ORIGINAL ARTICLE

Balancing – an equilibrium act between different positions: An exploratory study on general practitioners' comprehension of their professional role

ANDERS HANSSON¹, RONNY GUNNARSSON² & BENGT MATTSSON²

¹Munkedals Health Care Centre, Munkedal, and ²Department of Public Health and Community Medicine/Primary Health Care, Sahlgrenska Academy, Göteborg University, Göteborg, Sweden

Abstract

Objective. There is a call to make the duties and working conditions of the GP more transparent. The aim of this study was to explore practising GPs' personal experiences of their professional role and what they regard to be its salient characteristics. **Design.** An exploratory and descriptive study was undertaken by interviewing GPs and by performing a focus-group study of experienced GPs. The interviews were transcribed and analysed, and the text was categorized according to content analysis. **Setting.** The practice of the interviewed GPs. **Subjects.** Seven GPs in individual interviews and a focus group of experienced GPs. **Results.** A major theme, Balancing, was identified. It was derived from a number of opposing concepts to which different features were related. "The good shepherd" versus "The medical expert"; "Curing" versus "Caring"; "Short visits" versus "Long consultations"; "The personal doctor" versus "The society's doctor". In many consultations the GP has to contemplate how to stay in focus between these diverse roles. **Conclusion.** General practice requires a balance to be achieved between a number of opposing conditions. In their clinical work GPs have to adjust to and integrate alternative perspectives. Problems of recruiting new GPs might be associated with dilemmas in this balancing act.

Key Words: *Balancing, family practice, physician's role, professional role, qualitative research*

An uncertainty regarding the doctor's role, not least within general practice, is common and increasing consumer awareness places new demands on the doctor's role [1]. In Sweden, the recruitment of general practitioners (GPs) is a cause for concern, although the ratio of doctors is one of the highest in the world. In other countries, problems of exhausted doctors and recruitment difficulties have also been reported [2–6]. Yet, there are some exceptions as reported among Norwegian GPs [7]. In order to encourage the recruitment of doctors to general practice, limiting the breadth of their role has been suggested [8]. Swedish general practice differs from that in other European countries, as the healthcare is mainly publicly owned and consultation time is usually longer than that elsewhere (mean 15–20 minutes). Definitions of the content of general practice and the characteristics of the GP's professional role have been set out in a number of official

The difficulties in recruiting GPs are a cause for concern in many countries. GPs' working conditions and duties are therefore discussed and the GP's role and its salient characteristics are considered.

- The balance between different considerations emerged as a latent theme.
- The GP has to create and maintain an equilibrium between opposing demands in various clinical circumstances.
- Problems in recruiting new GPs might be associated with the difficulties inherent in this balancing act.

statements [9–11]. However, GPs rooted in day-to-day clinical practice do not often contemplate or comment on these definitions or statements. Their

Correspondence: Anders Hansson, Department of Public Health and Community Medicine/Primary Health Care, Sahlgrenska Academy, Göteborg University, Munkedals vårdcentral, SE-455 30 Munkedal, Sweden. E-mail: anders.hansson@vgregion.se

(Received 13 April 2006; accepted 22 January 2007)

ISSN 0281-3432 print/ISSN 1502-7724 online © 2007 Taylor & Francis
DOI: 10.1080/02813430701237705

views on their general practice duties and its characteristics are seldom reported in international general practice journals. Definitions and descriptions that are relevant to practitioners have, however, been called for [12].

By obtaining practitioners' understanding of their working conditions and getting personal descriptions by GPs of their perceived role, some features of general practice work could be further highlighted. Such observations could contribute to a diversified picture of the circumstances that characterize GPs' daily work.

The aim of this study was to describe and analyse the personal experiences of a number of practising GPs regarding their role and some characteristics of their profession.

