw out of hours work as a separate case from daytime work, maintaining that it is an emergency service and therefore continuity is not as important as dealing with immediate problems. But the argument many GPs made is that organisational changes taking place on this basis are undermining not only the principle but also the conditions necessary for continuity of care for daytime general practice as well.

It is important to note, however, that despite their different orientations on continuity of care, the majority in these different groups of GPs have joined together in their enthusiastic embrace of the cooperative movement for covering out of hours work. Cooperatives have been initiated and supported by the 'modernisers' because the cooperative system reduces what they regard as patient dependency on individual GPs or practices, but retains some constriction of demand, i.e. patients are triaged and access is controlled. Yet cooperatives have been welcomed by GPs who advocate continuity of care as well because they have facilitated a great improvement in quality of life within a generally more controlled context than use of deputising services, the most common previous alternative to 24 hour commitment. Working together with other local GPs means that they can have some control over the quality and ethos of the service, allaying some of their fears about inconsistency of advice and treatment. Feedback is built into

the system so GPs know who has seen their patients and what the advice was. These GPs were especially careful to support the authority of the patient's regular GP, encouraging them to see their own GP at the next available surgery time.

As an exception, GP 04 was perhaps unusually committed to continuity of care. Even though the cooperative had undoubtedly improved his quality of life, he was still unhappy with some aspects. He was unclear whether it would be triage nurses, the patient's GP, the cooperative GP, or the cooperative collectively who would be ultimately responsible for the advice given by triage nurses. But also, he said that when it was his turn on the practice out of hours rota, he didn't usually switch over to Nightdoc because he preferred to maintain a personal relationship with his patients and this was an important part of the satisfaction of his work.

Continuity of care under the system of 24 hour responsibility implies all of the points considered in the above section on time. In the case of this last GP, he gave me the impression of valuing relationships with patients more highly than most of the others in relation to concepts like having his 'own' time, even though he carries a heavy load of professional commitments in addition to those of his general practice and family. For him, continuity of care, like time, carried meanings which went beyond value in terms of efficiency.

## **5.12 GPs' opinions on the cooperative's system of nurse triage and advice**

GPs did not express strong views on nurse triage and advice but their comments reflected to a more modest extent their general orientations. The job oriented GPs tended to think that nurse triage was an efficient way of managing the mundane bulk of the work, especially since they were more likely to regard a higher proportion of calls as trivial. GP 17 thought that nurses using protocols were probably better at giving telephone advice than some of her GP colleagues or deputies, and some GPs admitted that they felt untrained to do telephone work. The more continuity of care oriented GPs thought doctors could have more input into medical problems, would be more confident and decisive, and 'would do a better job' than nurses, and GPs had the advantage that they could prescribe over the phone via a chemist.

Taking a middle ground position, GP 11 thought that some patients probably would prefer to speak to a doctor, but had an interesting view of the value of nurse advice:

‘I suppose the point is that firstly, hopefully they are experienced and know what they’re doing so from that point of view are unlikely to make mistakes. Secondly, the vast majority of patients who they speak to are not going to have life threatening illnesses, so whatever they say to them isn’t actually going to matter in terms of mortality or morbidity if they get it completely wrong, so they’d be unlucky to get it wrong on the one patient every week where it might matter. And in addition, even if they were seen by the doctor, you know, from time to time doctors will also make mistakes even if we go and see the patient. So, there are going to be errors, there are going to be catastrophes, me sitting here, with people going to visit, with telephone advice, but it’s all to do with risk management, and what people feel is reasonable, and is the risk going to be so much lower if all these people are seen. And the answer is [tisk], probably not that much lower. Maybe marginally, it’s all a gut feeling.’ (GP 11)

There were more opinions expressed about how nurse triage and advice was working as a system in their experience of the cooperative. Some had noticed the difference in referral rates and how busy or quiet it was depending on which triage nurses were working at the time. GPs were aware of plans to centralise the triage and advice for all four sites by having all the nurses working in a call centre, rather than working in the PCCs, and thought nurses might object to not having a GP on site to work with. This was because nurses would get no feedback from GPs on how they had managed particular cases who were subsequently seen, and would not be able so easily to check with a GP on any difficult cases, a view that some nurses did have. On the other hand, one GP thought centralisation would be better because she was worried about response times. Another thought that the advice was sometimes questionable, on the basis of what friends had told her about using the service. The accuracy of the call reports was criticised by several GPs, who read the call report before seeing a patient, to find that the patient presented a different story, or that other facts were wrong.

### **5.13 Observations from two nurse triage and advice study days**

I attended two study days for Nightdoc’s triage nurses. The first, which was also the cooperative’s first study day for nurses, was in July 1997 and was held at the postgraduate medical centre. My overall impression of the day was that it was a ‘rallying

of the troops'. There were about 45 nurses there, with a range of professional experience, from health visiting to A&E nurse triage. The day had been organised by the leading entrepreneur of the cooperative, who led the sessions. There were four invited expert speakers who spoke about their specialty and invited questions on triaging common problems. The nurses were given exercises to carry out in small working groups, and I was appointed a group facilitator at the same time as being introduced to the meeting. This meant that I got to know about six nurses as we worked through the exercises. It was also possible to talk to people at the tea and lunch breaks, and several of them introduced themselves to me and asked about the research.

There were two dominant messages put across throughout the day. The first was that triage calls should be completed in six minutes, with this 'ideal' referred to several times as a main objective for each nurse to take on. This was explained to me later as being the optimum time to keep calls down to because the cooperative's business manager had worked out that one nurse could handle the projected number of calls for the centre each evening if she kept them to that length. If they had to employ another nurse, the rate charged to each GP for telephone triage and advice would have to go up. The second message was that within each call where the outcome was for the nurse to give advice, they should incorporate education so that future calls could be prevented.

These key objectives seemed to have been 'bought' by many of the nurses: for example, they often incorporated them when they made comments and asked questions. Occasionally one or two questioning voices were heard, and at these moments I felt a ripple of tension around the room. An example was a discussion about how far nurses could go in giving advice, where the boundaries should be around nurses making decisions on their own, and at what point they should regard problems as being the GPs' responsibility. These more 'political' questions were not discussed fully, but it raised the issue for me of whether triage nursing was being seen at this stage as another professional resource in primary care, an adjunct to GPs, gatekeepers, or a new professional project for nurses.

The second triage nurses' event was held four months later in November 1997, and this time it was called a nurse training day. I was invited to attend by one of the Nightdoc

managers and a Nightdoc triage nurse who organised the day. By this time, I had been to the PCC for five observation sessions and knew some of the nurses from working with them there. The cooperative was developing rapidly and by then had plans to have a centralised triage call centre instead of having triage done at each of the four sites.

While people were arriving I talked with a new triage nurse who said she was finding learning about her new job quite difficult, especially getting used to the telephone advice support software (TAS). She asked about my research and another nurse joined us who expressed her resistance to pressure put on the nurses to be involved in research and to do further training. She said she thought of this as extra work which would cut into her other interests which she thought were more important. A little later she explained that she was very involved with her church and didn't like to have her spare time eroded because it was her time for doing church work. Her main paid work is as a school nurse, and she described how this service has been cut back by about 2/3rds since she started the work.

The triage nurse who organised the day first gave an introduction outlining what triage is and its history in Accident & Emergency Departments, where she still worked. She emphasised the view that triage nurses should build health education into their work because of the great degree of public ignorance. She said she had been to her hospital library and could find no research on telephone triage, so she encouraged nurses to see themselves in a challenging new role for which they needed to become more educated and research minded.

At this point there were about 25 people in the room, including nurses (all women), myself, two GPs and Nightdoc management staff. We were asked to get into pairs and discuss what sort of conditions should go into each of three categories: immediate, urgent and can wait. Then the organiser used a flip chart to write down some of the conditions she would put into each category and added other people's as she went along. This generated some discussion about the lack of protocols on particular subjects (not covered by TAS) or aspects of Nightdoc's work and how some people wanted more of them, but she said, 'we have to decide on our own, we have to do it ourselves'. Another issue was whether the calls shown on the screen should be taken in order or whether

nurses should pick out those in particular categories, e.g. chest pain, or children under five. This caused some debate, because at one branch it was thought that the receptionists had prioritised the calls, and one nurse reported being told off for taking them in a different order. It was suggested that during the day people should raise any of these 'hot topics' so that Nightdoc could address them and improve their work.

There followed a talk by a leading Nightdoc GP on existing research on out of hours issues. He prefaced this with a 'pep talk' about how nurses at Nightdoc were on the cutting edge, that this was why there were no clear guidelines, but this should be seen as an advantage because they could decide the shape of their future work. In 5 year's time, he envisaged, there would be 100s if not 1000s of places like Nightdoc, and then there would be established training etc., but at this stage, they had an opportunity to be in at the beginning. The GP then gave a history of the background to setting up the cooperative with an emphasis on the issues for GPs and the mechanics of telephone advice and setting up the cooperative. He outlined current research on the cooperative, and I was slightly alarmed to hear my research described as follows:

'Kathryn Ehrich's research is useful because if we can find out what is motivating parents, we can whack them with education about things like meningitis. Compared to people in the USA and Canada, the UK is not as informed about health because people don't have to pay.'

In the discussion following his talk, there was a great deal of response to his reference to patients making inappropriate calls. Nurses told 'atrocious' stories about the things people phoned A&E departments about, and they thought the vast majority was 'rubbish'.

There were further talks given by experts on paediatric breathing difficulties, tele-medicine, heart attacks, communication skills and complaints. The latter two were interesting because of the discussions that followed them. After the communication talk, which emphasised active listening, a nurse asked what to do about 'income support mothers' with no transport or money, and no medicines at home, who phoned for visits. The response was that these were social problems, and nurses should recognise their

boundaries. A Nightdoc GP manager said that letters would be sent out admonishing such patients, and the discussion turned into a general airing of grievances against certain kinds of parents.

At the close of the day, future plans were discussed, especially the plans to centralise nurse triage and advice for the four PCC sites by having them work in one call centre. Nurses expressed disquiet about not having doctors on hand for advice, and receptionists not having back-up from nurses. They also liked having a chance to see the patients they had spoken to on the telephone, and needed feedback on their decisions as part of their ongoing training. Some nurses wanted to know what doctors had said about them, what they thought of their role. They wanted clearer guidelines and goals for the outcomes of calls, and there were concerns about how to handle demands for visits. This discussion became quite noisy, with patients referred to as 'prats', and jokes made about advice to give: 'no antibiotics and piss off'. The meaning of this was unclear to me. It could be that nurses enjoyed letting off steam amongst colleagues, because in their working role they had to adopt a more caring attitude. Perhaps they also wanted identify with a kind of informal group 'macho' stance towards 'inappropriate' users in a similar way to that which I had observed amongst some GPs, for example at the cooperative's annual general meeting.

#### **5.14 Nurses' comments from observation sessions**

At the end of one of the observation sessions, a triage nurse talked with the GP for about 10 minutes, because she likes to get feedback on her work. When she was ready to go she asked if I'd like to talk some more so we did so while she had a cigarette outside before going home. She thought Nightdoc was a great thing that should have been set up years ago, and described herself as a big believer in Nightdoc, because it took the load off casualty departments. She was interested in this aspect because she had worked for many years as an A&E triage nurse, which was still her main job. I asked why they wouldn't have two triage nurses per session, since she was clearly working flat out to get through all the calls. Her first reaction was to say 'I handled them!'. perhaps a little defensively, but then she explained that Nightdoc had to break even, because doctors wouldn't want to join the cooperative if the costs were not kept down.

On another evening a rather different triage nurse (TR 04) was on duty, who I remembered from the study day raising issues about nurses taking on more decision-making. During the evening a call came in from a depressed young woman who was already under the care of the local mental health crisis team. The caller was feeling suicidal and wanted someone from the crisis team to visit her, but they wouldn't go out to her unless a GP referred her to them first. She said she didn't have enough money to come to the PCC, and the doctor on duty didn't want to see her there if she was demanding a visit. In the end a deputy (contracted by the cooperative) was sent to her, but the nurse was very annoyed about what she regarded as 'red tape' in this case. Her argument to me was that the deputy GP wouldn't know the patient, and this would compromise patient care seen from her position as a nurse, and she wanted the crisis team to accept her judgement that the woman should be visited. She contrasted markedly with most of the other nurses I observed, because she appeared to have a view of her role as a triage nurse as much more independent and professionally autonomous than the situation allowed, whereas the other nurses worked very much within the expectations defined by the cooperative.

Triage nurse TR 11 talked about her first year working at Nightdoc. She had become more firm with patients about home visits than a year ago, and she thought they could tell it would be harder to get one now. She didn't like the idea of centralised triage, because she preferred working on her own on the telephone. She had worked on a project developing triage in the ambulance service and found it too noisy working with another nurse.

Centralisation was not favoured by triage nurse TR 13 for similar reasons to those already given: she liked asking GPs about things, to know outcomes, and get feedback on what the doctor thought in certain cases. In short, the present system offered a 'learning tool'. She also talked about how some people use the service 'so inappropriately'. An example she gave was a man who phoned about his daughter, who had been vomiting earlier in the week, then had diarrhoea, saw her own GP during that day but was vomiting again so the father wanted a home visit. He refused to bring her to the PCC even though they lived very nearby. In telling this story, she gave no explanation as to what specifically made it inappropriate to ask for a home visit, except

for the family's proximity to the PCC, but her body language, in addition to her original description of the case as 'so inappropriate', made it clear that she regarded the man's demands as unreasonable.

However, her following comments perhaps shed some light on this. She said the pressure of six minutes limit on calls meant she had to cut people off from talking at length about why they want home visits, so eventually she just has to give in. She wasn't so aware of the six minutes target at the beginning of working there as she was when she talked to me, so perhaps the pressure to achieve this had increased, or she was made more aware of it for other reasons. At the nurse triage study days, the six minute target appeared to be part of the 'company credo', but so too was the need to avoid home visits, especially for children, and the nurse just referred to seemed to have been caught between the two imperatives (see appendix 2, a discourse analysis of a nurse triage - parent telephone conversation).

Originally I had hoped to have more information about the part triage nurses play in the construction of appropriateness of demand, but as it turned out, it was impossible to obtain all the telephone recordings I had been promised as part of the study design agreed with Nightdoc's research board (see section 4.6, chapter four). From the recordings I did get, and the conversations I had with triage nurses, it became clear that the study would have been better balanced with more input from nurses, and I maintain that further study of this important part of out of hours care is warranted. However, the significance of the role of triage nurses at the cooperative is represented more substantially in chapter seven where I focus on processes and interactions in the observation sessions.

### **5.15 Conclusion**

In this chapter I have reported the views of GPs and triage nurses from interviews, informal conversations, statements made in meetings and in the e-mail discussion list GP-UK. In none of these situations were patients (or parents of patients) present. Some of the remarks made by both GPs and triage nurses would probably be offensive to patients, and as a mother of a child who was under five years old at the time, part of me felt

dismayed that 'people like me' had to put our trust in people like 'them'. I was critical of some of their intolerance of and assumptions about particular groups, and what I saw as a 'victim blaming' attitude, for example that people who are poor have a 'dependent' mentality, or that parental anxiety is 'neurotic'. I was also sceptical of the blame cast on what I saw as simplistic explanations for demand, such as the loss of family and community resources for educating parents, and consumerist attitudes. As a parent, I felt patronised by the approach some GPs took to patients in the name of education.

At the same time, another part of me felt sympathetic to their problems. I too had done work which required me to visit people in their homes in the evenings, located in places that I didn't know and didn't like, and could understand that it is not so much the actual work but the conditions surrounding it, including what is perceived as inadequate pay, that can cause stress. I had also worked in places where the 'users' were sometimes characterised as the 'other', if not the enemy. Like most people, I am caught up, however unwillingly, in similar ways with the monetary and symbolic value of time, and I know that when people feel relatively powerless to change situations in which they feel unrewarded, they often take out their frustrations on less powerful people, simply because they can.

It is easier to admit to and display such feelings about 'other' people as groups than individuals, perhaps because there are usually individuals in any group we particularly like. This was probably as true for me about my research participants as it was for them about their patients: the majority in fact are very likeable. It was interesting, however, that GPs (nurses not so much) strongly represented themselves as individuals, and this has been noted as, paradoxically, a common characteristic of those who choose to go into general practice. Joining the cooperative therefore poses difficulties for those who feel critical of, or restricted by the practices of their colleagues, and there seemed to me to be broadly two groups: those who saw themselves as 'real medicine' or job-oriented, and those committed to building long-term relationships with patients. The former were all for routinising primary care, including the development of nurse triage and advice to deliver a more efficient system and to cut down on the number of calls they felt it was not appropriate for them to deal with out of hours. The latter were concerned that the cooperative would cause a further erosion to continuity of care, seen as a core value of

general practice, especially if they had not been using deputies prior to joining, and the loss of a different kind of 'efficiency' brought about by knowing patients and forms of practising in the daytime which cut down on out of hours demand.

The benefits for the majority of GPs who spoke to me in joining the cooperative were enormous, and this was an almost unanimous feeling. Moreover, the majority of GPs in the geographical area covered by the cooperative had joined it. In some ways cooperatives offer a form of contact with colleagues that seems ideal, because their daytime arrangements can remain relatively independent, yet they gain so much by sharing the 24 hour responsibility to provide a service to patients.

Many of the views expressed in this chapter reflect those reported in the literature reviewed in chapter one because they are based on the experiences of GPs before they joined the cooperative. However, taking their comments over a broader range of issues into account, including their perceptions of patients' (and parents') beliefs, behaviour and attitudes, and putting these in the context of their own professional and personal experiences of being a GP both before and after joining the cooperative, it is possible to make some further conclusions about how they constructed 'inappropriateness' of demand.

An important point is that it was not children but parents who were seen as the inappropriate users. This may seem obvious, but it is often taken for granted that children under five are not influential or responsible in relation to their own healthcare. In fact their only agency in this context seemed to be a prompting one, so that although children were present, they effectively had no voice of their own. It may be that a comparison between the ways in which children were regarded in the consultations and their interactions and behaviour at home would reveal considerably more agency in their own environment. This might also further illuminate the position of parents in negotiating between doctor and patient.

The focus on out of hours care was chosen because of the stress placed on this aspect of the conditions under which GPs work in their recent complaints featuring inappropriate demand. In my analysis I have argued that time was especially problematic as a signifier

of value. Time spent working at night and on weekends interrupted GPs' personal and family lives. For some GPs this represented an unacceptable intrusion, with resentment compounded by feelings that it was not possible sufficiently to enforce a boundary between work and home, and that patients were taking something away from them that could not be compensated for purely through financial means. These intrusions could also be interpreted as an affront to their status, because they usurp the power that people of rank have in the past derived through having the *choice* whether or not to give of their time.

Some GPs have seen a perceived loss of status as supported, for example, by the ethos behind the Patients' Charter, and a consumerist patient attitude attributed not only to previous Conservative governments, but also to the current (New) Labour policy makers. At the British Medical Association's annual conference (2000), GPs attacked the introduction of walk-in centres, calling them 'short term consumerist initiatives' (Carvel 2000:9). This points to a contradiction in policy, because the 1995 changes to GPs' contract gave support to those GPs with a 'real medicine' orientation who reject patients' out of hours demand when it is judged not to be purely clinical. Who, then, is to be the arbiter of appropriateness in requesting out of hours healthcare?

Introduction of the system of nurse triage pioneered by this cooperative, and now used as the basis for NHS Direct, can be seen as diffusing or solving this question, depending on one's point of view, and I found the situation of the triage nurses intriguing. Some nurses seemed to be surprisingly willing to adopt the position of 'handmaidens' to medicine that others have rejected. A few were clearly involved in Nightdoc because it offered them a potential basis for creating a new role as part of nursing's professionalising project. Indeed, subsequent developments - NHS Direct and walk-in centres - have opened up such possibilities much further. This is an area for further research, and I would argue that investigations need to focus on the interprofessional issues raised here, and not in simple terms such as how many GP hours are saved by giving patients nurse advice. Some of these issues will be addressed again in chapter seven. In the next chapter I will present the views of 'the other side', the users of the primary care centre.

## Chapter Six

### THE VIEW FROM THE 'USERS'

The data presented here are taken from 16 home-based interviews and a discussion held with a group of parents at a health visitors' mother and baby clinic. On all these occasions I encouraged parents to comment on any aspect of their experiences of healthcare for their children that they wanted to talk about. Sometimes they had their own agenda, and I only asked specific questions to probe on areas they hadn't raised. The general areas I tried to cover in the interviews included an idea of who they saw as constituting their family, what sort of knowledge they had about children before having their own, and who had helped them with advice and support since having the children. I asked them about their experiences of healthcare in general, out of hours GP services, and about using the cooperative on the occasion I had seen them there, as well as any other times they could recall. Most interviews lasted between one and two hours.<sup>1</sup>

The flow of the interviews was different in each case, and I was interested to see what parents would bring up unprompted. As in the interviews with GPs and nurses, parents' views were not homogenous, and I will give broad indications of how widely held were the opinions reported here. The mother and baby clinic discussion group was arranged through a health visitor who asked mothers who attended the clinic if they would like to take part, and about 12 mothers attended. The health visitors were there throughout the session, and we talked for about 45 minutes. Comments made in the discussion group will be attributed to DG.

#### 6.1 The constitution of knowledge

Parents had gained knowledge about child healthcare from a range of sources: their own mothers, books, health visitors, commonsense, and friends. Interestingly, no one mentioned learning about child healthcare from their doctor, despite the centrality of GPs

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<sup>1</sup> See the full text of an interview with parents in appendix 4.

when I asked about sources of advice on symptoms of illness (see next section). For some parents, the amount of knowledge needed came as 'a shock' (P 08) when they had their first babies. The helpfulness and availability of advice from midwives and health visitors varied. Some health visitors were 'too busy' (P 04), or gave mothers more attention for the first baby than subsequent ones (P 08, P 11). The discussion group put forward the idea that it might be helpful to be taught first aid in antenatal classes.

Parents had developed knowledge with experience concerning common matters such as how to lower temperatures, the use of antibiotics, vaccines, and how to treat minor viruses. This knowledge was paired with knowledge of what was normal for a particular child. For example, one mother described how, given certain symptoms, she would now demand a nebuliser straight away for one of her children, because of her experience with that child's previous asthma attacks (P 09), which was not the case with her other children who also had asthma. One parent felt that 'you have got to know yourself what is wrong with them and demand that something is done' (P 04).

Acquiring knowledge could be problematic because many parents felt they could only get an incomplete understanding. An example of this was over the question of MMR vaccines. One mother had been sure that the convulsions her daughter had suffered as a baby were linked to her MMR immunisation, but was unable to get a satisfactory answer from her GP about it. She felt her enquiries were 'fobbed off' (P 12) by the GP, but that as a parent she was ultimately responsible for her child's health so she wanted to be properly informed. A very common dilemma was about the use of antibiotics and parents' inability to gain information which gave them certainty about when they should be used. The following comments, which illustrate this complex problem, are taken from an interview with a mother who had brought her toddler into the PCC with an earache:

'M: She had had the flu for about a week and then after that an earache developed and then we went to the GP... Dr X said it may be due to the flu, the ear is aching but if you think a secondary infection is coming then bring her later on... But the following night I think probably the earache got worse and she was crying, she was putting her head down on the carpet and she was crying a lot, so my husband thought it was better to take her to emergency. so we brought her to [the PCC] and then they gave her antibiotics and she is alright.

K: Right, so you said you took her to the doctor, was that in the daytime or the day before, and did they say just leave it for the moment?

P: Yes because they say that some children 2 to 5 years, when they have flu they have ear infection, it may be caused by a virus. So antibiotics don't affect a virus, only a bacterial infection. So if the cause is a secondary infection then could I bring her for some antibiotics. So it is better to take her to emergency and get it over with because if she gets bad the sooner she will get better.

K: So you thought the sooner you get her started on antibiotics the better?

P: Yes, if she had started before she would have been better now, wouldn't she? I don't know, the doctor thinks that with the viral infection you don't give the antibiotics nowadays, this is new isn't it?

K: I think the doctor is saying that if the infection is caused by a virus then the antibiotics won't work, they only work on a bacterial infection.

P: Yes, so she wasn't sure whether it was viral or a bacterial infection.' (P 16)

What was clear in this case and typical of the comments of many other parents was that parents understood the argument that antibiotics only work on bacterial infections, but have no way of knowing whether an earache or other symptoms are being caused by a viral or bacterial infection, or if what starts as a viral infection develops into a bacterial infection, and so on. In this case, the mother thought the GP wasn't sure either.

These problems around antibiotics could be interpreted in terms of what Baruch (1981) referred to as the existence of two 'realities', 'parental' and 'medical'. The GP's criteria for treatment are embedded within a biomedical set of assumptions and objectives including the individual and population level dangers of overuse of antibiotics, while those of the parents have to do with the moral imperative of asserting their parental duty to protect from suffering: in this instance, achieving as speedy a recovery as possible. When the risk of harm is not obvious to parents on the level of their particular child's case, the question of whether antibiotics can be medically determined to be appropriate seems to be of secondary importance to the chance of speedier recovery.

However, in the case just referred to, what was also interesting was the process by which the parents negotiated the system. Having been told by their GP to wait and see if the earache got worse, they decided the next night to go to 'emergency' to 'get it over with because *if she gets bad the sooner she will get better*' (my emphasis). This indicates that the GP's strategy of asking the parents to wait and see was unsuccessful because they had no way of assessing what caused the earache symptoms and they didn't see the point

in 'wasting time' if they were going to end up using the antibiotics anyway. As the antibiotics were eventually given, and the earache went away, the parents thought it was the antibiotics that cleared up the infection.

In situations where parents found it difficult to get clear information, it became a matter of whether they trusted the opinion of the person giving advice, and trust depended on a range of factors other than knowing if the information was 'correct'. A major factor was gauging the educative message against their own experience and existing knowledge. If as in this case what they were told couldn't be made sense of in this way, they were unlikely to make use of it. All of these issues illustrate how successful education depends on recognition that knowledge is created in negotiated interactions.

## **6.2 Parents' sources of advice and support**

A theme that overlapped with knowledge was the question of from whom parents sought advice and support during episodes of illness or for worrying symptoms. Some parents expressed the view that they would like more help to be available from midwives, health visitors and practice nurses, but that health visitors in particular were too busy, did not give helpful advice, or told them to see the doctor about anything other than simple healthcare.

Most parents said that although they appreciated practical support from relatives and friends, they felt the doctor was ideally the best person to give them advice about any symptoms of illness, because their relatives and friends had a mixture of opinions, their experiences and children were all different, and the doctor's professional opinion was based on expert knowledge. It should be noted that when asked from whom they had learned about healthcare, none of the parents mentioned their GPs. Several people described being put under pressure by relatives to seek medical advice, so that although they had plenty of contact with their relatives, this did not mean they were less likely to go to GPs than those without so much contact.

Some parents had relatives who were healthcare professionals, but did not rely on them as a primary source of advice, either because the relative did not want them to, or

because they were given too much advice and felt they should prioritise opinions in favour of their own doctor. I think all of these points challenge the assumption of some GPs that 'breakdown of extended families' is a major factor in parents making inappropriate demands for their services.

### **6.3 Parents' atrocity stories about healthcare**

When parents talked about their sources of healthcare advice, it often led to their recalling significant events in the past which had shaped their views. For nine out of the 16 parents or couples interviewed, and some of the mothers in the discussion group, this took the form of 'atrocity stories' (Stimson & Webb 1975, Baruch 1981), and some of them had more than one to tell. The stories seemed to share a broadly common theme of doctors or receptionists not taking parents seriously enough, not agreeing to come out<sup>2</sup> or give an appointment, or the parents being kept waiting for someone to call or phone back. The parents typically had to take unusually assertive action whereupon it was discovered that the child was seriously ill and had to be admitted into hospital. The doctors in these stories appear in various forms: incompetent, uncaring, or fobbing the parents off. The parents are portrayed as having had to fight for attention and to be taken seriously, with subsequent events vindicating actions that might otherwise be seen as excessively demanding.

The stories attach blame on the doctors and virtue on the parents, but if the situation was as clear cut as that, one would wonder why people continued to consult doctors when so many atrocity stories are told. Baruch (1981) shows how parents, in their interviews with him, attended to 'the issue of their appearance as moral persons' (p. 279) by demonstrating that they have lived up to expected standards in caring for their children. Consulting doctors when they are reasonably worried is one such expectation, in which the limits to parental competence are also defined (p. 281). The atrocity stories explain why parents found particular doctors or their actions deplorable, yet their expectation is to consult GPs as a profession because their opinion is given priority over those of family and friends, in relation to illness if not to general childcare issues.

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<sup>2</sup> See a long example in appendix 4.

It is important also to look at the changing nature of people's relationships with GPs, and the tendency of both patients and GPs to try to smooth over conflicts and support the continuance of good relations even in the face of quite serious disagreement (Hill 1998). One mother told me an atrocity story concerning her first child which culminated in a life-saving emergency operation after many attempts to get her GP to take her concerns seriously. She has been registered with the same GP since she was five years old and remains on his list.

'K: Gosh. So, so after that did you address it with the doctor or anything?

M: Oh I remember so many things being said, oh that you should take the doctor to court and stuff and I was thinking, you know, I mean I don't know if wind is, if it was the same symptoms as bowel problems or whatever, I mean I am not to know. Yes, they are the professional and the fact of, you know, I know it wouldn't have cost me any money cause being unemployed, looking after a baby, you know, you would have help and that, but you know doctors and all that, you are supposed to respect, they are meant to be up there literally, not next to God you know, they are life savers and you don't want to knock them down or, you know, they say better the devil you know than the devil you don't.

K: Mmm. Cause you feel like you had to keep working with that doctor so you didn't want to make it difficult?

M: No, you have got a choice, don't you, you don't have to be with that doctor, it's just like being with a new mate, you don't want him to see your body straight away do you, you know. It's harder to take a doctor to court you know than a stranger, you know, there's loads of things that make you don't want to change your doctor, you know, yeah.' (P 11)

Later in the interview she mentions that she will get her boyfriend to take her younger child to the doctor because she thinks the doctor will look at her as if she is stupid or over anxious, and I ask her what she felt she would lose if she changed to another doctor:

'M: Probably wouldn't lose anything really, but it's just getting to know another GP all over again, you know, and the fact that, I don't know if they ask you questions if you change, but I would hate to have to say that I didn't have confidence in my last doctor to another doctor in case they think I might be a bit of a trouble-maker or something, you know.' (P 11)

I had the sense in this account that the mother saw herself in a vastly inferior position to the doctor she had seen since childhood. It was as if he was a senior member of the family, someone whose knowledge and status are superior and to be respected, and that

if she complained about him to another doctor, she, rather than he, would be seen as the source of the trouble. Perhaps most interesting was her comment 'it's just like being with a new mate, you don't want him to see your body straight away, do you'. This statement, equating the exposure of her body to a doctor with the same act but in an intimate relationship, was embedded within the broader context of her position of powerlessness. It seemed to me a deeply gendered portrayal, not of an abusive relationship, but certainly one which resonates with accounts from women and children who have been abused. Such accounts often report feelings of powerless in relation to the abuser, and not being able to tell anyone about it or get away from the person.

It seems likely that in their interviews with me, parents found telling the atrocity stories referred to here an important means of constructing themselves as moral and responsible persons. Having first met me in the context of their GP consultation at the PCC, they may also have wanted to establish their credentials with me, in the sense of Baruch's distinction between parental and medical 'realities', supporting their opinion of doctors with the weight of their own experience. But equally, the stories had the character of having been told many times to others, so that I don't believe they were constructed just for me even if they were constructed in a particular form for me. They seemed to me to come from a repertoire of credible information, a kind of accepted currency in the social world of families, friends and everyday life in which parents are held ultimately responsible for their children's safety and well-being. Thus the atrocity stories were also about possibilities of blame on themselves. In the next two quotes, both mothers are concerned that in spite of their best efforts - by using experience to deal effectively with high temperatures, or by providing an organic vegetarian diet - it may not be possible to avoid blame if their child became ill:

'A lot of these things have got to do with temperatures. I don't know whether that's because of my previous history with my children. But even then I did what I could for her which they assured me I did everything right, and she got to that stage where I tend to think even if you know what you are doing, children can get to a point where they are really ill. You don't want to let it get to the stage where you blame yourself for not doing the right thing.' (P 12)

'M: I actually be careful what I'm saying, not interfering [with how her relatives live]... I say of course it's their business, and of course I think the same response

from them, not to interfere mine. But they do of course, they all do. They say 'Oh, but the red meat has lots of iron in it.' Of course, I know, but - and that's why I'm so worried if something goes wrong with [her child], it's all my fault! You understand? Oh, it's all me then.

K: You feel they're going to say -

M: 'You see!' Yes. Of course, they wouldn't, of course, because they might be nervous, but they would be thinking. Actually my mother would say something. Yeah, no, because we are doing lots of things different from the others, maybe then they think if something goes wrong, it's because of what I chose to do... Yes, I think my mother would dare to say it, but the others, they wouldn't dare.'  
(P 14)

It is interesting that the first mother works as a childminder and talked throughout the interview about her responsibility for other people's children, which seemed to me to relate to Douglas' (1992) individualistic type which rested on a system of compensation. The second mother, who had grown up in a close Mediterranean family and had married into a large Irish family, seemed to anticipate the kind of blame more related to Douglas' moralistic, community type.

#### **6.4 Reasons for calling the out of hours service and attending the PCC**

The parents' interview accounts usually referred to an initial concern about the child, being worried, monitoring the situation and then reaching a point when they needed to consult a doctor or to find out whether further action seemed necessary. They described symptoms they had noticed but, in contrast to the transcribed telephone triage conversations, they did not go into nearly as much detail, probably because the purpose of our interviews was different and I did not probe them further. The symptoms were described more in terms of setting the scene for their own subsequent actions and decisions to call the GP out of surgery hours.

As noted earlier, sometimes relatives and friends were consulted and their response was to urge parents to have the child seen by a doctor:

'I had taken her to the doctor that day and they said she was fine so when I came home and she was progressively getting bad, because I had taken her to the doctor I thought, well, the doctor said she's fine so, you know, and me husband was gone out that night actually, and she was lying here and she was in a bad way

really. So I rang somebody and said listen to this, and what does this sound like, and they sort of, 'God, like take her straight away'.' (P 09)

'A fortnight ago I went to the doctor and said 'I am really worried, it is not normal.' My dad saw it and my dad said that it was not right either.' (P 04)

Some of the reasons people gave for using the PCC were strategic. Parents weighed up the pros and cons of using casualty, often opting for the PCC because they would have a shorter wait, but also because they judged the problem not to be a life-threatening emergency. Other strategies included using the PCC in the evening because they didn't want to wait and then have to call a doctor at 2am, or mothers waiting until their husband or partner came home so that they could discuss what to do. Some GPs interpreted this as deliberately not going to the surgery so that they could try to get a home visit or come out later with their husbands in the car, but my impression was that they were just uncertain how serious the symptoms were, that often they were very busy during the late afternoon and early evening with older children coming home from school and a meal being prepared, and that symptoms became much worse in the early evening. The one exception was a couple (P 03) who told me that their daughter had frequent episodes of tonsillitis for which they believed she needed antibiotics, but their own GP disapproved of antibiotics. They had therefore used the cooperative previously on more than one occasion to get them for her.

A very common reason for calling was concern about small babies. In the discussion group, the mothers all agreed that their babies were small and vulnerable, that things can escalate very quickly and get out of control, and therefore they wanted immediate help. High temperatures in small babies were a particular point of concern for many parents, and some of the mothers had knowledge of their own or other people's children having had convulsions or fits associated with high temperature.

A concept that parents referred to throughout the interviews was the reassurance they gained from having their child 'checked', which has the specific meaning of a medically trained person carrying out a physical examination to exclude any serious illness. It could be used in a slightly different sense, i.e. that reassurance could be possible over the phone if the parents were 'just checking' about something that they were really fairly

confident about (as in the fourth example below), but the usual use of the term meant they would not be satisfied unless the child had actually been seen.

‘I think a lot of people take the view, especially with a little child, one thing is they say they want a doctor to just check because although you can say it is nothing to worry about, as a parent you are looking [...] which is a very different thing than knowing there is nothing serious [...] and I don’t think, I think a lot of times doctors don’t see that.’ (P 01)

‘I want her to be examined, I want them to look at her and say, you know, like look in her ears, look in her throat, and say there is not anything, there is no infection, no you have got nothing to worry about. But when they don’t look at them, I mean they can’t say, I mean maybe they know just by looking at them there is nothing wrong with them, but to me I don’t think that is thorough enough.’ (P 04)

‘I know how to deal with temperatures but it is reassuring that someone has checked. They said he hadn’t got a chest infection... I have taken him three times before thinking it’s gone onto his chest... I won’t take any chances with them when they are really young as well, that’s why I want the advice from a professional service. That is what I expect. Babies can’t speak for themselves. I want them looked after by someone that can reassure me and knows what he’s doing... if it was something to do with a temperature or a rash, no, I would not be happy just talking to a GP, even my GP, I want the child seen.’ (P 12)

‘I though it would be best to just get it checked out, you know, so I just rang the clinic.’ (P 09)

‘Checking’ seemed to be a crucial concept to parents and it is interesting to consider how the importance of this specific kind of reassurance assumes a number of other things I have already mentioned. It assumes that the doctor’s expertise on the determination of the cause and seriousness of symptoms is taken as authoritative; that parents also have knowledge about both healthcare and their own child which they have put into use up to that point, and in deciding they should seek expert opinion; that checking will to a large extent absolve them of guilt if their child is indeed seriously ill, because they have carried out their parental duties correctly by recognising the limitations of their own competence.

Reassurance made parents able to cope with their child’s symptoms even if there was no other treatment:

'M: I felt more confident in [the cooperative GP] cause she did give her a real look over and I did go home feeling pretty satisfied cause after all [her daughter] was a lot better anyway.

K: So was it the fact that she did all the checks that made you confident or-

M: I didn't have to ask her to do anything, she just done it you know, whether she knew what she was looking for or whether she was looking in case it was an ear infection or, or any sort of sign of anything that could be sort of wrong that would have made her scream like that.

K: Did she give you anything for [daughter]?

M: Aahm, no, no, no she didn't, cause I had Calpol at home cause I think she asked if I had some.' (P 04)

When parents were seeking reassurance and did not feel reassured, even if the child was 'checked', it was a major disappointment:

'K: What were you hoping for?

M: I was hoping for someone more professional, um, [the cooperative GP] seemed to be as if he was, he'd just come out of a pub, he was just so cocky. I didn't like him, I didn't really trust him.

K: Right

M: I would have preferred someone to be more professional, as I've said, and um, caring and like, *putting my mind at rest*...

K: Right, and he didn't do that?

M: No

K: So, did you feel that he had actually checked [her son] over enough to make you feel that he was alright?

M: He did, um, well, I thought to myself well he must be the doctor so I've got to take his word for it, what else can I do? You know, he's checked him over, he's you know, I can't, I wanted a second opinion but I thought, I just thought, ok, he says he's ok, so what he says I've got to take as gospel sort of...

K: And when you left there, how were you feeling?

M: I was feeling really upset, and I came straight back here, and I phoned my Mum, my friend had already phoned up from hospital to tell her the situation ... [refers to GP's comments and compares him to hospital doctor who had said immediately after his birth he was in perfect health]

K: Right. So then, when you got home, were you still worried, just as worried about his actual health as you were when you went out?

M: Yeah

K: So what did you do then?

M: Well I just, I didn't phone [the cooperative] again because I just thought that I'd just been let down, so what was the point in phoning them? And I thought to myself, if, I'll see how he is through the night, and keep an eye on his nappy and... then I'll, then I thought well there's an emergency doctor service at the medical centre on a Saturday morning 9 till 10, so I thought I'd take him there because I do trust the doctors. I've been with the medical centre all my life.'

(P 06)

Several parents mentioned trust as a factor in whether they were satisfied with their visit to the PCC. In order for them to be reassured they needed the child to be 'checked' but also they needed to trust the opinion they were given as a result. Linked to this was the preference many parents expressed to see a GP rather than have nurses give them advice. However, this may have been more to do with the fact that parents want children seen, and as nurses gave telephone advice and GPs tended to see patients (although GPs sometimes also gave telephone advice), the preference was not so much for a GP rather than a nurse, as it was a choice for the child to be seen, whether it was by a GP or a nurse. Some parents were happy with nurse advice, especially when it seemed to be that they were 'just checking' something, and were therefore content to have phone advice rather than having the child more thoroughly and physically 'checked over'.

Looking at the parents views alongside those of the GPs reported in the last chapter, we can see that (with two notable exceptions) they tend to agree about the importance of seeing young children rather than giving telephone reassurance if the parents are really concerned. If the parents are fairly confident and are just wanting their own opinion confirmed, telephone advice would seem to be acceptable to both GPs and parents, although some GPs were particularly irritated with this type of call because they felt parents should only call if they were really concerned. The significance of this is that this cooperative pioneered nurse triage to deal with such calls, whereas many other cooperatives rely on GPs to take all the calls. It may be that more parents would be reassured by speaking on the telephone to a doctor rather than a nurse, or would accept having a child seen by a nurse, but my data cannot answer those possible questions. It does seem, however, that the acceptability of nurse telephone advice depends upon also having the option to have a child seen and 'checked out'.

Another reason people gave for using the out of hours service was the difficulty they had in getting appointments during the day (see next section), which reflects what some of the GPs said about organising their daytime surgery to make it less likely that people would have to resort to an out of hours call.

## 6.5 The constitution of appropriate demand

In reporting parents' views on the issue of appropriateness of demand it is important to note that I did not raise this as a specific topic in the interviews, but drew out any discussion that parents initiated which seemed to be relevant from my review of the literature. Since the interviews were jointly constructed, my influence on what was discussed may have been more significant than I would have preferred, but as far as possible, my intention was not to stress the concept of inappropriateness. This strategy was taken to avoid my putting across an emphasis on the topic because I wanted to elicit spontaneous references to it from parents, to find out how important the issues were to them, and how they framed them. As a result, many of the comments were embedded within discussion of another topic. Another point for explanation is that in one sense I am arguing that all of the topics identified so far have a bearing on the issue of appropriateness of demand because they give contextual information and present the larger picture. In this section I have organised the material to address the issue more narrowly, that is to include comments that seem to correspond with those made by GPs in our interviews and in the literature, and seemed more specifically to illustrate this concept.

It became clear that parents' experience of how their demand was perceived by others, and what they themselves thought was a legitimate use of the out of hours GP service, were markedly different. They seemed to have far more experience of being made to feel that their requests for help were inappropriate than of being asked how they thought their needs as parents of young children should be met. Comments on the former came more spontaneously, while the latter had to be more actively encouraged.

To take inappropriateness first, most of the parents made reference to people in general calling doctors out for non-emergencies, and some had direct experience of being told they should not have used the out of hours service:

'You think twice before you call them out. I know some people call them out over silly things, you know, I do try not to.' (P 02)

'M: I got told off by my GP for taking her there [to the cooperative] because there was nothing wrong with her.

K: What, you mean after your visit to [the cooperative] your GP said something about it?

M: Yes, he said I should not take her there.

K: Really, so when was that, did you take her to the GP?

M: I took her to the GP with chicken pox and he looked it up on the screen, it all comes up on the screen you know, what you have been up to and what appointment you have made, and it said 'visited the [PCC] clinic with sore throat' and he said 'you should try and visit us during the day'... and I think the whole thing together has put me off going back to [the cooperative], you know, I would go to casualty, they are not going to start having a go at me.' (P 04)

'[Mother talking about how good her group practice is] The practice is excellent...

K: What makes them good GPs?

M: Well they listen and they don't look at you as if you are some kind of neurotic mother and they do take you seriously' (P 08)

'M: I wouldn't have said it was worthy of a home visit really.

K: Right, so you wouldn't have asked for someone to come to you?

M: No, I wouldn't do that, no. I did that one time with one of the others when they were small and again they sort of, [...] wheezing and [...] and the doctor come out, you know I mean he was sort of mad like, you know like the child did improve and he was saying, like, she is a happy wheezy baby, you know like, it was embarrassing really....

K: so was it embarrassing because of the way the doctor was being, or

M: Well I think he was pretty annoyed to have to be called out.' (P 09)

'She doesn't make you feel guilty for being there' (P 10)

'We try to contact as little as possible, only if we are really concerned with things like the babies when maybe we should have some help, because at that time you are so emotionally involved that you end up seeking the advice. Because we just see so many people abusing the system that it just annoys me in a way... I have strong views of people who use the system... My views are that we should not abuse the system because if we exploit it then it doesn't work after a while, does it? Use it as it ought to be used.' (P 17)

Parents recounted experiences which had made them anxious about whether their requests for appointments with the GP would be seen as appropriate, for example with receptionists at their GP surgery. One couple had even changed doctor because the receptionists were so difficult about access to the GP:

'F: It was impossible.

M: They answered the phone, um... well, 'what's wrong with you?'

F: It was like a question they get [...] to get an appointment with the doctor. It was, it was serious twenty questions.

M: I mean, it was

F: It was very hard

M: 'There are no appointments, you can't come at the end, if it gets worse you have to take them to the hospital.' And that's the receptionist telling you that!

K: Right

M: At least they [at new surgery] offer to ask a doctor's advice or something.' [and later in the same interview:]

F: The receptionists ... you know, 'I need to see a doctor', 'why?', 'well, I ... I need to see a doctor basically'...

K: Yeah

F: And then, I don't know, 'why?', 'well, I'll rather tell the doctor that', but sometimes you would rather tell the doctor that [...] And she says, 'well, I'm sorry but you'll have to tell me why you need to see him', and I says 'well, I don't'. I won't tell her everything. Maybe I will if she approaches me differently.' (P 10)

Receptionists made parents frustrated when they seemed to be making judgements about how ill the child was instead of taking the parents' word; when they came across as creating a barrier to the doctor through complicated appointment systems; or by asking a lot of questions which seemed to demand that parents justify themselves, when parents didn't feel it was up to the receptionist to make a judgement:

'K: What do you think you would like in terms of the GP, if you could -

M: Well firstly the appointments, because every time I phone up, I mean especially with kids, they change so quickly, one minute they are fine, the next minute you think they are on death's door, and you don't know what to do with them, and you, and it's 'Well we can't fit you in till Friday', and this is a Monday morning, 'but if this is a medical emergency'. Well I am obviously worried enough about her to take her to the doctors. 'Well then...'

