

Advocates of the Poor:

an ethnographic study of the lived experience of a selection of Irish General Practitioners

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Abstract

This thesis, 'Advocates of the Poor', presents an ethnographic study of the practices of Irish general practitioners (GPs) who deliver primary care to marginalised populations, including individuals who experience rural isolation and loneliness, homelessness, addiction, asylum-seeking, systemic exclusion and inability to access secondary healthcare services. Framed within the discipline of human geography, the study interrogates the spatial, relational, and ethical dimensions of care provision in contexts marked by precarity and institutional constraint.

Drawing on immersive fieldwork, semi-structured interviews, and participant observation, the research foregrounds the lived experiences of GPs whose work frequently transcends conventional clinical boundaries. Research participants engage in forms of care that are mobile, improvised, and deeply relational, often operating in informal and under-resourced settings. The study critically examines how such practices reconfigure the geographies of healthcare and challenge dominant models of biomedical governance. It also shows how GPs themselves draw strength from 'making a difference'.

The thesis contributes to debates in health geography and critical medical anthropology by conceptualising general practice as a spatial and political act. It argues that the provision of care to marginalised groups constitutes a form of placemaking and resistance, wherein GPs navigate and reshape the socio-material landscapes of Irish health policy, austerity, and migration. The analysis reveals how GPs mobilise ethical commitments and professional autonomy to mitigate structural violence and advocate for more inclusive forms of healthcare.

By situating general practice within broader socio-political and spatial contexts, including the COVID-19 pandemic, this research suggests a nuanced understanding of primary healthcare as a situated, contested, and transformative practice. It offers original insights into the everyday geographies of solidarity enacted by GPs working at the margins of the Irish healthcare system and calls for a reimagining of primary care as a site of both medical intervention and social justice.

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Chapter One: Introduction

1.1 Introduction

1.1.1 Thesis overview

Despite policy initiatives in Ireland emphasising the importance of primary care for all citizens, the lived experience of General Practitioners (GPs) and its capacity to influence both the quality and the sustainability of primary care remains relatively obscure. This thesis critically examines the lived experience of a selection of Irish GPs from the health geography perspectives of place making and landscapes of care. Furthermore, it foregrounds the everyday healthcare practices regularly deployed by GPs against the backdrop of their annihilation during the early stages of the COVID-19¹ pandemic in 2020-2021. The theme of care and caring has been developed within Health Geographies (Parr 2003, 212–221) and in the understanding of place as a ‘field of care’ within Humanistic Geographies (Tuan 1979, 387–427). Much of the caring done in life is an ambient part of family and community living; to some it’s ‘something you just do’ (Milligan and Wiles 2010, 737). All healthcare delivered by GPs, however, must be at the standard of contemporary best professional practice, a challenging mandate in the face of expanding scientific knowledge, therapeutic advances and the increasing inequity that affects patients. The Inverse Care Law which states that ‘the availability of good medical care tends to vary inversely with the need for it in the population served’ (Tudor Hart 1971) still holds true in 2026. As patients’ healthcare needs continue to rise alongside a continuously

¹ Whereas COVID-19 was its official title, it was often referred to in the vernacular as ‘Covid’ or ‘the Covid’. I will use both appellations in this text.

expanding corpus of new scientific knowledge, more is asked of GPs who must contend with these challenges.

While GPs enjoy significant public trust, participants in this research claim that ‘Nobody knows what we do’. The Edelman Trust Barometer 2025 ‘observes a health ecosystem where trust and perceived legitimacy will lead to influence over people’s health decisions’ and goes on to report that ‘health trust is local’; people trust their own healthcare provider (Edelman Trust Institute 2025). A vernacular notion persists in the public sphere, however, of what a GP is and does. I argue that this is grounded, to a significant extent, in the viewpoint of people who, due to their own good health or financial constraint, do not consult GPs. My conceptual framework has been shaped, in the first instance, by working as a GP in an earlier career and listening to public discourse about GPs while being privy to my colleagues’ privately-held, opposing views. It was reinforced by doing MA research in 2018 that showed the highs and lows of GP experience in rural Ireland. It asserts that GPs have an inner life, well concealed by their professional demeanour, which warrants revelation within an anonymised, academic text. The conceptual framework also noted the issues facing retention of Irish trained GPs in Ireland and queried what might be the factors that currently render GP part-time (portfolio) careers more sustainable than full-time. It is on the ethnographic and theoretical task of making visible the lived experience of Irish GPs that this thesis is focussed.

In ‘Advocates of the Poor’, I propose to discern the lived experience of Irish GPs who care for marginalised people, whose voice is largely absent from academic literature since general practice has conventionally been researched in medical and economic rather than in experiential terms. Literature on policy, patient outcomes and therapeutics prevail over the voice of GPs making meaning of

their lived experience. But in the absence of this voice, primary care policies and planning lack solid foundations.

1.1.2 Thesis aim and research questions

The overall aim of this thesis is to explore the lived experience of a selection of Irish GPs whose practices are orientated mainly towards their marginalised patients. It aims to

- Understand the *raison d'être* of the exceptional GPs who challenge the prevalent neglect of marginalised patients.
- Show how intersubjectivity between GP and patient gives meaning to these GPs' lifeworlds.
- Foreground the deep relationships created by continuity of care which not only give great joy to GPs but can trouble them when their advocacy falls short of solving patients' problems.
- Highlight how events in their patients' lives affect GPs themselves; how they manage the upsets, how they balance their lives, how they manage to endure over decades- long careers.
- Acknowledge GPs' creativity in representing their patients' needs and report their fulfilment in augmented doctor/patient relationships that surpass mere transaction.

This thesis has three broad research questions:

1. How do General Practitioners who care for marginalised people in Ireland describe and make meaning of their working lives?

This question asks what GPs do and then interrogates why they do it. It emerges from humanistic health geography and centres the thesis on GPs' own narratives.

2. How do GPs' routine practices of care make place for their patients and their communities?

This question asks if and how GPs can be positioned as active geographical agents, not just service providers. It emerges from geographical concepts of place and placemaking, therapeutic landscapes and landscapes of care.

3. How do GPs experience, navigate and resist inequality, inequity and power relations in order to deliver best practice care to their underserved patients?

This question asks how GPs are positioned and position themselves as agents to make life more liveable for people who carry the weight of structural violence, inequality and inequity. It also interrogates the power relations that construct the milieu in which GPs conduct each and every consultation.

In order to answer these research questions, I carried out a series of semi-structured interviews with thirty-one GPs over a two year period which was interrupted by the COVID-19 pandemic and its restrictions. The draft questionnaire is in Appendix B. Travel to inner-city and remote parts of rural Ireland to visit research participants (RPs) in their own hinterland and workplace heightened my spatial awareness of their lifeworld and confirmed to me that in primary care, geography matters. To capture GPs' wide range of

lived experiences, interviews were coded inductively using Braun & Clarke's reflexive thematic analysis (2022). An (auto)ethnography of the COVID-19 pandemic was written because

- i. I worked as a clinical contact tracer (CCT) for the Health Service Executive (HSE) for six months during the COVID-19 pandemic: the experience threw into sharp relief my insider/outsider researcher positionality.
- ii. GPs recounted how they had repeatedly made requests of Government/HSE which had fallen on deaf ears. Once the pandemic escalated, however, funds were found and services were provided without delay. GPs were supported in an unprecedented manner and were duly acknowledged, not only for their key role in continuing primary care and rolling out the vaccination programme, but also for the validity of their claims.

The next section of this chapter (1.2) provides a brief overview of Irish healthcare to situate the thesis; the GP role is best understood with regard to the whole system. In Section 1.3 I move to describe poverty and marginalisation (1.4) and how these entities configure the lives, both of patients and of GPs – 'the second victims' [RP28].

1.2 Outline of the Irish healthcare service

1.2.1 Since the foundation of the State in 1922

Since the creation of the Irish Free State on 6 December 1922, serial governments have accepted the pledge of the 1916 Proclamation of the Republic to 'cherish all the children of the nation equally' (Government of Ireland 1916, 2013), an

ambition not yet achieved. Barrington's magisterial book on 'Health, Medicine and Politics in Ireland 1900–1970' tracks the evolution of healthcare in Ireland in the twentieth century, tracing the contributions of politicians, church leaders, evolving science and medical practitioners along the way (Barrington 1987). The availability of Streptomycin in 1947, the first antibiotic to treat tuberculosis (TB), took TB out of the realm of individual illness and platformed it as a matter of public health. Early attempts to introduce a more equal NHS type system emerged unsuccessfully around the same time. Power struggles between Noël Browne, Minister for Health from 1948 to 1951 and politicians who represented the vested interests of both the Catholic church and private medicine resulted in Browne's forced resignation, reinforcing power struggles, the vestiges of which are still at play today (Barrington 1987, 201–219; Wren 2003, 32–39; Browne 1986, 156–172; Deeny 1989, 174–178). Extreme poverty underpinned the prevalence of TB and other infectious diseases until the General Medical Services (GMS) were introduced in 1970 (Government of Ireland 1970). Uneven economic development has bequeathed a legacy of social disadvantage in small towns and in rural areas (Walsh 2023, 9) while homelessness has become a chronic problem in larger towns and cities due to financialisation of the housing market (Hearne 2020, 161). Successive economic policies led to a state of health inequality in 2017 (Rigby et al. 2017). After the 2008 economic crash, geographers examined the spatial justice implications of the crisis and the uneven recovery (G. Kearns, Meredith, and Morrissey 2014). It must be noted that at the time of writing, Ireland is among the wealthiest countries in the European Union (FitzGerald 2023, 21). Increasing inequality, however, has further eroded the lot of certain cohorts of marginalised people; this will be evidenced by GPs in the empirical chapters.

1.2.2 Structure of the Irish healthcare system in 2025

As determined by Bunreacht na h-Éireann, the Constitution of the Irish Republic (Ireland 1937), the government is led by the Taoiseach (Prime Minister), who appoints a Cabinet of fifteen government ministers and a variable number of junior ministers. Since the foundation of the state, there has always been a Ministry for Health whose minister reports directly to the Taoiseach. The current Minister, Jennifer Carroll McNeill, was appointed with the present government on 25 January 2025. She is assisted by three junior ministers, one who holds the brief for mental health, one who is responsible for public health, well-being and (illegal) drugs and a third, Minister of State for older people. As this thesis will show, some other ministries intersect with the healthcare brief. The Minister for Education and Youth oversees children with psychiatric problems who come to light through the education system. The Minister for Children, Disability and Equality, likewise, has responsibility for many of the people who are patients of this project's research participants. Healthcare is expensive, so the Minister for Finance and the Minister for Public Expenditure, Infrastructure, Public Service Reform and Digitalisation need to be well disposed towards capital and operating expenditure in the area of healthcare. The Minister for Health and her junior ministers are responsible for government healthcare policy and legislation.

The Health Service Executive (HSE) was established in 2005 with sole responsibility for implementing government-funded healthcare. The HSE is the biggest employer in Ireland and currently employs c. 150,000 people in WTE (whole-time equivalent) roles and a further c. 163,000 people in part-time and non-WTE roles. In March 2024 it was reorganised into six new Regional Health Regions, Dublin and North-East, Dublin and Midlands, Dublin and South-East, Mid-West, South-West and West and North-West. It was envisioned that a more

geographically specific, person-centred health and social care could be delivered by the integration of services in accordance with local need. The reorganisation takes its mandate from the 2017 health-care action plan called Sláintecare² which, since its inception, has become the compass for healthcare reform (Shortall 2017).

Healthcare in 2025 accounted for 21.5% of the Irish government's annual expenditure (€25.8 billion) and social protection for 22.4% (€26.9 billion) (Government of Ireland 2025). It follows, therefore, that these services are carefully planned, rigorously costed and subject to regular review. Primary Care Reimbursement Service (PCRS) accounts show that in 2024, €955,415,454 was paid to Irish General Practitioners, representing a figure just short of €1 billion euro, less than 4% of the annual budget (HSE 2024f). Under this heading, GPs were paid for capitation fees, medical indemnity insurance, rural practice grants, capitation for illnesses such as asthma and diabetes, out-of-hours work, secretarial and nursing support and several miscellaneous allowances³.

1.2.3 Sláintecare

Sláintecare might, in geographical language, be termed an exercise in therapeutic placemaking. In June 2016, the government appointed a cross-party group to the Oireachtas Committee on the Future of Healthcare. They produced the Sláintecare report in May 2017, proposing a ten-year road map towards a universal, single-tier healthcare system based on medical need, not ability to pay (Shortall 2017). Core strands include the abolition of the two-tier healthcare

² Sláinte is the Irish word for 'health'.

³ On publication of these figures every year, members of the public complain that their GP 'earned' X amount. GPs then reply that the income paid to the GP as a private contractor to the HSE covers all the Practice staff incomes, building expenses, heat, light etc.

system (outlined in Section 1.5), universal access to affordable, timely care, a shift of resources from hospitals to the community and the expansion of palliative care. The Sláintecare Implementation Office was set up within the Department of Health in 2018, and a Sláintecare Action Plan published in 2019 (Department of Health 2019). The COVID-19 pandemic stymied its rollout from January 2020, but long before this, a series of high-profile people joined the management team and left in rapid succession. Nevertheless, the pandemic expedited the roll-out of community diagnostics and tele-health facilities, which RPs acclaim throughout this dissertation especially in Chapter 6. Burke et al. (2021) have documented how, despite appearances to the contrary, the government's response to COVID-19 remained true to the policies of Sláintecare throughout the pandemic. However lofty the ideals and aspirations of any administration, poverty is a constant in human society with particular manifestations in Ireland that deserve elucidation and it is to these that I now turn.

1.3 Poverty and healthcare

History is replete with accounts of famines and natural disasters alongside the rise and fall of civilisations and the trades that filled their coffers. At any time, ideology determines who deserves to live and thrive, to suffer and to die (Sen 1987; Sen 2009). Although the name of Malthus is not on the tip of every Irish tongue, we bear a cultural memory of how his concept of the deserving versus the un-deserving poor created unnecessary suffering during and for a long time after the 1847 Great Famine, (Crowley, Smyth, and Murphy 2012, 87; Kinealy 1994, 11). In the early nineteenth century, the Irish Poor Law (1838), modified from the English Poor Law (1834), was based on the belief that poverty in an able-bodied person was a self-inflicted, moral failing and that they should earn their poor relief (Cassell 1997). At that time, Dublin was already served by

charitable infirmaries bequeathed by Protestant donors.⁴ The Medical Charities Act (1851) provided for the establishment of charitable hospitals in Ireland, beginning an era of Catholic dominance in hospital care⁵ (Kinealy 1994, 294) which is still extant today. Outside the cities, healthcare was now to be provided by the Irish Dispensary system, created in 1851 and divided into 723 dispensary districts in 1852 with a medical officer appointed to each dispensary (Barrington 1987, 7–8). Over time, dispensary doctors were tasked with such therapeutic interventions as were afforded by contemporary scientific progress: smallpox vaccination in 1864, registration of births and deaths in their districts, supervising the district midwife, surgical antisepsis and ‘control’⁶ of infectious disease (Barrington 1987, 9–12). Dispensary doctors of the past were the forerunners of today’s GPs. I cite these dates as a reminder of the progress made in healthcare over six generations. It is far too easy to forget how far we have come and what it takes to sustain individual and public health. Poverty and inequality are always, in theory⁷, the subject of planned healthcare and are incorporated into most government systems as a healthcare safety net. Whereas poverty signifies a lack of money or material resources, marginalisation arises from discrimination, stigmatisation and exclusion from decision making. The dignity of the individual is a core consideration alongside the practicality of

⁴ The Charitable Infirmary, Jervis Street, was founded in 1718. Dr Steevens’ Hospital was founded in 1733 and Sir Patrick Dun’s Hospital in 1808.

