Accepted Manuscript

BJGP OPEN

"Multimorbidity Plus": a secondary analysis exploring GP work in areas of high socioeconomic deprivation

McCallum, Marianne; MacDonald, Sara

DOI: https://doi.org/10.3399/BJGPO.2021.0117

To access the most recent version of this article, please click the DOI URL in the line above.

Received 29 June 2021
Revised 19 August 2021
Accepted 24 August 2021

“Multimorbidity Plus”: a secondary analysis exploring GP work in areas of high socioeconomic deprivation

Dr Marianne McCallum[1] BMedSci, MBChB, MRCGP, MSc

Dr Sara Macdonald[1] BA (hons), PhD

1. **General Practice Primary Care, Institute of Health and Wellbeing, University of Glasgow**

Corresponding Author: marianne.mccallum@glasgow.ac.uk

House 2,

General Practice & Primary Care,

1 Horselethill Road,

Glasgow,

G12 9LX

Table 1: Summary of Corbin and Strauss's work Managing Chronic Illness at Home: Three Lines of Work (17)

Lines of work: The different types of work required to manage Chronic Illness	**Illness work:** the work required to manage their illness. **Everyday work**: organisation and co-ordination of various types of work necessary to operationalize any plans of action. **Biographical work**: the work required in defining and making an identity.
Managing work: Strategies patients used to manage their workloads	**Conditional motivation:** Biographical schemes (work aligning with personal values) that helped motivate the patient to cope with their illness. These were hopeless if not attainable. **Management in Process:** Strategies patients used to maintain relative equilibrium. • **Calculating resources:** as all three types of work were in competition for limited resources patients needed to calculate and allocate resources, as well as moving resources flexibly as required. • **Maintaining fluid boundaries** in the context of division of labour, recognising shifts in roles because of illness and ensuring flexibility in how tasks are divided. • **Ongoing articulation of work:** planning and co-ordinating work, which will continue to vary so constant reassessment is required. • **Mutual sustaining:** importance of others to sustain commitment to the work, the importance of alignment, which is more than communication but is the process by which people "mutually align their actions towards the performance of some work."

Table 2. Table summarising characteristics of study practices and demographics of interviewees (with comparison, where relevant, to Scottish average)

Number of Participants	10 (5 trainers, 5 non trainers)
Location (Region of deanery) **West** **East** **South-East** **North**	 5 2 2 1
Average practice size **(Scotland Average)** **Range in practices interviewed**	5620 (5710) Range: 2827-9118
Proportion of practice in the most deprived quintile 2015) **(Scotland Average)** **Range in practices interviewed**	63.61% (16.2%) Range: 25.6%- 87.9%
Average Deprivation Score* **(Scotland Average)** **Range in practise interviewed**	4.54 (3.11) Range: 3.95 – 4.81
Age of interviewee **50+** **40-50** **30-40**	 4 5 1
Gender of interviewee **Female** **Male**	 8 2

*Deprivation score weighted by the proportion of the practice in each of the five deprivation quintiles: 1 (most affluent) – 5(most deprived). For example, practice 8 has a lower proportion of patients in quintile 1 but has a higher score as almost all their patients live in postcodes in the two most deprived quintiles.

