

Chapter 9

GPs AND ELDERLY PATIENTS: ORGANIZING A CARE NETWORK*

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ABSTRACT

Over the last years Old Public Administration has been gradually abandoned in favor of more decentralized management models, in which hospitals mainly provide specialized services and treat acute phases. Along these lines, primary care is gaining a new central role in giving direct medical assistance, but also in helping patients to manage autonomously their conditions. In this paper we analyze how General Practitioners (GPs) support a particularly fragile category, elderly patients with complex therapies, drawing on five focus groups with GPs, conducted in a mountain province of Northeast Italy. Through an analysis of GPs' self-representations about their work we have identified various kinds of strategies adopted depending on the circumstances. In this work we describe some of the complexities emerging from the redefinition of the healthcare systems with particular attention to GPs and their new relevance in promoting and safeguarding the health and life satisfaction of their patients. This new scenario imposes to develop new competences, to regain social legitimation they used to have, to build new forms of alliance and coordination with their hospital's colleagues but also with increasingly informed and demanding patients and relatives.

Keywords: healthcare organizations; ageing; self-management; primary care

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INTRODUCTION

In recent years, Western societies have undergone remarkable demographic changes; in particular, the life expectancy and average age of the populations increased. On the one hand, medical progress has led to the dramatic increase in life expectancy; on the other, it has extended the period of life characterized by a variety of chronic diseases and by a continuous need for care and assistance. Accordingly, several policies and public health programs have been implemented to keep elderly people socially active and to ensure their well-being. In particular, healthcare systems – of extreme importance for guaranteeing a high quality of life (see e.g., Graham, 2005; Deaton, 2008) – have radically changed their organizational structures and patterns of action: Old Public Administration has been gradually abandoned for more decentralized management models in which hospitals mainly provide specialized services and acute care treatment. Consequently, the management of chronic diseases and complex medical cases is increasingly delegated to patients, their relatives, and their caregivers.

In this context of change, primary care is acquiring a central role in providing direct medical assistance, but also in helping patients to manage their conditions autonomously (Altenstetter, Björkman, 1997; Saltman et al., 2007). In Europe, various reforms have given General Practitioners (GPs) a key role in the reduction of costs, and in the coordination, integration and improvement of healthcare services (Starfield 1996, 1998; Boerma, Fleming, 1998; Delnoij et al. 2000). As recently argued by WONCA (2011), despite the differences among national healthcare systems, in Europe GPs share the following fundamental features:¹

- they promote health and wellbeing by both appropriate and effective intervention;
- they are usually the points of first medical contact within the healthcare system; they provide open and unlimited access to its users, and deal with all health problems;
- they coordinate care, working with other professionals in the primary care setting, and they manage the interface with other specialties;
- they develop a person-centered approach oriented to the individual, his/her family, and the community;
- they are responsible for the provision of longitudinal continuity of care as determined by the needs of the patient;
- they promote patient empowerment and autonomy.

If the role of healthcare schemes in the improvement of life quality needs to be investigated, it is essential to focus on the GP's action, which is of extreme importance in the daily assistance of patients.

This chapter examines how GPs contribute to ensuring the health and wellbeing of a particularly vulnerable social category, namely elderly patients undergoing complex therapies. Drawing on qualitative research conducted in a mountain province of North-East Italy, in what follows we show the ways in which GPs work to enable elderly persons to manage their illnesses outside hospitals. To this end, we first describe the main characteristics of the research context and the theoretical background. We concentrate on the various ways in

¹ WONCA is an acronym comprising the first five initials of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians.

which GPs construct the relationship with their patients and their care networks as they work to ensure their health.