K: [...] a child of her age

M: Well usually they will try and fit you in but [...] they ask me what's wrong with her. I said I am concerned enough to take her to a doctor and [...]

K: They make you feel that you have got to justify going there?

M: Yes, I think like they don't understand enough, I mean they might think, they might know there is nothing wrong with them, but it is no help sending you home telling you not to worry about it...' (P 04)

'M: You did feel slightly frustrated because you were talking to the nurse and you wanted to talk to the doctor then [...] it was frustrating because you were talking to the nurse and she obviously did not feel it was a case for the doctor [...] we were talking to, like the receptionist and we wanted to talk to the main person.' (P 08)

One mother (P 11) described how she had learned to ‘cheat’ to get her child seen on the same day. When I asked her about the appointment system, she said that the receptionists would probably give her an appointment for that day or evening, but on a previous occasion she had been asked to wait till the next day, and just turned up and was given an appointment, so now she does that instead of phoning.

It is not surprising given these experiences and the beliefs they reflect that people were often concerned to determine with the triage nurse or GP that they were making a legitimate request, and several parents said they had not wanted to be seen as wasting anyone’s time.

As I indicated earlier, what parents themselves thought was a legitimate use had to be read between the lines, and sometimes I had to probe more directly because comments were not so readily forthcoming. Parents in the discussion group felt it shouldn’t be necessary to be ‘pushy’ in order to get their children seen by a doctor because something serious could easily be missed and people shouldn’t be ‘palmed off’. One mother said:

‘you have to justify yourself a lot to get the doctor out. They’re a service, but they’re not acting as a service.’ (DG)

Put in a more positive way,

‘M: My good experience, we have had Dr X who was wonderful ... she has come out with no problem, everything has been fantastic.  
K: Tell me what is it you felt was good when you had -  
M: I think the speed of which they would respond to you, they would phone back and say that we said we would be there within 20 minutes and they were. I think that Dr X has got a - do you know her? - a wonderful bedside manner. She immediately puts you at your ease, and so I think that is important... the ones who have been good have been very good, and I think if they are coming into your home they have got to be approachable, and understandably, I am sure they have lots of people waste their time.’ (P 01)

As in the last quote, the issue of home visits and the question of whether people could have home visits or would have to go to a PCC came up frequently, possibly because parents were aware that this was an important issue in the context of my research looking at the introduction of the cooperative. Most people who had used the PCC had

found it helpful, with some notable exceptions, but they were wary that it might not always have been so easy to get there if they didn't have the car, or if their child was so ill they didn't want to take them out, or they had other children who would have to be woken, dressed, and taken out in the middle of the night. Many parents said they felt it was important that a doctor should still be willing to come out on a home visit if the parent was really concerned about a child and there was no means of getting to the PCC within reasonable convenience:

M: I think the only thing that does concern me is that if it is a real emergency, would they come out to us? Would you have to go to them? I mean if you said, 'I am very distressed, could someone come out to see us?', would they say no, this is [the cooperative], you have now got to come in? [later in interview] If one of us is really poorly and we just know we can't get there, I just don't think someone should say, 'Look, this is what's happening now, you have got to get here.' Because you just know, you are that poorly, they are that poorly, you can't possibly get there, and sometimes with [husband] away and I am here on my own, I can't take them out at 10 or 11 at night on my own, I would have to wrap them up, put them in the car, I mean you have still got to be, if there is a real emergency that you have a home visit.

K: So if your husband was not here you would find it hard to go out with the children?

M: I just don't know. I just don't think it is something you could expect a young mum to do, and ok, some people, I mean I am fortunate because I have a car, but if you say a young person on their own with no form of transport, a very poorly child, or they are very poorly, and phoning up and someone saying 'You have got to come here', and you just can't in certain situations, you just can't do it. You know, every situation is different [...] I think every case is different and you have got to listen to what is taking place and think, right. in this instance this should happen.' (P 01)

'I would much prefer someone to come here because I don't think it's fair for me to take a young baby all the way up there if he's in distress, so I would think it would be better for them to come here' (P 06)

Sometimes transport was a worry, but it seemed to be less of a worry than that of taking the child out at night, possibly in bad weather. One mother got her boyfriend to come over with some money because she didn't have enough to pay for a taxi, and others said they would get a friend or a taxi to take them. Some parents said that before their GPs had joined the cooperative, they had always been willing to come out for a home visit on the parents' judgement that it was necessary, and this was an important factor in their appreciation of the GP generally, an indication that there was a good relationship.

What was appropriate in terms of whether parents should use a casualty department or the GP 'emergency' service was sometimes unclear. In one case, the parents of a child who had some of the most dramatic symptoms I had seen talked about the concept of emergencies dealt with by A&E, as opposed to out of hours GP services, at length (P 08, see appendix 4). The father formulated this into a question:

'F: ... so they should not really be expecting to deal with medical emergencies, GPs, they must be on call knowing they are going to deal with people that are unwell.

K: Right [...]

F: So what they are actually thinking they are meant to be doing, they are saying they don't want to do a medical emergency, but you would not take a medical emergency to them, you would go and get an ambulance, so you don't want to deal with routine things because they can wait till the morning, so where do they actually really fit in this, and do they need to be there at all?' (P 08)

Many parents had previous experiences of long waits, or thought they would have a longer wait, at A&E and therefore appreciated being able to see a GP quickly at the PCC. This was *one of the main areas for praise of the cooperative*. However some were willing to wait at A&E because they thought there would be better access to equipment and specialist advice if needed; or had been told off for using the cooperative PCC; or they had found on a previous occasion that staff at A&E seemed to be friendly and wouldn't make them feel they shouldn't be there.

## **6.6 Parents talk about healthcare professionals**

One of the topics I asked about was what impact parents thought out of hours work had on GPs. They imagined it was stressful, a 'drag', thought they should have compensatory time off, and they could understand how the cooperative would make their lives better. Some parents said doctors should be prepared to come out to see their own patients, or see them out of normal surgery times, because it is part of the job, to be expected, and because people don't get sick only during certain hours. One woman (P 02) made a comparison to her husband, who worked for a gas company and had to be prepared to work all hours and at short notice.

Parents seemed to be quite active in constructing various levels of continuity of care. As referred to earlier, one parent (P 11) had been registered with the same GP since she was a child but didn't like him and tried to see other GPs in the practice. The couple who had changed GP because of the receptionists at their old surgery (P 10) were happier with the new practice but much preferred to see the woman GP and not the GP they were registered with because she seemed 'concerned, very warm, genuine' and was equally good with children and men. One mother (P 02) explained that she had no confidence in 'locum' doctors so she tries to make an appointment with one of the practice partners, both of whom she trusts '100%'. Several parents spoke of doctors with whom they felt they had a personal relationship, had known for a long time, whose opinion they could trust, and therefore they tried to see them if possible, although it was often a long wait for an appointment.

Continuity of relationship often went together with a personal kind of relationship, although this was not always the case. A couple whose children had quite serious chronic illnesses described a time when their GP sat in their steamy bathroom with them when one of the children had croup, and a number of other occasions when one or other of the GPs in their practice had been especially caring:

F: I think one day [their son] had such a bad attack we were on the phone to the surgery during the day to get some help and I think we were still holding on the phone and he ran out the surgery with his bag and he was knocking at the back door and we were still hanging on the phone [...] you know, fantastic [...] the practice is excellent [...]

K: What makes them good GPs?

M: Well they listen and they don't look at you as if you are some kind of neurotic mother and they do take you seriously. I think it also helps because they have both got young children and they take an interest in the children as well. They make time for them, they don't rush you.

F: They talk to the kids

M: Yes they talk to the kids and they also, I know it is on the screen, but they build up a rapport, and they remember things, you know, you go in there and if they have seen [their son] he may say 'Oh, how is [their daughter]?'. He remembers that someone else was ill last week. He always asks, he makes it feel personal, it makes it feel very personal.' (P 08)

There were a few parents who had received such care and then had a bad experience with the GP they had known a long time, or with a new GP. This made them particularly

upset and they compared the two doctors, or in one case thought her doctor should have cared more about her since she had been with him so long. One woman felt very let down, not by any particular doctor's behaviour, but by the failure of the cooperative triage nurse, her own GP and the hospital paediatrician between them to pick up the signs when her child had been abused by a childminder, resulting in a head injury:

'M: It's an awful shame, it's the one regret I have is that this was not detected twice, you know. I know the first time it was only a phone call but you know, it just angers me cause it would have been a little bit of medical evidence ...

K: Did they realise that the child was with somebody else?

M: Yes.

K: They did

M: Well, nobody would be interested in our lives. Nobody gives a damn, you know, you can abuse children willy nilly and honest to god, you know, I mean I am only beginning to realise this now, but it just goes on and nobody really cares, you know, that's the way I feel.' (P 09)

Some parents said it was not necessary to know a doctor for a long time if they were professional and could inspire trust, and that in an emergency they would accept another GP, but others had had bad experiences with deputies. One mother said:

'I would only ring if I knew it was a dire emergency. I used it a couple of times with [daughter] and once with myself [...] but they never seemed to - I know it sounds awful, but generally they were foreign and I could hardly understand what they were saying, that's what you got from that number.' (P 02)

The mother quoted above with a more personal relationship with her GP compared that to her experience of a deputy:

'Just as [the cooperative] took over I had, January I had flu and I could not walk. My legs went and I was having vertigo or whatever, and [her husband] phoned the doctor and that was when we found it had changed service. We got the duty doctor or whatever, and he came out, and one, you are embarrassed because you have not seen this person before, you are embarrassed that you feel you have not got a relationship with this person, and in the middle of the night I felt rough, and he was out, he wants to know everything, he wants to know your date of birth and you don't - lucky [husband] was there - but you don't want to go over all that, your address of your GP and everything, and he was like acting like he just did not want to be, he just treated me like I [...] how I felt about him. I did not know him, you know, you are a stranger and I don't feel well, go away, and he said I had something and the next day I got no better so I phoned our GP, and

they came out and it was totally not the same diagnosis. He was rushed but his diagnosis was wrong.

F: Yeah, it was different

M: What he said was wrong, what he said was fine but I do feel that if it is a big practice and they are doing one night a week, I don't feel that is a problem, I think it is still the personal touch.

K: It is just

M: Because they still have to go and work in [the PCC], I mean all the doctors take it in turn, don't they, so they still have to go, I know it may be not once a week or whatever, I don't know how much they work but they all have to take turns.

K: Right, so how do you, if you could, maybe there is a different way of looking at it, but if you can think about how you see this out of hours commitment from the point of view of the doctor, do you think that they, you know, do you think that they should be prepared to do -

M: Yes, I do believe so, I think that they should for the personal touch, and they know the patient better than if it is - especially the elderly people, not just young children. Elderly people, they get to trust a doctor and if they phone up they don't want to see a stranger or go to [the PCC] or whatever, they want to be able to talk to someone they know.' (P 08)

Attitudes towards triage nurses varied from not valuing their advice or preferring to speak to a GP, to finding it acceptable as a resource in its own right. Parents P 10 talked about the difference between being asked 'twenty questions' by receptionists at their GP's practice and the questioning from the cooperative's triage nurses. They felt the former asked formulaic questions which seemed not to be informed by knowledge, whereas with the latter,

'you know they are qualified persons, you know why they're asking you... and you know that what they're asking you, they may be able to work out something in their minds and give you something to do... you know that they're giving you some sort of advice that may be helping him... it was just a relief as well, to have the nurse asking you questions, we were just getting through and actually talking to someone for advice.' (P 10).

The discussion group commented that they accepted nurse advice if it seemed sensible, but not if they felt they were being 'fobbed off'. They were concerned about how much could be achieved over the phone, and didn't know how they were making an assessment. Some parents had a good experience with nurse advice from the cooperative; liked the attitude of the person they spoke to; thought the advice was helpful, and sometimes better than the GP. Others were frustrated because they wanted to speak to a doctor; wanted the child seen; felt the nurse was trying to 'dictate' or was

curt; didn't know who the person was; and in one case the nurse made the mother panic.

It seemed that in general, in addition to their ability to compare doctors they may have seen through changes with those they were registered with at different times, the use of deputies and now seeing different GPs at the cooperative made it possible for parents to make further comparisons, and in a minority of cases to play off the different ways GPs practised. This led many of them to conclude that if they had a good relationship they preferred to see their own GP out of hours, but it was acceptable to see a different GP at the PCC as long as they were able to inspire trust and confidence, which was the case with many of the GPs they encountered there. It seemed to be a better experience than they remembered having with deputies who had visited them out of hours before their GP joined the cooperative.

Because of political difficulties between the cooperative and the deputy service the cooperative was using at the time of my observations, I was not able to go on any home visits. This meant that I was also unable to do follow-up interviews with parents who had received a home visit. However, in those cases the deputies would be likely to be more comparable with the deputies parents had seen before their GP joined the cooperative, because they were being supplied by the same commercial company. The GPs at the PCC were all working in local practices, and the situation now is that the cooperative is using its own doctors to do home visits.

## **6.7 Conclusion**

In this chapter I have reported the comments made by parents in the interviews and discussion group on how and why they used the cooperative; their wider views on healthcare and who they drew on for knowledge, advice and support; and some of the beliefs and opinions they have about the kinds of relationships they have with healthcare professionals.

One remarkable feature of these conversations was that so many (nine out of 16) of the parents spontaneously told 'atrocious stories', although this was not entirely surprising in

light of the literature. Another possibility is that despite my efforts to present myself as not part of the cooperative or a GP, they may have felt it necessary to justify their use of the PCC. These stories seemed to serve the purpose in the interviews of demonstrating that doctors could be fallible, and that the parents had done all they could in fulfilling their responsibilities. The parents did not generalise from the failings of the GPs in the stories to all GPs, rather they seemed more interested in claiming their own competence as different but equal sorts of experts on their children's health. They valued medical opinion despite bad experiences with individuals, but portrayed themselves as having to act as their children's champions in negotiating the healthcare system.

The issue of the 'proper' use of antibiotic treatment is emblematic of the wider dilemmas about appropriate demand. Many parents are aware of the issue, but express frustration when given seemingly pat advice such as not to ask for antibiotics for viral infections. Determination of whether symptoms are caused by bacteria or a virus is beyond the scope of parents without a medical qualification, so it is useless advice unless doctors give it as part of a dialogue recognising the skills and experience parents do have, such as knowing what is normal for a particular child and noticing unusual symptoms and signs of suffering.

The social relations commented upon in these interviews involved varying degrees of trust and capacity for blame, both in healthcare and family environments. Given the moral content of their accounts but also the frightening experiences some of them had had in the past, it is not surprising that many parents feel the need to 'check' that they are doing the right things when they are concerned about their children's health. Yet most of the parents had been made to feel guilty for 'wasting' doctors' time at some stage, sometimes by receptionists more than GPs. I would argue that checking should not be regarded as trivial, because knowledge is relationally negotiated and constituted: even when parents are confident of their own skills, social pressures, some of them medically induced, make them unlikely to be reassured unless they put those together with medical knowledge, and diagnoses depend upon parents providing the history.

The feeling of barriers put up making it hard to see the doctor, or being fobbed off with insufficient information or attention, were factors that went against good relationships

with GPs. Positive factors were trust, confidence in the advice (which stemmed in part from having the child actually seen, or a real exchange of information), and a feeling of being cared about personally.

In contrast to this and the last chapter which considered the views of parents and professional health carers individually, in the next chapter I describe the context and processes of interaction between these parties.

## Chapter Seven

### ENCOUNTERS: PROCESSES AND PRODUCTS OF INTERACTION

This chapter establishes the departure of the thesis from more conventional approaches to this topic, and substantiates my earlier arguments about the inter-constitutive ways in which the research topic crystallised through the methodology. The previous two chapters focused on health professionals' and parents' views and experiences as distinct voices, but of course all of the data reflect the interactive way in which they were created, including the different kinds of exchange I as researcher had with people in each setting. These accounts can be regarded as 'laminations'. They are the way I have framed and interpreted the material as continuing dialogues between all the parties concerned including myself as researcher.

This chapter draws on the full body of data which, in addition to the PCC and home-based interviews, includes 20 tape recorded telephone triage and advice conversations between parents and triage nurses (in one call, a GP); my fieldnotes and tape recordings of observations at the primary care centre on 14 occasions lasting about six hours each (which incorporated observations of receptionists, triage nurses, patients, consultations, GP interviews, and also GPs undertaking many telephone advice calls); and observations at two nurse triage study days.

By way of providing some contextual background, it is worth noting, for example, how in the triage and advice recordings and patient consultations with GPs I observed at the PCC (both of which usually lasted no more than ten minutes each on average), the parents were asked to focus on the detail of symptoms, their exact qualities and timing. In contrast, the interviews with parents lasted an hour or more, and parents talked with me in the privacy of their home without any health professionals present. The purpose of the talk was completely different, and the more familiar and relaxed circumstances allowed them to talk about many additional issues compared to the more pressing context of the telephone conversations and observations. The PCC observations varied a

lot, particularly in terms of how much time I had to talk with GPs, depending on how many patients needed to be seen, and whether there was another GP on duty. On one occasion, because the session was so full, the GP and I agreed to have a further discussion on the telephone the next day.

### **7.1 Healthcareers and families in negotiation**

Although there are interactions between people in many different roles in the context of out of hours care that could have been studied (see for example the LSL Out of Hours Project, 1995), it was those between parents, GPs and triage nurses in this setting that were of central interest to me. As I have cited earlier from the medical literature, the contentiousness of the topic of inappropriateness highlights the potentially important powers GPs (and triage nurses by extension) have in relation to parents' responsibility for their children's health and wellbeing. It provides a focal point where the effects of these powers can be seen in play, and they can be interpreted as more or less positive in different circumstances. In talking about their 'own' GP, and where relationships were good, parents reported feeling that their GP was a source of support in the sense of offering information and advice, and sometimes caring and emotional support as well. Where the relationship was marked by conflict, parents had suffered sometimes severe difficulties in carrying out their responsibilities. Parents may or may not have a great deal of interest in the relationship they have with their GP(s), yet their role as parents (perhaps more so than on their own behalf) means that its quality brings up the possibility of more or less helpful consequences. Clearly GPs and nurses have a corresponding although not necessarily as intense a stake in their relationships with patients.

It could be argued that since my data come from what in most cases were 'one-off' meetings rather than ongoing relationships, they cannot be compared directly to other discussions of doctor-patient relationships which assume longevity and/or continuity. However, in any first consultation between a doctor and a new patient for the first time, both parties will make judgements based on that initial encounter and these may be the basis on which they decide to go on with the relationship or not. That first meeting may also be influenced by past meetings with others, and will in turn influence future meetings for or between that patient and that or other doctors; indeed people often try out more

than one doctor in a practice and see which one they prefer for particular needs. Also, the current changes mean that the trend is away from continuity of care and access to primary care is becoming not only more fragmented but multi-professional. For both of these reasons, the idea that most daytime consultations are part of exclusive, continuous relationships is probably not the predominant reality today. In this changing context one-off meetings may become more the norm and are worth investigating for both continuities and discontinuities with previous models. Finally, I think one of the effects of these changes suggested by my data is that for patients, or parents, individual encounters may carry greater significance in forming people's views of the new out of hours service, precisely because they are less frequent and there is less of a chance to gain the more complex impression of another person more likely in a continuing relationship.

At the same time, the methods I used made it evident that judging the quality of relationships between patients and the GPs at the PCC could have been misleading if I had only taken into account that single consultation. Despite the difficulties in obtaining tape recordings for all the triage calls relating to patients who came in, I was able to collect triage recordings, observe the consultation, and interview the parents subsequently for seven cases. This allowed for a more complex understanding of the interrelationship between the broader social context and longer-term experiences of the child's family and the consultation. If I had had to make a judgement about the quality of doctor-patient relationships on the basis of my observations at the PCC, I would have said that with a few notable exceptions, most of the consultations were conducted cordially and had a satisfactory outcome, and I would expect the GPs to say the same. Taking all the information available to me subsequently into account, it became clear that some of the aspects of the consultations were much more significant to parents than I had realised at the time, and that the outcomes were unsatisfactory to parents in more cases than it had appeared, reflecting the findings of Stimpson and Webb (1975).

a) Examples of conflicting perspectives, expectations and responses

Perhaps an example of a most unsatisfactory outcome was the meeting between a GP and the mother whose telephone call with the triage nurse is transcribed in appendix 2,

where it can be seen that she did not originally intend to come in for a consultation, but wanted telephone reassurance. It was a very hot and humid evening, and the GP on duty that evening, a white British man aged about 33, arrived in an irritable mood because he had been caught up in the traffic and had to move his car because he didn't know where he should park it. It was his first session for the cooperative, and he was unsure of the way he was supposed to work. Although we had discussed my study on the telephone and the details of the observation, on the night he refused to have the tape-recorder on, the only GP to do so. During the evening he had to speak to his wife on the telephone because she wanted him to come home and deal with a spider in the house. Altogether, he was not in a happy state, and Helen and I agreed to treat him delicately. At the end of the session when there were no patients waiting he came out to the reception area where Helen and I were talking and joined us. He spoke very angrily about his lot as a GP and his many dissatisfactions with the way patients behaved. I learned later that he was negotiating to move to a new practice.

During his consultation with the mother in this case, whose child was nine months old, he seemed slightly irritable and impatient, and said to me afterwards that the consultation was a waste of time. In order to carry out his examination, he needed the mother to hold her child in a certain way, which I had seen other parents do and involves presenting the ear by turning the child to one side, putting one arm around the child's arms, and the hand of the other arm around the child's head above the ear. This ensures that the child won't wriggle around or push the doctor away with their hands and arms when the doctor inserts the light into the child's ear. It is not a natural posture for parents to take and is a technique parents have to be shown. Some of the GPs sensitively explained this when they could see that the parent didn't automatically display competence at this procedure. On the occasion in question, the GP was somewhat patronising about it, and the mother appeared to be embarrassed because she hadn't known what to do. The consultation was generally tense, and as she left the room with her child, the mother turned to the GP and said 'I do look after her you know!'. Later in the evening, the mother's mother telephoned to complain about the GP's manner and its effect on her daughter:

‘Dr: Hello  
GM: Hello did you just examine my granddaughter xx?  
Dr: Yes  
GM: Yes you did, my daughter has come back quite distressed  
Dr: Why is that?  
GM: In your attitude, in *the way you spoke to her*  
Dr: Well I explained to her basically *what should be done and what was appropriate*. I did not speak with any attitude at all. I am sorry if she took it that way.  
GM: She did take it that way. She was very distressed. Generally if a mother brings a child to a doctor it is because they are *concerned* -  
Dr: Absolutely  
GM: - and *I have to point out that this child is in a stable loving relationship, and you can see from the child, very very well cared for* -  
Dr: I never intimated anything to the contrary -  
GM: I am not saying you did  
Dr: I think what I am trying to explain to your daughter was in this sort of situation the way that GPs try to *educate* mothers to assess the situation themselves. First, as I am sure you know, 80% of respiratory tract infections, like ear infections, throat infections, are actually viral in nature and can be looked after really with regular paracetamol syrup -  
GM: But if when you ring a clinic like this, and I think this is an excellent idea that you are actually running, and you are actually *advised by the nurse that speaks to you to bring them in and have the child checked over*, then I think perhaps just a little bit more *understanding*, especially for first time mothers -  
Dr: Sure, and this is why I actually sat there and *explained* it to your daughter  
GM: She does actually understand, but *she is not one that would throw things down a child's throat, because I certainly don't believe in that*  
Dr: Well to be honest with you, you know, I have been, *I am a very experienced GP* -  
GM: I am not doubting you at all  
Dr: - and if I offer some advice it is up to your daughter whether she takes it or not. *I am here to offer health advice*. I am a health adviser as well as somebody who treats, so in that situation I feel it is important -  
GM: Perhaps sometimes it is in *the way it is spoken*  
Dr: I think as well you would need to have been there, I think once again if you were not there -  
GM: No, I wish I had been -  
Dr: - to listen to the conversation, well there probably would have been a very sensible conversation  
GM: - and I wish perhaps her partner should have been there  
Dr: - probably a very sensible idea too  
GM: - anyway I just wanted to point that out because she was stressed - because *you could actually put people off coming*, and she is so concerned about her child.’  
(P 04) [*italics indicate my emphasis, not necessarily in speech*]

This extract is unique because it is the only example I have of a recorded complaint, and because it is the grandmother complaining on behalf of her daughter, yet it contains a number of themes I will be addressing later, so I will use it to introduce them here.

First there is the problem that the two speakers are addressing quite *different agendas* and that during the consultation these were probably *unvoiced* (Barry *et al* 2000) except for the mother's comment as she left the consultation. The grandmother wants the doctor to acknowledge that the way he spoke to her daughter caused her distress, that he should show understanding, especially when her daughter was invited by the triage nurse to come in to have the baby 'checked over'. The GP's language is about what is appropriate and should be done, explanation and education, health advice and medical treatment. The former is asking for a response to emotional issues, the latter is offering something more 'rational' and dispassionate.

Secondly, the grandmother resorts to a *moral claim* to support her case, that the child is in a stable, loving relationship and is very well cared for. This implies that the grandmother believes her daughter's moral status as a caring and competent mother has been called into question, or that one or both of them believes it has. The grandmother's tactic of countering the GP's justification of his behaviour in the consultation in terms of giving the appropriate information, of educating mothers, with her own moral agenda, is consistent with Silverman's (1987) argument that 'we', by which I think he means social scientists, but perhaps at the same time could mean society generally:

have moved a long way away from treating doctor-patient communication as a matter of imparting accurate clinical information to the patient... in these medical encounters we are dealing with dilemmas of discourses rooted in a profoundly moral universe. These dilemmas encompass... the likelihood that medical accounts may be heard by parents as a 'charge' against their fulfilment of their parental duties. (p. 263)

When the GP denies he has cast a slur on the mother's competence, the grandmother also denies that she inferred it. On the other hand, when the grandmother refers to her daughter not being 'one that would throw things down a child's throat', the GP counters with his own moral claim to competence, 'I am a very experienced GP', and she similarly denies she was inferring otherwise. This touches on the nature of the conversation as a

whole, which has the tone of a confrontation that cannot be fully expressed on either side, both parties having something at stake that would be lost if they really lost their tempers. Again, it is interesting that the complaint comes from the grandmother and not the mother. Although I was aware from her parting remark that the mother was angry, it was not a full confrontation since she did not stand her ground and argue, and the GP made only a minimal, bland response to her. I think left to herself she would not have complained, but there was something that impelled the grandmother actively to place the blame on the doctor for her daughter's distress.

Finally, the grandmother said to the doctor that she wished she and/or her daughter's partner had been there, as if the daughter was not capable of handling such a situation by herself. This could be read as supportive, or possibly undermining, raising the issue referred to in chapter five about family involvement and whether it is always as supportive as those who mourn the 'loss of the extended family' think it is.

In her study of problematic consultations, Hill (1998) argues that (within a context of an ongoing doctor-patient relationship):

The common aim of the consultation seemed to be less focused on making a definitive diagnosis than on maintaining a positive and continuing relationship. When things got difficult, the negotiation would be brought to an end by one or other party backing down. Humour and other strategies were used to reduce tension and to move the discussion away from an area of conflict.' (p. 61)

In the context of my study, people did not have reason to expect an on-going relationship, yet it was remarkable how little conflict was expressed overtly. There were instances when people's body language, non-verbal utterances, or words left unspoken made it clear they were dissatisfied, but they left it at that. It seems to me that it need not be the continuing relationship with a particular person that is at stake, but a more generalised wish not to be confrontational on both sides. In Goffman's essay 'On Face-Work' (1967), this maintaining of another's, and saving of one's own *face*

means that the line taken by each participant is allowed to carry off the role he appears to have chosen for himself... This kind of mutual acceptance seems to be a basic structural feature of interaction... [however] It is typically a 'working'

acceptance, not a 'real' one, since it tends to be based not on agreement of candidly expressed heart-felt evaluations, but upon a willingness to give temporary lip service to judgements with which the participants do not really agree. (p.11)

An example of this was when a couple brought their one year old boy in with a suspected ear infection (Obs 7), saying the child has 'invariably' been given antibiotics because 'it gets really out of hand', but the GP tried to persuade them to wait a few days, explaining why it is often unnecessary and undesirable to use them. However, she eventually went out of the room to get them a dose for that night as well as a prescription. While she was out of the room, the parents looked at each other and raised their eyebrows as if to say, we had to have a lecture but at least we got the antibiotics in the end. After they left the GP said she sometimes wondered why she bothered to try getting people not to take antibiotics. They could have argued more directly for their point of view, and she could have refused to give them a prescription, but in this case the GP backed down and they all saved face.

Giving prescriptions for antibiotics despite what they said about the dangers of inappropriate or overuse was one of the main instances where GPs' behaviour contradicted what they said when patients were not there. Some reasons for this were discussed in chapter five, but looking at the interactions between GPs and parents in the consultations, each one could make the GP act in a different way because the nature of the interaction shaped their own response. (GP 13) referred to the 'text book medicine' found in large group practices, in contrast to what he finds he has to do in a husband and wife partnership, taking into consideration that if some people are not given prescriptions for antibiotics during the daytime surgery, he knows they will call out of hours in order to try again to get one, costing him extra money and defeating his efforts to reduce such prescriptions. In these circumstances, at least he can save himself an out of hours fee by giving the prescription, since he cannot control his patients' behaviour or that of a deputy GP. Those in leadership positions in the cooperative as an organisation who pushed the message against overuse of antibiotics appeared not to be able to control the prescribing habits of individual members either.

In another case (Obs 6) the conflict was more openly suppressed. Both parents brought in a little boy with a stomach ache, high temperature and a blocked nose. They had seen their own GP twice and been given antibiotics, but they were worried because the child kept crying. After examining the child and giving advice, the GP tried to conclude the consultation. The father, who had said very little up to that point, looked at the crying child and said 'But he's like this day and night'. When the GP answered with more explanation and the comment 'there is no magic solution', a phrase she used several times that evening, and suggesting they see their own GP in the morning, the father gathered their things and left the room making no eye contact and without another word, leaving the mother to say 'Okay, thank you very much.' I wanted to contact this family for an interview, but it turned out they had come in without an appointment and the address they gave, according to one of the receptionists, was known to be a bed and breakfast hostel. As there was no phone number, I decided not to pursue it, because I thought if I went to see them unannounced it might seem intrusive. I imagine it must be very difficult in such circumstances to have a child crying day and night, but the GP was unaware of their living situation, and didn't pick up on the father's comment as especially significant.

b) Emotion work

The case just referred to can be compared to a similar one with a rather different response from the GP. In this case (Obs 4), a mother was very worried about her child's high temperature and shaking. After careful examination of the child, and the GP's explanation and reassurance, she was apparently still worried and not content, but did not verbalise this directly, only by continuing to ask questions prefaced with 'it's just that...'. The very experienced GP on duty at the PCC tried more reassurance and explanation, but then in a gentle tone of voice tried to draw her out rather than simply conclude the consultation:

Dr: ... now if you are not happy with that, what I can do is we can get a paediatrician to have a look at him to get a second opinion, but you have had three opinions and they have all been the same.

M: I know but it's just that he is boiling, he is shaking, he is cold, he is not eating

Dr: Well I do appreciate that. Have you got other children?  
M: Yes [...]  
Dr: What would you like me to do?  
M: I don't know, I mean, I will take him home, yes, but I was scared something was going to happen because he is so hot and he is -  
Dr: As I say, the only danger that can happen [further explanation follows]  
All right, is there anything else you want me to do or say? I'm happy to send you to see the paediatrician if you would like that.  
M: No, I just want him better.  
Dr: He will get better, I promise.'

In this example the GP is concerned to address the unresolved feeling in the mother's questions, such as her use of the word 'scared', and although he uses further explanation, he also responds to her on an emotional level. He uses the word 'danger' rather than using the language of statistical risk (Douglas 1992). Medically, it would be impossible to be absolutely certain that the child would get better; nevertheless, he says 'He *will* get better, I *promise*'. I am sure he did not mean this to be taken as a literal guarantee; the word promise means more of a pledge, a declaration of commitment, a statement of intent to be taken on trust. Since he cannot reassure her with technical information, he offers her his *personal* assurance, i.e. asks her to trust him. Perhaps it is unsurprising that this GP was one of those who most strongly manifested a continuity of care orientation. In this case, although it was not particularly likely to be the same, the relationship was constructed in a way which reflected how he spoke about his ongoing relationships with his own patients. Some of them waited until he returned from holiday to make sure they saw him and presumably put up with their ailments until then, suggesting that what they got from the consultation was over and above, or more important than purely 'medical' treatment.

It was interesting to note that some of the GPs who advocated a more biomedical orientation in their discussions with me seemed to act quite differently with patients than I might have thought if I had only interviewed them. A particularly striking example was the GP whose tape-recorded and transcribed session appears as appendix 3. Early on in the session he had described himself as a 'technician'; and was scathing about 'the continuity of care fable', and patients who consult for trivial matters or turn up for emergency sessions for what turn out to be not true emergencies. His language and tone of voice were such that one would imagine him being pretty tough to deal with. Then

later in the evening, I observed him in action in the particularly dramatic case of child 'C', when there was no disputing the seriousness of the symptoms. This same GP was concerned and sympathetic, speaking to the boy in affectionate terms such as 'sweetheart', with a warm and soothing tone of voice. In my fieldnotes I wrote:

Dr L got the little boy up on the examination couch as soon as they came in the room. The boy was very distressed and could not bear to be touched or examined. He made whimpering noises straight away. The father was also upset, and from time to time seemed to be holding back tears, sniffing and clearing his throat. Both Dr L and the father kept saying they would not hurt the boy, but when they said this their voices conveyed anxiety; they were louder, the speech was more rapid, and they tended to talk at once over the sounds C was making. When the father was sitting down at the desk talking to Dr L, he had his left hand on his knee, with his elbow fully up and projected forward, so that his whole arm formed a 90 degree angle. I thought this was an unconsciously but strongly defensive posture, as if he were literally bracing himself.

Dr L seemed to be in his element for this consultation. At times he was demonstrating his technical and diagnostic skills, at other times he rested his forearms on the couch where C lay and gazed upon the boy's frightened face, as if to look right inside him trying to understand what was causing the problem. He also disclosed that he had a little boy about the same age ... Some of the time he seemed worried himself, and went into long technical speculations about what might be wrong, in a way which demonstrated his knowledge, but was clearly making the father even more alarmed. He also spoke to the father about procedures that were going to be painful in euphemistic terms that the father appeared to understand as not for C to understand, e.g. 'this is not a fun thing... it's not going to be much of a spectator sport either', or spelling out the word blood. At certain points when he was explaining things to the father he covered the lower half of C's body with a white hospital blanket. Then when he went to lift it again, C became distressed because he didn't want to be touched.

Dr L went out of the room to call the paediatrician. I chatted to the father about my project and tried to help him relax a bit. I offered him a drink but he didn't want anything. Dr L came back and announced that he had persuaded the paediatrician to come to Nightdoc from the hospital. At this point he was in hero mode, appearing strong and masculine towards the father, in a way which I felt was intended to give the father confidence. He came back in the room with Dr R [his trainee registrar, a young woman] and asked if C would mind his friend looking at C's rash. There followed more questions, more technical, medical hypothesising, and Dr L apologising for being alarming but trying to reassure the father. Dr L suggested the father might like to phone home, so we all left him and C in the room.

When the paediatrician arrived, he spoke first to Dr R in a way which indicated that they already knew each other, and she said she was glad it was him who had

come. He started to talk about the case and then asked if Helen and I were medical people, and we told him we were researchers doing an observation. When he went into the room, Dr L closed the door with Dr L, the paediatrician, the father and boy inside the room.

The examination done by the paediatrician [looking for torsion of the testicles] made C cry and scream, and outside the room Helen, Dr R and I waited, talked and winced. The men's voices were firm and there was a feeling that inside the room, terrible things were being done which had to be done, and the men were in there doing it, while we women huddled together outside.' (Obs 5: my fieldnotes)

The episode described here illustrated more clearly what his orientation was. It was not simply that he saw himself as a technician and split off the more caring and humanistic qualities he displayed on this occasion. It was more that, as Good (1994) argues, it was precisely when his technical skills and knowledge were most called for that he was able to use these other qualities. What really annoyed him were the times when the technical knowledge he so enjoyed using was not, as he saw it, really required, and thus he found it so difficult to summon up the other qualities from inside himself.

I think many GPs accept the 'emotion work' (Hochschild, 1983) of general practice as part of the job, but don't necessarily value it intrinsically:

'This patient actually rang for advice, I think, and was told to come up, and that's not unreasonable, and now I see them, I can see that they don't need any particular medical input. But as I was saying to a colleague, reassurance is as important as a prescription on many occasions. But it is annoying.' (GP 03)

Sometimes 'emotion work', though not referred to in those terms, was seen by GPs more in terms of dealing with the patient's emotions, at other times in terms of working on the management of their own emotions. The former view probably reflects the agendas around in the late 1960s and early 1970s, when many of the participants in my study trained, including the notion of 'patient-centred' practice, and the Balint (1957) inspired idea of the doctor as medicine, as in the comment above, equating the value of reassurance with that of a prescription. The latter view was less talked about, although the GP above admitted that giving reassurance in the absence of any 'medical' input could be 'annoying'. Another GP expressed it candidly:

‘The only thing with this job is you have to be very controlled yourself, you can’t get angry with people, that’s the only problem. In our practice, you know the people, you can’t get cross with them.’ (GP 13)

In the same way that it was apparent in chapter 5 how most GPs talked about emotions as attributes of patients, it was unusual to hear any of the GPs I observed acknowledge the interactive nature of the emotional content of consultations. This may be because, as I have indicated, there was little overt display of emotions by patients or GPs. The relative absence of emotional display *within* the consultations is in itself an interesting feature, especially considering the amount of emotion expressed in my interviews with parents, but also to a lesser extent with some of the GPs. One example was a GP who (referring to a consultation I had not observed) recalled a ‘really contentious consultation’:

‘I remember I went to see somebody who was one of somebody else’s patients and it was one of these quite dirty houses, a single mother with four children, and she had a sore throat and I was really irritated, you know, at the time. I really don’t think it was fair to call a doctor out at night when all you have got is a sore throat, and she said if you feel like that you should work [...] It was a really really very contentious consultation, and I mean it is true that people like us, to people like them, are floating around with nice cars and good income and obviously all sorts of material benefits and rewards that they don’t have, but they think we should sweat blood because [...] I mean I appreciate it is not a big deal to go out to somebody’s house and look at their throat and either give or not give antibiotics, but it is a big deal when you have been working all day and it is difficult to find strange houses in the dark. It really is a big deal, and I was so angry, and she was obviously angry with me, and we sort of mirrored around that emotion.’ (GP 03)

In this case, even though the GP acknowledges her own anger, and that she and the patient ‘sort of mirrored around that emotion’, the justification for her own anger is in terms of the patient’s attributes and the unfairness of the patient’s behaviour. She told another story about a mother who belonged to her practice and brought her child into the PCC in the evening with a nappy rash. She recalled that her partner, who was on duty with her that night, had become

‘really irritated, but I find it difficult to be annoyed overtly [...] because it just destroys your relationship forever, it’s never going to be the same again if you’re really up and running. I mean, they may actually feel guilty, but I feel that they think I’ve been aggressive.’ (GP 03)

These comments accord with Hochschild's (1983) findings that doing emotion work effectively calls not just for 'impression management' or 'face' work (Goffman, 1967) but summoning up and demonstrating emotions, or suppressing them, a process involving both internal states and outward appearances. If the person has to do more of this than they can cope with, they can become alienated from those emotions when called for in their personal relationships and succumb to 'burnout' in their working lives. A common feature of burnout is the depersonalisation of those who make demands for emotional labour. Some GPs and triage nurses seemed to depersonalise patients by lumping them together in derogatory categories, and the GP quoted above referred clearly to her effort to contain irritable feelings in order not to jeopardise the relationship with patients. An interesting feature of many of the GPs though was how the more their medical skills and knowledge were needed, the more easily they were able to do emotion work, but in the absence of the stimulation of 'real' medical challenges, they found the emotion work boring, irritating or a waste of their time.

## **7.2 Moral tales**

A feature in many of my conversations with parents, GPs and nurses was the tendency to construct 'the other' as unreasonable, ignorant or incompetent. As was seen in the previous two chapters, parents told 'atrocious stories' in which health professionals on previous occasions had appeared to be incompetent, remiss or rude; and GPs recounted examples of stupid questions and demanding patients. Nurses talked about both GPs and parents in these ways, but could also often see both sides, and were sometimes caught in the position of mediating between them. I have also referred to the influence of other members of the family on consultations, and the importance of moral accounts in parents' talk about how they care for their children.

In the observation sessions, it often felt to me as though there was a diffuse atmosphere of 'waiting to be impressed' about the claims of any patient and the advice of any health professional, and some of the views expressed in the interviews may explain this. Although there were seldom any overt displays of strongly negative feelings during consultations, they were sometimes expressed to me afterwards. However, it was often

the case that when children were brought in by more than one adult, there were subtle indications of how the adults felt about the advice being given in the way looks were exchanged or the manner in which their speech coincided or overlapped. Usually these indicated support for each other but sometimes there were also tensions between them. There are many examples I could select from my data to discuss this in relation to moral issues, and indeed the issue has already surfaced in other sections, but the following case also demonstrates the value of having more than one context to consider.

The parents of a two year old boy brought him for a consultation (Obs 11) because they were concerned about several white lumps on his legs and swellings on his knees. We can see in the following exchange the parents' resistance to the GP's suggestion that the lumps could have been caused by insect bites:

- 'Dr: Anything bit him or -  
M: No, not to my knowledge. And he's like, bangs and falls over all the time and he's the age he is, so whether he's fallen and banged it or something I don't know.  
Dr: It's definitely swollen.  
M: Mmm  
Dr: How is he in himself?  
M: He's got a bit of a rash as well  
Dr: This looks like bites  
M: Bites?  
Dr: Yeah. Same maybe there as well  
M: I see, yeah  
F: What are they?  
Dr: They look like bites  
F: *Bites!?*  
M: Mmm. Nothing that would have bitten him though  
F: *Nah*  
M: It's like an itchy rash. See I get allergic reactions to shampoo sometimes, and this is how I come up  
Dr: This is not allergic, no this is not allergic reaction. Bring him here and [...]  
M: Mmm  
F: [...] be bites would it? We've got three others and us two, and I can't see him just getting them on his own.  
Dr: Well children, do you have any pets in the house?  
M: Yeah, we've got a dog but [sounds of struggling with child's clothes/lifting him onto examination couch]  
Dr: It hasn't got fleas or anything?  
M: No/

F: /Perfectly  
Dr: Try and do it this way [helping with child's clothes]  
M: We know that cause we took her to the vet's last week cause she had a skin condition.'

We can see that the mother wants to offer alternative explanations to counter the suggestion of bites, first 'bangs and falls', then an allergic reaction, then (following the exchange above) the information that the child is on antibiotics for an ear infection. After some discussion about this, and as he examines the child, the doctor returns to the subject of bites:

'Dr: See why I say it's bites, it's raised in the middle [...]  
M: Yeah/  
F: /attracted to him  
M: Mmmhmm ... yeah, you see it's definitely swollen  
F: [says something very quietly to her]'

After this exchange the doctor stops using the word 'bites'. There is more discussion about the ear infection, and the father brings up the question of a bump on the child's knee. When the father then asks 'It's to do with the rash is it?', the doctor doesn't challenge the word 'rash', but simply says 'Yeah'. He prescribes Piriton syrup (an antihistamine) and Calamine lotion and the atmosphere becomes cordial, with many pleasant 'thanks' and 'byes', and the father telling the child to 'say thanks doctor'.

On the surface, it seems that the consultation was satisfactory in the end. I spoke to this mother on the telephone shortly afterwards to ask for an interview, and she said she thought the PCC was 'brilliant', she was a 'regular user', and we fixed an appointment. Yet when I visited this family at home, I did not feel at ease at first. The house is on one of the locally 'notorious' estates, and although we had made a definite appointment and I could hear they were at home, they didn't answer the door. I waited in my car for about five minutes and went back and tried knocking again. This time they answered, and the mother said she had forgotten about the appointment, apologising because she had not yet dressed that day. Their Staffordshire Bull Terrier was sniffing my legs and I said in a

genial sort of way that it was probably smelling my dogs.<sup>1</sup> There was someone else with them in their living room, the father was on the telephone, and the television was on. I offered to make another time with them if this was inconvenient, but the mother thought it was fine to carry on, so when I explained that the television would be picked up on the tape recorder, she asked me into the kitchen and we talked there. The husband came in for a few minutes to ask about the tape recorder, and the child was at home and kept trying to climb over the child gate to get into the kitchen.

Before beginning an interview I went over again with the mother who I was, what the research was about and who it was for, and talked through the consent process, as I did for all the interviews. The mother told me that the reason they brought the child to the PCC on that evening was because she was worried about the knee swellings, and had shown the swellings to a friend who advised her not to ‘mess around’ and to see a doctor quickly, because her child had had encephalitis and the symptoms were a swollen joint and a rash. This made my respondent panic even though she has had plenty of experience with children, having had four, and has plenty of support from her mother who lives ‘around the corner’. When she phoned the PCC, the triage nurse made her feel that she was probably panicking unnecessarily, but she wanted a doctor to actually see the knee. I then asked her what she thought of the consultation, and she said that although they felt the GP had examined the child thoroughly, they both thought the doctor’s theory about bites was ‘rubbish’. They ‘weren’t happy’ about the bite diagnosis because it didn’t seem a convincing explanation for the knee swelling. She said they didn’t tell him her fears about encephalitis because he seemed to dismiss their emphasis on the knee swelling. They accepted the prescription because they felt, ‘you have to take what they say, what can you do?’, but really she likes ‘to know what’s wrong with them before I give them medicine’.