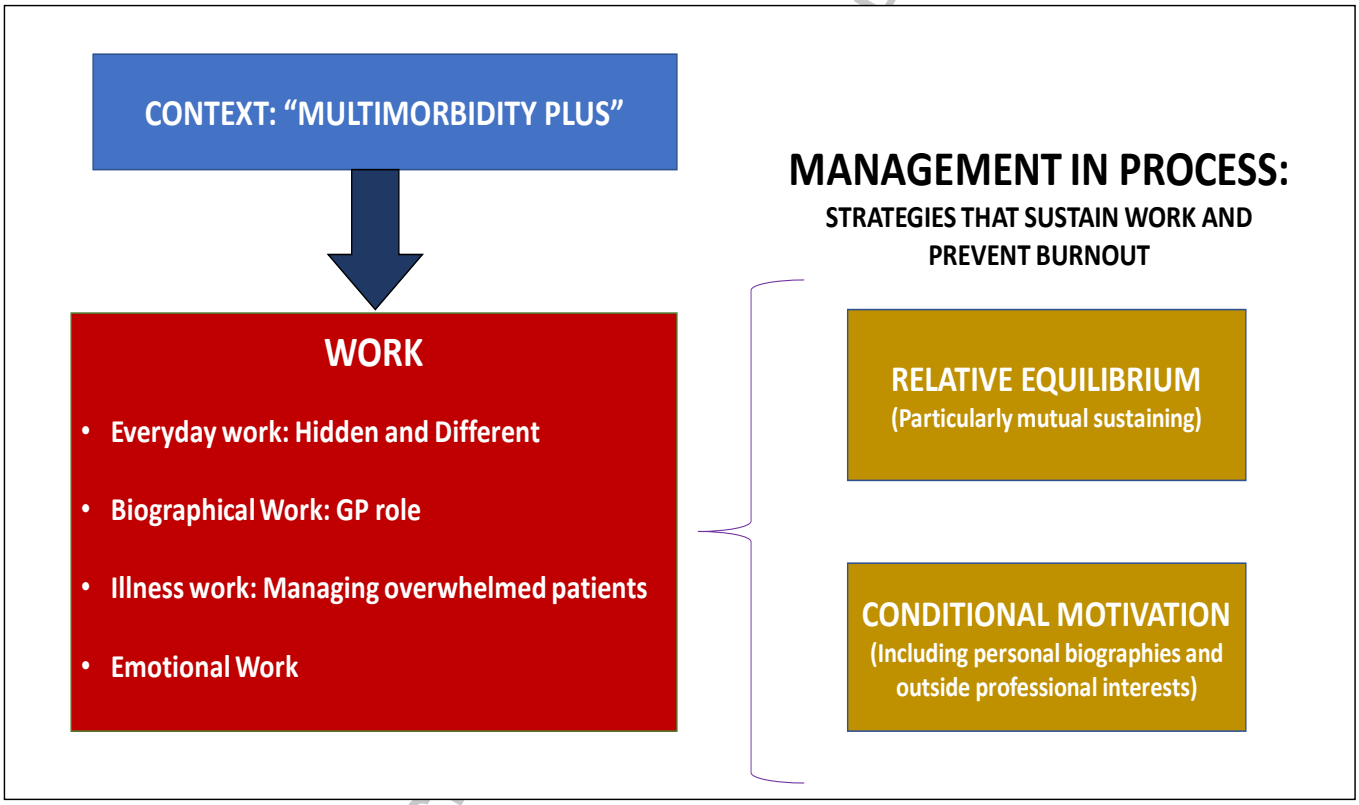

Figure 1: Summary of themes and Subthemes and their relation to one another

Box 2: The importance of Team ethos

*"you need colleagues that are going to be very much committed to stepping in and committed to having discussions because people's lives are very complex" (*GP 6, F, 40-50)

*" but if you want to do it properly in my opinion you have to get a bit involved, and that has a cost, and if you can share that with colleagues then it doesn't break you." (*GP 6, F, 40-50)

*"you can have, when you are dealing with patients who potentially are very chaotic at their core. And there can be that, almost like, at times, an agenda conflict. At times the interface can be a hostile one. Not always at all, but there can be a challenge there. If your team were broken and you were trying to deal with all of the issues, you just couldn't do it. So you need your team to be with you because you just never know who's the one who might be having a bad day." (*GP8, F, 30-40)

"I don't think any of us are feeling we absolutely have to do this because otherwise we'd go broke. I think there is a feeling with all of us that we're kind of privileged to be able to do the kind of medicine that we do here, and if the income isn't as good as it is down the road then you know, that's fine"(GP 5, 40-50)

"you speak to each other at the end of the morning, at the end of the afternoon. You make sure that you are talking about things that are difficult to deal with, that's with the fellow GPs, and then with your staff"(GP2, 50+)

Box 1: Summarising how the context of socioeconomic deprivation created different everyday work

Multiple migrant populations

"we're trying to count non-English speaking groups and we think it is in excess of 5% in our surgery and our surgery looks slightly United Nations from the outside." (GP 9, M 50+)

*"I didn't mention also the challenges within a deprived practice are increasingly em immigrant populations. I appraise as a GP and I appraise some of the outlying, more of the suburban outlying practices, and just coming down to the fact that several GPs in those kind of areas have said they've never used the telephone interpreting service. I use it, earlier this week, I counted up I had used in over 50% of my consultations. Which instantly builds in the time factor because everything is slowed down when you are interpreting and translating. Em and and a lot of these people are very new to this country there are massive health issues, language barriers, culture barriers, all sorts of things which again is this raft of hidden work that is never recognised so yes we need far far far more GP time in a practice like this and em than perhaps elsewhere."(*GP5, F, 50+)

Low Health Literacy

"You're dealing with people who can't read and write, and I just saw a man this morning who'd been to the Urology clinic with quite significant problems, and they sent him away and said you have to fill in a bladder chart. I'd already discussed doing a bladder chart with him and he said he wouldn't do it because he can't read, but they'd given him this thing and they hadn't questioned it and he'd just decided not to go back because, you know 'I can't do that because I canny read."(GP7, F, 40-50)

*"Yes I mean a huge number of our patients can't read or write, so the spoken word, you still have to use very simple language with them, so it's a different way of communicating. You can't just hand a leaflet out. They've not been reading on Google, they've not been looking at different things, they will come in getting us to be their advocates, and to fill in forms for them because they can't do that. And that's very different from being a GP in an affluent area, even recently I was helping a friend out in her practice in Town X, it was a completely different concept where people wanted a bit more self-management or have the money to go and pay for a physio for their back pain, or aren't labourers so their back pain isn't impacting as much on their work, so it was nice seeing a different aspect of what I do here."(*GP 8, F, 30-40)

Managing chaotic lives

"*the decision making that goes on with running a practice in an area where there is social complexity and where there is more expression of emotions than you might otherwise get when people are …..under the influence of alcohol and under the influence of drugs, when people are struggling to get through life, struggling to financially manage then there is….is naturally more expression of emotion and I think I can say that is just relating to the demographic rather than just the personality" (*GP 6, F, 40-50)

"when you see them you then have this range of issues….. this range of psychological, social and physical needs that you do your best to address in the contact you have because you know that they may go away and the chances of catching them again are small" (GP2, F, 50+)

Abstract

Background

There is a GP workforce crisis, particularly in areas of high socioeconomic deprivation where multimorbidity, and social complexity, is higher. How this impacts GP work, and how they manage workload has not been fully explored.

