FQS FORUM: QUALITATIVE SOCIAL RESEARCH SOZIALFORSCHUNG

Volume 9, No. 2, Art. 2
May 2008

The Doctor's Tale: Enacted Workspace and the General Practitioner

Frances Rapport, Marcus A. Doel & Paul Wainwright

Key words: workspace, general practitioner, mixed-methods, photo-biographic-elicitation interviews

Abstract: The environments and landscapes in which we live and work say much about who we are and how we act, yet there is little in the literature that considers Primary Care professionals' reflections on workspace and its impact on practice. The paper addresses this lacuna by presenting the findings of Phase II of a novel, two-year, mixed-methods study of UK General Practitioner (GP) workspace. Phase II employed photo-biographic-elicitation interviews supported by photo-biographic data from Phase I, to examine 8 GPs' understandings of their workspace in relation to professional practice and self-identity. Through distillation and summation of datasets, the paper establishes the pivotal role of workspace in Primary Care. Unlike many qualitative studies, the paper emphasizes ambiguity and difference rather than certainty and similarity as characteristics that prove to be of major significance in understanding the particularity of GP workspace. Like CHAUCER's *Canterbury Tales*, GPs' individual stories are set as a sequence of tales within what might be called a *frame narrative*—the overarching narrative of British general practice providing the frame for the particular stories of the practitioners. Although working environments may be similarly structured, how GPs perceive, perform within, and move through their own setting is unique to each.

Table of Contents

1. Introduction
    1.1 The UK Primary Care setting
    1.2 The Welsh healthcare context
2. Purpose
3. Context
    3.1 Phase I
    3.2 Overview of Phase I findings
4. Phase II
    4.1 Method
    4.2 Analysis
5. Results
    5.1 Space—a particularity of understanding
    5.2 Sententious statements
    5.3 Embedded concepts
6. Strengths and Weaknesses of the Study
7. Discussion
Acknowledgments
References
Authors
Citation

© 2008 FQS http://www.qualitative-research.net/fqs/

> He had a chamber in that hostelry,
> And lived alone there, without company,
> All garnished with sweet herbs of good repute;
> And he himself sweet-smelling as the root
> Of licorice, valerian, or setwall.
> His Almagest, and books both great and small,
> His astrolabe, belonging to his art,
> His algorism stones—all laid apart
> On shelves that ranged beside his lone bed's head;
> His press was covered with a cloth of red.
>
> (CHAUCER, 1977)

1. Introduction

Jose ORGETA Y. GASSETT has remarked that the landscapes in which we live say much about who we are, and LEFEBVRE reinforced this view when he observed that studying the socio-spatial structures that surround us can encourage a better understanding of how life is enacted. DE CERTEAU, in considering the impact of space—*life's landscapes*—on our lives, suggested that space is a constituent of action rather than a mere backdrop for action, whilst KEARNS & BARNETT commented that space is not only the environment in which we produce social constructions, but also "an interpretable text, which contributes to meaning in the broader canvas" (1997, p.2213). [1]

WARREN brought to our attention the concept of *organizational aesthetics*—the notion that the aesthetic experience of the workplace plays an important role in defining the professional's performance. However, although there have been a number of studies considering the aesthetic value of workspace and professionals' performances within it, this has been largely confined to the business community (MCDOWELL, 1997; BOYER, 2004), with few studies concentrating on healthcare settings. Those studies that have done so have focused on its appearance, design, and organizational features (HARRIS, 1997; JOHNSON & BROWN, 2003), and, to a lesser degree—and primarily within hospital locations—, on the patient experience. In the latter case, for example, RADLEY and TAYLOR (2003a, 2003b) considered patient experiences through rehabilitation following surgery and the effects of the hospital ward on recovery. [2]

Not only has the healthcare setting been overlooked in Secondary Care, scant attention has been paid to the effects of workspace in Primary Care. Outside the work of ARMSTRONG (1985) and ARMSTRONG and GOTHILL (1999), who concentrated on the GP's role in relation to the development of the surgery, there is a dearth of research in this area. This offers considerable scope for a study to understand better how Primary Care spaces impact on care provision, professional practice, and the professional's sense of self. [3]

1.1 The UK Primary Care setting

The healthcare setting in which British GPs consult is known as the Primary Care setting. Primary Care defines community-based health services: the first point of access for people to healthcare services in the UK. The UK Government's Department of Health describes Primary Care as: "the health services that play a central role in the local community, such as family doctors (GPs), pharmacists, dentists and midwives" (http://www.dh.gov.uk/, 2007), commenting that every individual has the right to best access and practice. [4]

The early work of ARMSTRONG (1985) highlighted developmental aspects of the GP surgery from early post-war years until the mid 1980s. ARMSTRONG defined GP workspace as "enclosing profoundly interesting doctor-patient interaction" (1985, p.654), thus identifying GP spaces as more than mere physical backdrops to a consultation; they are the environments in which the roles of the professional and the patient are played out. ARMSTRONG described this as: "a space with internal and external social boundaries which in their turn are intimately linked to the events which occur within them" (1985, p.654). The impact that space has on patient-professional interaction is further considered in the more recent work of BORNSTEIN and colleagues (2000), who indicated that where patients are concerned, the kind of spaces that define the surgery are on the list of priority factors that patients consider when choosing a GP. [5]

Until the 1920s and 1930s, UK GPs worked from home (ARMSTRONG, 1985). GPs now work predominantly in purpose-built spaces, with each room containing the same style of furniture as the next, fitted out by an interior decorator with little regard for the needs of medical practice or individual practitioners. These are National Health Service (NHS) managed spaces, which are part of a cost-rent scheme where GPs are scrutinized for their fund management, whilst space is re-arranged to accommodate greater use of information technology and new patient record-keeping systems. Within the last couple of years Primary Care has undergone dramatic change, reflecting both contractual and societal shifts. This is further affected by movements away from generalist to specialist positions influencing the place of the GP within the organizations in which they work. [6]

