‘We can only do what we have the means for’ General practitioners' views of geriatric outpatient care

Anna Herzog\textsuperscript{1}\textsuperscript{2}\textsuperscript{*}, Beate Gaertner\textsuperscript{1}, Christa Scheidt-Nave\textsuperscript{2}, Martin Holzhausen\textsuperscript{1}

\textsuperscript{1}Charité Universitätsmedizin Berlin, Department of Biometry and Clinical Epidemiology, Hindenburgdamm 30, 12203 Berlin, Germany

\textsuperscript{2}Robert Koch Institute Berlin, Department of Epidemiology and Health Monitoring, General-Pape-Straße 62-66, 12101 Berlin, Germany

\textsuperscript{3}Alice Salomon University of Applied Sciences, Alice-Salomon-Platz 5, 12627 Berlin, Germany

\textsuperscript{*}Corresponding author. Robert Koch Institute Berlin, Department of Epidemiology and Health Monitoring, General-Pape-Straße 62-66, 12101 Berlin, Germany.

Email addresses:

AH: annaherzog@posteo.de

BG: gaertnerb@rki.de

CSN: scheidt-nevec@rki.de

MH: holzhausen@posteo.de
Abstract

Background

Due to demographic change general practitioners (GPs) are increasingly required to care for geriatric patients with complex health problems. Little is known about the subjective appraisals of GPs concerning the demanded changes. Our objective is to explore how general practitioners view their professional mandates and capacities to provide comprehensive geriatric outpatient care.

Methods

Preceding a controlled intervention study on case management for older patients in the primary care setting (OMAHA II), this qualitative study included 10 GPs with differing degrees of geriatric qualification. Semi structured interviews were conducted and audio-taped. Full interview transcripts were analyzed starting with open coding on a case basis and case descriptions. The emerging thematic structure was enriched with comparative dimensions through reiterated inter-case comparison and developed into a multidimensional typology of views.

Results

We found three types of views: ‘maneuvering along competence limits’, ‘herculean task’, and ‘cooperation and networking’. The types differ in regard to role-perception, perception of the own professional domain, and action patterns in treating geriatric outpatients. One type shows strong correspondence with a geriatrician. Across all groups there is a shared concern with the availability of sufficient resources to meet the challenges of geriatric outpatient care.

Conclusions

There is need to develop role models for GPs in geriatric outpatient care consistent with different conceivable models. Geriatric training is likely to be of impact and help in this respect. At any rate, however, comprehensive care for older patients with complex health problems in general practice requires additional resources in terms of reimbursement, in order to render comprehensive assessment and close interaction with nursing and social services feasible.

Keywords

Geriatric outpatient care
General Practice
Qualitative study
Attitudes of health personnel
**Background**

In recent years, demographic changes in the constitution of general practitioners’ (GP) clientele have demanded alterations in ambulatory clinical practice in order to adequately meet older patients’ health care needs [1]. These geriatric patients are characterized by multiple, simultaneous, and synergetic health problems, functional limitations, and psycho-social challenges [2, 3]. Treatment and care here does not primarily focus on the cure of single identified diseases, but rather has to deal with syndromes and interdependent multimorbidity and patient complexity, that is the influence of not only health-related characteristics, but of also cultural, socioeconomic, environmental, and patient behavior characteristics [4]. On the basis of the target group’s needs it is argued that the provision of health care for older people requires integrated networks of health care and social services to provide the continuity of care [5].

Geriatric outpatient care poses a significant challenge to a GP’s geriatric knowledge and ability to synergize various kinds of information and could best be tackled in a multiprofessional team [6]. In Germany, multiprofessional teams are not the norm, and specialized geriatric care has so far largely been restricted to the hospital setting. Usually, the general practitioner will see all patients and, depending on his or her clinical evaluation, refer patients to specialists and therapists. In Germany, as in other countries, the level of geriatric training varies highly among GPs [7, 8].

Few studies have been undertaken to elucidate the professional action patterns and attitudes of GPs regarding geriatric health-care. Some findings suggest that the level of specialized professional training can play a role in utilization of specific assessments and recognition of responsibilities [9-11]. Also, attitudes and perspectives of GPs will influence the range of health problems encompassed in their subjective expertise [9] and their treatment decisions [12]. The separation between professional domains is highlighted repeatedly as a barrier and interprofessional cooperation as a chance for comprehensive treatment and care in older patients [1, 9, 13, 14].

A number of recent studies are available that address GPs’ attitudes and practices concerning the concept of age and aged patients[15, 16], multimorbidity management [17, 18] dementia diagnosis and treatment [10, 19] palliative care [14], oral health in older patients [9] and the use of geriatric assessment [20, 21]. However, to our knowledge no studies have so far addressed GPs’ perspectives regarding the current situation and rising challenges of ambulatory geriatric care in general.