Aim:

To explore GP work in areas of high socioeconomic deprivation, and the strategies GPs employ using Corbin and Strauss's 'Managing Chronic Illness' model as an analytical lens.

Method

Secondary analysis of in-depth interviews, with GPs working in areas of high socio-economic deprivation (n=10).

Results

All three types of work defined by Corbin and Strauss (everyday, illness, biographical) were described, and one additional type: emotional (work managing GPs' own emotions). The context of socioeconomic deprivation influenced GP work, increased multimorbidity PLUS social complexity ("Multimorbidity plus"). Healthcare systems, and self-management strategies, did not meet patients' needs; meeting the resulting gap created extra hidden everyday work, often unrecognised (source of frustration). GPs also described taking on "illness work" for patients who were either overwhelmed, or unable to do it. Some GPs described biographical work asserting their professional role against demands from patients, and other professionals. Work aligning with personal values was important in sustaining motivation; strong teams and outside professional appeared to build resilience.

Conclusion

GPs working in areas of high socioeconomic deprivation experience different types of work; much unrecognised and not resourced. Current strategies to reduce burnout could be more effective if the complexity of different types of work was addressed, personal values supported, practice teams and outside professional interests were supported.

How this fits in

Understanding GP work, and how best to support this is critical, particularly in areas of socioeconomic deprivation where multimorbidity and social complexity are higher. GPs carry out four specific types of work (everyday, illness, biographical, emotional). Socioeconomic deprivation influences this work, which often is not recognised by the wider health system, and is under-resourced. Current workforce strategies focus only on illness work. Our work suggests that supporting all types of work may be beneficial, particularly for practices working in the context of high socio-economic deprivation

Background

Multimorbidity (the presence of 2 or more long-term conditions) is a major challenge to global health systems(1), and is associated with poorer outcomes and increased healthcare utilisation(2). The challenge posed by multimorbidity is not simply increasing prevalence(3), but the paucity of evidence on how best to manage it(1, 4). Multimorbidity disproportionally affects communities experiencing high socioeconomic deprivation, where it starts at an earlier age(3).

Additionally, in areas of high socioeconomic deprivation, GP consultation rates are higher, covering more problems in less time, with no additional resource(5-7). In this context psychosocial problems are more common, referrals more complex(8) and patients often struggle to manage their illness (9). Consultations demonstrate lower levels of patient enablement, and higher levels of GP stress(6, 7).

This mismatch of resource and need exemplifies Julian Tudor Hart's Inverse Care Law ("*The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced*."(10)), as relevant today as it was 50 years ago(11). In the UK, universal primary care limits the impact of market forces and removes most financial barriers to care, but more equitable distribution of resources, including in primary care, could more effectively mitigate health inequalities(11, 12). However, this must be set in the context of challenges in recruitment and retention, particularly in deprived areas(13).

There is a GP workforce crisis in the UK(14), with an urgent need to reduce GP burnout and stress(15). This paper focuses specifically on practices in Scotland: while there are some important differences in how GP care is delivered between the devolved nations the primary care system is broadly comparable and experiencing similar strains across the UK. Current strategies to manage this crisis focus on reducing GPs' clinical workload, and shifting aspects of illness management to other health professionals(16). Understanding if, and how, socioeconomic deprivation impacts GP work,

and what strategies GPs use to manage that work, is critical to ensure primary care services are effective, well- equipped, resourced and supported.

Previous explorations of the nature of work in the context of chronic illness have typically focused on the work of patients. Corbin and Strauss 'Managing Chronic Illness' (summarised in table 1) proposed that managing chronic illness required three types, or 'lines', of work: illness work (work required to manage illness); everyday work (organisation and co-ordination of various types of work necessary to operationalize any plans of action) and biographical work (the work required in defining and making an identity). These three lines of work require to be balanced, defined as "relative equilibrium." Instability of relative equilibrium requires the enactment of strategies to maintain balance and adjust to changes in context; resulting in "unending work"(17). We are not aware of these propositions being applied in the context of professional work but given that the management of chronic illness is at the core of general practice work, Corbin and Strauss's propositions offer a potentially useful analytical framework for exploring different types of GP work, and, whether socioeconomic deprivation influences the work that is carried out.

Aim:

To explore GP work in areas of high socioeconomic deprivation using Corbin and Strauss's 'Managing Chronic Illness' analytical lens.

Method

Study design

The original study(18) employed qualitative interviews to explore GP training in areas of high socioeconomic deprivation. During inductive analysis several themes about GP work in this context appeared. A qualitative secondary supra-analysis(19) of the in-depth interviews (n=10) was performed, drawing on Corbin and Straus(6, 7)'s 'Managing Chronic Illness' as an analytical lens was performed.