CARING FOR ELDERLY PATIENTS: THE GP'S WORK

In Italy, the GP's role has changed significantly in recent years (Cipolla et al., 2006; Speranza, 2012). In spite of a highly decentralized and specialized healthcare system, various institutional actions have assigned an important (and atypical) role to GPs. These professionals seem distinctive for two main reasons: on the one hand, they take a holistic approach to patient care by seeking to understand the patient's general conditions; on the other hand, they play a gatekeeper role by regulating and permitting access of patients to health services (Vicarelli, 2006). Consequently, GPs have acquired a strategic position in the resolution of certain major social issues. One of these is the progressive ageing of the population (Italy is one of the countries with the highest ageing index in Europe) that has increased the number of patients with a variety of chronic diseases and in constant need of care and assistance.²

This study focuses on the ways in which Italian GPs manage elderly patients with chronic diseases so as to keep them out of healthcare institutions. For this purpose, we shall use the theoretical tools provided by the multidisciplinary debate that, in recent years, has analyzed how the elderly manage their health. This strand of studies has involved various fields – for example, gerontology, sociology of health and illness, organizational analysis, and science and technologies studies – which have underlined that the management of elderly patients involves diverse actors (people, institutions, and technologies):

- National healthcare systems seem increasingly fragmented among local and national organizations with different competences and responsibilities. Patients and their social networks (partners, relatives, neighbours, and so on) interact with various healthcare professionals, so that the paternalistic doctor-patient relationship is superseded (May, 1992). In particular, elderly patients are redefined as service users, and in turn as consumers, able to judge the quality of service provision and contribute to treatment decisions (Chapple et al., 2002). Consequently, the elderly walk away from the stereotype that represents them as inert and with poor cognitive skills (Lumme-Sandt, Virtanen, 2002).
- Social relations play a key role in the management of patients and their diseases. Family, friends, and neighbours seem particularly crucial in supporting the elderly directly (through medications, measurements, and so on) or indirectly (for example with exhortations and motivating actions). In particular, the family constantly and extensively supports the elderly in their daily lives, while peers and neighbours intervene with carework (Gallant 2003, 2007; Prohaska et al. 2001). However, compared with the family, friends and neighbours seem to give restricted support to the self-management of disease (Gallant 2003).

² The ageing index (which in Italy was 185% in 2011) is the ratio between the population over 65 years old and the population aged under 14, multiplied by 100. The data come from the urbistat.it website, which processes demographic data provided by ISTAT (Italian National Institute of Statistics).

- Medications permeate the homes, routines and, in general, daily lives of elderly people. As Hodgetts (2011) argues, medications should be considered “social objects” situated in circumscribed social realms and embedded in certain social practices. Elderly persons undergoing complex therapies and their caregivers constantly interact with drugs characterized by their packaging (including the label, instructions, pill colour and so on), which influences therapy management and care practices. The designs and names of medications often mislead elderly patients and their caregivers (Ward et al. 2010; Hellier et al. 2006; Shrank et al. 2007), so that they must take precautions to avoid dangerous mistakes.
- Various studies have shown that older patients use, reconfigure, or avoid telecare technologies designed to support them in management of their diseases. These infrastructures serve different purposes: for instance, transmitting information from patient to doctor (Peinado et al., 2009), involving the elderly in treatment decisions (Rogers et al., 2005), creating peer support networks (Cornejo et al., 2013), and favouring constant communication with relatives and other caregivers (Rowan, Mynatt, 2005; Mort et al., 2013). Telecare technologies are therefore designed as means to empower patients and their care networks, which, however, may use and appropriate them in unexpected ways.

Previous studies have underlined that the elderly are involved in heterogeneous networks in which family, friends, technological infrastructures, doctors and other caregivers are connected with each other. Elderly care extends beyond the traditional doctor-patient relationship, so that the patient’s wellness results from collective work in which physicians are flanked by other actors.

Hence, in analyzing how GPs guarantee the health and wellness of non-institutionalized elderly persons, we will not conceive the doctor-patient relationship as dyadic, private and separate. On the contrary, as May (2007) suggests, we will consider it as situated in an extensive network comprising institutions, professionals, technologies, relatives, friends, and other caregivers. Elderly care seems to be work enacted by heterogeneous networks with different (but interconnected) logics and practices. In what follows, we focus on the various ways in which GPs construct the relationship with the patient and his/her care network. These will be:

- 1) Relaying: when GPs delegate action to specialists;
- 2) Mediating: when GPs must negotiate patients’ requests and/or manage conflicts in the therapy network;
- 3) Configuring: when GPs try to understand whether patients will be able to manage the therapy so as to configure a proper care network;
- 4) Coordinating: when GPs modify the therapy and organize the care network strategically.