1.2 The Welsh healthcare context

It should be emphasized that this study was conducted in Wales, one of the four countries that constitute the United Kingdom, and clearly there are some differences between Welsh and English, Scottish, and Northern Irish settings. Wales, for example, places particular emphasis on the management of some healthcare areas as priorities, including chronic diseases such as cardiovascular disease, asthma, and other respiratory diseases. These conditions are particularly relevant in Wales as a result of the once thriving mining communities and the effects of mining on respiratory health, as well as the marked socio-economic deprivation in many parts of Wales. However, chronic-disease management is also of concern to a UK-wide healthcare context and differences in policy documentation across the UK are not readily evident. The recent Welsh

Assembly Government document *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century* (2005) (http://www.wales.nhs.uk/), for example, prioritizes the long-term health needs of the population, the requirement for high-quality care, durable design for healthcare spaces in Primary and Secondary Care: priorities that can be seen to match a UK-wide health agenda as evidenced in recent NHS Health Commission documentation (http://www.healthcommission.org.uk/). [7]

2. Purpose

This paper investigates the relationship between professional practice and the physical setting of healthcare by presenting the findings from Phase II of a novel, two-year, mixed-methods study of GP workspace. Phase II employed photo-biographic-elicitation interviews with respect to photographic and biographic data from Phase I, examining UK GPs' reflections on workspace in relation to professional practice and self-identity. By presenting a theoretically and methodologically informed analysis and interpretation, the paper establishes the pivotal role of the workspace in Primary Care. [8]

3. Context

3.1 Phase I

We have already published a detailed account of Phase I (RAPPORT, DOEL, ELWYN & GREAVES, 2006; RAPPORT, DOEL & ELWYN, 2007). To set this paper in context, it is worth recapitulating what is presented therein. The aim of Phase I was to investigate the role of workspace in shaping and mediating: the *self-identity* of primary healthcare professionals; the *interactions* between primary healthcare professionals and their patients and colleagues; the form and character of contemporary *medical practice*; and the changing *institutional demands* placed upon primary healthcare professionals. Conceptually, the research was informed by: the critique of everyday life literature that has established the importance of spatial practices for the maintenance and transformation of social systems (LEFEBVRE, 1991); the actor-network theory literature that has supplanted the long-standing ontological apartheid between active subjects on the one hand and passive objects on the other, by redistributing agency and power to associations between humans and non-humans (LATOUR, 2005); the multiple and event literature that has sought to think through how an unruly and ineliminable excess perturbs every situation (BADIOU, 2005); and the literature on the use of innovative qualitative methodologies (SPARKES & SMITH, 2002) and within-method approaches in healthcare research (RAPPORT, 2004; RAPPORT, WAINWRIGHT & ELWYN, 2005). [9]

Phase I of the study employed a within-method, qualitative data-collection and analysis framework that combined two datasets—digital photographs and object-oriented biographies. Twelve GPs were asked to write a two-page biography about their surgery and to take at least five photographs of their room. These

© 2008 FQS http://www.qualitative-research.net/fqs/

datasets were collected from a random, stratified sample of GPs, drawn from across the Greater Swansea region, West Wales. The study employed an inter-textual analysis of the two datasets (STANLEY & MORGAN, 1993), analyzed discretely and then in relation to one another. Inter-textual analysis enabled the researchers to explore how datasets responded to, and were transformed by, each other, and how a range of representations of the social world related to one another (STANLEY & MORGAN, 1993). [10]

3.2 Overview of Phase I findings

Phase I disclosed four major themes: *workspace*, *re-appropriated space*, *life space*, and *sacred space*. [11]

Workspace concentrated on the nature of work and labor, and paradoxically revealed space to be both embodied and disembodied. Embodied space, particularly noticeable in the photographs, referred to the way space was offered as an extension of the human body and although people were absent from the photographs, their presence and labor were clearly visible. [12]

Re-appropriated space highlighted how GPs inhabit space to enact relative social status, to imbue a unique object or event with a sense of aura, and to encourage workspace to resemble domestic spaces, full of home comforts, intimacy, and safety. Re-appropriated space revealed GPs' reactions to the alienating nature of work and disclosed the way in which re-appropriation takes place through the acquisition of ornaments; some of which are symbolically charged, such as the crucifix, family photographs, and paintings that populate the consulting rooms. [13]

Life space indicated the *lived-in* nature of space: the supportive and individual character that offered an excess of personal symbolism. Life space was space writ large—striving to be more than mass-medical intervention but nevertheless not escaping its social and institutional contexts. Photographs and biographies alike revealed the extent to which the rooms were something other than medical spaces. Biographies disclosed the relationship between life space and patient interaction: how space that extends the medical arena awakens the practitioner to the possibilities of accommodating patients' needs more effectively, and photographs revealed how medical imperatives can be domesticated and dissimulated. [14]

Finally, *sacred space* engaged with the ethics rather than the aesthetics of space. Most of the spaces within the consulting room were essentially *profane* (profane space holds no taboos or prohibitions and as a consequence it is acceptable to display seemingly incongruous objects within a healthcare setting, such as soft toys adorning computers or a medley of accoutrements around the desk). However, there was part of the room spared from profanity—the examination area, with its couches, white walls, discrete screens, and near absence of ornamentation, personalization, and domestication. Sacred spaces were reserved for the fundamental work of medicine and healing the sick—examination, diagnosis, and prognosis. [15]

In addition, Phase I showed that up to half of the sample were neither wholly satisfied nor wholly dissatisfied with their workspace. They constructed environments of *best fit*, working within the parameters of inadequate spaces, in which a lack of function became habituated into daily routines. Within this situation, GPs were experiencing, but unable fully to contend with, advances in technology and modernization, and accommodating the inadequacies of space by making do with what was available. Nevertheless, although just over half the GPs were experiencing feelings of helplessness in the face of change the others were making their presence felt through embodied, personalized or authorial spaces. [16]

4. Phase II

4.1 Method

We decided to treat the two phases of this study separately, in terms of the staged manner in which the work would be carried out, as we were exploring a novel methodology that had not been used within Primary Care. This would not only encourage the research team to understand the value of the staged approach and how phases impacted on one other, it would also provide practitioners with time to reflect between phases. Finally, the team was keen to analyze and interpret Phase I data independently of Phase II, such that the latter would offer validation and add to our understanding. [17]

All twelve GPs who took part in Phase I were invited to participate in Phase II. Following consultation with the Local Research Ethics Committee, eight GPs consented to take part in tape-recorded, photo-biographic-elicitation interviews to ascertain their views on their Phase I datasets. Interviews typically lasted for one hour. To aid reflection, GPs were sent their original datasets at least two weeks before they were interviewed. Interviews were semi-structured in accordance with a pre-defined schedule (Box 1), designed to reveal professionals' views of the different datasets and methods employed.