Setting:

A sampling framework (described in detail in the original paper(18)) identified potential practices serving populations experiencing high socio-economic deprivation. Within this group we intentionally sampled potential practices of different sizes, and from a variety of geographical locations across Scotland. Fifteen practices were originally contacted, eleven responded and ten GP were able to go onto full interview. Table 2 summarises the main characteristics of the practices, and gender and sex of the interviewees.

Data collection

In-depth interviews were carried out using a semi-structured topic guide (Appendix one) by one researcher (MM). The interviews were all conducted between January and May 2017, lasted between 45 and 60 minutes and were audio recorded, transcribed verbatim and anonymised.

Data Analysis

The inductive thematic analysis from the original study has been published(18). A secondary supra – analysis analysed the transcripts using Corbin and Strauss's work on 'Managing Chronic Illness' as a theoretical lens(17, 20). A coding framework, characterised by Corbin and Strauss's themes, was applied to the transcripts.

- Everyday work
- Illness work
- Biographical work
- Conditional motivation
- Relative Equilibrium
    - Calculating resources
    - Maintaining fluid boundaries of labour
    - Ongoing articulation of work

- Mutual sustaining

A line-by-line analysis (MM, SM), using the theoretical framework, on two of the transcripts determined the applicability of the framework. It fitted well with the data. MM and SM discussed the fit of the themes in the remaining transcripts and the framework was then applied to all transcripts using NVIVO software (version 11) to manage data.

Ethics

As this was an evaluation of an educational service the authors considered formal ethical approval was not required. This was confirmed by advice from the NHS Research Ethics Committee. All interviewees provided full informed consent (Appendix 2) for their anonymised transcripts to be held for five years and used for further research.

Results

Figure one summarises the final key themes (context, work and management in process) developed from the original framework, and how they inter-relate to one another.

1) **CONTEXT: Multimorbidity Plus**

All GPs interviewed identified key characteristics of the communities they worked in that impacted their work: higher prevalence of early multimorbidity, patients managing the impact of poverty, alcohol and drug addiction, vulnerable families, migrant populations, and patients for whom life was chaotic.

They described how the experience of multiple disadvantage limited efforts to improve health outcomes for patients. All recognised the increased burden of multimorbidity, at an earlier age, which they felt distinguished their work from those serving more affluent populations. While increased medical complexity made this harder to manage, balancing the management of increased medical complexity in the context of social complexity was particularly difficult. One characterised this as “multimorbidity plus”:

*"it is known there is more multimorbidity, I think often the multimorbidity is what's talked about rather than the **multimorbidity plus** perhaps a greater chance of having difficulties with literacy plus greater chance of having an ethnic element coming in, it is the several layers" (GP 6, F, 40-50)*

2) WORK

Everyday work: hidden and different

Managing this "multimorbidity plus" (Box 1) was perceived to result in work unlike that undertaken by colleagues who worked in other, less deprived areas.

*"I think all GPs are always very very busy, but we have to ask ourselves are we busy with the same things and what does the NHS want to focus on? So, um, we have on the one hand probably the worried well that keep affluent practices very busy, and probably also the fear of making mistakes there. And they have the high elderlys- but we also know from the sample point of the Scottish allocation formula the deep end practices are underfunded in relatively to the um morbidities, and also I think we have to spend much more time in safety netting, patient education or sometimes opting for, because our patients are struggling to understand the safety netting." (*GP1, F, 50+)

This different everyday work was described as "hidden" by GPs. Health system configurations, with an emphasis on self-management and self-referral, failed to consider the everyday realities of patients' lives, further disadvantaging an already disadvantaged group. The additional GP work required to fill this gap was absorbed into routine everyday work, unrecognised and under-resourced, by the wider health system.

"I think, as I said earlier, a lot of the increased workload in this kind of context is completely hidden and therefore unmeasurable and therefore unrecognised and I think it's a dream to think there will ever be any additional funding to recognise that kind of work, it's never going to happen" (GP 5, F, 50+)

All the GPs found work overwhelming at times, and the current workload was felt unsustainable. Several were quite fatalistic about whether this could ever change given the wider issues with GP shortages.

"we're all busy and we're all sort of treading water just to stop ourselves from drowning so it's a workload issue. And we've got this very difficult chicken and egg scenario, that if there were more GPs we would all feel less stressed, but we're now all too stressed to train more GPs… What could they do to help us? I don't know. Invent more hours in the day and fewer patients. It's workload, it's too busy. We just don't have the headspace and the time and capacity any more to do it." (GP 10, F, 40-50)

Biographical work: GP role

Biographical work to assert professional identity was described across interviews: some GPs described a persistent struggle to define what they saw as their role as a GP against pressures from patients and other professionals.

"in our patient population I think one of the main challenges is that they don't, there's always this feeling that we're not quite doing what we were trained to do. We were trained in the orthodox this is how illness presents, these are the symptoms, this is the diagnosis, you make your management plan and off you go. Whereas I think in a deprived population so many of the presentations are they just don't follow those pathways, you know patients are polysymptomatic, much of their illness behaviour comes out of mental health problems, it's a complexity about teaching in that kind of context" (GP 5, F 50+)

Constantly asserting professional identity, including refusing requests (e.g. letters for housing applications), was an ongoing source of daily biographical work. Other GPs however viewed managing social complexity, and attendant patient advocacy, as key parts of their role; they embraced these tasks and absorbed them into their professional identity and therefore spent less time grappling with biographical work. For these GPs embracing this wider role appeared to give them a sense of peace and purpose, as it aligned with personal values about equity and justice. However, the downside of this stance was that absorbing such roles created additional routine work (e.g. doing the referral for patients who struggle to use the self-referral system in context of low literacy, building links with the third sector).