⁵ Mater Hospital, Cork was founded in 1857, Mater Misericordiae Hospital, Dublin was founded in 1861 and Mater Infirmorum Hospital Belfast, in 1883.

⁶ Ignaz Semmelweiss had discovered the importance of hand washing as an antiseptic procedure in 1847, but his ideas were slow to gain traction in the medical profession. John Snow’s breakthrough findings on the epidemiology of cholera in 1854, Louis Pasteur’s work on fermentation (1857) and Robert Koch’s isolation in 1882 of *Mycobacterium tuberculosis*, which causes TB, ushered in the era of hygiene and antibacterial therapeutics.

⁷ Each successive Minister for Health initiates new strategies for healthcare. Wren itemises these aspirational policies and forensically analyses their shortcomings in terms of what was actually delivered (Wren 2003).

improving general public health. Policy makers, however, must use deprivation indices to determine levels of need in a population.

1.4 Marginalised people

Poor is lacking in material resources, marginalised is shunned, precarious [RP01].

The terms ‘marginalised people’ or ‘deprivation’ were rarely used by GPs who participated in this research. These categories provided the framework that I chose when planning and deciding whom I would approach for interview. Because GPs in Ireland can set up in practice wherever they choose, most GP Practices will have a mix of income groups in their patient populations. City and suburban practices located geographically in areas of deprivation usually have a predominance of poor patients; remote rural areas are similar in that regard, except that they may earn some private fee income from tourism in summer. It follows, therefore, that GPs in this research have mixed cohorts of marginalised and better-off patients in their practices. My object of enquiry was the GPs themselves rather than their patients.

The axis of inequality in Ireland is graded in a sophisticated, yet accessible manner by Haase and Pratschke’s Deprivation Index (2016; 2017), now known as the Pobal HP Deprivation Index (Pobal 2023) and widely used by policy makers. Derived from census and other data, this allows a mapping of multiple deprivation for the Republic of Ireland (see Figure 1):

Based on earlier deprivation indices for Ireland, as well as analyses from other countries, three dimensions of affluence/disadvantage are identified:

Demographic Profile, Social Class Composition and Labour Market Situation (Haase and Pratschke 2016, 3).

Each dimension is measured by a number of indicators and computed from data supplied by members of the public at the taking of a national Census, the most recent being 2022, 2016 and 2011. Data are aggregated and mapped at different scales; for the purposes of this research I consulted the Small Area maps, a Small Area (S.A.) being an area with between fifty and two hundred households. There are almost 19,000 Small Areas on this map. Whether the marginalised patient is a rural 85-year-old widower living alone in an isolated, old house that needs a downstairs toilet, or a single mother in a city suburb, caring for her child with autism while awaiting assessment and support from the Child and Adult Mental Health Services (CAMHS), much is demanded of, and given by their GP and primary healthcare team. Because poor people get sicker and have worse outcomes, they visit their GP more often (Smith et al. 2019, 23) . The resulting continuity of care creates a deep intersubjective relationship which can frustrate and worry the GP when their care and advocacy fall short of solving patients' problems. I will show, in the empirical chapters, how these vectors play out in GPs' lifeworlds.

Uneven distribution of healthcare resources is expedited by the Irish two-tier system. Although this inequity warrants a political economy critique, I include it at this juncture to weave a tapestry that depicts the forces which sculpt the lives of patients presenting to GPs every day.

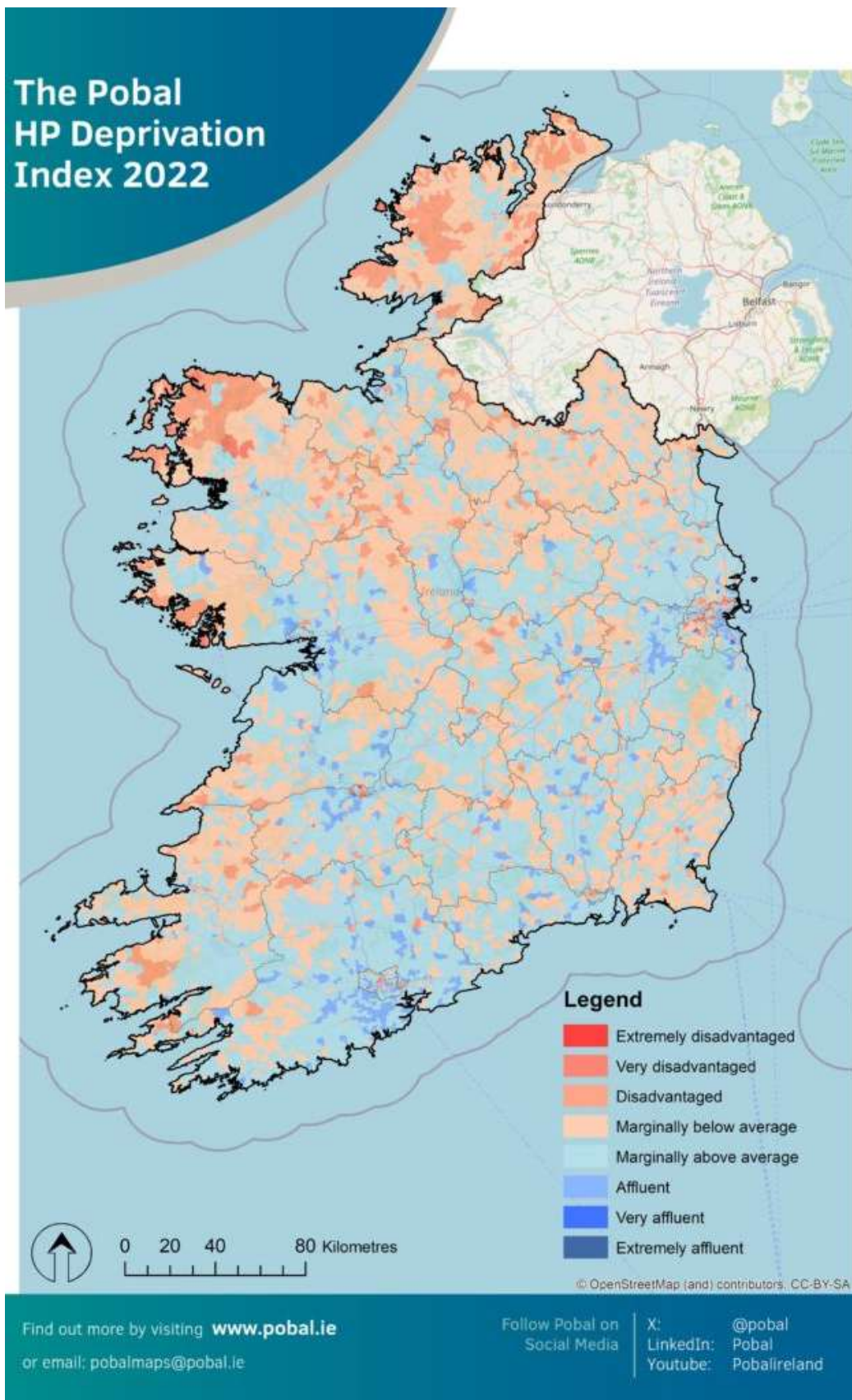


Figure 0-1: Map of the Pobal HP Deprivation Index 2022.

Source: <https://www.pobal.ie/pobal-hp-deprivation>

1.5 A two-tier system

Despite being one of the richest countries in Europe, Ireland is the only European country without universal coverage of primary healthcare (The Lancet Editorial 2025).

As of November 2024, only 32% of Irish residents have access to free primary healthcare either by holding a GMS card or a GP visit card (GPVC). The remainder divide into two groups: those who can afford to pay for healthcare, either out-of-pocket or with the help of a private health insurance company, and those who are deemed both too well off to qualify for a GMS or GPV card and too hard up to afford private insurance. Rather than calling this anomaly a three-tier system, the two-tier framing has become entrenched, based, as it has been, on the dichotomy of those who can pay for healthcare and those who cannot. I will describe the items of service to which those in different groups are entitled, but first, I will explain how the two-tier system came about.

Rich and poor people have always had different levels of access to healthcare. Private and public practice in Ireland from 1650 to 1940 is well documented by Jones and Malcolm (1999) and in the mediaeval period, by Grace (2020; 2021). Private patients were treated by qualified doctors skilled in the latest scientific techniques while the general public were assisted by neighbourly midwives, wise women, bonesetters and herbalists. Since the foundation of the state in 1922, universal healthcare that is free at the point of delivery, based on need rather than ability to pay was the goal of a new republic, and would have to be introduced stepwise, because of cost. Citizens had universal access to all public hospital beds until 1971, when the Minister for Health 'agreed to provide private and semi-private accommodation for those with limited or no eligibility who wanted to be treated as a private patient' (Burke 2009, 27). Hospital consultants could now admit their private patients to a publicly funded bed in a public hospital. A new consultant contract in 1979 (Burke 2009, 30)

gave them the best of both worlds – state salaried, pensionable posts, with the right to unlimited private practice, inside or outside public hospitals. This consultants' contract turned heavily state subsidised, private medicine into a growth industry, encouraged the development of private hospitals staffed by consultants on state salaries and consolidated the two-tier health system of preferential access for private patients in public hospitals (Wren 2003, 57).

The complete lack of a system of accountability enabled consultants to delegate patient care to their non-consultant hospital staff while they saw private patients at a private hospital : a television programme by the public broadcaster RTÉ documented this lucrative practice (Traynor 2018). This scenario prevailed until the introduction of the new POCC (public only consultant contract) in 2023 (Department of Health 2024). It is easy to see how blockages were created in hospitals. When all hospital beds are occupied, nobody can be admitted to a bed until a patient is discharged. Hospital consultants are the only doctors who have the rights of admission and in their absence, patients are not treated in a timely manner. The backflow leads to delays in Accident and Emergency (A&E) departments with queues of ambulances outside, carrying sick people awaiting an A&E bed. Nor can GPs get a timely public appointment for their patient either for hospital investigation or for treatment. The thematic chapters which follow abound with instances of such inequity recounted by GPs who participated in this research. The two-tier status quo of wealthy hospital consultants and supplicant GPs has become embedded in public perception over the past five decades. Burke recounts a merry-go-round of a series of governments, health ministers, policies and statements which 'copper-fastened the two-tier system' while effecting little material change (Burke 2009, 30).

1.5.1 Tier 1: The GMS card

Following the Health Act, 1970 (Government of Ireland 1970), the government introduced the GMS scheme in 1972, allowing those who were entitled to it to choose their own GP- the Choice of Doctor Scheme. GP remuneration was and

is based on a capitation fee and a series of practice allowances that vary in accordance with need and geographical location. Entitlement is determined by means testing, based on a person's weekly income, age, marital status and number of dependents. Chronic illness is factored in too, to cover the cost of doctor visits and prescription medications. Groups automatically entitled to a GMS card include people in receipt of certain social welfare payments, people who receive the Carer's Allowance (who care, full-time, for a dependent relative in their own home) and people in long-term residential care. While all prescription medication is free to GMS patients at the pharmacy, entitlement varies from time to time depending on the particular drugs, the condition being treated and the redrawing of an income entitlement by the government.

1.5.2 Tier 1: The GP Visit Card

The GP Visit Card (GPVC) was introduced in 2005 with a view to providing for people with limited means free-at-the-point-of access GP visits. Since its introduction in 2005, categories of people entitled to a GPVC have been expanded incrementally. In 2015, it was announced that all children under the age of 6 and all adults over the age of 70 became eligible automatically. This policy was resisted by some GP groups who reckoned that the GP service might be over-run, but the Minister prevailed (McDonnell et al. 2022). In 2019, those in receipt of the Carer's Allowance or Benefit automatically became eligible for a GPVC. In 2023, free GPVCs were made available to all children aged under 8 years. Income thresholds were raised, bringing an additional 500,000 people into the scheme (Department of Health 2023).

1.5.3 Tier 2: Private practice

Since this research is concerned, first and foremost, with the lived experience of GPs who care for marginalised people, I did not invite GPs with predominantly

private practices to interview. However, as most GPs have a mix of private patients and GMS patients in their practices, the distinction between their respective situations is one of the significant ‘drains’ [Research Question 3]⁸ in their lifeworld. GPs in this research who have a mixed GMS and private practice described how they dreaded asking a patient ‘How are you fixed for healthcare insurance?’ when the patient’s clinical needs required a secondary care procedure such as cataract surgery to stop them losing their sight or hip replacement to stop them losing their mobility. It is usual for private patients to get a hospital appointment in a matter of weeks whereas GMS patients must wait for a number of years, during which their health deteriorates. Many people in ‘the squeezed middle’ cannot afford to consult a GP at all. The empirical chapters contain numerous examples of this type of healthcare inequality and the extent to which this unfairness not only disturbs GPs but also galvanises them into advocacy. I will cite participants in this research who get very upset when they witness their patient’s health declining, over a period of months or years, because they can afford neither private healthcare nor private insurance.

1.5.4 Miscellaneous other government healthcare payments

Private patients who do not qualify for a GMS card may avail of other healthcare assistance from the HSE. The Drugs Payment Scheme (DPS) allows anybody whose regular prescription medication costs exceeds €80 per month to reclaim any expenditure above this amount. The Long-Term Illness Scheme provides free medicines and appliances for chronic conditions such as cystic fibrosis, epilepsy and diabetes. The Maternity and Infant Care Scheme provides free GP and hospital care for all pregnant women and their babies until six weeks after birth. Essential medical supplies for people with spinal injuries are

⁸ Research Question 3: What aspects of your everyday practice drain you?

provided once approved by the HSE and prescribed by a doctor. These include dressings, gloves, incontinence sheets and catheters. Finally, Cross-Border and Treatment Abroad Schemes enable patients to access procedures in other EU countries or in the UK, if they cannot get timely access in Ireland.⁹ Because of the scattergun entitlement, patients with limited means do all they can to stay entitled to free services. Those with limited health literacy depend heavily on their GP's advocacy.

This section has shown how easy it is for a patient to fall into a healthcare 'gap' either by being poor or marginalised, or when their circumstances change. Not only might they have a health problem requiring a GP visit, but they also have the worry of incurring healthcare costs.

1.6 How to become¹⁰ a GP in Ireland

1.6.1 History of GP training

GP training in Ireland is tightly regulated by law and GPs must maintain their specialist registration with the Irish Medical Council by annual re-accreditation. It was not always so structured and regulated. In his comprehensive history of Irish General Practice, the historian Michael V. Hanna outlines the slow evolution of the Irish GP from dispensary doctor with a basic medical qualification (BMQ) and some arbitrary clinical clerkship to fully accredited specialist primary care clinician (Hanna 2024, 144–175). The Royal College of General Practice was founded in the UK in 1952, four years after the establishment of the National Health Service (NHS) (ibid. p. 144). Vocational training of GPs was implemented in the early years of the RCGP and was

⁹ Rural TDs regularly organise bus transport for their constituents to have cataract surgery in Northern Ireland.