© 2008 FQS http://www.qualitative-research.net/fqs/

Purpose

Validate Phase I analysis and interpretation

Extend understanding

Aims

Relationship between workspace, professional practice and identity

Findings (Phase I)

1. Work space (embodied and disembodied)
2. Re-appropriated space (personalized and dissimulated)
3. Life space (more than medical space)
4. Sacred and profane spaces

Components: self, others, objects, system, space.

1. Biography

Why did you use this form/style for the biography?

What is the significance of the biography as a whole?

Which elements are the most significant? And why?

What else about your workspace could you have written about?

Was there anything about the workspace that could not be written about?

Having re-read the biography, is there anything that surprises you about it?

Do you have anything else to say about the biography?

2. Photographs

Why did you use this form/style for the photographs?

What is the significance of the set of photographs as a whole?

Which elements are the most significant? And why?

What else about your workspace could you have photographed?

Was there anything about the workspace that could not be photographed?

Having reviewed the photographs, is there anything that surprises you about it?

Do you have anything else to say about the photographs?

3. Relationship between photographs and biography

What is the relationship between the photographs and the biography?

Box 1: Interview schedule [18]

© 2008 FQS http://www.qualitative-research.net/fqs/

4.2 Analysis

The multi-disciplinary research team, comprising health services research, human geography, and nursing, analyzed transcripts individually and collectively (VAN MANEN, 1990, 1997). The team covered a wide-range of expertise and had extensive knowledge between them spanning, amongst other things: qualitative methodology; the study of spatiality and its impact on working practice, consumerism and identity; healthcare research including nursing and medical care; and ethics. These competences lent themselves to a broad analysis of emergent aspects within the interview data, their influence on practice, self-awareness, and function (which became more directed as aspects were revealed and embellished), and the manner in which meaning was derived. With our experience of using these novel methods in other studies, we foresaw some of the challenges of analysis. These included the manipulation and clarification of different data types at one and the same time (photo-biographic interviews), whilst working towards a position of enhanced understanding. In addition, we considered how the Primary Care setting contextualized the different datasets, and by so doing enabled the methods to situate the world of the objects and spaces within a broader social, historical, and institutional context. The methods of analysis, whereby we considered the relationship between the interview transcripts and the data we presented to interviewees, meant that textual and photographic data were given an equal weight in our analysis and the inter-textual framework specified that the researcher must uphold consistency and integrity during the complete process of clarification. In particular, the different data types highlighted how objects were used and their impact on everyday working practice. [19]

Data were subjected to a process of distillation, which led to summative presentations of each transcript: a process derived from VAN MANEN's sententious approach. This searches for: "the fundamental or overall meaning of a text" (VAN MANEN, 1990, p.94), whereby the essential elements of an individual's presentation, those telling phrases or aphorisms, are revealed. VAN MANEN describes this process as: "A thoughtful, reflective grasping of what it is that renders this or that particular experience its special significance…what constitutes the nature of this lived experience" (p.32). It is the essentiality of data—the indispensable aspects of each person's text without which the whole would lack meaning—that is paramount. An essential understanding discloses core concepts by which data can be recognized and understood in their fullness. The process is enabled by the development of brief summative statements that are derived by reading and re-reading texts and refining understanding through individual and group analysis. The final summation illustrates the very essence of the complete piece, without losing the ability to encapsulate its breadth of meaning. It is then possible to elaborate on certain aspects of the distillate in order to enrich understanding. Thus the analysis moves from an essential to a broad presentation—unlike other approaches, such as thematic analysis, that move from a wide canvas to an irreducible essence. [20]

Using a sententious analysis for this study ensured that the researchers undertook a thorough data appraisal, encouraged a debate around holistic

© 2008 FQS http://www.qualitative-research.net/fqs/

meanings within the text, and allowed a full consideration of the relationship between parts and wholes of texts (VAN MANEN, 1997). The approach also enabled the team to consider the process of data collection (WARREN, 2002), data's ability to address the study's aims and objectives, and the subjectivation of space through *thick description* (CRANG, 1997). [21]

The rationale for using the sententious analytic approach in this study can be found within the literary structure known as a *frame narrative*—a device that enables a writer to present a number of vignettes within an overarching story to reveal the significance of difference and an essential presentation at one and the same time. Geoffrey CHAUCER is recognized as having put the frame narrative device to excellent effect in *The Canterbury Tales*, in which a party of pilgrims tell each other tales to pass the time on their journey from Southwark to the Shrine of St Thomas a Beckett at Canterbury (CHAUCER, 1997). The characters are a varied group, representing most of the branches of the middle classes at the time and include: a miller, monk, knight, nun, and physician. The pilgrims' different types of tales reveal their individual personalities and touch on many aspects of human behavior. Some are told as an argument, in retaliation for others' tales; some as a boast, to instill a sense of one-upmanship over others in the group. The tales are organized into a literary structure known as a *frame narrative* (ZACHER, 1994; COOPER, 2002; WINDEATT, 2003). *The Canterbury Tales* is evidence of CHAUCER's ability to present a number of smaller narratives within the main story. Other examples of frame narratives include: *The Arabian Nights*, *Frankenstein*, *Citizen Kane*, Ovid's *Metamorphoses*, and *The Decameron*. [22]

Frame narratives have many variations (ZACHER, 1994). In *The Canterbury Tales*, the individual tales touch on universal themes of human nature and the structure of society of the period, but at the same time reveal the different personalities and characteristics of the individuals. The device of the frame shows how people are drawn together in a shared activity or practice, in this instance making a pilgrimage, and follow this pursuit within a shared social world, and yet retain their individuality, pursuing their journey in very different ways. The individual's role in the frame narrative raises questions about the reasoning behind each tale, the way the teller tells the tale, and how the teller is at the same time an embedded character, a participant in the tales of others, and part of the overall structure of the frame. [23]