The materials presented in the next section originate from five focus groups conducted with GPs (for a total of 22 GPs involved) in a mountain province of North-East Italy, and in five territorial zones: the two main towns in the province (each with a hospital) and three valley communities (one with a hospital, one close to a town with a hospital, and one distant from such a town). The variety of the zones selected made it possible to compare among areas

in which elderly patients are embedded in different social and healthcare networks. The focus groups discussed the logics and practices of GPs in managing elderly patients with complex therapies, and, in general, the representations of GPs concerning the 'elderly patient' and the 'management of complex therapies'

MANAGING CARE NETWORKS: GPs' STRATEGIES

In care networks, patients, as well as specialists, are an active and important parts of the therapeutic regimes that GPs enact. We have mentioned the decentralization of health care services that makes the positioning of GPs with respect to their patients and to specialized doctors more complex. Furthermore, the transformation of medicine and population ageing has changed patients' health expectations, and consequently the relationship between patients' networks and GPs, in both social and professional terms. The GPs in the focus groups particularly stressed that the high expectations of patients and their relatives in the chances of recovery seriously affect the management of therapy:

We can relieve their suffering, but we can't remove it completely. And then they start to take it out on us. And they start to... to have reactions – I mean – doubts about our commitment and also about our professional ability. And that's not nice. And then it alters the relationship between the family members and us. In the sense that when you go and meet these reactions of extreme distrust, perhaps they believe in you from a professional point of view in some respects, but they expect more than you can give [FG#2, GP#2]³

On the one hand, GPs consider medicine to include wellness and the overall quality of patients' lives according to their age and conditions; on the other hand, patients, especially older ones, find it difficult to accept the old age.

To summarize, when GPs deal with older patients, they need to deploy strategies that take account of the various configurations of therapy networks, including those influenced by expectations, as well as by institutional issues. Strategies are therefore as mobile as the network: rather than depending on GPs choices, strategies are adopted in relation to changes in the therapy network. In the following sub-sections, we describe four specific strategies – identified in fieldwork – used to construct the relationship with the patient and his/her care network.

Relaying

When GPs are overloaded and under pressure from patients, they use specialized doctors as a resource by acting as *relays*: they re-direct patient's issues to specialists without entering into the merits of the therapy but delegating action to specialist decisions:

Specialists are important from our personal point of view... because they can give you some breathing space...in the sense that you can offload not so much the gravity of the

³ In order to ensure the anonymity of the doctors involved in the research, they will be indicated with the abbreviation GP#n. The abbreviation FG#n instead denotes the focus group concerned.

problem as the demand for it to be solved [...] you so often find yourself with people faced by everything, and you don't know what to say to them any more [...]. [Then] specialists are undoubtedly useful when we ask for them. We too need specialists for problems that we... that they know more about than us in the specific field! [FG#4, GP#2]

This strategy can be deployed by GPs for either *tactical* or *patient-led* reasons. The former refer to the need of GPs to “take a breath” due to the work overload, so that they relinquish their autonomy and power in exchange for time to pursue other activities related to both their professional and private lives. The latter refer to the increasing pressure applied by patients who want rapid solutions for their illnesses: patients may consider the GP's action insufficient and directly ask for specialist consultancy. Moreover, GPs need to rely on specialized knowledge in order to deal with specific problems.