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<sup>1</sup> This is something I found myself saying a lot in similar situations in the past. I remember when I was training to do interviewing for the MRC being told that it helps to have dogs, because being used to them makes people with dogs more relaxed with you. Previous work experiences had made me well used to making myself relax in such situations and to appear as easygoing as possible, in case people are feeling defensive about the interview. This is an example of researchers’ emotion work, though not everyone does this.

As the interview progressed, this mother recounted a number of emergency situations they had faced with the children, and 'atrocious stories' about the doctors with whom they had previously been registered. These included one GP trying to cancel an ambulance that had been called for a child having a fit and the ambulance driver and doctor having an argument; and her loss of a baby when the GP removed a coil without noticing she was pregnant. In contrast, she was very happy with the practice they now used. The doctors explained things and it was no problem getting to see them. The health visitors at the new surgery also compared favourably with those from the old practice who would arrive unannounced and had an intrusive attitude.

This case shows some of the processes giving occasion for the mother's display, if not of virtue, at least of confidence in her competence and the wish to avoid blame. First, the parents in this consultation were clearly morally offended by the suggestion of bites, and the mother's claim in the consultation, there is 'nothing that could have bitten him', is backed up by the father's 'Nah'. Her offering of alternative possible causes, and their joint defence against the implication that the dog might have fleas, are interesting because of the connotations fleas have with uncleanliness and the idea many people have that it would be morally reprehensible if parents allowed animals to cause infestation of their children. It may be that the suggested explanations were an expression of an 'official morality' about parenting (Voysey, 1975), in response to their perception of a 'moralistic' type of blame as in Douglas' (1992) framework. Secondly, during the interview she demonstrated her knowledge of how to deal with children's illnesses in general and of her particular children's individual healthcare needs, commenting that the triage nurse 'only tells me what I know anyway'. Thirdly, her criticism of the bites diagnosis is lent weight by her evidence that *some* doctors had clearly proved themselves fallible in her experience: by this manoeuvre, in comparison to the fallible professionals she has described, she can claim both relative competence and avoidance of blame.

Another issue is why they didn't mention her fear about encephalitis during the consultation, particularly in the light of her bad experiences with her previous GP surgery, but brought it up with me. There are a number of possible explanations I could suggest. First, a poor estimation of *particular* doctors does not necessarily change one's general orientation towards doctors as a category of people towards whom one must

show a certain degree of deference, especially to their medical opinion, hence her comment, 'you have to take what they say, what can you do?'. Linked to this, many parents have expressed the sense that making their own tentative diagnoses is not welcomed when consulting a doctor, even though one is expected to notice and report relevant symptoms at the optimum time, something Bloor and Horobin (1975) referred to as a 'double bind'. In this case, the mother was willing to assert her ideas about bangs, falls, allergies, and antibiotics for the ear infection, but when he did not appear to be taking these seriously, she felt unable to introduce the medical term encephalitis. It was clear that if she felt she had successfully instilled in the doctor the idea that this was a person he could engage in a dialogue with, she might have come out with her fear, but in the event, she chose not to.

The mother's readiness to be more forthcoming with me is also worth considering. It may be that my having explained at length on the telephone that I was not a doctor, my research was independent and so on, reiterating this before starting the interview, and her having allowed me into her environment, she was more ready to disassociate me with doctors or the staff of the PCC, so that it wasn't necessary to suppress their real view of the consultation. Her remarks about the health visitors from her previous GP surgery alerted me to the importance she attached to outsiders not imposing themselves on her in her own home, indicating that making an appointment by phone, offering to come again at another time, and going through the consent process carefully were all significant in not being identified as someone like those intrusive health visitors. I think people often put researchers in an anomalous category, and are rightly suspicious about giving personal information to them<sup>2</sup>, but in my experience, this sometimes allows people to express things they might not otherwise have an audience for. An exception was an even more ambivalent situation in which a father I had met during an observation session talked to me for over an hour on the telephone about why it would not be a good time to interview his wife. Returning to this case, perhaps I was not threatening because I had no power to affect their medical care in any way, a point I emphasised in the consent process. Yet another possibility is that she hoped I would confirm their scepticism about the bites theory.

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<sup>2</sup> I put myself in both categories here, having been both a researcher and a subject of research.

Taking all of this into account, it might be asked how important all of this is, given that the child was obviously fit and well by the time I visited the family at home. I think there are at least three answers. First, the follow up interview showed that the parents were not happy with the consultation, despite their friendly goodbyes to the doctor. Secondly, the reason was not that they didn't think he was thorough, but that his diagnosis was unconvincing and failed to reassure them, because he didn't engage in a discussion of their own ideas and fears. Thirdly, his diagnosis was morally offensive to them (even if it was correct), a point which I think he picked up because he dropped the word bite, but for the parents the issue was still alive. So although the consultation could have been seen as bounded and closed by the GP, for the parents the fears they had before the consultation and the moral issue arising within the consultation were left unresolved.

The importance of other family members in the moral dimension of childcare, which I have referred to earlier, was a feature of many consultations. In the following case a baby was brought to the PCC by her apparently very young parents and the mother's mother (Obs 4). The mother was concerned because the baby was spitting up thick saliva and the mother thought she was choking. After taking a history and examining the baby, the GP tried to offer reassurance that the baby seemed not to have anything wrong with her:

- 'Dr: Hmm. [to the baby] You causing your mum a lot of distress, are you? I'd just say that she's a lovely baby, and I can't see anything wrong with her.  
M: Nothing at all? So ...  
Dr: She's got a little catarrh in her throat .... nothing there now  
GM: Cause I thought uh it's better with solid  
M: ... choked with the solids  
Dr: Yes she could have done, [...] held it [...]  
M: the spit was like, bubbles coming out and it was thick saliva and she wouldn't stop spitting so we turned her to her front  
Dr: I just wonder if she inhaled some of the solids perhaps and she spit it out [...]  
GM: because when I came in from work I was trying to see if she was in pain  
Dr: Well it's very hard, we're only speculating now because she's a lovely baby and she's, you can see she's lovely and well, but uh the way you desc-  
F: [...]  
Dr: Pardon?  
F: Would you be able to detect if she's got asthma?

Dr: Um you can't usually detect at this age if they've got asthma particularly, it's uh, you don't usually diagnose asthma until the age of one. Is there a family history of asthma?

M: Is there a family history, not really.

Dr: I would have thought your speculation that she may have choked a bit on a little bit of solids she had, had difficulty in clearing it out is the most likely thing because she's so well now. What did you give her at six o'clock?

M: Mince, mince with spinach in

Dr: A baby food is it?

GM: No I make my own food, baby food ...

Dr: Is it properly Moulid?

M: Yeah, vegetables really

Dr: Was it properly Moulid?

M: Mm

Dr: I can only speculate because she's so well now isn't she?

M: No when I came back from work I panicked that ...

Dr: Lots of mums do, there's no reason you should feel bad about it

M: You're alright C?

Dr: Well it's very nice to see you C. [Same name] is my favourite singer. She'd be one of my eight, one of my eight desert island discs, [name]

M: Alright then, thanks a lot anyway

Dr: Sorry I haven't got a full answer for you

GM: I hope she's all right

Dr: If there's a change or difference we'll bring her straight back all right?

M: Alright then

Dr: but I don't expect she will, I expect she'll settle down now and go to bed

GM: Okay then. Alright, thank you, bye bye

M: Thank you, bye bye

Dr: [to baby] Bye gorgeous'

The matter of what the baby, who is five months old, is eating is clearly an issue, with the grandmother claiming there is something 'better with solid' foods, but the mother suspecting that the baby has choked on something she has eaten. Added to this is the fact that the grandmother is making the foods herself, leading the GP to ask twice if the food is being 'Moulid' (made into a sufficiently smooth consistency). The father's tentative question about asthma is treated by all of them in the consultation as almost peripheral, serving to emphasise the apparently close engagement between the mother and grandmother over the care of the baby.

After the consultation the GP remarked that the social dynamics were particularly interesting. I think the GP has taken into account that the parents are very young, and live with her mother, whose involvement in the childcare is perhaps regarded with some ambivalence. He makes several attempts to reassure the mother that the baby is well, is

indeed 'gorgeous', and that the mother shouldn't feel bad about panicking. I think his repetition of the question, 'is it properly Moulid' could be interpreted as a further subtle backing up (which he has already offered earlier) of the mother's own theory that the baby has choked on the food, since it is clear by now that it was the grandmother who has prepared the food and therefore would have been responsible for not making it smooth enough. Since the family all live together, he is careful to play this down a little by saying he can only speculate.

The correct feeding of infants is typically a very absorbing issue for parents and not infrequently the subject of disputes and potential for blame by other people (Oakley, 1979). In my experience, mothers of babies under six months old can almost always report how many ounces of milk their babies are having each day, as well as the details of any solid food they have been given, with five months being a time many parents begin to introduce solids. What may appear to anyone who has never been responsible for day to day baby care as obsessive attention to these matters is very understandable from the point of view of carers, because of the many pressures and scrutiny they are subject to. The GPs' history taking for this age group typically included questions about how babies were being fed and whether they were putting on weight, as was the case here.

The triage conversations allowed me to gain some further understanding of the moral issues that are brought into help-seeking. During one conversation (NTC 03) the mother of a seven week old baby asks first about whether what she describes as diarrhoea could be caused by gastroenteritis. The nurse questions her closely on the exact symptoms and then explains that the baby's symptoms would not be regarded as diarrhoea. The mother then raises the issue that although she is breastfeeding, she has been giving the baby a bottle at night, and wonders if that is causing what she now refers to as loose stools rather than diarrhoea. There is some discussion about the correct formula to use, and the nurse suggests that she could try just giving breast milk and see if it settles down. The nurse then asks:

- 'N: Are you trying to wean him off so you can go back to work?  
M: No, I'm not weaning him off. It's just that, um, in the evening he doesn't settle and I've given him -  
N: He's feeling hungry?

- M: Yeah, and maybe because I'm a bit tired, I'm probably producing less [...]  
N: Less milk, yeah  
M: And that's why I think, you know, just two or three ounces, sometimes he doesn't take it.'

In this exchange it seems that the mother's anxiety about the stools stems from her use of formula milk. Her statement that he doesn't settle in the evening is interpreted by the nurse in terms of the baby being hungry. This is picked up by the mother, and a corroborating suggestion is made that perhaps he is hungry because she is tired and not producing enough milk. Another possibility that strikes me is that like many mothers, she thinks that formula milk will make the baby go to sleep and sleep for a longer time than breastfeeding. It is not uncommon for breastfeeding mothers to give formula milk at that particular time rather than daytime feeds specifically for that purpose, but since there is a lot of pressure for mothers to breastfeed, they may feel guilty about giving formula. The mother's remark, 'just two or three ounces, sometimes he doesn't take it', could thus be an attempt to minimise the importance of the formula feed. Also, she comments that she is tired which she suggests may be causing her to produce less milk. Breastfeeding experts say that sufficient milk will be produced according to demand, so that if you introduce bottles, the supply will go down. But sometimes the increase in demand does not produce an increase in supply quickly enough, or it is taken in smaller amounts more frequently, because the baby is satisfied by the whole experience of feeding and goes off to sleep before taking as much as they would from a bottle. Many mothers think that their babies seem hungry so they introduce supplemental bottles rather than wait for an increase in demand to stimulate higher milk production, despite the advice urging them to keep to breastfeeding. When mothers are tired, perhaps it is easier on their conscience, given the pressure to breastfeed, to justify getting a good night's sleep by saying the baby is hungry, and that they are not producing enough milk, than to say they cannot tolerate more frequent feeding and therefore more disturbed sleep. The nurse's question 'He's feeling hungry?' could reflect a belief that a baby not settling at night may be hungry, or it could be a response that arises from a lot of experience of this kind of conversation, where mothers frame the problem of wanting to cut down the frequency of night feeds in this way, and nurses go along with it to be supportive to the mother's needs and avoid making her feel guilty.

I think the last three examples all illustrate how such issues as feeding and cleanliness, and childcare more generally, can be constituted as moral issues within the contexts of the family and social nexus, how these processes may inform decisions to consult healthcare professionals, and can extend into consultations. They also exemplify how the 'framing and reframing' of issues in the consultation, before and afterwards, creates 'laminations' (Goffman, 1974), which is not the same as 'narrative reconstruction' (Williams, 1984) because there may be no attempt to reconcile numerous laminations in a cohesive narrative. The laminations are more dialogic, because they are continually subject to further negotiation of meanings and interpretation with different audiences.

### **7.3 The constitution of knowledge: education as a negotiated and contextualised process**

As noted in earlier chapters, the policies of the cooperative, the BMA and the Department of Health on the use of out of hours GP services constantly stress the need for patient education and knowledge about how to assess and treat common symptoms. However, in this section I argue from my data that knowledge was brought into play for different purposes and was *negotiated* between the actors in consultations. The relational, epistemological and ontological status of knowledge was variously constructed according to how much parents and doctors asserted their own point of view, agreed with the other, or engaged in more or less open debate.

A typical example of knowledge not being a simple entity independent of the negotiative context was when a GP (GP 15) was very reluctant to give guidelines on how to tell if a sore throat was caused by a virus or bacteria, because he argued that there were so many clinical factors to take into account. I think that although they might not describe it in the same terms, some GPs acknowledge that relationships and the decisions arrived at during consultations are constructed differently each time, taking into account the context and circumstances of many people involved, including not only those present but others who may exert a powerful influence on what each person feels they have at stake. All these factors throw into question the status of knowledge. A view of knowledge as provisional and dependent on clinical factors means that it is subject to interpretation and

construction through its context, i.e. it is relationally constituted in an interactive, dialogic process.

My notes from an observation session give some indication of the number of elements at play around the theme of the negotiation of knowledge and education during a fairly typical consultation:

‘The first patient was D, 3 months old, brought in by his mother and her mother. Dr. P asked about her pregnancy and delivery history, vaccinations, and what the problem was. Mother and grandmother both answered. Baby was lethargic, had a high temperature - 101/102 degrees even with Calpol, had diarrhoea and sickness, had glazey eyes, one eye red and swollen. Mother said the baby had a heart murmur, and cartilage in his throat. Dr. P was asking questions constantly, interrupting them when their answers developed into further explanation than he was seeking. He explained that he likes to see kids under 18 months because you can never tell, that there is no point in giving antibiotics if it was a virus which he thought it probably was. Explained that it is important to give Calpol regularly at 4 hour intervals. Mother said he’s had this for three days. Dr. P listened to baby’s chest etc., told them to persevere with Calpol for 6-12 hours. If no better, review with their GP, or call again. If any rash, go to A&E. Showed them how to detect meningitis type of rash with glass. Gave them a bottle of Calpol from the drug cupboard. Grandmother reiterated several times it’s better to be safe with a baby.’ (Obs 2)

The first of the issues to note was the part the grandmother played in the consultation, and how her reiterated moral justification for their visit reciprocated with the GP’s statement that he likes to see kids under 18 months because ‘you can never tell’. In this way they jointly constituted the consultation as legitimate. By contrast, the mother’s mention of the heart murmur which had not emerged during the history taking; her efforts to give the doctor more information than he wanted; and her statement that she had already tried Calpol for three days are relatively ignored. The GP’s attempt at education about not using antibiotics for virus illnesses, the use of paracetamol, and detection of a meningitic rash do not seem to be addressed particularly to any of the mother’s concerns, but seem rather routinised. I have also written in my notes on this observation session that I noticed that when mothers were accompanied by their own mothers, it seemed to be the grandmothers who ended up holding the baby for examination, and that on two occasions the GP had undermined the mother’s confidence by not taking the time to show the mother how he wanted her to do this. Interestingly

enough, this was the same GP who received the complaint phone call from the grandmother who did not accompany her daughter, and suggested that perhaps it would have been better if she had been there. This leads me to speculate that, recalling his generally unrelaxed state on that occasion, he himself felt more confident having a more experienced person present, and that he found it uncomfortable having to relate to newer mothers' lack of knowledge and anxieties on an emotional level. Another point was that he talked later on about how much he enjoyed a previous post working in an A&E department, and expressed with contempt his boredom at using his skills and knowledge at this level. All together, these factors may help explain why he tended toward giving routinised information, even if it is good advice in many ways.

In the section above on doctor-patient relationships, I discussed the ways in which conflict tended to be suppressed by both patients and GPs, even though they did arise and frequently they were over questions of how and whose knowledge was brought into play, the interpretation of symptoms, treatment and/or 'education' of parents. As I reported in chapter five, parents thought that GPs were sometimes fairly dismissive of the kinds of knowledge they offered. For example, a couple brought their 6 week old baby to the cooperative because they were worried about a rash on the back of his neck and other symptoms (Obs 9). They mentioned they had tried 'the glass test', and the GP asked if they were thinking about meningitis. They said they didn't really know. After examining the baby, he said it was probably just heat rash. The mother asked 'is there any way of being able to tell then if it's a heat rash or not for future reference?' He tells them he thinks it's likely to have been heat rash because it's gone down so quickly in the cool air, but more important is the way the child seems in himself. When they had gone he commented to me with a wry expression, 'she says they've been doing this glass test but didn't know why she was doing it', yet when she asked how to tell if it was heat rash in future, he didn't explain the purpose of the glass test. He added that it was usually a waste of time giving people advice about rashes, because they need to be seen. It may be that 'needing to be seen' is another way of saying that parents and doctors have to exchange information and interpret it together. However I don't think this GP was acknowledging the mother's attempt to equip herself with the sort of knowledge many GPs say parents should have.

Some GPs thought that people had erroneous or irrelevant ideas based on family health beliefs and this can be seen, if only subtly, in the following exchange. A father brought in his daughter who had symptoms of a urinary tract infection, for which he was given a prescription for antibiotics, and told she needed to have a urine test. Just as the father stood up to leave he said:

F: Well, actually in our country normally we sip some lemon juice with white sugar, it should be alright, that's what the mother did last night, she had some lemon juice with sugar, she was alright in the morning, then it started again.  
Dr: Yeah. She needs to have it properly looked into, ok.' (GP 11)

I think the last two examples are further illustrations of Bloor and Horobin's (1975) findings that parents are often in a 'double bind' situation in relation to knowledge in the consultation. If they reveal too strong an opinion about diagnosis or treatment, they may be seen as not deferring sufficiently to the doctor's expertise; but if they appear to have too little, or the wrong kind of knowledge, they may be regarded as incompetent in their role as parents. In many of the consultations, parents demonstrated negotiation skills which seemed to indicate they were fully aware of this position, yet were prepared to try to get their word in despite it.

Disagreements about what were the most appropriate treatments were thus both suppressed, but at the same time the subject of attempts at negotiation. In the following exchange, the mother involved was the GP's own patient:

Dr: [Examining child's ear] It's a bit pinker than the other one, but she hasn't got a really up and running ear infection, and the evidence is that you shouldn't rush to give antibiotics.  
M: She's in a lot of pain, I don't know what to do to ease it.  
Dr: Paracetamol  
M: She says it's not helping. Yesterday I was giving her paracetamol every four hours.  
Dr: Well, you can't give children this age aspirin, you can give ibuprofen, if you don't find that paracetamol works. But on the whole paracetamol should work, if you persevere with it. But it may be one degree pinker than the other, but it's definitely not a severe, up and running acute ear infection.  
M: *I thought it was an antibiotic job. She was up all last night, and I'd given her paracetamol, and I thought it couldn't wait until tomorrow. I thought it was just now, starting her on antibiotics -*

Dr: No, it definitely isn't necessary. I should tell you that they've just been doing research, and even if it's an infection, it often gets better without antibiotics, so you don't need to rush.' (Obs 3b, my emphasis)

As in the conflict cited in the complaint example, the mother and GP seem to have different priorities. There are two points to make here. First, the mother can be seen making a limited presentation of the child's problem initially, then making a more assertive request for her preferred treatment when her more open statements fail to elicit a prescription for antibiotics. The mother's attempt at negotiation of treatment is met with the GP's effort to use 'knowledge' to educate, and their strategic statements go right past each other. They each recognise only those parts of the other's talk that they can use to key in their own points. Secondly, the mother is concerned as quickly as possible to alleviate her child's pain, and clearly believes antibiotics will effect a more speedy recovery; but the doctor remains determined to act on the professional knowledge that infections *often* get better on their own, i.e. she is acting on an interpretation of statistical risk on a population basis. Perhaps also the mother was already aware of her doctor's views, and thought, not expecting to see her at the PCC, that she would see someone who would prescribe antibiotics. Another possible interpretation is that although the GP is stating the agreed policy 'line' on the use of antibiotics, she may personally feel ambivalent or uncertain about it. It might be interesting in this respect to know what GPs do for themselves or their own families in similar circumstances.

This case therefore points to the difference between many parents and GPs in what constitutes their knowledge base. In several of the interviews with parents whom I had also seen during consultations, it was possible to make links between behaviour which appeared to the GP to stem from ignorance or unreasonableness and a parent's previous experience causing them to be suspicious of medical advice, and in particular, of taking phone advice without the child actually being seen. The basis of parents' knowledge was usually past experience about their own children or those of their friends and family, and particularly how their children had responded to any similar previous episodes. The importance of high temperatures was an issue about which parents with previous knowledge or experience of febrile convulsions were particularly worried, and chronic illnesses such as asthma were cited as issues about which parents felt their particular

knowledge of their own child should be recognised in consultations. But in contrast to this kind of knowledge, some GPs based their views of parents' behaviour on past experiences of seeing hundreds of cases, so that instead of finding out more about why an individual presented a concern in a certain way, or was worried about particular symptoms, they seemed to address them in a routine way.

I have referred in previous chapters to the way that attempts at 'education' were made by GPs in the belief that with knowledge, people would learn not to use GP services 'inappropriately'. We can see in the observation transcription (appendix 3) how the GP describes using his surgery waiting room as a 'stage' to present educational messages to patients about which cases are emergencies and which are not:

Dr. [Re: emergency appointments at the surgery] ... it's an emergency, therefore they come down now. They have to wait though, the purpose of that is they have to wait. Clearly if you've got a very sick person they don't wait, but if it's just routine rubbish, they have to wait, and in fact you keep them waiting in order that they learn.

K. That they learn, what?

Dr. The inappropriateness of what they've come down for. [...] The doctor is responsible for educating them as to whether or not it was appropriate.' (Obs 05)

This GP used the waiting area space at the cooperative in a similar way. On one occasion he appeared deliberately to embarrass a patient in order to make a point about the appropriateness of her use of the PCC. A woman arrived at around 11:00pm and said that she thought she had lost a tampon internally and wanted the GP to examine her to see if it could be retrieved. She told the receptionist she had a taxi waiting outside, and asked the receptionist to speak to the GP straight away. When he came into the waiting room he (in his own words) 'pointedly ignored her [and] gave the advice loudly to the receptionist, like this is an abuse' (appendix 3). One of the parents who was waiting to consult him about her baby observed this scene, and in our interview at her home six days later she told me about the impression it had on her:

M: When I was waiting to be seen in the waiting area, there were a couple of other people who were waiting to be seen, and um, the nurse was in and out and was discussing the problem with her in front of us all, and if that was, and you

know, we all knew her business, and, because it was all out in the open, she wasn't taken somewhere private to talk about it

K: This was another patient?

M: Yeah, and I thought to myself, if they asked me anything about me, I'm not discussing anything in the open. I thought that was a bit informal.

K: So it was the nurse that was in the room next to the receptionists, came out of her room and talked to the receptionist?

M: Uh, talked to the receptionist and then came out to the patients saying, 'Oh, the doctor won't speak to you about your problem, but he doesn't think, find it urgent', and it was embarrassing for her, you know, it's just... (P 06)

This mother was not at all happy with the consultation she eventually had with the GP, partly because she 'didn't like his attitude', and this led her to discount his advice. So in this case, what he saw as education was interpreted very differently by his audience. In chapter six I referred to the issue that parents often felt that it was difficult to get clear information from GPs, so that it became a matter of trusting their opinion rather than being in a position to judge their advice in terms of medical knowledge. It seemed in some of the other interviews that parents were as likely to pick up on the tone of attempts to educate them when these were aimed at promoting self-reliance, as they were to gain useful knowledge. That is to say that for some the information was put over in a way that they could make use of and found helpful, but for others the only message they received was not to 'bother the doctor', without a clear idea of how to deal with particular situations, either because new symptoms or circumstances had arisen, or because they felt their own knowledge of that child meant they should seek help even if the GP didn't agree.

I think for all the above reasons, the emphasis that many GPs put on parents gaining more 'knowledge' as if that is central to their problems in organising out of hours care, is highly problematic. Knowledge is often seen by medics as though it were a 'package' that could be transferred by various means, but I would argue that knowledge is negotiated and constituted in context, and transformed in interaction by people needing to reconfigure it to make sense of it in their own case.

#### **7.4 The position of triage and advice in this system**

The system for taking incoming calls at Nightdoc is structured around the concept of triage. Triage nurses were seen by most GPs as another health professional resource, who can offer a large percentage (around 50%) of patients the advice they need, and thereby relieve them of a great deal of the out of hours burden. Nightdoc has formulated target rates for 'converting' calls from GP consultations to triage nurse advice, and nurses undertake training in order to maximise consistency of advice and increase conversion rates. However, training to further these aims has met with a number of issues being raised. Nurses may have different personal and professional aims and objectives to those of the cooperative, in relation to which they have an employee rather than member relationship.

The process of parents talking with the triage nurse is key to how they perceive the whole episode of using Nightdoc and negotiating 'appropriate' access, whether they receive a home visit, see a GP at the primary care centre, or get nurse advice on the telephone. The triage conversation was rarely referred to in the GP consultations, but was an important part of the account given to me in follow up interviews with parents at home. Although GPs and nurses know the purpose of triage, patients may perceive it as a form of gatekeeping, or another obstacle they have to overcome to get to see a doctor. Some parents compared this to the difficulty of getting past the receptionist at their local surgery, or described it as being 'fobbed off'.

However, it was clear from my observations that nurse triage and advice is such an important part of the way that Nightdoc has been set up that it would collapse without them. Triage nurses handle more than half of the workload, because they give advice to an average 50% of callers, in addition to the triage work that would otherwise have to be done by GPs.

For my first observation at the cooperative I decided not to sit in with the GP, but to get first overall impressions of how people carried out their work in this particular setting. I sat for an evening in the waiting area, listening to the receptionists and triage nurse, whose doors were open and who agreed to be observed, and gaining a sense of how

patients would experience visiting the PCC. The triage nurse (TR 01) on duty that evening appeared very keen to fulfil the cooperative's ideal in terms of how she performed on the telephone, achieving the six minute call length goal, and maximising the conversion of calls from home visits to PCC consultations. At one point during the evening, a receptionist came into her room and said 'You're slowing up mate, that holiday didn't do you any good.', but I recorded that she had taken 39 calls between about 6.30pm and 11pm.

After about an hour of my observation, joined on this occasion by Helen Harland, the triage nurse made some jokey comments as asides to us. Later on she came out and sat next to me, looking over my shoulder and asking what I was writing. I think she may have been both curious to know what we were writing about her, and anxious that she was making a good impression of performing well at her job. It put me in the difficult position of feeling that I was perceived as doing something like a 'time and motion' study, not helped by the lack of time to talk between calls in the same way I could with GPs.

From the telephone conversations as we heard them from her side, it was possible to glimpse some of her repertoire in negotiating parents' help-seeking. One of the statements she made several times was that if parents wanted a home visit from a deputy doctor, they might wait two to three hours, whereas if they came to the PCC a doctor would see them straight away. Another point she made was that rather than seeing a deputy at home, at the PCC 'we're not using doctors that you don't know', but it was not obvious how patients would have known the cooperative doctors more than deputies since they had a fairly small chance of seeing a doctor from their own practice. There was evidently some persuasion needed with some people, and this sounded to me like part of a sales pitch. Since her door was open, her comments to callers, and her asides to us, could be overheard by people in the waiting area, and patients could also see how she was using the computer as she spoke to them. I wondered whether she was aware of how patients might feel about her remarks since they would have spoken to her earlier in order to be invited to the PCC.

It was noticeable how different the working atmosphere was depending on the personnel at the PCC on each occasion I was there. Some GPs worked closely with the receptionists and nurses, going to their rooms and talking with them throughout the evening, discussing cases and procedures, and organising various services for patients. Other GPs were more removed, working in their consulting room and not really coming out except to get patients or speak briefly and more formally to the other staff. Similarly, some of the receptionists and triage nurses were very deferential to the GPs, while others were more assertive. They came in to the GP's room and pointed out a procedural matter, or gave the GP some call reports to get the GP to make some of the triage calls, sometimes remonstrating with the GP in a jokey way for not answering the calls quickly enough. The triage nurses also had varying thresholds for getting patients home visits or PCC consultations, and this would have contributed to some extent to how busy it was, in addition to external factors.

The position of triage nurses in the physical space of the PCC was analogous to their professional status. They were located in the room between those of the receptionists and the GPs, with more control over uptake of calls than receptionists, but with more pressure to deal continuously with calls waiting, because there would usually be quite a long list on the screen, than GPs had patients in the waiting room. They also dealt with more personal and medical matters on the telephone than receptionists did, but because this was on the telephone, it was not as intimate as a face to face consultation and possible examination. The level of information and advice they could give was similarly in between, although closer to the GPs, indeed many of the GPs took telephone calls and performed very much the same role as the nurses.

A striking aspect of the triage nurses' work was that for their whole session they were connected to a headset and positioned in front of a computer screen. The screen displayed a list of calls waiting, and then when the caller was on the phone, the triage and advice software which they had to interact with as well as the caller. The TAS system uses a pathway design to investigate main symptoms, and all of the options explored are then recorded on a 'call report'. The call report was taken by the receptionists to the GP if the patient came in for a consultation, and all of them were faxed through to the patient's GP for information (what the advice and treatment was, and how much the

cooperative would charge the GP). Therefore the nurses could, if they had their door closed, spend their entire session without ever actually seeing any patients, and since the time I was observing at the PCC, the cooperative has now reorganised the system so that the triage nurses for four PCCs now work in one centralised 'call centre', separate from the PCCs. I think this physical separation of nurses from patients is an interesting development. Some of the triage nurses I met seemed to regard this as an advantage over the kinds of nursing based on more continuous and physical contact with patients, and some of them missed that kind of interaction. The other aspect of this form of work that some of the nurses seemed to like was that it was in a sense taking a slice out of the GP's role, it was less a form of 'caring' and more the dispensing of professional advice. In this sense there could have appeared to be a blurring of the boundaries between nurses and GPs, and little difference in what they offered to patients over the phone, but from what patients and GPs said to me and the subsequent centralisation, I think there are still distinctions made between nurses and GPs in the way advice is valued.

## **7.5 Configuring work**

In the previous chapter I referred to the concept of 'checking', which parents and triage nurses used in slightly different senses: to have a child 'checked' by a GP, involving a physical examination or at least the GP seeing the child; or parents 'just checking' with the nurse or GP that something they are concerned about can wait until normal surgery hours or can be dealt with by themselves. Appendix 2 shows my discourse analysis of a nurse triage-parent telephone conversation, and illustrates how a mother's attempts to 'just check' that there is nothing seriously wrong with her daughter put the triage nurse in a dilemma because it is sometimes difficult to give such reassurance over the telephone. The triage nurse has to manoeuvre between the demands of patients and those of the cooperative as her employer. In the case analysed, we can see that the nurse tries to satisfy herself that the mother does not need to bring a child into the PCC to be seen, but has nagging doubts that there may be signs of asthma. Given the pressure on nurses to produce telephone advice outcomes whenever possible, and to avoid being seen to bring people in 'inappropriately', she seems to struggle with two equally unsatisfactory outcomes until she moves the conversation around to getting the mother to take the decision.

The difficulty for nurses in providing authoritative answers to requests for reassurance can also be seen in appendix 3, when the nurse came in to see the GP to check the advice she was giving to a patient. This happened at least once during most of the sessions I was there, and I had the sense that the nurse was 'checking' both on the patient's and her own behalf. On one occasion (Obs 9), although he was asked, the GP left the decision about whether someone should bring their child to the PCC or see their own GP in the morning to the nurse. Given his overall framework of practice, in which 'educating' patients to reduce demand featured strongly, I would think this may have been an attempt not to reinforce checking behaviour in the nurse as much as the patient.

Applying Woolgar's (1991, and Grint and Woolgar, 1997) concept of 'configuring the user' (see chapter two) as part of the conceptual framework to my discourse analysis material, we could say that 'the user', in this case the mother, is configured early on in the conversation to give the required information rather than telling the nurse about her concerns in her own way. Throughout the call there are instances of the nurse achieving this with the use of such manoeuvres as rapid fire 'mechanistic' questioning and cutting in before the mother has finished her sentence, until the mother appears to be trying to produce more compliant responses. The mother also tries to present herself as an 'appropriate' user by apologising in case she is seen as wasting the nurse's time. After offering several of these comments, saying she was really 'just checking', the nurse answers 'you're right to worry', confirming her configuration not only in how she uses the technology but also in acting appropriately as a mother. This is important because, as I have argued in the discourse analysis, the triage nurse is not after all completely autonomous, and rather than incur blame for the decision to bring the child in for what might (and indeed did) turn out to be judged by the GP an 'inappropriate' consultation, the nurse constructs the mother as 'worried' so that she can justify inviting her to the PCC in these terms.

I discussed in chapter 5 the atrocity stories doctors and nurses told about inappropriate demand and these also resonate with Woolgar's ethnography, with the category of 'users' denoting the construction of a dichotomy of experts and non-experts, insiders and

outsiders. Many problems in the 'machine' can then be attributed to the ignorance of the user, who simply needs to be educated to understand how to use the system.

There are of course other technologies employed and constitutive of the 'PCC as machine', notably examination procedures. Frankenberg (1966:293-4) notes the importance of observing not only who does what, but also who does *not* do it, and what it is they do not do, and this provides another useful aid to seeing how actors are configured and construct themselves. It was clear from many observations that parents in the consultation situation attended to their child in terms of dressing, undressing, comforting, positioning and presenting them for examination; whereas the doctors almost never helped with these things, or touched the children except to examine them. There seemed to be clearly differentiated roles to do with what sort of physical contact was appropriate, with examination and diagnosis being part of the 'technology' around which a legitimate involvement seemed to be constructed. Again, parents could be seen as 'outside' of this technology, but equally, doctors were 'outside' of the child-parent bond. The following extract from my journal is an attempt to describe my impressions of these differentiated performances:

The child's body, especially the infant's body, becomes an object constituted as the embodiment of whether the parents are good enough carers. The doctor represents medical power to approve or not of the parents' care practices. The child's body is examined as the evidence.

Women with small babies have produced this infant literally with their own labour. The life of these two, and sometimes fathers, in the early days is characterised by intense absorption with each other. The times and amounts of feeding, sleeping patterns, frequency and quality of stools are all important topics of conversation. The tendency of new parents to talk about such matters in detail and at length is well known, often a source of boredom for friends and colleagues not in the same position, and even conflict when new parents find they have less attention to give to others.

Some health professionals are sensitive to this and demonstrate an appreciation of this special state. Others seem to wade in with a medical appropriation of parents' work, symbolised for example by asking them to undress the infant and place them on the examination couch for the doctor to inspect. I noticed this as a moment when new mothers seemed flustered, there was a change in their physical movements and a sort of ritual feeling like the way women sometimes say they adopt when undergoing gynaecological examinations. Eye contact with the doctor is disrupted, people move around each other awkwardly, doctors

sometimes do something else while the infant is prepared. Mothers ask how far to undress the infant, talk to the infant with a reassuring tone of voice while unpeeling their clothes. There is then an uncomfortable time for the mother when she is not supposed to be touching the baby, following by a reunion involving the mother putting the clothes back on. I noticed mothers were often not receptive to what the doctor was saying at these points in the consultation, being preoccupied with negotiating this separation, which often made the baby cry or start fussing, so that when the mother got the infant back, she was absorbed with settling them again.

There is something about very young babies and their mothers that is still sexual, associated with the physical act of recent birth, breastfeeding, constant close physical contact, the sounds they make, the gazing into each other's eyes. They have not completely separated somehow, they are a bound couple, and in a real sense the baby is still being 'made'. This is not to portray this state in an overly romanticised way: it can be a kind of tyranny as well as a profoundly positive experience.

A doctor's examination can be seen as a disruption of this bound couple. Of course, it need not be only the mother who feels this, or only very young children. I observed a similar thing when the father of a four year old boy had to try to persuade the boy to be examined. In this case there was an additional factor of the boy's pain and distress because of the illness he was suffering.

I observed many examples of configuring in the processes of triage and advice conversations, consultations, and in interviews. Some of these aspects have been discussed previously but can be conceptualised slightly differently within actor network theory. There was the work that parents do to 'configure' themselves as making 'legitimate' demands, e.g. presentation of themselves as competent, responsible, respectful of doctor's knowledge and advice, including the use of justification and reference to how families and friends encouraged them to consult, and entailing the correct use of technology such as phone and appointment systems, thermometers, medicines and surveillance of their children. GPs and other primary health care personnel similarly engage in work to 'configure' patients as 'appropriate' users, using appointment systems, forms of questioning, 'education' for future occasions and so on. Children too are part of the configuring process (Laerke 1998) and are taught to submit themselves to questioning and physical examination, cooperating with requests to make various movements or keeping still, and contributing verbally or keeping silent at the right times: 'say thanks doctor'. The closure of the consultation is a heavily ritualised stage of the consultation (much written about in the GP literature) which involves (often) the writing and presentation of prescriptions, opening and closing of doors, leave-taking

postures and gestures; and affords all the parties with opportunities to convey, question or confirm assessments of the appropriateness of the visit.

At another level, I could see in the observations that assumptions were made about processes of configuration, for example some GPs make assumptions that patients have been 'vetted' by the triage system, and therefore they should be presented only with 'appropriate' cases. However, for the patient, it may not be at all clear exactly who they are consulting, what criteria were used to enable them to be there, and therefore whether they will be perceived as making an appropriate consultation. Conversely, patients may assume that having given in great detail the presenting symptoms and reasons for their concern during the triage process, the doctor will have a good idea of the nature of their visit. However, they are usually asked to go through the whole story again for the GP. Although the triage nurse records information about the triage process on a call report, which the doctor sees before patients are called into the consulting room, these details are often incorrect, or the emphasis on certain symptoms is not what the patient would recognise as the main complaint. This sometimes led to the doctor feeling that they got off to a misinformed start with patients, and to patients looking confused as to the inaccuracy of the report.

There is also potential for disjunctures in these processes. By the time patients are seen, the story may have changed considerably for a number of reasons. One is that coming in to the PCC instead of having a home visit can then influence how strongly parents put their case for attention. I would like to have had more data on this by having more of the triage recordings to compare with my observations, but this proved a major problem. Nevertheless, other factors were observed which also contributed to disjunctures in the configuration process. Parents could gauge how serious their child's symptoms seemed to be in comparison to others in the waiting room. The passage of an hour or more between speaking to the triage nurse, travelling to the PCC and waiting to see the GP meant that symptoms could change markedly. It was very common for children who had been screaming at home, with a high temperature and who seemed very ill, to pick up considerably having been out in the cool air, which caused both relief and manifest embarrassment in the parent who then often attempted to convince the doctor that the child had been quite unwell only half an hour previously.

## 7.6 Conclusion

In this chapter I have shown the importance of taking into account the context of health care outside of, before and after the cooperative consultation. This has included the importance of family, and has illustrated how the input from family and friends may be behind encouraging demand rather than creating demand by their absence as has been assumed by some GPs. Another important aspect is that the context after a consultation contributes to how people 'make sense' of what was said, so that for example if antibiotics are withheld on a wait and see basis without investigation of what that means to the parents, it may only be the doctor who waits, while the parents go elsewhere and get them. The context of consultations also changes GPs, so that their views in interviews are not always those displayed in their actions with patients, but rather than citing this as a criticism, I see it as integral to my overall argument, that knowledge is relationally constructed in particular circumstances. Of course medical knowledge is based on the scientific method and the principle of statistical generalisation, but the application of that knowledge needs to be achieved in combination and in dialogue with the knowledge parents have about healthcare and their own child. The same can be said about demand: parents cannot be expected to judge whether the symptoms they are worried by add up to something medically serious, or as is often equally important, to rule out what they don't add up to.

I have noted how the emotion work of suppressing irritation at patients or exhaustion of using particular emotions for work can result in emotional alienation, depersonalisation and blaming of patients, a symptom of 'burnout'. On the other hand, some of the GPs were happiest when they could use their medical knowledge to intervene in situations that were emotionally fraught for patients. As Good (1994) suggested, routine medical procedures and speaking practices are used to restore order, or to achieve the effect, rather than moral reflection (p85), but GPs can feel more excited by their work than this might imply. For many it happens when they can use their technical knowledge and skills: this is when work is 'fun'. Good argues that doctors are trained to see their technological skills as the means by which to 'tame' the soteriological manifestations of illness, so that being in control, using one's medical skills and thereby taking charge of

the situation is like the fulfilment of the heroic grand narrative, the achievement of their quest. They are charged with emotional energy. In comparison, the mundane cases are annoying for doctors, it is difficult for them to summon up emotional interest. No wonder, then, that doctors with this orientation want to cut out what they see as routine reassurance work: it lacks any emotional charge because it doesn't call on those aspects of their work that are most exciting, and at the same time, calls on emotional labour which tends not to be as highly valued.

In all of these respects it can be seen why the introduction of nurse triage and advice has been welcomed and can be very effective if the symptoms are easy to describe over the telephone, are relatively common and the implications fairly predictable. Some nurses are also more experienced at and more interested in addressing the moral issues inherent but often unvoiced in many common healthcare situations when parents are 'just checking' that they are doing the right thing. The problems seem to arise when parents are given reassurance but moral concerns are left unaddressed, or the child has not been given a proper 'check', meaning a physical examination, when parents want both. This implies that GPs will still need to see patients with what GPs probably consider to be trivial symptoms, even though many parents will be satisfied to have telephone advice so the numbers will be reduced.

The system of nurse triage within the out of hours primary care centre can also be seen as a technological manifestation of the shifting ground between GPs and nurses taking on some GP roles in the development of primary care. This technology, if nurses are included in that description, can be seen as configuring the patients to make appropriate use of the service. We can also see how nurses are configured in the process: they are given a limited amount of authority and autonomy on the one hand but on the other the purpose of the autonomy is to make only a limited number of appointments for consultation appropriate and thus to uphold the ultimate authority and status of the GP.

In conclusion, I have revisited some themes and identified some new ones raised by professionals and parents in their talk with me as well as with each other. I have explored how these themes manifested themselves in the processes and interactions *between* these people (and in the case of triage conversations, without my presence).

This reflects how the methodology allowed for multiple perspectives on the issues raised somewhat more partially by participants in conversations alone with me, for example when the data show contrasts between what people said and what they did, or how events appeared at one time compared to how they did in the light of further information. In addition to this aspect of the data, which is usually thought of as ‘triangulation’, it also became apparent how some of the issues different people raised did not feature at all for the others involved, or were seen in terms of quite distinct purposes, so that one could visualise this more in terms of different maps, which did not always have the same points of orientation.

The narratives presented in the consultations were short, focused, or partial versions of events put into medical, but often containing moral accounts of how the parents had assessed situations, being careful not to assert too directly their own diagnoses. The longer narratives in home-based interviews had meeting points with those in consultations, but sometimes the significance of those gave a totally different perspective to what happened in the consultation. If the GP’s story of the consultation is added, and then my observation of it, a kind of ‘map’ could be imagined, with the different players sometimes going over the same ground, sometimes at the same time but often not, meeting at points in different combinations and so on. Features on the map that will be unnoticed by some people or appear strange and unrecognisable will be taken for granted or represent landmarks to the others. The issues of cleanliness and feeding of infants are examples where perhaps the medical view would be more biologically based but the mother’s (it is usually mothers here) view is mediated by perception of social/ moral pressure. Sometimes utterances may express eruptions from one to another person’s time and space positions on the map, for example when the father exclaims ‘Bites!?!’, bringing his moral orientation into the agenda, and pulling the doctor off his biomedical track momentarily.

How does this way of thinking help further our understanding of the topic of this research? I think it is important to reconceptualise ‘inappropriate demand’ in a way that recognises the fragility of meanings in out of hours consultations. The circumstances are such that parents are probably both especially concerned and conscious that they may be perceived as ‘wasting the doctor’s time’, so that a variety of moral aspects of the

parents' experience are likely to be higher on their agenda than during daytime surgeries, even if they are unvoiced at the time. GPs oriented to thinking of out of hours work in emergency only terms and using biomedically based forms of education and reassurance as a way of containing the consultation within that framework are likely to be working in a different terrain to those of many parents. This may lead to confusion and dissatisfaction on both sides which probably will not be voiced, but may be expressed in other ways and have unanticipated knock-on effects. If the parents' particular moral concerns are not discovered, biomedically oriented reassurance is unlikely to allay them, and might even, as in the story of the 'clicky hip' (in appendix 3), raise new ones.

Most primary healthcare workers are working under difficult conditions, and perhaps it is easy to overlook the emotional exhaustion that can occur when people may be bored and yet required to do emotion work which is not highly valued professionally. Yet parents should not be blamed for using services inappropriately when often their reasons for asking for advice are consistent with their moral duties and caring responsibilities towards their children. Everyone involved needs reassurance and appreciation for their contribution to the production of health in children, and indeed themselves. Put in a more positive way, perhaps GPs could be persuaded that relating and responding to people's hidden, and often moral, agenda is as important a demonstration of knowledge and skill as practising more biomedical medicine, and may well makes everyone's lives a little easier rather than harder.