5. Results

Eight of the original twelve GPs participated in Phase II. Results are presented, in keeping with the analytical approach, through summative renditions of practitioner data and then through broader presentations. Sententious analysis revealed the major, overarching concept within the data: *space—a particularity of understanding*; and a number of embedded concepts: safe space, personal space, iconic space, ephemeral space, restrictive space, communicative space, changing space, and geographic space. The remainder of the paper then concentrates on these embedded concepts. [24]

© 2008 FQS http://www.qualitative-research.net/fqs/

5.1 Space—a particularity of understanding

Although working environments may be similarly structured, the manner in which GPs perceive of, perform within, and move through their own setting is unique to each. The interviews brought out the characteristics of the individuals and their particular views on practice and self-identity as much as, if not more than, any shared identity. It was this aspect of enacted workspace that presented the major concept: *space—a particularity of understanding*, revealed through the practitioners' singular expressions. Space within general practice is critically linked to how GPs practice, and both space and practice are highly individualized and personalized. This also led to the realization that in order to understand enacted workplace, people's transcripts could not simply be reduced to an amalgam of joint practitioner awareness, but had to retain their complexity, nuance, and ambiguity. Thus, the data laid claim to the irreducible particularity of one's personal engagement with his or her data. This is highlighted in the essential summations below. Each summation is a distillation of the whole of that person's interview and each is quite distinct. [25]

5.2 Sententious statements

Dr1 Space is safety. Space must be safe and safely managed. However, the barriers come from both sides. Space and work, one's profession and professional identity, come together over time to match one other. One performs the role of a GP, but that performance needs to be carefully staged to conceal and protect oneself. ("That's me, playing doctor.")

Dr2 Space is about quality and intimacy. It speaks of the passing of time, the importance of practice, the imaginative endeavour, and dedication to the profession. ("It's part of me.")

Dr3 Space embodies how one feels about work, as well as the physical placement of objects. The spaces in which GPs work are varied and have to be manipulated and managed to support that variety. ("I like to have some sort of control over the area I am working in.")

Dr4 Space is purpose, belief, and conviction. Space is a strong moral code and expresses strong moral fibre. The room is my very personal territory, but the images and text also speak of structure. ("It was a familiar room to me.")

Dr5 This space works. Space is about having pride in one's consulting habits, about "calling a spade a spade," and about feeling comfortable with oneself and one's surroundings. It encourages people to have confidence in the consultation and allows me to achieve my agenda. ("Why change a formula that works?")

© 2008 FQS http://www.qualitative-research.net/fqs/

Dr6 Space is about the personal rather than the actual. It is creative, homely, and necessarily individual. Space is about being a deviant—defiant and funny. I would like my room to be a sanctuary, where you have to burrow your way in—a jungle, a gallery. Space must be comfortable and informal. All the medical accoutrements of space and the computer are just an intrusion. ("It's a lovely haven of art and plants.")

Dr7 Space is up front. You find me as I am. My space is frank and practical, an organized chaos ("putting things in places"). Space reflects the day-to-day activities of the hard-working doctor. My space is also particularly oppressive and unremittingly claustrophobic. I frequently need to come up for air. ("It is quite a confined space and it is quite intense.")

Dr8 Space maps change—change in personal circumstances—, which have now changed for the better, change in the pecking order and change in hierarchy. Space must be enabling for both professional and patient. Space allows for a higher order to come into being. ("To look beyond and out through the window.") Space should encourage good practice and be enabling for patients, allowing them to present themselves and their own views to the doctor. ("You build up a relationship of trust … The consulting room has to reflect that.") [26]

5.3 Embedded concepts

The summations above are raw and pithy. Aphoristic in VAN MANEN's sense, they are the "meat" of each individual's transcript and the essence of the major issues raised by each GP. In order to add body and clarity to their form, we now expand upon them—presenting the dimensions across which they range, and how each GP perceives space in his or her own unique way. Consequently, the summations may be regarded as eight very different articulations of space, each of which has been disclosed from a point of view peculiar to each GP. They comprise safe space, personal space, iconic space, ephemeral space, restrictive space, communicative space, changing space, and geographic space. The remainder of the paper then concentrates on these embedded concepts. [27]

5.3.1 Safe space

Dr1, who practices in a "rough area" and whose patients include ex-prisoners and drug users, is unique in her consideration of space for its aspects of safety and security. These dictate the relationships that unfold within the room and result from the clientele that frequent the practice, the pressure on space within a small practice, the need to share space with many other health professionals, and to "maximize its use." For Dr1, safety and security have paramount importance. These concerns precipitated a more guarded approach to patients than other interviewees, with a "my side of the room and their side of the room" attitude. Divisions are enacted during the consultation which influence the doctor in presenting "a side that is open to the patient: the right-hand side, and a side that is not: the left-hand side." The side that is closed to patients is described in terms of "secrecy" in a double sense: a space of privacy and a space that need not

concern the patient. This is a workspace where patients are purposefully kept away from "what they do not need to be involved in." For Dr1, this ensures ongoing control, and for this to continue space must be rendered without adornment: "One certainly can't signify one's family," for the protection of both the patient and the practitioner. Unlike some of the other practitioners, Dr1 offers less of a sense of the family practitioner in the interview (although this is perhaps a somewhat outmoded notion it is still one that comes through strongly in other participants' interviews) and presents less of the therapeutic engagement than is shown by some other GPs, and more of a defensive attitude. [28]

5.3.2 Personal space

In stark contrast to Dr1, **Dr6** presents a highly personalized space, with plants, paintings, knick-knacks, and posters strategically placed around the room for maximum affect. The patient is thus introduced to the doctor's approach to practice through the rendering of space as familiar but also, in a rather idiosyncratic way, as deviant and funny. By highlighting the personal, the irreverent, the humorous, and indeed the humanity of the GP, Dr6 believes that he can support patients in a "comfortable" environment. Both patient and doctor can express themselves more effectively: "It just frees things up a bit." Thus space, for Dr6, demands a movement away from traditional aspects of medical practice ("I am not always at ease with traditional, medical roles"), where the tools of the trade are all important and the doctor holds a position of authority, towards a more relaxing and welcoming environment. Whilst Dr6 believes that this turn to informality makes practice more enjoyable and patients more receptive to care, patients may nevertheless still wish to defer to the medical accoutrements that adorn the room, and, on occasion, succumb to their symbolic function. [29]