Relaying work is both a side effect and a symptom of the changes in GPs' reputation and authority over recent decades. The dominance of pharmaceutically driven medicine and the increase in life expectancy, as well as the blurring of the boundaries between lay and expert knowledge and the growth of patients' expectations in regard to chances of recovery have undermined the authority of GPs and their control over patients' therapies:

So we've lost... authoritativeness. Because there came a point when we found it convenient to hand over our patients to the specialists. But now, according to me, we're dealing with the consequences. If we don't rebalance things a bit, they'll start despising us. I don't know if you agree [expressions of assent] [FG#2, GP#5]

As a consequence, a disappointed GP reported that they were often seen by patients as mere “clerical workers” having lost their professional status:

I remember this episode at a supermarket... There were two people talking at the check-out, two patients, and one said to the other “Look, my doctor has retired” - and she didn't know that I was the replacement for the doctor who had retired - “But don't worry“, the other one said, “take any of them, they're only pen-pushers”. [FG#2, GP#3]

To summarize, in the clinical encounter based on *relaying*, GPs give up their decision-making power and acting as ratifiers of the specialists' prescriptions (often more legitimized by patients). *Relaying* is an *effect* of the transformation of medicine, and in its turn it *affects* the professional status of GPs.

Mediating

GPs are embedded in a complex network of caregivers that includes patients, their relatives, specialized doctors, as well as district nurses, care workers and neighbours. Thus therapy becomes a joint enterprise, a collaborative process. Within this process, GPs are often called at stake as mediators, and the mediation concerns negotiation of patients' demands, the management of conflicts, and the restoring of the therapy network.

The patient's release from hospital is a situation in which mediation by GPs is particularly delicate: in fact, the hospital is considered by GPs as an “abstract” setting “outside the chaos

of society“, where patients “obey” the personnel that assists them entirely for the administration of medicines.

I reckon that the hospital is able to abstract itself. But it can also say, “Right, I’ve got this patient and I can see that he’s in an acute state. I stand outside all the chaos in society, because we have our rules, our protocols, we do our own things”. When the patient is discharged, he returns to his GP [...] But besides the doctor there’s the nurse, who has her own ideas, then there are the relatives, who have theirs as well [...]. As long as the patient is in a hospital, he obeys the doctor and the nurse, because if he doesn’t, if he doesn’t obey, they’ll tick him off. But when he gets home, he says: “Finally I’m at home, and I can manage things how I want”. So he is a bit more free. [FG#1, GP#5]

The transition from hospital to home thus involves a re-arrangement of treatment that needs to comply with the mundane settings of therapy management.

Moreover, after patients are discharged from hospital, they are less willing to follow the indications, and their opinions and practices concerning their therapy may diverge from those of their caregivers. The hospital discharge letter is the only direct source of information for GPs on the health of their patients from hospital, but it is often poor and ambiguous in terms of details and needs to be re-interpreted (for instance it may lack important information on drugs previously administered and then removed because of side-effects).

This attitude seems reciprocal. GPs admit a lack of communication with specialized doctors, who cannot have access to their patients' records:

I send him a hospital admission request for suspected pulmonary focus with complications, and they find themselves with someone they know nothing about, when I’ve got all his details in my medical records ... so, I mean, all it would take is even limited access to our case files [FG#2, GP#1]

The GP’s mediation work therefore consists in re-connecting the web of the therapy basing on few traces and contested discourses. It also involves issues of responsibility:

My problem with discharge is that when the patient is discharged, the hospital department and the doctors no longer have any say in the matter and responsibility for that patient. [...] So you’re on your own. They’ve discharged him and that’s it, they’ve washed their hands. It’s a problem that really grinds me down [FG#1, GP#1].

Whereas in relay GPs try to delegate responsibility to specialized doctors, the mediation strategy produces an additional load of responsibility for GPs.

A further case in which the mediation strategy occurs is negotiation among the GP, the patient and his/her relatives. The social network of patients can in fact provide support as well as criticize and challenge the GP’s choices, especially with terminally ill patients. In the following case, for example, a GP prescribed morphine for the patient in order to reduce the pain, but the relatives complained that they could not communicate because the patient is asleep, and they demanded a different therapy:

The other day I had this bed-ridden soporose patient... in a terminal condition, let’s say. And the family members told me: “But if we increase the morphine, he sleeps”. But excuse me, I said, is it better to see him suffering or asleep? He’s going to sleep in any case.[...]. But

the family were critical. Though they asked for information and, quite rightly, they wanted to have their say [FG#2, GP#3]

Whereas social networks can help GPs to deal with emotional issues related to illness, GPs also need to re-frame expectations and emotions:

So, there are some family members, and it depends like everything else, who are able to accept and manage the situation. They can allay the person's fears, they help them keep to their therapy schedules, they remind them of consultancy appointments and examinations... But there are others who say: "So we've got to try everything. [...]". In some way we've got to restrain the therapy and slow it down [FG#2, GP#2]

The mediation work often involves the management of conflicts that arise between GPs and patients' primary networks, especially in the case of end-of-life patients.