¹⁰ 'Becoming' is life-long and kinetic, as is 'being' (Gerada 2021; McCormack 2009).

undertaken by many Irish medical graduates until the introduction of GP training schemes in Ireland, the first being in Galway in 1971 (O'Kelly et al. 2004, 9). An Irish faculty of the RCGP was founded in 1953 and four Irish faculties thrive to this day, their members often holding joint membership and officership of the Royal and Irish Colleges. But Ireland's impoverished economy after World War II caused 'an unstoppable flow of emigrants' (Garvin 2005, 215). Gilmartin refers to the 'medical carousel' as doctors moved abroad after basic training (2015, 59), not knowing whether they would ever have the opportunity to return home. She cites Armen, who found that '71 per cent of doctors trained in Irish medical schools between 1950 and 1966 had gone abroad, mostly to the UK and also the US' (Armen 2008, 109).

1.6.2 Cultural history of Irish primary care

When Ireland gained its independence from Britain in December 1921, it had inherited structures of medical training and practice developed over time under the influence of British political philosophy, new world-wide scientific findings and public and professional zeal to improve morbidity and mortality rates. The Poor Law (1838) had bequeathed a network of local dispensaries where GPs saw people who could not afford to pay a fee (Geary 2012, 241). After Independence, administration of these dispensaries was transferred to county level as poor law unions were abolished. Early in the life of the new Irish state, the Catholic Church inserted itself as an influential player in determining health and social policy (Barrington 1987). Despite a series of initiatives intended to improve population health by addressing, inter alia, a tuberculosis epidemic, endemic typhus, high maternal and infant mortality¹¹, little progress was made in the field of public health (Hanna 2024, 105). Regarding family life as their

¹¹ All strongly associated with poverty and inequality

own field of operation, Irish bishops stymied effective change, particularly with respect to the proposed Mother and Child Health Scheme of 1951 (McKee 1986). The net effect on Irish general practice was that the old dispensary system limped along, under-funded and increasingly ineffective, in tandem with its mirror image, private practice for patients who could afford to pay medical expenses out-of-pocket. Then, as now, GPs practising in wealthier districts earned more from their private practice than did those in poorer areas. Growing pains and power struggles of the new state stymied the development of primary care in Ireland until the increasingly unfit-for-purpose dispensary doctor system finally withered and was replaced by the GMS in 1972 (Hanna 2024, 102, 108).

1.6.3 ICGP GP training and accreditation

The Irish College of General Practitioners (ICGP) was established in 1984: that same year, General Practice was recognised as a speciality by the Irish Medical Council (IMC). These initiatives brought to an end the period when a doctor with a basic medical qualification (BMQ) could begin practising as a GP. In 2005, the Health Service Executive (HSE) undertook responsibility for GP training, delivered through fourteen regionally developed schemes, with exams and accreditation provided by the ICGP (Government of Ireland 2004). After sixteen years, in 2021 the ICGP took over GP training with thirteen regional schemes. Candidates from all over the world take this training and examination.

The ICGP uses the slogan #BeAGP to promote its GP training programmes (ICGP 2019). The web page that invites medical doctors to train in the speciality of General Practice offers the following incentives:

- Opportunity to specialise and train other GPs.

- Provide continuity of care within your community.
- Achieve real work life balance doing what you love.
- Experience independence being your own boss.
- Enjoy freedom to live and work where and when you choose.

To become a GP there are several steps. The Leaving Certificate is the state exam sat by all Irish students at the end of their secondary school education. Since 1976, results obtained in this exam are scored for competitive entry to third level education via a government-run body, the Central Applications Office (CAO). Applicants who wish to study medicine must also sit the HPAT – the Health Professions Admission Test, which evaluates ‘generic skills like logical reasoning, problem-solving, non-verbal reasoning and the ability to understand people’. Successful applicants gain entry to medical school in one of five Irish medical schools, University College Galway (UCG) and University College Cork (UCC) and three in Dublin: University College Dublin (UCD), Trinity College Dublin (TCD) and Royal College of Surgeons in Ireland (RCSI). A six-year course of academic, scientific and clinical education leads to a basic medical qualification (BMQ) after which the new doctor must work as an intern for one year in order to become eligible for registration by the Irish Medical Council. At this stage, they will decide how they wish to specialise and whether they wish to train in Ireland or abroad. Doctors who are undecided work in a series of hospital jobs, at home or abroad, to gain exposure to the various specialities. Each speciality has a carefully designed training programme lasting several years, before the doctor can acquire the necessary expertise to have their name entered on the Medical Council’s specialist register.

Basic medical training is also available to those who decide in later life to pursue a career in medicine. Those who already have a primary degree in the health sciences may apply to study postgraduate medicine in any of four colleges in Ireland: UCD, RCSI, UL and UCC. According to its 2024 prospectus (ICGP 2024), the four-year training cycle is divided as follows: Year 1&2 are spent in hospital posts such as Paediatrics, A&E, Psychiatry, Obstetrics & Gynaecology, Medicine and Medicine of the Elderly. Trainees are called Senior House Officers (SHOs) and have a half-day of training facilitated by the training scheme each week. Years 3&4 are based in supervised general practices with a nominated GP trainer. Trainees are known as GP Registrars and have two hours teaching with their trainer and a full day's teaching with their scheme each week. GP training is extremely relational and concludes when the trainee acquires their Certificate of Satisfactory Completion of Specialist Training (CSCST) and passes their Membership of the Irish College of General Practice (MICGP) exams, which entitles them to be enrolled on the Medical Council's specialist register. They may now be employed as a GP, either in an already established Practice or, if they can afford it, to set up a new Practice.

I provide this detailed account of GP training not only to give a sense of its duration and rigour but also to draw attention to the number of different places where GPs work along the way.¹² During any given placement lasting several months, they work long hours, nights and weekends with colleagues and form deep bonds of acquaintance, attachment and friendship. Marriages between medical doctors are not uncommon. 'Where did you train/do your Paeds?' is how they 'place' each other. Were it not for these networks of kindred spirits,

¹² A former colleague told me that trainee doctors who like surfing gravitate towards Sligo training schemes because of its famous Atlantic surfing conditions.

which some research participants snowballed on my behalf, I believe I would not have secured enough interviews.

1.7 Profile of General Practice in Ireland

GPs are the bedrock of primary healthcare in Ireland. Historically a GP worked 'single-handed' from a dispensary for public patients and a privately owned premises for those who paid out-of-pocket. Latterly, GPs began to form partnerships and would work from a privately owned premises in partnership with colleagues. Since the foundation of the HSE in 2005, it has invested, along with public-private partnerships, in the construction of large purpose-built primary healthcare centres which can accommodate a general practice, a pharmacy, community psychiatry facilities and community health nurses (Mercille 2019, 416–419). There is no single, accurate account of how many GPs work in Ireland, for reasons given below. The current estimate is 3,110 according to the Primary Care Reimbursement Service (PCRS), 4,456 (Medical Council) and 5,257 (OECD) (Connolly, Kakoulidou, and McHugh 2025).

The population that they serve was recorded as 5,149,139 people on the night of the last Census in April 2022 (see Figure 1-2). This is the first time the population has exceeded five million people since 1851, an indication of the death, emigration and persistent structural violence that followed the 1847 Famine (CSO 2022a).¹³

¹³ The Irish Census counts citizens in the Irish Republic. Data from before independence in 1922 count everybody on the island of Ireland. The population of Northern Ireland is currently estimated at 1.9 million people.

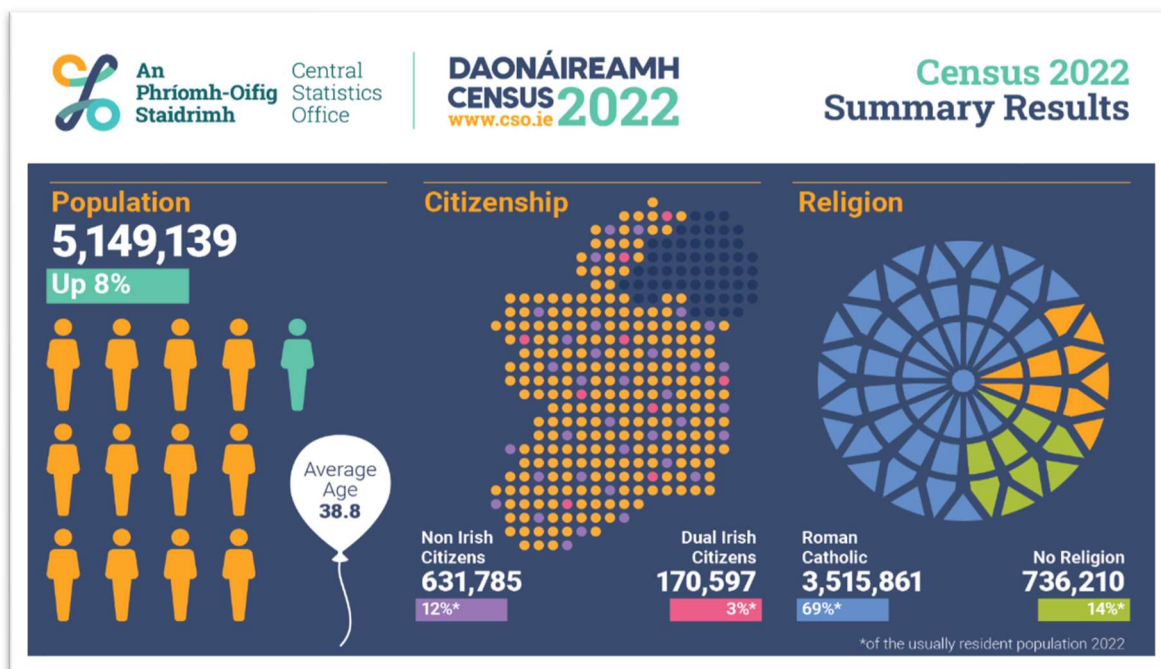


Figure 0-2: Census of Ireland 2022 Population data.

Source: <https://www.cso.ie/en/statistics/population/censusofpopulation2022/censusofpopulation2022-summaryresults/>

The Central Statistics Office predicts that the Irish population will reach seven million people by 2057, due to natural increase and inward migration (Central Statistics Office 2024).

The proportion of the population aged over 65 years is predicted to grow too, due to better general health and healthcare (see Figure 1-3 for the current

Figure 0-3: Census of Ireland 2022 Population data.

Source: <https://www.cso.ie/en/statistics/population/censusofpopulation2022/censusofpopulation2022-summaryresults>

population pyramid). An adequate GP workforce is required to service this demand (Connolly et al. 2023; Connolly, Kakoulidou, and McHugh 2025; Department of Health 2025a). Considering that it is intended to make primary care free to all citizens, government will not only have to plan for workforce staffing but also give serious consideration to how to retain trained GPs. The findings of this research unmask affective dimensions of the GP lifeworld that must be factored into their deliberations.

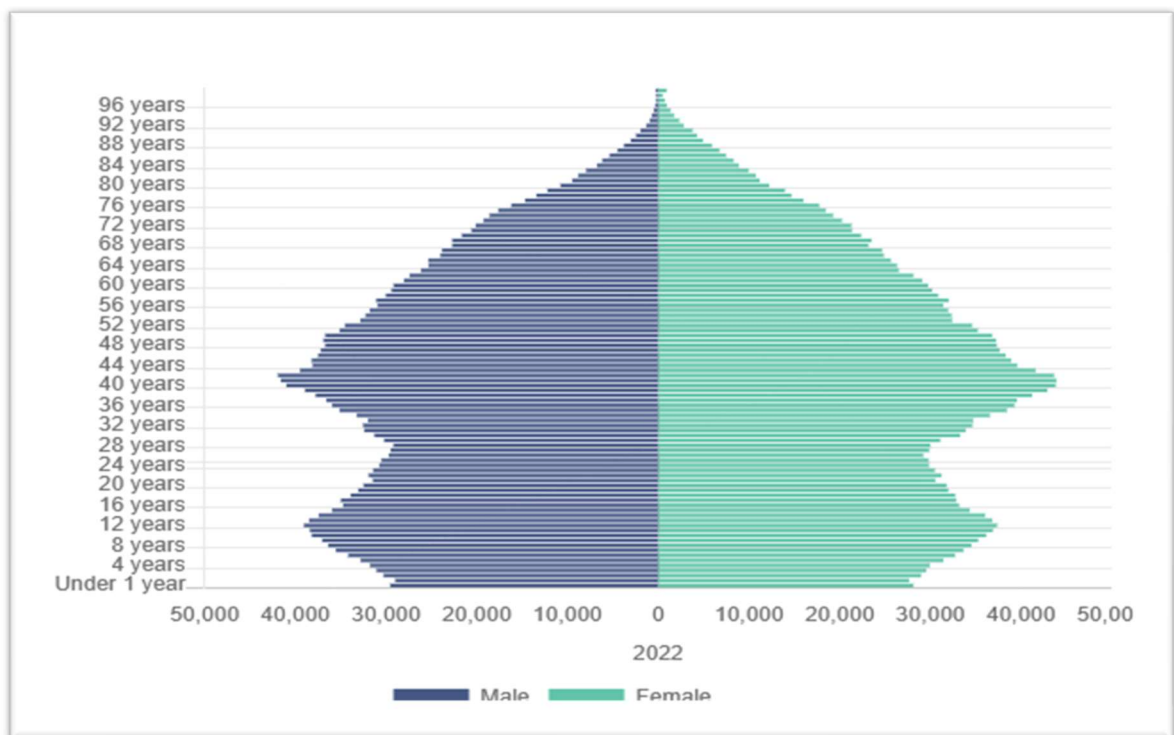


Figure 0-4: Census of Ireland 2022 Population data.

Source: <https://www.cso.ie/en/statistics/population/censusofpopulation2022/censusofpopulation2022-summaryresults>

1.8 Where's the geography?

All of the foregoing assembles a jigsaw with most of the necessary pieces for a healthcare service. Input from economists, policy makers, politicians, healthcare experts and community-generated data such as the Census are fundamental to

a matter as important to citizens and as expensive to the exchequer as healthcare. However, having visited GPs in their workplace and lingered to get a sense of place beyond a mere interview, I ask - Where's the geography in all this? When doing fieldwork, the clues are everywhere. I took my cues from Frank Mitchell's epic '*Reading the Irish Landscape*' (1997), walked the ground, had conversations with everybody I met, took photos (as memory aids, not allowed to be included here), wrote copious contemporaneous memos and then found that the GP, at interview, would reiterate and reinforce my impressions. Except that at interview, the GP's communications were not merely words; they lit up, they frowned, they became exercised as they spoke. And they received me courteously, their warmth leaving a lasting impression. Such human geography as resides in this project was not in bald data, but in relational and emotional aspects of the interview, how I was received by Practice staff, how we communicated afterwards when I sent them the transcript for their approval. The real geography in this research resides in the concept of place, as articulated by participants in this research and represented in Chapter 4.

Andy Burnham, Mayor of Greater Manchester has taken the concept of 'Place First' and headlined it in conceiving how his city might become more liveable (Burnham 2025). Local control of finance, investment in infrastructure, support for culture and creativity, empowering community are all being fostered to make Manchester a better place to live. In the empirical chapters, I cite GPs who make place in like manner by their actions every day, but who, unlike Burnham, only refer to place as a given, an incidental, as somewhere they like to live and work. I argue that place must be foregrounded by those who would like to see primary healthcare made available where citizens need it, so that they don't need a car to get to a GP in rural Ireland, so they can have a terminal illness and die in their own homes. And rural living will lack the 'territorial

cohesion’ to be sustainable if GPs cannot be attracted to work in the countryside (Mahon et al. 2023).

