Recovering the self: a manifesto for primary care

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Huge political, ideological and organisational changes are engulfing primary care, placing intense pressures on the sense of self for both patient and doctor within the consultation.

A recent Health Foundation report urges us to develop care practices rooted in a philosophy of people as 'purposeful, thinking, feeling, emotional, reflective, relational, responsive beings'[1]. GPs are encouraged to work collaboratively with patients, fostering shared decision-making and promoting self-management. This assumes that patients (and doctors) have agency and capacity, the ability to make their own choices and decisions and the power to take action in a given situation. But these assumptions are problematic when you are running 15 minutes late during a morning surgery with 18 patients, most of whom are unknown to you, and your QOF screen pop-up urges you to update the patient's CVD risk assessment score and take action to reduce their HbA1c levels.

We wish to give clinicians 'permission' to do person-centred care by offering a language of self that they can use to describe and defend their practice. Our principal motivations in establishing the centrality of the self in primary care are to offer hope to those entering the field, encourage those jaded by their current experience in practice, and provide vital underpinning to the generalist cause.

Threats to the self

Patients' sense of self can be severely affected by the suffering they experience, whether the vitiating impact of socioeconomic deprivation, the fragmenting effects of sustained domestic violence, the catastrophic consequences of serious disease - or simply the effect of an imbalance between everyday demands and their resources to manage[2].

In parallel, doctors' sense of self is being eroded. Pressures to comply with a plethora of disease-focused clinical guidelines and public health agendas leave little room for clinical judgement. Organisational changes make this more problematic: as practices become bigger the opportunities for continuity of care decrease[3]. And in the UK the current general practice workforce crisis further reduces the possibility of offering the essential personal elements of care.

The primary care consultation is now dominated by the presence of technology in the form of the computer, delivering a range of additional voices into the consultation and making strident, competing demands for clinicians' attention[4]. An increasing proportion of GP consultations is conducted remotely, by telephone or other devices. This may help to meet access targets but it significantly reduces opportunities for therapeutic engagement with patients.

Medical education has little to say about what it means to be a person, about what might constitute the self. Despite 'patient-centred' or 'person-centred' care being the rhetoric of many educational endeavours, the notion of the 'self' or the 'person' at its core is rarely unpacked. Too often GPs fill this vacuum by employing metaphors and explanatory practices derived from a reductionist scientific paradigm. Too often GPs view patients as mechanical systems and their diseases as puzzles, seeing themselves as problem solvers and controllers of disease[5] – in stark contrast to rhetorical public statements about self-care and collaboration. And too often biological explanations trump biographical interpretations of patients' problems, leading to over-diagnosis and the medicalisation of human suffering[6].

Recovering the self

The solutions for many of these problems lie in structural, socio-economic, political and organisational changes. However we consider that recovering a sense of self, for both patients and doctors, is an essential prerequisite for making genuinely person-centred primary care a practical reality.

We propose five key polarities, related to the selves of patients and GPs, visible or potential within every consultation. We recognise that the generalist physician delivering person-centred care is confronted with huge complexity; and that clinical wisdom involves the capacity to hold in balance a range of perspectives, acknowledge tensions, and avoid the dangers of becoming stranded at one pole.

1. ***Passive or active patients****.* Patients may at times be passive victims of circumstance or disease, who need to call on the expert resources of the medical profession to save or restore their lives[7]. An undue emphasis on the autonomous patient can lead to harmful indifference[8]. But if we pursue paternalistic models too far we risk losing sight of patients as purposeful and responsive persons. We should remind ourselves that patients have creative capacity[9], that they are capable of leading their own lives and of finding meaning in purposeful engagement with the world around them[10].

2. ***Attached or detached clinicians.*** The clinician has to be able to see the patient both as an object and as a fellow human being. She must balance biology and biography, delivering care according to guidelines and best evidence while exercising judgement about the interests of the person in front of her. Successful application of the medical model to the analysis of the problem the patient presents requires an *I-It* relationship. She must look at the situation objectively, seeking to understand what is going on in terms of physiology and psychology. At the same time if she is to elicit the narrative, communicate effectively and unlock healing potential, she requires the inter-subjectivity[11] and shared mind[12] of the *I-Thou* relationship.

3. ***Bureaucratic or autonomous encounters****.* Clinicians and patients are increasingly portrayed as part of complex hierarchies of expertise and technical divisions of labour, in which both knowledge and practice are undergoing rapid restructuring in the face of new ways of regulating conduct and measuring performance[13]. But overemphasis on this instrumental approach to the organisation of medical work leads to the slow collapse of the idea that clinicians possess individual expert authority and act with discretion as autonomous professionals, and to the collapse of the notion of the patient as the recipient of care.

4. ***Individual or social selves****.* The language of 'self-management', 'informed choice', 'controlling diabetes', and 'lifestyle choices' frames patients as agents who make informed choices based on a rational weighing up of alternatives. This implies an individualist, rationalist version of the self. However the self also has a moral and emotional dimension constructed through relationship with other human beings, often mediated through material artefacts and technologies. If doctors or patients

become stranded at the individualist pole, the more collective, distributed notion of selfhood in which 'who we are' is meaningful primarily through our relationships[14] becomes neglected.

5. ***Physicalist or humanist theories.*** The empirical scientific method has been hugely successful in the physical sciences and defines the knowledge base of medicine. But an account of the world as only matter and energy risks leading to an impoverished view of being human and hence of medical practice. Physicalist theories of mind omit the essential component of consciousness, namely that there is something that it feels like to be a particular conscious thing. Qualia, and thus human self-awareness, cannot be contained within a purely physical account of the self[15]. Doctors have both an instrumental and a moral need to take personhood seriously. An academic model is required that includes human consciousness as a valid and significant entity.

Conclusion

There is an urgent need for critical intelligence and debate about the nature and roles of the persons who take part in primary care consultations, and the many and various pressures exerted upon them, in order to support practices that enable patients and doctors to recover their sense of self.

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