The more patients' conditions worsen, the more demanding their relatives become. This requires important negotiation work by GPs in order to manage the treatment. GPs thus adopt tactics to mitigate expectations in specific interactions with patients through situated adaptations of diagnoses:

It happened like this. A seventy-year-old woman with lung cancer was in the terminal phase of the disease, right? She had a heart attack and died. Then the family said to me, "Ah, but what if she'd been hospitalized when she got this pain...?". I said "But no, at her age there was nothing more that could have been done. She would have died in a hospital anyway" [...] Home care for the terminally ill isn't done with bad intentions, it's usually done with good ones. This is the example that comes to my mind [FG#3, GP#1]

Mediation work by GPs takes place between hospital and home, between patients and their relatives, but also between life and death, specialized medicine and general medicine. It requires mobilizing a number of actors as the GP's allies in order to support the legitimacy of the therapy and ensure its adequate management.

Configuring

When prescribing a therapy, a GP must understand whether or not the patient will be able to manage it. In other words, GPs must identify their "final users" and configure them for correct therapy management:

To patients that don't have particular problems, who are compliant, "smart" and perhaps live alone and are self-sufficient, I usually give the information [directly]. Obviously if the patient is unreliable, has problems, and if there's a relative or someone who... Informing the patient or the caregivers depends on the situation at hand [FG#1, GP#5]

Once the "final user" (the patient or the main caregiver) has been identified, a first configuring task consists in training patients and/or caregivers in how to administer drugs, as well as to recognize side effects or specific symptoms:

The training [of the patient] takes place on two levels. One is training in how to administer drugs, which in some cases is not easy, for example in injective therapies [...]. There is also training in detecting the side effects of drugs. It must be explained to a diabetic patient how to recognize a hyperglycaemia and how to treat it [...]. If the patient has a haemorrhage, they must know what action to take. [FG#1, GP#1]

A further way to configure patients and/or their caregivers as users able to manage the therapy autonomously consists in advising them on how to arrange the domestic setting and the therapy tools within it (i.e., blisters in the cupboard and weight record in the bathroom, etc.). Such tools and arrangements connect everyday life routines with therapy management practices.

The configuring strategy acts on the patient's network as well as on the therapy itself. Like mediating, it happens when patients switch from hospital to home care, when GPs must adapt therapy administered at hospital to mundane settings. Here configuring refers to the GP's ability to reduce the prescription according to the patient's actual situation – an action of which GPs are particularly proud:

I come across overlapping therapies, with drugs forgotten. An example is amiodarone: a load of patients have been taking it for years and nobody knows who gave it to them... so I sometimes chuck it out myself [FG#3, GP#3]

In fact, specialized doctors at hospitals may prescribe and administer drugs not currently in use, and/or they may prescribe drugs that are freely administered in hospital but have very limited access in the market. Moreover, when GPs deal with older patients on low pensions, they must consider whether or not prescribed drugs are provided by the national health service:

We often have elderly patients living on minimum pensions, and out of seven or eight drugs on their hospital discharge letter they have to pay for three of them ... and not just a couple of euros each... [...] So either you find some dodge or you take them off the drug or you explain that certain medicines are not really essential. [FG#3, GP#3]

Concern with the cost of drugs in relation to the patient's economic circumstances is a further element that emphasizes the broad and holistic approach adopted by GPs in organizing therapy for their patients. GPs consider hospital therapies too "demanding" compared with the effects achieved and with little chance of compliance by the patient. Therefore, GPs try to redefine the therapy formulated by specialists in order to make it manageable at home and, at the same time, not too "demanding" for its users.