The Economic and Social Research institute (ESRI), a policy research body founded in 1960, has reported on ‘the geographic profile of healthcare needs and non-acute Healthcare supply in Ireland’ following concerns expressed in the Sláintecare report (Smith et al. 2019; Walsh et al. 2019). Smith et al. find significant deficits in some geographic areas and conclude that:

The data show that there is an unequal distribution of non-acute services across the country. The finding that the distribution of supply is unequal even after controlling for healthcare need factors is consistent with anecdotal evidence of inequity in access to non-acute care cited in many policy documents, and it underlines the importance of moving towards population-based resource allocations if equity is to be improved (Smith et al. 2019, 142–143).

Walsh et al. echo these findings and highlight similar patterns across geographic areas where facilities for care in the non-acute (or GP) sector are underserved (Walsh et al. 2019). Analysing the problem from the perspective of marginalised patients, Barlow et al. find that people in very deprived areas consult their GP more frequently:

Area-level deprivation appears to have a significant association with an individual's utilisation of GP services, even after controlling for many determinants of individual-level demand for GP care and a proxy for GP supply. This implies that government policy towards development of primary care should consider the extent of deprivation at local level (Barlow et al. 2021, 8).

Participants in this research hold these views too, as the empirical chapters will show, the saddest case of all being the low-income working poor who do not qualify for a GMS card and cannot afford to pay for either doctors’ fees or medicine from a pharmacy.

Geographical literature is replete with research papers and book chapters on how people experience healthcare service. Descriptions of the Hokianga Clinic

in New Zealand resonated strongly with the community feeling of two GP Practices I visited along the Western Seaboard (Kearns 1998) and others I visited for MA research in 2018. Their 'positive influence on both individual well-being and community life' was palpable (Cattell et al. 2008, 556). In both of these facilities, the GP had had an input at the design stage, similar to two practices I visited in deprived city areas. Parr's observation in 2003 that much research remained to be done around the experience of delivering and receiving mental healthcare and caring remains valid today (Parr 2003; Parr and Philo 2003). This research presents a small selection of findings which may incite further research in this area.

1.9 Thesis contributions

As outlined at the beginning of this thesis, we know little about the lived experience of Irish general practitioners, beyond anecdote. Despite a thrust from government to mitigate inequality and inequity among patient populations, healthcare continues to be unequally distributed so that marginalised or under-served people bring to the consultation not only their healthcare issues, but also their embodied legacies of structural violence. It is fair to assume that above and beyond clinical presentations, GPs are regularly confronted by structural issues that they cannot solve, and that over time, this bears down on and frustrates them. But this thesis is not about the patients. Rather do I invoke them continuously because they are the substrate, the unremitting life force of physical, psychological, economic and sociological embodied problems that present to GPs every day of their working lives. There is a lack of qualitative research that explores this experience, a lacuna that 'Advocates of the Poor' aims to highlight.

Census data shows a growing population in Ireland and predicts an increasingly top-heavy proportion of ageing and older people. Modern science has delivered therapeutic advances such as vaccination, preventive measures for chronic disease and unforeseen pharmaceutical treatments for formerly fatal conditions. The huge power of large language models (LLMs) in diagnosis suggest a growing role for artificial intelligence (AI) in diagnosis (Blease 2025). However, all healthcare interventions must be calibrated and delivered at individual level by a professional healthcare worker so it follows that more GPs will be needed in the Irish medical workforce; we must train more and we must retain those we have trained. Exploring the vectors at play from a Health Geography perspective enables me to shift the focus of enquiry to the inner lives of GPs by listening to what they, themselves, say about what gives meaning to their lifeworld. This thesis reveals the joy of intersubjectivity in the doctor patient relationship and proclaims that it underpins the capacity of individual GPs to persevere.

With this in mind, I sought interviews with GPs who work, mainly, with marginalised people. My experience as a former GP expedited access to time-poor GPs and facilitated interviews in a GP lexicon. Rather than taking an overview of their expressed views, this thesis presents their accounts in the hope of writing an über-narrative faithful to their lived experience. The process of coding interviews and reflexive memos, and the slowly-dawning certainty that saturation would never be achieved, revealed to me that this research finds its natural home in the theoretical mycelium of Latour's Actor Network Theory (Latour 2005) and Thrift's Non-Representational Theory (Thrift 2004). Although apparently random to the uninitiated, a GPs daily caseload has its own ordered rhythms and cadences. A nimble approach that renders their skills (and those of their teams) invisible equips most GPs to contend with any and all clinical presentations. An empathetic disposition invokes their creativity when

problems seem insoluble and leads to the relentless advocacy that makes a difference for their patients. Had I used a methodology that did not involve meeting GPs in person at their place of work, this research would have been arid and mono-layered.

'Advocates of the Poor' foregrounds GPs as essential placemakers in their communities, both urban and rural. It depicts them working with sleeves rolled up in landscapes of care. The empirical chapters add to existing literature that depicts GPs' contributions to their respective societies and to society at large. It takes the quotidian, taken-for-granted GP presence in a community and valorises it in a manner that ought to galvanise policy makers who plan our healthcare futures. It is about the future of GP service and practice in a potential era of continued health service delivery inequalities

1.10 Conclusion

In this chapter, I have provided an overview of my ethnographic research of Irish GPs who are 'Advocates of the Poor'. I have signposted the gaps in academic literature, the cognitive dissonance in the public sphere concerning what GPs are and are not and my own disquiet at the discursive vacuum. I have identified Health Geography as a discipline that, were it to be able access research participants (both as subjects and collaborators) has much to offer both practitioners and policy makers of primary care. I have thereby justified the research and buttressed it with appropriate methodology and theoretical underpinning. Drawing on Michel Foucault (2003 [1963], 2002 [1969]), I have given a brief archaeology of general practice and how an individual comes to be a GP in this scientific and highly accountable era. The particular structures of the Irish healthcare system and GP training are outlined lest a reader from another country assume that our system is the same as theirs. I have alluded to

factors that have the capacity to render GP work unsustainable in the future; these are narrated more authentically by RPs in the empirical chapters, shorn of my researcher representation. In conclusion, I now summarise the structure of this thesis.

1.10.1 Structure of this thesis

In the next chapter, Chapter 2, I explore the literature of medical and health geography to ground my research into the lived experience of GPs who care for marginalised people. I begin by tracing the evolution through time of medical to health geography, using the opportunity to take cognisance of the material, scientific and theoretical advances that highlighted limitations of earlier approaches. Throughout this thesis I recall and draw the reader's attention to matters we now take for granted (such as antibiotic therapy or modern ante-natal care) which transformed the morbidity and mortality outcomes of everyday healthcare concerns. I then consider the influence of post-structuralist thinkers and go on to valorise qualitative research in giving voice to participants. Inequality and inequity of access permeate both the patient and the GP experience. I discuss Ireland's two-tier healthcare system, the structural violence that trickles down from our colonial past and explicate the syndemic¹⁴ (Singer 2000; Singer et al. 2017), the phenomenon that makes an epidemic much worse for people who are poor.

¹⁴ Syndemic: 'The syndemics model of health focuses on the biosocial complex, which consists of interacting, co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction' (Singer et al. 2017)

It takes a long time and significant resources to train a GP. I examine their professional and geographic formation and draw attention to their lifelong becoming.

Since general practitioners are difficult to access for interview and they require absolute confidentiality in order to speak, the methodology chapter (Chapter 3) describes how this was achieved. The ontological and epistemological underpinnings of the dissertation are outlined, followed by how qualitative analysis was done. Due regard was extended to ethical aspects of research interviews and to the COVID-19 ethnography.

‘No Doctor, No Village’ is the clarion call for GPs who are placemakers, especially in rural areas. In Chapter 4, I explore the geographical concept of ‘place’ and how GPs make place for marginalised people in rural and urban areas, emphasising the importance of continuity of care. The foundation of good patient care is a good doctor/patient relationship; emotional labour is an additional burden for participants in this research, borne willingly. Although they may not articulate the concept of place, GPs are at its fulcrum. As participants described their everyday consultations, the breadth and depth of their engagement – at clinical encounter and beyond – was noteworthy and continually raised the question of what life would be like for marginalised patients without such advocacy.

The theory of ‘Landscapes of Care’ is then introduced in Chapter 5, since any act of care surpasses the dyad of giver and receiver. Concentric ripples and spirals of care extend from the source through the recipient and beyond and then boomerang back to create a multi-dimensional mycelium of care which, although acknowledged while it exists and thrives, is not fully appreciated until it’s gone. The workforce crisis in Irish general practice, due to retirement and

emigration, is referred to throughout the dissertation. Chapter 5 examines how primary care is enacted, sustained and challenged within the landscape of primary care. The nature of care and caring is examined along with the amount of hidden work it takes effectively to advocate for marginalised patients. Research participants speak volubly about their supports at work: their colleagues on the Practice team, the consultation models they deploy and government initiatives such as the Chronic Disease Management Programme. With regard to the next generation of GPs, a shifting demography is addressed within the overarching concern of how continuity of care can be sustained with fragmented GP time-commitment. The importance of a diverse primary care team and the facility to adapt to algorithmic and artificial intelligence imperatives is considered too.

Chapter 6 is an (auto)ethnography of the COVID-19 pandemic which might have scuppered this research, but instead, afforded deeper insights. The lives of family members, neighbours, friends, contact-tracing colleagues and members of the public wove the tapestry of this chapter as we all surfed pandemic waves of fear, illness, death and social isolation. Unlike hospital doctors, participants in this research experienced the pandemic as an addition to their workload and managed it accordingly. Changes such as telemedicine, long overdue, became available in primary care. The pandemic exposed and exacerbated existing inequalities. In the concluding chapter, I consider the vectors that will bend and shape general practice in the future, and how GPs must assert themselves to safeguard the practices which sustain both the patients and themselves.

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Chapter Two: A Literature Review

Within this chapter I explore literature that investigates this subject, with particular emphasis on the perspective of human geography. The study of the lived experience of general practitioners resonates strongly with the priorities of what has been termed Health Geographies in contrast to the focus of earlier Medical Geography. Even before that, positivist rationale from the age of reason laid the foundations for a perceived scientific 'certainty' which continues to be hammered and chiselled into more fluid ontologies by structuralist and post-structuralist thinking. Section 2.1 addresses these transitions along with assemblage and non-representational theory. My interest in the healthcare of marginalised people comes from a concern with inequity and unfairness; these themes are well established within the geographical study of inequality, and this body of literature is surveyed in Section 2.2 which concludes by reviewing relevant works on inequality in Ireland. I have focused in particular upon the doctor-patient relationship and while this topic has mainly been the concern of Medical Sociology, it also draws from studies of medical power that have been influenced by the work of Michel Foucault. Several geographers refer to this work to study medical space more broadly. The formation of a GP- professional and geographical is then outlined. I cover these issues in Section 2.3. and then turn in Section 2.4 to consider the work of the consultation along with its downstream hidden work. An important part of my geographical approach is to highlight the way that healthcare both produces and rests upon practices of place, the co-presence of persons and their mutual creation of attachments and meanings. I cover these themes in Section 2.5 which ends by noting how the COVID-19 pandemic deleted so much of these place-based practices. Having worked as a GP and Contact Tracer, in Section 2.6, I draw on the

autoethnography literatures to make meaning of my experience. While the pandemic became a syndemic, it expedited the introduction of digital healthcare technologies. In Section 2.7 I locate the care given by GPs to their patients and patient population within the framework of Milligan and Wiles' 'landscapes of care' (2010) in the contemporary Irish healthcare system.

2.1 From medical geography to geographies of health and wellbeing

It is interesting to contemplate how this research might have been done before the geography of health evolved from the subdiscipline of medical geography. GPs' 'lived experience' would have been perceived as anecdotal, neither demonstrating nor proving anything of value. Qualitative research, lacking 'rigour', 'validity' and 'reliability' was likewise regarded as soft (Baxter 2020, 306). Before we all had access to desktop computers, word and data processing, rapid communication via e-mail, data was recorded longhand, entered in ledgers, then synthesised by amateur or professional mathematical statisticians. It was the apogee of positivism, an ideal medium for biomedical evaluation of health. Medical geography concerned itself with the ecology of disease and the spatial distribution of health services (Meade and Earickson 2000) and also included studies of healthcare provision, particularly in relation to healthcare need (Haynes 2015; Powell 1995). It expedited both the understanding and the management of diseases that compromised individual and public health. The various siloes where dwelled researchers concerned with disease and ill-health, their patterns and possibilities for intervention are thoroughly explored by Dorn et al. (2010, 55–70). Health geography since the 1990s, with the introduction of subdisciplines like therapeutic landscapes would indicate an openness to qualitative research and attention to the everyday lived experiences of communities and individuals trying to achieve a quality healthcare 'status' or

at least a healthy lifestyle. Opportunities remain, however, for medical geography, geography of health, sociology, anthropology and medicine to collaborate more effectively.

In this respect, the COVID-19 pandemic fostered interdisciplinary collaboration in Ireland and worldwide; the threat of high numbers of deaths brought researchers together, funded more immediately than ever by government which took its mandate from the novel coronavirus's daily case load and modelled projections. All government data on healthcare was placed at the disposal of researchers who shared data between the jurisdictions of the Republic of Ireland and Northern Ireland (Nolan et al. 2021), and internationally. Dualisms were dissolved in the public interest; participants in this research say that changes have occurred in their practice that will never be reversed. Citizens' Assemblies in Ireland (ongoing since 2013) have given us a new framework for deliberative democracy which might encourage more collaborative dialogue (The Citizens' Assembly 2025). It is to be hoped that more interdisciplinary communication will lead to better outcomes in delivered healthcare (Finlay and Rowles 2021).

2.1.1 From positivism to post-structuralism

Positivism was the engine of Enlightenment thinking from the seventeenth to the nineteenth century (Comte 1974 [1877]). Observation, classification and prediction underpinned canonical work by Linnaeus (2024 [1735]) and Darwin (2009 [1859]). John Snow's mapping of the cholera epidemic in London in 1854 (Keeler and Emch 2018; G.Kearns 1985) was a crucial public health intervention and, here in Ireland, William Wilde's extensive ethnographic and statistical tabulation of the 1847 Famine had helped enumerate its multiple pathologies (McGeachie 1999). After World War 2 (1939–1945), 'Jacques May formed a

Medical Geography Department in the American Geographic Society in the 1950s, establishing medical geography as a distinct subfield of geography' with a particular focus on infectious disease (Keeler and Emch 2018, 45). In 1946 the WHO defined 'health' as being composed of 'our physical, mental and social well-being, not merely ... the absence of disease or infirmity' (WHO 2014). Healthcare and its funding were seen as a key instrument to rebuild democracy with a functioning economy after the ravages of war.

While helpful, this top-down perspective could not have withstood the 1970s cultural turn in the social sciences. Demographic changes after WW2 and the American-Vietnam War (1955–1975) along with the dissemination of domestic televisions in the 1960s gave voice to ordinary people and their cultural subgroups as never before. Civil rights movements in the USA (1954–1968) foregrounded endemic racism. Hormonal contraception (1960s), *inter alia*, created the conditions of possibility for feminism.

In 1963 the Cuban Missile Crisis alerted people to the possibility of nuclear war. Carl Sauer (1925, 2008) had articulated the geographical concept of place in 1925 and now brought a cultural component to landscape studies. Yi Fu Tuan's *Topophilia* (1974), Anne Buttimer's 'Values in Geography' (1974) and E. Relph's 'Place and Placelessness' (1976) 'reimagined place as socially produced' (Sothorn and Reid 2018, 96).