5.3.3 Iconic space

Irrespective of the fact that since the introduction of the new GP Contract in the UK, less medical intervention takes place during the consultation, the need for routinely performed medical interventions has increased. Consequently, tools such as the blood-pressure monitor have now taken on an iconic status, whilst at the same time offering patients reassurance:

> "The sphyg' is like a religious icon and they worship it, and they say: 'Can you do my blood pressure with that?' And I say: 'Yes I can, but it's always been normal.' And they say: 'Oh but I'd like it done.' And then they feel marvellous when they go out. So it's important to them, like going into a place of worship and seeing the crucifix." (**Dr6)** [30]

This reference to the crucifix echoes the popular assumption that the GP has taken over the position once held by the parish priest (see e.g. ILLICH, 1976) and suggests a secular version of the confessional. The patient discloses to the GP, who hears the confession of the patient's body, and gives absolution so that the patient may go away relieved and unburdened. [31]

Dr4 discussed the accoutrements of the room, but took forward the notion of iconic representation within the workspace in a very different way to Dr6. Unlike Dr6, who perceives the medical instruments and other such iconic objects as largely dispensable, for Dr4 they offer both a sense of familiarity and lend themselves to the notion of sacred spaces within the room: "The appearance of it, you get to be comfortable, we all like using … the same implements for whatever we are doing" (**Dr4**). [32]

These are spaces where the GP presents his own personal beliefs and convictions manifest in his moral being and medical practice—for although they are "all using the same implements," they are all perceived and applied differently. This doctor works to a code of practice imbued with moral purpose and space is personal, enabling, and representative of the doctor's strong professional ethic. The General Medical Council (GMC) certificate is an example of an icon that plays a particularly important role in the fixtures and fittings of this doctor's room. It represents the voice of authority and says: "You are entitled to be a doctor because a board of your peers says that you are capable of doing this job and worthy of doing this job." The crucifix (a real one, not the metaphorical sphygmomanometer/crucifix of the previous example) is another icon present in the room because:

> "I am unashamedly a Christian, but then I've got to say to myself: 'Oh. What has that got to do with being a doctor?' I think it has got a lot to do, I think it's got a lot to do with everything in life … It's actually a statement that says: 'Don't forget that there are greater things in life than you or anything else.' There is more to life." (**Dr4)** [33]

Icons such as the crucifix, the GMC certificate, and this doctor's antique, roll-top desk, with its grounded presence, make the room more familiar, emphasize the authority and power of the practitioner, and lay claim to the doctor's longstanding practice. However, the tangible presence of even the strongest of icons is lessened when the doctor needs to work with or negotiate with the patient, at which time the doctor concentrates solely on communicating with the patient. Whereas the sphygmomanometer/crucifix was an icon for the patient, in this case the real crucifix is present as an icon for the practitioner, reminding him of a lifelong and higher vocation. [34]

5.3.4 Ephemeral space

Unlike **Dr4**, who presents space and the solidity of the objects within it as offering a sense of the stature and moral fiber of the practitioner, **Dr2** refers to the ability of space to be ephemeral. For Dr2, space is about the transitional qualities of GP practice—the quick-wittedness of the practitioner in judging the needs of patients, and the GP's dexterous use of different areas of the room within a concentrated period of time: the desk for consultation and communication, the couch for medical examination, and the sink and shelving for cleansing and storage. Space also speaks of transit—the GP's ability to be physically present in the room but mentally in motion—, moving in an ethereal sense through time and space to

travel both alone and with others through conversations across the Internet. This motility has a rejuvenating effect:

> "Trying to get back to a more, I don't know, global or balanced perspective really. But also that's why I mention sometimes the email communication because that really does sort of re-tune me sometimes when that does occur, and that sometimes does put me in a quite energized or positive sort of frame." (**Dr2)** [35]

Thus, recognizing the opportunities for using space and time imaginatively, Dr2 can relish space for its specificity, intimacy, and ability to heal the practitioner. The imaginative endeavor not only supports the creativity of the practitioner, it also emphasizes the way in which the doctor practices and shows dedication to the job. Although, as with Dr4, space alludes to the passing of time, in this case it speaks not of the longevity of practice but of its transience. It allows the GP to traverse the workspace, encourages the practitioner to escape the confines of the room, and break free from constraints of fast through-put and demanding consultations:

> "The transition in between patients and the sort of, different modes and sort of refreshment or sort of, resituating yourself between patients, and the links to outside so that, either through communication or even consideration of the space, some sort of personal re-alignment between patients … You do have to sort of re-set yourself really. But sometimes you do need to draw a longer breath." (**Dr2)** [36]

5.3.5 Restrictive space

Dr7 describes the restrictive physical setting of her room as follows: "It is like a tomb, you know, you sometimes feel like you are locked in this room … I do feel after about two hours in here I need to come up for air" (**Dr7**). [37]

Like Dr2, Dr7 expresses the need to cut loose from the confines of the surgery, remarking on the pressure that comes with unremitting workloads, the quick succession of patients, and: "the feeling of confinement." However, unlike Dr2, her solution is not to transit the space in novel and creative ways, but to accept space for what it is and to work within the parameters of its limitations. For Dr7, whose surgery is near a busy public highway and whose room looks out onto a car park and a main road beyond, the blinds are kept firmly shut at all times: "I cannot open my blinds." Furthermore, although Dr7 recognizes the limitations of the present layout for supporting patient–practitioner communication, the room does not lend itself to rearrangement. As a result, Dr7 works in a dark, claustrophobic space. In spite of this, Dr7 clearly feels affection for the room, and talks with some pride about the way in which work goes on within an "organized chaos." "You have to have everything available to be able to access it … I have got notepaper there, the top of my desk is very messy … lots of interruptions and I have to change my tack" (**Dr7**). [38]

Consequently, despite the room's oppressive atmosphere and disorder, Dr7 finds her space "manageable." In addition, she tries to make the best of the space by