Coordinating

With respect to mediation, coordination benefits of additional trust from the therapy. Rather than mediating tactically among different requests and actors, coordination works to modify the organizational level of the therapy and to deploy the network of "stakeholders" strategically:

According to me, the role of the general practitioner is to coordinate all these... stakeholders that rotate around the patient, because he's someone with an overview. We've talked about it this evening, we've all said something, which in the end... For example, I'm one of those who believe that the nursing home is nothing but the continuation of the GP's role in institutionalization [FG#4, GP#1]

Coordination manages the encounter between the institutional and practical dimensions of care on the basis of the GP's skills in managing an extended network of actors encompassing patients, caregivers and health organizations. The emphasis here is on institutional, local and social aspects, and the GP's task is to align all the actors involved in the joint enterprise of the therapy. First, the GP must share the therapy with the patient and the patient's primary network in order to delegate treatment-related tasks such as – in the case of diabetes – measuring blood glucose levels or performing insulin injections, as well as organizing the diet. In the case of scant continuity of support at home or when there is no primary network, GPs enact institutionalized protocols, such as ADI (Territorial Integrated Assistance) or welfare measures. ADI involves new professional caregivers in the everyday care of patients, such as nurses and social workers, who must be coordinated by GPs. This is a difficult task, at least in Italy: whereas local nursing personnel has high turnover and is assigned geographically depending on where patients live, GPs are assigned by patients' choice. This contradiction jeopardizes coordination, because it would be easier for GPs to work with the same nurse in assisting their patients.

This is a major organizational contradiction, and it's specific to Italy [...]. A patient who lives in *** can choose any doctor practising in the town of *** as his doctor. But he probably has only one nurse in that district – which will also have very high turnover. This is a very serious matter. The district nurses keep on changing, so that it is never possible for a doctor in a town like ours to know the nurses working with their patients, because they constantly change. [FG#4, GP#1]

Because it is focused on organizational processes, a successful coordination strategy contributes to the creation of a protective network in which frail patients can be monitored and supported by various trained caregivers. In light of the transformation of professional skills and knowledge in health care, with the advent of new specialized caregivers, coordination has become all the more important:

Now there are these highly qualified professional figures coming up. I'm thinking about the graduate nurses, who want to have their space and status. I'm thinking about the OSSs [*operatori socio sanitari*, social health workers], who can also work in the community [...] I see the difficulties in coordinating the OSSs with the professional nurses [...] Either they put their minds together and go in the same direction, or the professional nurses take advantage and use the OSSs as their gophers. Many of the OSSs have taken evening courses, they don't have the skills. For example: if an OSS measures an 84 saturation and doesn't report it to the professional nurse, it means that he understands nothing about what he's doing, right? This happened to me. A man had a fall, and the professional nurse told the OSS "measure the parameters". But the OSS didn't know how to do it, so the professional nurse did it. So there's all this... coordination of roles, so that things work as they should, someone running the show [...] Who can get this across? Either the very attentive caregivers or a GP, who's on the spot

and can stimulate the other stakeholders to rebalance the system... this is the only thing that can be done. If it isn't done, it's obvious that institutionalization is the result [FG#4, GP#1]

The coordination-based strategy aims to track and monitor specific situations. By being able to delegate tasks and to control the heterogeneous actors that constitute the “planet patient”, GPs can establish continuity in the care process.

CONCLUSION

The medical professions are undergoing profound transformations. While hospitals become acute care treatment centres and nursing homes turn into long term residential facilities for elderly persons dependent on care, the concern of policy makers and healthcare managers is to promote an active, healthy and independent ageing process in order to keep elderly people out of care institutions as long as possible.

As a consequence, GPs and territorial health services are becoming the cornerstones of the healthcare system, and they are required to actively promote the autonomy of patients, empowering them and their families and supporting their self-management. This role is clearly envisaged in the policies and regulations mentioned in the introduction, which define how GPs are expected to support patients in leading healthy, independent and satisfactory lives.