Until the mid-seventies, the axiom that Structure = Function had monolithic authority in the social sciences and in medicine (Bourdieu 1977, 1984). Structural Marxism had gained traction as an explanatory framework for most of society's ills (Harvey 1989; Massey 1984). In due course, the mainstreaming of heretofore silent voices did away with binary oppositions and essentialist identities, ushering in an era of post-structuralism. Using Magritte's 1929 image

of ‘Ceci n’est pas un pipe’, Barthes threw down the gauntlet of perspective (Barthes 1977, 32–52): *No, what you see is the image of a pipe, not a pipe*. Foucault, simultaneously, unravelled and articulated the architecture of power throughout hallowed pillars of society, the church, the professions and government (Foucault 2003 [1963], 1991 [1975], 1998 [1976], 1992 [1984], 1990 [1984], 1991, 2001 [1961]). The roots or rhizomes of power were interrogated by Deleuze and Guattari (1988). Spinoza’s monism, long dormant, was awakened and splintered the twin bastions of ‘rational’ Cartesian dualism and Newtonian mechanics, clearing the field for discourse about emotions and embodiment (Spinoza 1677, 1996).

Post-structuralist geographies of health [...] share a concern for the dynamic relationship between people, place and health but reject the idea that the meaning of these experiences is centred in an autonomous, rational subject’s physical location. Instead, post-structural geographies of health pursue decentered accounts that relocate the production of meaning from the individual to the way individuals are defined as subjects within discourses, the processes of embodiment by which individuals are placed in the world, and the state strategies by which individual health is politicized (Evans 2018, 131).

Although the first cases of HIV/AIDS were reported in 1981, Ronald Reagan, USA president from 1981 to 1989, declined to refer to it officially until 1985. HIV/AIDS could be said to straddle the transition of structuralist medical geography to post-structuralist geography of health; in its early days, discourse lacked the patient-centred focus that nowadays, leads to policies and practices which make patients feel empowered.

Humanism became a central tenet of human geography once researchers began to question ‘how the world is experienced, how subjects manifest active agency [...] and to reject overly universalizing laws that aspire to a scientific ideal’ (Sothorn and Reid 2018, 97). Phenomenology had urged thinkers to go back to ‘the things themselves’ (Husserl 1970 [1900]), an injunction understood by all doctors who must take a history repeatedly to try to uncover the aetiology of an

elusive diagnosis. Sartre (1946, 1975, 1991), de Beauvoir (1949,1972), Merleau-Ponty (1962) and Bourdieu (1977, 1984) foregrounded the everyday experiences of ordinary people and, indeed, their own, to elaborate experience into an existentialist philosophy. In 1943, Georges Canguilhem's medical doctoral thesis unpacked the spectrum of normal and pathological, leading to his influential career in the philosophy of medicine (Canguilhem 1978). Canguilhem was Michel Foucault's doctoral supervisor and his philosophical sherpa, and his ideas of the historical rootedness of what is normal continue to resonate:

The common assumption is that normal equals healthy and that pathological equals sick or diseased but Canguilhem repeatedly questions such elisions, certainly in a philosophical sense, albeit continuing to use such distinctions when detailing – and in effect seeking to deconstruct- the oppositions routinely deployed by medical authorities and others, patients included, down the centuries (Philo 2007, 85).

Deconstruction proved to be the means of unravelling top-down doctoring in general practice. Whereas hierarchies prevailed before phenomenology, a partnership approach with patients is preferred by all participants in this research, as their narratives will show. Models of the consultation, referred to earlier, all put the patient's narrative first, where the doctor may listen, observe and discern the affective register, before speaking.

2.1.2 Affect

First and foremost in every patient's presentation is their affect, discerned on the phone-call when they book the appointment, spotted by a well-trained receptionist who knows them, observed by staff who come and go in the waiting area and witness whether this patient is behaving in their usual manner – either chatty or reserved, well-groomed or dishevelled, whether accompanied by a friend or relative or not. Affect transmits to others before a word is spoken. It includes a presentation of self that is not consciously intended nor reflected

upon; seemingly bodily, and outside 'the operation of the rational mind' (Rose 1993, 9). If a person's affect causes them discomfort, they work hard to conceal it until the nurse or doctor closes the consulting room door, giving themselves further emotional labour so that they do not break down in public. In the context of a long-standing continuity of care, practice staff have a pre-existing relationship with and knowledge of the patient that enables them to facilitate plain speaking and to pave the way for a wide-ranging history taking and examination, and fruitful intervention.

Affect is notoriously difficult to define as it encompasses the full range of dispositions, conventionally seen as from positive to negative, that afflict sentient beings. Spinoza's monism was sidelined by Cartesian dualism at a time before modern scientific knowledge came into play. Jones and Malcolm give a good account of the role of religious Christian orthodoxy in Irish medical practice 1650–1940 (Jones and Malcolm 1999): doctors had to 'know' right from wrong and reflect this in their behaviour and actions. Only when the cultural turn came could they step down from the pedestal on which they had been positioned and express their full humanity.

Older GPs in this research were trained in the Cartesian paradigm, before the molecular structure of endorphins was elucidated in the mid-1970s (binary: real illness versus imaginary illness), before the mainstreaming of feminist philosophy, beginning in the mid-1970s (binary: male = right, female = wrong), before the expansion of LGBTQI rights from the 1980s onward (binary: heterosexual = normal, all other gender expressions except celibacy = deviant), and before the sequencing of the human genome around the turn of the millennium (binary: people whose 'seed, breed and generation' are known belong *here*, all others = foreign). The 'cultural turn' influenced their practices through their continuing medical education and relationally, via their patients

who began requiring partnership rather than patriarchy from their healthcareers. Younger GPs are digital natives, more attuned to networking, less inclined to contemplate a career as a single-handed GP who owns their own premises than as a member of a primary healthcare team working out of a HSE-owned building. GPs in this research gave numerous examples of how their marginalised patients' affect engaged their own, leading to a mutual understanding and good therapeutic outcome.

2.1.3 Non-representational theory

To research the politics of affect was the challenge posed by Doreen Massey to Nigel Thrift in 2003. His 2004 paper on non-representational theory (NRT) explored affect in all its dimensions: history, philosophy, deployment then and in the future. 'Thrift sought to alert geographers to the embodied and performative nature of practice, much of which subsists prior to reflexive or cognitive thought' (Cadman 2009, 456). Already, 'being-in-the-world' (Heidegger 1962 [1926]) had been foregrounded as a state of being that does not require representation. This would apply not only to the unwell patient, trying to verbalise their symptoms, but also to the doctor who carries their own emotional housekeeping or lack thereof into their consultations. Academic work must interrogate these unreflected -upon elements:

It is the perception of this self-perception, its naming and making conscious, that allows affect to be effectively analysed – as long as vocabulary can be found for that which is imperceptible but whose escape from perception cannot but be perceived, as long as one is alive (Thrift 2004, 63).

Thrift counsels 'a new structure of attention' (ibid. p. 67), involving 'qualities like anticipation, improvisation and intuition' to help perceive the imperceptible. His paper had seminal influence in shifting the emphasis of health geography towards emotional and affective perspectives. This research will highlight the joys experienced by GPs in their working lives, and the

compromising overflow into their personal lives when their workload cannot be accomplished. Emigration patterns, burnout and early retirement of GPs suggest that primary care needs to be delivered differently, for the benefit of patient and doctor alike. NRT leads to assemblage theory, and it is to this that I now turn.

2.1.4 Assemblage

There is a rather kaleidoscopic quality to assemblage. Its elements are constant but as the cylinders rotate one on the other, they assemble and reassemble themselves in apparently random fashion, each image being completely different to that which went before and that which succeeds it, each image having its own integrity. In the empirical chapters I will detail how the geographical and professional formation of GPs moves them from one post to another; in career as in consultation with patients, they become adapted to constantly changing and unpredictable workload. Participants in this research like it that way and could identify with the following:

One assemblage does not have the same forces or even speeds of deterritorialization as another; in each instance the indices and coefficients must be calculated according to the block of becoming under consideration, and in relation to the mutations of an abstract machine ... (Deleuze and Guattari 1988, 357).

Assemblage is defined in the Dictionary of Human Geography as

The contingent, non-necessary coming together of various phenomena, actors, institutions, or processes to form a temporarily stable bundle of relationships and capacities [in which the world may be seen as] a complex, changing and emergent product of interactions that are only partly planned, ordered or controlled (Rodgers, Castree, and Kitchin 2013, 18).

GPs in this research speak about the assemblages in which they find themselves included: teams of healthcare workers with specific areas of responsibility in which patients dwell, families and neighbourly networks of their patients, sports clubs where they volunteer as honorary medical officer, local

committees. These assemblages constitute a component of their professional advocacy, without which patient care would be merely transactional. GPs know, intellectually and viscerally that ‘the way that things hold together in assemblages is down to their relatedness’ (Allen 2011, 156).

2.1.5 Towards a geography of health

In 1993, New Zealand geographer, Robin Kearns called for ‘a postmedical or reformed medical geography’ (R.A.Kearns 1993). He put ‘place’ and ‘the collective experience of place by communities’ (ibid., p. 139) at the heart of his argument, not as a container for people and their wellbeing, but as a phenomenon that people experience, on which they confer meaning. In terms of how it makes us feel, place itself has agency. By now, feeling had become valorised as a way of knowing¹⁵. R.A. Kearns urged that ‘concerns [of health geography] would consider the dynamic relationship between health and place and the impacts of both health services and the health of population groups on the vitality of places’ (ibid., p. 145). Without using the word, he advocated for intersectionality in discourse. The success of his intervention is that we now incorporate most of the ‘isms’ in healthcare research and delivery, sexism, ageism, racism, ableism. At the time of writing, however, feminism continues to await proportionate representation for women in scientific research (Criado-Perez 2019; Blease 2025, 132).

In R.A. Kearns’ 1993 article, feminism was distinguished by its absence. The voice and theories of feminist geographers such as Doreen Massey and Gillian Rose, and feminist thinkers such as Judith Butler, Elizabeth Grosz and Julia

¹⁵ Subsequent research on the microbiome in rats and humans provide scientific evidence of how the gut microbiome has a neurological connection to the brain via the 10th cranial nerve, known as the Vagus nerve (Cryan and Dinan 2012; Cryan et al. 2019).

Kristeva were not adequately represented, according to Dorn and Laws (1994), who reckoned that R.A. Kearns had not gone far enough. They wanted more social, feminist and queer theory to authenticate heretofore 'deviant', medicalised bodies. Only with their inclusion would R.A. Kearns' reconceived place be valid. R.A. Kearns and Moon's reply (2002) was robust and expansive. They acknowledged Dorn and Laws' critiques and admitted the lack of feminist perspective. Further expansion of the sub-discipline would best be achieved by embracing its 'magpie' tendencies (p. 612), by placing the body – all bodies – at the centre of discourse and by focusing on inequalities and inequities. And so it has come to pass. Geographies of mental health (Wolch and Philo 2000; Parr 1998, 2000; Parr and Philo 2003; Parr 2008; Conradson 2005; Curtis et al. 2009; Curtis 2010; Philo, Parr, and Burns 2003; Philo et al. 2024; Duff 2012; Dear and Wolch 2014; Pearce et al. 2018), geographies of disability and access (Hall and Wilton 2017; Gleeson 2002), queer geographies (Browne 2007; Browne and Bakshi 2013; Giesecking 2020; Kinkaid, Parikh, and Ranjbar 2022; Tucker 2011), geographies of ageing and childhood (Bourke 2014; Guzmán et al. 2021; Grove 2020; Finlay et al. 2015), geographies of migrants and migration (Gilmartin 2015, 2016; Brown 2024), geographies of inequality (Dorling 2011; Pearce and Dorling 2009; Pearce 2014; Boyle 2003; Curtis and Jones 1998; Nash 2002) are now very well represented in the literary canon. Books about geographies of health and healthcare are readily available. Journals such as *Gender, Place & Culture*, *Social Science & Medicine* and *Health & Place*, among others, provide streams of new research.

2.1.6 Mind the gap

Nevertheless, a gap remained that has persisted stubbornly to this day. R.A. Kearns and Moon (2002) recommended closer collaboration between the disciplines of health geography and medicine (p. 617); outside Canada and New

Zealand, there's little evidence that this has happened (Kearns and Neuwelt 2009; Kearns, Neuwelt, and Eggleton 2020; Agarwal 2009; Molinaro et al. 2024). It took a crisis to drive them together. As part of the Irish response to the COVID-19 pandemic the National Public Health Emergency Team (NPHE) was created. Chris Brundson joined this team as a geographer with expertise in modelling. Beyond this instance, I'm not aware of any other Irish public health research or policy unit that includes a geographer on the team. Viveka Guzmán, a Mexican GP who has trained as a geographer and published on ageing and COVID-19, is a rare example in Ireland (Guzmán et al. 2021; Guzmán et al. 2023). Finlay and Rowles commented on this lacuna in the USA (2021). Kearns and Moon argued in 2002 that the one-up-position taken by medicine over other specialities was historical and that outdated views of others must be scrapped by all for progress to be made.

There are still constraints within which health geographers have to work. These can vary from access to research sites and research data to the privileging of certain research designs. [...] qualitative studies are only now attracting a degree of respectability (R.A.Kearns and Moon 2002, 617)

Fast forward, then, to 2020 when the dissonance persists. In Chapter 1 'Introducing the Routledge Handbook of Health Geography', the authors enumerate the 'key omissions that we had explicitly sought to include as chapters' (Crooks et al. 2020, 6). Among them are 'the body and embodiment, knowledge translation, public geographies and health- services research' (ibid. p. 6).

We sought, unsuccessfully, to include chapters on the body, workplaces and hospitals as key sites of health-geographic inquiry (Crooks, Andrews, and Pearce 2020, 229).

This gap is identified again by Pearce whose 'life course of place' suggests a vacancy on the research team for a primary healthcare provider (Pearce 2018, 1496). It is within this very wide and enduring lacuna that I place my research.

Concerning mental health, Philo et al. bridged the gap in 2024 in their response to editorials in the International Review of Psychiatry that proposed a discipline of ‘geopsychiatry’ (Philo et al. 2024; Bhugra and Ventriglio 2023a, b, c). The geographers contend that the psychiatrists’ proposals convey:

‘a sense of ‘reinventing the wheel’, given that there is already a long-standing subfield, with interdisciplinary connections, called ‘mental health geography’ or ‘the geography of mental health’ (Philo et al. 2024, 80).

and that where the discipline of geography is mentioned, the authors fail to acknowledge the theoretical and philosophical underpinnings of contemporary geographical thinking. Philo et al.:

recognise just how much more we need to know before we could begin to encompass psychiatry, its history and theories. And we would have welcomed a little more equivalent circumspection from the editorial authors as they, from their psychiatric background, strive to represent the literatures, debates and accomplishments arising from the discipline of geography (ibid. p. 82).

and end by thanking Dinesh Bhugra for his invitation to academic dialogue (ibid. p. 84). At a time when public debate continues to become ever more polarised, this engagement epitomises best practice in interdisciplinary discourse. Research on primary care might benefit from similar collaboration. The emotional voice of general practitioners is largely absent from the academy: the deep, enduring relationships engendered by continuous care exact a high personal price. This must be factored into the debate as a key element of the delivery of healthcare.

2.2 Geographies of inequality and inequity in healthcare

Inequity and inequality: these terms are sometimes confused, but are not interchangeable, inequity refers to unfair, avoidable differences arising from poor governance, corruption or cultural exclusion while inequality simply refers to the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources (Global Health Europe 2009).