© 2008 FQS http://www.qualitative-research.net/fqs/

setting out symbolic markers—placing a few choice objects within easy view of patients and doctor in order to say: "This is my room." These include: a family photograph and magazine pictures of rural scenes which, seen within an area that is predominantly devoid of personal effects, also proves to be an effective way of telling other professionals who also use the space to whom the room belongs. "I consider this to be my room, although it has to be used by other people and having some personal items in here probably puts my stamp on it … That enables me to identify with this being my room" (**Dr7**). [39]

5.3.6 Communicative space

Dr5 concentrates on the ability of individual GP to make things happen effectively within the workspace, which is put down to the good communication skills of the practitioner. Dr5 prides himself on his succinct and direct way of communicating, so patients know what is wrong with them and what can be done about it. Open communication, which according to Dr5 accounts for: "80-90% of my work," is the GP's prime aim and Dr5 is able to ensure that patients, be they children or adults, are fully informed at all times. It is the practitioner who holds the key to the smooth running of the consultation and to steering the consultation appropriately:

> "There are lots of studies of how much information people retain. It's about 10% of your average consultation, so if you waffle on about how nice the weather is and what sort of car you are driving, what happened on the news the other day, it turns into gobble-de-gook … I am not an indulgent pap-talker." (**Dr5)** [40]

Dr5 reflects that the practitioner is in a privileged position, and to make the most of this privilege, practice must take place within a space that is "comfortable" so that even the most difficult consultations can run their course. The notions of privilege and comfort suffuse the interview:

> "I think the other thing is that people aren't used to being touched on a regular basis and I am very privileged in that I touch people all the time … I mean I have seen 24 people this morning and probably touched 21 of them … You have to do it carefully and not in a way that you intimidate the person." (**Dr5)** [41]

Comfort is brought about by the evolution of the workspace into a unique setting that instills confidence in the practitioner. A unique workspace can also provide the practitioner with the distractions necessary to conduct a successful consultation. In the case of Dr5, distraction takes the form of a quirky space filled with dozens of clocks and a large fish tank:

> "I have always had a fish tank in here because I like fish and when I am stressed I can look at them. But it is a bonus for the kids really and they will talk about them and whilst you are talking about the fish you can be looking at their ears, taking their temperatures or getting a good history from their mums." (**Dr5)** [42]

© 2008 FQS http://www.qualitative-research.net/fqs/

Thus the uniqueness of space serves the purpose of supporting the practitioner whilst meeting the patient's needs. "That's the way it's evolved and that's the way it works." [43]

5.3.7 Changing space

Whilst other doctors discuss space in terms of its iconography, its ability to comfort, its success in serving the professional's needs, and its safety, efficacy, and intimacy, **Dr8** concentrates on the function of space as registering change within professional hierarchies, especially with respect to the occupation and "ownership" of workspace. Space, for Dr8, signifies the hierarchical extremes of privileged status or lowly position. However, space has the potential to be flexible and expansive, and is able to adapt to meet the needs of the professional as circumstances change. Consequently, space registers an individual GP's development from trainee to registrar, from junior to senior partner, and in all cases, space is in flux. Dr8 considers the photographs and biographies in terms of the space he once shared with a more senior partner and discusses the change towards the role of full-time partner in a growing practice. Space is now enabling where once it was restricting: "So it's like seeds in here and I'm thinking: yes. I can see why that is like it is now." Space has become encouraging and liberating:

> "My room opens out onto the field. So, apart from cattle and sheep, and the occasional farmer who comes past on a tractor … I can have my room open, and the window open, which is lovely." (**Dr8)** [44]

Space now offers autonomy and signifies future prospects, and it is suggestive of the long-lasting relationships the doctor wishes to build with his patients:

> "General practice is about ongoing relationships. You see patients repeatedly over their lives and you build up a relationship of trust and they want to know what makes you tick as well. You are not just a faceless individual that's sorting their technical problem out." (**Dr8)** [45]

As with Drs 2 and 7, for Dr8 space reflects the temporality of practice but in this case it has brought about a long-awaited and dramatic change of status and thus pays homage to the practitioner's ultimate "arrival":

> "You know I took a long route through training and I had always been the junior doctor and now suddenly I had got to where I had wanted to be and I was slightly frustrated that I didn't have the trappings of getting everything when I look at it. There is a certain amount of saying: 'Yeah, now I've got my room I can personalize it. I am now a partner, you know, I am there.' I hadn't realized how important that was to me at the time." (**Dr8)** [46]

© 2008 FQS http://www.qualitative-research.net/fqs/

5.3.8 Geographic space

Dr3 presents a range of alternative "ways of seeing" space, and spends much time reflecting on the challenges of the research project and how necessary it was to concentrate on what was absent from the photographs and biographies as well as on what was present. Dr3 oscillates between what he would have liked to have presented—a rounded picture of all aspects of the workspace including the larger surgery area, the waiting room, and the patient's home—and what he actually presented: an in-depth account of the consulting room. Dr3 comments: "I haven't explored the rest of the geography of my practice. I have just explored my room." Considering why this was the case, Dr3 notes that he was preoccupied with those spaces that were controllable (his room) as opposed to those less controllable, such as the waiting room:

> "Maybe that again is because I don't have much control over the way [other areas] are set up … When you have a definitive place that you can call yours you can start imposing your own control on it." (**Dr3)** [47]

Having spent a considerable period of time working in a hospital where you are "an itinerant and you walk from ward to ward" before becoming a fully-fledged GP partner, Dr3 has taken the opportunity to "gain some sort of control" over the workspace and, as a result, he now feels a much greater sense of security and belonging. This in turn has had a positive impact on his practice and his patients' experiences:

> "The way that I practice and the way I interact with patients. Umm and I accept that and I try to manipulate it sometimes, and sometimes I try and behave in ways that step outside the limitations of that space as well." (**Dr3)** [48]

Dr3 is also more interested in "the way I inhabit the space rather than the space itself," noting that "The way I feel about it is more important to me than physically how it is. So, I think that if you change your physical environment you do it for a particular reason." For Dr3 one can always imagine a room's physicality, whereas the descriptive geography, what he calls the "psycho-geography," and the GP's underlying perceptions of space, are much more difficult to ascertain. [49]