Material and methods

Different ways of obtaining information were used:

1. *Individual interviews*. A purposeful sampling of GPs in terms of age, number of years in practice, urban or rural setting was used. Seven GPs, two women and five men, aged between 45 and 55 years, were asked to participate and all consented. They all had more than 10 years of professional experience in general practice; two worked in large cities, four in medium-sized towns and one in a rural area. The interviews were conducted and transcribed by AH. They lasted between one and two hours, were audiotaped and took place, with one exception, in the GPs' surgeries. Each interview began with semi-structured questions such as: What are your duties as a GP? What would you describe as the characteristics of your duties? In the course of the interviews, deepening of the content, clarifications, and condensing were achieved by means of more targeted questions.
2. *Focus-group interview*. Five clinically experienced GPs, partly affiliated to an academic general practice unit (three women, two men; mean age 58 years), were asked to participate in a focus group led by BM. The discussion was audiotaped and lasted for 90 minutes, and started with the same questions as the personal interviews. Clarifications, further explanations, and examples were asked for during the conversation in order to obtain a full understanding and a rich and varied range of information.
3. During the course of the project preliminary experiences and tentative interpretations have been presented at academic seminars as well as at scientific meetings with Nordic colleagues.

Data have been discussed and appraised, and comments have been made.

The study was approved by the Regional Research Ethical Committee.

Analysis

The personal interviews were carried out over a couple of months. Each interview was listened to shortly afterwards and the experiences gained from one interview partly influenced the subsequent ones. The focus-group session was held when all the personal interviews had been completed. The texts were analysed according to a qualitative content analysis [13,14]. Tapes were listened to repeatedly and the interview texts were read a number of times to obtain a sense of the whole. "Units of meaning" were identified, summarized, labelled as codes, and sorted into categories and sub-themes. Tentative categories were discussed by the researchers and revised. Preliminary results were sent to the interviewees for comments and feedback was received. At the end an underlying meaning, a latent quality, was formulated into a theme.

Results

The theme "Balancing" appeared to be a latent theme in the GPs' descriptions and images. This key feature emerged as contraries and opposing features related to various clinical conditions (Table I).

Balancing between the holistic perspective and the medical expert role

This was the main observation that arose in the personal interviews. The sub-themes that created the balance were labelled "The good shepherd" and "The medical expert".

The good shepherd sub-theme emerged from a number of categories often quoted as important in the GPs' work. A protective, trustful, guiding person is sketched:

... you serve as some kind of contact for providing support or hope ... (Woman, 47)

... it's about understanding and containing the patient's situation ... (Man, 53)

The medical expert sub-theme embraced some basic medical tasks in the primary care position. Good-enough medical competence, the first contact function, and its implications in the diagnostic process and the breadth of duties are highlighted.

Table I. Categories and sub-themes on which the main theme is based.

Main theme	Sub-themes	Categories
Balancing	The good shepherd vs.	To see the whole human being; to be a protector of the vulnerable; to be a teacher and guide; to provide security
	The medical expert	To represent adequate competence; to be the first medical contact; to have wide-ranging medical duties
	Curing vs.	To recognize well-defined problems; to offer a safe treatment possibility; to cure is rewarding
	Caring	To work with psychosocial complexities; to focus on the relationship; to be familiar with uncertainties
	Short visits vs.	To have a certain turnover; to have less personal engagement; to satisfy politicians
	Long consultations	To have individual meetings; to see problems from different angles
	The personal doctor vs.	To obtain confessions; to offer continuity
	The society's doctor	To care more for others; to act in conflict with the patient's will

... but then you should not forget that my main task is to make medical decisions, that's what they expect from me and it's my principal duty .... (Man, 52)

In the good shepherd element the humanistic perspective is discerned, comprising knowledge and understanding about human beings and an ability to communicate. The medical expert is characterized by atomism and medical facts. Emphasis is placed on biomedical knowledge. The informants sometimes labelled this as the two sides of the discipline. An attitude of "you have to sift the wheat from the chaff" is presented.

Balancing between curing and caring

Patients' problems during a working day vary to a great extent. In some symptom presentations restoring to health can be offered (curing), in others the patient has to live with the problems (caring) [15].