## **Chapter Eight**

### **RESEARCH AND HEALTHCARE: DIALOGIC PRACTICES?**

The two main aims of this study have been to examine the contentious subject of ‘inappropriateness’ of demand for out of hours general practitioner (GP) services for children under five, and to develop a methodology that would allow for reconceptualisation of the issues rather than assuming parameters in accordance with how one party to the transactions - that is GPs - have generally constructed ‘the problem’. I have described my approach as ‘dialogic’ to take account of a sense of fluidity between voices, awareness of layers of time and space forming laminations of meaning, and the ongoing interchange between my research participants, myself and future audiences.

The first two sections of this chapter draw on a synthesis of views and practice, bringing those of professionals and parents together with my observations of their interactions to understand how some organisational changes and strategies in relation to out of hours care are being played out, and to discuss some unforeseen consequences of the cooperative solution to the problem of ‘inappropriate demand’. This focus reflects that of the first chapter, in which I reviewed the ‘applied’ literature originating mainly from health services provider and research sources.

The third, fourth and fifth sections offer some interpretations of my findings using the theoretical framework outlined in the second chapter of this thesis, drawing on a broader range of social science literature. This leads to an examination of underlying conceptual assumptions, evident in the practices but also in the general approaches to healthcare of my research participants, and related to broader currents of change in contemporary healthcare policy and organisation.

The theme bringing all of this chapter together is the focus on the moral contents of social relations in healthcare. These are not often given detailed examination but they are

inseparable from the technical and organisational aspects, and are key to my reconceptualisation of 'inappropriateness'. The chapter will conclude with suggestions for further research arising from this work.

### **8.1 The context and consequences of organisational changes in relation to out of hours healthcare**

A range of broad reconceptualisations of significant importance to general practice has been brought about as part of the process of what appeared to be initially more narrow technical approaches to the specific problem of out of hours demand. The pressing impetus embedded in these technical approaches to the management of this particular problem has opened up the possibility of re-thinking far wider issues in general practice. For example, it has become possible to consider splitting off undesirable aspects of work for general practitioners and 'disowning' them, either by redefining and claiming a narrower province of their own work so the rest could be undertaken by others (nurses), or by reconstructing various aspects of their work (mundane, non-urgent or 'social') as illegitimate. In this section I address three major areas in which these reconsiderations appeared to be occurring.

#### a) Changes in the organisation of healthcare establishing a perception of patients as not a 24 hour responsibility

The most obvious strategy of GPs to address the crisis over the out of hours component of their contracts was to form cooperatives, making it more possible to talk about 'organisational' strategies rather than talking about individual GPs or even group practices as if they were still operating autonomously to the extent they have been able to in the past. Even if some GPs were holding on to their independence during the daytime, the introduction of cooperatives represents an unprecedented collectivisation in general practice. GPs at Nightdoc worked with other GPs only at especially busy times - weekends and bank holidays - but there were other opportunities to meet and work with other members of the cooperative. This particular change has delivered substantial relief from the 24 hour 'burden' that had been the source of so much complaint and threatened the future viability of general practice as it had been constituted since 1948.

The formation of cooperatives followed other previous attempts to share out of hours cover, such as the growth in size of practices, multiple practice out of hours rotas, and the use of deputising services, but the effects are incrementally larger, in line with the much greater membership of cooperatives. One of the greatest effects is that GPs have a lower number of out of hours sessions to cover under more controlled conditions. However, there are also shifts in thinking about healthcare that have accompanied this development. Green's (1996) work comparing single-handed with group practice GPs' perceptions of boundaries of space and time showed the tendency for the former to identify the local population as their community while those in the latter thought of their professional colleagues as their community. Working in cooperatives, together with the introduction of primary care groups, has the potential to create an identification with an even larger group of professionals and still further distance from the local patient community which, as Green argued, erodes the sense of 24 hour commitment to patients and enforces ideas of 'my time' as opposed to time for patients. There are now a range of additional opportunities for GPs including salaried positions and a choice to take posts only if a cooperative covers out of hours work. These opportunities mean that it is now possible for GPs not to regard patients as their 24 hour responsibility even if their contracts still retain this responsibility officially.

Along with changes in perception is the reality that it is no longer likely that patients will be able to contact their own GP or even one from their own practice out of hours, so that already a large challenge has occurred to the principle of continuity of care. This situation links to splits in professional views and to political trade-offs between continuity of care and the rhetoric of choice and access, which are seen as fundamentally opposed to each other. What is now provided for in practice has brought the issues of 24 hour responsibility and continuity of care, both long-standing and contentious issues, up into the 'thinkable' end of the agenda for policy formulation and change.

b) Re-defining and re-configuring demand so that a smaller proportion of people or problems are considered appropriate for GPs themselves to manage

In addition to being able to think of 24 hour responsibility for patients and continuity of care more flexibly, the formation of cooperatives has meant that a more collective consensus has had to be reached on how to manage out of hours demand. Nightdoc has tackled this by developing the nurse triage and advice role, putting nurses on the 'front line' to give the bulk of advice, and introducing procedures with the aim of routinising the work to achieve a relatively consistent response (although there is still great variation between nurses). A by-product of this is an endorsement of the view that a smaller proportion of calls are considered appropriate for GPs to manage directly.

One way of considering this is to focus on how the triage process provides GPs with gatekeepers (apart from receptionists), something GPs have long envied in their colleagues in hospital medicine. Triage is used to block access to the GP and patients perceive this to be the case. This mechanism of filtering demands from the bottom could be said to enhance the status of GPs intraprofessionally by introducing an extended hierarchical structure and, in relation to patients, by making GPs a scarcer commodity. At the same time it allows them to take advantage of benefits at the top, e.g. controlling the managerialism of the health service, and the financial advantages of banding together.

Another perspective is to consider how moves towards systematising primary care allow GPs choices to relate to those people they wish to spend time on and to resist undesirable contacts with others. The two tier framework for out of hours contact reflects a split within the profession, similar to the trends that can be seen in the organisation of nursing whereby one pattern is for highly specialised technical work, another pattern is for more holistic, interpersonal or 'emotion' work: the same people are often not inclined to work in both modes. As I have discussed in chapter seven, the more dramatic or technically demanding work seems to be necessary for some GPs to maintain their genuine interest, and only then does this level of skill trigger their capacity to do 'emotion work'. The more mundane, and what is often described as the 'social' end of work in general practice seems to them intolerably boring.

A further way of considering these changes is how they have opened the door for nurses to take up initiatives such as managing walk-in centres and brought about the burgeoning of NHS Direct. Although these initiatives have been government led in contrast to the cooperatives, which have been largely a GP led innovation, the use of nurses in these ways has undoubtedly followed the pioneering of nurse triage and advice, and in Nightdoc the development of NHS Direct for that area of work was actually originally led by the cooperative.

c) The rejection of 'social' needs as part of general practice

Leading on from the sense that certain types of problems or people have become 'disowned' through the cooperative strategy of routinised triage and advice is another important argument which is usually assumed rather than fully articulated. The thread of this argument starts with a stress on what is good for the system/group as against the 'quirks' of the individual, and what patients' 'need' as against what they may 'want'. A supporting view (although not a new one) is that the health service cannot afford people to be treated on a personal basis, because patient demand is inherently bottomless, and in any case drugs and technology are very expensive commodities. Thus if people have problems which are outside the remit of what medicine can provide at a certain economically efficient level - as provided for example by the triage system which keep calls to a minimum length and follows the algorithmic logic of the TAS software - then those patients have the option of having their healthcare concerns met through private medicine. This view ties in with the idea held by some doctors that 'social' problems are not within the province of medicine, and GPs do not wish to be involved in the management of such problems. This rejection of 'social problems' is buttressed by arguments that inappropriate demand can be blamed on the breakdown of the social matrix, loss of the extended family, and so on, rather than considering this division as part of a much longer trajectory of increasing depersonalisation of medical care.

## 8.2 Some unforeseen/unintended consequences of the cooperative 'solution' to the problem of 'inappropriate demand'

### a) Differences in doctors' practices are made more apparent

One of the (presumably) unintentional products of working more collectively is that differences in doctors' practices, for example in prescribing and interpretation of symptoms, are made more apparent amongst them. This resonates with Crombie *et al*'s (1992) findings that medical practices tend to be more individualistic than theory or training might suggest:

although their medical education and the construction of diagnostic rubrics for the purposes of epidemiological studies appeared to constrain general practitioners to express their patients' illnesses in rigid somatic labels, they resisted such oversimplification in practice. In the continued absence of a vocabulary to describe the diagnosis made 'simultaneously in physical, psychological and social terms', doctors appeared to use 'politically correct' language for the purposes of epidemiological recording, although this language could not express the complexity of how general practitioners thought about, and responded to, 'what is wrong'. For the most part this could not be expressed as diagnostic labels or numeric rubrics, but rather as narrative and critical appreciation. (Marinker 1998:76)

This kind of process was evident in the use of the call report for nurses to record main symptoms, and then for the GP to write notes after consultations to be forwarded to the patient's own GP. This passage of the call report from nurse to PCC GP to patients' own GPs was one way in which differences between GPs became evident amongst all concerned. Patients sometimes implied in consultations, and certainly in the interviews that they had received treatment which differed from what they expected from past experience, and conflicting professional advice was mentioned by patients, GPs and nurses. Some GPs expressed their dilemma over whether to follow the Nightdoc policy or what they thought was the 'right' thing in a particular case, but whereas nurses were expected through training to become more 'consistent', only one GP raised the idea that similar efforts should be made by GPs (see appendix 3).

b) Demand may be stimulated rather than suppressed

It is hard to quantify this because forms of out of hours care keep changing so rapidly. In the time between when I began my study to the time of writing, the cooperative has changed radically, taking into account for example the establishment of NHS Direct in the same area. It should be possible in theory to compare aggregated practice based statistics before and after joining the cooperative, but the advent of NHS Direct means that only a short window of time would be relevant. In addition, Hallam and Henthorne's (1999) study based on seven case studies found that

there appears to be a 'honeymoon' period in which demand levels fall slightly and GPs much appreciate their new-found freedom from practice rota commitments. Some members of well-established cooperatives, faced with rising demand and possible increases in their rota commitments to meet it, are less sure that [cooperatives are] *the* answer. They believe cooperatives can encourage demand and are an unwelcome step towards 24-hour access to routine care. (1999:71)

This has led one health authority in their study to project a 10.3% annual growth rate. As the quote also illustrates, there are fears that the changes in organisation will result in establishing patients' perception that although they may no longer be regarded as their own GP's personal 24 hour responsibility, cooperatives offer another resource which can be called upon more readily, fuelling rises in demand. Hallam and Henthorne also found another unexpected effect was that some GPs were now less willing to make home visits during the day since they had found patients willing to travel to the PCC out of hours.

Looking to the future, and putting the issue of levels and appropriateness of demand together with the concept of continuity of care, we can begin to explain why groups of GPs with very different views have so enthusiastically embraced the cooperative movement but resisted the announced introduction of walk-in centres. Cooperatives have been welcomed by GPs who value continuity because they have provided GPs with a great improvement in quality of life within a generally more controlled context than use of deputising services. Working together with other local GPs means that they can have some control over the quality and ethos of the service. Feedback is built into the system so GPs know who has seen their patients and what the advice was. They have also been enthusiastically supported by the 'modernisers' because the cooperative system reduces

what they regard as dependency on individual GPs or practices, but retains some constriction of demand, i.e. patients are triaged and access is controlled.

By contrast, continuity oriented GPs have expressed objections to walk-in centres because it will be more difficult to keep control over long term treatment; they fear they will disadvantage patients with particular kinds of illness e.g. people who are chronically ill; patients may be more likely to get conflicting advice; and if casual services are promoted, patients may lose incentive and opportunities to use surgery appointment systems. Working in a depersonalised system will lead to less satisfaction with the work and role, and greater burnout. 'Modernisers' object because they see demand going up with casual access; work duplicated; and loss of control over their gatekeeping function. There may in addition be financial implications if care is fragmented.

c) 'Education' of patients may occur but not as intended

Another unexpected possibility is that education of an unintended nature can occur. Parents may learn how to play the system better next time, or go straight to A&E as one mother told me she would do in future, after being chastised for using the cooperative by her own GP. Or they may learn that they can get nurse advice by telephone very easily, and pick up the phone more readily than they would before when the only option was to 'bother' their own GP. The possibility of people using walk-in centres and NHS Direct and not using the GP they are registered with was illustrated in the recent case of a 37-year old man with mental health problems who

had such a poor relationship with his GP that he always called out of hours services when he was ill and stored the follow-up notes meant for his GP - in the glove compartment of his car. (Moore 2000:6)

Differences between the ethos of cooperatively run PCCs such as the one I observed and the new walk-in centres will be interesting to compare, for example in their use of space. In the PCC, the waiting room was used by one GP to 'educate' people that he only expects to see urgent cases there. This was similar to Jeffery's (1979) report of how staff in casualty departments made what they termed 'rubbish' patients wait for treatment, while patients regarded as 'good' were seen more quickly. Some of the walk-

in centres will presumably use the waiting room space to give a very different message, for example if they are intended to encourage attendance by primary care users who are seen as not having sufficient opportunities for registered list and day surgery access, such as homeless people.

The 'education' of primary care users as to when, where and how to use the new services will also take place at a time when a number of changes are all having an impact on how both new and traditional services evolve and operate. These potentially confusing conditions underline the probability that unexpected consequences of educative efforts will continue to arise.

d) How the triage and advice role is developing for nurses

In the light of recent developments - NHS Direct and walk-in centres - the significance of the study has become broader than first envisaged because the key elements of change (development of cooperatives and telephone advice and triage) targeted at a more narrow conceptualisation of problems, are now seen as vehicles for more fundamental and rapid change. Nurse practitioners within local surgeries are steadily developing their role in primary care and are in some areas pushing to take more of a lead in Primary Care Groups and in running out of hours services. In this scenario, GPs could find that what they introduced as an adjunct to or delegation of their services has increased critically the autonomy of nurses within primary care.

Bowling (1981) found that over half of the GPs in her study on delegation in general practice thought that the presentation of 'trivia' was a serious problem. Their complaints focused on their lack of interest in or intolerance of social and emotional problems, particularly when they had a high workload. Yet a significant group of those who expressed these views were strongly resistant to delegation of any tasks to nurses, especially diagnosis. They had 'feelings of threat to independence and professionalism and fears of role encroachment' (1981:136) which she explained in relation to their longer-term history of role and status insecurity and emphasis on their role as 'personal' doctors. Echoing Cartwright (1967), who argued that GPs exaggerated the amount of 'trivia' as a reflection of frustrations that general practice could be regarded by

consultants in hospital medicine as not 'real medicine', Bowling's case is that GPs' unwillingness to delegate even when they felt they were overloaded with inappropriate demand could also be explained by deep-seated socio-political reasons:

Autonomy is the basis of professionalism and consequently it is not surprising that the medical profession is anxious to preserve it... On the other hand, more doctors were willing to relinquish their role of first contact *in the home*. This aspect of their role seemed to be particularly unpopular and was seen as unnecessarily time consuming. (1981:138, my italics)

It seems then that my study supports these earlier findings in that much of the blame on parents for inappropriate demand stems from more fundamental professional insecurities and discontents. The fact that GPs have compromised on total autonomy in areas of work they felt were especially irritating, out of hours work and home visits, is understandable, but at the same time it creates openings for colonisation of work.

Broadbent (1998) provides an analysis along similar lines in her study of practice nurses and health promotion as a professional project (drawing on Witz 1992) which arose in part from the 1990 GP Contract. GPs' rejection of health promotion as defined in the contract could be described as a demarcationary strategy but it has also allowed this role to be absorbed by practice nurses, and Broadbent discusses gender issues relating to these moves. Another way of looking at this is in terms of 'jurisdiction' (Abbott 1988), emphasising the centrality of claims for areas of work entailing exclusive intellectual knowledge and control, and constantly shifting parameters within a competitive social system. According to this view

The direct creation of subordinate groups has great advantages for the professions with full jurisdiction. It enables extension of dominant effort without division of dominant perquisites. It also permits delegation of dangerously routine work. (Abbott 1988:72)

These issues will be interesting to follow in the future because the creation of nurse triage and advice and NHS Direct, born (directly or indirectly) out of such delegation strategies, may play into the moves towards professionalisation of nurses. The conditions in terms of government policy appear to be such that nurses may be well placed to use these initiatives to make further steps in their professional project.

e) Resistance to new forms of out of hours care

The previous three chapters provided examples of GPs who maintained that continuity of care was a core value of general practice, despite joining the cooperative; and I observed nurses who in a subtle way resisted routinisation as a strategy to cut down on inappropriate consultations. Professional advice which conflicted with parents' other priorities or other opinions gave cause for resistance to healthcare suggestions or treatment, and in this chapter I have explored how interventions can have the opposite to intended effects. Some cases contained a number of these elements, for example when one of the GPs who had expressed concern not to undermine the authority of the patient's own GP repeatedly encouraged a man to see his own GP in morning, until the patient's numerous excuses finally made it clear he wouldn't promise to go. Instead of regarding this as simply irrational behaviour I hope I have demonstrated that there are probably various ways in which the patient saw his resistance as making sense.

Doctors who work within the cooperative but are not fully behind those aspects of its ethos and objectives that tend towards routinisation can also engage in 'subversive' behaviour which can lead to unintended consequences. They can take a more easygoing approach to prescribing and thereby (inadvertently) increase demand. They can adopt a more censorious attitude, and if the patient is not satisfied and then goes to their own GP in morning, the PCC consultation will be regarded as an extra expense. A variety of behaviours may be seen as undesirable yet be defended by those who have to balance competing interests in each case.

In advocating a critical phenomenology which incorporates the idea of resistance, Good (1994) considers 'how medicine constructs its objects' (p.65), drawing on Foucault's notion of medical discourses as consisting of 'practices that systematically form the objects of which they speak' (p68). In the course of resisting technologies of routinisation in the guise of medical imperatives, acts of 'resistance' (whether intended in this ultimate sense or not) also serve to reject the constitution of patients as inappropriate users or people who can be blamed for the effects of shifting organisational and professional relations.

### 8.3 Dependency and power

Many GPs regard medical criteria as the only ones to be considered when accounting for the appropriateness of demand, and paragraph 13 of the GPs' terms of service was revised in 1995 to clarify their right to decide on clinical grounds if, when and where to agree to requests for out of hours consultations (Hallam and Reynolds, 1999). However, Hallam and Reynolds (1999) argue that the interpretation of what constitutes clinical grounds, particularly on the issue of 'social' needs, remains 'fudged, leading to uneasy compromises' (p.65). The social origins of demand, whether on the individual or collective level, were seen by some of my research participants simply as disqualifiers, rather than integral to health problems. Rejection of the inclusion of the social aspects in healthcare demand was sometimes expressed as an attitude of blame cast not only on particular patients but on more diffuse notions, such as that of 'the breakdown of society', and 'the loss of extended families', as well as whole categories of people such as those on low incomes, and single parent families. This attitude was particularly prominent in the e-mail discussion list, GP-UK. Along with their beliefs about these social factors, many GPs resented being asked to manage the effects on patients of social problems which it was not their job to deal with, and felt that people were less reliant on social networks to learn about basic healthcare for their children. In this way, categories of people having socially related healthcare needs, who fall outside strictly medical criteria for appropriateness, are relegated to the 'inappropriate' demand category, leading in turn to being seen as dependent and thus morally undeserving. This form of 'victim blaming' seems to me to have serious implications for current policy initiatives, standing in stark contrast to the recent emphasis on addressing social inequalities in order to reduce the effects of poverty and other forms of deprivation on people's health.

The labelling of particular kinds of demand or patients as 'dependent' is another form of the same processes that lead to their being termed 'inappropriate' users. Dependence, like inappropriateness, is not an intrinsic quality or individual attribute: it is the enactment of social processes which must be seen in the context of relations within specific social, political and economic settings (Williams 1998; Hockey and James 1993; Williams and Wood 1988). Further to this, as Alderson and Montgomery (1996) argue in relation to children, if not allowed opportunities for self-determination, 'it is often

mistakenly assumed that they do not have the personal qualities or the capacity for autonomy' (1996:18, cited in Williams 1998). This may explain some of the attitudes I encountered that certain kinds of people are dependent, but I would argue such views should be challenged because they can be based on oppressive, blaming and incorrect assumptions and ignore the inter-related social forces that constitute people in particular ways.

The power of medicine is predicated on generalised knowledge achieved through a scientific biological framework combined with mass experience. Parents by comparison have more specific knowledge and limited experience, or partial knowledge of the medical framework, and in these terms are constructed as having compromised autonomy or being dependent. The medical framework of knowledge denies parents the opportunity or permission to assert themselves autonomously because it denies their frame of reference as equally legitimate. Instead it is assumed that because parents cannot demonstrate autonomy or equal knowledge in terms of the medical framework, they do not have adequate competence, and are thus dependent.

Silverman (1987:225-9) makes a further point, drawing on Foucault, allowing for a more subtle interpretation of reports of dependency. He argues that

effects of power are least visible when free subjects define and assess themselves through professionally-defined bodies of knowledge... the patient volunteers versions of the behaviour and motivation based on socially approved standards... Moreover, the doctor largely avoids overt policing. Instead, he offers the opportunity for the patient himself to produce the professionally desired response which the doctor then supports and reinforces. (1987:225)

In this way parents' reporting of 'trivial' symptoms, or 'checking' that they are doing the right things for their sick children can be seen as voluntary surveillance on behalf of medicine's power to judge their competence. Rather than seeing certain groups of people as dependent, it can be argued that such people have become especially adept at internalising or 'bearing' this particular 'power situation' (Silverman 1987:229).

#### 8.4 Virtue and blame

The ethnographic material in this thesis shows that contrary to talk about management of the problem of inappropriate demand in technical and bureaucratic terms within a medical framework, this becomes a moral issue in practice: each party's engagement in moral evaluations of both virtue and blame are crucial to and embedded within the social relations between them. The debate which appears to be going on between 'social' and 'medical' aspects of healthcare is itself 'inappropriate' because the two are actually inseparable in practice. Organisational initiatives that fail to take account of the moral frameworks within and from which people operate can produce unexpected and unintended consequences. One of these may be that parents inculcated into the performance of voluntary surveillance and 'checking' make presentations in what they regard as a spirit of virtue, only to be perceived as time-wasters.

In GP and nurses' accounts, moral issues entered into conversation differently to how they appeared in practice. They had the nature of informal talk about the 'other', a kind of professional complaining about patients like teachers do about students, librarians about readers, and so on, serving as a form of distancing from uncomfortable aspects of the job, or depersonalisation. This can occur when those aspects of a person's job which most call for emotional labour seem to become exhausting, and I have argued that when so called trivial work is seen as boring and less valuable, less emotional energy is generated for GPs with a more instrumental orientation. Moral language can be used in such a way as to defend other aspects of the self by splitting off and demonising certain patients and problems. The formation of the cooperative in a form which allocates undesirable work to triage nurses can be seen as acting on this split organisationally.

My purpose has been to present an analysis to try to interpret and explain these processes, rather than to take another moral stance. Inevitably one does hold values and these inform the research and its interpretation, but I have found myself more sympathetic to GPs than those who see medical sociologists as 'doctor bashers' might expect, even though I could appear to be taking the side of parents as the 'underdog' in this situation. It was apparent that many GPs also felt vulnerable in these encounters, in terms of their professional standing, and in carrying out what they regarded as a stressful

occupation. Doctors as people are also not able to operate totally outside of the moral paradigms of their patients insofar as they share similar cultural or social contexts (Helman 1978), and of course many GPs are also parents. Despite parents and GPs often having such qualities in common, perhaps it is not surprising that they can both resort to blame as a coping reaction to situations in which their frameworks clash in other respects.

## **8.5 Commodification and continuity of care**

**‘Human variability is such that for a seriously ill person the physician cannot be a replaceable part. If we insist on treating ourselves as such, we should not be surprised if society treats us as labourers rather than as professionals. We should also not be surprised if it does something to us as people. As we withdraw from our patients, we will be the poorer for it. Our professional lives will be less satisfying, and we will lose much of the depth of experience that medicine can give us.’ (McWhinney, 1989)**

McWhinney’s statement addresses the existence of two factions within general practice that became apparent to me in my research, and I have analysed and interpreted this phenomenon in a set of interconnecting ways.

Emotional labour theory helps to explain why GPs disown some kinds of work on the grounds that it is social in origin rather than ‘real’ medicine. Such work calls less on technical skill and knowledge, and carries less professional prestige than hospital specialist medicine, and therefore generates for some GPs less positive emotional energy. The emotion work of caring has largely been regarded as women’s role in the professional organisation of healthcare and therefore less valuable. Depersonalisation, blaming and distancing - all main features of ‘burnout’ - can be seen as both individual reactions and more organisational strategies. Within the former, patients can be treated in routinised ways, or with stereotyped responses, so that one avoids the burden and distress of long-term exposure to suffering, or the boredom of dealing with ‘trivial complaints’. Within the latter, the triage system could be seen as a distancing strategy, in that barriers enable GPs to be protected in a similar way to hospital specialists. By reducing contact with numbers of patients, doctors can spend more time on things they like doing, for example concentrating on more ‘real’ medicine. On the other hand, others

have advocated continuity of care and the personal doctor-patient relationship as a core value of general practice, claiming it as an aspect of medical work over which GPs have exclusive jurisdiction. In this perspective the new initiatives could be seen as allowing more time for relating to fewer people in a more personal way, enhancing what they find an emotionally and professionally rewarding way of working.

However, when such work is routinised and delegated, a classic managerial move, what starts out as the notion of a technical solution becomes the production of technicians. The human relationship is relegated in favour of rational management; 'a fortunate man' (Berger and Mohr, 1967) becomes 'one dimensional man' (Marcuse, 1964). By formulating themselves as technicians doing jobs, instead of having a professional 'calling' and personal relationships with their patients, some doctors make themselves prisoners of commodification, i.e. they take away the basis on which they were perceived as central figures to whom people displayed deference. Derrida (1966) uses the concept of 'decentring' to explain breaks from the past, in which given situations could be viewed and read as having been set up according to central principles. Doctors, for example, based their work on the medical model, and had a concept of themselves as occupying a particular social position in relation to their patients and other people. But a symptom of the postmodern condition is that such central principles no longer hold. Doctors can no longer work unproblematically according to the medical model, and GPs are losing some of their social status and the rewards this brings. Medicine is a body of expertise to which others relate with ambivalence, and rather than occupying a central social position, doctors' knowledge is regarded as a technology to be used as one resource among many, which doesn't necessarily confer knowledge or status in other areas.

Notions that people have become over-reliant on GPs to give basic health care in place of the 'extended family' appear to be 'beliefs' not based on any particular evidence, but they also highlight a division of views in general practice. Such beliefs tend to be referred to by those who seek to 'modernise' general practice, but who fear the scenario that people will come to regard them as a service to be used like other 24 hour services, hence the logic of statements like McWhinney's. What the 'modernisers' resent and see as dependency and trivial demand is recognised as the very stuff of general practice by those who support the personal doctor-patient relationship and continuity of care.

The characteristics of consumerist rhetoric and organisational responses to them are posed against a system which offered continuity of care, now seen as unviable. In the new scenario, 'education' and 'evidence-based medicine' are no longer seen as aids to practitioners enhancing their work with patients in a long term relationship, but as the means by which common or mass, rather than personal care is delivered. When changes are made which improve working conditions such as the use of cooperatives to alleviate the strain of out of hours work, the balance of opinion sways in favour of re-educating the public not to make inappropriate demands. Users of primary care are constructed as consumers having arbitrary and instant needs, and continuity of care is seen in opposition to this. When policy favours the routinisers, the other branch produces statements about the loss of personal care which appeal to the public ideal of general practice. But if these changes are developed into a system in which GPs are merely another form of healthcare worker delivering a technical service along with nurses and their status becomes devalued, the cries about loss of continuity of care will go up, and indeed, already have.

The issues around personal doctoring and continuity of care are complex. Distinctions need to be made between different aspects of continuity of care, and circumstances under which it is more or less desired by patients. For example, patients who value the concept of a personal doctor because they appreciate someone knowing their medical history do not necessarily wish to talk to their doctor about all aspects of their lives or very private issues (Fitton and Acheson, 1979). The permutations of circumstances and contexts in which it is favoured or not are myriad, so that it is not possible to argue whether or not it is a good thing in and of itself. However, it is possible to analyse its utility in the shifting social relations of healthcare in the same way that I have tried to examine the issue of appropriateness, for which continuity of care is a key construct.

The claim to continuity of health advice becomes a moral one, perhaps because so much advice is contradictory, and individual case histories are so complicated, that consideration of symptoms needs to be contextualised not only in terms of the person's history but also their family and social life; because of the almost unspoken 'irrational', yet entirely rational hope that you can trust the person who examines and treats your child, and that they will care about the child as an individual person known in the context

of their life and family. Expression of this wish was widespread in parents (e.g. see appendix 4). This aspect of relationships between health care professionals and their patients is one where there are stark differences between private and NHS health care and yet even in private health care, people expect rather than 'demand' it.

There are political and professional moves being made towards replacing the registered list system with registration within primary care groups, and in out of hours care, the principle is already being put into practice. Like the nurse telephone advice pioneered by cooperatives which has fed into the development of NHS Direct, it is envisaged by many GPs that walk-in centres will eventually open the way for further fragmentation of the registered list system. By looking at these developments in terms of a trajectory of change, it can be argued that they foretell the end of the personal GP-patient relationship as a central *organisational* feature of general practice.

Further to this, I would argue that whereas in the past, the principle of continuity of care was a taken for granted feature of general practice, this key element is in demise as a *symbolic or culturally central* feature of British healthcare. In relation to out of hours care, it is already the case that continuity of care has been removed as a central principle in general practice. Cooperatives have substantially extended the opportunities deputy services already provide to allow GPs to reorganise their services so that continuity of care may soon be seen as no longer necessary for 'in hours' services either. The changes being put in place as this thesis is being written have yet to reach their full fruition, so they cannot be studied other than at an early stage. The maxim 'time will tell' applies, and of course, it may be said that many changes in policy or service arrangements could be looked at as developments so that time will always tell. However, I believe that these changes have the potential to make a profound and fundamental break in the way that people have perceived and experienced the National Health Service since it was set up in 1948, i.e. through the *possibility* of continuous direct and personal contact with a named general practitioner and/or his or her immediate colleagues as patients registered on the list of a particular GP or practice. This is not to say that every person, or even people in whole areas of the UK have such a relationship, or that they would not prefer something different. Nor is it to ignore the fact that for many GPs, general practice is focused more on the technical or disease aspects of general practice, and they have tended to regard

these as separate from aspects (emotional, psychological, social) which others argue necessitate continuity of care. It is simply to say that this is what most people have in the past experienced, conceptualised or *believed* was the bedrock of the NHS, a symbolic and central social, political and economic institution in the life of the United Kingdom.

For all of these reasons I think these issues are worthy of public debate. Important questions need to be asked now, because once the current structures are dismantled, they will not be easy to reconstruct. How will the professional roles of nurses, nurse practitioners, triage nurses, health visitors and general practitioners be reconfigured in relation to each other? It has been suggested that continuity can be achieved through electronically accessible patient records, but what about continuity of *carer*, and the kind of information that is not easily recorded in this form, e.g. knowledge of family histories, especially in relation to long-term problems or mental illness? How will the gatekeeping role of GPs be affected, and how will this in turn affect the flow to and - equally important - from hospital departments? What is the evidence that the new arrangements will actually be more cost effective, when research has shown that the British system of primary care, with its traditional focus on continuity, is already one of the most economical and

is said to be the envy of the world... Although Britain's healthcare statistics are not the best in the world they are far better than expected given the comparatively low funding of the healthcare system and the relatively inadequate systems of social support. (De Maeseneer, 2000)

Will the political usefulness of the appeal of convenience, choice and access lead to damaging those aspects of the system that still provide continuity? Given the existing deficiencies in the system for providing social support to which De Maeseneer refers, what will be the knock-on implications if primary care increasingly rejects the more social aspects of healthcare?

The medical sociology literature on the doctor patient relationship in general practice in the UK has reflected the assumption of continuity of care as either a defining or a desirable characteristic of at least a substantial component of general practice. The present circumstances indicate that such assumptions may need to be revised, and

research has now to move on from the old doctor-patient or patient-centred models to models which take account of multiple sources and voices in the production of health. A 'dialogic' methodology which goes beyond models which rely on doctor-patient dyad and 'sealed unit' views of consultations could make a significant contribution to the building of new conceptualisations of social relations in healthcare.

## **8.6 Summary**

I have shown that it is not sufficient to approach demand for out of hours healthcare simply as a technical or organisational problem. Complicated and embedded processes and social relations need to be investigated and understood to make sense of how demand for out of hours care is constituted and how the problems for all involved can be tackled. As part of this analysis, I have re-emphasised the moral and emotional dimensions of these social relations in the face of contemporary preoccupations with particular forms of logical evidence and rationality. I have uncovered a substantial number of areas in which there are strongly held positions about healthcare and about what people can and should, or should not do and in what circumstances, and yet resistance, counteractions or ignorance in relation to such forces persist despite sophisticated measures to circumvent them. This is because scientific or organisational imperatives disguise largely moral proscriptions and to understand interactions at this level more attention needs to be paid to the play of moral beliefs and assumptions between all those involved, rather than locating these issues within the province of motherhood alone, or within the doctor-patient relationship as a bounded system.

Another sense in which the research has had to be broadened out to reflect the issues is in relation to time. Out of hours events are rarely one-off episodes. They are part of processes reaching back to the past, and forward to future experiences and expectations. They are points in multiple chronotopes interconnecting within and between the stories of different people. Each event is set in the context of other changes in people's lives, with relationships being reconfigured over time. These processes happen in what for GPs are outside of their daytime surgery hours, but these may be precisely the times when parents are most 'on duty', especially if they are at work during weekdays. They could even be regarded as the majority of the time during which healthcare activities can

be undertaken, and of course in terms of personal and family experiences of illness, such time boundaries - between 'in hours' and 'out of hours' care - appear alien to the continuities of such experiences.

This discussion leads to how the analysis of 'inappropriateness' has been broadened out in a further contextual sense. I have shown how the difficulties involved in negotiating 'appropriate' supply of and demand for out of hours services cannot be seen in isolation from, and indeed have recently had a major impact on, more fundamental problems concerning 'in hours' general practice. The changing out of hours arrangements that I have addressed - the introduction of GP cooperatives and nurse triage and advice - can be seen as part of a trajectory away from what have been considered to be key aspects of continuity of care and therefore need to be investigated both from the point of view of patients' experience, and those who are debating whether this threatens a core value of general practice or is a necessary step towards the only viable future. In addition, the rapid and extensive growth of cooperatives might have been seen originally as a solution to the crisis in general practice, particularly in relation to 24 hours a day healthcare, but it is taking place in the wider context of the rhetoric of consumerism, shifts in interprofessional practices and relationships, and government initiatives to develop 'primary care', and has in turn helped to constitute particular positions within those debates.

### **8.7 Suggestions for future research: A dialogic practice?**

A central theme of this thesis has been to support the proposition that healthcare is a morally constituted category, and to examine this phenomenon through a methodology that could be termed 'dialogic practice'. This involved taking account of the views of patients, healthcare practitioners and my observations of them to produce a synthesis of the everyday consequences of policy and practice and the contexts and processes in which these arose, together with an analysis of their underlying assumptions and often unvoiced moral agendas. The work I have done for this thesis suggests further questions for research and use of the methodology developed in this study, and I see these as falling into four areas.

The first builds on the finding that difficulties in providing out of hours services cannot be tackled within that narrow setting because they affect the whole of general practice. We are at a point where relationships are being reconfigured and therefore it is important to see the effects of this. It would be useful to know how NHS Direct and walk-in centres affect the continuity of relationships between patients and GPs, perhaps focusing on people who have healthcare needs which seem particularly to imply the need for continuity, such as those with chronic illness or users of mental health services. Questions around how this relates to forms of work that GPs with different orientations feel are most rewarding, as well as cases where patients find it most important, could then be investigated. Is healthcare moving in the direction of a consumer orientation; is this a retreat from patients; and if so what can we say about the attempt to separate moral and biomedical aspects? For whom and in what circumstances does a less personal and local service represent a loss, or conversely, freedom from moral opprobrium?

A second area takes the new initiatives into account and builds on the research methodology used in this study to develop further the focus on context and process. Out of hours consultations are not just one-off events, and future research could look over a longer period at the choices people make between a range of options, exploring the significance of different critical life stages and people's varying ability to make use of services. This could be locality based to follow the cumulative effects of people's ongoing experience of a variety of services, and further changes in provision.

The third area this work highlights that needs more investigation is the changing roles of nurses, in particular in NHS Direct and walk-in centres. Are there particular groups who could be said to be pursuing a professional project for nurses in out of hours care and in what ways? How do they see their new roles in relation to general practice and primary care, and in relation to jurisdiction issues such as diagnosis, treatment and health promotion?

Finally, could this dialogic approach also be a way of conceptualising a model of general practice in which the kinds of blaming response some GPs have demonstrated are less

likely to arise? Dialogic practice formulated in this way would be both medically and patient driven, recognising structural issues in differential access to healthcare, allowing for conflicting orientations in a more dynamic sense than terms such as 'partnership' or 'patient centred' imply, but at the same time for a genuine sharing of expertise. It would assume the longitudinal aspect of patients' experience without assuming that continuity of care or personal care are the only models for conceptualising this.

The reconceptualisation of inappropriateness of demand for GP services for children under five has proved an important and worthwhile endeavour, and the methodology I developed a valid and interesting one. Together these have led to an opening up of the issues for further debate and ongoing research: a dialogic practice.

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## **Appendix One**

### **List of interviewing themes on which to base questions**

#### Parents'/children's constructions

How do parents and children perceive the service offered by GPs out of hours, and what significance does it have in their experience of care for the child's health and well-being?

Do parents' constructions of 'appropriateness' incorporate the prevailing practice arrangements and 'message' about what is allowed, and if so, by what processes?

How do the present co-op arrangements compare with the previous practice arrangements, and what is their experience of how the changes were introduced?

Are parents aware of assumed influences such as the cost of deputies and the accountability for complaints and what their attitudes about them are?

How do parents think GPs perceive the service they offer out of hours, and what significance do they think this has in relation to GPs' work as a whole, and their other commitments?

#### GPs' constructions

What are the processes by which GPs have arrived at the prevailing practice arrangements, 'messages' about what demands are legitimate, and their own constructions of appropriateness?

How do GPs perceive the service they offer out of hours, and what significance does this have in relation to their work as a whole, and their other commitments?

What significance do GPs think out-of-hours services have in parents' and children's experience of care for the child's health and well-being?

To what extent do GPs think parents' constructions of 'appropriateness' incorporate the prevailing practice arrangements and 'message' about what is allowed, and if so, by what processes?

How do the present co-op arrangements compare with the previous practice arrangements, and what is their experience of how the changes were introduced?

How much do GPs think parents are aware of assumed influences such as the cost of deputies and the accountability for complaints and what do they think their attitudes about them are?

## Appendix Two

### Discourse Analysis Exercise

**Transcription of telephone conversation between mother of Baby X and Triage Nurse at 'Nightdoc'\* Primary Care Centre, evening in August 1997, with my annotations.**

**Kathryn Ehrich, CSHSD**

Transcription notes:

N - nurse

M - mum

R - receptionist

Words in [ ] are my notes or a description of a sound.

[...] means I could not make out the word from the recording

... means a pause.

// means the end of one section of speech overlaps with the next, or both people are talking at once.

\*Nightdoc is a pseudonym. All names and information that could make people or places easily identifiable have been omitted from the transcript.

Call lasts approximately 7 minutes.

The child in this case was 9 months old.

- 1 [dialling and ringing sound]  
2 M - Hello?  
3 N - Hallo is that x's mum?  
4 M - Yes it is

**A triage nurse looks at her computer screen and chooses the next call to make from a list made by the receptionists/call handlers. Each line gives the name and date of birth of the patient, GP they are registered with, telephone number caller has called from, time of original call, and main symptom or illness.**

**Most of the nurses start the call with a question such as "Is that Mrs (or Mr) Jones?", or ask something like "Did you call about Alice?", but some go straight into introducing themselves.**

- 5 N - Hello it's the nurse from [Nightdoc] here.  
6 M - Hi  
7 N - Hi. She's got a sore throat, has she?

**This is typical of the opening remarks made by nurses, first to say they are the nurse from Nightdoc, then to ask about the main presenting symptom. Sometimes they say something more open like "How is she?"**

- 8 M - I think it is a sore throat, [laugh] but she sounds alright now, [laugh] I hate to waste  
9 your time

**Although the mother confirms that a possible "sore throat" is why she has called, she immediately signals her doubt about whether the child's symptoms are serious enough to call at this point, and her concern not to be seen as wasting the nurse's time. I think it would be unusual for most mothers to call a doctor for a sore throat by itself, unless it seemed to be severely sore, and her comment that it "sounds alright now" indicates that it was something she heard that concerned her. The laughing could also be read as expressing her ambivalence. She could be using the phrase "I hate to waste your time" to establish herself as a person who**

**that in this kind of situation, it is quite possible that the other person will see her as wasting their time, and she tries to forestall this.**

10 N - That's all right

**Reassurance from the nurse indicates this was heard as it was intended.**

11 M - Um, like earlier, she's been like it all day, sort of on and off [...] she's got quite a,  
12 goes [squeek] she went like that and then nothing's coming out properly

**Having been reassured, the mother elaborates that although she thinks her daughter is alright now, she has been "like it" all day. She does not refer directly to soreness, but to the sound her daughter is making. "Nothing's coming out properly" indicates the sound is unusual.**

13 N - Mmm

14 M - So [...]//

15 N - Uh, when did she start this sort of sore throat?

**At the point where she says 'mmm', the nurse has paused. It could be that she is not sure what to make of the information so far, hearing the ambivalence and getting no clear message about the main symptom. She tries a more open category: "this sort of sore throat".**

**The pause could alternatively, or additionally be to allow the mother to tell her story, but it is brief and subtle, not an overt invitation. After listening to other tapes, one can hear whether and at what point nurses allow this 'window of opportunity' before moving on with the software protocol. In GP training, there is a school of thought, following Pendleton and Balint, that one should allow the patient to say what they are concerned about fully before beginning to ask questions. In this context, nurses are operating on a very tight time scale - a target of six minutes per call, and because the pattern of the calls is driven by their training within the co-op, it is more uniform and predictable. The callers, by**

contrast, usually have less experience of the technical aspects of this kind of conversation. Although they may be used to presenting symptoms over the phone, or to a nurse or GP in the surgery when time and access are similarly constrained, I think use of the software influences this context because it seems to make the nurses' questioning sound somewhat mechanistic. The caller can hear the keyboard being used, the nurse sometimes stops speaking while typing, and the diagnostic trajectory seems pronounced and formulaic because it shapes the conversation in a way that appears to arise out of the context of the two speakers. Callers may have experience of other contexts in which the person they speak to on the phone is interacting with both the caller and the computer. So there are two elements to the parents' part of the interaction with the nurse: they have to negotiate access to information and/or to medical help within a medical diagnostic environment, and they have to negotiate by extension with software that they can only negotiate with via the nurse. In both cases they cannot be sure about how their part of the interaction will be assessed or heard because they do not have direct access to the diagnostic environment.

Information about the onset and duration of symptoms, and the timing of the call in terms of how long the parent has been concerned, is established within the first few sentences and is important in the nurse's evaluation of the symptoms and of the 'appropriateness' of the call. During my observation sessions, and the nurse study days, I heard jokes about parents who called about such things as cold symptoms that the child had had for only a few hours, which would be deemed not long enough to be concerned about because colds 'normally' last for at least three days and are not considered serious sicknesses. They also derided parents who called about symptoms that had gone on for a longer time if they thought the parent should have consulted the doctor in normal surgery time over that period.

16 M - Well she was a bit croaky this morning, but perky enough

Mother uses the term "croaky", again sticking to a description of the sound rather than accepting the term "sore throat". Responding to the question "when did she start", she does not simply give a time period, but qualifies how her daughter

seemed. She minimises how bad it might have been by saying “a bit” and that this morning she was “perky enough”. She may be indicating here that it wasn’t bad enough this morning to warrant taking the child to the surgery, but at the same time the symptoms have been there for more than a few hours. These phrases could be read as subtly but skilfully strategic in presenting herself as making an appropriate call because they cover her both ways: in answer to a possible question “why didn’t you come earlier”, she can say she did not come during normal surgery hours because in the morning the child was “perky”; but on the other hand she did not phone too soon, i.e. the minute the symptoms started.

17 N - Has she got a temperature?

The nurse’s question is relatively open, i.e. she doesn’t say “have you taken her temperature?”, which would have implied a specific request for a thermometer reading. The distinction in health psychology between sensations, symptoms and signs may be pertinent here. A sound or feeling hot are sensations. The mother is not ready to call the sound a symptom, or to offer a thermometer reading as a sign, sticking instead to her description of sensations.

The computer software (TAS) prompts for questions along pathways depending on previous answers (see call report extract, note 1). There are standard prompts which follow on from the original main presenting symptom. For those associated with ‘cough’, see note 2.

18 M - No, she’s not hot//

The mother’s answer is correspondingly open, and does not indicate whether “she’s not hot” means she has not noticed the child looking hot, felt her with her hand, or taken a thermometer reading.