6. Strengths and Weaknesses of the Study

The strengths of the within-method approach utilized in this study were manifold. The approach revealed a richness of data that, we argue, would not have been achieved with other analytic frameworks. Furthermore, the methodology, with its labor-intensive analysis, its responsiveness to personal interpretation, and its ability to combine visual and textual clues ensured a thorough investigation of both unique and shared qualities across participants. In this case, the approach brought home the strongly individual characters of the GPs and by returning to them, we clarified not only what they perceived the nature of their practice to be, but also how differently they viewed that practice. Thus, the data evidenced the importance of understanding the individual to understand the group, and

© 2008 FQS http://www.qualitative-research.net/fqs/

highlighted a variety of ways in which workspace was utilized to suggest it is the practitioner who is not only the driving force behind practice, but intrinsic to practice. [50]

The three-tiered data capture, using two separate phases, secured rich, detailed, and extensive data and highlighted: the complementary nature of these methods, the way each method challenged participants, and how participants responded in different measure to phases, depending on their preference for one medium over another. It was clear from their comments and feedback that the methodology played a large part in the dedication and application participants showed to this study, and we would argue that the depth of data would not have been achieved had we not used this novel, staged approach. [51]

By encouraging participants to consider each phase as a discrete unit, as well as seeing each phase as part of a broader study, the team revealed unanticipated nuances within the data that allowed us to clarify how space impacts on practice and the practitioner. In addition, the team gained unexpected insights into data gathering and handling techniques, and how heterogeneous datasets might best be used to complement, rather than undercut, one another (SILVERMAN, 1994). This became perhaps the study's greatest challenge, for multiple forms of data need to enable the construction of a fuller account rather than introduce methodological confusion and flaws. To overcome these potential problems, the team had to be clear about how datasets would be analyzed from the outset, as well as the potential value of an inter-textual analysis framework (RAPPORT, DOEL & ELWYN, 2007). [52]

7. Discussion

We would like here to return to the notion of *frame narrative* for its ability to emphasize difference and detail whilst retaining an overarching storyline. In *The Canterbury Tales*, the stories are as diverse as the pilgrims and say as much about the people doing the telling as they do about the tales that are told. And so it is with the doctors' tales in this study. As each unfolds, we see the unique character of the doctor, their approach to practice, and their relationship with their workspace. We see the manner in which they take on the subject matter through our staged data capture and analysis, and we understand their personal responses to practice and self-identity through the notions they offer up of a well-functioning or dysfunctional workspace. Pursuing our analogy of *The Canterbury Tales*, we find a frame narrative in the organizing structure of general practice, with many common elements in the practice of all participants, not least the fact that they are governed by the GP contract and have been forced to accommodate the increasing demands of information technology within their consultations. Yet within that shared structure, each doctor's personality comes through, emphasizing the individuality of the practitioner telling the tale, and illustrating that distinctiveness within the wider GP context. [53]

We began this paper by drawing attention to the importance of our landscapes and workspaces to our identity and the way our socio-spatial structures reveal

© 2008 FQS http://www.qualitative-research.net/fqs/

how we enact our lives, with space being a constituent of action and an interpretable text. According to a recent publication from the Royal College of General Practitioners, "At the heart of general practice is the doctor–patient relationship, and the patient-centered clinical method in the consultation. Values such as a commitment to interpersonal care are highly prized by patients and flow from relationship-based care and continuity." For the GP, the patient is not seen simply as an example of a diagnostic category. One cannot have a relationship with an element in a taxonomy. If we are serious about "the patient-centred clinical method," based on the doctor–patient relationship, we must acknowledge, with ERIKSON (1958), that "the patient is a universe of one." What follows from this is that the GP is also a universe of one, no more a mere exemplar of a taxonomic category than is the patient. Our GP's tales illustrate vividly the interaction between the practitioner, the patient, and the space they both briefly inhabit and which becomes a constituent of the actions that form the relationship between these two unique individuals and on which General Practice is predicated. In a literal sense, general practice is essentially a spatial practice. [54]

This study is atypical of most of the qualitative health-research studies of practice and practitioners, which tend to focus on similarities between professionals or across professional groups. These data are also atypical of outputs from the qualitative analytic approaches frequently adopted within health research, such as thematic or content-analytic approaches, where shared themes are revealed or the essence of the lived experience sought. Furthermore, what makes these data particularly unusual is the interplay between the personality of each doctor and his or her approach to practice, as revealed through the construction of the place of their practice from the physical space in which they work. The comparison with CHAUCER draws attention to the way in which each of the doctor's tales forms an element of that narrative device which gives us different perspectives on the common experience of general practice and the place in which practice takes place. They illuminate the importance of the built environment, the furnishings and equipment, and the physical layout of the room, at once very similar and yet essentially and experientially unique. We gain a deeper understanding of the nature of practice, the shared and the particular, and the methodological approach that allows individuality rather than sameness to emerge, whereby the more ambiguous and nuanced revelations come to the fore. Consequently, although there is clearly an organizing frame to the narrative of general practice, within that frame, the richness and diversity of address—*the exceptional tales of these doctors*—really shine through. [55]

Acknowledgments

We would like to thank the GPs who took part in this study for their time, energy, and honesty. We would also like to thank Vicky DAVIES for her administrative support in organizing these complex, mixed datasets.

References

Armstrong, David (1985). Space and time in British General practice. *Social Science & Medicine*, *1*(7), 654-666.

Badiou, Alain (2005). *Being and event*. London: Continuum.

Boyer, Karen (2004). "Miss Remington" goes to work: Gender, space and technology at the dawn of the Information Age. *Professional Geographer*, *56*, 201-212.

Chaucer, Geoffrey (1977). *The Canterbury Tales* [In modern English]. London: Penguin Books.

Cooper, Helen (2002). The Frame. In Robert Correale & Mary Hamel (Eds.), *Sources and analogues of The Canterbury Tales Vol 1* (pp.1-22). Cambridge: Brewer.

Crang, Michael (1997). Picturing practices: Research through the tourist gaze. *Progress in Human Geography*, *21*(3), 359-373.

de Certeau, Michel (1984). *The practice of everyday life*. Berkley, California: The University of California Press.

Erikson, Erik (1958). The nature of clinical evidence. In Daniel Lerner (Ed.), *Evidence and inference* (pp.73-90). Glencoe, Illinois: The Free Press of Glencoe.