Hence, we were interested in understanding how the issue of geriatric outpatient care is conceived of by general practitioners. We chose a qualitative interview approach in order to elucidate this complex topic. The leading research question was: How do general practitioners view their role in geriatric outpatient care and what lines of action do they subsequently take? We hypothesized that geriatric training might have a major impact on these views.
Methods

The study was nested in the project OMAHA II Maintaining autonomy among
community dwelling vulnerable elders by individualized case management in primary
care, a non-randomized controlled intervention study on the effects of individualized case
management for general practice patients aged 70 and older in Berlin. The study was
conducted jointly by Charité Universitätsmedizin Berlin and Robert Koch Institute Berlin
from 2011 to 2013. The study was conducted by the Research Collaboration Autonomy
Despite Multimorbidity in Old Age: Interventions to Mobilize Resources (AMA II) in
Berlin, Germany.

The main study was performed with the approval of the ethics committee of Charité
Universitätsmedizin Berlin. For the research reported in this paper we assured informed
consent of the interviewees and data protection in accordance with Charité’s official data
protection officer. We report the results in accordance with the COREQ guidelines [22].

We aimed to recruit a sample of ten interview partners. Potential interview partners had
to be actively working in office practices or primary healthcare centers. We approached
eligible GPs who were either cooperating in the OMAHA II intervention study or had
previously been involved in general practice research projects. As we were in contact
with 20 eligible interview partners we could sample on the basis of categories and include
GPs with single and shared practices in three German cities (≥100,000 and <500,000
inhabitants, ≥500,000 and <1,000,000 inhabitants, ≥1,000,000 inhabitants) with different
degrees of geriatric qualification, which was in our interest due to the initial hypothesis of
its possible impact on different views. The geriatric qualifications were defined as: (a)
high in persons with a formal qualification as geriatrician or a complementary training in
geriatrics for GPs; (b) intermediate for several years of professional experience in a
geriatric institution without formal qualification in geriatrics; and (c) none where neither
of these criteria were met. Interviewees were contacted by postal mail. All of the
professionals approached agreed to be interviewed on the basis of information about the
study aim and data protection policy. No sort of reimbursement or gratification was
granted.

Data was collected by semi-structured expert interviews in October and November 2011.
Three were conducted by telephone, seven personally by the same experienced
interviewer, trained in qualitative interview techniques. Duration was 30 to 90 minutes.
All interviews were tape recorded and fully transcribed.

The interview partners were asked to give a general overview on their practice and
describe the prevalence of geriatric patients and importance of geriatric disease patterns
in their daily work, which services they usually offer to geriatric patients, and what
challenges they encounter in this context. Additionally, professional background
(specializations, professional experience) was ascertained.

We aimed at elaborating characteristic views of GPs on geriatric outpatient care. GPs’
perspectives on geriatric outpatient care were conceptualized as social representations,
i.e., systems of values, ideas, and action patterns shared within groups concerning a
certain subject - in this case geriatric outpatient care. Social representations serve as
orientation to the individual and enable intra-group communication [23, 24]. Analysis
started with open coding on a case basis and case-descriptions. The emerging thematic
structure was enriched with comparative dimensions through reiterated inter-case comparison and was developed into an empirically grounded multi-dimensional typology [25].

We succeeded in including 6 female and 4 male GPs with specializations in general as well as internal medicine working in different practice forms into the sample. Two GPs had a single practice, four GPs were engaged in practice sharing and four GPs worked in an ambulatory healthcare center. Seven practices were situated in cities with ≥1,000,000 inhabitants; two practices in cities with ≥500,000 and <1,000,000 inhabitants; and one practice in a city with ≥100,000 and <500,000 inhabitants. Three of the GPs had high, one had intermediate, and six had no geriatric qualification.

Results

Three types of views

We identified groups of GPs with different types of representation of geriatric outpatient care: (A) as ‘maneuvering along competence limits’, (B) as tantamount to a ‘herculean task’ that the GPs embrace with full professional and personal commitment, and (C) as ‘cooperation and networking’ (Table 1). Three dimensions to characterize and compare the respective types were identified: (1) GPs’ perception of their own role, (2) GPs’ definition of their professional domain, and (3) GPs’ patterns in interaction with other professions and institutions. Three of the four GPs with intermediate or high geriatric qualification pertain to type (C), that is all GPs in this group have intermediate or high geriatric qualification. Group (B) is comprised of one GP with high and one with no geriatric qualification, and group (A) consists of five GPs with no geriatric qualification.

- Table 1 -

(A) ‘Maneuvering along competence limits’

The representatives of this type perceive geriatric outpatient care as a challenge confronting them with the limits of their mandate and capacities. That is, they encounter competence limits in the double meaning of the term.