"And any self referrals are usually very difficult, for example um physio self referral because quite often our patients don't know how to fill the forms out…So in most of the cases if it's something that should be seen urgently it's not picked up by the physios because our patients just can't fill it out properly" (GP1, F, 50+)

Illness work: managing overwhelmed patients

GP participants felt that the increased medical and social complexity impacted on their patients' outcomes and ability to self-manage. For many patients, overwhelmed by the work of managing long-term illness, decision-making became the responsibility of the primary care team. GPs in deprived areas felt that many of their patients preferred a more doctor-centred approach:

"It's interesting, I look at the college [RCGP]… this whole concept of shared decision making and, I actually think you consult in a different way in a deprived practice and I think your decision making…. You do some of it with chronic disease but actually it's a lot more, doctor centred eh, to use that old model because it's your patients would look at you like you've got two heads and I'm stupid. When I do shared decision making, they're like 'what you asking me for?'" (GP 8, F, 30-40)

Emotional work

One area of work that did not feature in the Corbin and Strauss framework was emotional work. Emotional work characterises the work of GPs to manage the impact of observing, and at times being unable to offer help in, the difficult situations patients experience. The impact of this was significant for most of the GPs.

"there is, I think there is a greater potential in your day to be emotionally knocked when working in a deprived area… and that that has a drain on you, your energy and resources. So obviously there's lots of emotional things happen in general practice but I think it is difficult sometimes to realise what awful lives some people lead and you have to share that with them."(GP 6, F, 40-50)

3) MANAGEMENT IN PROCESS

Conditional Motivation

Corbin and Straus recognised the importance of conditional motivation via biographical schemes: activities that aligned with their values, and sense of identity. We found evidence of this in our analysis of conditional motivation. The impact of wider values, and the alignment of identity and purpose in their work environment (particularly in the context of reducing inequality and making a difference), provided ongoing motivation to continue their work.

"…think as medics we should be aware of where the health care problems are greatest and I don't think it's good enough to just take yourself off to some leafy suburb where life's a bit easier. Because

that's not where the problems are and it's not looking to see, if you know we want to understand about health problems and disease within society, then we need to look at the whole picture and the impact of the way in which we run our society and the effect its having on our population and we all have a responsibility to that."(GP2, F, 50+)

All recognised the impact of wider social determinants of health on patients' lives and framed their work, and what could be achieved, within that context. This is in keeping with Corbin and Strauss's findings that successful biographical schemes must be achievable. While recognising that what could be achieved was limited by wider factors, the potential to make a difference in people's lives, provided powerful motivation and resilience:

"And those lovely moments where you actually, really can make a real, that satisfaction that you can make a real difference in somebody's life." (GP8, F, 30-40)

Similarly, being involved in additional professional activities, that allowed them time to reflect and remind themselves of their early motivation for opting to work in general practice was important. All the GPs were involved in external activities (undergraduate or postgraduate training, appraising, local medical committees, part of the Scottish Deep End GP(21) Steering group). These roles fostered resilience and reduced burn out by offering a break from clinical work and provided professional tasks that could be completed in contrast to the uncertainty and unending demand from clinical work.

"And the task is contained when you've finished teaching, the kind of teaching I do, you turn off the computer and the lights and it's finished, done, you drive away and that session is done. There is nothing following it, no one is going to phone, you know there's no letters, no one is going to become ill overnight. So it's great, it's brilliant, it's like liberation. Likewise, with appraising it's a contained task, once you've done it you've done it and that's it, and I find that really helpful that at least part of my work is like that." (GP 5, F, 50+)

Relative equilibrium

Examples of GPs and wider practice teams articulating work, allocating resources and having fluid boundaries were all seen within interviews. As in Corbin and Strauss's work, this was in response to changes in resource, or to relieve recognised areas of pressure.

However, of the strategies identified by Corbin and Strauss, the need for mutual sustaining was uniformly recognised as vital. GPs spoke of how a supportive flexible team, with a shared ethos, was essential in managing workloads (Box 2).

Discussion

Summary of main findings

Our analysis suggests that, in the context of high socioeconomic deprivation, general practice comprises several lines of "work", stretching far beyond the biomedical management of illness. Neither the hidden everyday work, nor the additional emotional work, were perceived to be recognised or resourced within the wider healthcare system. While current strategies for managing workload primarily focus only on reducing illness work(22), our research suggests that strategies that support and resource the additional and varied nature of work are required. Supporting factors that appear to build resilience are necessary to support GPs, and prevent burnout, particularly in areas of high socioeconomic deprivation.

Our analysis extends Corbin and Strauss's 'Managing Chronic Illness' model and offers a useful analytical lens to understand professional management of chronic illness in areas of high socioeconomic deprivation. While the context of high socio-economic deprivation brought unique workload issues, much of the work described by GPs was thought to align well with GPs in other communities. It is likely therefore that Corbin and Strauss's 'Managing Chronic Illness' would be useful to explore professional work across other contexts.