The curing sub-theme is based on categories that are often associated with clearly defined and doctor-centred actions. A clear and unproblematic symptom presentation of the illness often gives relief and sustenance to the GP. A straightforward condition is a favourable prerequisite for a well-established remedy. In some consultations there is a short distance between commitments and rewards:

... if a nevus is successfully removed it feels as if you have really done something .... (Woman, 55)

The caring sub-theme is supported by categories that involve complexities, longstanding relationships, and more patient orientation. Psychosocial realities will unavoidably be involved in many consultations, especially if a person has a chronic disorder with little restorative potential. It also implies preparedness for the unknown and an ability to take care of and manage unforeseen events:

... the doctor-patient relationship is important if you can't cure the patient .... (Woman, 53)

... many patients often need to talk about other things than purely medical stuff .... (Man, 53)

Balancing between short and long consultations

A surgery consists of a mixture of short and long consultations. Providing a combination of longer and shorter visits was mentioned by many informants as an optimal solution.

The short visit sub-theme became apparent through categories that call attention to variations, fast results, an instrumental approach, and managerial adjustments. Many GPs stressed the necessity of having a certain turnover of patients. Long consultations jeopardize the timetable and the same time for all consultations brings monotony and irritation. Short consultations are usually associated with well-defined problems and less personal engagement. They can be completed more fully and it is possible to leave these patients more easily. Fast consultations increase the consultation figures, sometimes at the expense of quality:

... the shorter consultations are more immediate and you don't get involved as much .... (Woman, 55)

... it's sometimes nice with the ease and the pace of short consultations .... (Woman, 59)

The long consultation sub-theme emerged from the categories that indicate individuality, understanding, and comprehension of the patient's problems. Longer consultations facilitate deeper and more reflective understanding in an individual contact. General practice as a speciality is at a point of intersection between "medicine" and "humanism" and needs to value the understanding gained from personal narratives. Longer consultations give a more

comprehensive and reliable picture of the patient. Understanding of the background and details of the patient's story enhance the progress of diagnosis and therapy:

... sometimes 30 minutes are necessary to get a real encounter, it has to do with respect for the patient ...
(Woman, 57)

Balancing between being a doctor for the patient or for the society

GPs have many loyalties, and according to Hippocratic tradition the patient's interest is the first task. Loyalty conflicts are, however, embedded in the doctor's role. There are moments in every day's work that require a balance to be drawn between being committed to the patient or the society (personal doctor or society's doctor) [16].

The personal doctor sub-theme is backed by categories that embrace confidence and continuity. Many GPs receive openhearted stories and truths from the patient. Narratives are often told in trust and are aimed at being exclusively part of a special patient-doctor relationship. Continuing contact brings security and safety to the patient:

... I have worked for almost 25 years in the same village, and often a very personal relationship developed ... (Man, 58)

The society's doctor sub-theme is based on categories that include autonomy threat and disputes with patients. The responsibility to the patient is sometimes in conflict with a sense of duty to others. Elderly patients with insufficient insight into their own limitations create choices that are opposed to the individual's best interests. In patients with epileptic seizures the GP needs to report anomalies to the body that issues driving licenses:

... it is hard to give reports to authorities that are not accepted by the patient ... (Man, 58)

... when we write sick certificates, we have a responsibility towards the society ... (Man, 53)

Discussion

General practice requires a balance to be achieved between a number of opposing conditions. The GPs have to adjust to and integrate alternative perspectives. The achievement of an equilibrium is accomplished along quite varying courses.

Comments on methods

The process of compiling the information has been ongoing over a couple of years and data from different sources are brought together. The number of informants is relatively small but information has been collected in various ways over a period of time. The creation of the categories is supported by a number of pieces of data. Establishment of the themes was inspired by both the personal interviews and the focus group, and the mixture of information from each supported that from the other. The GPs represented both sexes, urban and rural primary healthcare, and brought experience from different primary healthcare centres. Thus, the results reflect a reasonable variation in GPs' perspective on the subject studied. We think that the trustworthiness of the findings is satisfactory.

Interviewing one's peers implies some methodological issues [17]. For example, a common background and interests may promote confidence between the interviewer and the interviewee, and could augment the trustworthiness of the interviewer. On the other hand, an interview might be seen as a test of the professional characteristics of the interviewee, which can constitute a hindrance to open-heartedness and confidentiality. A need to project a certain positive skilled identity to a colleague may shape the informant's responses. The objectives of our questioning had, however, few aspects of a checking of knowledge and we feel the informants were quite free and sincere in their comments, although maintaining one's professional role in the interview situation, as both interviewer and interviewee, constitutes a limitation in our study.