There are competence limits such as uncertainties resulting from the challenges of being facilitator between patients and specialists or experiences of helplessness when being confronted with patients’ social or care-related shortcomings. However, most examples deal with lack of time for consultation and treatment, and lacking prescription-budgets. Thus, economic issues play the central role in the explanation and justification of what is done/not done and which requests are to be regarded as beyond the competence limit.

Role definition in (A)

GPs in this group see themselves as stand-alone medical experts and service providers. Even if they delegate tasks to team members or professional caregivers and acknowledge the need for good communication with specialists or hospitals, they understand these aspects as peripheral and consider the medical services they themselves provide as central. Secondly they share a rather technical understanding of their work.

‘And these ideas, yes, that the doctor assumes quasi also pastoral function - of course many elderly people have that. And I feel honored when I'm credited with
that. Have to say, though, that I haven’t been trained for it, I am not qualified in any special way. However, there are simply also people who just want technical service from me. Pain away. Why they have knee-pains, or so, they do not at all want me to assess such things.’ (OMAHA-II-2011-t-04, 336ff.)

Expectations going further are often beyond what they feel to be in the position to provide. Some physicians in the group explicitly identify themselves as ‘entrepreneurs’. Most, however, take a merely pragmatic or even critical stance towards the economic frame binding them.

‘It has to- if that were to be part of my tasks; it has to be linked to my budget. I don’t want extra money for this, but still I want to be able to do something in this respect so that it doesn’t simply run contrary to economic practice management. And economically reasonable practice management isn’t that which is best for the people, but it is so that I don’t go broke with my enterprise.’ (OMAHA-II-2011-t-04, 812ff.)

**Definition of professional domain in (A)**

Accordingly, GPs in this group define their professional domain narrowly, and in close fit to formal resources and requirements. In their understanding, this is what they have been trained for and, more importantly, it is what is refundable in the German health insurance system.

‘At the moment I have lots of women to whom their wartime experiences come to mind again […] and who start to talk of these. And there my problem as a doctor is rather: ‘How long am I able or willing to listen?’ I could stay hours listening. They would surely appreciate. However, health insurance would not appreciate to pay for this. And again, I don’t believe I am trained for this. I am trained do prescribe pills.’ (OMAHA-II-2011-t-04, 450ff.)

As the range of possible actions is restricted to refundable services, there is only occasional opportunity to help patients to achieve goods or services other than by prescription. A sense of injustice is often expressed about being blamed for not providing comprehensive care:

‘We’re not that bad, but we can only do what we have the means for. We’re not too stupid to recognize when people have a need for rehab or training or anything else. Only it is no use that we recognize it, if we can’t do anything then.’ (OMAHA-II-2011-t-04, 131ff.)

**Action pattern in (A)**

The dyadic doctor-patient interaction is the paradigmatic situation in the narrations in type (A), with the GPs being supported by their practice team. Worries exist about conflicts of interest between general practice and other professions. E.g., in the following quote a GP explains why he would prefer a case manager within the practice team over an external one:

‘It’s as if made of one piece, and she will have a certain - I also say that, that plays a role as well – loyalty towards me. Yes? More than, I may say, a stranger, who comes there and says ‘Well what? The doctor didn’t prescribe walking training?’
My assistant would never say such a thing, because she knows that I can’t prescribe it, because my budget for physiotherapy is limited.’ (OMAHA-II-2011-04, 228ff.)

Strategies in dealing with competence limits in (A)

We find three different strategies of dealing with competence limits in the group. The first is to define limits of legitimate request quite narrowly. This leads then to the rejection of demands that are perceived to come from public opinion, health-care-system structure or patients directly. An extreme example is one physician’s opinion that from the moment on when a person is in a state of frailty, he or she is no longer the usual patient of a GP. This point of view is tied to the assumption that the person will almost necessarily move into a nursing home and that the ‘normal’ GP is no more responsible from that time on. Other GPs in the group utter frustration about the perceived competence limits that comes close to overburden. In this context the strategy of denying tasks may also be understood as a means of self-protection.

[Through geriatric assessment] ‘Yes, well we are merely picturing the misery, and then we can’t do anything.’ (OMAHA-II-2011-04, 10ff.)

Interviewer: ‘What is it about geriatric conditions that you perceive as challenging?’

GP: [...] ‘that I often feel the patients aren’t sufficiently cared for, just at home, you see? I mean, not from a medical stance, but that they would simply need a little more affective attention, being talked to, and so on. Or that they really don’t cope anymore at home, for example that they don’t eat and drink enough, em, but aren’t in a state yet to receive a care level. I can’t really do anything. I always try to put them stationary in a Rehab, you see? Just to improve the state a little and make people a little fitter. But that is only just a temporary thing, you see? Mostly, when they are at home again, it will be like before.’ (OMAHA-II-2011-21, 78ff.)