Strength and limitations

One strength of this study is that participating GPs, despite coming from a range of practices (in terms of location and size), were consistent in their description of work and the challenges they encountered. We believe our findings regarding GP work reflect socioeconomic deprivation, not just local geography. Additionally, using Corbin and Strauss's well-established 'Managing Chronic Illness'(17) as an analytical lens provides a framework to interpret our findings, increasing and extending its applicability in settings outside of patient experience, and providing a basis for further research exploring health professionals work in other contexts.

Limitations include the small sample and the recognition that GPs working in other areas have different challenges. In addition, these interviews are a secondary analysis and four years old, they don't take into account the impact of the pandemic, which has had a significant impact on GP, and wider NHS, workload. We also did not have information on GP workload (eg. number of patients/GP, number of consultations/day) which would be expected to impact the participants experience of work. Future work may wish to look at exploring this, although as our results indicate how to meaningfully measure GP workload is difficult; factors such as social complexity which significantly impacts experience of work are hard to quantify, and not routinely measured. Further research with GPs in other contexts is required to understand GP workload and wider applicability of this analytical lens. Nevertheless, many of the GPs had worked in other contexts, and concluded that work in areas of high socioeconomic deprivation presented additional challenges.

Comparison with existing literature

Our findings are in keeping with wider literature on general practice in deprived areas, in relation to the pressure of increased multimorbidity(3, 7, 9), increased prevalence of psychosocial problems(3, 7, 9), impact of social complexity(3, 7, 9, 23-25) and issues created by multimorbidity at a younger age(3, 26). Similar to the layers of "multimorbidity plus" described here, previous work has framed multimorbidity, in the context of socio-economic deprivation, as the combination of physical, social

and psychological problems(27), and the difficulty managing with a lack of emotional or social resources(25, 28).

Patient capacity to self-manage is key, yet is often not taken into account(29). Self-management strategies may be unachievable when patients lack capacity and resource (9, 25, 28). The GPs in this study identified systemic barriers, and inflexible systems that failed to account for differences in capacity to carry out tasks.

Previous work has illustrated variation in how GPs in deprived areas view their role(25, 30). For instance, GPs who view unhealthy behaviours as a product of wider social factors, in contrast to those who viewed them as choices, had a wider definition of their professional role, including patient advocacy(25, 30). Our work demonstrates that those GPs also required less biographical work. Debate regarding the GP role continues, particularly in the context of increasing workloads (22, 31, 32). This includes how the expertise of general practice to define and manage problems can be recognised and whether GPs should be "consultants" in general practice (32). The new Scottish GP contract envisions GPs as expert generalists who manage the most complex patients(22). Our findings show that complexity must be extended to incorporate social, as well as other medical, factors.

Emotional work (33), or emotional labour,(34) is recognised in the wider literature, predominantly in a nursing context(35). In the context of GPs working in socioeconomic deprivation there is, to our knowledge, no specific research on emotional work, though managing patients' distress has a recognised emotional impact(25). Self-reflection in peer groups; social and wider organisational, or workplace, support; and the maintenance of professional boundaries all support emotional work(33-36).

Current policy promotes shared-decision making(37), yet GPs report making decisions for overwhelmed patients, and being "doctor-centred" in response to patient preference. Patient centred care (PCC) has no official definition; the literature describes a wider more holistic

"philosophy" (38) including communication, partnership, recognition of wider context and focusing beyond illness to healthy lifestyles(38). Concepts of PCC vary by professional lens (particularly between managers and clinicians) (39).

Understanding what builds GP resilience, particularly in areas of high socioeconomic deprivation where professional burnout is higher(15), is crucial given the current workforce crisis. While much research focuses on individual characteristics, and supporting individuals(40), the importance of teamwork is critical(40, 41). In the context of socioeconomic deprivation, where "resilience is enacted through teams not individuals"(41),the value of flexibility for health professionals working in this context is recognised(41), as is motivation(42) for professional well-being, and reducing burnout(41, 42).

Implications for practice

Current strategies to manage GP workload and stress have focussed on reducing illness work, for example by shifting specific parts of routine work to other members of the team, eg. pharmacists, physiotherapists) Our findings suggest that this approach may have limited success if other areas of 'work' are not also addressed. First, everyday work that was described as "hidden" by participating GPs needs to be understood, quantified, and adequately resourced.

Second, we found that emotional work contributes significantly to GP workload. Supporting practice teams, allowing regular time for practice reflection, and regular personal supervision may be of value to help GPs manage this work. In addition, resourcing GPs to be involved in other interests outside their clinical work (eg. teaching, cluster work) appears to be likely to be of benefit, particularly if it aligns with underlying values.

Managing multimorbidity creates work, but the social complexity that creates "multimorbidity plus" significantly increases workload. Efforts to reduce GPs' work should include staff who can manage social complexity, e.g. welfare rights workers(43). Recognition of the impact of personal views for

motivation should also be acknowledged. Initiatives that allow GPs to explore personal values and motivation, and how to align these with their professional work, may help prevent burnout(41, 42).