Comments on results

The shepherd and medical expert roles were the most frequently quoted opposed features. However, in most patient encounters the GP needs to balance and integrate these qualities. In all symptom presentations the patient as a person is involved in the appraisal; the patient should never be seen as '50 kilograms of working material'. The relationship between these concepts is illustrated in an image (see Figure 1).

The Caduceus, the staff with two intertwined snakes as the symbol of medicine, illustrates the connection. According to Greek legend, two snakes, the symbols of knowledge and wisdom, are held in balance – while still fighting – by the winged staff of Hermes. Knowledge represents medical science, where truths succeed each other in a never-ending flow. Wisdom, or humanism, is that which is added to knowledge – i.e. how knowledge is applied in

Figure 1. Caduceus: The staff with the two intertwined snakes and the symbol of medicine. The snakes may represent the sub-themes the good shepherd and the medical expert.

practice and in relation to the human being who seeks help [18].

The division experienced between these two perspectives needs to be integrated. It could be relevant to talk about different approaches towards the same person. The GP needs access to both human and natural science. But the different perspectives are not conflicting and one does not exclude the other. Instead they derive from the same origin, the person who is knocking at the doctor's door saying, "Doctor, I have a problem . . ."

The sub-themes cure and care are not mutually exclusive – in many consultations they often go together. Yet, they represent two different approaches and call for different elements in the GP's way of working. It is important to find a balance between these concepts in everyday work, and to apply the right approach to the appropriate situation [19].

Many trends in modern medicine are about fast achievements, and public expectations regarding the possibilities to abolish pain and discomfort are usually higher than the availability of resources. A latent discontentment and disappointment on the part of patients is often at hand. When the hospital doctors' treatment alternatives have come to an end the patient is frequently passed on to primary care and the GP has to deal with the management of longstanding illnesses. These problems require other therapeutic approaches than the cure remedies and many GPs report difficulties in managing patients with chronic problems.

As mentioned earlier, consultations in Sweden are comparatively long. What would be regarded as rather short visits in Sweden are looked upon as long in many other countries [20]. Consultation length is determined by variables related to the doctor, the organization of healthcare, and the doctor's country, as well as by issues related to patients. The tension between long and short con-

sultations is not only a question of real time. It is also a factor that seems to be related to basic conditions of general practice. There is always a constant variation of minor and major problems presented to the GP and doctors vary in their approach to symptom presentations. Some GPs have a tendency to aim more at a whole-person perspective while others focus primarily on particularities. But the individual GP also has to consider these alternatives, and how to balance these approaches could be a dilemma.

In judging between the personal and the society perspective, the main focus must be the individual standpoint – this is a cornerstone in the obligation of the GP according to the informants in this study. A continuous long-lasting personal relationship provides many advantages for the GP, both diagnostic and therapeutic. But there is a risk in being too close and not unmistakably independent. Mutual investment in the relationship made by both the GP and the patient over a number of years complicates decision-making in achieving the appropriate balance between the two concepts [21].

Concluding remarks

The poles and the balancing act between the positions presented in this study probably also apply to doctors other than GPs. However, these tensions seem particularly relevant to general practice. The acceptance of patients of all ages and with all types of problems makes the task harder, and some GPs are anxious about having to encompass different roles – that of doctor, psychologist, social welfare officer, clergyman, police officer, and solicitor, to mention a few typologies [22]. This may lead to experiencing the professional role as confusing and difficult to balance. A daily concern about where to put the emphasis could lead to uncertainty and indecision, which may in turn be a factor in the problem of GP recruitment. The poles in the balancing concept are sometimes regarded more as contraries and incommensurable units than complementary aspects; more a case of either/or than of both/and.

Today's medical training, both university and postgraduate, has a focus on themes where the general practice considerations are less visible. It is more clearly focused on the medical expert than the shepherd perspective and more on cure than on care. Longer consultations and interest in looking at problems from different angles is less evident in the curriculum, as is how to solve the dilemma of being an envoy for the person or being a representative of society, which is not easy to find in textbooks.