The second strategy is budgeting with resources. It ranges from the perfection of office management to rather precarious but permanent workarounds for structural shortcomings, such as redistributing time resources:

‘If you’ve got as many as possible young and healthy who only come with a cold occasionally, then you can work up a bolster allowing you to speak longer times with the others – that’s how it basically is.’ (OMAHA-II-2011-p-09, 64ff.)

The third strategy is long-term involvement in supporting change processes as participating in studies or doing research on the development of instruments and practices, active membership in professional and scientific associations.

(B) Herculean task

Geriatric outpatient care is tantamount to comprehensive dedication to the whole of patient well-being to the GPs in group (B) and requires the use of a wide spectrum of means including rather unorthodox ones. Owing to its all-encompassing nature as well as shortcomings in health-care structures and individual circumstances, in the view of these GPs the task of geriatric outpatient care takes on herculean extent.
**Role definition in (B)**

The GPs in this group have an altogether different role-understanding from the first type ((A) ‘maneuvering along competence limits’). They see themselves as companions through the life course.

‘You are the patient’s advocate and you care for all areas of life, considering them in what you do next’ (OMAHA-II-2011-p-17, 589ff.)

It is essential for the fulfilment of their role to be both professionally and personally involved and committed beyond the usual. They report to work overtime and spent large effort on home visits.

‘I dedicate so much time here. No one sees that. If I tell you that I make home visits practically every day before consultation hours, and now, how does the day look like for the rest of today? Well when we’ll be finished now [around six o’clock on a Monday evening] I drive to a home visit first. Then I drive to a clinic and then to a nursing home. Then I drive home to that patient in the wheelchair. Young man. Then I go for another home visit. And then I go home and see that I still write a report. That’s it.’ (OMAHA-II-2011-p-17, 571ff.)

Close familiarity with the patients as well as their social and local surroundings are seen as essential means to fulfil their role.

‘Or, for instance, I brief the savings bank and they will call me and say ‘This cannot be happening, she wanted to draw 25.000’Mark’ [Note: ‘Deutsche Mark’ used to be the German currency before the country entered the Euro-zone.]. […] Well, you have to try and put up nets, otherwise they get lost. And I try and tell at the bakery as well: ‘In case something strikes you as odd, call me!’ Actually, I do also buy my rolls here. And the bakery woman will call me then.’ (OMAHA-II-2011-t-11, 485ff.)

**Definition of professional domain in (B)**

The professional domain of these GPs is wide and holistic. The comprehensive health- and well-being situation of their patients is their scope of action and they adopt a perspective that draws very much on the individuality of each person and situation.

‘You can’t describe a disease in numbers. Because everyone reacts differently to certain things of course. One responds more to attention, the care-related pitfalls, empathy for his suffering. One says ‘I am entitled to this, I’ve paid my ten Euros after all, I want the full program of medication, all there is!’’ (OMAHA-II-2011-p-17, 36ff.)

**Action pattern in (B)**

Quite similarly to the understanding in type (A) the interaction pattern is physician-centered. Although they undertake it to activate patients’ social environment, it remains the doctor who is the center of action. In contrast to the first group, however, the

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1 By the time of the interview, German patients were required to pay a practice fee of ten Euros per quarter at the first visit in the time period.
interaction pattern is also expansive. I.e., the range of possible moves is extended widely beyond what is formally required, beyond what is strictly necessary in the medical sense, and beyond what is covered by health insurance.

‘Well, I actually have gone as far as to not just make a home visit with older folks but sometimes also to go shopping for them. Yes, I get going and bring some food, so they would have something in the fridge once in a while.’ (OMAHA-II-2011-p-17, 188ff.)

The explicit reason for acting in this way is often the great need encountered with patients in precarious situations. The action pattern implicates high costs in terms of personal involvement, time and money as explained in the following quote. It is concerned with a situation where a patient was found incapable of remaining alone in the proper housing.

‘I employ medical assistants. In a case like this, they will sit and phone the insurance and the nursing home. That is actually not their job. And I pay. The correct way would have been for me to get the patient into hospital with some constructive diagnosis – wouldn’t have been in her interest, especially as a geriatric patient.’ (OMAHA-II-2011-t-10a, 125ff.)

In accounting for the expansive character of the proper actions, the use of knowledge from earlier experience and further training as well as a consciousness of precarious aspects to it are reported.

‘I always counsel concerning advance health care decision; simply because I can and know. But I don’t know on what slippery legal ground I may be.’ (OMAHA-II-2011-t-10, 141ff.)