Gothill, Mathew & Armstrong, David (1999). Dr. No-body: The construction of the doctor as an embodied subject in British general practice 1955-97. *Sociology of Health & Illness*, *21*(1), 1-12.

Harris, Michael (1997). Designing today's hospital for the future. *Journal of Healthcare Resource Management*, *15*(10), 22-25.

Johnson, Jackie; Brown, Katherine & Neil, Kelly (2003). Designs that make a difference: The Cardiac Universal Bed model. *Journal of Cardiovascular Management*,*14*, 16-20.

Kearns, Robin & Barnett, Ross (1997). Reading the landscapes of private medicine: Ascot hospital's place in contemporary Auckland. *Social Science & Medicine*, *56*, 2203-2315.

Latour, Bruno (2005). *Reassembling the social: An introduction to actor-network theory*. Oxford: Oxford University Press.

Lefebvre, Henri (1991). *The production of space.* London: Basil-Blackwell.

McDowell, Linda (1997). *Capital gender: Gender at work in the city.* Malden, MA.: Blackwell.

Orgetta y Gassett, Jose (1961). *History as a system and other essays: Towards a philosophy of history*. New York: Norton.

Radley, Alan & Taylor, Diane (2003a). Images of recovery: A photo-elicitation study on the hospital ward. *Qualitative Health Research*, *13*(1), 77-99.

Radley, Alan & Taylor, Diane (2003b). Remembering one's stay in hospital: A study in recovery, photography and forgetting. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *7*(2), 129-159.

Rapport, Frances (2004). Shifting sands in qualitative methodology. In Frances Rapport (Ed.), *New qualitative methodologies in health and social care research* (pp.2-17). London: Routledge.

Rapport, Frances; Doel, Marcus A. & Elwyn, Glyn (2007). Snapshops and snippets: General practitioners' reflections on professional space. *Health & Place*, *13*, 532-544.

Rapport, Frances; Wainwright, Paul & Elwyn, Glyn (2005). Of the edgelands: Broadening the scope of qualitative methodology. *Medical Humanities*, *31*(1), 37-43.

Rapport, Frances; Doel, Marcus A.; Greaves, David & Elwyn, Glyn (2006). From manila to monitor: Biographies of general practitioner workspaces. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *10*(2), 233-251.

Silverman, David (1994). *Interpreting qualitative data: Methods for analysing talk, text and interaction* (3rd edition). London: Sage Publications.

Sparkes, Andrew C. & Smith, Brett (2002). Sport, spinal cord injury, embodied masculinities, and the dilemmas of narrative identity. *Men and Masculinities*, *4*(3), 258-285.

Stanley, Liz & Morgan, David (1993). Editorial: Introduction. *Sociology*, *27*(1), 1-4.

van Manen, Max (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London: Althouse Press.

van Manen, Max (1997). From meaning to method. *Qualitative Health Research,* 7(3), 345-369.

Warren, Samantha (2002). "Show me how it feels to work here": Using photography to research organizational aesthetics. *Ephemera*, *2*(3), 224-245.

Windeatt, Barry (2003). Literary structures in Chaucer. In Piero Boitani (Ed.),*The Cambridge companion to Chaucer* (pp.214-232) Cambridge: Cambridge University Press**.**

Zacher, Christian (1994). Review of KS Gittes' framing the "Canterbury Tales". Chaucer and the medieval frame narrative tradition. *Speculum*, *69*(2), 481-482.

Authors

Frances RAPPORT (PhD) is a social scientist with a background in the Arts. She is Professor of Qualitative Health Research at the School of Medicine, Swansea University, and head of the Qualitative Research Unit. Frances RAPPORT co-leads an all-Wales group of qualitative researchers and methodologists: "Qualitative Inquiry Cyrmu," holds the position of Honorary Senior Research Fellow at De Montfort University, Leicester, UK, and is a Fellow of the Royal Society of Arts. Her research interests include: advances in the field of qualitative methodology in healthcare, professional workspace and health practices, and assisted reproductive technology medicine.

Contact:

Frances Rapport <corresponding author>

Professor of Qualitative Health Research

Centre for Health Information, Research and Evaluation
School of Medicine
Swansea University
Grove Building
Singleton Park
Swansea, SA2 8PP, UK

Tel: 01792 513497
Fax: 01792 513430

E-mail: f.l.rapport@swansea.ac.uk

Marcus A. DOEL (PhD) is a human geographer and a social scientist. He is Research Professor of Human Geography, Head of the School of the Environment and Society, and Associate Director of the Centre for Urban Theory at Swansea University, and a Fellow of the Royal Geographical Society (with the Institute of British Geographers). His research interests include poststructuralist spatial theory, the geography of complementary and alternative medicine, and the intersection of visual culture and consumer culture.

Contact:

Marcus A. Doel

Professor of Human Geography

Centre for Urban Theory
School of the Environment and Society
Swansea University
Wallace Building
Singleton Park
Swansea, SA2 8PP, UK

Tel: 01792 513090

E-mail: m.a.doel@swansea.ac.uk

Paul WAINWRIGHT (PhD) qualified as a nurse in Southampton and had a range of jobs in the NHS before moving into Higher Education. He worked in the Centre for Philosophy and Health Care in Swansea University until 2005, which is where he developed his interest in the Medical Humanities. He is now Professor of Nursing in the Joint Faculty of Health and Social Care Sciences at Kingston University and St George's University of London. His research interests centre on the nature of practices in health care, from a philosophical and an empirical perspective.

Contact:

Paul Wainwright

Professor of Nursing

Faculty of Health and Social Care Sciences
Kingston University and St George's University of London
Sir Frank Lampl Building
Kingston Hill
Kingston upon Thames
Surrey KT2 7LB, UK

Tel: 0208 5478718
Fax: 020 8547 8767

E-mail: p.wainwright@hscs.sgul.ac.uk

Citation

Rapport, Frances; Doel, Marcus A. & Wainwright, Paul (2007). The Doctor's Tale: Enacted Workspace and the General Practitioner [55 paragraphs]. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *9*(2), Art. 2, http://nbn-resolving.de/urn:nbn:de:0114-fqs080227.

© 2008 FQS http://www.qualitative-research.net/fqs/