In this study, we have considered how, given this overall picture, GPs actually work to fulfil these expectations. We have focused on GPs' self-representations of their work with elderly patients and their care networks.

Zooming in from the macro level of the societal expectations to the micro level of everyday interactions with patients requires setting aside the clear-cut distinctions of the prescriptive plan of policies and laws to enter the multifarious plan of practice, where the boundaries of concepts such as health, autonomy, and life satisfaction blur and blend.

Drawing on the analysis, we now focus on three cross-cutting themes that emerged from the field research.

Balancing GP's Own Role

At times, in their worst case scenarios, GPs perceive themselves as only a part of care networks made up of patients who do not follow their indications, low-skilled caregivers, intrusive families, idealistic hospital doctors, and unruly territorial nursing services. Each case is unique, and its characteristics often change over time. In this multifaceted scenario finding a position and a role in the network and providing support for the autonomous and healthy living of elderly patients are two tightly intertwined activities, the former being a precondition of the latter.

We have identified four strategies that GPs use to support their elderly patients. This is by no means meant to suggest that they were equivalent for our interviewees. GPs are well aware that reducing their role to mere administration (relaying) greatly reduces their professional status, and endangers their reputation in the long run. The same applies, to a lesser extent, to pure mediation among other actors.

Configuring and coordinating, by contrast, are in full accord with the image of the GP's professional role. Not being able to live up to their professional representation, in fact, symbolises the struggle by GPs to adjust to their role as a cornerstone of the entire system; a role that has been defined by high-level policies but which they, at times, feel inadequate to sustain.

Balancing and Redefining Life Satisfaction and Health

This book invites reflection on the social influences on life satisfaction and health, implicitly presenting them as neighbouring concepts. Our exploration of GPs' work invites to reflect about this coupling. The pursuit of better health can lead to a more satisfactory and independent life. But, at times, it can also lead to time and energies being devoted to unrealistic hopes. One of the most demanding tasks for the GPs covered by our research was finding a balance between the health expectations of patients and their quality of life. On many occasions, patients and their families were described by GPs as having unrealistic expectations about the efficacy of therapies and little concern about their possible side-effects. In this regard, terminally ill patients provide a clear illustration of the trade-off involved in the decision process. The GPs described their actions as undertaken to resist the pressure to over-medicalise the last stages of lives, and to propose a shorter-lasting but peaceful end as an acceptable outcome. Sustaining a balance between life quality and health, however, is a networking and sense-making activity. It requires finding allies in the care network, persuading the uncooperative actors, and proposing an alternative perspective from which they can look at their experiences. In the course of these actions, however, not only must health, death and life-satisfaction be balanced, but they must also be given new meanings so as to readjust the care network and to enable it to play its part in the process.

Balancing Life Satisfaction for Patients and Their Network

As we zoom in from the regulatory plan to the everyday activities of GPs, we witness the difficulty of clearly defining who is the target of their activities, whose life satisfaction they help to improve. While the care network is a valuable ally in supporting patients and improving their overall well-being, GPs also seem to try to care for the network itself by not overburdening it with tasks and responsibilities which might prove emotionally challenging. End-of-life decisions again provide striking examples. GPs strive to pave the way for the painless and gradual "exitus" of patients. At the same time, however, these decisions pursue a harm-reduction strategy to minimize the stress and the grief of relatives associated with the imminent loss of a loved one. On these and similar occasions, it is hard to tell who is the primary beneficiary of their work. Our findings suggest that at times GPs consider the care network to be a tool to be crafted to ensure patient well-being and quality of life, while at other times it is the network and its actors that GPs try to preserve from unnecessary stress.

In conclusion, in this study we have tried to describe some of the complexities emerging from the redefinition of healthcare systems with particular regard to GPs and their new importance in promoting and safeguarding the health and life satisfaction of their patients. Our analysis reveals that GPs represent themselves as not entirely at ease in managing these

complexities. This new scenario requires the development of new competences for GPs, so that they regain the social legitimation that they used to have, build new forms of alliance and coordination with their hospitals colleagues, but also with increasingly informed and demanding patients and relatives.

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