Opposition towards economic motivation and bureaucratic structures in (B)

The GPs in group (B) point out how their efforts are about responding to personal needs in an appropriate, namely human manner and out of an intrinsic motivation rather than for economic benefit. At the same time, remuneration and health insurance structures are perceived as reducing health matters to economic issues and consequently debasing patients to cases.

‘Yes, well I am supposed to be more economic. Whether patients fall by the wayside thereby is a second question. That’s my responsibility again, not the health insurances’. [That is] The straight statement that doctors still deal with people and insurances juggle with numbers which then aren’t realizable, not as they wish.’

(OMAHA-II-2011-p-17, 31ff.)

The GPs show an affinity towards rather informal, quick-way structures that offer great closeness to the patient’s life-world.

[I wish for] ‘a less complicated social structure, where you could just call and say: ‘here, I don’t know how to go on’. Just as I said like once, where I grew up, nurse Sigrid, who was simply there and went around on her bicycle. That can’t be, I know that after all. But that I have an office for social services all open access and that I don’t always have to go via cost units.’ (OMAHA-II-2011-t-10, 637ff.)
(C) Cooperation and networking

GPs in this group share the idea that the complex care needs of geriatric patients can effectively be dealt with when the GP is cross-linked to a comprehensive set of other professional services and actively engages in building up and/or using networks. The GPs understand the limits of their own service to the patient not as limit of geriatric outpatient care but more as points where another provider takes over.

Role definition in (C)

The GPs in this group define their role quite similar to that in group (A) as that of medical experts. However, in contrast to group (A) they are cross-linked to other actors important for geriatric outpatient care and see this as an essential part of their role. They understand themselves as hubs in a network. And the benefits of this kind of cooperation are also perceived of as professional successes.

‘We have developed a net of institutions over time, with which we work together, so that we can make offers according to needs. You see, there is the day-care clinic and mobile rehabilitation. We have a number of settled physiotherapists, occupational therapists, and neuropsychologists with whom we work together quite well. Not to forget the coordination center so that you can actually offer something for every constellation. Well, not always, but that would be the ideal case.’ (OMAHA-II-2011-p-07, 52ff.)

This enables them at the same time to focus their own work on the medical issues in the narrower sense. So we have an aspect of comprehensive commitment combined with a narrow definition of role that also serves as means against overburdening.

Interviewer: ‘Do you give counsel on advanced health care directives yourself?’

GP: ‘Seldom. Frankly I lack the time. Because that is such a complex issue and one should do it reasonably. And it is all about values and stuff, not specifically about medicine in my opinion. So I always point out that each institution you feel related to ethically, religiously or else provides information nowadays – however they look then – pre-formulating things according to the proper understanding of the world. […] And for the rest, if medical questions remain, I offer that one can talk it through with me again.’ (OMAHA-II-2011-p-07, 102ff.)

Definition of professional domain in (C)

The professional domain is as wide and holistic as in group (B) in the sense that the complex patient situation and well-being is regarded as the proper subject matter. As already shown, this is often accomplished by the induction of interventions by other actors. Hence, here we see a difference in their definition of the professional domain to that of group (B): despite the comprehensive perspective on the patient, the GP concentrates his/her own direct activity on medical issues. And then in addition to it, group (C) regards it as one of their tasks to understand enough of non-medical aspects, to know to whom they should pass on the baton.

‘Yes, well we are very happy in the first place, that we have the case manager whom we can send at times to do a home visit, which perhaps is not yet medically necessary, to sort out the pitfalls at home – need for assistive equipment, such
stuff. And to see also whether or not applying for a care level may yet be sensible. Especially people who are all alone perhaps. […] Of course, in the event of doubt, that is good afterwards and necessary for care and escalation of assistance. That when you realize somebody needs more care, that you can do more.’ (OMAHA-II-2011-p-22, 57ff.)

**Action pattern in (C)**

The work-ratio of the GPs in group (C) is cooperative. Using and building up institutional networks is distinctive for them. Referral or making contact appear as services in their own right to a far wider extent than in the other two groups.

‘For sometimes you can do simple things. To make the connection with the church parish again when someone says ‘spiritual live is so important to me and somehow I don’t get in contact anymore’; or other things.’ (OMAHA-II-2011-p-07, 572 ff.)

**Expectations and reflection on cooperation in (C)**

As seen above, the GPs in group (C) share rather positive expectations towards benefits of ‘cooperation and networking’ and higher trust in other actors’ impact compared to the two other groups. This includes also positive expectations regarding the possible transfer of expertise from other fields to general practice.

‘I notice increasingly that it is a curious thing that the care sector is much more advanced in these assessment-areas than medics are. Care is trying to manage very much evidence-based and has generated a pile of instruments there. […] There’s more circulating than you would expect as a doctor and perhaps it were reasonable to take up one or two things, yes, into everyday practice.’ (OMAHA-II-2011-p-20, 130ff.)