Some authoritative and leading GP representatives are calling for more of the GP's core conditions to be included on the medical agenda [11,23,24], and for more of the essence and perspective of general practice to be incorporated into hospital clinics. GPs have a lot of experience in how to manage the individual perspective and the humanistic and caring approaches that are attributes that are sought after and valued by patients everywhere.

Acknowledgements

The authors would like to thank the participating GPs for their willingness to participate. The project was supported by grants from the research and development council in Fyrbodal. Dr Luke Zander, Senior Lecturer (retired), Department of General Practice, Guy's King's and St Thomas's Hospitals Medical School, St Thomas's Hospital, London gave valuable comments on the writing of the manuscript.

References

- [1] Deber RD. Physicians in health care management: The patient-physician partnership: Changing roles and the desire for information. *Can Med Assoc J* 1994;151:171-5.
- [2] Kmietowicz Z. GPs shut surgeries in protest at government targets. *BMJ* 2001;322:1082.
- [3] Smith R. Why are doctors so unhappy? *BMJ* 2001;322:1073-4.
- [4] McGlone SJ, Chenoweth IG. Job demands and control as predictors of occupational satisfaction in general practice. *Med J Aust* 2001;175:85-6.
- [5] Chew M, Williams A. Australian general practitioners: Desperately seeking satisfaction. *Med J Aust* 2001;175:85-6.
- [6] Murray A, Montgomery JE, Chang H, Rogers WH, Inui T, Safran DG. Doctor discontent. *J Gen Int Med* 2001;16:452.
- [7] Nylenda M, Gyldbrandsen P, Førde R, Aaslund OG. Job satisfaction among Norwegian general practitioners. *Scand J Prim Health Care* 2005;23:198-202.
- [8] Edwards N, Kornacki M, Silversin J. Unhappy doctors: What are the causes and what can be done? *BMJ* 2002;324:835-8.
- [9] Heyrman J, Spreeuwenberg C, editors. Vocational training in general practice. Leuven: Katholieke Universiteit Leuven; 1987.
- [10] Toon P. What is good general practice? Occasional Paper 65. London: Royal College of General Practitioners; 1994.
- [11] McWhinney I. A textbook of family medicine. Oxford: Oxford University Press; 1997.
- [12] WONCA. The Core Competencies of the General Practitioner/Family Doctor. WONCA Europe definition 2002. Available online at: <http://www.euract.org/html/pap04106.shtml>
- [13] Graneheim UH, Lundman B. Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today* 2004;24:105-12.
- [14] Patton M. Qualitative evaluation and research methods. London: Sage Publications; 1990.
- [15] Bignall J. Talking shop. Tomorrow's doctors: Caring more, curing less? *Lancet* 1999;353:936.
- [16] Lynoe N, Mattsson B. Doctor for patients or doctor for society? Comparative study of GPs' and psychiatrists' assessments of clinical practice. *Scand J Prim Health Care* 2004;22:228-32.
- [17] Coar L, Sims J. Interviewing one's peers: Methodological issues in a study of health professionals. *Scand J Prim Health Care* 2006;24:251-6.
- [18] Davies R. The cunning man. Harmondsworth: Penguin Books; 1994.
- [19] Landström B, Rudebeck CE, Mattsson B. Working behaviours of competent general practitioners: Personal style and deliberate strategies. *Scand J Prim Health Care* 2006;24:122-8.
- [20] Deveugele M, Derese A, van den Brink-Muinen A, Bensing J, De Maeseneer J. Consultation length in general practice: Cross sectional study in six European countries. *BMJ* 2002;325:472.
- [21] Balint M. The doctor, his patient and the illness. London: Pitman Medical; 1964.
- [22] Robinson WD, Priest LA, Susman JL, Rouse J, Crabtree BF. Technician, friend, detective, and healer: Family physicians' responses to emotional distress. *J Fam Pract* 2001;50:864-70.
- [23] Heath I, Sweeney K. Medical generalists: Connecting the map and the territory. *BMJ* 2005;331:1462-4.
- [24] Rudebeck CE. General practice and the dialogue of clinical practice - on symptoms, symptom presentations and bodily empathy. *Scand J Prim Health Care* 1992(Suppl 1).