19 N - //And, is she able to swallow properly?

**Another prompt stemming from ‘sore throat’. There is in one sense little distinction between the mother’s and the nurse’s language, throughout this opening exchange, but there are differences in how the language is used. The mother’s descriptions are not in line with the diagnostic software environment the nurse is working in. Also, at this point a certain amount of compliance has been negotiated with rapid fire closed questioning, having only very briefly allowed the mother a chance to tell the story in her own way, and by cutting in before the mother has finished her sentence.**

20 M - Yeah, she’s, she’s full of life now believe it or not [laughs] but earlier on when I  
21 rang she was, she wouldn’t stop crying, she was, you know, she couldn’t get a cry out,  
22 it was just sort of//

**The mother makes another statement indicating she is not over-concerned about the symptoms - “she’s full of life now believe it or not”, with a laugh that could be interpreted as an attempt to lighten the tone of the conversation, but distinguishes between now and when she made her original phone call. She also returns to her description by sound - “she couldn’t get a cry out”. At the same time she positions herself as a person who may not be believed. So in a way, the nurse finds herself in a double bind: she has to respond to the call with enough detailed questioning to make a decision, but she perceives the mother to be possibly an unreliable witness, or ‘bad historian’. Perhaps this feeds into the nurse’s motivation to make the mother take the decision.**

23 N - Mmm, is she breathing normally?

**The nurse gets back to her agenda. Again, she cuts in before the mother has time to describe the sounds again.**

24 M - Um, I couldn’t sa - she seems to be now, but when she was crying she was having, it  
25 sounded all wheezy and hoarsey.

**'Wheezy' is commonly used as a word to describe the effect of asthma on breathing. In answer to the question of whether the child is breathing normally, mother starts to answer "I couldn't say": does she know what the nurse means by 'normally', or is it that she still wants to keep to a description of the sound?**

26 N - Has she got a cough?

27 M - She has been coughing a little bit today, yeah.

28 N - Mm hmm. And has she had a cold recently?

29 M - No

30 N - Has she got a rash at all?

31 M - Not on her body, no.

**Mother's voice becomes a little uncertain here. Has there been a jump in what she was expecting next? Wheezing, cough and cold all go together in the category of 'breathing'. Where does 'rash' come in? The mother's answer is ambiguous - does the comment "not on her body, no" mean there is a rash on the child's face? Does she realise the nurse is using a software package? There is a little shift in her responses now - she starts to be more 'compliant' in answering the questions.**

32 N - No, and when, when she, sort of was hoarse, was she drooling? You know was

33 there dribble coming out?

34 M - Um, well she was sort of crying and that and

35 N - Mmm

36 M - Well she was dribbling and crying and

**I can imagine the mother trying to be helpful here by answering the questions but not following the logic, because they aren't explained. If she is answering them even though she doesn't understand their relevance, one could interpret that as 'configuring herself' as compliant, trying to produce the right answer rather than knowing what to say.**

37 M - And, did you give her anything, any Calpol or anything?

38 M - No I haven't given her anything like that, I gave her like a menthol bath and put  
39 some Snuffle Babe and that on her earlier

**At this point, the nurse doesn't indicate why she has asked about Calpol (paracetamol in a syrup for children). However the mother demonstrates that she has taken some actions, which I would understand as meant to alleviate breathing problems. The nurse doesn't follow up these remarks, perhaps because she is still following the protocol? The issue of when and whether to give Calpol becomes an issue in the GP consultation, and the mother brought it up in my interview with her. The key point here was that because she didn't think the child had a temperature, she didn't think she needed Calpol.**

40 N - Mmm, and is - she's able to, she's taking her feed normally is she?

41 M - Well she's eaten, not eaten too badly today, no

**I have always found it fascinating how English people use 'no' in answer to a question when they mean yes!**

42 N - And she's drinking well is she?

43 M - Yeah she's drinking all right, yeah

44 N - Yeah, yeah. So really it was the husky voice

45 [sound of typing starts here and continues throughout]

**Having checked through related questions, the nurse returns to the symptom presented in the mother's terms, i.e. the sound of the child's voice. At this point, I think the nurse has begun to check over the details as they will be recorded in the call report, because she goes on to repeat some of her questions. At the bottom of the page, she will type in her summary note. As she does this, she allows the mother to talk more spontaneously.**

46 M - Yeah, that's what, that's what it sounded, really you know like hoarse and husky,

47 like I said. You don't want to bring anyone out for nothing. I just wanted to check that

48 you know, it's nothing.

The mother returns to the theme of not wanting to be seen as calling ‘for nothing’, and concern about bringing anyone “out”, i.e. asking for a home visit. Perhaps she feels that the nurse has eliminated the possibilities of anything ‘serious’ when she says ‘So really it was the husky voice’. Also, the nurse has suddenly stopped cutting her off because she is typing, so that she has space to fill. She offers the nurse the opportunity to close the conversation with the comment that she “just wanted to check that... it’s nothing”, i.e. that if the nurse will reassure her it’s ‘nothing’, that was all she was asking for, not a home visit.

I think this is a key moment in the conversation, and it encapsulates features of many of the interactions I observed parents having with nurses and GPs. These features are: that parents want to ‘check’ with a health care professional, i.e. expert knowledge, that the sensations or signs they have observed are not immediate causes for alarm. However, many GPs are not willing to offer reassurance about these signs unless they can physically examine the child, and indeed, many parents feel the same. This means that “checking” that “it’s nothing” is very difficult to negotiate over the phone. In practice, the parent is told what to try to alleviate specific symptoms such as a high temperature, but they are almost always given the advice to call back if they are still worried, and/or to go and see their own GP in the morning. Perhaps by going through the process of discussing the signs and advice for symptoms, the effect is the same, that parents feel they have done all the right things. In that case ‘checking’ consists of parents getting reassurance that they have acted upon what they have observed as well as anyone could expect, but it is not a sharing of responsibility in the sense that someone in authority has given them an expert opinion on the child’s health status because no one has said definitely that ‘it’s nothing’. This type of negotiation was common, and some of the GPs I observed and interviewed expressed intense frustration about the concept of ‘just checking’. One GP spoke with heavily sarcastic derision about parents who wanted to ‘check’ that their child was okay before a holiday, or weekend, or because of what he perceived as trivial symptoms. Yet parents are constantly under pressure to refer to professionals if in any doubt about their child’s health.

49 N - No, no, I think you're right to worry, you know. Um, when did she last have a  
50 wet nappy?

**My point is confirmed by the nurse saying “you're right to worry”. The message that comes across is, it is the job of the parent to pick up signs that may be symptoms of something serious. In this case, the nurse seems to want to get the mother to say she is worried, because then she can get her to bring the child in without it being the nurse who has brought her in.**

51 M - Um, about an hour ago

52 N - And that was good wet one, was it?

53 M - Oh yeah, yeah

54 N - Um, and she's not coughing or wheezy now?

**Both coughing and wheezing are asked about for suspected asthma. I think at this point this is what the nurse is worried about. When she said “I think you're right to worry”, my feeling is that the nurse is more worried about this possibility than the mother. She could also be attempting to reassure the mother that it was okay to ring for advice.**

55 M - She seems to be all right at the moment

56 N - Have you got any asthma in the family, or has she got asthma?

57 M - Um, my sister's got asthma, yeah

58 N - Mmm, and so do you think it was a sort of asthmatic type wheeze?

59 M - I'm not sure but it might, like [...] this is my first baby, like my mum and my auntie  
60 thought it could be like croup or something

61 N - [sound of typing] ... Well as she's alright now and you're not worried about her,  
62 just keep an eye on her, you know, monitor her overnight

**This could be seen as ‘upgrading the formulation’, i.e. pushing the statement to the point where it is likely to produce either further elaboration or a retraction. I**

**think she is pushing the mother to either take responsibility and say she really is not worried, or to come in.**

63 M - Mmhmm

64 N - and, uh, don't worry about giving her too much to eat, just give her plenty of fluids

65 M - Right

66 N - Have you given her any Calpol?

67 M - No, I have got some here I think

**This is the second time the nurse asks this question, and this time the mother indicates that she thinks she has some Calpol, which she didn't the first time.**

68 N - Well if you think she's got a temperature

69 M - Mmhmm

70 N - you can give her some Calpol

71 M - yeah

72 N - and, um, if you, if her breathing gets in any way laboured or if she starts having  
73 coughing spasms or anything like that, you can bring her straight up here to see the  
74 doctor up here

**This is the nurse covering herself, in case it is as she suspects, that the child may have asthma. She also introduces the idea of the mother bringing the child in to the PCC. Up to now, the only possibility the mother seems to have in mind is that she may be perceived to be asking for a home visit.**

75 M - Right

76 N - So shall I tell you where to come?

77 M - Yeah, please

78 N - You come to [the General] Hospital

79 M - Yeah

80 N - and you see - you can park in the disabled slot

81 M - [...]

82 N - You'll see a reception desk in front of you

- 83 M - Yeah, I know the reception area  
84 N - [directions given]  
85 M - Yeah  
86 N - You come to [directions given] and it's all signposted [Nightdoc, spells out], and  
87 you'll see the GP quickly here.  
88 M - Right

**This could have been the end of the conversation. She has covered herself by telling the mother to monitor the child overnight, and to look out for laboured breathing or coughing spasms, but she is still uneasy.**

- 89 N - And so you're sure she's got no temperature?  
90 M - Well I haven't got a thermometer down here, but she doesn't feel like she has  
91 N - Yeah, um, and you don't, don't think she's coughing now, her breathing's fine?  
92 M - Well, she seems to have been alright for the past half an hour or so  
93 N - Yeah, so would you say she had sort of a cough spasm, did she?  
94 M - She has been coughing today, yeah  
95 N - Yeah, but she didn't vomit with them?

**Instead of closing the call, the nurse re-opens it. She goes over the symptoms again. But again, the mother is noncommittal: she cannot give a thermometer reading, she limits the reassurance she can give the nurse to the past half hour, and will not say coughing 'spasm'.**

- 96 M - No. She, she, she also, when I, I haven't been in all day, I have been visiting  
97 relatives, um, she started - she did have a time when she held her breath, but like she's  
98 quite prone to that anyway, so

**This is another key moment because just when the nurse is trying to get the mother to go one way or the other, two new pieces of information are given. The news that the mother hasn't been in all day could signal to the nurse that the parent may not have been with the child all day, perhaps she has not been there at all, and is**

**therefore not able to give an accurate picture - a 'bad historian'. Just at this crucial point they are interrupted by the receptionist.**

99 R - Can you do [another name] on the line? Sorry ... [nurse goes off the line for about

100 N - Hallo?

101 M - Hello

102 N - I'm sorry about that Mrs X, sometimes we get urgent calls here

**What does this mean - her call is not urgent?**

103 M - Oh right, okay

104 N - Um, so when did the cough start would you say?

105 M - Um it was just this afternoon, just this - She wasn't coughing like badly, you  
106 know, for a long time, it was just sort of [uh huh huh huh huh huh huh]

107 N - Yeah, so sort of a wheezy cough?

108 M - It sort of, sort of sounded hoarse as well

109 N - Right [sigh]

**All the nurse's attempts to get the mother to identify the cough in relation to the 'diagnostic environment' fail because she will only describe the sound and not interpret it. The sigh could be heard as exasperation, and I think the response that follows from the mother indicates she heard it as such.**

110 M - It sounds quite funny really [laugh]

111 N - Yeah, well, as you're quite, you're certain she's alright now

**I think here the mother's comment and laugh, responding to the sigh, can be understood as trying to wrap up the conversation by lightening up the tone. She has answered questions about the cough already, and has been told what to look out for and how to get to the PCC if she decides she wants to come, so there may not seem much to be gained by going through it all again. However, the nurse does not laugh in response, and still sounds a little exasperated. Another upgrading formulation is used, to force the mother into the position of either**

**saying she is quite certain, or less than certain, but the mother can't be absolutely certain, that's why she has phoned. This manoeuvre produces doubt, so that the 'worry' is then firmly in the mother. This is important because then the nurse can't be blamed for getting the patient in unnecessarily.**

112 M - Oh she seems fine, she's still not quite, you know, her voice isn't quite normal but,  
113 you know, I'm not as worried as I was earlier

**The mother wavers here between saying "she's fine", but "still not quite... normal". She doesn't want to have the 'worried' label attached to her, but knows that if she takes a position of never having been worried, the legitimacy of her call will be undermined.**

114 N - Why don't you bring her up to see the doctor anyway, just to be on the safe side,  
115 because if it's something, you know, like asthma it needs to be checked out

**The key words here are "just to be on the safe side" and "it needs to be checked out". This allows them both to be satisfied. Neither of them is taking responsibility for determining what may be wrong with the child or whether it is a serious illness, instead it is being deferred to the doctor to "check". The use of such phrases as "have the baby checked over" or "just check her out" came up in many (47%, n=19) of the triage call recordings I analysed.**

116 M - Yeah

117 N - Okay?

118 M - What time are you there till?

119 N - The doctor's here until 10.30.

120 M - So it's going to close soon.

121 N - Can you get here?

122 M - Um, I'll just have to ring my mum to see if she can give me a lift

123 N - Yeah, well I'll, I'll make a note that you're coming up

124 M - Yeah

125 N - Okay, so do try and get here before 10.30

- 126 M - Right  
 127 N - Okay?  
 128 M - Okay then  
 129 N - And as she's still got, um, a husky voice and you, you know, you weren't there  
 130 when she had this coughing spasm  
 131 M - Mmhmm  
 132 N - Perhaps it's better to have the doctor have a, just to check her out

**This sequence shows how the nurse has closed off the discussion to her satisfaction. She has now got the mother to agree to come in with the child, and she has pinpointed the problem as a coughing spasm (fitting in with her diagnostic terminology, but note the mother would not say the word spasm), and on her belief that the mother was not with the child all day (which was not actually the case: she was out visiting relatives *with* the child). This is all rounded off with the phrase "it's better to have the doctor...check her out".**

- 133 M - Yeah, I think I [...] happier  
 134 N - Yeah  
 135 M - Yeah, okay then, thanks  
 136 N - Alright then  
 137 M - Bye now  
 138 N - Bye

**Note 1**

The call report recorded the following pathway of questions:

ENT/Dental ->	Sore Throat ->	Onset
		Fever
		Drooling
		Swallowing
		Breathing
		Cough
		Cold
		Rash
	Cough ->	Onset

Character  
Diff Breathing  
Sore throat  
Cough spasms

The nurse's summary read:

Has a husky cry, feeding normally, last passed urine an hour ago, mum worried it is asthma as sister has asthma, mum was not present when she had coughing spasm earlier. Given PCC appointment.

## Note 2

Extract from advice protocol accompanying TAS system developed at Kings College Hospital:

“Cough - Healthcare:

### A&E/GP Urgent if:

Associated with shortness of breath, haemoptysis, chest pain.

If you suspect pulmonary embolus or pulmonary oedema.

Coughing up blood.

Associated with chest pain and fever.

Fever lasts >72 hours.

### GP routine if:

Cough with yellow/green phlegm >12 hours

Cough persists longer than 3 weeks

[further sections on 'home care advice' and 'education']

## Appendix Three

### Observation session at the primary care centre

A Friday night in September 1997, from 7 pm to 12.15 am

Dr L - GP  
Dr R - GP registrar  
K - KE  
D - dad of patient  
M - mum of patient  
P - paediatrician  
H - Helen  
N - triage nurse  
R - receptionist

If two people are talking at once, the second person's line will start with //  
If I can't hear some speech, I will put ... [my extra notes in brackets]

If speech is interrupted by another speaker, the end of the line breaks off with-

Immediately preceding the start of the tape-recording, KE, Dr L, and Dr R (a GP registrar working in Dr L's practice) were standing in the corridor of the primary care centre (PCC) talking about general practice, my project, and out of hours calls for children. Dr L was giving an example of the sort of call that particularly irritates him, people who try to get him to see their child just to have a check up before they go on holiday. I asked him to come and sit down in the consulting room, where I had set the tape-recorder up, so that I could record what he was telling me. The three of us sat down and I turned the machine on.

Dr L - 'thought we'd just get it checked out.' Well, that was fascinating, thank you very much for entertaining me like that, but as he isn't unwell, or if is he's not unwell, are you sure he is not unwell? 'No he's fine.' If you'd like to pay for a private medical I'll happily do that -

Dr R - You, did you say this?

Dr L - Yeah, but it's outside the realms of the NHS. He's well, and I'm not checking him out.

Dr R - [laughing] I'd have said, yeah alright then.

K - So what did they say then?

//Dr L 'But I'm here now.' Well so what? You're not any more. bye bye. Enjoy your holiday.

K - So you didn't look at the kid?

Dr L - No

K - So say again, while the tape is running, say again your sort of general view about under 5's

Dr L - Well it's not under 5's, it's any one

K - right

Dr L - any child who, if a parent says a child is unwell I won't talk to them about it I want them down the surgery. I don't want to talk about their ill health. I want to see the child in order to make sure that the child is well.

K - So you don't take any telephone calls from patients?

Dr L - Rarely, rarely, I find it's totally and utterly hopeless. The information is either garbled, they only take out of it what they want, you give advice, they get it wrong. It's easier to see them and just ensure there isn't a problem. 'Well he's got a bit of a temperature' - what does that mean? 'He just doesn't look right, he's got some neck stiffness' Well is that a stiff neck or is that meningitic? Well there's no point in talking about it. I don't see why I should go out to see that. Bring the kid down. If the child needs a jab of penicillin I've got everything down in the surgery. If it needs uh, if it needs uh, any lines putting up I'll put lines up down the surgery, you know, I am trained as a technician and that is what I do, I am a technician. So I don't see why I should go out in some bloody ill-lit place where I can't do anything and no one is there to help me, no chance. But I'm happy to see any child - and we have a policy - we'll see - if they phone up, they come down now, or - we have a wonderful policy. Do you want to be seen? Come down, now. Now if it's not an emergency they get a bollocking.

K - what do they, what's not an emergency?

Dr L - whatever, any appointment, it's done on an emergency basis. Right, you say it's an emergency, come down. 'Oh I can't I've got my hair to do' or 'I'm just going, I'll bring them down after -' Well sorry, I am afraid we don't have planned emergencies.

K - So, do all your appointments have to be an emergencies or

Dr L - No no no, they are by appointment, but people that phone in

K - ah ha right, they say I want to see you this morning, then that's

Dr L - It's an emergency, well clearly because they haven't booked up, therefore it's an emergency, therefore they come down now. They have to wait though, the purpose of that, is they have to wait. Clearly if you've got a very sick person they don't wait, but if it's just a routine rubbish, they have to wait, and in fact you keep them waiting in order that they learn

K - that they learn, what?

Dr L - the inappropriateness of what they've come down for

K - so if they say it's an emergency they have to routinely wait

Dr L - well no not necessarily. They, really it depends on how different doctors do it. Me, I pick them off as I go through surgery. My colleagues might, they take a different view, some of them take a different view - um, 'well have them down at the end of surgery so they don't have to wait'. Well, why? Why shouldn't they wait, it's an emergency. You are providing them with a service, but they have to realise that it's a service that is an emergency service, not one that, oh well we'll bypass the system

K - right, I see, so it's to teach them not to bypass the system

Dr L - absolutely

K - so rather than wait till next day

Dr L - mm, and the doctor is responsible for educating them as to whether or not it was inappropriate. You see you can have a trivial emergency which although isn't an emergency and is trivial, needs sorting out. That's perfectly ok, but someone presenting with a routine problem in the guise of an emergency, that's rubbish, you see what I mean, I mean there are trivial emergencies which are trivial but none the less need, kind of, an immediacy to sort them out

K - so can you give an example

Dr L - oh kids, I mean, earache, that's the biggest load of crap of all, because most of them are viral, 96% of the stuff is viral, you are not going to do anything for them, but everyone loves coming down they love coming down - because you've seen it, in some way that makes the pain the child is in, and the fact they haven't given them paracetamol, whatever, that's ok. You can't do anything about it.

K - so that's trivial but it's an emergency because it needs to be dealt with

Dr L - it's family medicine

K - right

Dr L - the family are anxious about poor little Tommy or Sybil is crying. Given him any pain relief? 'Oh I didn't want without you seeing'. Normally people that are shoving shit down their neck like it's going out of fashion, they're taking selenium and zinc and they're giving them this and that and the other cos they've heard that auntie Doris, you know, and all of a sudden they can't take paracetamol syrup. You know, health beliefs, I mean that's a fascinating one, they take so much rubbish - 'I hate taking pills doctor', yes but these might save you - 'But you know I hate taking pills' - don't then. 'But then I'll die doctor' - well, take them then.

K - so what happens to the, let's just imagine um, a mother comes in with a 2 year old and he's had a high temperature, they've been giving him Calpol and everything and it's started, it's four days and still isn't going down, something like that where they think

now something that should be done about it, you know they feel like they've got to the limit of what they can do about it, so when they came in on an emergency basis, like say it's Friday and they say well it's not getting any better so

Dr L - ah now you come to the Friday cusp.

K - right ok

Dr L - The Friday cusp is, oh God it's the weekend, my God get it checked it out before the weekend. But why? Well you tell me why?

K - well I don't know, this is something that people will sometimes say

Dr L - oh I know, yes, absolutely

K - what will you say to them?

Dr L - I say why is it different now to the way it was two days ago? What is it that has brought you now to me and what are the worries that you have?

K - Ok this is, I'm role playing now. I'll say, well I thought if it was 4 days then that would be about the length of time that they should have a temperature of 102 or 103

Dr L - Why?

K - Maybe that's what they've been told before, that if it doesn't go away after 4 days, or 5 days -

Dr L - What is it you're worried about?

K - that it's maybe something wrong that I don't know what it is, but it should have gone by now

Dr L - But what is it you mean

K - that there's something wrong but I don't know what it is

Dr L - Well I would pursue it, what is it you've heard about?

K - that I've been told that if it's a virus or something that the temperature might be up for 3 or 4 days, usually

Dr L and now that it's not gone down what are you worrying about

K - that it's something serious that I should be

Dr L - but what have you heard about the worries you have

K - it's not something I've heard about, so I don't know

Dr L - What do you think is wrong with the child?

K - that they've got a high temperature and I can't control it

Dr L - lots of people get high temperatures

K - but it has gone on for 4 days and they're crying and crying and they seem uncomfortable and I don't know why they've still got this temperature after this many days

Dr L - A lot of it about actually

K - Yeah [laughs]

Dr L - Any of your children's friends got it

K - lets say they haven't

Dr L - well I'd be much more interested in the next question is, would be your social isolation and the fact you haven't got a family network, that's the thing that comes up, I mean, because that's the immediate thing, that's lateral thinking, I mean, when I'm screening like that, that I'm much more focused on the other stuff because if a child has just got a temperature, from my point of view, if there are no other things, and I'm eyeballing the child the whole time, the child is still looking around and still getting in my bucket with all the bits and pieces it shouldn't be, and the mother hasn't got a clue how to look, you know, this is not an unwell child.

K - ok, well let's say the child's got a temperature of 104 for five days, 105

Dr L - yeah, doesn't impress me very much, a temperature, with children, unless there's other features

K - ok, now the child has been vomiting constantly for 4 days , and a high temperature

Dr L - there is only one thing I am interested in. I will look into the child's eyes but that's because I'm looking for something in particular, and I will probably look at their mouth and at the same time I'll have been tweaking their skin. I'm only interested if they're dehydrated or they've got a conjunctival rash. If they've got a conjunctival rash they'll be with a ... in and penicillin quicker than you can shake shit off a shovel. But I'm looking for dehydration and that so I mean my, I'm looking for mening-

[Helen arrives, having had to go home again to get her tape recorder]

K - Hello Helen. This is Helen

Dr L - oh God you better sit down, I'm just uh, otherwise I I I'd have brought you in, I'd have made sure you came in by yourself under your steam. I've been alarming your colleague

//K - We're just talking about the um, this is Helen who is doing some observations as well and we're just talking about parents these bloody parents who worry about their children

Dr L - no you said that, I never said that [laughing]

K - I'm trying to think of an example of someone who's um

[phone ringing]

K - I don't know if Mike's

Dr - I should ... [goes out of the room]

H - How're you going to work?

K - I wanted to ....

H - Yeah now the thing is, I need a power point I think

K - I've got this one going on in here

H - Have you got in on power, or on battery?

K - No it's on power

H- It's on power, so that's the power point

K - The idea would be for you to use it in the other room if you...

H - Oh dear, it took me longer than I thought with

[several voices in this bit that are not clear]

K - We haven't had one patient in yet ....

H - .... so this is it, are you going to work for me [the tape machine]? Only bought it today so...

K - Well go and set it up in case you get a patient, or in case [Dr R] wants to go

Dr R - We have a three year old on its way...

K - Oh right, oh yes, oh yes, ok

Dr L - Yes, lovely, aaah, I don't want to steal your thunder, you know

H - Are you going to see if you can get, or if it's going to be quite quiet are you going to see if you can get the under fives directed into the room that you're in?

Dr R - Hardly up to me

K - I don't know if I

Dr L - the room that [laughing]... I'm here in my consultative capacity

H - I just thought if we're going to swop round because we've had a late start can we make it 9.30, when we have our strategy meeting, which basically means going down and have a cup of coffee and a gossip, a nicotine fix

K - I just don't know if we're going to get any patients

H - So you're telling me I am not going to have a nicotine fix, huh?

K - Oh you'll definitely get one, you'll definitely get one. Why don't I just come and get you

H - Yes, do that

K - at an appropriate moment

Dr L - Um, y- I'm sorry, you've lost your thread, with the child

K - [laugh] Right, so, um. Right, I'm trying to imagine how you'll react if you decide it's inappropriate, or on the other hand

Dr L - I tell them

K - ok so at this point

Dr L - but there may be a - this - but it may be inappropriate but you can be educational and reassuring, or there are others where you actually just have to confront them with the fact they're liberty takers. Now a new mother will not present her 4 or 5 year old like that unless they have got a social problem of some sort and they're actually, the child's the symptom carrier. If it's a new mother who is very anxious and neurotic and hasn't got very much in the way of family support etc and they've not had a baby before and they're worried that the baby is vomiting after every feed, well that's possetting and it's nothing to worry about and you need to encourage them and you need to then employ a different set of skills, you actually then engage in flooding, come back and see me next week, keep a diary of -

K - so then they get sick of it too

Dr L - mm, yeah. But at the same time you're also involving other people ... what do you think, you ask the health visitor, is there a problem, do you know what the social backup is, has she joined a new mothers' group, all that stuff. So you can still be reassuring, say yes I understand, it must be difficult not having uh, you know, uh, living up the 14th floor and you know, uh, x- partner kicks the shit out of you and doesn't support you

and all that stuff. So you can be supportive and there are others who come because they have run out of Calpol and I'm sorry that's like having a plaster in the house, Calpol, with a child

K - Right, I'll think of an example I saw here, um, I think the child was about three months old

Dr L - Mmhmm, oh right do you want us, do you want to work in this room?

Dr R - I don't mind

H - We have the technology

Dr R - I don't mind

Dr L - Which is the room that  
// Dr R - I've got my stuff next door

Dr L - ok well we, yeah fine, ok

K - ...

Dr L - Uh - I'm here supervising [Dr R] because [Dr R] is a trainee, registrar, whatever the hell, um, and they aren't allowed to see people themselves, well, load of old crap she's a fully qualified doctor, done and all the bits and pieces, but the system ... so I'm just here to kind of adorn the environment, and to

K .... do you mind if one of us comes in with you

Dr R - I don't mind, you can

Dr L - What is it?

Dr R - Three year old, vomiting, temperature

Dr L - The classic

[can't quite hear but we are sorting out who goes in where]

K - Ok I was thinking of this case here, I mean do you have any sort of view of, sort of, up to so many months old

Dr L - I take it all

K - Ok, I think this child was under 3 months I don't remember how many exactly, and the child had a temperature for, I don't know, a couple of days or something, but what she was really worried about was the child was shaking, shaking all day, and so the doctor who was here examined.... he wasn't basically that worried about the shaking, but she really was and she sort of didn't really want to leave until they'd addressed it

Dr L - Did the child demonstrate the shaking, or what the mother thought was the shaking?

K - I don't think it was at the time, it wasn't all the time, but it was all day on and off

Dr L - why, did they address why the mother came up then and not spoken or taken the child to the doctor during the day? What was it, what was it about it now that brought them here?

K - I don't think he asked that

Dr L- It's a very good question, it's the fairy godmother question. If you had a wish, one wish, what is it that you want me to do...

K - Right, I think she just wanted to know if the, what the, why the shaking was happening and if it was something to worry about

Dr L - ...doctor addressed that... so it was a dysfunctional consultation on the basis that the maternal problem was no better and the paediatric problem was not a problem according to the doctor who saw her, both on the basis that the child was the symptom carrier really, who had the symptom, and we're dealing with mother's anxiety or ignorance, or ill-education, whatever you want to call it, without - first child?

K - I think so, she had her mother with her and I think her mother was also worried about -

Dr L - Cultural background?

K - Umm, I can't quite

Dr L - White, black, other?

K- Um, white, lower-middle, upper-working, I mean, nothing very - I mean, what struck me was the mother, the mother's mother was here, they were both worried about this shaking, they didn't know why the child was shaking, and that this, this was the main thing, she wasn't that worried about the temperature

Dr L - Did the doctor take a full history of the pregnancy, delivery, special care baby unit, breast or bottle, weight gain, family history of problems, epilepsy, febrile convulsions, stuff like that?

K - Not the whole of that, no

Dr L - Well, none the less the child was well, so that's ok, but I mean, even though I would be not particularly worried I would still take a full detailed history, cause you could be wrong, ... you think you're always right and then big big big trouble, but nonetheless you guide, you have to safety net your basic knowledge with humility and take a full detailed history because you can be wrong. You may have pre-judged it, you

can't afford to pre-judge it because you can make a mistake. ... a kid with meningitis is a bad mistake to make. But then see I've got, I've seen lots of sick children, I've worked in a paediatrics IPU[?] so you're not really, you may be not talking to the right person. I mean I know a sick kid, I can spot a sick kid as they come through the door.

K - Let's think of another story altogether. Ok, I've come in and, yes this was interesting, um, the child kept vomiting

Dr L - how old?

K - um, do you remember those people who were in the Harvester, they phoned from the Harvester?

H - Oh gosh, yes, um

K - What about 3 or 4?

H - I'd say about 18 months actually

K - Oh because the other child was with them

H - Yes that was the confusing thing, it was an entire family

K - Yeah, but they were in the Harvester

H - The, the problem was about 18 months

K - ok, and the child was vomiting and vomiting and vomiting all day, or for longer, or?

H - Yeah

Dr L - So they went to a Harvester to celebrate this, mm? Well that tells you something doesn't it, for a kick off

H - We found that very intriguing ...

Dr L - Yes, it gets better

K - I think they were possibly American, they were black

H - I didn't think of them being American

K - I thought the man sounded a bit

H - It's possible, I know

K - they were black anyway, and um, and the child definitely had a male name and it was definitely a female child

H - No, it wasn't

K - the other way around, I mean we were discussing this, weren't we?

H - It looked, it, it! Poor thing

K - The child, because we don't know if it's a girl or a boy

H - It looked like it had, um, it had um

K - Corn rows, plaits

H - Yeah, the hair was braided, but it was braided in a more feminine style, but no it, you're right, I think it was Jason

K - something like that, anyway

H - this is one of the first ones, this is why it's so difficult to recall

K - mm, yeah, it was quite a long time

Dr L - so you've got an 18 month Afro-Caribbean child vomiting

K - mm, and I think that that was the main thing, they just

Dr L - acute onset all day

K - I think it's been all day, hasn't it

H - But the child seemed very jolly when he walked in

K - the child walked in here as right as rain

Dr L - yeah, as they do

K - ok so

H - I think they'd been rather obnoxious on the phone, I remember that, he was very obnoxious, and it was to a particular triage nurse who, they all have different styles but she was one of the ones that is, um, less give and take, she's more

Dr L - directive

H - directive

K - how do you start with them?

Dr L - First of all they'd have got a bollocking for being rude to one of my colleagues on the phone

K - well no you don't know that, you just get the call sheet

Dr L - oh I do, cause I ask

K - what you go and talk to them each time, for each patient

Dr L - yeah, normally, were there any problems with, oh yeah, I do, because I won't have professional colleagues abused

//H - I don't think he was rude, I think he was just very very awkward about not wanting to come here but she said to him, but you're out anyway, you're in a Harvester. I don't know whether he wanted a visit at the Harvester-----

Dr L - Probably, I mean they could, patients and their relatives can be strange, so, that would have been interesting, that I would have brought up immediately, I won't tolerate stuff like that. What I say to my professional colleagues is one thing but I won't let others do that, unless there's a particular thing

K - So they've come in, and they've had this bollocking first

Dr L - oh it would have been under the guise of education, they wouldn't have been left in any doubt, but, and then I would have taken a history. If the child was well, then prodded their tummy, looked in their throat, in their ear, if you've got a well child, you've got a well child who's just been vomiting, end of story, advice

K - Would you have told them that they shouldn't have come for that reason, or that that wasn't a reason to come here, to...?

Dr L - I would have asked them what they were worried about, what was it that they were particularly worried about

K - so now that, you're the doctor the next day in the surgery, just got a fax to say Nightdoc are charging you x number of pounds for this consultation, and then they come and see you again shortly after, about something completely different, do you say anything about it?

Dr L - Not on one. It all depends what track record they've got. If they've got a track record of totally inappropriate things, I wouldn't engineer, I see you phoned Nightdoc, what were, you know, .... you were out at the Harvester. Why did you take a sick child out? Sorry but I don't understand that.

H - Actually it's interesting, I did briefly write down something and it was, I overheard the triage nurse saying, um, you know, um 'You say he's only had it for an hour and now you're saying he's had it for two days.' The first story, they obviously changed their story. The first story was....

Dr L - I mean if it was an hour, I would have said well just wait, I mean, sorry that doesn't need, you know, I mean that's just common sense, you know, what you want, dr it was because he vomited. If it was two days and they took the child out, ... much more

interesting, why did you go out if you've got a sick child, I mean, were, you know, I'm afraid I don't understand that, perhaps you could tell me about it. But I don't have a problem you see in confronting people - I know, you don't have to do it in an adversarial way, but I think, I'm just curious, I'd love to know why any bloody parent would take a sick child out, or a child that is throwing up, I mean .... even if you're going out to some kind of family do where, you know, it was pre-planned, it was a birthday, I mean you don't take a sick child, you just don't, well, I don't, as I'm the arbiter of good taste in this matter.

K - So before your practice was in Nightdoc, what did you do for out of hours calls?

Dr L - You're looking at it. We did our own.

K - So you did all your own, and what would you do in those sort of scenarios if they phoned up and asked for a home visit

Dr L - ....

K - what if they really wanted you to see the child? Say no I am not going to come?

Dr L - No I'd say if the child's no better in a few hours, I'll phone back anyway in a few hours and we'll prob- I'll review the child in the surgery tomorrow morning. And then they are usually, if you're going to be, if you wanted to push the point, then you'd say well, what if they insist? Ok, come down to the surgery. 'It's three in the morning.' Yes that's right, it's three in the morning for me, I have got to get out. Bring the child down to the surgery. 'Well it's my right to have a home visit.' No it's no ones right to have a home visit. What is their right is to have appropriate medical care. The site at which that is provided is down to me. So the option is ...

N - Are you the doctor?

Dr L - I'm one of the doctors, there is another, the one that's actually, I'm the supervising doctor this evening-

N - Oh are you, can I just ask you a question?

//Dr L - Yes of course of course

N - Um, there's a 34 year old lady who basically took two of her thyroxin tablets this morning and she's now, she says her head feels like it's in a vice and she feels quite strange

Dr L - It won't be from the thyroxin

H - It won't be, so that's

//Dr L - What dose is she on?

N - One

Dr L - Do you know what, whether it's 15-

N - Oh no, all she said is it, she said she's taken 1mg, so I assume it is 0.5 micro

Dr L - Yeah, I'd have thought so too, it wouldn't be from that, I mean she well, any history of migraine or anything like that?

N - Well no, I mean that's what I was just checking, I was going to go through that, but I mean she's just, it's not going to make her get really...

Dr L - you wouldn't even notice, no, I mean, I mean, you'd only, you only start getting any overt effects of thyroxin after you've been taking it for a considerable while and

//N - Yeah because that's what I thought, I mean, because we vary it, you know, they start to feel a bit over don't they

//Dr L - absolutely, yeah, and then you'd usually wait and do a check of TFTs[?] now and then again in 4 weeks... you'd reduce or increase

//N - Yeah, that's what I said but I just wanted to check

//Dr L - So no no no no I agree with you

//N - speak to you, that's alright, that's fine

Dr L - Sorry where were we waxing lyrical?

H - You were taking about your, um, out of hours care prior to the co-op

Dr L - Yeah, that's what we did, but then I was low visitor anyway.

H - Would the calls come through to your home?

Dr L - Yeah, probably, or whoever yeah

H - It's just that I was confused when you said come into the clinic

Dr L - Oh yes but I would make them come down to the surgery

K - So why would you do that?

Dr L - Well because they want to be seen. I'm happy to see them. I of course tell them that if it's inappropriate then we may not be the correct, the right practice for them.

K - So first they have to come to the surgery so you have to go to the surgery and they have to go to the surgery, so you never see them at home

Dr L - Rarely, unless I'm worried. You know I may

//K - Mmhm. What would you be worried about?

Dr L - Well something in the history, when I would take a history over the phone and there are lots of times when people are phoning up for advice and they said something that has worried me and I have gone, and then other times where they think there's a problem, well, you know, wouldn't worry me, from a doctoring point of view, it don't

worry me, and I will decline their kind offer of invitation to visit their home at three o'clock in the morning.

K - So you tell them that they must come to the surgery

Dr L - absolutely

K - and then you say to them if it's inappropriate

Dr L - no I say, I don't think this is necessarily. Should I be proven to be correct, then we may have to look at whether we are the correct practice for you. But I may not, but I may say that at the time at the end of the consultation.

H - Is that as strong as it gets, because I mean earlier you said I give them a bollocking for

Dr L - But you can, no one's in any doubt when I am being icy

H - Right, and how do they respond to that, or I mean obviously each one will respond differently but when you have done that, what's been the reaction?

Dr L - 'Well I was worried', yes I appreciate that but you told me, I wasn't worried, 'well you could have been wrong', my experience is that I am not wrong for these particular reasons and you always have the opportunity to phone me again if it changes. I told you that I can be contacted, if the situation changes in any way, don't hesitate to call

H - So generally they would step down, would they?

Dr L - Well I mean, I neither care, I I I don't care whether they want to carry it on because that's not a particular problem for me. I am not worried about that kind of confrontation. I will happily, if they want to do battle over it, that's fine by me, if they want to say I'm sorry I was very anxious and, fine, I won't punish them unless they deserve, if they want to cross swords with me at 3 in the morning they'll learn....

H - No, me neither

Dr L - But you know, but it, I was the lowest of the visitors and my two partners, I mean I made three night visits in two years and between [my two partners] they did over 150, or something you know, something ridiculous, well, ridiculous. But that doesn't mean that I'm good and they're bad. I'm happy with my judgement and they've just gone just in case. Well I don't ... just in case. Once I've made the decision I live by that decision but of course they can, but people, you say to them, please phone again, if you're worried or you get round it by saying I'll phone you in three hours. If you want to actually leave it you say I'll phone you and then you take the agenda into your realm of activity and surveillance and not left it with them. That's far better. If you do that you have to jot it down in your diary, phone, so that you do it, if you don't you're on a hammering.

Dr R - Can I ask about the three year old?

Dr L - Share it with us

K - well it doesn't it have to be hypothetical then, you see, we can

Dr R - um, all day history of cough, vomiting after coughing bouts, so it wasn't really vomiting

R - Anyone want any more drinks?

Dr R - no, I've had

//Dr L - Oh I'd love a cup of tea, please, yeah

R - There we are

Dr L - Thanks very much

Dr R - It wasn't really, it wasn't really a vomiting child

//R - Milk and sugar?

//Dr L - just milk please

//Dr R - and he's still very, it wasn't really a vomiting child, he was just vomiting after coughing bouts, and um, temperature today but no other symptoms at all other than he was complaining of some ear ache as well. Um, family have been talking maybe asthmatic, but don't, the GP doesn't really seem to know. Um, and they've given him some Calpol. So he was happy, alert, co-operative, temperature 36-

Dr L - Is that the little bugger that was holding the FP10 and looking in here?

Dr R - could have been

Dr L - kind of Turkish, Asian looking child

Dr R - yeah, looking very cute and bouncy and alert and well

//Dr L - that's the one, the ... child, yes, no, I noticed that one

Dr R - temperature 36.4, red bright ear, chest clear, tonsils a bit inflamed, very well.

Gave antibiotics and there's probably no evidence to say that I should, and

//Dr L - ...family medicine

//Dr R - and it's ... and uh

Dr L - 'just check it out doctor'

Dr R - and I gave, also prescribed some paracetamol syrup because she asked me to, and I've recommended it in my consultation. I prescribe it if I've recommended it, if they just come and say by the way I've run out of Calpol I say go and buy it. That was it.

K - Did they want to know why you suggested antibiotics?

H - I discussed whether she wanted me to give... I said look, it's been 4 days now. I don't know whether an antibiotic is necessarily going to help him get better quicker. Would you like to try one or not and she said yes please ....

K - And they were happy? And how did you feel about it?

Dr R - Fine

K - [laughing] how did you feel, but I mean did you think that was a complete waste of time or

Dr R - he probably didn't need to be seen, um, because it might have been more appropriate if we said give him the Calpol and wait an hour and phone back because the temperature was 38 and it had come right back down but I am still at the stage where I am relieved if they've not got meningitis and I'm quite happy, if the rest of it ...

K - Right. What's this one?

Dr R - This is diarrhoea

K - How old are they?

Dr L - Yes in more ways than one

//Dr R - One and a half

K - one and a half?

Dr R - Yeah

K - I'll go in this time

Dr L - Yes in more ways than one that's diarrhoea.

Dr R - ...

Dr L - That's what I was saying before, there are trigger emergencies which are not true emergencies but they need to be sorted out and you don't mind those, it's the ones that pretend one thing and come as another that's the ones that you mind, that's your classic trivial emergency isn't it

Dr R - but, I mean

Dr L - but again, she'd been seen a health visitor who was advised about the previous thing, why

Dr R - why again

Dr L - why is it problematic now?

//Dr R - and we, and we'd given advice on non-urgent diarrhoea already over the phone, so

//Dr L - why? What is it? But yes, but what is it they think is going to happen you see, this comes back to the thing I was talking about, these health belief models, that people hold, and that we give in to them as doctors and co-professionals, I mean not doctors alone, but whatever, that they think that, you know, my magic wand and the duracell batteries is going to cure it

Dr R - Okay

K - Can you please tell them that I'm a researcher and that they will be taped, they have to know that

Dr R - Yeah, oh yeah

[voices too soft to hear]

H - Which practice are you in?

Dr L - The [name] Surgery, [town]

H - I recognise [Dr R] from somewhere and I can't place her

Dr L - She works here, well work- did the scheme here

H - Has she worked at the [town] Health Centre at all

Dr L - Don't know

H - I just, you know when you know someone and can't place them, mind you I'm not very good at placing people anyway. So uh, where were we? Kathryn was talking to you, Kathryn's interested in the under-fives, I'm more interested in the doctors themselves and how the co-op system works for them in comparison with the system before ... just basically the differences, compare and contrast

Dr L - Uh, well, I think it is wonderful, that simple. Um, I like the idea that I'm only on six times a year, if I choose to do...by Sunday I'll be doing three times in 10 days, but two of those were to earn some pocket money.

H - Oh right

Dr L - Um, to do a five hour session or a seven hour session for me is nothing, I mean, I don't care, I could quite happily do ... and not do another for six months. I'd happily do a session all through the day and night, I'd have no problem, but that's because I've got a strange work ethic, I hate work, therefore I like to get it over and done with

K - Why do you hate work?

Dr L - I hate working, I'd much sooner be doing something else. I'd ... the time, wouldn't you? I mean I don't mean hate work, but I don't, work is something that when I am there I just want to work.

H - When you say, right, so let me

//Dr L - I don't hate the work, I just hate work, so the only way I can do that is to get through it. I like working. I mean, I have two modes on and off, you know what I mean?

H - Yes, I can very much relate to that, yeah

Dr L - And, when people say, did you work hard? I don't work hard, I just work. If there are 50 patients out there I've worked just as hard as if I've seen one, because, d'you know, I I I'm not sure if I've explained that desperately well, but I don't have, I can't work hard, I work at one speed the whole time, and that is to do as well as I can as quickly as I can. Because, that's, I've always done busy jobs, so I don't, I can't do it any other way, I don't feel comfortable. I do a worse job if I'm talking about the meaning of life when there's no reason to talk about the meaning of life. If it's a ... medical mechanical problem, then I want to deal with it as professionally and appropriately as I can but in the shortest amount of time to expedite the thing. If I'm dealing with a psychological problem than it's a kind of counselling thing and it takes a bit longer but I won't spend any more time on it. I mean some people think the more time spent the better you are, well that's crap as well, you know, if it's a counselling, something needs counselling, it takes 3 minutes, spending 10 minutes on it doesn't mean you've done it any better.

H - I think I'm grasping you

Dr L - Yeah? I mean, just because you feel that, you know, that there's a functional time it must be good, there's no inverse law - [knock] thank you very much - there's no inverse care law about that that says, you know, the, you know, the, or a direct proportionality law that says you got to spend a proportional amount of time, you know, if it's a simple thing, it's a simple thing.

H - I was interested the way you say, you use the words medical and mechanical next to each other, do you consider

//Dr L - there are some, there are some medical problems which are medically mechanical

H - for example, give me

Dr L - nuts and bolts, um

H - because I'm not medical at all, so

Dr L - Um, if someone comes in with rectal bleeding, there are a certain number of questions you're going to ask, you ask the the the kind of holistic stuff, have they been feeling well lately, have they started to lose weight, cause then, have they noticed their trousers or their skirts are hanging off them, has their tummy got bigger? Any other features that have worried them, have they had a change in their bowel habits. Then, that's mechanical, you have to know that stuff, right?

H - Right

Dr L - You're going to ask them their past medical history, have they ever have had any other features relating to it, and ask them about their medicines so you know whether they've been precipitated by, I mean if they're on non-steroidal anti-inflammatories, aspirins, steroids, warfarin

H - which is?