Yet, they also reflect on challenges and prerequisites for good cooperation.

‘Especially in case of dementia it is obvious that the caregivers – professionals or family members – have the decisive role in the communication with the patient. I can recognize or try to evaluate certain risk potentials only through the information of the caregiver. The patients are often less capable of recognizing their own wishes or afflictions, and insofar the key is intense observation of the diseased and the daily contact, which is clearly the role of the caregivers. So as a GP you depend much on being informed well and knowledgeably. And whether that occurs is very different.’ (OMAHA-II-2011-p-20, 168ff.)

‘Sometimes it is not that the professional qualification is insufficient but rather the social competency. Yes, taking the telephone after-work, because the doctor’s consultation is only in the afternoon and you are already finished. That means you well have to overcome your weaker self. And someone does while another doesn't. And so I have to say cooperation can be quite different.’ (OMAHA-II-2011-p-20, 165ff.)
Discussion

It will already have occurred to those readers who are familiar with geriatric medicine, that the definitions of role, domain and action pattern of type (C) come closer to the picture of a geriatrician than the other types. This was our impression when we finished the typology and in the following we will underpin this by drawing on the 2004 position statement of the European Union Geriatric Medicine Society (EUGMS) [5]. As it is edited by one of the world's large international geriatric societies and explicitly covers a concise definition of geriatric medicine and a list of skills required by a geriatrician we rely on the text as an appropriate reference point for our analysis. We extracted the following quotes as key-statements on the subjects of general role definition, definition of the professional domain, and action patterns, i.e. the dimensions of the typology.

‘A geriatrician combines obtaining a sound medical and social history with the ability to comprehensively assess and examine older patients, paying particular attention to atypical presentation, co-morbidity, functional assessment and polypharmacy.’ (p.192) He 'directs and advises a multidisciplinary team in a patient’s treatment, rehabilitation and long-term care plan where necessary, respecting at all times the expertise and skills of other professionals.’ (p.191)

According to this quote one could summarize the general role of a geriatrician according to EUGMS as that of the specialist in geriatric medicine who leads a multidisciplinary team. Regarding the definition of the professional domain the statement says:

‘Geriatric medicine can be described as ‘the specialty for health related problems in older people [...] The term ‘health related problems’ emphasizes the interaction between physical, mental, emotional, social and environmental aspects.’ (p. 191)

‘The geriatrician has knowledge of palliative care, of health promotion and preventative health care and of the local social support system.’ (p.191)

In the context of our typology this should clearly be summarized as a wide and holistic definition of the professional domain.

‘Geriatric medicine demands multidisciplinary teams of specially trained geriatricians, nurses, physiotherapists, occupational therapists, speech therapists, social workers, psychologists and dieticians in both the community and hospital settings. [...] The EUGMS recognizes the importance of developing nursing and professions allied to medicine. [...] The EUGMS is well aware of the need for cooperation with other hospital and community specialties, both for training and the implementation of new technology and ideas, in order to guarantee the availability of modern medicine for all older people.’ (p.192)

The demand for active exchange and interaction with other professions and institutions for the benefit of care and exchange and enhancement of expertise are stated here in a clear manner. Thus we can speak of an action pattern of cooperation and cross-linking as the proclaimed norm. So we see in the following figure that in our typology type (C)
coincides in two dimensions with the picture of the geriatrician as drawn by the EUGMS statement.

- Table 2 -

We have set out to explore GPs’ views of geriatric outpatient care and found three types of views within the sample, distinguished by different perceptions of the own role, the professional domain, and action patterns. The provision of geriatric outpatient care is perceived of either as ‘maneuvering along competence limits’ (Type (A)), as ‘herculean task’, (Type (B)), or as a task of ‘cooperation and networking’ (Type (C)).

When we talk about action patterns, however, we solely rely on the GPs self-reported assertions. Within our study we have no external source to describe behavior, e.g. actual frequency of cooperation. So we do not have independent data to assess the process and outcome of care quality provided by the GPs in the sample. Focus on single diseases rather than complex situations may produce adverse outcomes [26]. Thus the narrow definition of the professional domain may be of disadvantage for patients. The impact of different sets of definitions of the own role, of tasks and modes of action on actual behavior and quality of care needs to be examined in future research studies applying quantitative methods and assessing objective criteria (such as mortality or declines in health status) as well as patient-centered subjective criteria (such as quality of life, or overall wellbeing).

Regarding the sample, we also face limitations. The size of the groups in our sample, though regular for a qualitative study, cannot serve as a basis for estimations about the distribution of the represented types among GPs in Germany in general. For example, it may well be that there are many more GPs with a very high degree of commitment such as in the group ‘herculean task’ than other [27]. And there might also be additional types to be found. Also, due to our initial hypothesis, our analysis is partly focused on differences in relation to the degree of geriatric qualification and does not integrate such potential influential factors as age, gender, years of professional experience as a GP, or location of practice (city or rural area), that may well affect the expectations and attitudes of GPs towards professional issues [14].