Unequal access to healthcare not only predicates poor health outcomes in terms of morbidity and mortality, but also ‘generates mistrust and reduced social cohesion’ (Schenkman and Bousquat 2021, 15/17). The ‘five As’ of availability, accessibility, accommodation, affordability and acceptability signify multiple healthcare barriers for marginalised people (Penchansky and Thomas 1981). 1984 research on spatial variations and inequality of access to healthcare services suggest that improved access to primary care benefits marginalised people (Joseph and Phillips 1984). Early crusaders for fair healthcare provision included Virchow (1985 [1848]; Virchow 2006 [1848]), Engels (2009 [1845]) and Tudor Hart (1971). Levels and degree of inequality stand alone as detractors from a nation’s health status (Pickett and Wilkinson 2010; Pickett and Wilkinson 2015; Pickett and Wilkinson 2017; Wilkinson and Pickett 2018). The manifest degradation of people who cannot access decent healthcare has exercised many geographers (Curtis and Jones 1998; Curtis 2003; Dorling 2011; Dorling 2014; Mohan 1987; Eyles 1987).

Class inequality is woven into classical anglophone works of literature by Charles Dickens, Thomas Hardy, George Eliot, George Orwell, Mark Twain and John Steinbeck, all taught in Irish schools and interpreted in accordance with a teacher’s or school’s paradigm, sometimes characterising it as a natural order. Geographers who problematise class inequality include Del Casino and Jones (2007) and Duncan and Legg (2004). While Karl Marx was more philosopher than geographer, his work on class inequality stands as a timeless resource (Marx 1906 [1867,1885 and1894]). David Harvey helps interpret Marx by his writings and his You Tube classes ‘Reading Marx’s Capital’ (Harvey 2010, 2011). Then Slater makes Marx relevant to Ireland. Intrigued by realising that while Ireland starved during the 1847 Famine, Marx was spending his days in the British Library, studying ledgers that detailed contemporaneous food exports from Irish ports (Marx and Engels 1972), and his evenings verifying his findings

with the Burns sisters, Engels' Irish companions, Slater wrote about class inequality as it manifested in mid-nineteenth century Ireland (Slater and McDonough 2008; Slater and Flaherty 2009). Despite recent prosperity, these inequalities persist in Ireland, mediated by income, social class and urban/rural milieu. Contemporary maps of deprivation in Ireland remain faithful to those drawn up in the nineteenth century (Crowley, Smyth, and Murphy 2012).

2.2.1 Overview of healthcare inequality in Ireland

The Lancet recently faulted Ireland for its poor universal coverage of primary healthcare: 'despite being one of the richest countries in Europe ... 58% of residents do not have access to free primary health care'¹⁶ (The Lancet Editorial 2025). Ireland's two-tier system is blamed for this anomaly:

Category 1 comprises individuals who qualify for free primary care through medical cards or GP visit cards, typically based on their age, very low income (e.g. individuals aged 65 years without dependents earning <€184 a week, or chronic health conditions; Category 2 includes individuals who do not qualify for these cards, encompassing many low-income and middle-income earners for whom primary care costs can be a significant burden' (ibid.).

Lacking a system of universal healthcare, Ireland does not yet have a universal patient record for data analysis, so proxies are used for research. Government spending on healthcare is administered by the Department of Health and cost approximately €22.2 billion in 2022 (O'Malley et al. 2023). Key statistics and analytics are published annually and regularly updated on the Department of Health's 'Statistics and Analytics' webpage (Department of Health 2025b). The Health Service Executive (HSE) is responsible for primary care and social care services. Its expenditure on primary care in 2022 was €4.83 billion, of which 40%

¹⁶ With the exception of the COVID-19 pandemic when the government provided free primary healthcare for all citizens, this situation remains unchanged since fieldwork for this research was done in 2020- '22.

was spent on GP services. Resources to support marginalised people have been outlined in the introductory chapter.

2.2.2 Census and other health-related data

Census data provide a superb dataset of self-declared measures of life in Ireland, published under the following profiles: Population Distribution and Movements; Housing in Ireland; Households, Family and Childcare; Disability, Health and Carers; Diversity, Migration, Ethnicity, Irish Travellers & Religion; Homelessness; Employment, Occupations and Commuting; The Irish Language and Education (CSO 2022a). This dataset is used as a key source of information for policy makers. Government also publishes annual reports on National Healthcare Statistics and 'Health in Ireland: Key Trends. The Healthy Ireland Survey 2023 investigates self-reported health issues among citizens aged 15 years and over. In 2023, 76% had visited a GP in the previous year with an average of four visits per person (Government of Ireland 2023). Amid concerns about an ageing GP population (Irish Medical Council 2021a, 2024b) and the emigration of newly qualified GPs (Hanlon et al. 2024), the ICGP is currently training more GPs than ever before, with 565 trainees in training in 2024 (McGovern 2015; HSE 2024e). Access to any meaningfully nuanced health data, especially as it relates to primary care, is fraught with difficulty in Ireland and effectively stymies interdisciplinary collaboration (Foley et al. 2018; Houghton, Gleeson, and Kelleher 2003; Bell et al. 2018).

2.2.3 Irish indices of deprivation

Using census data since 1991, Trutz Haase and Jonathan Pratschke devised a statistical model to create the Haase-Pratschke Deprivation Index. The index estimated scores on a multivariate synthetic index of affluence and deprivation based on a selection of indicators to represent three different dimensions of

affluence/deprivation: demographic profile, social class composition and labour market situation (Haase and Pratschke 2016). The renamed Pobal HP Index has, over the years, supplanted other indices used in public policy, such as the Trinity National Deprivation Index (formerly Small Area Health Research Unit Index), also computed from Census data between 1996 and 2016 (Teljeur et al. 2019). Geographies of affluence and deprivation are mapped on the HP Index, affording comparative analysis, freely available to all but criticised by a minority for its opacity. Census 2022 data was gathered in April 2022, coinciding with the end of fieldwork for this research and it reflects the state of the country as we emerged from the COVID-19 pandemic. The HP deprivation indices for small areas (SA -100 households) were the tool I used to select GPs I invited for interview: by excluding areas of relative advantage, I was able to target GPs who find meaning in working for most of their career with marginalised people.



Figure 2-1: Map of Pobal HP Deprivation Indices by Electoral District, 2022.

Screenshot. Source:

<https://data.pobal.ie/portal/apps/storymaps/stories/5cf638fb421a40778f5c2cfcd108abc32>

2.2.4 TASC and ESRI publications

TASC, the independently funded Think-Tank for Social Change, has researched and published a series of reports on inequality in Ireland (Hearne and McMahon 2016; Hearne 2017; Sweeney 2018, 2023). These reports are instrumental in government policy making and delivery of service, subject to the ideology of the time. Before its dissolution in 2008, the Combat Poverty Agency¹⁷ had researched and advised successive governments on poverty from 1986 to 2008 (Combat Poverty Agency 2010). The Economic and Social Research Institute has provided an invaluable series of research publications with the objective of informing government policy (Smith et al. 2019; Lunn et al. 2020; Connolly et al. 2023; Walsh and Hill 2024; Devlin, Whelan, and McGuinness 2024; Roantree et al. 2021; Roantree, Barrett, and Redmond 2022; Roantree and Doorley 2023). These are timely and relevant to social justice.

2.2.5 Social determinants of health

Social Determinants of Health (SDH) are generally believed to provide a useful framework within which inequality can be addressed. The WHO broadly defines SDH as ‘the conditions in which people are born, grow, live, work and age, and people’s access to power, money and resources’ (WHO 2025). Key factors include socioeconomic status, education, healthcare access, neighbourhood environment, and social connections; under these headings, governments who subscribe to WHO principles attempt to intervene to minimise inequality and to improve population health and quality-of-life outcomes. In a 2023 review of interventions influencing health and care inequalities in general practice, Gkiouleka et al. assert that ‘general practitioners

¹⁷ On its dissolution, the Combat Poverty Agency was incorporated into the Department of Social Welfare.

especially can mitigate the effect of social determinants of health because they deal with the psychosocial aspects of patients' health' (Gkiouleka et al. 2023, e463). However, they conclude that 'the evidence base for general practice interventions that can reduce health inequalities is scarce. Studies mostly describe inequalities rather than investigating the mechanisms that drive them' (ibid, e468). This paper cites 128 references, none of which comes from the pen of a geographer. Given that geographers offer GIS mapping skills, *inter alia*, the absence of interdisciplinary collaboration between them and medical researchers, in this and in other high quality research papers, points to a lacuna that beggars belief.

2.2.6 Structural violence

Structural violence underpins and characterises the healthcare needs of most marginalised people. The term was first used by Galtung to describe violence that endures and has no particular beginning or single causative agent (Galtung 1969). It manifests from one generation to another in cycles that people cannot escape, one classical Irish example being the poverty of small tenant farmers during and after the 1847 Great Famine which reduced the population of Ireland from c. 9 million to 2 million over a century by starvation, infectious disease and emigration (Crowley, Smyth, and Murphy 2012; Kinealy 1994; Mokyr and O'Grada 1983; McGeachie 2016). Paul Farmer claims that 'sickness due to structural violence results from neither culture nor pure individual will but historically given and economically driven processes and forces that conspire to constrain individual agency' (2003, 40). Embodied consequences of colonial oppression are well documented in academic literature (Mintz 1985; Olusoga 2021; Dalrymple 2019) and have been hidden in plain sight in novels such as *Jane Eyre* (Brontë 2006) and *Mansfield Park* (Austen 2017). These were taught to me in secondary school without reference to the sugar/slave trade or

colonialism. 'Epigenetic trauma' (Nie et al. 2022), a downstream consequence of colonisation is familiar to us in Ireland; we have a global diaspora of c. 43 million people, a built environment left to us by the English and a legacy of immiseration, lyrically expressed in our folklore, music and oral history¹⁸. Ohlmeyer cites Friedrich Engels' letter to Karl Marx in 1856 observing that 'Ireland may be regarded as the first English colony' and goes on to state that Ireland was the 'laboratory' for British colonialism (Ohlmeyer 2024). That 'the body keeps the score' is entrenched in our culture (van der Kolk 2015). Franz Fanon, a psychiatrist who observed the effects of colonialist practices on his fellow Algerians, wrote that they 'dehumanize the native or ... turn him into an animal' (Fanon 1961, 32).

Fanon's case histories (ibid., Chapter 5) are appalling and resonate strongly with the Irish experience. It is not surprising, then, that colonised people's gait reflects their experience (Beaumont 2024), nor that socio-economic deprivation becomes partially encoded in our DNA. Social epigenetics has recently emerged as a field of study which provides further evidence of the lasting harms done by inequality (Martin et al. 2022). Earlier, Felitti had associated Adverse Childhood Experiences (ACEs) with higher morbidity and early mortality in later life (Felitti et al. 1998; Felitti 2019). Poverty, homelessness, substance addiction and domestic violence provide ample opportunities for the ACEs to thrive in a child's life with dire consequences later on in adulthood (O'Sullivan 2023).

¹⁸ Listen to Irish rugby supporters sing the song 'The Fields of Athenry' at an international championship match, then read the words, to get a flavour of the traces of national feeling (St. John 1979). The most passionately sung line is 'for they stole Trevelyan's corn that their young might see the morn'. Charles Trevelyan's ideology made starving, underclad people work for relief. The spectre of the 1847 famine persists to this day... 'God gave us the potato blight, but the English gave us the famine' is a well-known saying.

A further example of structural violence in Ireland is that perpetrated after Independence by our own masters on ourselves. Into the power vacuum created by the departure of the British rushed the Catholic Church and its acolyte politicians. Any individual whose actions might injure their family's or community's respectability was consigned to the emigrant ship or to a carceral institution; women who became pregnant out of wedlock disappeared wholesale: approximately 30,000 of them were sent into Mother and Baby Homes and Magdalene Laundries, 10,000 after independence in 1922 (Ferriter 2012; Department of Justice Home Affairs and Migration 2013).

It follows, therefore, that inequality is worth studying for its own sake, how it comes about, how it manifests and what can be done to mitigate its harmful effects. Wilkinson & Pickett explain in *The Spirit Level* why inequality disadvantages everyone in society and in *The Inner Level*, how it becomes internalised to the detriment of people's health (Pickett and Wilkinson 2010; Wilkinson and Pickett 2018). The Gini coefficient is used at all scales to show to what extent a given group, organisation or country deviated from perfect equality. Gapminder, the brainchild of epidemiologist and statistician Hans Rosling, is a user-friendly way to explore the multiple inequalities in our world (Rosling 2014). Dr Julian Tudor Hart (already mentioned), a GP in the Welsh mining valleys, stated in 'The Inverse Care Law' that 'the availability of good medical care tends to vary inversely with the need for it in the population served' (Tudor Hart 1971). In his wake, Dr Michael Marmot has championed the fight against inequality in the UK and globally (Marmot et al. 2008; Marmot 2015) as has Graham Watt, a founder of the Deep End GP service in Glasgow (Babbal et al. 2019; Watt 2019). The British National Health Service (NHS) was introduced in 1948 on foot of the Beveridge Report (1942), to provide everyone in the UK with healthcare based on their needs, and not on their ability to pay;

its model, although currently under threat, has been widely respected and valorised throughout the world.

2.2.7 Deep End GPs

The group 'Deep End Ireland' was launched in October 2016 and is modelled on the original General Practitioners at the Deep End project in Scotland (Babbel et al. 2019; Deep End GPs 2025; Foell 2025; Watt 2019). Deep End GPs work in the most disadvantaged communities in Ireland; eleven of 31 RPs declared membership of Deep End and declined to name other members although they sign letters to the daily newspapers. Working with marginalised people creates a GP experience very different from that of dealing with more affluent patients. Deep End GPs support each other by having regular online contact and by meeting in person for mutual support. Three RPs said that they had stopped attending their monthly Continuing Medical Education (CME)¹⁹ meetings because colleagues had no understanding of what their work involved or why they chose to do it. Their public advocacy presents evidence of healthcare inequalities and call on government to act. O'Dowd's account of the growth of his group practice in a Dublin suburb paints a graphic picture of how such advocacy is generated by the needs of a patient population (O'Dowd 2019).

¹⁹ In order to fulfil the statutory conditions for a GP to have their name re-entered on the Medical Register each year, GPs must provide evidence of attending regular continuing medical education (CME). The ICGP, through its tutors, holds monthly CME meetings in its 37 regional faculties. GPs say that the social component is an important aspect of these meetings.

2.3 Power/Knowledge and formation of General Practitioners

General practice, the focus of this dissertation, is shaped by the career trajectories and life experiences of people professionalised as general practitioners. This biographical treatment must also be supplemented by an understanding of the broader context in which the medical power they wield has been constituted. Here, it is worth pausing to consider the reception within Health Geographies of the ideas of Michel Foucault (1926–1984).