Implications for research

This study was a secondary analysis of existing interviews that sought to explore whether Corbin and Strauss's 'Managing Chronic Illness' has utility beyond patienthood, and if it was a useful analytical lens to understand GP work. While our findings demonstrate the applicability of the analytic lens we since the original data were collected the GP workforce experience has changed, particularly due to the Covid Pandemic. Repeating this work in the current context (as we emerge from the pandemic) would allow deeper understanding of the impact that COVID has had on GP workload. In addition, wider sampling to understand GP work in different contexts (for example, affluent and rural populations) is needed as we would expect different workload implications in different contexts which may require different resourcing. This is essential information to ensure proper resourcing of primary care teams, and to fully understand GP work demand in different contexts.

Conclusion

Corbin and Strauss's 'Managing Chronic Illness' provides a useful theoretical lens to understand GP work in areas of high socioeconomic deprivation and may be useful in other contexts. GPs in deprived areas describe several types of work, some of it hidden; strategies are needed that support all these types of work. In addition, initiatives that enhance team ethos, personal motivation and support outside professional activities could further build resilience in the GP workforce.

Funding:

Marianne McCallum carried out this research as an NHS Education for Scotland funded Health Inequality Fellowship.

Ethical Approval:

Under UK 'Governance Arrangements for Research Ethics Committees,' ethical research committee review is not required for service evaluation or research which, for example, seeks to elicit the views, experiences and knowledge of health care professionals on a given subject area. Similarly service evaluation' that involves NHS staff recruited as research participants by virtue of their professional roles also does not require ethical review from an established NHS research ethics committee.

Competing Interests:

Marianne McCallum is a member of the Scottish GPs at the Deep End group.

Acknowledgements:

The authors would like to thank John McKay for his supervision in the collection of the interviews for the original project, and his comments in the preparation of this manuscript. We would also like to thank David Blane for his advice and comments in preparation of the manuscript. Finally we would like to thank all the GPs, and their practices, who gave up their time to participate in this study.

References

1. The Academy of Medical Sciences. Multimorbidity : a priority for global health research. London: Creative commons, 2019.

2. Payne RA, Abel GA, Guthrie B, Mercer SW. The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. Can Med Assoc Jl. 2013;185(5):E221-E8. doi: 10.1503/cmaj.121349.

3. Barnett K, Mercer SW, Norbury M, et al. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012;380(9836):37-43. doi: https://doi.org/10.1016/S0140-6736(12)60240-2.

4. NICE. Multimorbidity: clinical assessment and management 2016 [updated Sep 2016; cited 2019 Aug 08]. Available from: https://www.nice.org.uk/guidance/ng56.

5. McLean G, Gunn J, Wyke S, et al. The influence of socioeconomic deprivation on multimorbidity at different ages: a cross-sectional study. Br J Gen Pract. 2014;64(624):e440-e7. doi: 10.3399/bjgp14X680545.

6. Mercer SW, Jani BD, Maxwell M et al. Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socioeconomic deprivation in Scotland. BMC Fam Pract. 2012;13(1):6. doi: 10.1186/1471-2296-13-6.

7. Mercer SW, Watt GCM. The Inverse Care Law: Clinical Primary Care Encounters in Deprived and Affluent Areas of Scotland. Ann Fam Med. 2007;5(6):503-10. doi: 10.1370/afm.778.

8. Walton E, Ahmed A, Burton C, Mathers N. Influences of socioeconomic deprivation on GPs' decisions to refer patients to cardiology: a qualitative study. Br J Gen Pract. 2018;68(677):e826-e34. doi: 10.3399/bjgp18X699785.

9. O'Brien R, Wyke S, Watt GG, et al. The 'everyday work'of living with multimorbidity in socioeconomically deprived areas of Scotland. J comorb 2014;4:1.

10. Hart JT. The inverse care law. The Lancet. 1971;297(7696):405-12.

11. Mercer SW, Patterson J, Robson JP, et al. The inverse care law and the potential of primary care in deprived areas. Lancet. 2021;397(10276):775-6. doi: https://doi.org/10.1016/S0140-6736(21)00317-2.

12. Marmot MG. Fair society, healthy lives: the Marmot Review : strategic review of health inequalities in England post-2010. London: The Marmot Review; 2010.

13. Fisher R DP, Miqdad A, Thorlby R,. Comparing General Practice in area of high and low socioeconomic deprivation in England 2020 [updated 2020 Sep; cited 2021 June 05]. Available from: https://www.health.org.uk/publications/reports/level-or-not.

14. Buchan J, Charlesworth A, Gershlick B, Seccombe I. A critical moment: NHS staffing trends, retention and attrition. Health Foundation, London. 2019.

15. Pedersen AF, Vedsted P. Understanding the inverse care law: a register and survey-based study of patient deprivation and burnout in general practice. Int J Equity Health. 2014;13(1):121. doi: 10.1186/s12939-014-0121-3.

16. NHS England. NHS Long-term plan: Primary Care 2019. Available from: https://www.longtermplan.nhs.uk/areas-of-work/primary-care/.

17. Corbin J, Strauss A. Managing chronic illness at home: Three lines of work. Qual Sociol. 1985;8(3):224-47. doi: 10.1007/bf00989485.