Dr L - standard, warfarin, uh rat poison, uh given for, if they've got clotting diseases

H - oh right, yeah

//Dr L - yeah? You want to ask about the non-steroidal anti-inflammatory and aspirin because they provoke bleeding, and so do steroids, or can do, so those are the kind of basic stuff you'd ask about. Of course, if they're a haemophiliac, you know, again that would be the same as being on warfarin in some respects because of their bleeding problem, and then you can examine their tummy and shove a finger up their arse, I mean, that's mechanical, ...debate, that's what has to be done

H - Mmhm, do you consider that more mechanical than analytical?

Dr L - ... semantics, but I mean we maybe using different words, but for me that is the way it is, that is the nature of that problem. Now at the same time while I know that I'm going to do that, so I'm not going to waste time and talk to them, what I'm going to do is whilst I am prodding and poking their tummy, I'm taking a history because I know they - they're going to have a finger up their arse, so I'm going to have them on the, on the bed prodding and poking and taking a history at the same time so I don't extend that consultation because I have done it before, so I know I'm going to do, so it's going to be really quick and slick because I can't do it any - I don't mean that I'm, I just want, that's the way I run, that is the way it has to be for me, I'm used to doing busy jobs and I just want to do it, that's the way I would do it, and that is mechanical because I know that is how it's going to be. Now they may also have worries 'oh doctor is it cancer?', and that will come out when they've dressed themselves and I give them my notes, because they're going to say 'what is it doc?', and it might be something simple or something not and whatever it is it's going to have to be followed up later. They've got bleeding from their back, but it's not an emergency, actually, unless it's torrential, and when they come to you the first time as an emergency that's not true, and so that is definitely not true

H - Why isn't it true?

Dr L - Because they've noticed it before but something's happened, they've heard something, a friend of theirs has got cancer or something like that, right, something's brought them. There's always a precipitant, there's s rarely not a precipitant

[end of side one, 45 minutes]

H - You're not likely to see any patients, are you?

Dr L - I'm not, not unless ... well, I mean, by that I mean I can't imagine that Dr R is not going to be able to deal with anything. I'm just here as, to be support, a crutch.

H - Mm, so where were we, um, that's interesting, but we could actually, or maybe, we've gone off this, it's my fault asking the mechanical question, .... the issue of out of hours care, which is really my, what I'm interested in, my research ... journals and bulletins is like the stresses and strains of being a GP, and uh, a key thing that cropped up again and again and again is the out of hours issue. Now because the old-fashioned sort of traditional out of hours care really doesn't seem to exist anymore, it's all co-ops and things like this going on, I've got no way of personally comparing and contrasting, I'm relying on the anecdotes

Dr L - Well the the the hateful thing about the on-call system is that you're at the beck and call of Uncle Tom Cobble and all, I mean, 'you're on call, I just thought I'd phone and ask, can I have a repeat prescription?' or 'I haven't had time during the week to do this', and they're just phoning you the whole time, so the calls have been passed through to you, so your time according to the patient is dedicated to them. This is not an emergency service, you're on call. There's no correlate as far as they are concerned with your time and this being an emergency, so there you would be with your family, girlfriend, boyfriend or other - your time's not your own, you can't do anything because the poxy bleep or phone or whatever may go off, and it might be for a load of old cack or it might be for something really tasty from a medical point of view, you don't know. So you can't relax, so you can be with your family, but not, because you can't really participate and do anything, because you can't, because you are on-call, so you can't be a normal human being, you are an on-call human being

H - and how does it make you feel when you get phone calls like a repeat prescription

Dr L - I put the phone down on them

H - Really

Dr L - I'm sorry this is totally inappropriate, this is a total abuse of the medical service, this is for medical emergencies, goodbye. I do not listen to them, I don't want to hear them, and even if they say 'well, it's for my funny turn, I might have a fit', you may well do, that'll teach you in future to put your prescription in on time, it's not my fault that you, I can't be held responsible for your inadequacies. I don't have any, there's no problem like that, you don't just know he's an epileptic  
//H - and have you ever had complaints though?

Dr L - yeah

H - and, what what sort of complaints are they, and how does that make you feel?

Dr L - I don't care. I don't care because medically speaking there was nothing wrong, so I don't care whether they don't like the fact - that I shouldn't make them feel this, that or the other. It was never a problem for me. 'He wouldn't come out, he only wanted to have us down at the surgery.' Well that's not a problem. Did you go? 'Well we had to.' That's right.

H - So obviously this is much better for you

Dr L - Oh this is, this is as near as one's going get to Nirvana as far as I can see

H - Right, so this is better. Are there any downsides that you can see to this?

Dr L - Well only at the moment, but I think that will be addressed. Uh, lack of consistency.

H - Could you expand on that?

Dr L - Yeah. I'd like everyone to be like me, in as much as it has to be a consistent approach, or be like someone

H - right

Dr L - this is the way we deal with these kind of calls, this is the way we deal with this kind of problem

H - So you mean like a proper policy

Dr L - It would be nice to have, uh, yeah, lowest common denominator guidelines

H - so are you aware of um, I mean could you give me an example or at least create one for um, you know, Dr A treating a situation like so and Dr B treating a situation like so, to give an example

Dr L - No I'm more, I would be more concerned at not whether there's variance between treating earache or something, because there's always going to be that, to a certain degree, but whether it's appropriate or not, and that the patients should be policed. Once the patients are policed then I would start policing the doctors.

H - So you're talking about inconsistencies within the patients

Dr L - Uh inconsistencies in the way patient are dealt with if it's inappropriate or advice or reassurance or education.

H - What do you mean by education?

Dr L - The simple stuff. Your child's got a temperature, why have you brought them out wrapped up, swaddled. What do you believe? 'Well it's a cultural belief that you wrap them up.' Well, that's why third world kids die, sorry, no. The child should be running around in his nappy, undressed, sleeping with a light sheet over it with some air going through the room, with some Calpol and if that does not work and you have done all the other bits and pieces, tepid water sponging, have you tried that? These are the kind of common things you do, and I will go through it, one two three four five, and then, yeah, then you're educating them.

H - I sat in with the triage nurse and that's always their, that seems to be their job as well, they're always giving  
//Dr L - It's everyone's job

H - such advice. Um, do you find the actual triage system consistent

Dr L - Um, I'm not much fussed about it in as much as, if a patient wants to be seen they have to be seen, it's no, you can't deny them, so they're up shit creek anyway. So it's, it's a system that can't be judged on that criteria

H - so how would you

//Dr L - It's a .. that you have to then look at, you know, a set of criteria that you have to develop a kind of scoring system of some sort

H - Yeah, how would you create this consistency though?

Dr L - Well, ask doctors, that's like asking, you can't, doctors are cowards, loose cannons

H - As are the patients

Dr L - The patients are easier to control than the doctors

H - Why would you say that?

Dr L - Because doctors think they know it all

H - Right, and why do you, sorry I've got to

Dr L - Because as a group they are arrogant people lacking in humility and they're own limitations. So it's very difficult when you, and remember GPs are sub- contractors to the health service so they are self-employed, they're their own bosses. That's what keeps them alive. I rest my case m'lord.

H - It's just so interesting to hear someone who is a GP to refer to your group in this manner, I mean there must be exceptions, you can't just say

//Dr L - Of course there, oh absolutely, of course there are exceptions. but as a group they're a bunch of loose cannons

H - Have you noticed a difference between the younger GPs that are coming through?

Dr L - I don't know actually.

H - Mind you, you are only, you're not exactly uh old

//Dr L - Uh, I think I'm not, they lack experience, not just because they're young but they lack experience, they don't get enough experience in their hospital jobs

H - Mmhm, why is that, I mean

Dr L - They're molycoddled too much, they can't make decisions. They want to take it to a democratic committee about what I should do now

H - Has GP, has the training changed or, is there just generally a different ethos or, why is it?

Dr L - I'm not quite sure but I think it's very worrying. They just don't have enough experience. Um, I don't think age is a barrier to ignorance

H - Right

Dr L - I don't think chronological age reflects maturity either.

H - No, I'd agree with that

Dr L - You know, just because you're 15 doesn't mean you can't be mature and have a mature outlook, just because you're 60 doesn't mean you can't be immature and stupid and do daft things.

H - and throw a tantrum, yeah. Right, so, the one thing that struck me, um, was speaking to a young doctor the other day, was his absolute out and out refusal to contemplate out of hours um care in the context that it was prior to the co-ops and everything, and basically he said, well if it was like it used to be I wouldn't do general practice, and the comment he made was the older GPs were more vocationally trained, and for me it's just a job, and um, I don't know I mean, when you trained did, and you were aware of out of hours practice, was this sort of like, something that put you off or worried you or?

Dr L - Part of the job. You won't find anyone that loves it, or loved it, unless you're dealing with some kind of psychotic illness, but as a rule no one liked it, it was what the job comprised, you know. But it's a bit like whores and business, most whores won't allow, you know if it's a female whore, prostitute, whatever, they won't allow men to kiss them because that's personal, they can do anything else they like, but they won't, but there's a lot of research been done

H - Well that analogy has sort of gone way over my head

Dr L - no but they they they, there's a lot of research apparently that's been done and kissing is something

H - I know, I know, I've seen Pretty Woman too

Dr L - no, they they, no, but I mean, that's apparently, now, you know, I can't figure it out, but, you know, so there are some bits of the job that are perfectly acceptable and you can rationalise and other bits that you can't and I'm saying that's true for general practice. There are some bits of it that we didn't like but it was part of the job. No one liked it but it had to be done. No one chose to do it - but you see there are a whole group of - this thing about young doctors and not wanting, you know, that people are vocationally trained, well I mean that shows an incredible arrogance that they know, or this individual knew what these other people thought, because for a start there are lots of

people who never did their own on-call, they deputised anyway, so it never was an issue, but they paid for that privilege. The same, it's called, it's you dice and slice, you take the bits you want, it's an eclectic view, some took an eclectic view, they would pay for that privilege of not seeing a patient after 6.30, or 6.00 or whatever

H - expensive though

Dr L - But that was the work, that was fine, that was the -

R - Can you take a call for me please?

Dr L - Mm. Do you want to take it in here?

R - Yeah...

Dr L - Ok.

R - It's on line two

Dr L - Ok. Hallo, good evening my name is Dr L-----, what can I do for you? (pause) Right, hold on a minute, right, so your mother has come down and she is complaining of a pain in the upper part of her tummy, right, going, right, and there's also pain that goes up to a shoulder blade, right, which shoulder? Ok, does the pain go up into her neck or into her teeth or down her arm, has she got any sensation of numbness or weakness or tingling or heaviness in her arm? (pause). Ah, right, right, now that's much more interesting, so, how long as she been diabetic? Mmhm, ish, ok and how long has she had high blood pressure? Ok, now can you tell me what medication she is on, do you happen to know that? (pause) So her blood, so, right, so that's metformine [?] isn't it? The, the medical name for that is metformine isn't it? Yeah that's metformine, yeah, and she doesn't take any medication for her high, where are you from, it sounds like the middle east, yeah, ok, uh ok, and when was the last time she was seen by a doctor? (pause) And is she regularly supervised? No, oh well. How old is she? Well, yeah well that's the thing, uh because of the, I mean she's got two major risk factors. She's got her high blood pressure and she's got her diabetes, and those two things are actually risk factors, well no no, they're major risk factors for having problems with your heart ok, um and that is obviously something, and obviously anyone with chest pain one has to be aware that that is a possibility. Um I think really she's going to need to go to a casualty, the reason being is she is going to need an ECG just to make sure that she's not having any kind of either angina which is basically cramp of the heart, where the vessels can go on and eventually lead to heart attacks, so we would need to know about stuff like that, or whether or not she's in the process of having a small heart attack. Now do you have any aspirin? Right, does she take it normally? Right, right, well I would, right, I'd give her two extra ones now, yeah, yeah, and I would take her up to your local casualty. (pause) Well if you just hold on I'll find out exactly what, how they do that from here, hold on a moment. (pause)

Hallo, hi, um what we will do is we will, are you going to come up to [hospital]? You won't be able to go to [another hospital], they don't accept emergency cases... um, I will phone down to casualty. What you will need to do is phone the ambulance, just phone 999 and just tell that uh, well all you have to tell them is she's got chest pain, and you've

spoken to one of the doctors at Nightdoc who thinks that it is possible that she might be having a heart attack or angina and we will, I'll phone down to casualty, ok? You're welcome, bye bye.

(pause, goes out of room, comes back in with man and boy aged 4 years, 9 months)

Dr L - This is a colleague of mine who is doing some research into how we deal with children

D - right...

Dr L - Right C can you lie down for me just here, right, and dad comes up and stands right next to you, you just lie down and...Oh dear, ok

D - I'm here, I'm here, ok, we're not going to do anything to you

Dr L - I'm not going to do anything to your C, I'm just going to cover you up for a moment, right now ... that's it, right, now then, tell me what's been going on

D - Right, started Tuesday morning he woke up, quite severe rash, quite raised

Dr L - Mm, you mean like this?

D - Yeah it was worse than this,

Dr L - Yeah

D - yeah, it was similar to that, slightly different, slightly whiter

Dr L - Can I have a look at your tummy here and see whether you have got a, hhh wowie

D - That has actually down quite a bit

Dr L - Cor it's like someone's spilt paint here isn't it? Are you ticklish?

D - See it started off just on his elbows and knees, you see

Dr L - Just look up

D - He went to school because I thought it was just bites[?] School sent him home, took him to the GP. He said it's an allergic reaction and it got much worse. took him back to the GP and he said see how he goes on piriton etc., then it got much much worse, took him back to the GP because it started swelling up, his face, in fact last night his eyes were closed it was that swollen, and...

Dr L - Can I have a prod of your head, can I wiggle your head around? Right, ok, now

D - now, some of the rash has gone a little bit but if you look at his um,

Dr L - We'll have a look there in a mo. Can we lift you

C - [starting to whimper]

Dr L - Let daddy do it, go on

//D - Very sore. What do you want me to do? Pull his trousers down?

Dr L - Yeah, I just need to have a look

C - [cries]

D - C, I promise you darling, listen to daddy, he's not

//Dr L - I won't hurt you, promise, honestly, I just want to look, I won't do anything to touch

C - [crying]

Dr L - daddy will do everything, alright

D - Look, he's not even going to touch, right

C - [crying]

Dr L - Just pull this down so I can have a look, ok, that's it, that's it, right, ok

//C - [crying]

Dr L - I just want ...for me young man?

C - uuuh

Dr L - It's alright ... just let, uh, I won't hurt you I promise, just put your leg down for me, told you I won't hurt you,

D - He won't darling, I promise you C, he's very nice

//Dr L - ahah, don't, I'm looking at, I won't hurt you, just put your legs down sweetheart.

C - hhhhuh

Dr L - Does that hurt or is it ticklish?

C - It hurts

Dr L - It hurts, ok, just, I won't hurt you, I promise. I won't hurt you, I just want to just

C - ow [crying]

Dr L - Has he normally got a foreskin?

D - No

Dr L - So he's been circumcised?

//D - He's been, yeah

Dr L - He's been circumcised, right

C - [crying]

Dr L - How long has his scrotum been discoloured?

D - Just tonight, started earlier tonight. The GP, our GP did see it and it wasn't as bad

Dr L - Dr X?

D - Um, actually it was Dr Y, Dr Z came in and gave an opinion as well

Dr L - and what did they think it was? I won't hurt you, just

//D - They're just not sure, they said if it gets worse go to the hospital. And his tongue's beginning to get it as well ....

//Dr L - Stick your tongue out for me.

D - Not a well bunny is he?

Dr L - Well, you're an interesting little man, aren't you?

D - Thing is, his sister

//Dr L - ... can I just do your tummy? I won't hurt you

//C - [whimpering]

Dr L - I won't, I won't sweetheart, alright, I won't sweetie

D - His two year old sister ... getting the rash

Dr L - How much did he weigh when he was born?

D - 6 ish

Dr L - and he's never had any major medical .....has he come into contact with any unusual conditions ... things around at school or nursery

//D - nothing major, no, not that I know of, he does go to school, but no. The rash has gone down a lot to what it was. They put it down to viral at [hospital] last night

Dr L - What he's been seen?

D - He was seen at [hospital] last night, they discharged him

Dr L - So hold on, he's been in hospital

D - We went, this is why we're here, we went, we were told, we went to [hospital] last night

Dr L - by whom, who told you

//D - we just went with the GP, with a letter from um Dr X and Dr Y, um, and um, they saw him, saw the paediatrician

Dr L - what did they think

D - uh, a viral rash, um, and they said if there's any problems come back within 24 hours, you'll, you know, come back straight to the ward. Well I phoned them up, I said can I bring C back, they said no, go to A & E. I said I'm not prepared to do that. I said I don't want him to see a junior doctor to go through the whole performance again. I said you promised I could bring him back. And they said well you know, the doctor said no, you have to go through A & E, so I said I'm not doing that, I'll come here

Dr L - Mmhm. Right, well! Well, I certainly think he needs to be seen by the paediatrician,

D - right

Dr L - ok, um, and this is - I won't hurt you, I promise, I've got a little boy who's just a bit older than you and I won't hurt you, I promise. If I am going to do something I'll tell you, alright? I mean this child is definitely an allergic type phenomenon. It's got all the hallmarks of an allergic phenomenon. It's raised, it's blanches if you touch it, right so it's got the kind of urticarial side to it and the, an allergy. The interesting part is it's flitting, and I mean it's beautifully pink etc. I'm interested about his eyes swelling, I'd like to, he is going to probably need a urine test and probably may need some B-L-O-O-D-S tests, which we don't have to talk about, but that's what we may well need. He will probably, because of the discolouration, etc., he may well be kept in, just to monitor

D - What do you think that is then

Dr L - well, it is difficult to assess because the only way to assess it is to examine it, and the secret of this is, someone's going to do it anyway, and there's no point in me doing it now because

//D - because they'll only do it again

Dr L - do you see what I mean, it not that

//D - no, I understand

Dr L - we've got to be pragmatic here. There's no point in making the little chap endure what he doesn't have to. At some point he's going to, and, but there's, this is not a fun thing, and he's obviously anxious about it, so there's no point putting the little chap through the mill more than necessary, because it's not going to be much of a spectator sport either,

D - [clearing throat] no

Dr L - ok? So one has to be pragmatic about this, so he will need uuuhhh tests, because there are certain conditions that you can get where you can get them, the testicles twisting

//D - yeah  
//Dr L - but that doesn't, that's not,  
//D - I understand  
//Dr L - but you may have to have corrective surgery

D - yes I understand

Dr L - They will want you to try and remember the last time he ate and the last time he drank, if that's going to be the case  
//D - yes

Dr L - because, it's, although it's an emergency, it's not a life and death emergency, but it means that he's done rapidly if it's that, ok, so, they'll want, they'll, so the reason I'm giving you the information is so that you can think about it alright, because they

//D - ....

//Dr L - no, I understand that too, but the fact that I've mentioned it will alert you to the fact that you can think of it in moments when you've got,

//D - [sniffing and clearing throat] right, got it

//Dr L - not to uh uh distressed about it, but it is going to need to be seen, and you know, and, as I say, it is interesting that, interesting medically, from Dad's point of view, it's just bad news, in the sense that, poor little chap is in distress

D - [sniffing] yeah, .... going on with my daughter as well

//Dr L - yeah, and I think that we need to

//D - see her

Dr L - sort that out. Right, I'm going to, do, trying to think, right let's just cover you up for a moment

//D - ...best not to pull them up

//Dr L - no no I I think you should take these off and we'll just cover you up for

D - shall we do that C because it's more comfortable son

//Dr L - yeah, yeah, yeah. It's alright we're not going to touch you or do anything but we're just to cover you with this little blanket, alright

D - I'm staying with you, right, all the time

//Dr L - yeah, right, lets just cover you up put your legs down, right, that's it, there we are, is that better? Right, take a seat

D - ..... [sniffing, clearing throat]

Dr L - Do you have any questions you'd like to ask me?

D - no, I'm

Dr L - Is there anything you'd like me to go over that, in case I've either, or is there anything that I said that is alarming at all?

//D - apart from everything, yeah, no, I'm ok with what's going on. Um we've got private health care, now whether

Dr L - I don't think it's even, it's not an issue  
//D - not even, whether, if we stay or whatever

Dr L - it's not an issue, no.

D - yeah

Dr L - Right, so this has really been going on for about three days?

D - yeah

Dr L - [writing] Three day history. Rash, urticarial in nature. Where did it start?

D - Um, the knees wasn't it C and elbows I think

Dr L - and then it was flitting

D - Mm, it got so severe that you couldn't, you hardly saw any of his body before, his face was completely-

//Dr L - Viraceous and urticarial

D - Yeah I have got a question, do you think the two things could be coincidental?

Dr L - which two?

D - the um, the rash and the other thing?

//Dr L - It's possible, they may be related or they could be totally separate. I mean, that's not really a very helpful answer,

//D - mm, yes, no, no, ...

Dr L - but they could be discrete things, but they also can be related. Uh, but his eyes were swollen. Did, were, was it the rash or

//D - yeah, I don't know, it was

//Dr L - or were they just puffy?

D - it was everything, he just, his face just looked, you know, puffed

//Dr L - so yest-so yesterday [writing] face swollen and peri-orbital odoema...GP [hospital] paed's rash and today seen GP

D - he had sores around the base of

Dr L - when you say sores, can you describe them

//D - it was like red marks around the base

Dr L - of his, uh, penis

//D - his penis, yeah

Dr L - but they're not there now?

D - I don't know because we haven't

Dr L - we'll have a quick look. Can we just look, we're not, I promise I won't touch, stay there, it's ok, don't get worried

D - look, can you see

C - [whimpering]

D - it looked quite open, the wounds, earlier. Sort of distorting, isn't it?

Dr L - Mmm. [writing] Sore area on base of dorsal shaft of penis, worse ...hospital

D - He's asthmatic as well

Dr L - Ok, what does he take? Has he got Ventolin syrup or a puffer?

D - No he we use a nebuliser when he's bad.

Dr L - Has he been in hospital for his asthma?

D - When he was much younger. More often than not we keep him out now, because we treat him at home ...

//Dr L - Ok, not important. Ok so [writing...] asthma...

C - You alright C? Yeah? You've calmed down

Dr L - If you want to take, if you want to wrap him in the blanket and have him on your lap

D - I think he is more comfortable

Dr L - Ok, oh no that's alright, or if you want to sit on there with him that's fine, it's not, from our point of view what ever makes you both comfortable

D - yeah....close your eyes, yeah, mm? ... itching

Dr L - Is it an itchy rash?

D - Oh yeah, he's been tearing himself apart.

Dr L - Has he got any marks on his bum, on his buttocks? I didn't notice

D - There were, I don't know if there are now

Dr L - Has he been complaining of pains in his joints?

D - No he never mentioned it, he hasn't been sick or anything like that, have you?

Dr L - The reason I was asking about whether he was circumcised was that you can get a condition if you're not circumcised where the foreskin draws back over the shaft and it

actually constricts the top, that's why a lot of kids, I mean, um because it's quite swollen, that could have happened, but if I'd seen a Star of David I'd have twigged, but I didn't so

D - I don't believe in badges

Dr L - There's always someone who will point it out to you anyway

D - [laughs]

Dr L - Ok, anything you want me to clarify before I go and talk to the paediatricians?

D - No

Dr L - Sure?

D - Well, think about it. Um, .... You all right for a minute? I'm just going to make a telephone call, yeah? Ok.

[Dr L left the room]

D - You ok son? ..... been pathetic for the last couple of days

K - You took him to [another hospital] last night

D - Yeah, and they said bring him back. When I wanted to bring him back they said you can't. I said that's outrageous, you can't say bring him back if there's a problem if you don't let him. Like hell if I'm going to sit in there and put him, in the state he's in, in casualty department for three hours before they see kids with nappies, know what I mean?

K - Mm. I do.

D - Because only because he's been through it already, it's not been a very .... it's too distressing.

K - You won't want to be worrying about this at the moment, but if I just give you this, it's just a little information sheet about what I'm here for, and maybe, you know, when the crisis is over, which hopefully won't be long, I could give you a call, see how C is, and if you feel like it, you could be part of the study. It's a study to find out how people feel about the out of hours services especially for children under five. I suspect you might have a few things to say.

D - [laughs] Just a few

K - Yes, but I'll leave it for a little while

//D - not here anyway

K - I'm not part of Nightdoc, I'm an independent researcher. I'm based at Brunel University and I'm doing a study funded by the health authority, so I'm nothing to do with

D - You're not biased any way

K - No, what I'm really trying to do is to give parents an opportunity to talk about it from their point of view because, I mean most of these services are set up really more for the way the doctors want to organise it and, you know, the way they've set up this co-op in particular is very helpful for the doctors not to have to be on call every night in four or whatever, it's marvellous from their point of view

D - It's great from the patient point of view because you can see someone who knows what they're talking about instantly

K - Right, right, well it's important to hear the parents' point of view, so as I say, don't worry about it now, if you get a call from me in a little while, that's who I am, and hopefully it'll all be clear by the time

D - Yeah, ok, mm, yeah he'll be fine

K - Do you think C would like a drink or anything, or maybe not in case

//D - I think in the circumstances, it's best not

K - Would you like anything, coffee or tea, or

D - No. They don't have scotch here do they?

K - [laughs] Well you might have to drive so I better not [laughs]

D - I don't drink anyway

K - Water, or orange juice?

//D - No, I'm alright at the moment, I'm absolutely fine. He's calmed down I think.

K - Are you relaxing a little bit C, just a little bit. I've got a little boy who's four, and I've left him a cold tonight with Daddy.

D - Yeah, horrendous

K - I mean this isn't a cold, so I'm not comparing

D - No, I know what you mean, it doesn't matter, you know, you just - I've got 5 children.

K - Mmm. Is C the youngest?

D - No, he's the middle one aren't you?

K - The middle

D - .....

K - that's part of the job description isn't it

D - Yes. Goes on your application form

K - Yeah [laughs] yeah. Well you've come to the right place this evening.

D - Oh yeah, no doubt about that. I didn't tell him he had his tonsils out here three weeks ago

K - Oh did he really? That's interesting. You could tell him, yeah. I mean I don't know if it's significant or not. Was that in an emergency situation?

D - No, no, controlled.

K - I don't know anything about the hospital here, although actually I was at a lecture one day ... the paediatrician from here, he was excellent.

D - They had a lovely paediatrician here who suddenly died. His name was L. Yes, I think that was his name, he'd been here for years, he was fantastic. He dropped dead in the hospital... No it's a great, a nice hospital in a dreadful building

K - Yeah, it's very big isn't it?

D - Revolting

K - I can't think of the name of this ... gentleman, I think he has a slightly Irish accent, and ... he was excellent, really all round helpful attitude, you know, I'd be very confident if I had to deal with him

D - Yeah. With some you do and with some you don't.

K - Yeah. So what did they do at [hospital]? Examine and

//D - Yeah, this is what happens unfortunately, you get seen by a senior house officer first of all, she was lovely, really nice, she gave her opinion, but she couldn't actually do anything without being seen by the senior registrar, so it was a totally pointless exercise to be examined by her because she couldn't give a definitive answer and nothing, no treatment could be acted upon on her say so, so every patient is seen twice before anything could be actioned. And then the senior registrar came along and she was also very nice, but had a completely different diagnosis to the first one.

[knock knock - Dr L came back in to the room]

Dr L - The mountain will come to Mohammed. The paediatrician will be coming here

D - Oh really

Dr L - There's no point moving him for the same thing

D - Right

Dr L - A little gentle arm-twisting always works huh? Because if he's comfy here and calm, there's no point reinventing the wheel to go down there to go up there to - he'll come to us. You alright there?

//D - Well done

Dr L - Yeah? Yeah? Sure? Ok. Do you want the door closed or open? It's probably a bit stuffy.

D - He seems terrific this guy. You don't get many GPs like that, do you? [laughs] ....

Dr L - C, can my friend have a look at your rash

//Dr R - Hi

//D - Hi [Dad and Dr R recognise each other]

//Dr R - I'm glad [Dr L] saw you

D - Oh right, and not you?

Dr R - Not me

Dr L - This little man has had a rash, how long has he had it? Is it two or three days? He's got this funny rash here which comes and goes and is viral, have we had a look at his hands, can we have a look at your hands? Oh oo, it's cold isn't it, and it's really itchy, blanches beautifully

[end of tape]

Dr R - He's very good, Dr ?

Dr L - And what we need is to sort this little man out.

Dr R - Mmmm

Dr L - An unhappy bunny, huh?

Dr R - He wasn't very well last week, was he? When I was there you said he had a headache.

D - He had his tonsils out here three weeks ago and then he got an infection afterwards, as a result of it, he wasn't, he was, then he got over that, and now this so

Dr L - Bit unfair, eh, C?

//Dr R - You're not your usual self, are you? He's usually running around like a mad thing, C.

Dr L - Well there we go. Now, what's your favourite game, what game do you like playing at home?

D - Giving Daddy a hard time

Dr L - Oh that's, yeah we all like doing that. You know the interesting thing is, no matter big you get, you can still daddies hard times.

//Dr R - Has he had a rash like this before?

D - No

Dr L - You know, I give my Dad a hard time, and he's nearly, well he's so old.

Dr R - When did it start?

D - Tuesday morning

Dr R - I mean it's almost urticarial really, isn't it, really?

Dr L - Absolutely, but the interesting thing is it's, violaceous, it tends to be a bit pinker

Dr R - ... down his face

Dr L - goes all the way down, but it's not confluent, can we just look at this end, your toes?

Dr R - Has he had a temperature at all?

D - Mmm, on and off. His blood pressure was a bit high last night at [the other hospital]

Dr L - Of course that's much more interesting when you start hearing that, if we had a ...protein, because the thing that you would think of ... but this does not look like a nephrotic[?] child - oh the translation of that is sometimes you can get a syndrome whereby you can lose a lot of proteins in the body because for some reason the kidneys aren't working as effectively. So instead of keeping the protein in and passing out the water, the sieve in the kidney effectively, instead of being like that, nice and, opens up so it lets all the big things through, and what happens is because you pass out all this protein, the, the um, the blood, or the blood contained within the circulation becomes dilute, alright, you have to think... becomes dilute, so what happens is, water leaks out of the tissues and the become waterlogged, you know. they become ... swollen

D - Not toxic? Not poisoned?

Dr L - No, no, no, they're just losing fluid because it's more concentrated on the outside, but you know, again, highly treatable condition, should that be the case, but I mean, we're just talking medically,

D - I realise that

Dr L - but it doesn't exhibit that. Although interestingly his blood pressure was up, because that would be consistent with that, but he's not, because he'd start, I mean have you ever seen a really good going nephrotic? I've got some wonderful photos when I was doing paed, you have to, no, to to

D - Next to your Majorca shots

Dr L - No, but hardly ... but you can't miss it, you cannot miss it, I mean when it's a good going one... But he doesn't show any of those signs

D - Right

Dr L - Which is the interesting thing

Dr R - You know you said his blood pressure was up? How do you know, do you measure it -

D - They, they did it last night at [hospital]

//Dr L - at [hospital]

Dr R - Oh right, so we went to, right, I see. So what did they say at [hospital]?

D - It was viral. And they wouldn't see him again tonight

Dr L - But they said 'If you bring him up to us we will be only too happy to see him on the ward'. That's known as the Pinocchio syndrome

//D - Yeah, and when I, when I phoned the ward, I said I've got to bring him back, I'm worried because of this additional problem

//Dr R - Yeah, yeah, right, so he had the rash but not the bruising

//D - yeah, not that, that's tonight, and our GP saw the bruising, well, it wasn't as bad when he saw him, it was mild and he said 'if you're at all worried go straight back to [hospital]

Dr L - And it's the [practice], I mean it's not as if they're a bunch of turkeys, they're a good GPs

D - They would not, they said you've got to go to A&E. I said I'm not. I said I'm not sitting there to see, to see nobody

//Dr L - ...coming to us, the paediatrician is coming to us, so there's no problem

D - No

Dr R - I'm glad he's on actually

D - What are you going to do about my daughter?

Dr L - Hold on, this is called counting before they're hatched

//D - Is it, ok

Dr L - Relax, as much as you can given that your anxieties about C, that, you know, let's cross one bridge at a time ...

D - Go to sleep C

Dr R - He's dying to isn't he? I think this is what we call an appropriate use of Nightdoc

Dr L - Absolutely

//K - Mmm

Dr L - So how old's your daughter?

D - Hm? Mm m, two

Dr R - Has she got similar symptoms?

D - Mmm, she's developing a rash and it's coming along rapidly

//Dr L - And that's obviously, in a way that's reassuring

//Dr R - It's good, yeah

//Dr L - because, yeah ok, so that in itself is a reassuring feature, but because things are reassuring, any good doctor has to be sure, he can't be reassured, we have to be sure, so all that is happening now is not to alarm you and him, it's actually to, because I happen to be anxious and neurotic, I like knowing things, alright, so forgive my anxieties but, I apologise

D - If you weren't doing this I'd be unhappy, so

Dr L - Yeah, so would I, I'd actually want to hang my stethoscope up if I wasn't, you know, so we have to do what's appropriate, and believe me, I don't when it's not app - I mean you know I don't have a problem with saying cheerio to parents when there's no problem. There's a problem that needs to be sorted out - it may be minor, but nonetheless it needs to be, have the 'i's dotted and the 't's crossed about that. Do you want to phone your other half? Because she must be having brown trousers herself

D - Mmm, don't know what I'm going to say to her, though

Dr L - well just say to her

D - I can't use the mobile, shall I use

Dr L - Oh I think we could just about see our way to giving - I don't know how it works, but come in through

D - Is that all right C can I go and phone mummy? Yeah, you going to be ok for a minute?

C - want to come with you [?, croaking]

K - you can use this phone

//Dr R - if you just press 9 and get an outside line

[Dr R and K leave the room, Dr L gives him the phone]

D - thank you. [Dad dials the number]

Hi. Uh, yeah umm [clears throat] yeah I'm in the room, we've seen the doctor, and um the paediatrician is coming up to him here. I don't know. He's concerned actually.

Mmm? I don't know. Mmm? I don't know. Well they, about the bruising, mm, he mentioned um, twisted, um whatsits, twisted testicles. When they twist, they might need to do surgery or something, I don't know, I don't know what's going on right now.

[sniffing] Anyway, let's hope - they've managed to get the paediatrician to come up here instead of taking him anywhere else, but um. They don't know what it is, yeah brilliant, oh don't they? No, it looks like, you know, an allergy thing but if it's infectious it could be, I don't think they really know. Yeah, they said, you know, it's good to know that but we'll have to deal with one patient at a time.... one of the doctors here knows us ... I don't think he knows, but ... oh yeah, yeah she does, yeah, just outside the room... I might need you to come [sniffing], ok, yep, alright, speak to you later, bye.

[voices outside the room]

P - Hi, how are you, I'm W.

Dr L - Hi.

P - You are?

Dr L - Dad

D - I'm his Dad

P - Oh right, hallo, can I come in?..... Hallo sir. You alright?

Dr L - This is another friend of mine

[closes the door - Dr L, P, D and C inside]

P - So many people in here. How old are you sir? Right, shall I stand over here, shall I sit over here, I'm Dr H. So hallo, so you went to [hospital]?

D - yeah

P - Did they have a good look at him, yesterday?

//D - reasonably so

P - Yeah and did they find a cause for his uh blotchy rashes?

D - Uh they put it down to um a viral sort of allergy

P - Has he had any fevers at all?

D - I think he's, he's been getting quite hot and cold I wouldn't, not raging but

P - Ok, when was he last well?

D - When was he last

//P - last well, when was ...

D - Well, he had his tonsils out here three weeks ago - Mr G? Um, he then got an infection after it in his throat and he was treated with antibiotics, then he was, he went - started his new school, he was fine for a week, you know really, ok, and then this

P - Yeah, right, yep, ok, right. Apart from the rash, what else have you noticed?

D - Well obviously he's been lethargic, because he's, he just feels so rotten and then there's the uh,

//P - yeah, the bits down below

D - the other problem

Dr L - describe what you said to me about his face yesterday

D - yeah his face was very swollen. It looked like he'd been in, you know, the ring with Mike Tyson and then dropped in boiling water because it was, the mouth was pouty, his eyes were closing and puffy, he just, he just looked distorted

//P - uh huh, right, ok, right, ok. Has everyone else been well at home?

D - They've been well, there's coughs and colds

Dr L - They ... blood pressure last night and it was a bit elevated

P - Right, can I have a look at him? Can I have a quick look at you before I send you home, if I promise to send you home would that be all right? Can we do that, let me have a quick look, how does your hand

C - Don't touch

P - Don't touch, ok I won't touch. Have you noticed any, you mentioned his face looked like Mike Tyson, but what about his hands?

D - His hands are swollen as well, I think they still are a little bit puffy

P - Has he been coughing?

D - Yes but he is as- he is asthmatic.

P - Now this lovely beautiful rash that he's got

D - He's not going to hurt you C

P - I'm not going to hurt, I'm not going to do anything actually, I'm just going to - that rash, when you look at it, is it the same when you look at it a few hours later?

D - No it's changed, it changed, it started off almost whiter but raised

P - Ok, can I just lift this up?

C - [starting to cry]

D - The rash, it was worse, yeah much worse

//P - worse, ok. Ok, alright, that's fine. I'm going to do, to put this down, is that very sore?

C - Oww [sobs]

P - Is that very sore?

D - Alright, alright darling, alright, alright, just the blanket

C - [crying]

P - Can I have a quick listen to your tummy? I'm not going to, we'll leave that, that's good, that's fantastic, that's good. [pause] That's wonderful. Ok I'm going to get my watch out. Wonderful. Are you able to sit up? Oh not really, ok that's fine. Can I just put my hand on your tummy? Just here, like that [whistling]. Did you manage to get a look at his ears, nose and throat, or? Can I have a quick, just see his throat. I'm going to shine a little light into your throat, that'll be easy won't it?

D - His tongue's a bit sore now

P - Is it? Mm, he's not having a good time, are you?

D - Uh, no.

P - Open very very wide for me. Pop your tongue right out, that's beautiful, that's beautiful. Now, as...as a last .. I'm going to look but I'm not going to touch ok? Going to look, but not touch, ready? That's it, ok I'm not going to touch. Do you think that's swollen?

D - It's hard to tell

P - I'm touching here, do you see ...

D - He's not going to touch C

P - Ok, that's fine.

C - [little whimper]

P - Quick lift here [whistles], quick here. Now what I'm going to, I'm just going to touch you I'm going to be very very gentle. I'm going to be very very gentle. I'm just going to hold your hands for a moment ok

//C - [screams]

P - Alright, ok, there, that's nice. I just need to have a little feel so you're just going to have to just relax one second...

//D - Sorry ....

C - [screams and cries]

D - It's alright now, oh I'm sorry [kisses] alright

C - ?Let me go! Let me go! [screams, howls]

P - Good, alright, well done

Dr L - I didn't see any point in my doing it, for you to do it

P - Alright, all done, all done, all done. You see the skin's very dented, doesn't feel like there's torsion, feels like it it's .... I know it's a bit aggressive

Dr L - No, no ...

P - I think uh, um, [hospital] are absolutely right, I think he has himself a horribly nasty viral illness that's wiped out, given him more than this rash of bumps and bumps, and um, and sometimes you can get a rash down below just like that which is called scrotal oedema, it's where it just swells down there, but it doesn't involve the testies, and in fact the whole skin feels quite hard and it feels like it's a swelling of the skin and not the inside of the sack, so, and that would fit with the rest of the clinical picture. So I'm sure he has himself quite a mild vir- a mild illness but it's obviously presenting itself with a really horrible rash and I think what we need to do is not treat the underlying illness because I can't treat the virus that's probably causing this, but I can certainly make his symptoms seem a lot better

D - Right

P - and the way to do that is I'd probably put him onto oral prednisolone for 3 days and give him some piriton for three days, because I think, can I can just show

D - steroids, isn't it

//P - yeah, can I just look at your hands

//D - he has that with his asthma

//P - does he? Because this would all fit with urticaria, wouldn't it, that rash, and that would fit with um, if you have the scrotal oedema, that you can get rid of the urticaria, which is an allergic response, and um, ah, it would, if he didn't have the rest of the rash then I'd be worried what was going on the scrotum, but I guess that if he's got the rest of the rash - there's only one other thing I'd just like to take a little swab of his throat, I'll do a little swab and that won't take a second, then if we, do you have any prednisolone or piriton here?

Dr L - I can ask, not not prednisolone

P - You haven't got the tablets

//Dr L - We might have the soluble

D - I think we've got some at home

//Dr L - Soluble?

//P - Uh, well if I bring some up

//D - Yeah, the little pink ones

//Dr L - Yeah

//P - Well if I bring some up, if we give him 30 milligrams now, and we give him some more piriton - who's your GP?

D - Dr R

P - Right, does Dr Y have a surgery tomorrow morning?

Dr L - Yes he will do

//D - Yes he does, he's expecting to see him tomorrow

//P - Fine, well I'll come up, I'll write a letter to Dr Y who can have another look tomorrow morning. I'm around tomorrow morning anyway. We'll give him a dose of periton prednisolone now, you can go home

D - Right

P - Ok, I don't think anything nasty is going on with his testes at all, I'm sure this is all related to the same rash, otherwise he'd be very unlucky to have two things going on, right? And the fact that it's exquisitely tender to touch the skin, it's not the content of the scrotum, do you agree?

Dr L - Yeah

P - It's, I get the feeling that if, not even, even the thing pressing on it is giving him pain, I would imagine that's not from his testes but that's from the skin, so hopefully by tomorrow morning you may see the rash disappearing, if not then we'll see you again

D - Right

P - Is that ok?

D - Yeah, yeah, if that's what, if you're sure

P - Ok, do you, I'll go and get you some pr...

//Dr L - ...come back ... I think, I mean, my concern was that he'd been seen, and he'd been seen again by a GP, and there were a lot of doctors who've seen him, and the child was actually in

//P - There was quite a lot of distress, yeah

//Dr L - distress, and uh

D - But I have a, my other, one of my other children has just developed the rash

P - yes, have they?

D - Yes, and it's  
[everyone talking at once]  
//P - you were saying  
//D - that how contagious can this be?

P - Oh, um, the thing is that children come out with a rash, you're very unlikely to come out with a rash, would your other child, children run into trouble we'll know [well no], the reason why I'm treating him is because I think he's got a lot of pain and distress down below, and I think that's the principal reason for treating him. If the others come out in a rash, fine. If they're not good with it then the question is whether they ought to go and have periton and steroids and you can see the benefit that he has and the worse case scenario is that -

D - they have to get it as well

P - they have to get it as well, but don't you start self-prescribing, then you need to come up and be seen somewhere here

D - I know, yeah, no I understand, I wouldn't do anything that silly

P - so if I go and get some predasol, and then um, I brought a throat, could we swab his throat and then um, is that alright? And then I'll bring the predasol up just so you don't have to go back to emergency, do you need, have you got some periton

Dr L - We won't have any, uh.....

D - We've got periton at home

//Dr L - ...can mix it, you can mash up the tablets

D - No we've got liquid, it was prescribed by the doctor

C - [whimpering]

P - Ok I'll go and get you some predsol, and um, and we'll send you home, I'm sure that's the right thing to do

D - Yeah, oh that's great

P - Is that alright?

D - Yeah, it really is

//P - Fantastic, right

D - Thank you, thanks for seeing him

//P - I'll come back in a few minutes, is that ok?

//C - [crying] I don't want that!

Dr L - I just want to take a little -

D - It doesn't do anything

//Dr L - it's alright, ... a little stick, all you have to do is open your mouth sweetheart

//C - [crying] No, no!

Dr L - alright, then you can go home and see mummy

//D - we're going home C

//Dr L - open wide, open wide

//D - It doesn't hurt....

//Dr L - It won't hurt, just open wide, just open wide, there's a good boy, you just open wide

D - he's not going to hurt you

Dr L - Let me pull these ... bloody stick here, I'm sure that that will make life a lot easier

D - You're such a good boy

C - [crying]

P - There's something else I wanted to ask you, please can I take a picture of it?

Dr L - Do you want to start your modelling career?

C - No!

Dr L - No, you know what, you said, we were describing about when I did my paediatric rotation over at [name of hospital], this was shortly before it closed down, we were saying that I had...you can't... we said, was that like the family pictures, it's not, it's the way you teach others who never may...

//P - well let him have this and then I'll...

Dr L - find, I just have to find a lolly stick

//C - [crying] Daddy!

P - before I do anything, can I, what I want you to do is I'll try taking a picture of the rash, is that ok, so no touching

//D - a photograph

P - just a quick photo, I'll show you the camera, look, it's a very simple camera, and all it does, is it does that, so if I stand here if we just take the sheet- blanket back, is that alright

//D - not going to hurt you, or do anything

//C - [crying]

//P - we'll just take this back, ready, that's ok, that's ok, that's alright, put your leg, that's lovely. fantastic, oh well done, that was easy wasn't it

D - If you weren't a doctor you'd be arrested for this, you do realise? [laughs]

C - [crying] Uuuuugh, Daddy

//P - ..... that's ok, very good

//C - [crying] Uuuuugh, Daddy

D - I know son, we're going home in a minute, [sniffing], we're going home

P - Good, that was all, one more picture and then I'll be leaving you, ok there you are, is that ok? I'll come back with some tablets, is that alright?

Dr L - No no, I'm not going to touch you, I just want to look inside your mouth, just say aah. [C coughs] Ooh you cough for the moment, right, just go aah, just looking at your throat [C coughs again] done, done, that's it, sorry, you're a good boy C, I was impressed with that, let's have you up again, it's all done, that's it  
//C - [crying, coughs]

D - I don't know, how do you treat viruses normally?  
//C - Ouch, my throat. Daddy, it hurt my throat

Dr- Just dismount their response ... this is part  
//C - Daddy

D - Yes, son

C - It hurt my throat

Dr L - I'm sorry young man  
//D - I'm sorry.....

Dr L - I was trying.....

Dr L - oh don't be mean! [Father and Dr L making joking noises]

D - I can't hit him really

Dr L - Don't be mean

D - He might hit me back

C - Uuugh, want to go home

D - We are going home in a minute, yeah [sniffs, sighs], ahh dear. [pause] You've given your old man the fright of his life tonight, I must tell you C.