2.3.1 Michel Foucault (1926–1984)

That Foucault, philosopher and thinker (Philo 2011), researched and theorised medical practice is not surprising when one considers that his maternal grandfather was a professor of Medicine in Poitiers in rural France and his father was a local surgeon. Like several participants in this research, his kitchen table capital would have familiarised him with medical discourse from childhood. This research, however, is more concerned with his contribution to the geography of health (Philo 2000, 1992; Driver 2017; Condrau 2007; Ettlinger 2011; Elden 2007; Crampton and Elden 2007). Whereas much of the history of medicine has been written in the tone of the ‘great man theory’ (Jones and Malcolm 1999, 1), Foucault takes an ever wider perspective²⁰ on medical practice that re-theorises it through the spatial lens of human geography. Power and power relations, their conditions of possibility and their ebb and flow over time required a whole new lexicon for description and analysis (Foucault 1991 [1975], 57,68). Whereas ‘epoch’ heretofore defined a historical period, Foucault uses the term ‘episteme’ to describe not only a bounded period of time, but also

²⁰ Perspective itself is a geographical construct, made familiar to Europeans by Johannes Vermeer’s painting ‘The Geographer’, painted in 1669 as an illustration of the wealth earned by Dutch traders by their increasingly distant, lucrative colonial conquests.

its paradigms, discourses and discursive arguments (Foucault 1974). Structures of power are analysed not as passive items in law or politics but as entities with agency; power is not only possessed, it is exercised, and it is capable of producing subjects. 'Docile bodies' who have unknowingly internalised prevailing paradigms, perpetuate dominant narratives like prisoners in Bentham's panopticon (Foucault 1991 [1975], 135–170). Surveillance (ibid. p. 170), normalisation (ibid. p.177) and regular examination of subjects (ibid. p. 184) socially produce compliant people. Whereas GPs spend considerable time teaching patients to examine and change their salutogenic behavioural patterns, the Socratic axiom that 'the unexamined life is not worth living' behoves GPs also to examine their own (Antonovsky 1996; Nails and Monoson 2025).

Medical doctors have significant powers, so normalised in the course of their working lives that several participants in this research expressed doubts in that regard. A Foucauldian perspective suggests that their powers are conferred on them by statute, by their protracted education, by their scientific knowledge of diseases and therapeutics and by the art of healing. Power laid down in a sedimentary fashion, over time, can become normalised. Knowledge confers power; power to alleviate a patient's symptoms and immanent power conferred by reputation, when GPs do a good job. Yet, the regulations by which they are registered to practice medicine are so onerous that they might well be 'docile bodies' themselves. Born into an episteme with its own unconscious background assumptions, educated within a contemporary scientific paradigm and practising medicine within a population with its own dominant narratives, they are subject to a variety of governmentality (Elden 2007; Ettlinger 2011; G. Kearns 2014; Legg 2005, 2018). Those who consult the GPs in this research are people with hardly any power; poor, sometimes homeless, often addicted to alcohol or drugs, with hardly any social capital outside their own peer group. The interface of these GPs and patients is where power manifests, acts and

transforms. The relational space where patient and GP co-constitute each other is the most meaning-ful component of General Practice, as participants say in the thematic chapters that follow. Foucault's 'medical gaze' becomes no more than a starting point; writing in 2000, Philo considers 'a diffuse medicalized social geography, an unspecific medical gaze casting its eye over the whole social realm' (Philo 2000, 17). Since time immemorial, and still, twenty-five years later, the medical gaze is a key instrument in a GP's toolkit (Bleakley 2013). Although some may chastise medical doctors for their use of the 'medical gaze', this burdensome attribute has been branded it onto their consciousness by protracted professional formation. Years after my own retirement from medical practice, I am constantly reminded that 'you cannot un-know what you know'.

Foucault's ideas were well received by medical geographers. Accustomed to interrogating the provenance, axes and deployment of power in society, they welcomed his prolific output up to his death in 1984 as he dismantled contemporary 'givens' and showed them to be subjective, contingent and grounded in a narrow version of history. His exploration of how medical history was constructed has been identified as 'a field of spatial analysis'

²¹(G.Kearns 2007, 248). Foucault's reference to Hippocrates' 'Of Airs, Waters and Places' (ibid., p. 253) not only invokes the concept of space but also prefigures Gesler's 'therapeutic landscapes' (Gesler 1992). The networks of historical carceral spaces described in *Madness and Civilization* (2001 [1961]) and in *Discipline and Punish* (Foucault 1991 [1975]) map readily onto a contemporary Irish population whose mental healthcare issues are treated in the community,

²¹ Foucault's discursive historiography differed significantly from the canonical 'great man theories' by which medical history is conventionally framed. Most medical doctors to whom I have mentioned Foucault have not heard of him.

their caregiving internalised by a governmentality of data, algorithm and telemedicine.

‘This book is about space’ is the opening line of Foucault’s *Birth of the Clinic* (Foucault 2003 [1963]; Philo 2000, 11). Philo’s interrogation of Foucault’s spatialisation- primary, secondary and tertiary begin with a wide angled lens that narrows its focus until it delves within the spaces of the body.²² This framing is familiar to all of us who lived through the COVID-19 pandemic and consumed media reports of its manifestations through these lenses- new science, government regulation and daily data. Philo’s oeuvre continues to be inspired by Foucault and this research takes particular interest in his work on Canguilhem, Foucault’s doctoral supervisor and on the ‘rural panopticon’ where some of my Research Participants live and work (Philo 2007; Philo, Parr, and Burns 2017, 2003). How space shapes human lives is a matter in constant need of discursive foregrounding. Legg broadens the discussion to include Foucault’s more recently translated works and explores the concepts of governmentality, biopower and biopolitics in population geography:

With his genealogical work, Foucault identified a contemporary taken-for-granted power relation, with specific impacts upon the body, and traced its multiple origins in order to expose the contingency of, and thus to denaturalise, the present (Legg 2005, 139).

Illich’s ‘Medical Nemesis’, first published in 1975, dismantles the powers of the medical profession and goes so far as to say that doctors are sometimes responsible for harming patients (Illich 2003). More recently, Blease says so too, and backs up her assertions with robust data (Blease 2025). It behoves us to pay ‘attention to the different scales at which biopolitical processes occur, and to the

²² Foucault died in 1984, from an AIDS related illness before the widespread availability (in the developed world) of CAT scans, MRI scans and PET scans which can show the body’s internal organs in any plane, with microscopic detail.

variety of levels at which these processes must be analysed' (ibid. p. 152) in the face of the commodification of healthcare not only by healthcare professionals but, more significantly, by the capitalist 'broligarchy' (Cadwalladr 2025).

Foucault had his own definition of geography and geographical terms, preferring the term 'archipelago' to 'geographical metaphors such as field, displacement, domain, region, and horizon' (Ettlinger 2011, 540). When questioned about geography at interview in 1980, he said:

'Once knowledge can be analysed in terms of region, domain, implantation, displacement, transposition, one is able to capture the process by which knowledge functions as a form of power and disseminates effects of power' (ibid., p. 540).

Following geographers who research Foucault, our obligation must be to tease apart the messy conditions of life in all its manifestations and analyse mycelia of power, however they germinate and hyphate, so best to deploy resources in the common good (Sheldrake 2020; Tsing 2015).

2.3.2 Becoming a GP

Clare Gerada was an English GP for all of her working life. Before she retired from her NHS practice in London in 2015, she had become Medical Director of the Practitioner Health Programme in the UK and had written 'Beneath the White Coat: Doctors, Their Minds and Mental Illness' about her lifelong becoming (Gerada 2021). She wrote the book because, having had incapacitating burnout herself and finding her way back to health with the help of counselling and paid sick leave ²³, she felt obliged to share her experiences

²³ I mention this because, while state- paid sick leave is part of the social contract in Europe and the UK, we might assume it exists in other jurisdictions. The USA is the salient example of a wealthy nation that lays almost all the expenses of illness on the private individual and their insurance.

and contextualise them within the framework of contemporary medical practice. Gerada's story is not atypical. Like many doctors, she was the daughter of a GP, grew up over the shop, and in her own words 'internalised an identity and particular values' during childhood (Lentz and Laband 1989; Gerada 2021, 4). While her experience of burnout is not much reflected in this research, the joy of being a general practitioner (Thomas et al. 2023), the privilege of being able to access people's inner lives by caring (Tronto 1993, 101–125) and the deep meaning GPs infer from their everyday work (Crossley 1996, 141) are echoed by all Research Participants. The training and regulation of general practitioners in Ireland has been described in the Introduction and will be referred to throughout the text, as is their statutory obligation to maintain professional standards, audited throughout their careers (Irish Medical Council 2016). However, their becoming is lifelong.

Such is the onus of scientific and professional education required to be a GP that it would be understandable if they took refuge in data and lost sight of the importance of caregiving along the way. Humans are, after all, messy. But the narrative accounts in this research recite, again and again, participants' struggle to become more human. Books written by and about doctors in the literary canon give us great insight into their work in various circumstances and historical eras. Lucia Gannon's *All in a Doctor's Day: Memoirs of an Irish Country Practice* (2019) convey the highs and lows of her working life in Co. Tipperary. A.J. Cronin's *The Citadel* (1937) takes us to the hardship of Welsh mining valleys in the late 1920s, before the NHS came into being. *Madame Bovary* (Flaubert 1994 [1867]) was the wife of a mid-19th Century French GP who resisted the role thrust on her by marrying a rural GP and Tertius Lydgate in *Middlemarch* (Eliot 1950 [1871]) was a GP who allowed the desire for financial and social status to erode his idealism in middle England. These latter two have become classics by remaining true to the experience of rural doctors.

The Irish tuberculosis epidemic with its savage morbidity and mortality are well chronicled by Noël Browne's autobiography (1986); born into poverty, his siblings and his mother died from TB, his education and medical training were undertaken by a philanthropic doctor and he went on to become Minister for Health in 1948, a year after Streptomycin was made available for treatment of TB. His battle with the Catholic Hierarchy to nationalise healthcare give clear insight into power struggles between the medical establishment, politicians and churchmen during his ministry. James Deeny, a medical doctor and Chief Medical Officer of the Department of Health at that time gives a wider context to contemporary contentions (Deeny 1989, 178). The 'becoming' of all parties in that damaging fracas are well chronicled from all sides (Barrington 1987; Wren 2003; Browne 1986; Deeny 1989). Among other things, Browne was an activist and an advocate for the poor. In his becoming, he confronted powerful, vested interests, an experience narrated by some participants in this research in the thematic chapters that follow:

Becoming designates a process-based ontology of movement, in which the world is conceived of as a dynamic and open-ended set of relational transformations. Becoming is frequently distinguished from and sometimes opposed to being (McCormack 2009).

Whereas it might seem that an individual 'becomes' a GP on the day they graduate or has their name enrolled on the specialist register, the reality is that their becoming continues throughout their professional life. 'Flux, change and continuous transformation' (ibid. p. 1) characterise the GP experience. To some GPs it may even (occasionally) feel like transfiguration, for, as Deleuze and Guattari remark (1988, 299) 'affects are becomings'. Patients in a continuous care relationship over decades sculpt their embodied health carers by their pain and suffering. New drugs, new therapies, new technological interventions come to bear on them as non-human actors (Foster 2007). Their becoming, in synch with that of their patients, conforms more to Thrift's Non-Representational

Theory (2008) than to the linear genealogy beloved of those devoted to any great man theory (Jones and Malcolm 1999, 1–4). Sahlins’ ‘mutuality of being’ accurately captures the relationship that develops after years of doctor-patient intersubjectivity (Sahlins 2013).

2.3.3 Geographical formation

GPs also undergo geographical formation (G.Kearns 2015). Because the qualifying exams are carefully calibrated and overseen in order to ensure selection of candidates based on merit rather than social capital, successful candidates may be assigned a place in a university either near their home or far away. Hospital placements during their training may require travel to unfamiliar parts of Ireland. Their experiences as trainees may warm them to a new locale and sense of place or may reinforce their determination to work in a place like their home. In this research, RPs declare the love of the sea or the city, dedication to the underserved or desire to live and work where they grew up as vectors that determined where they set up practice. Their lifepaths are amenable to writing, mapping or storytelling in an interview (See Research Question 1²⁴) sometimes with luck or happenstance playing a role (Daniels and Nash 2004; Johnston 2015). A skein of philosophical reflection ran through all GP interviews, particularly those near the end of their careers, as they recounted how they ended up where they were.

2.4 The consultation

Family Medicine has a unique consultation process, which establish as a relationship over time, through effective communication between doctor and patient. Each contact between patient and their family doctor contributes to an evolving story, and each individual consultation can draw on this prior shared experience. The value of this personal relationship is determined by the communication skills of the family doctor and is in itself therapeutic. [Family

²⁴ Research Question 1: How did you come to be a general practitioner?

Medicine] is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.

The approach of general practice must be constant from birth (and sometimes before) until death (and sometimes afterwards). It ensures the continuity of care by following patients through the whole of their life. The medical file is the explicit proof of this constancy. It is the objective memory of the consultations, but only part of the common doctor-patient history (WONCA 2023).

Into the encounter known as the consultation, two people²⁵ bring their very diverse and complementary sets of needs and expertise. Whereas most consultations happen in a consulting room, people who are homeless or precariously housed may consult a healthcare worker wherever they dwell – under a bridge, in a park, in a facility for intravenous drug users, in a Safetynet mobile clinic (Safetynet 2024) – a primary care heterotopia familiar to GPs in this research, but not to most others (the Safetynet service is described in Chapter 4). Confidentiality indoors requires a sound-proofed space, respect demands comfortable furnishings and room temperature. Whereas decorum might be easily achieved with educated patients who have social and financial capital, its absence among chaotic patients can lead to non-delivery of healthcare unless the Practice is organised to accommodate them. Consultations are usually bounded by space and time, but marginalised people require a more fluid version of both in order for their healthcare needs to be anticipated and met. Participants in this research assert that ‘Medical dominance’ no longer has a role in primary care consultations, especially with marginalised patients (Bleakley 2013; Willis 2006).

2.4.1 Proximity

Agarwal invokes a theory of proximity to ‘patients experiencing social inequity’ which includes ‘three nested elements: physical, narrative and moral proximity’

²⁵ The patient may be accompanied by a parent, carer, companion or social worker. The doctor may be accompanied by a trainee GP, a trainer GP, a nurse or chaperone.

(Molinaro et al. 2024, 2). These consultations take more time and were seen by participating physicians as ‘an act of resistance to and threatened by remuneration structuring within Ontario’s primary health care system’ (ibid. p. 4). Rather than have a nurse dress the patient’s wounds, some participants did it personally which ‘allows for a re-embodiment of the patient within their own body’ (ibid. p. 4) and helped with ‘exposure therapy’ where a reluctant, traumatised patient gradually became more comfortable seeking primary healthcare. Agarwal is one of very few medical practitioners who writes in the discipline of human geography. Her chapter on the ‘Geographies of Family Medicine’ locates primary care work in place and in community (Agarwal 2009, 116–117). ‘The clinical geography of each consultation’ (ibid. p. 122) comprises acute care, chronic care, preventive care that is both targeted and opportunistic and the cultivation of relationship over time’ (ibid. p. 122). ‘The key to Asclepian healing is always accompaniment’ (Kearney 2021, 70). Furthermore, recent research on 0.5 million UK patients shows that ‘patient satisfaction and ability to have health needs met is associated with face-to-face access to GPs’ (Burch, Whittaker, and Lau 2025, e375). GPs in this research know this and make themselves as available to patients as they can, as the thematic chapters will show.

2.4.2 Supports for practices in marginalised communities

In Ireland, marginalised people receive their healthcare through various structures. Rural GPs may avail of the Rural Practice Support Framework. The Chronic Disease Management Programme is a funded protocol for patients with a GMS medical card or GP visit card who have a specified chronic illness such as Type 2 diabetes, COPD or cardiovascular disease. However, mobility problems for the elderly characterise rural marginalisation: they need the GP or healthcare worker or home carer to visit them at home. An Irish form of ‘rural

spatial ageism' has been identified, manifested in disconnected policy that 'illustrates a neglect of rural settings and the older people that live within them' (Zhou et al. 2025, 10). This explains, in part, why the obligation to care falls back on the individual GP.