18. McCallum M, MacDonald S, McKay J. GP speciality training in areas of deprivation: factors influencing engagement. A qualitative study. BJGP Open. 2019;3(2):bjgpopen19X101644. doi: 10.3399/bjgpopen19X101644.

19. Heaton J. Reworking qualitative data. London: Sage Publication; 2004.

20. Corbin JM, Strauss A. Unending work and care: Managing chronic illness at home: Jossey-Bass; 1988.

21. GPs at the Deep End 2017. Available from: https://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/.

22. Scottish Government. GMS contract: 2018 2018. Available from: https://www.gov.scot/publications/gms-contract-scotland/pages/0/.

23. Mercer SW, Guthrie B, Furler J, et al. Multimorbidity and the inverse care law in primary care. BMJ : BMJ. 2012;344. doi: 10.1136/bmj.e4152.

24. Mercer SW, Higgins M, Bikker AM et al. General Practitioners' Empathy and Health Outcomes: A Prospective Observational Study of Consultations in Areas of High and Low Deprivation. Ann Fam Med. 2016;14(2):117-24. doi: 10.1370/afm.1910.

25. O'Brien R, Wyke S, Guthrie S et al. An 'endless struggle': a qualitative study of general practitioners' and practice nurses' experience of managing multimorbidity in socio-economically deprived area of Scotland. Chronic Illn. 2011;7:45-59.

26. Stirling AM, Wilson P, McConnachie A. Deprivation, psychological distress, and consultation length in general practice. Br J Gen Pract. 2001;51(467):456-60.

27. O'Brien R, Wyke S, Guthrie B, et alAn 'endless struggle': a qualitative study of general practitioners' and practice nurses' experiences of managing multimorbidity in socio-economically deprived areas of Scotland. Chronic Illn. 2011;7(1):45-59. doi: 10.1177/1742395310382461. PubMed PMID: 20974642.

28. Chew-Graham CA, May CR, Roland MO. The harmful consequences of elevating the doctor–patient relationship to be a primary goal of the general practice consultation. Fam Pract. 2004;21(3):229-31. doi: 10.1093/fampra/cmh301.

29. May CR, Eton DT, Boehmer K, et al. Rethinking the patient: using Burden of Treatment Theory to understand the changing dynamics of illness. BMC Health Serv Res. 2014;14:281.

30. Babbel B, Mackenzie M, Hastings A, Watt G. How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care. Crit Public Health. 2017:1-13. doi: 10.1080/09581596.2017.1418499.

31. Hunter T. The expert medical generalist. Br J Gen Pract. 2018;68(675):495-6. doi: 10.3399/bjgp18X699329.

32. Reeve J, Irving G, Freeman G. Dismantling Lord Moran's ladder: the primary care expert generalist. Brit J Gen Pract. 2013;63(606):34-5. doi: 10.3399/bjgp13X660823.

33. Pisaniello SL, Winefield HR, Delfabbro PH. The influence of emotional labour and emotional work on the occupational health and wellbeing of South Australian hospital nurses. J Vocat Behav. 2012;80(3):579-91. doi: https://doi.org/10.1016/j.jvb.2012.01.015.

34. Edward KL, Hercelinskyj G, Giandinoto JA. Emotional labour in mental health nursing: An integrative systematic review. Int J Ment Health Nurs.26(3):215-25. PubMed PMID: 28374961.

35. Kerasidou A, Horn R. Making space for empathy: supporting doctors in the emotional labour of clinical care. BMC Med Ethics.17:8. PubMed PMID: 26818248.

36. Rose J, Glass N. An Australian investigation of emotional work, emotional well-being and professional practice: an emancipatory inquiry. J Clin Nurs.19(9-10):1405-14. PubMed PMID: 20500350.

37. National Institute Of Clinical Excellence. NICE guidelines: shared decision making [cited 2021 09 Jun]. Available from: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making.

38. DeSilva D. HelpingMeasurePersonCentredCare. London: The Health Foundation, 2014.

39. Gillespie R, Florin D, Gillam S. How is patient-centred care understood by the clinical, managerial and lay stakeholders responsible for promoting this agenda? Health Expect. 2004;7(2):142-8. doi: 10.1111/j.1369-7625.2004.00264.x.

40. Robertson HD, Elliott AM, Burton C, et al. Resilience of primary healthcare professionals: a systematic review. Brit J Gen Pract. 2016;66(647):e423-e33. doi: 10.3399/bjgp16X685261.

41. Eley E, Jackson B, Burton C, Walton E. Professional resilience in GPs working in areas of socioeconomic deprivation: a qualitative study in primary care. Brit J Gen Pract. 2018;68(677):e819-e25. doi: 10.3399/bjgp18X699401.

42. Veage S, Ciarrochi J, Deane FP,et al. Value congruence, importance and success and in the workplace: Links with well-being and burnout amongst mental health practitioners. J Contextual Behav Sci. 2014;3(4):258-64. doi: https://doi.org/10.1016/j.jcbs.2014.06.004.

43. Glasgow Centre for Population Health. At the Deep End: integrating money advice workers into GP practices 2019 [updated 28 Jan 2019]. Available from: https://www.gcph.co.uk/latest/news/877_at_the_deep_end_integrating_money_advice_workers_into_gp_practices.