C - Daddy, can I sit up?

D - Yeah sure

C - .....

D - Is it sore?

C - Yeah, [crying] get my clothes on now

D - Yeah, ok. Do you want to know what ....

Dr L - sorry you were saying?

D - uh, hold on

Dr L - Ok, sure

C - I can't get down

D - Don't worry, you don't have to get down because I'll carry you

C - I can't get down

D - I think carefully is the word, that's clever, that's good, I won't, that's it, if I just put it on gently, like that, is that ok?

C - Yeah

D - That's it, hang on, put your arms round my neck, that's it, if I lift you up, how's that? Is that good?

C - Yeah

Dr L - It's horrible when kids are ill. If it makes you feel any better, when mine are ill, I don't feel any better than you, do you know what I mean,

//D - probably worse because you

Dr L - because I know the shit of what it could be, yeah, and - do you want to shove it on the floor? - and even though there's good common sense and the fact that you've got experience and you are experienced and you're knowledgeable, in inverted commas, it don't make it any better, alright

//D - Yeah, yeah

Dr L - You haven't reacted outrageously

//D - No I

Dr L - .... concerned about ...

D - we've come to terms with lots of things over the years, which .... my oldest boy suffers, we've just found out he's got something ... as well

Dr L - .... your main concern, you know, I mean if you've had your

D - Oh it's terrible

Dr L - suspicions raised, and you're looking for - I don't mean you're looking for, what you're looking for is not problems

D - Yes

Dr L - but you're aware that there can be that's the problem

C - Dad, I want to speak to Mummy

Dr L - Do you, no probs, be my guest.

D - That's nice

Dr L - Press 9

D - thank you ever so much

Dr L - We're at the other practice, you're at the [name] Surgery

//D - Which one? Oh, I just advertised on your cards.

Dr L - Oh good, well done. A very sensible move

//D - [on phone] Hi, oh nothing, he's coming home. He's seen the paediatrician, he said it's, you know, it is a viral thing, he thinks it's just part of the rash that happened really, it's nothing actually inside that's the problem, they're going to put him on the steroids

C - Daddy

D - Yeah the prednasol, which is the same ones that he has, and they're going to get some now, and he's going to see Dr R tomorrow, but it is a, it's a viral thing. Mm, he's very upset, he wants to talk to you, here he is

C - Daddy. Hello Mum. [can't tell what he's saying]

//Dr L - Oh right I didn't know that....

D - Yeah we just did the advertising cards

Dr L - Which....

D - [name of the salon], hairdressers

Dr L - Yeah, where is that?

D - Just opposite, um, you know ... DIY shop? Opposite there, a big hairdressers.

Dr L - .....

D - Hello? Right, see you shortly, bye.

C - Please Daddy I.....

D - I expect to see you in there.

Dr L - Well, funny enough I need to get my hair sorted out, I've got ...

//C - Daddy.....

D - .....[Dr R] comes in there

//C - Daddy I don't want to have any [very croaky voice]

D - Mmm?

C - I don't want to have any

Dr L - You make them up in a drink, Daddy will put them in a drink for you

//D - the what, tablets? No you just drink it down, you know you have um, do you know like you have when you had your bad asthma? Yeah? Do you know that, do you remember that one, the little pink stuff?

Dr L - ....

D - It comes up and down, up and down

C - I don't want any tablets

D - Yeah but ...

//Dr L - It will make your willy better

D - It'll make the whole thing better

Dr L - It will make your will better

D - Don't cry. We can put it in something ... yeah yeah

//Dr L - ... whatever you fancy

C - ... some Disprol

Dr L - ooh that's a good idea

C - instead of the tablets

Dr L - Instead of? Maybe as well as

D - Disprol [whispers/laughs]

Dr L - My kids, they love Calpol when they're well, soon as they get unwell you cannot get my kids, you cannot get my kids to take Calpol when they're unwell

D - Is that right?

Dr L - Whatever it is, it's a bit of a...

P - Ok, you're going to go home

//C - Daddy I want some Disprol

Dr L - He wants Disprol

P - Ok, you got Disprol at home

D - Yep

P - Good. Can you put 4 of these in water, they fizz up, make up in a drink, give it to him at home, ok there's another 4 in case for tomorrow morning, and then see Dr Y tomorrow morning in surgery, I'll write a quick note for you.

D - Great

P - Is that all right? And, um, just make sure the others don't get like that. Have you got boys or girls?

D - Uh, how many have we got? We've got two girls and three boys.

P - Well there's definitely, one thing's for certain, the girls won't get the same thing.  
//D - won't get the same, mmm. But what could they get?

P - I don't think there's one defined for the girls, I think you're alright. Is that ok?

D - Yeah

P - Good, why don't you get him dressed outside and get him all dressed up and stuff, and I'll give you a quick note for Dr Y, is that all right? We can um, we can send this, the results go back to Dr Y .... paediatric. Have we got any headed Nightdoc paper that I can write

Dr L - Uh, well what we can do, if you write it on the back of the sheet we use that gets faxed across, it will get faxed over now

P - ok, alright, won't be a few moments, alright  
//D - That's great, ok, we will go out the front. Thanks for seeing him

P - That's all right, not a problem, poor bloke. Right, what a state, what a state kids get into.

Dr L - you can write it on there and we'll fax it across

P - If I put another sheet, if I wrote another sheet ...

Dr L - we can fax the whole lot, they can just do it as a

P - It's put, so it's um, right. .... was quite interesting, I thought he might that actually, but um, it's unusual, he gets about one a year.

Dr L - Yeah I haven't seen one for donkeys years

P - There um, it's a difficult one to call, a very difficult one to call with a scrotum that's tender

Dr L - Well the point was that I wasn't going to examine the kid - I knew that I was going to ask you to have a look or whoever

P - he hasn't got the biggest testes in the world, they're quite hard to feel, but the skin is quite indurated and I just think it's probably the skin that's um. that's doing him harm ...[writing] It's quicker to see them here sometimes if I go, by the time they go downstairs and they get assessed

//Dr L - yeah well absolutely, I mean it's expeditious from your point of view and from theirs. I mean the worst thing is that it seems they did see the kid, and Dad just didn't want you know, uh, either a cas officer prodding and poking around who didn't know his arse from a hole in the road, I mean we've all been there but you know, that's the way you learn but you know

[discussing another case]

P - [writing, pause] Do you - I'm sure you prefer this system here don't you?

Dr L - It's much better

P - It's much better, yeah. In fact if this was around I would have, well, I would have stayed in general practice, I went into general practice, I would have stayed in it if this was

Dr L - It makes, this makes life palatable. I mean I, this is my session, but I did Friday night last week because uh, pocket money, and I'm doing Sunday night because I'm not doing anything, for pocket money, but this makes life palatable, you don't mind being on call

P - What's the, do you have staff to help you here?

Dr L - Yeah there is, well R [Dr R] is doing tonight. The only reason I'm here is because GP registrars can't be here by, not that she needs a supervisor, but, medico-legally I've got to be here, um, yeah there's a nurse that does the triaging and there are two receptionists who handle the calls coming in, log them, and it's a very effective system

P - It's to do, we're very dependent on who's up here actually, it makes a big difference to our referral ...

Dr L - Yes, I'm sure. Well, we know there are different qualities in GPs as we know there are different qualities in

//P - in all hospital staff, I know

P - The other thing to think about is um, quite large auxilliary lymph nodes

Dr L - He's got some quite large, quite a lot of ....

P - If he was younger and the rash was longer you'd have to think about Kawasaki, because they can have a quite profound polymorphic rash. He's got ....

//Dr L - ... not so long ago

P - An Asian child, Euro-Asian child

//Dr L - white child, no, mother's white, [name]

P - Yeah, rings a bell, name rings a bell, did she come back as one? Was, did she

Dr L - Well the kid had been seen by several people at the practice, and this kid came in and was bloody unwell, I mean you didn't need to be a professor of anything to know this kid needed being sorted. Joints swollen

P - Yeah sometimes the joints ..

Dr L - and sent her up, and I thought it was but she didn't have the, all the hand peeling and stuff, and you were worried enough to, you or one of your team, one of the team ...  
//P - she went to [hospital] ... was it positive?

Dr L - they're still following

P - Yeah, I mean we probably over-diagnose it, but it's better that way than the other way

Dr L - Well yeah, you don't want to look silly if the child has a major problem with their heart on the basis that it's been untreated

P - The other thing that gives you this, actually, we get the same thing with micro-plasma, which is why if his chest is clear he's unlikely to have micro-plasma. There you go, it's a great condition, ... scrotal oedema, it's fabulous. I've written a book actually ... which I did from here, and on the front is a picture of scrotal oedema, it's such a, it's such an eye catcher ... tomorrow if it's not. I would be, you'd be very unlucky to have scrotal torsion and the same condition

Dr L - Well that's what I went through with them, yes you can get it, but to have two things at the same time is exceptional, I mean

P - Mmm. The other thing is that his um, the other thing that helps is his penis is a little bit swollen, which is a feature of ideopathic scrotal oedema, you get swelling of the genitals, particularly if they're circumcised, they're like they've got cauliflowers round them

Dr L - I said this, I said to him is he circumcised, and it ended up he was Jewish, and he says oh no, he's circumcised, so I said well, so I explained why I asked the question, I said oh it just didn't look right, but, you know

P - Yeah ....

[speaking about another case, then private conversation about their careers]

P - Well will this be able to get faxed over with this, alright, and then. um, I think on that I just said .....[reading out quickly what he wrote] and um ... if we just write on the form they'll send it to Dr Y

Dr L - I'll tell you, if you want to take that because we don't have your forms here

P - You've got, if you stick that on there and just send it to and give it to the lady on the desk

P - Right, is that ok? Was that, was that fun?

//Dr L - Fine, lovely. That was fun. And maybe .... more interesting for you

P - yeah well, you won't see one of them for ...

[both leave the room - long pause - tape ends - last side starts. A woman with a small baby has come in, introduced to me and asked if I can use the tape-recorder. She has given Dr L the symptoms she is worried about- diarrhoea and vomiting, and he has asked about how she is feeding the baby. He starts to examine the baby on the couch, but as I recall, he needs a tongue depressor or something and goes out to get it.]

K - How old is [?]

M - Three weeks

K - Aaohhhh, poppet. How was the birth?

M - Terrible

K - Was it your first?

M - Yeah

K - Yeah, was it here?

M - Yeah

K - Did you have um

M - I had the epidural, then gas and air, then, because my legs went really numb...

Dr L - [coming into the room] Nightmare ....delivery, 15 hours of unadulterated joy, wasn't it?

K - It sounds a bit like mine

Dr L - Can you just pass me that stethoscope from the bag? That's fine. [long pause as he checks the baby over.]

K - [to mother] Is he good at the, uh, squirting you in the eye?

M - Yeah

Dr L - I've been peed over, pissed over, and puked over, and pooped over by experts. You'd have to get up early, young man, to try anything on. [long pause, baby sneezes] Bless you! Got a clicky left hip.

M - What's that mean?

Dr L - Nothing

M - Nothing

Dr L - But he needs, they need to check on it, that's all, after you know, at the six week check, I'll put it in the note, that they should check you've got a clicky left hip. Yeah, you won't like this bit very much, I'm sorry about that young man but nonetheless we still have to do it. Right, well, you have a well baby, ok.

M - So what do you think's causing the sickness and diarrhoea then?

Dr L - It's just a bug that's going round.

M - Is it?

Dr L - Now, what you have to do with the for- with the feeding is you do what's called re-grading. Now what that means is you're giving him what three ounces did you say? Right, ok, so what you do is you're putting in what three scoops in two or three ounces yeah, what you do is you cut that down to, SMA right?, well you cut that down to 3/4s of a spoonful in the same volume, then you move up to one teaspoon, or one scoop, then two scoops and then three scoops, right, so over a day or two days you re-grade it, fluids, that's fine, because all you're doing is replacing, you just want to make sure that he doesn't get dehydrated, alright, and just giving him fluid. Now the reason you cut down on fluid. Now the reason you cut down on milk is, in the milk is fat, the problem with fat is it stops the tummy emptying, so what then happens is it lingers in the gut. If he's a bit snotty and he's swallowing all that snot, it gets all, it stays in the gut, irritates it, and they throw up. Alright? So he's either throwing up at this end, or crapping at the other end, which is no use, so what you do is you cut down the amount of fat, the gut can absorb that, and he doesn't get dehydrated, alright. And that's all that is necessary, alright? So are there any questions you'd like to ask me?

M - [has answered yes, ok, right, yes etc.during Dr L's explanation] No, as long as he's alright. What about this clicking hip?

Dr L - The clicky hip, that'll be checked at the six week check and then probably subsequently later.

M - So what could be wrong then, if he's got a clicky hip?

Dr L - You monitor it because, em, there is a thing called congenital dislocating hips, which can, which can be a problem, but that's why once you've picked something up, you just check it. So he'll be reviewed. So there's nothing to worry about.

M - I'm worrying now.

Dr L - No, I said there's nothing to worry about.

M - .... Do you think I'm an overly concerned mother.

Dr L - Have I given you that impression?

M - Neurotic

Dr L - Have I given you that impression?

M - Yes

Dr L - No, no, that's, that's, what you're describing is your fear that I may think you're that. Now, right, have you had babies before?

M - No

Dr L - No, therefore you are showing maternal interest, that's different  
//M - [laughs] yeah

Dr L - That's different. Now if you were one I would tell you, believe me

M - Would you?

Dr L - Oh yeah

M - Another outspoken man in this world, eh?

Dr L - Oh no, no, just one that, but I mean there's a difference you see. If you're anxious because it's unusual that's fine. Now that you know that there's nothing wrong because of the following features, if it happens again, you're going to say right, last time this is what we did, I'll try that. Now then, what you would then do is after two days of you trying that, then you would be concerned, you'd come back to me or someone like me and say, well, actually, for three days I've tried this, it hasn't worked, I know, it's been explained to me before, I'm happy about that, but this is different, right? Now, should you come back again to me and say, well it's just the same as before, and I say well fine, have you tried what we discussed last time and you say no, I'd say, why? and then you say well, I just lost my head, I just went to pieces, I'd say fine. then I'll go over it again. But sometimes people just ... you know, there's a difference because um they're interested in ....this is different. There's a very good trick I'll show you, if you just, you take your finger, but that side up, you just press into the top of their palette, they start sucking, they can't help themselves, it stimulates the sucking reflex, it's a cheap, it's a cheap soother.

//M - yeah, yeah, yeah, yeah, mmm, mmm, mmm, oh right, ok

//Baby - [cries, crying gets more and more insistent until he's really yelling]

//Dr L - Ok, so today, diarrhoea. So, the pregnancy, NAD, the delivery, nightmare

M - Are writing that down?

Dr L - Yeah, 15 hours, failed venthouse, forceps, episiotomy, ...

[baby still screaming]

K - I used to do that thing with my finger, the only trouble with that was, I had my finger in there, I couldn't do anything else

Dr L - Just press gently, just wiggle it about, and they just stop, they can't help themselves

M - [baby stops crying, mother laughs]

K - Now you try driving

Dr L - That's the bugger, then [writing]

K - That's the trouble

M - He's going to swallow my finger

K - They're really strong suckers aren't they?

M - Yeah. Oooaw

K - But like I said, now what do you do, it's like holding your finger in the dam, isn't it? Can't take it out. You're one of those sucky babies, you like sucking. Tickles you as well.

M - Are there are notes I need to take?

Dr L - No, we fax this across

M - Oh right, so I can go now then.

Dr L - Yeah if you - are you wouldn't like me to go over anything that we've discussed?

M - No. My mind's at rest. As long as it's, it's just that I read in a book, that any diarrhoea and vomiting is dangerous

Dr L - No, that the, well it's like all these things, that's, believe, you mustn't believe everything that you read. It's dangerous if it's in the third world. It's dangerous if you don't recognise it and you don't do anything about it, so what you normally do in fit healthy babies is you withdraw the milk, or you make it as. like dishwater, right, give them plenty of fluids, now if they are constantly throwing up, what you do, that's still not a problem, what you then do is you give them incredibly small amounts frequently, alright, literally teaspoons, that will keep a baby hydrated, because if the gut's that inflamed, it won't tolerate it and it just comes up again, you'll get it all over your shoes, alright. But giving them very small amounts, very frequently, you can keep a baby out of hospital, because all they're going to do is they're going to try the same, right, so what you can do at home is - to stop coming in here to wait five hours down in casualty for someone to do exactly that - if they're that bad and you really can't control it by these simple measures, then they're going to wind up on a drip anyway, alright? Now, it sounds as if I'm very cavalier, but from a medical, for me as a technician and as a pure

doctor, not worried about mums and dads and whatever, that's dead easy, but it's much nicer to keep everybody at home if you can, but it means that you have to be convinced that you're ok, and happy to do it. If you're unhappy to do it, then that's a good reason for going up to hospital, alright, because me telling you and you believing are two different things. If I tell you, and you think I'm ok but you're really not committed to it because you're still desperately worried, then all that happens is that you get anxious and neurotic at home, thinking are you doing the right thing, when, then that's a good reason for sending you up to hospital, yeah, but if you're happy and say right, I know how to deal with this, I've had it explained to me, and you've tried it, and it's still no better, then you say, look, hold on Jose, this is, enough's enough, I've tried it, let's do it the other way, fine. Ok? Alright, now I want to see you get out that door holding that with your finger in there, do that and you've passed the test, alright?

M - You'll have to scream mate

K - ....now, see ...

M - Right, thanks very much, bye

Dr L - You're welcome, see you

[long pause, then door closes]

Dr L - Now, I'm Dr L, tell me about your problem

[this case is a young woman with cystitis, was told last time to get medication straight away if it came back. Examined, given a prescription. My hand is aching so I'm not transcribing the whole thing. Long pause, people going in and out.]

H - You see this is why I sort of went into shock when you said that, when she said that ... right

Dr L - Sorry, you

H - The um, the child that came in, I think you saw immediately after C

Dr L - Can't remember, which one?

H - He was a half-caste boy with a white mother ....

K - He was about four?

H - Maybe you didn't, I thought you did, we'd gone, and it seemed to be abdominal

Dr L - I don't recollect it, I mean I can't say I didn't, but I don't recollect it

H - It must have been [Dr R], but yes I saw a fascinating piece of . like. social play, because I was sitting in reception, and C had come out and he's obviously a very sick child, no one can dispute that, you're looking at a sick child, but her little boy looked very lively, very healthy, got the toys out, played with them, and um. C said 'Hurts

Daddy', and the receptionist went 'Aaw, you're going home', loads of sympathy, loads of attention, and this woman, she went to her sick child, well, her lively child, she went 'let's look at your tummy now, ooh it's going down, isn't it', like she's trying to justify the fact that she's here, and it was just, it was brilliant

Dr L - yeah, well you can't do it better than that.

H - It was so fascinating.

Dr L - Well that's actually, sometimes that's why the waiting room experience is very useful. That's why, like I was saying you earlier, that's why I bring them down, so they can get a real true reflection of what emergencies are all about, because when a really sick person walks in they don't wait, they come straight into my room and I make it demonstrable to everybody, this is a sick person, they need to be seen before you, whoever the you is, and it is, it needs to be the advertising, the demonstration has to be openly demonstrable, this is sick, this is routine. It's very, I mean, it is, it's self serving

H - Anyway we were sitting outside having our strategy meeting, and I was only about 1/4 of the way through my cigarette, and she was out of there

K - She was out like a flash, and I thought, after C, she probably got in here and you know, you threw her out [laughing]

Dr L - No, not at all, I don't actually think it was me, that one, because I usually say if I know, I've eyeballed them, don't sit down. I mean I've said to patients, don't sit down, you're not staying that long.

K - Really

Dr L - Yeah, well particularly if they're well, you know they're well, I mean you know, it's ok, don't bother making, don't bother sitting down. It's like that mum who said, 'you probably just think I'm anxious and neurotic'

H - to which you said?

Dr L - no you're afraid that I think you're anxious and neurotic. that's different

H - and you really thought what?

Dr L - that she was a first time mum and she was worried

K - The baby was only, what, three weeks old

Dr L - yeah, see, a first time mother

K - She had a horrible birth as well

H - oh really

K - Yeah

Dr L - Oh I put down, nightmare delivery

H - Well there's no such thing as a good delivery in my opinion, but

K - Well some people say they ...

Dr L - No they're mad. They've got some kind of neurological deficit I'm sure, mm. It can't be right

H - Or they've just got sadistic tendencies, they want the rest of us to feel like they've missed out on the birth experience

K - mm

Dr L - I think it is a wonderful thing to miss out on the wor- birth experience

H - Yeah, it's a shame Marks & Spencers don't do children

K - Yeah

H - Where was I?

Dr L - the social?

K - No, no, no, I've done that. Oh [...] woman!

Dr L - Well she weren't gonna see me, and that was obvious - and the only reason that they were protecting her from me by asking is it ok because they know that I would have given her a flea in her ear

H - Mmm. Did you actually see ...

Dr L - No I pointedly ignored her, I gave the advice loudly to the Receptionist, like this is an abuse

H - I think she had a taxi waiting at 11.30

Dr L - I would have kept waiting until midnight .....but I mean you know, that's just medicine on the hoof. If it's convenient I'll go to Nightdoc. Sod that, let her wait three hours down there in bloody casualty

K - I liked what, what was interpreted as acute back pain, it turned out to be

H - a lodged tampon, but she wasn't sure, it might be

Dr L - Well, she'll have to wait and someone else can delve in her pelvis, because I'm bloody well not, certainly not at 11.00 at night for a non-emergency

H - have you actually, I mean speaking as a woman who uses tampons, I find the idea of possibly having a lodged tampon, that you weren't sure of

K - Mm, she wasn't sure if it was lost or not

H - Like, I could not imagine the scenario. Have you ever come across-

//Dr L - Well, I have, you know I have, I've actually found like hamsters, I mean, but that's in, not truly hamsters, but you know, a collection of tampons, but then that was someone who was psychologically disturbed, not that they'd actually forgotten and, um, I've come across toxic shock syndrome due to it, I mean I don't understand it either so I can't, and I just thought I was a chauvinistic bastard, but I can't figure it out if you, how you can put one of those up you, ... and not remove it

//H - but if, have you ever known someone who, yeah

//Dr L - so to speak, I mean I can't figure it, you know, I mean I can't get my head round it but

//H - but anyone who's used one and can't get it out, that's the thing

Dr L - Ah, then yeah, no I've come across that

H - You have

Dr L - Yeah

H - right, and there is a

Dr L - I can't figure out why they can't get it out. I think it is because they're a bit too delicate and can't put their hands down there

K - I'd rather do it than have someone else

Dr L - No, no, no, but I can't, but again that's something else that I just assume that I'm just a male chauvinist pig and I'm insensitive, I mean I wouldn't say anything but I'd come out and think, *what was all that about? You know, particularly if you know,* basically if it's just, you know, just a little way up, ok it's not at the ... you know, but

H - the what?

Dr L - the opening

H - oh right

Dr L - but it's just a, you know, I can't figure out why they can't put a couple of digits in and yank it out but you now, I just put that down to me being

H - Well then I'm obviously a male chauvenist pig as well, because

Dr L - Well that's ok, you can be an honorary member, I will sponsor that

H - That'll go down well at the feminist club, won't it? [laughs] Oh dear, I'm tired now, sorry...

K - Your tired. Do you want to go home.

H - No this is my last one. I must get the most out of it I can. But due to being tired, my inspiration's dried up, I haven't got any questions to ask.

K - Well, shall I remind you?

H - Yeah go on please.

K - Well Helen is particularly interested in - I'm particularly interested in under-fives, but Helen is particularly interested in stress and burnout, any comments about stress and comment that you can

H - If you can think of anything more about it

K - When you did your, you were saying to me that when you did your out of hours work you didn't do very many home visits, so even though you didn't do very many home visits did you find just being telephoned in itself very stressful?

Dr L - Yeah, well yeah, I mean you have to because if you don't then you're an idiot because each phone call could, the shit could hit the fan. It might be nothing, but I mean me I don't worry about it but that's me, but my colleagues, my two partners did more visits than me on the basis that they were worried about what they'd heard or whatever. Me I make a decision and I live by it and that doesn't mean they can't, it just means they function differently. My attitude about getting calls any of the time you don't know what it's going to be.

H - Do you think you are quite exceptional with that attitude?

Dr L - Don't know.

K - So was it more stressful for you to have calls even though you didn't  
//Dr L - I hope not. No, because, it's not your time, you see you can't use that time even if you are not going out, you can't use, that's what I was saying to you, you can't use it because you have to be around, you have to be available, you couldn't partake of the family, you couldn't partake of going out with friends because you didn't know what was going to happen, you couldn't start a game of tennis or lovemaking or shopping or you name it

H - Did it affect your family as well, I mean

Dr L - It was horrible

H - Did you get complaints?

Dr L - Yeah it was horrible

K - How often were you on call?

Dr L - Not ... I mean it would be one in three, could have been worse, but when someone was away it was one in two, and you know it's not conducive to normal functioning, either as part of the family or as a human being, in my opinion, that's why so many doctors are strange, or maybe they're strange and that's why they go into that kind of work where it facilitates them being strange and therefore

H - Were you on call all night or did you ever switch over to a deputising service?

Dr L - Um, we had the facility to either be on call all night or not. If you weren't you paid, it was individually billed so you could do what you want to, and it didn't bother me because I weren't going out anyway so it was fine except you'd get woken

H - and then you'd have to go and do a full day of work the next day

Dr L - yeah

H - and were you, when you were on call, were you always guaranteed that you'd be interrupted, would you ever be on call

Dr L - Oh yeah absolutely

H - which, sorry

Dr L - You couldn't guarantee that you wouldn't be interrupted but there were plenty of times where you weren't but that was just as stressful because yes the phone rings at home, you don't know who, is it social or is it business? And you know, with other people business is such that you know any contact usually means money, whereas as in my line of work it was aggravation, because someone wants something from me, not what I could provide them with, well from their point of view it was, but from mine they just wanted something from me, in my time

K - what is your patients perception of that is, in terms of what it means to you, how much do you think they-

Dr L - They don't give a shit. They want their problem sorted out. They do not give a shit that you have been on all day and all night and you are tired the next day. They do not give a shit. What they say is, when their problem has been sorted, oh poor dear, you're still here. God you poor things, I don't know how you do it. But they don't give a shit at the time, they want it sorted. It is pure mercenary, want it sorted. You are their meal ticket in terms of getting their problem sorted, that is what they want. They do not give a shit about your family, they do not give a shit about you, what they give a shit about is their problem, you are the catalyst to get them better

K - so how does this changed your life

//Dr L - and they do not care that you are used up and the only difference between the catalytic process and the medical process is the catalytic process. the catalyst is left

unchanged at the end of it, in the medical process there's usage, and exploitation, and that's not because of the patient, that's because of the way the system is set up

K - Mmhm. So the system here is different, how has that affected your life?

Dr L - Simple as that, it's revolutionary. I come in six times a year and do this, unless say, I've been here three times in the last ten days, but once is only because I had to be, the other two occasions is pocket money. If I'm not doing anything on those particular evenings I may as well earn a few bob, as you can tell I don't find-

H - Who pays you for that?

Dr L - They do here

H - They pay you here. Did- you're rotaed

Dr L - Mm. You have to do six sessions a year

H - So you only have to do six sessions a year, you're not paid for those six sessions

Dr L - No, that's part of your full com-, you know

H - So you must be taking up someone else's slot when you do your extra on top

Dr L - or someone can't do their slot

H - so the money therefore must be coming from the GP who isn't going to do their slot, surely, I'm just trying to work out the economics of it

//Dr L - Uh, the economics of it is if they don't, then they've already paid certain monies into Nightdoc, ok, my, Nightdoc pay me, I don't care whether it is Dr x, y or z, long may they not do it and long may they be healthy but not come in on the evenings that I'm not doing anything socially, I'm happy to come in, earn £120 for sitting here talking to you guys, that's fine

H - Do you think the co-op affects the standard of service to the patients in any way?

Dr L - I think you've got a thing in mind, what, could you actually clarify that

H - [yawns] It's, I had a glass of wine before I came out, I think it's finally got through my system. Um, so far we-, I'm just trying to be a good social scientist, to look at it from every angle, and so far we've very much concentrated on how co-ops are good for the GP, of course there's more than just the GP involved here, there's the patient too, but I was wondering what your perception of how it is for the patient in general, not just the under fives but patients in general

Dr L - I don't think the patient honestly gives a toss as long as their problem's sorted out. The one thing they will probably miss is the convenience having a pet come and visit, their pet coming and visiting

H - someone from the practice

Dr L - Mmm. Or, there's, a lot of the work that's been done is that it doesn't really matter who comes as long as someone comes, it's a doctor and the problem is addressed, not necessarily sorted, but addressed, they miss the fact they can still watch Coronation Street and auntie Sibyl can be throwing up merrily on the couch, but as long as they don't have to move off their arses that's what they really care about, that's the biggest issue for them

K - But what about, one of the GPs made a point about, particularly elderly people, was that whereas if he answered the call he would have access to their notes and he would be able to tell if there was some ongoing palliative care or something like that or concurrent, comorbidity or whatever, and if the deputy was sent they wouldn't have any idea about all that, and they'd-

Dr L - Ah the continuity of care fable

K - Yeah, so do you think that that matters?

Dr L - Not at all

K - But in that case then these people will be getting admitted into hospital and you know for an elderly person that can be really disturbing-

Dr L - Yes but why do you think they might be admitted to hospital?

K - Well because somebody coming along hasn't got any access to their notes and this person may not be-

Dr L - doesn't matter, it's an emergency, why do you need notes for an emergency? As a doctor you see, when they come into casualty downstairs, you don't have their notes, what you do is you make an assessment, is this an urgent medical or surgical case, dead simple, don't let's worry about the diagnosis, sod the diagnosis, doesn't matter. Is this urgent? Once you've established that then you've made your decision. If it's non-urgent, you don't give a toss about all the other things, it's neither here nor there. If it's urgent, you don't give a toss anyway because you've got to sort out the immediate problem, if it's non-urgent why do you need to know all that stuff? Because it'll hold, it'll hang fire till tomorrow when, continuity of care, the pillar of society can go back in and cater to his wonderful patient. What does it matter? The notes are irrelevance, is someone sick or are they not sick? If they're sick, you sort out what ever the sick problem is. If they're chronically sick you don't need to do anything except put your finger in the dyke until the morning. If they're a hospital case, they're a hospital case. So I don't understand the dilemma.

K - Well it's the second scenario, if they're chronically sick-

Dr L - Not your baby, what your baby is is to sort out the immediate problem. If they're chronically sick and it's non-urgent, then there's no problem. Why do you need the notes?

H - So where does the transition get made from someone who is sick enough to warrant coming in here but not sick enough to require a trip to A&E?

Dr L - I'm confused

K - Well there is a sort of middle phase isn't there. There's 'don't waste our time', then there's something that's legitimate for here, and there's something that's legitimate for A&E, but sometimes it's difficult to gauge the middle-

H - how is it stratified?

K - because it is not like going to the doctor in the daytime, here it has to be a medical emergency, but if it's a medical emergency why don't they all go to casualty?

Dr L - Good question, [everyone laughs] she wishes they would, well I mean, but what you're-

//K - Do you want to sit down [to Dr R], you can sit next to Helen and you can

//Dr L - the dilemma is if they come up here, they can come up here. If you think they're going to need medical referral they'll be referred. What are you struggling with because I sometimes get confused, not with what, but I...

K - We're wondering what, where in the scheme that you're plotting is the person supposed to decide that this is the right place to come whether they are a medical emergency or a casualty.

Dr L - They phone here, don't they? It's never been a problem for patients before, patients used to go to casualty all the time, irrespective of whether they had a GP on call.

//K - yes but

H - How many of the patients seen tonight were appropriate, for here?

Dr L - They all were, the ones I've seen. Oh no, I mean really that cystitis one, the last one, was just I was feeling in a good mood, you know, load of crap really, could have waited till the morning.

H - Oh was that the elderly lady?

Dr L - No, no, no, that was another one, that was, no, that was the young 18 year old with cystitis

Dr R - Did you see her?

Dr L - Yeah.

Dr R - What did you say?

Dr L - I was actually benign

//Dr R - were you nice?

Dr L - Unusual, because I should have actually told her off, but I couldn't be bothered,  
.....

Dr R - It's the Cs

Dr L - They're ... well no, it was medicine, I mean that was proper medicine, ..., um now  
the elderly lady was valid, she had a ... an infection of the tissues of the front of her leg,

H - sorry

Dr - sudden onset. She was fun as well

Dr R - I heard you laughing

Dr L - Yeah she was a hoot. She tickled me.

Dr R - I was seeing to one of her parents next door  
//Dr L - She said, no she said, 'If I were a bit younger',

Dr R - She didn't  
//H - Awww

Dr L - She did! She said 'I could ...' She was funny.

H - Did you test her eyes?  
[general laughing]

Dr L - She saw the white stick, but she left her guide dog downstairs.

H - Sorry that was horrid

Dr L - No, no, ... you're a social scientist, you have to make comments

[end of tape]

The conversation between Dr L, Dr R, H and K ended shortly after the tape stopped, and K and H made photocopies of the call reports to take away. Before we left, Dr L. gave H the name of his practice partner to talk to and agreed to ask him if H could interview him.

## Appendix Four

### Family interview

Family interview held in October 1997, in the home of C's parents  
Case P 08

K - Kathryn

M - Mum

D - Dad

----- used for unclear speech

[tape machine turned on]

K - I stopped you right in the middle of saying interesting things a few minutes ago because I didn't want to lose it, but can you start by telling me a little bit, you know, who is in your family, who are you all?

M - Right, well we have five children, um [name] is the oldest, he's 11, and [name] is 6 and C is almost 5 and [name] is 2 and [name] is a year and [father] and I, I'm 31 and [father] 34- 35.

K - Right, and that's, the family lives here, does any one else live here?

M - No just us

K - What about your family, do you have other family near by or

D - Yeah my mother lives up the road, um I've got two sisters and a brother, they all live not far from here, um [mother's] parents live further away, [town about 40 miles away]

M - and my sister lives in a town just outside [same town as her parents]

K - so when you started having children did you have much experience of looking after children, or did you know much about

M - no

K - what it means when they do different things?

M - No I mean it's a culture shock, it's um you know a big shock

K - What was it like when they were little, did you feel did you have people to ask about things?

M - In the beginning when you have, [first child, age 11] was quite a demanding baby so there was a big break, and then we had [next child] and I found that things changed so

much within - I think people were more helpful when I first had [first child] and then when I had - I noticed the cuts and everything had changed after, after [2nd child] the hospital routine had changed a hell of a lot

K - Right, so where did you have [first child]?

M - [hospital]

D - They were all born at [hospital].

M - and I found um the care after [first child] was brilliant but then it just changed a hell of a lot, I've noticed

K - Right, so what, what sort of care did you get?

M - Well they were helpful with how to bath and they were there to help feed and show you how to change a baby's nappy which

K - Was that in the hospital?

M - in the hospital

K - Did you stay longer?

M - I stayed with [first child] longer because he was in special care for a week. With H they left me alone I suppose they thought I had one, but I noticed how different the hospital changed, there was a young girl there with her first, obviously no idea of children, and she didn't receive, like, any help really. I was quite surprised within 5 years how much it had changed.

D - By the time we had [first child] I mean it was -

M - Yeah, you practically deliver it

D - deliver it yourself and uh, you know pay on the way out [all laugh]

K - Yeah

M - No [hospital] - the Maternity Unit I think's very good, but I just feel they're under a lot of pressure

K - Right. So what about, was there anyone else around in terms of you know health visitors or

M - Yeah, you have um, I don't think the health visitors, I don't, I think they're a waste of time to be honest, I really do. I had one, after I had C I had terrible post natal depression and we had a man health visitor who was excellent

D - was excellent

M - He was fantastic, he was there -

D - What was his name? [HV's name]

M - [HV's name]. He was such a lovely man he would just phone and say I'm coming, but the health visitors I've had before and after C, they come for their 10 day or what ever, they just come for that and give you a read book, and if you need them they're at clinic

D - Yeah, they seem to know nothing

M - They know nothing, you know. And I think they are a waste of time but [HV's name] I mean he was absolutely fantastic, if I was having a bad day I knew I could phone and he would be there and he would also phone me if he didn't hear from me he wouldn't leave it for me to approach him and he moved to [town] way, he moved up there

D - When he couldn't take any more

M - but the health visitors I don't give them much credit, I must be honest. The doctors, I've always had very good doctors.

K - Have you always had this-

M - No, we originally used to belong to [another surgery] Dr D there, he was our local doctor, and he was very good, but the health visitors were the same there as well, you know just round for their 10 day check

K - yes right

M - The midwives up until we came here, the midwives you always used to see at [hospital] and they, they're very nice there, the midwives were fantastic weren't they? Yeah, couldn't fault them

K - Right. So when you said you know that the health visitors really didn't seem to know, what sort of things were you asking about?

M - Well with C as I say I was very very ill and I did have a lot of support by the doctor and [HV's name] the health visitor, but when I had [fourth child] there was very little help I mean the health visitor there, we were actually at a different, we moved around a lot, we were at a different doctor's surgery, [name of surgery], and the health visitor there

D - She was only 10 wasn't she?

M - No she

D - No she wasn't, she was very

M - No actually she was quite good, she was a

D - Which was the one that was very very young and wasn't

M - Yeah she was quite sweet, she was just studying, she hadn't actually qualified for her health visiting, but the main health visitor I don't think I saw except when I went ... I don't think she bothered, and when I moved here we've got another one now who once again, I mean I'm fortunate my doctors have looked after me everytime I have the babies, they make sure if I need any medication they're there, but the after care from the health visitors, for someone who may be at risk, not now but when I had him, you would think they would pay a little more attention but they didn't

K - Did they ever make you feel that you could phone them about little ailments or

M - No, no

D - only [HV's name]

M - they never, only [HV's name] yeah, they never made me feel, if I was having any bad days, except for [HV's name], I could ring and just ask for advice, and even now I think if I needed advice I wouldn't go to a health visitor

K - Right, is that because of the advice they give or

M - They just don't seem to, I don't know whether it's they just don't have the time or whether they do everything in clinic and if you want to see them you go on Thursday or Friday and that is their hours, I don't know, but I could never feel I could phone [that health visitor] at the clinic and say could you come and see me or

K - And so do they run any sort of general advice clinics or

M - I don't believe they do. I've never been told if they do, they never ever approach me, they have a normal baby clinic but they're so, they are busy I mean you know can't take up much of their time, but the aftercare and I think for somebody who was as bad as I was, you would never have believed I was once bad, the after care I've had since having two more children.

K - It's funny because some of the health visitors are very much more active in what they provide and one of the people I have spoken to said that their health visitor has a clinic where you can actually use it like a creche. You can go there and they will look after your child for you completely while you sort yourself out, go and see the doctor or anything. It's, you know, a pretty good system, but they do vary a lot. I don't know what the set up is, but

M - No, this lot, you just see the health visitor on a Thursday or Friday, there's um doctors as well and you see the midw- uh the health visitor if you want the babies weighed. It's mainly up to you when you go there whether you want to see the doctor as well the health visitor

K - so the health visitor was a dead loss

M - Mm [laughs] sorry

K - What about anybody, anybody else, I mean did your family sort of chip in with advice, was it welcome advice, or was it-

M - Yes I mean

K - forthcoming or

D - It's not advice really

M - It's just - you do need the help I mean

D - You need some, you need hands on, don't you, help

K - Yeah

D - especially when you get to five

M - yeah it would just be nice, I mean, my family- J's mother's not well, um she wouldn't be able really to help, but my parents are very good but now they live so far away that, um, and also they find it a bit of a struggle, a few years ago my mum wouldn't think twice, she would come down, she'd look after all of them, in fact she did when, after C, [father] and I went away for the week and they came and looked after the three children then, but now I think she finds it a bit tough. It's very difficult I mean you can't rely on them, you can if it was a dire emergency....

K - So with, I mean I suppose with [first child] you learned a lot and then, you know it's down to each individual child isn't it, but, what were the sort of things, can you remember back then what were the sort of things that you had to learn for the first time in terms of looking after, you know, coughs, colds

M - Yeah, I mean I was never ever until I started my own children, I wasn't a maternal person, so it wasn't like I loved being with babies before, or ...it's just a shock, I think your first child, you think it, it's you know a baby and it's real, um it's hard I mean [first child] was a demanding child and he still is, but I mean the aftercare after, I hear people now say that when they have the baby they're shocked at how they're left to deal with it afterwards but I mean I couldn't fault the care I had after [first child], they were there to help show me what to do with the nappy, help me feed him, um encourage me because he was in special care, he wasn't feeding properly, so he was being fed with a tube, and so they were encouraging me to try and keep my milk flow, because I wanted to breast feed, to keep that going, um you know I mean I found the help for a first time mother very very rewarding

K - and how was his health after sort of the first year of so, did it affect his health at all having...

M - No, no he's um, he's fi- I mean, he's just very demanding type of boy

K - Was he crying a lot or

M - Um, was he crying

K - just wanted feeding -

M - Yeah, he was one of these babies you had to hold him all the time

K - Yeah

D - .....

M - Yeah, C was worse, but my parents they lived literally just 5 minutes ... and my mum was very good, I had a lot of help.

K - So when you had [first child] was that the doctor who was in [name of surgery]?

M - yes

K - and if you had things like high temperature in the night or things like that were they quite helpful did they give you advice or did they

M - With [first child]? Yes. Well I find, I find the health of children has changed. I don't think they maybe used to panic as much, not panic but I mean 10 years ago

D - It's the meningitis thing

M - Yeah I think that has changed

D - meningitis wasn't heard of

M - yeah it was heard of but it wasn't a big fear

D - I think now it's so high profile, they panic

M - before they were like if it's- give them Calpol, still bad in the morning, bring them in, but now I've noticed you know I could phone the doctor's surgery tomorrow and say, you know, and they know us very well down there obviously. I say oh you know C has got a temperature and I wonder if the doctor should see him, I'm seen, whether I have to sit and wait, but when I had [first child], it was, they were a bit more laid back they weren't so on the - not on the ball, but they weren't were they. they were totally, if it was the middle of the night and I used to phone if you phoned - once in fact the doctor didn't come out, did they?

D - No well that was, yeah, funny enough I was going to, that was the one I was about to say

M - Yeah, the doctor wouldn't come out and

D - but that was a different surgery. That was when we lived in [town] and he was, [first child] was older, he was four

K - so you were living in [town] and what happened?

D - Yeah, well [first child] had, it started off, he was beginning to feel unwell, sore throat, high temperature, took him to see the doctor I think first didn't we

K - which doctor was this one?

D - This was at - what was it, [name of health centre]

K - oh yeah right

D - doctor ? um, what was his name, no

K - not Dr B?

D - No, um

K - not Dr P?

D - Nope. Who was it? I'll think of it in a moment. Anyway so we took him to the doctor, and he was seen and he said he was not well said give him calpol the usual thing and then he got progressively worse and then he had a fit which was a ----- and we phoned the doctor and said look he is getting worse we are a bit worried so he said

M - he was delirious

D - he was delirious. He did not know, you know, so he said, 'Well see how he is in a few hours and then phone me back'. He was still reluctant to come out even after all this had gone on. In the end I phoned up again and I said look he has got much worse and I am getting very worried and he said, 'Well if I came out to every child with a temperature right I would be running around all night long.'

M - and we told him he had had a fit

D - Yes, so I said to him you either get here now or what ever the consequences are I said you will have to deal with me in the morning. So eventually he said, 'Oh I'd better come out', and he he did not come out. He would not come out that night. Anyhow he came the next day and said it was tonsillitis so he had still gone all night. During that day he had got worse and worse he

M - he could not move

D - He was desperately ill at this point, so the doctor then decided that you know he would take me seriously he came out and said actually he said, 'I think you had better get an ambulance right, I hate to tell you, I really think that he might have meningitis', right, so we just went spare, rushed him into hospital and they were waiting the team at the door, you know absolutely fantastic help they gave him a lumber punch, which I had to --- which was horrendous. Anyway thank god it was not but he did have double pneumonia

M - and the doctor was just saying it was a ----- sort of virus

D - They got all the top doctors in [town], they got a professor in, I mean it was

M - They started him on antibiotics, they really did - he could not move

D - yes he was desperately desperately ill and

M - and you don't take them to the hospital because the doctor is just saying what - now we would, but before you don't have the experience I suppose. He was saying it is just a virus or tonsillitis and these are the effects you can get, you don't think it is possible. But I mean he was so poorly, and in the end the doctor came out and he came and said 'I am in a meeting', he said I won't be able to get there till after 7.00. when he arrived he like potted up the stairs and [first child] had not moved from bed and he took one look and he tried to get him to move his neck and he could not, and they did not tell me at the time but he could have taken [father] to one side and he said, 'I think it could be meningitis'.

D - Well you know he actually looked quite horrified

M - In fact I think he phoned us every day after that

D - Actually from that point on he was fantastic, he really, but so that was our bad experience of

M - the only real one

D - but we have had some good help as well, I mean C was being a very bad asthmatic and I remember one time at this surgery, Dr X and he ----- and very helpful towards C and [mother] which was she was ----- and I think one day he had such a bad attack we were on the phone to the surgery during the day to get some help and I think we were still holding on the phone and he ran out the surgery with his bag and he was knocking at the back door and we were still hanging on the phone, right. So from the other end of the scale you know fantastic

K - So your doctor that you have got now is a model doctor

D - Yes the practice is excellent

M - the main doctors that I have seen -----

K - and what makes them good GPs?

M - Well they listen and they don't look at you as if you are some kind of neurotic mother and they do take you seriously. And I think it also helps because they have both got young children and they also take an interest in the children as well. They make time for them or they don't rush you

D - they talk to the kids

M - Yes, they talk to the kids and they also I know it is on the screen but they build up a rapport and they remember things, you know you go in there and if they have seen C he may say, Oh how is [fourth child] he remembers that someone else was ill last week. He always asks he makes it feel personal, it makes it feel very personal

K - so when you have [...] was C the first child who had any asthma in the family?