The typology supports the initial hypothesis that geriatric training has a major impact on how the GPs perceive of geriatric outpatient care and their own tasks in it. All of the members of group (C) are trained and/or experienced in geriatrics and refer to geriatric knowledge and standards in their narrations. Especially one of these GPs reflects about how the training in geriatrics changed the way of dealing with patients. We assume that the training is indeed an important factor in inducing a paradigm of cooperative working and foster a professional self-image such as in the type (C) group, and do rather not assume that the GPs in the group have had an altogether different understanding of their role and tasks in the first place.

However, there was one case of one GP who is a fully trained geriatrician and yet holds rather strong reservations against institutional cooperation. Instead we find the typical mindset of group (B) in this case. There is no necessary step from undergoing geriatric training to developing a certain mindset. Drawing on the individual case analysis, we can find actual and/or perceived lack of essentially helpful or only competent institutional cooperation partners in the surrounding of this GP’s practice as a factor thwarting the
options for establishing networks. The case could albeit also point to the possibly strong
impact of role definitions once they are established. The depth psychological importance
of professional self-images of GPs for developments in the whole area of geriatric
outpatient care has been stated before [28]. Our study supports the finding that definitions
of the own role (whether conscious or not) serve to justify the exclusion and inclusion of
certain sets of services. In turn, the belief that the role definition is ‘the norm’ in the sense
of ‘what ought to be’ is stabilized by the fact that the exclusion of certain services is
common over a certain time. Viewpoints and practices unfold self-stabilizing dynamics,
immunizing against the demand for change, and have been described as ‘causal loops’ in
the establishment of conventions among GPs as well as in patients [29]. A deeper
approach in future studies should enlighten more factors in individual developments.

We have presented the phenomenon of declining tasks that are tied to comprehensive
geriatric care in type (A) under the title of coping with competence limits. In one
perspective we can see this as a causal loop or as the self-stabilizing nature of blind spots.
For example, a lack of interest in specialized services offered by non-physician health
care professionals increases a lack of knowledge about such services, which in turn
makes the option of cooperation even less interesting. A similar phenomenon of
excluding certain tasks is found by Melchinger and Machleidt [19] in their study on
dementia-care by German GPs. They also analyze this as a strategy in coping with
competence deficits and cite justifications analogue to our own findings: skepticism
towards the benefit of therapeutic efforts and an unawareness of specialized services
offered by other health care professionals. From another perspective suggested by our
interviews, the declination of tasks is the result of an effective and highly needed strategy
of self-protection against overburdening and frustration on the side of the GPs. This is
highly rational, if we consider that in the discussion about the adaptation of general
practice to geriatric outpatient care there is a risk of (re)stylizing the GP as a mythical
‘über-doctor’ who is the diagnostic filter before specialist treatment, gatekeeper to any
further care, and primary reference person for any life world questions [28]. Examples of
GPs as in group (B) with their high self-expectations and commitment may well foster
the concern in their colleagues, that embracing the tasks of comprehensive approaches to
geriatric outpatient care is likely to lead straight to definite over-burdening. This might
explain reservations against the demanded change that function as barriers to it. Thus,
more attractive other role-models should be promoted in the context of the demanded
changes. Geriatric training might be one way to do so but more should be found.

Although we see the importance of role- and task definitions for the representation of
geriatric outpatient care and impact of different representations on geriatric outpatient
care, remuneration modalities appear in all interviews as structuring conditions for GP
activities and decisions, even if the GPs take very different stances towards them. The
high degree of orientation at compensation structures in group (A) has already been
described in detail as have been the efforts in group (B) to compensate limited resources
by personal commitment. In group (C) we can observe efforts to build up networks which
may be interpreted as a bottom-up initiative to establish structures more apt for
comprehensive geriatric outpatient care. On the other hand we find that even among GPs
with this approach and a cooperative working paradigm, the degree to which they
succeed in altering their working routines and living up to their own ideals is reported to
be quite limited by the conditions they find themselves in. Only one of the three GPs in
group (C) was at the time of the study in a position to rely on such a network as she should like. She was the only one to regard her practice as one with geriatric focus. This included offering a physician-conducted extensive geriatric assessment as a regular service. In the cases of the other two, there was a big gap between aspiration and reality – according to their own evaluations clearly due to budget restrictions. This is in line with earlier findings that the mode of remuneration is a primary influence on GP behavior [29] and with the demand for the development of adequate compensation systems for comprehensive, patient-centered primary care [30], including performance metrics allowing to reward quality of care [26]. The need for this has been emphasized especially for aging populations with complex care needs and need for specialized services such as geriatric or palliative care [27, 31, 32]. According to all GPs in the study, the current remuneration-logic is a barrier to the delivery of comprehensive geriatric care.

