Primary care and its mid-life crisis

Organisations and human beings are subject to the rules of development which underpin the human lifecycle. Metaphorically, the ages of the primary care world can be analysed like Shakespeare's ages of man. Age transitions are complex processes and involve a painful process of loss and identity adjustment. When a doctor moves into the mid-life crisis of a career the process of change produces feelings of insecurity, a degree of disorientation and sense of pain in relation to a 'self-ideal' based on a secure profession, a healthy body and a respected belonging group. On all these levels, the world of general practitioners is in a state of 'dis-ease'. The mid-life crisis in the primary care world was first triggered when doctors lost their sense that the NHS was a trustworthy 'environmental mother' which would look after its dependant professionals. Since about 1990 many doctors have felt that their 'organisational mother' has been mortally wounded and is no longer wedded to an ideal of care but bound to the penny-pinching political master of the NHS.

The Thatcher government unleashed cuts and split the profession into those who are with us and those who are against us. Since then doctors have coped with a dual and emotionally paralysing double bind. To keep the death of their beloved NHS mother at bay whilst discharging their primary task of caring for patients; to remain legally responsible for patients whilst lacking the power to treat them in accordance with their best judgement. The sense of loss and professional disorientation among doctors has reached the mid-life crisis point with the introduction of PCGs and PCTs, which clearly destroy any hope of a return to a

pre-Thatcherite version of general medicine. A point of no return has been reached. If this latest reform doesn't succeed the morale of many doctors will sink even lower. Doctors know that they are indispensable but their 'rejuvenation' as a profession will not happen by itself. 'Compulsory' positive thinking imposed by reform enthusiasts will increase levels of resentment. The sense of 'disillusionment' in primary care has to be acknowledged and psychologically worked through in a 'therapeutic' and 'healing' rather than an 'evangelical' and 'transformational' way.

The individual GP and the primary care organisations have, like any patient, the propensity to confront their discomfort with reality only when they have a sense of crisis. This is because humans and organisations tend to deny the importance of death, creeping decline and the role of misfortune in their affairs until they regress to sufficient levels of despair. The whole of primary care has been crying out for an adjustment in the pace of reform. It seemed, at first, that New Labour had heard the message and wanted to spread the introduction of PCGs and PCTs over a decade. Under the pressure of stemming the 'hysterical' media wave of bad news stories and eager to win a second term, they have lost their heads and forced the pace against their better judgement. This attempt at enforced change is already back-firing because it is experienced as attacking and abusive rather than helpful and sensible. Some of the change evangelists among the doctors are the active agents forcing this accelerated change. A few can satisfy their own political ambitions and in doing so defend against their fear of being discovered as someone who identifies with those GPs who yearn for a return to the hallowed days when doctors were in charge. PCGs, like all groups, are bound to change at the rate of their slowest members. The current drive towards

modernisation can only succeed if enough support is given to the majority of doctors who have to implement it.

After fifteen years of continuous change doctors have to ask the questions associated with the mid-life crisis. Individually and collectively, many doctors have reached a level of despair that requires them to review their careers and the value of their profession, and take stock of what is left of their ideals of general medicine. Even more fundamentally perhaps, the doctor-patient relationship has changed from one of basic trust to one of basic distrust. The transformation of a sacred and private consulting space between the doctor and the patient has changed into a semi-public encounter which is profane and stripped of its magic potency. This loss of vocational discretion, in psychological terms, borders on an 'inner premature retirement'. Doctors face the painful task of integrating politics, management and medicine in an up-to-date professional identity in tune with a changed social and political environment. This reconstruction of self can only be accomplished if doctors let go of the idea that the patient always comes first. Self-care is the best route to better patient care.

In a context of yet another modernisation drive doctors can only give less rather than more. Those amongst us who have worked in a supportive way with doctors must be aware of how this runs against the grain. It amounts to a betrayal of the original ideals of the profession. This betrayal can only be accepted when doctors are helped to acknowledge their own part in bringing this state of affairs about. The formation of PCGs is the logical result of the increased delivery of patient care through multi-disciplinary teams and in group practices. PCGs are the end product of the 'disenchantment' and 'secularisation' of the six-minute consultation. The sad fact is that the middle-aged doctors were trained to

be 'single handers within' and have found it a great strain to be 'groupish' enough to feel at ease in any form of group practice. Yet, most of them have participated in meeting their patients in a group context by embracing the team approach. It is a fallacy of the modernisers to assume that doctors are capable of making PCGs work because most of them practice in partnerships. The partner groups I have worked with as a group analyst are all in need of developing group and leadership skills by integrating reflection and action learning. For such professional development to occur supervision groups have to be legitimised in primary care. These 'learning sets' will need competent group supervisors and a break with the Balint model which focuses on how the doctor can give even more to the patient. It is not the heart sink patient that needs more attention and better supervision now but the doctor.

Supervision is well established as a method of continuous development in other professions. The transfer of this method of learning into general practice is long overdue and can tackle the negative 'Self Image' of general practitioners. General practice is, in the end, not about health promotion and wellness but is a 'keep death at bay' service. It is 'perverse' that policy makers make so much of health and so little of illness in medicine when the population is growing older and potentially more chronically dependent. This controller approach to monitoring the quality of general medicine misses the point about the real skills of general practitioners and primary care teams. Evidence based medicine is the brainchild of academic medicine and political policy makers. Their concerns mirror the practices of the secondary care sector and its scientific apparatus; it somehow fails to come to grips with the core of what a general practitioners has to cope with. The paediatrician and psychoanalyst Winnicott distinguished between 'doing' and 'being' in the act of caring for a patient. Total Quality schemes in the

NHS are based on the doing and fixing; the gifts of general practitioners are rooted in the being and the curative impact of the doctor's perspective.

Doctors have been burdened with too many secondary care procedures and projected fantasies of health improvements in recent years. In consequence their capacity to be there for the patient - come what may - is wearing very thin. The drive for more and more efficiency re-inforces the propensity of GPs to see themselves as second best. Politicians and primary care reformers need to help doctors out of a basic outlook in which they define themselves as being 'only a GP'. They are something special; they need to recover their feeling for being out of the ordinary.

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