M - no [child's name] had allergy asthma where certain things would trigger her off

K - right

M - but C he was only 8 weeks when he had his first attack and his was more ----- where as [other child] she would just go for a year and not have any sign and then go near something

D - something would set it off

M - yes something would set it off and then she is more ----- and that turns into asthma where as he would start with a cold and the asthma attacks would last for three days real wheezy and yes but he was quite scarier but em

K - has he ever had a situation where again out of hours

D - yes a lot

K - right so what happened there

M - well before it changed to the Nightdoc we always used to have ----- doctor before they were very good

D - they just always came

M- they always came

K - was that GP at ----

D - yes of [...], from there any of them, they never ever had any hesitation they would always come and see C without any question

K - and have they been called out for other children or

M - once he had got another case where Dr X was at the door while we were waiting to phone us back

D - yes he decided to come round instead

M - [first child] has got a disorder called ----- it has only just been diagnosed and he gets [describes symptoms] and one Saturday he was complaining of a headache and then he, Dr ---- said when he spasms and he was screaming like ----- I'd better go and check just in case

D - yes so he was having a bad day. We were on the phone to Dr X just to try and get some pain relief or something. He is under [specialist children's hospital] anyway [first child] and so he was going to phone back in half an hour to see how he was but he decided to pop round anyway, and I think it was a Saturday

M - it was

D - probably --- his working day

[mother brought daughter down stairs]

K - so what does croup involve is that when they have sort of got like a bark?

D - yes a barkie cough

K - and you can get steam or something?

M - steam

D - but I tell you the best thing is just keep them upright that is what they were saying. Dr X sat in the bathroom with us

M - yes with [daughter]

D - he was sitting in the bathroom with us with steam making sure she -----

K - They sound brilliant

D - They are

M - They are very good

K - But did they ever have a deputising service there?

D - Yes in the middle of the night I think one came out to you once, remember that Indian doctor when you had, remember when your leg was bad in the middle of the night, he came out to you?

M - That was after it changed over to Nightdoc

D - Was it?

M - Yes in January it changed

D - Oh maybe it was then

M - But before that always, we never spoke to anyone else. They changed I think in January

D - Yes but I am sure we had, once or twice I remember with the car we had a doctor in with one of them possibly. I am quite sure.

K - Sometimes they would have a situation where perhaps after midnight they would ----  
- or if you had somebody really early in the morning it might have been, so now when you use Nightdoc have you used it

D - Once, that was it, we have spoken on the phone and taken telephone advice

K - So right, when you did that, did you say anything else, that you wanted phoned advice, or did you just start telling the problem or

M - Well this was with C again, he had an MMR, do you remember, pre-school MMR and his arm, I think he thought we were neurotic, he said, 'Well it does go red slightly.'

D - It ballooned

M - It was like this he had a nasty reaction, she, you did feel slightly frustrated because you were talking to the nurse and you wanted to talk to the doctor then

K - Right, did you say

M - She did not seem to take me seriously. She was like saying when children do have their immunisations they do tend to get a lump and it could go red and

D - I said it is not a lump, I said his whole arm is red and swollen

M - But she still, in the end they didn't

D - I can't remember how that resolved

M - No the doctor did not phone us back and we took him to our surgery the next day and he was on antibiotics. He was just unlucky he had a very nasty reaction, but that time in particular it was frustrating because you were talking to the nurse and she obviously did not feel it was a case for the doctor

K - Did you say you wanted to speak to the doctor?

D - Well I think we probably would have wanted to. I think she just spoke on our behalf

K- and said

M - yes she said I will speak to the doctor and they will call you back but she phoned us back and said

D - I think it is a bit wrong because there are risks with immunisations which are not fully, I mean

K - So on that occasion

D - especially with MMR

K - So on that occasion you weren't happy

M - We weren't happy, not with that. We felt we were talking to like the receptionist and we wanted to talk to the main person

K - Right

M - and found it difficult but

K - So you did not want someone necessarily to come out but you did want to speak to the doctor?

D - Sometimes things get lost in translation. The nurse could easily say 'Look I have got these people on the phone, the child's arm has got a bit red, what shall I tell them?' And it could have been like that, I'm not saying it was. And the doctor could quite easily say, 'Oh tell them to see the GP in the morning so give him calpol don't worry about it.' --- which is probably what happened because that was how we read the message

K - So when all this happened to C, do you want to tell me right from the start what happened, because I know you went to the [hospital] ---- and

D - yes we went to [hospital] first

K - what was the first sign of any problem?

M - Well he woke up, he came home from school on Tuesday or Wednesday evening and he had a couple of, on his shoulder what looked like nat bites. right, just normal bites and the next day he said they were itchy he just had two on his shoulder and he went to school and I ---- he had just started school, he does not want to go, you know, so I said, don't be silly it is only a bit, and then I got a phone call from the school saying that he is in the medical room and he is complaining that his skin is itchy and said he has got a couple of spots. So I just said he had these spots this morning and they just looked like nat bites and I said is he ill? So she said 'Not particularly, no' so I said well monitor him and if he gets worse I will pick him up. Anyway an hour or so later they phoned and said he was hot, his feet were covered and there were like heat bumps all over his body. So I

picked him up from school took him to the doctor's. The doctor's first reaction was an allergy and said, 'Have you eaten anything, has anyone given you something out of their lunch box have you touched any berries from the tree?' And he said no and I phoned the school to ask if he had been playing with anything that was different, plastacine that he might not have used and they said no and then he started to get swollen and then the spots went like most spots do on the skin like ---- and he was becoming

D - irritated

M - yes, unwell. Next he was lolling around and looked not very well so I took him back to the doctor's and he was not happy with - he had been on piriton as well, so it was hard to say whether he was dopey because of the piriton or dopey because he was not well

K - and you saw the same doctor the next day?

M - yes and he said he did not want to take any chances because now the spots had gone purple and sent him to, he said 'Where do you want to go?' and because we had them at [hospital] I always say [hospital] out of habit so you took him to [hospital]

K - and what happened at [hospital]

D - well they saw him at [hospital] and went straight to the ward not through A & E

K - why was that

D - they said bring him straight to the ward because then kids are seen there because it was a doctor referral so we went straight to the children's ward, saw obviously a junior doctor after about three hours I think it was hanging around. This was the first assessment. They she said yes it is an allergy and then ----- so she said 'Just keep taking piriton but before I do anything I have to get my registrar to look at him', and we waited another hour or so and the SHO to come and see us. ----- they actually could not make any decision or any plan of action whatsoever, it was a pointless link in the chain but anyway eventually ----- she was also extremely nice and said 'No it is not an allergy it is almost certainly a virus', and she said her diagnosis was completely different to ----- anyway so but hers was so definitive, I mean she really knew, she recognised the kind of rash, could identify it, gave it a name, you know and she was you know 100% correct and that was how we left it. But she did say to us 'If you have got any problems, if you are worried, if anything changes, particularly if you get mouth sores, if it affects his eating or anything you are worried about within the next 24 hours. just come straight back here and we will see him.' So we left it and said thank you very much. They said 'He is not in danger, he is not ill, just take him home and keep going with the treatment', which we did you know. The next day he started to develop sores and this rash in his mouth and his lips and his tongue, and then he got the other unfortunate symptom which you unfortunately had to witness

K - I remember, yes

D - So he, I thought I'd better phone, we phoned, no we went to see Dr Y, we took him down there and he said 'Well, you know, take him home see how he is if you are at all worried go to the hospital', so we brought him home. I came home from work and said ----- and said I am very unwell, so I got on the phone to [hospital] and got put through to the ward and I said we were in last night and I am going to bring him back to see you, you know he has got worse and these are the things that have happened. So they said, 'Oh, just hold on a second, we are busy here, you can't bring him here.' So I said what do you mean, we were told yesterday by a senior doctor that if there were any problems to bring him straight back. So she said, 'Well hang on I will go and speak to a doctor', and she came back to the phone and the doctor said you have to go to A & E and I said I am sorry I am not going to do that I am not prepared

K - did this person speak to the same

M - no it was not

D - I don't know, I don't know I actually, I said I am actually not prepared to let him sit in A & E to be examined by another junior doctor and then go through all the note taking and all the history and all the rest of it again, I said he's too unwell ---- I am not going to do that and she got a bit stropy with me on the phone. I said look, you have got to tell me I can bring him straight to the ward and she said, 'Well I will ask again' and she came back again and said, 'No, I am sorry you still can't', and I said well and I just did not know what to do, did we? So we thought, right, the best thing to do is to phone - after a lot of debate deciding where to go we thought we would try and get hold of one of our own GPs

K - So what were the sort of things that were going through your mind in terms of what you could do?

M - Well what worried me was when I saw the doctor last time on the Friday evening I said it is this rash and I said it is not blood poisoning and he said 'Well I can't say, I don't want to say yes and I don't want to say no. If there are any concerns take him back to the hospital and that is what, because it was going purple and deeper colour and he was deteriorating, you just start, you do think the worst, and you keep thinking, well you know God forbid if it is anything, it is being ignored and it was getting worse and then it might be something ----- you might need, you can't take chances it might be too late

D - and we were really just, and then we ----- I really did not want to go to A & E there was just no way I wanted to put him through it anymore especially as we had already seen you know a doctor. I wanted, and we have got private health care as well so we could have you know tried to see one privately, but I think at that point it was bordering an emergency, you know we thought at that time, so we thought we would try and phone the surgery number and see what happens if we get through to [hospital where the PCC is] and I explained to the person who answered at [hospital where the PCC is] I told her the whole story and said, you know, we don't know which way to turn because [hospital] won't help. We don't want to go to casualty, we want a doctor right, a minimum GP level, I do not want to see you know a junior house doctor I want the minimum of a GP opinion as to whether he should be still, keep him at home, or whether he should be admitted or seen by a paediatrician. I want him assessed again, but if we

can't see our own GP, he was not one of the doctors on call, I want to see - so they said 'Well yes we understand that, we will call you back.' So eventually they, well in fact I did have to call back again because the call was quite a long time coming back, I did phone back again. They were obviously busy and they said, what they suggested was we bring him down and let him be seen here and take it from there and the rest you know about because you were there. And then I can honestly say that from the moment I walked in there and the doctor saw C, there were no complaints at all

K - Right. And do you think, once you had been through that route, did you feel that you had done the right thing?

D - yes -----

K - So do you think your own GP would have handled it any differently or done anything differently from the doctor you saw there?

D - no I think he would have done exactly the same thing and I think the fact that they got the paediatrician

K - yes that was pretty amazing

D - he actually came straight from the ward

M - they sent him straight back and it was straight to hospital anyway he would have come out Friday night he would have had no hesitation sending him

K - right so

D - but I think he got actually got the paediatrician to come in ----- so he knew and I mean I was getting very frightened at that point I must say. But it all happened with a bit too much haste, you want them to act quickly but you think not quite that quickly.

K - I think from where I was sitting, you know, the doctors. sometimes it is quite interesting to see something serious, where as so many of the things are routine. To see something different, they just sort of, oh all right, and they get into gear, because there is something really happening here, which is the last thing on earth you want to hear, because you are thinking oh my god it is serious, but to them it is just interesting you know, and it is very difficult

D - and they were getting a little bit technical in discussing him, but having said that see, I need, I like to be told if something, I want to know the facts, the details, I want to know exactly what is going on, I don't want to be fobbed off and old rubbish

K - right, and you had Dr L didn't you?

D - yes [full name] yes

K - I mean he, I think he really relishes the chance to do something significant

D - yes, and he took the sting out of it as well, he was very good to me. I came home and I don't, and I said if we weren't happy with our doctor I would go to him without any hesitation, I thought he handled C and the whole situation extremely well and of course the other doctor R who we know anyway

K - oh, do you know her?

D - yes

K - oh right, because she has been on the paediatric ward?

D - no, she did some training at this surgery here, and she also was a customer of ours. We have ----- we knew her and she knows C as well. When she saw the sheet, you know who was coming in, she actually said I don't want to see C, you had better handle it because I know she opted out anyway so

K - oh, that was funny then

D - yes

M - When was it she came in to have her hair done? She said, oh the next Monday or something we were in the surgery and ----- Dr L came in ----- it is funny, he came in to get his hair cut as well.

M - and he had never been in before, but he came in on the Monday [father] does not work, so he went back to work after having his hair done saying 'well, how is C?'

D - --- like the patient of the week

K - yes, that is right

D - the little black bull

K - Poor thing, it was terrible. I think he felt like he did not want to do any more examination or moving him to some other place where he would have to go through it again

D - exactly yes

K - you know, because he already got distressed about having everybody poking and prodding him

D - yes, it was too much, which is why I did not want to go to A & F and I would not have gone to A & E, under no circumstances. And funny enough, and I am dead right wasn't I, because of what happened after that day because it did not get any better. He got worse again, when we took him home he got

K - did they give you anything for that?

D - yes, steroids, yes, he put him on steroids which you know started to help

K - they did not give those to you in the hospital?

D - no, that is right but on the Sunday morning

K - so you saw him on the Friday night and then what happened?

D - Did you see the GP on Saturday?

M - I had to take him to Dr Y on the Saturday just to check him over. The rash was still the same, his willy was still the same and, but the doctor said well the steroids will get into his system

D - yes, give it a chance because he will come in on Sunday morning, so we did that and on Sunday morning he had gone back down and his lips were blue

K - where did you take him on Sunday?

M - to our surgery

D - yes Dr Y said I will come in Sunday morning, bring him in

M - up to here was blue, his legs were blue, his lips were blue

D - and he was just like a wreck, so I took him down there and he said ----- and he was obviously not happy about it and he said, 'I had better phone the paediatrician', so while we were there he got on to the phone to him and funny enough as soon as he said the paediatrician you know, the paediatrician said, 'Oh, well how is C?'. 'Right' he said, 'well that is why I am phoning', so he said 'Well I want you to see him if possible you know and see what happens', so he said 'Well I mean I am in A & E, bring C down', and then he can see him there so I took him straight down where I had the most horrendous experience

K - Oh no! What happened?

D - because, well I took him to

K - at [hospital where the PCC is]?

D - I took him there and all that was meant to happen was that he was just going to come and examine him, it was not, nothing else was meant to be going on. Went to the desk, was called into triage first and I don't know if you know the set up in A & E

K - I don't know the A & E there, no

D - it is a little cupboard where two nurses sit and they have got all their observations and instruments for blood pressure, and basically they called us in, sat him down, did not talk to him at all I don't think --- we have got quite an unwell, very nervous, frightened

four year old who has been through everything this week, sat him down, did not talk to him, threw this thing round his arm to take his blood pressure, right, he started crying, lunged at his ear, right, to take his temperature. Anyway he freaked because he had not seen one of those before, and they did it with absolutely no care whatsoever, so if they did it to an adult, you know, it reminded me a bit of, you know one of these ----- hospitals in the middle of the jungle where you just queue for hours, you know, do the injection, that is what it reminded me of. And I thought what the hell is going on? And then they said right, I want him to do a sample in here and we are going to put ---- on his --- hands to do blood tests, we are going to do this and this, and he freaked, he was hysterical, he has got my hand and he would not do a sample and anyway, I said, she said 'Well I have got to do it, he has got a rash and I have got to do all these things'. In the end I just freaked at this nurse because I was tired as well ----- the whole week and I said to her, I said 'You just slow down and talk to him and you will find these things easy, because he is very co-operative'. I said 'You have not given him one chance', I said 'What do you think you are doing?' and she, again she just ----- and then walked out and another nurse passed by and she gave you know, did the raised eyebrows thing, as if to say we have got a right one here, yes, and I complained

K - yes, terrible

D - I was ----- I had to put up with him crying and screaming for an hour while he got this cream on his hands saying take this cream off, I don't want it on, and then when the paediatrician came in, in fact the paediatrician that we were meant to see did not come first of all, it was another doctor, so we had to go through, so he had to go through the whole thing

K - did they say where the other one was?

D - no they said he was coming. Anyway then eventually he did come and he said 'I did not ask for blood tests or anything like that.'

K - oh my god

D - which he had not done. All he wanted to do was to see him and assess him. Anyway, amazingly enough by that point the steroids seemed to have kicked in and C ---- up and he was absolutely completely turned the corner by sort of Sunday lunchtime, and from that point on it got better and better, so that was the very reason why I did not want to take him to A & E like on two occasions, right, and it just backed up my theory of what I did not want him to go through. But in the end he ended up going through it and I tried so hard to avoid it, because I honestly thought that we were just going to go there and he would be expecting us, and we would be seen by him, and then if they wanted to do anything else they would do it from there

K - oh boy, what a nightmare

D - ----- A & E

K - yes, well I think em one of the things that people have said, that, you know, you don't want to have to keep telling the story again and again

M - that is right

K - you know, if you have had, like if you had phoned on that Sunday, and if you had not made that arrangement with the doctor and phoned Nightdoc again they might have sent out a deputy or ----- it saves having to tell the history I mean

D - but there is no way round that though is there ----

K - well I mean your doctor tried to short circuit that by being available to you

D - he was, yes, that is quite true

K - but, and it may have been that he might not have foreseen that that was going to happen and could have, or maybe not have been able to ----- and then you would have had a new doctor from Nightdoc wouldn't you probably, and I mean I would not know -- -- but normally you might have seen someone again that week as well, I mean, yes the only way round it is for the doctor to be on call 24 hours a day, then you will always get your own doctor

D - but they have too many patients now, they would never get any time off would they?

K - well it depends on how they set it up. If the surgery is quite large then, they have 6 or 7 doctors in some surgeries, then one night in 6 or 7 and some of them feel it is worth that sort of continuity

M - I think, I think before, even though we had good a experience with the Nightdoc, I think the experience before was fine how it was. I could not quite understand because just as it took over I had, January I had flu, and I could not walk. My legs went and I was having vertigo or whatever and [her husband] phoned the doctor and that was when we found it had changed service. We got the duty or whatever, and he came out and one. you are embarrassed because you have not seen this person before, you are embarrassed that you feel you have not got a relationship with this person, and in the middle of the night I felt rough, and he was out, he wants to know everything he wants to know your date of birth and you don't, lucky [husband] was there, but you don't want to go over all that, your address of your GP and everything, and he was like acting like he just did not want to be, he just treated me like I ---- how I felt about him. I did not know him, you know, you are a stranger and I don't feel well, go away, and he said I had something and the next day I got no better so I phoned our GP, and they came out and it was totally not the same diagnosis, he was rushed but his diagnosis was wrong

D - yeah, it was different

M - What he said was wrong, what he said was fine, but I do feel that if it is a big practice and they are doing one night a week, I don't feel that is a problem, I think it is still the personal touch

K - it is just -----

M - because they still have to go and work in Nightdoc, I mean all the doctors take it in turn, don't they, so they still have to go. I know it may be not once a week or what ever, I don't know how much they work but they all have to take turns

K - right, so how do you, if you could, maybe there is a different way of looking at it but if you can think about how do you see this out of hours commitment from the point of view of the doctor? Do you think that they should be prepared to do

M - yes I do believe so, I think that they should, for the personal touch and they know the patient better than if it is, especially elderly people, not just young children, elderly people, they get to trust a doctor and if they phone up they don't want to see a stranger or go to Nightdoc or whatever. They want to be able to talk to someone they know and

D - but I just think though that doctors are people generally, they become, you can be ill between 9 and lunch time and 3 till 6 but only if you have got an appointment. So if you are going to be ill in three days time you can have an appointment with the doctor that you want to see, but, and it has become generally, no, I am not saying, with the kids we get dealt with I'm not saying that is how we are treated, right, because I don't think we are

M - but you hear a lot of people say that

D - but I think that is the general feel of the way things are, that you can't get an appointment to see a doctor and they don't seem to have a system, where they used to do it very well at [other town]. They used to keep one doctor free every surgery for example, for first come first served basis, and all the others have appointments, but that was brilliant because if you wanted to go there you could go and wait and you would see a doctor that day. There was no telling which doctor it would be, it would be someone you would know from that practice, so it did not matter if you did not have an appointment as long as you were prepared to wait, but you could not moan, you would just go and wait, which was fine. But the out of hours should be the same thing, you know, you can't say that you are not, you might feel fine during the -----

K - night time is always worse

M - kids or adults

D - are always going to be ill in the night

M - yes I mean they always seem to be worse night time

K - right but em

D - I mean we have had situations, 'Why didn't you phone earlier?' and you say well I was not ill earlier you know

K - what sort of thing was that

D - I can't remember now

M - it was normally say like [daughter] has just woke up and her croup, that kind of thing is always worse at night, when she has been laying down, or even when C has asthma he goes to bed if he is on his asthma attacks routine, when he is asleep he will wake up and is 10 times worse than what he was in the day time, but you can't, you don't know that is how it is going to be

D - some of the drugs he has been on, we can't give them to him without the doctor's permission first, and we have been told to phone, you know to check so, and then they like to examine him first before they put him on them

M - but I think that now the doctors have not got this system where you are always seen by one doctor in the practice, I think does put people off, I think it puts people off

K - right

M - I am not saying that they use it maybe a little too blase, but they are not, they feel they don't know that person, to go and speak to a stranger

D - yes I think there should be a system where your GP, even if you can't contact him yourself, so I am just thinking now ----- if we phone up Nightdoc and we, you know, get a message through etc. and tell them what the problem is, but it is an ongoing problem that Dr Y has been dealing with, I am not saying that we should be able to phone him at home, but why couldn't Nightdoc be able to get in touch with or even a contact number to say let's speak to your GP and ask, get some information from him and give him the choice as to whether he wants to see the patients?

M - like [hospital] would say you have got to get referred by your doctor, when it was -- - scenario well your doctor is not on duty

D - you can't get hold of

M - and we see another doctor, it is like banging your head against the wall. But at [hospital] they had a policy where they had a system, if it was an emergency, to speak to doctor Y and you know

D - the problem with that is that he could be contacted by phone, that would give the continuity wouldn't it

K - so what you are saying is that the continuity of care has worked before now because of one thing the trust and the knowing ---- but also, there may be information to do with the treatment because of an ongoing condition

M - yes that is right

D - yes, because by the time C went to Nightdoc he had already had 3 or 4 days of different treatment and been seen by ---- doctor. Now there was, when you think about it, there was no communication between either [hospital where the PCC is] or [the other hospital] at the time of the, what I suppose I would call the crisis point, at that point

there was no communication, so we, they were relying on information that I was given, not medical, it was only what I saw and I was confused anyway and I don't think I gave information correctly, because I was panicking, so why should there not be a system set up where it could be, there should be contact, right, I mean ----- from the point of a telephone call after I phoned the nurse, the nurse could have said, 'Well let us get hold of your GP and find out what has been going on up till now and then decide what to do.' That could work couldn't it?

K - Well this, I mean I would not like to answer for your GP because I don't know what his actual attitude is, but as far as I know for Nightdoc, Nightdoc has about 120 GPs who belong to the [hospital where the PCC is] branch and they have got 4 branches they have got [names of branches and possibly a new one opening] and, you know, I don't work for Nightdoc so I am not speaking on their behalf, I am only telling what I also learned a little bit about for my research, and what they are trying to do is to alleviate the doctor from what they find very stressful, because even once a week being on call is very stressful for some GPs, not for all because they don't see it all the same way, but for some you know especially if they have been doing it for years and years. There is something about working at night and having to go out and find people and find, you know ----- it is one of your partner's patients and they don't know, maybe you don't know what you are going to find, You don't know if you are going to come home and you have just got home and there is a call from someone who is saying ----- you know, you just don't know, and there are all sorts of stresses. And even if you don't get any calls you can't relax, you can't have a drink, you can't do anything else because you could get a call, you know, there are all sorts of things. Often they did not have the day off or the morning off the next day, anyway so they are tired the next day, well they would be tired the next two days because you know they haven't slept all night. So even one day a week for some GPs just over the years you know, the thought of doing it for 30 years they just could not stand it. As I say, some doctors are very different ----- they say they like to see their own patients and some of them say you really learn a lot about the family if you go to their home, and you know the good things, but on the whole a lot said they could not cope with it. So by joining a cooperative where a greater number cover the time, they actually only have to do a session at Nightdoc every two months, which is really a huge long time to get over it and, you know, also the way they do it is the Nightdoc doctors come in for a session either up till midnight or on a weekend, it could be one of three shifts you are there. After midnight it is closed so you get the deputising service for any ----- you speak to the deputising service whether or not you get a ----- again is depending on the condition, and also all home visits are done by a deputy so Nightdoc doctors don't have to go out, so the Nightdoc doctors do the sessions at Nightdoc, they don't do any home visits any more, the deputising service comes to you. If you have a home visit you see, if you want to speak to a Nightdoc doctor you either go there or, I mean I suppose there may be occasions when they would refer, sometimes when they are very very busy and the triage nurses can't get through the calls enough, one of the doctors might phone you. [One of the doctors] is very hot on that, he is one of the main people who set this up

D - I think ----- I mean GPs have always done home visits, I mean it is a bit like saying, you know I am going to become a train driver, but I am not driving at night you know what I mean? It is a bit part and parcel of the job. I mean ok, it is a bit naff having to go

out in the middle of the night but you know if you go to be a GP, isn't it part and parcel?  
I just don't understand that.

K - Well I don't know, at times, I can only say what some of them say, I mean for example when I have spoken to some of the younger GPs, some of them will talk about it a bit more like they are comparing their standard of living, or their quality of life to other people their age with a similar amount of training, a similar amount of time and so on, and they will say well you would not get an accountant or lawyer or somebody to come to your house, you would not get anybody else to come and see you, why should I go out, and I mean we say

D - but it is the nature of the job

K - the job demands it, but this is the kind of argument that they make. And they will also say that, well those other people in those other jobs get so much more money than

D - but they should not have done it, I hate to say it

M - but don't they get paid for the calls that they make

K - they do get paid

D - they used to get paid a lot a lot per call, didn't they? Something like £40 per visit or something stupid like that ---- a relative who is a doctor, but you know I think some of their motives for entering the profession and very questionable though. I think, I mean do you enter a career as a doctor because you want to have a good living, work your way up the scale, become a consultant, take on private patients, become a surgeon, earn an absolute fortune? Right you can do that ----- you want to become a GP right, if you want to become a GP you know you have got a pretty hard life ahead of you, but you have got you know that is what you head for, but you don't do it ---- because you want to save peoples lives, or you want to do it for your own benefit

K - I think another issue is, again this is one of the things that they put to me, was that, well that one thing is that some people are not part of these practices, so if it is every referral for tonight and they are working all through the night and they don't have any time off the next day, then they do sort of, I mean I remember one GP said to me as he has done that his whole career and he is now in his 40's, like mid. late 40's you know, he said this is why so many people become very strange because they have got this sleep deprivation and it makes them, after a while you know, imagine you go through it when your children are tiny and you sort of can't wait until they are all over 5 - to get unbroken sleep regularly becomes something that you sort of crave, well they get, you know they get to the point when they are sort of doing it for a point of view and they just can't actually physically stand it any more, so that is one thing. But another thing is that sometimes not all doctors go into medicine the same way they come out. They may go into medicine with very unrealistic attitudes about what it is all about, and they may not have any idea about which branch they want to do, and they may end up in general practice without having set out to. And also medical training itself changes people. I think it makes, the sort of medical training system makes people think in a certain way which is very different from, like you are saying, what are their motives for going into it?

I think their motives for going into it are far more like what you are saying, to save life and make a difference, then when they go through the whole training it becomes something very different, it becomes technical and ----- dealing with it in a certain way it can be quite brutalising. And so they come out of it a different person, harder in some ways and they sort of, like I said to you before, you know here is an interesting case, I mean you and I would not have something happen in front of us like what was happening to C and come out of it saying that was interesting, you know, we say oh my god, run out ----- in fact human being's normal reaction, but when you have been through all that for long enough you sort of like ----- I mean I am, this is just one view this is not what everyone feels, but I think what a lot of GPs feel like is that something like what you have described is very rare, the vast majority of people who call a doctor out in the night have called because something is worrying them they are concerned, they did not know what to do but ----- does that doctor feel it is a medical emergency? And if they feel that a lot of their calls are not then they feel like, ok I have been doing this for the last 20 years I can't even sleep any more, I have got to go to surgery tomorrow morning and this person is calling me because... and they have all got those, they have got their stories - because they did not have any calpol in the house, because they did not know what to do if a child vomited, because somebody has got a headache - this is when they feel they are taken for granted. Yes but you are not actually asking them to stay the night, you are asking them to ---- or something far more mundane. I am not saying that these are arguments one way or the other, I am just saying this is the way some of them become, they come to feel, and the world changes people. Also another view is if it is a medical emergency, this has been explained to me by someone at Nightdoc, if it is a medical emergency it really should not matter who it is that sees you because you are dealing with something that must be dealt with who ever deals with it, it must be dealt with there and then. It should not really matter who. Now we have seen that, ok it would have been nicer to see someone who knew the history and especially if they could have spoken to the GP and so on, but they are ---- if it is an emergency any doctor should be able to give you something to get you through the night

D - you are absolutely right

K - some people don't regard these out of hours issues as having to be emergencies. I mean some people will say, the doctor will say ----- do feel free to call it does not matter, they put no pressure on the patient at all, so that the patients don't feel it has to be an emergency, they don't even have that feeling

D - well maybe then there is a lack of communication. Maybe patients should be aware of what they can or what they should or should not phone for and it should be spelt out

K - but like everything people

D - you know do not phone if you have a headache, if you have a sore throat, if you have a ---- attack but do phone if you have a headache with the vomiting and with a stiff neck and with this and

M - but then people, they still go to them if their child is ill or if they are ill. the way they look at it it does not matter what time of day, they are not well and their child is not well. they should be able to phone, some people do

K - it is very hard to give advice

M - it is very difficult

K - you see it is very hard to give advice in advance that will cover all the possible little things, you know it is very hard to say, you know, don't call for this or that because sure enough the person who should have phoned, 'Oh well, I should not phone because it was only this', and

D - yes that is true

K - you know it is very ---- on the ----- on the continuity of care in terms of getting information back from your own GP I think, and this may change or this may not be quite what it appears to me, but I think that the attitude at Nightdoc is we are here to cover that type of ----- you should not be bothering them, it is for medical emergencies. This doctor is ---- as any other doctor so that is why they would not phone your GP

D - but what about a link into the computer

K - that might come but

D - so at least they can see the notes, I don't know if that happens

K - you know they do have some things, like I know with elderly people who may be suffering from a number of illnesses or which may have a treatment plan, and you know especially palliative care where it is really a holding ----- to keep them out of hospital I think they have -----

D - yes other wise they could give them

M - yes, that is one of the things I was going to say. What happens if an elderly person sees a stranger, the elderly person does not know what medication they are taking

K - I think there are some GPs who have a system ----- you know when they are not actually available, someone is contacted or something, a treatment plan has been worked out. There are district nurses, there are other people you know, Nightdoc works with other people like district nurses and so on. There is a certain amount of that that does go on and it is the sort of thing that they may be able to improve, and one of the worries that some of the GPs do have and have held off from joining Nightdoc because you know they want to ---- continuity of care

D - yes but it is a question of people not just using out of hours because ----

K - they talk about people, some GPs will talk about 24 hour culture will be about ----- you know and yet other ones will be very committed and always having their patients so I was always, we were brought up like em but I am sure they had less patients. I'm sure they did -----

M - the doctor did not always come out but you knew that you would see, if it was an emergency, you would see your doctor or one of the team of doctors

K - Do you have any strong views about where the doctor sees you in terms of, I mean in terms of the thing of going out ---- is that is the doctor sees you in your home, does that mean anything different to you than if you see the doctor

M - no

D - no, only if you have got a sick child and you don't really want to take him out in the cold

M - because even in the day time if a kid, if I manage to get the kids there I would not want to waste their time, but if I am able to get the kids there in the car I would do that rather than, and if they, it was very very very ill

D - I tell you one thing though that is an issue that I have just thought of, is that you are normally restricted to joining a particular surgery right, and that boundary for that surgery is based on if you require a home visit, if you are out of that boundary they won't be able to come and visit you, so if they are a member of Nightdoc, they are not going to visit you anyway. So why should it matter which surgery you should belong to?

K - I suppose that is a good point. I have never heard that one, yes, I will put that to them

M - right, if we want [husband's] mum to join our practice

D - our practice, but she is out of the boundary

M - she is not going to ever ask for one of the doctors, there is no one is going to come and see her -----

K - well they might in the day time which I think, day time home visits are another matter, you know, they do quite a few in the afternoons, between surgeries they will go out and do -----

D - well perhaps in a working day

K - and particularly elderly people that might be just the sort of thing they do, I don't know but it is a good point, I will bring that one up. They are actually very, you know the people who set up Nightdoc, I was saying before, they are actually are very keen on what might come up, things that they haven't thought of. I think they are generally interested

D - well I thought it was just nice to go there and be treated like an human being ----- and it does make a difference definitely

K - so what did you think about the advice in terms of if you of you wanted to phone for advice in future, what would you think about the telephone advice

D - fine

M - yes, I mean I think, we know I think when it is an emergency. The only time we did not get the advice, that they did not take seriously, was when he had his immunisation, but then that was the difference, he could not see his arm and she was probably thinking he has had his immunisation he has probably got a bump and

K - so do you think that is a problem that they don't see what you are trying to describe?

M - yes, I mean that time it was because it was difficult, we had never seen that sort of thing before, but obviously to the nurse as many children do when they have their injections they do get a slight lump, and when we were saying it was swollen she was probably visualising the size of a 10p bump what kids get

D - but this was from his shoulder

K - but some people will say, especially if it is something that they have not themselves seen before, they want somebody else to actually look at it because that is what will reassure them, that is a doctor looks at it and ----- before so you know what I mean --- something to do with seeing it

D - yes

K - it could be

D - but you still can't decide ----- it is not going to solve any problems

M - yes but even

D - but it is whether you are seen or not

K - I mean if the nurse has not actually seen this thing then you might feel that you are not satisfied

D - that is right, which we weren't, yes but just because they ----

K - but I think some parents might be not satisfied with the ----- from the telephone they want somebody to actually see, you know, so they will want the doctor to come out to them or they will take the child there but they won't be satisfied with

M - no, not always just advice, no, I mean if I know, you know, you just want to hear it from the doctor, you know, the doctor's medical, to hear that everything is ok and

K - [someone was yawning] I think we have all had enough and we want to be like ----- but is there anything else that you feel important to convey about all this or what

M - no

K - anything that you think

D - only that in an ideal world, like they have ---- three doctor on call every night so ----- we want to have everything available to us all the time so ---- if you had a worry you phoned the doctor and he was here in half an hour you ----- well you would, wouldn't you, that is what you really like, but a real emergency you have still got 999

K - right

M - yes I mean

D - let's be honest, if you are really worried you dial an ambulance

M - yes I mean if the child was, you were, you would rush straight to hospital I mean if the child swallowed something that they should not have

D - dial an ambulance, yes, but they are never going to get the real medical emergencies are they, the GP. Nightdoc is never going to get C. Nightdoc is going to get unwell people that really don't want to wait until the morning if they are having a bad night, but they are not going because, when was the last heart attack they had there?

K - they have had people phone

D - yes, I am sure

K - and then they would say go straight go up to emergency and then they would ring an ambulance

D - yes, that you can, yes, but very few people have been taken there having a heart attack

K - I mean now I am talking about how much of an emergency does it have to be to warrant going to Nightdoc and is that bordering onto

D - yes, that is right but only because they are saying you should ----- but if it is a medical emergency it does not matter who they are seen by, so there is no need to ----- if it is a medical emergency, but I would call a medical emergency, right, an ambulance job, right, and if people worry to the point where you think, we have got to get, this person has got to be in hospital, and anyone with common sense knows that you are not going to call your GP first you go ----- hanging onto their chest or they are unconscious or blood poisoning, you would not, wouldn't you, or you have got a limb falling off or something, I would call that a medical emergency, so they should not really be expecting to deal with medical emergencies, GPs, they must be on call knowing they are going to deal with people that are unwell

K - right

D - surely they must have that in their minds

K - well this is one of the conversations I have had with Nightdoc. It is, you know, I have said the same thing, you know, surely your point of access is something before ----- some one who knows something about everything but not enough

D - yes

M -to put a leg back on or

D - that is right but what they actually, I am only thinking of a result of what we are talking about

K - yes, I am glad

D - so what they are actually, are thinking they are meant to be doing, they are saying they don't want to do a medical emergency, but you would not take a medical emergency to them you would go and get an ambulance, so you don't want to deal with routine things because they can wait till the morning, so where do they actually really fit in this and do they need to be there at all?

K - well I think that is a good question

D - well if they are not there at all then there is no question of

M - ----- they would not ---- you just have to go to casualty

D - yes, so therefore maybe there should be more open clinics, right, for non medical emergencies, medical non emergencies, up until midnight, right, and be done with it, so you could actually just go there at one of these Nightdoc clinics with two or three GPs every single night and you know if you can't get to your own GP in normal surgery hours just go to one of these. You get, you see who you get, and then you know, and that is it, take the pressure off the surgery, take the pressure off the home visits

K - well I think it is a funny thing in a way, they, in a way it has arisen out of the problem of the 24 hour ----- and they have tried to do something which cuts back on that but by doing that, in a funny sort of way they are providing what you say but not with that philosophy behind it necessarily. It has come from a different angle but in fact what they are doing is extending the services rather than reducing them although, and I think they would say that that does offer patients something more than they have had before, they can see a doctor more easily really because they can come there. because in the past some doctors you just would not get them to come out, there was not an option to go and see them, so it was, you know, you would phone up and get a very stony reply and you would have to wait, or you would go to A & E, but now they are trying to offer something more

D - in-between yes

K - and

D - which is good, a good thing

K - I think it can work out but I think some adjustments need to be made in a way in terms of ----- but also, you know, GPs need to remember now that even if in the past they had certain attitudes which kind of defended them from too many demands at night, if they changed the system in order to cope with that, then they need to change their attitude about people using it, but it has not quite

D - I think

K - but it has not quite caught up

D - I get the feeling as well, I get the feeling that ----- a little bit of a monster they have where they are not actually running together

K - it has probably run ahead a little bit of how people's mind sets actually change, you know, it has only been running since September last year, so it is just a year and in that time maybe one individual GP may have only done 6 sessions, so they themselves have not got used to it and

D - but I was thinking, you know, what you really use those people for really to call out people is almost for them to say, and I think I have talked about it before now, whether you should call an ambulance or not

K - yes, right

D - it is almost, you know, calling an ambulance is a big step, once you call an ambulance you are committed to a hospital visit and major trauma, so maybe, don't you think, you actually want the doctor to say whether you should call an ambulance or not, I think that is, I am thinking of my own feeling. I have been through it thinking shall we call an ambulance, we have thought that before haven't we? But we thought we don't want to waste an ambulance, we'd rather wait for a doctor

K - so you feel safe by somebody assessing it

D - yes

M - I have a classic example of my parents. My father has got ----- and he is stubborn and won't go to the doctors unless he is really poorly and ----- my mum, he gets all upset, like she goes to phone an ambulance, so she goes out the room to the doctor like can you come and see [him] because I am not happy, so when the doctor comes he is cross because you have phoned, but as soon as the doctor says 'Oh I think you had better get an ambulance', it is almost like a relief off her shoulders because someone else is telling her and it is making my dad think, yes, it is serious

K - right

D - other people do use it like that I think, I have done that, I think we have done that

K - so it reinforces your decision to have somebody else there to mention it

D - yes, that is right, because really and truly if it is really an emergency there is not a lot the doctor can do, I mean it is not the movies, is it? It is very rare that a doctor can perform a life-saving, I am not talking about an emergency ----- or something like that

M - but calling the doctor out in the middle of the night always makes me think, well for some reason night time is the worse time because you know it is out of their normal hours, it is not in the day time, there is no where else you can go except hospital and the doctor comes out, you have got that in the back of your mind ----- go to hospital and you are ----- or you are waiting for a sanction for that, either way you are

D - yes

K - yes, and another thing they were saying was, I have heard it said that some GPs felt that they are intermediating between people in families, you know, maybe ---- has been out all evening and gets home and is tired and whatever and the child is screaming and all you want to do is go to bed, and they say 'Why haven't you got the doctor here?', you know, so the doctor comes in to the situation where it is an argument between the parents really, you know, that is quite common apparently

M - I can see it happening

D - yes you can

K - anyway it is late, so is there any thing else at all

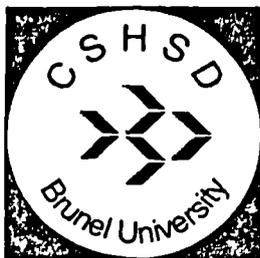
D - no, otherwise we will start off again and you will never get home! For the benefit of the tape, the conversation is over!

## **APPENDIX FIVE**

### **List of documents**

**The documents listed below appear on the following pages.**

- a. Research Project Information Sheet for GPs**
- b. Research Project Information Sheet for parents**
- c. Research Project Consent Form for parents**
- d. Primary Care Centre waiting room notice**



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## Research Project Information Sheet

My name is Kathryn Ehrich and this is an invitation to participate in a study of decision-making and communication between General Practitioners and families with children under five. I am carrying out this study with funding from North Thames Health Authority, and with supervision from Brunel University. The aim of the study is to try to understand the processes by which both parents and GPs decide about the appropriateness of out of hours consultations, and particularly to understand how the out of hours GP services are perceived by families in providing health care for their children under five.

Approval for this study has been obtained from the \_\_\_\_\_ Research Committee, and the \_\_\_\_\_ Research Ethics Committee. The study will involve my being at the Primary Care Centre during evening and weekend sessions from time to time during August and September, and again from January to March 1998. I would like to sit in on your sessions, initially at the \_\_\_\_\_ site, to observe the process of how parents' reasons for bringing a child to the Primary Care Centre are presented, and how you manage the consultation. I would like to use a tape-recorder to help me make notes of what is said in the consultation. If circumstances permit, I will seek your comments on consultations during the session. If it is not possible to do this during the session, or if you prefer, I can arrange to visit you at another time to hear your views on this issue

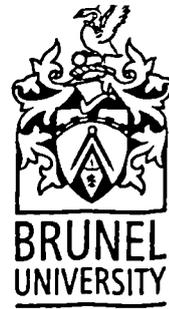
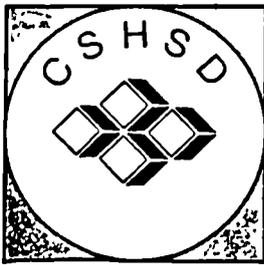
I will also be phoning a sample of parents a few days after their visit to the Primary Care Centre to seek an interview with them in their home about the significance of the services offered by \_\_\_\_\_ co-operative in relation to how they care for their young children. Children under five may be invited to play with toys or puppets, look at pictures or stories, and to talk to me about 'going to see the doctor', or 'when the doctor came to my house'. If at any time the parents or children do not wish to participate, this will be accepted and they do not need to give a reason. I will assure them that this will not affect their relationship with their GP or the GPs at the Primary Care Centre in any way.

The research project does not have sufficient funds to offer you a fee for your participation. However, it is hoped that the research will be of value to \_\_\_\_\_ in seeking to ensure quality of care at the Primary Care Centre, and will help to enhance GPs' and other health care professionals' understanding of the needs of families with children under five. It is also hoped that this knowledge will contribute to new approaches to the out of hours issue, a long-standing problem for GPs which is widely regarded as a source of dissatisfaction and stress in your work in general practice.

If you would like to talk to me about the study, or ask me any questions about it at all, please feel free to contact me by writing to the above address or by phoning me on 01895 203306, or 0181 445 0588.

Thank you for reading this information sheet.

b.



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## Research Project Information Sheet

**Please read carefully.** My name is Kathryn Ehrich and this is an invitation to participate in a study of decision-making and communication between General Practitioners and families with children under five. I am carrying out this study at the Primary Care Centre with funding from North Thames Health Authority, with supervision from Brunel University, and with approval from Ethics Committee. The aim of the study is to try to understand how both parents and GPs decide about the urgency of consultations, and particularly to understand how the services of GPs outside of normal surgery hours fit into the wider picture of family health care.

The study will involve my being at the Primary Care Centre, with my Research Assistant, Helen Harland, during evening and weekend sessions from time to time during August and September, and again from November 1997 to January 1998. We will be sitting in on consultations between families and GPs only if you have indicated that that you are willing for us to do so. We will use a tape-recorder to help us make notes of what is said in the consultation. All the information you give me or Helen about your family will be treated with complete confidentiality and will not be reproduced for anyone in any way which could be linked to you as individuals. Names and details will be changed and people will be described in ways that mean you cannot be identified. This information will be kept in secure offices and your file will have a code number instead of your name or address on it.

**If for any reason you would rather not have Helen or myself sit in on your consultation, please tell the receptionist or the doctor. This will not affect your relationship with your GP or the GPs at the Primary Care Centre in any way whatsoever.**

I may also be phoning you a few days after your visit to the Primary Care Centre to ask if I could talk with you at a more relaxed time in your home about how well you think your family's needs are matched by the services offered by GP co-operative. Children under five will be invited to play with toys or puppets, look at pictures or stories, and to talk to me about 'going to see the doctor', or 'when the doctor came to my house'. **If at any time you or your children do not wish to participate, this will be accepted and you do not need to explain why.**

The research project does not have sufficient funds to offer you a fee for your participation. However, it is hoped that the information you give me will have a direct influence on improving the quality of care you receive from the Primary Care Centre, and will help to improve GPs' and other health care professionals' understanding of the needs of families with children under five.

**This information sheet is for you to keep. If you would like to talk to me about the study, or ask me any questions about it at all, please feel free to contact me by writing to the above address or by phoning me on 01895-203306.**

**Thank you for reading this information sheet.**



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## PRIMARY CARE CENTRE

### To all patients:

Please note that at this session there will be a research observer in the Doctor's surgery.

If you would prefer her not to be present, please tell the Receptionist, or the Doctor.

Information about the Researcher is contained in an Information Sheet in the tray on the table.

Please help yourself to a copy.