Conclusions

This qualitative interview-study with ten German GPs unearths three different ways of how GPs view outpatient care for geriatric patients, identifies barriers for the development towards comprehensive care in general practice and suggests possible strategies for improving geriatric outpatient care.

In combination with specific definitions of the own professional role, the professional domain, and action patterns regarding cooperation and networking, respectively, the provision of geriatric outpatient care is perceived of as ‘maneuvering along competence limits’ (Type (A)), as ‘herculean task’ (Type (B)), or as a task of ‘cooperation and networking’ (Type (C)).

The findings give reason to assume that geriatric training is one important factor for enhancing the contribution of GPs to multidimensional and multi-professional comprehensive care for geriatric outpatients. Therefore, the beginning implementation of GP-targeted advanced training is a promising basis for positive development. The definition of the own role and tasks should be addressed explicitly as a part of professional training. Among the interviewed GPs, we find in part a declination of tasks related to the provision of comprehensive geriatric care and analyze it as a strategy of self-protection – mainly against overburdening. This supports the idea that changes in geriatric outpatient care can be promoted by making possibilities known of how to provide comprehensive outpatient care without increasing the workload. Apart from the need to raise awareness among GPs regarding cooperation in general, however, the health care system itself should also establish and strengthen such structures. For example, more recent advancements in German legislation such as Case Management and ‘care mentoring’ (German ‘Pflegeberatung’), center their attention directly on individual patient’s needs and wants and provide active assistance and counselling regarding health care and care-related alternatives (cf. §§ 7a and 92b Sozialgesetzbuch Elftes Buch/Code of Social Law XI). Rather than installing parallel structures offering support to older patients, resources should be used to strengthen an interprofessional primary care network. Incentives for cooperation and networking could possibly help to foster delegation across professions, thereby easing the burden upon single GPs. On a more basic economic level, the more complex patient setup in geriatrics needs to be respected: the reimbursement-structure should account for the fact that more time is essential for
adequate examination and medical history taking in older patients.
Within these frameworks, finding a realistic perspective and manageable understanding of one’s role appears to be the future core challenge on the side of GPs in geriatric outpatient care.

**Abbreviations**

GP: General practitioner; EUGMS: European Union Geriatric Medicine Society

**Competing interests**
The authors declare that they have no competing interests

**Authors' contributions**
All authors have substantially contributed to the initial design of the study and have critically revised the questionnaire for the semi-structured interviews and data interpretation as well as drafts of the article at various stages. All have given their final approval of the version to be published and agree to be accountable for all aspects of the work. In addition to this there were the following areas of focus:

AH conducted all interviews, transcribed them and did the most part of data analysis. She drafted the first versions of the methods, results, and discussion sections.

MH drafted the first version of the background section.

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**References**


### Tables

**Table 1 – Three types of views**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>(A) ‘maneuvering along competence limits’</th>
<th>(B) ‘herculean task’</th>
<th>(C) ‘cooperation and networking’</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) GPs perception of their own role</td>
<td>solitary medicine expert</td>
<td>companion through life</td>
<td>cross-linked medicine expert</td>
</tr>
<tr>
<td>(2) GPs definition of their professional domain</td>
<td>narrow, fragmented</td>
<td>wide, holistic</td>
<td>wide, holistic</td>
</tr>
<tr>
<td>(3) GPs action patterns in geriatric outpatient care</td>
<td>physician-centered</td>
<td>Physician-centered, expansive</td>
<td>cooperative, cross-linking</td>
</tr>
</tbody>
</table>

**Table 2 - Comparison with ideal-typical geriatrician**

<table>
<thead>
<tr>
<th>Dimension</th>
<th>(A) ‘maneuvering along competence limits’</th>
<th>(B) ‘herculean task’</th>
<th>(C) ‘cooperation and networking’</th>
<th>geriatrician according to EUGMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) GPs perception of their own role</td>
<td>solitary medicine expert</td>
<td>companion through life</td>
<td>cross-linked medicine expert</td>
<td>geriatric specialist, leader of a multidisciplinary team</td>
</tr>
<tr>
<td>(2) GPs definition of their professional domain</td>
<td>narrow, fragmented</td>
<td>wide, holistic</td>
<td>wide, holistic</td>
<td>wide, holistic</td>
</tr>
<tr>
<td>(3) GPs action patterns in geriatric outpatient care</td>
<td>physician-centered</td>
<td>physician-centered (expansive)</td>
<td>cooperative, cross-linking</td>
<td>cooperative, cross-linking</td>
</tr>
</tbody>
</table>