Urban practices that serve marginalised populations are entitled to a social deprivation practice grant (O'Shea et al. 2024). Safetynet provides clinics and a mobile service for homeless persons (Safetynet 2019), and Merchants Quay Ireland which serves drug users (Merchants Quay Ireland 2019). Organisations such as Simon, the Capuchin Day Centre all have consultation rooms for GPs who work there on a sessional basis. The Inclusion Health Network, spearheaded by Dr Clíona Ni Cheallaigh, a consultant in St. James Hospital, provides hospital care in a 'person-centred, multi-disciplinary approach to care delivery' (Merchants Quay Ireland 2019). Her clinic in Dublin has demolished the obstacles to patient care that formerly excluded marginalised Dubliners. Other cities need a similar service.

2.4.3 GP care work, visible and invisible

Many GP practices have a mix of patients from all walks of life. A GP's working life is busy, and their working day is long (Collins and Homeniuk 2021). A 2019 study of 123 GPs showed that Irish GPs work a mean of 9.9 hours per day, spending 6.3 hours (64% of the working day) in face-to-face consultation (Crosbie et al. 2020, e489). Beyond their clinical workload of patient-facing work, what accrues to each consultation is hidden work that must be done in a timely manner to complete their patient's care (Barnard et al. 2024; Foell 2025; Woolford et al. 2024). GPs in this research call this 'paperwork' or 'admin', a misleading euphemism since it can occupy them well into the night. The days when GPs did 12 to 30 home visits each day are long gone (Kmietowicz 2006,

39), replaced now by dispersed care across the primary care team (Jimenez et al. 2020, 8–10) and online consulting (Kitchin and Dodge 2011; Banks et al. 2017; Mold et al. 2019; Walley et al. 2024). The COVID-19 pandemic drove many GP consultations online (Homeniuk and Collins 2021; HSE 2020a; Hatef et al. 2024) with the loss of the intersubjectivity between doctor and patient so treasured by both (Crossley 1996). GPs in training are exposed to many different consultation models to help them hone their own professional practice: Balint (1955), Starfield (1994), Calgary-Cambridge (Kurtz and Silverman 1996), Pendleton (2003), Charon (2006) and Launer (2023) train them to elicit a patient's narrative and to find personal equilibrium in the face of uncertainty. These are outlined in more detail in Chapter 5 as elements of the landscape of care. The HSE provides online educational modules to teach healthcare workers how to perform teleconsultation.²⁶

Safety-netting²⁷ is now a standard way to end a consultation; the GP tells the patient what to expect from the recommended treatment and when to seek help if their symptoms deteriorate (Jones et al. 2019; Murphy 2022; Almond, Mant, and Thompson 2009).

General Practices and centres of primary care are designed to maximise wellbeing in a population. Fond and proud accounts of their building, given by

²⁶ I took these modules when I worked for the HSE as a Clinical Contact Tracer and found them very thorough. They are password protected within the online training environment.

²⁷ Safety-netting: 'the most frequently recommended components were communicating uncertainty, advice on worrying symptoms and red flags; the likely time course of the illness; how and when to seek further medical care; arranging planned follow-up; primary care investigations and organisational components (Jones et al. 2019, e72). Safety-netting was considered to be particularly important when consulting with children, the acutely unwell, patients with multimorbidity, and those with mental health problems (ibid. p. e70). GPs regularly used 'safety-net' as a verb in this way.

RPs in this research, were echoed in Hokianga (R.A.Kearns 1993, 143) by Kearns and Neuwelt (2009). Neuwelt, like Agarwal, is a medical doctor who writes about the humanities with a particular focus on the care work done by practice receptionists in the waiting room area (Kearns and Neuwelt 2009; Kearns, Neuwelt, and Eggleton 2020) The 'body ballet' of a general practice can only flow smoothly when all members of staff and patients agree to its convention (Seamon 1980, 2018).

2.5 GPs as placemakers

It was long after I had finished my fieldwork that I came upon the 'Routledge Handbook of Placemaking' (Courage 2020) which has no reference whatsoever to the role of healthcare in placemaking. Stories told to me by Research Participants in the thematic chapters which follow would argue to the contrary. I had interviewed GPs who dressed festering wounds on the bodies of intravenous drug users; who had attended at maritime disasters and pulled casualties out of the sea; who had, over several years, represented a single mother whose beloved, autistic child TUSLA wanted to take into care; who did extra house calls on isolated, elderly rural patients so that they could stay in their own home long after the services would have had them admitted to a residential facility and who had grieved the suicide of a fourteen year old boy whom they failed to get admitted to a CAMHS residential psychiatric services after 4 pm on a Friday because nobody answered the phone So, what were these GPs if not placemakers? If they were just delivering bare, commodified primary care (with apologies to Agamben (1998 [1995])), why did they keep doing it?

2.5.1 Place as ‘prequel’

The making of place is a recursive practice through which people mutually constitute each other (Cresswell 2015). Long shorn of its perception as a container for activity defined by Euclidean co-ordinates, place was characterised by Agnew as having ‘locale, or place as setting for social interaction; location, or place located in geographical space; and sense of place, or attachment between people and place’ (Agnew 1987, 27). That place was a starting point for existence was argued by Aristotle in the fourth century BCE (Cresswell 2009, 170) and drawn on much later by Hegel (1977 [1807]), who believed that it was a necessary condition for the actualisation of spirit, and by Heidegger whose ‘*dasein*’ stated that in order to be-in-the-world, one had to be somewhere²⁸ (Heidegger 1962 [1926]). Buttimer developed the concept into a better one – *lebenswelt*.²⁹

Once aware of lifeworld in personal experience, an individual should then aim to grasp the shared world horizons of other people and of society as a whole (Buttimer 1976, 281).

The idea of place as a living, kinetic, contingent experience was further developed around that time by Tuan (1979), Relph (1976), Seamon (1979) and Pred (1984), whose writings are an enchanting tour through what worked in some societies in the past, and what might be possible in the future. Since Gesler first articulated the therapeutic effect of place, many geographers have developed the concept (Gesler 1992; Gesler 2005; Foley 2010, 2015; Bell 2015;

²⁸ I trekked Heidegger’s Rundweg in the Black Forest in August 2019 and was underwhelmed by its timeless Nazi-like perfection ...rolling hills and valleys forested up to the treeline, the soundscape of bells around cows’ necks and a tiny chapel tolling the Angelus at midday, where Heidegger held and hosted writing retreats in his cabin by the babbling brook before returning to his wife and sons back in Frieberg, Germany. It was quite the experience of cognitive dissonance.

²⁹ *Leben* means ‘to live’ in German. *Welt* means world.

Willis 2009; Cox and Holmes 2000; Bell et al. 2018). Rural GPs, in particular, spoke of their engagement with the place where they live and work and how they socially prescribe therapeutic place engagement for their patients.

2.5.2 Liveability

To make people's lives 'liveable' is the goal of all primary carers.

Liveability is a life of meaning, contribution, and value, according to the varying means by which all individuals in a community- regardless of ability, cultural identification, ill health, and background – are supported in their pursuit of the good life, and as they contribute to their community, and work to have their humanity and dignity recognised and valued by others (Duff and Hill 2022, 2).

The concept is explored by Butler (1999, 2014), Massey (1994, 2005) and Browne & Bakshi (2013), who write about gender identity and exclusion, and Katz (Skelton 2011) who writes about struggle in the face of structural inequalities. Studies have shown that elderly people thrive in their own homes if a supportive infrastructure is in place (Grove 2020; Guzmán et al. 2023; McGarrigle et al. 2017; McGarrigle et al. 2020). GPs who retire from practice in remote rural areas despair of the 'sticking plaster' primary care provided by the HSE for their elderly patients when their post is not filled (Skillen 2025).

Research Participants who care for patients who may behave chaotically said that 'you need to be a certain kind of person' to be well disposed towards them. Over time, patients come to know when a GP treats them with respect, and they can have confidence in them. Molinaro et al. cite one patient who 'took four years to trust' their GP (Molinaro et al. 2024). A visceral and emotional knowing occurs at a pre-verbal level (Bondi, Davidson, and Smith 2016) that is not only felt by the subject, be it patient or doctor, but transmitted too (Thrift 2004). Deep End GPs support each other in knowing what their very marginalised urban-dwelling patients need and finding the enduring strength to deliver the care

that they need (Babbel et al. 2019; O'Carroll 2019; Watt 2019; Smith 2024; McGinnity 2012). Rural GPs, likewise, support each other through the Rural, Island & Dispensing Doctors of Ireland (RIDDP), taking inspiration from the research of Liam Glynn et al. of UL (2023; Glynn 2024), Homeniuk et al. (2023) and Stanley et al. (2023). For GPs who find their niche, providing service for their patients, caregiving becomes a source of joy that sustains them in the face of most vicissitudes (Thomas et al. 2023).

2.5.3 Relational care

When it works for everybody, patients and primary health carers alike, the experience of care giving is relational. Although Duff and Hill's 2022 paper refers to the in-patient experience, the conceptual framework of 'Wellbeing as social care' applies to patients who are limited or immobilised at home by pain or illness (Duff and Hill 2022). 'Social, affective and material relations' (ibid. p. 3) are at the core of their concerns to effect 'maintenance and repair' of individuals and their communities or 'commons'.

Care, in this respect, ought to be understood in Tronto's terms as a collective activity that takes place in concert with others, both human and non-human, in the slow weaving of a life-sustaining web of relations and supports (Duff and Hill 2022, 5; Tronto 1993).

In this respect, most GPs have a network of hospital colleagues to whom they refer patients for secondary care. The network is built in sedimentary fashion from the earliest days in medical school and refined as doctors hone their skills and craft through years of practice. Feedback from patients who feel that they

were well or badly treated reinforces connectivity in the healthcare system in a care-ful³⁰ way (de la Bellacasa 2010).

A GP's capacity to provide immediate and chronic primary care diffuses through a locality, and I will return to this in Section 2.7. The GP as placemaker is a key actor in enabling people to live and age-in-place in their communities (Grove 2021). People have accidents, children spike fevers at short notice, elderly people with multiple chronic illnesses have precarious health. All take comfort from having a GP available who will diagnose their ailment and both advise and act on its urgency and treatment. Cummins et al. emphasise embeddedness; 'the processes and interactions occurring between people and places and over time which may be important for health' (Cummins et al. 2007, 1828). A GP would read this as 'continuity of care', an idealised situation which has significant bearing on the outcomes of primary care interventions (Barker, Steventon, and Deeny 2017; Pereira Gray et al. 2018; Sandvik et al. 2021). In the web of healthcare, a GP's presence in a rural area, an inner-city clinic or a mobile clinic for homeless people may be seen as a 'node' in the flows of local and regional wellbeing (Cummins et al. 2007, 1832). As RPs in this research say, they like becoming part of the local community. People recognise their car, know their daily and weekly habits, whether they like to play golf or go fishing during their time off. This is the kind of relational belonging referred to by Conradson (2005), Dyck et al. (2005) and Cattell et al. (2008); it creates relationships outside the clinical framework which enable place attachment to grow (Lewicka 2011, 213). Sharing the blue and green spaces in their locale with their patients is more likely to occur in rural than urban areas. GIS offers immense possibilities to calculate where GPs might live and work: 'will it work

³⁰ Maria Puig de la Bellacasa hyphenates the word care-ful to make it more active, more transitive, more an active practice than a passive descriptive adjective.

here'? (Nykiforuk and Flaman 2011, 64) is the question that most exercises policy makers and primary healthcare practitioners alike.

2.6 Landscapes of care and caregiving

Were general practitioners to confine their clinical concerns about a given patient to the presenting complaint brought to the consultation, their findings on history taking and physical examination, laboratory investigations and a subsequent wrap-up consultation to bring closure, primary healthcare would be purely transactional, an etiolated version of that which is presented in this research. It would be quite easy and very tidy for a GP to confine their clinical questioning to matters concerning the presenting complaint and to swerve matters arising from need, want, inequality, inequity and social precipitators of ill health. Many GPs do. Commodified general practice affords this abstraction; a time limit on the consultation permits only one complaint per consultation and may thereby shear the patient's presenting complaint of context. Notices in the waiting room of a local GP practice recently bought by Centric ³¹ have this edict in strident notices on the waiting room walls. Online consultations provided by private healthcare companies end with the GP saying 'I have no access to your healthcare records, so my advice and prescription are based only on what you have told me'³².

When care is meted out in time slots and corporatised, it becomes a unit of supervision rather than a form of care. The time required to provide the relational and emotional dimension of care is put at risk, thereby disregarding the voluntary human engagement and mutuality that are at the heart of caring, even when it is paid (Lynch 2022, 88).

³¹ Centric is a for-profit conglomerate that buys up GP practices from retiring GPs.

³² Personal experience: a friend recently asked me to sit in on her online consultation with her health insurance provider and I heard the GP say this.

All of this is quite contrary to the landscapes of care explored by Milligan and Wiles (2010; Wiles 2023, 2024) which ‘emerge from and through relationships of care’ (Milligan and Wiles 2010, 736), and to the accounts given by participants in this research.

2.6.1 Defining care

Care may be defined as

a species activity that includes everything that we do to maintain, continue and repair our world so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web (Fisher and Tronto 1990, 40).

Milligan and Wiles’ (2010) area of concern lies not in medical or paramedical care but in care as its requirements arise in everyday life, and as others are called to provide it. However, I choose their framework because participants in this research go way beyond providing rudimentary professional care for their patients. Geographers who have carried the torch for care, caring about and caring for include Parr (2003), Lawson (2009, 210–213), Middleton (2021) and Greenhough et al. (2023).³³ It behoves us to remember that care in the home of children, of elderly people, of disabled people was, in the past, referred to as a ‘vocation’; *vocare* is the Latin for the verb ‘to call’.³⁴ The need arose; the carer was called into action and thereby created an affective zone around the person or people with needs. I take this framework to apply to the GPs in this research who, as their testimony reveals, not only provide primary care to but also advocate for their patients as much as they can. Landscapes of care ‘can encompass the institutional, the domestic, the familial, the community, the

³³ At the risk of appearing sexist, all of these authors are women.

³⁴ ‘Advocate’ also has its roots in the Latin verb ‘*vocare*’. ‘*Ad*’ translates as ‘towards’.

public, the voluntary³⁵ and the private as well as transitions within and between them' (Milligan and Wiles 2010, 738). Sociospatial dimensions of care include the home, the workplace, childcare centres, drop-in centres and 'are shaped by issues of responsibility, ethics and morals, and by social, emotional, symbolic, physical and material aspects of caring' (ibid. p. 740). The issue of proximity (p740) became central when the COVID-19 pandemic led to social isolation; as a contact tracer I experienced caring deeply for and about somebody to whom I only spoke once, whose face I never saw. Caring calls on our reserves of compassion, often heretofore unknown and acknowledged, but made manifest by the act of caring (Lawson 2007; Kleinman 2009). That an ethics of care might become a social theory is argued by Tronto (1993) and Lynch (2022, 198–199) and by Milligan and Wiles (2010), who articulate the contagion of care and caring from its smallest unit, from one person to another, to an expanded network or assemblage in which complex organisations do their work in a 'care-ful' manner.

The definition of care has multi-level meanings in the Irish language and the Hiberno-English lexicon used in Ireland (De Bháldraithe 2009; Dolan 1998; Pearsall 1998). Healthcare in Ireland, as in all developed countries, is highly regulated by national laws and policies (Government of Ireland 1970, 2001, 2024; Shortall 2017; Government of Ireland 1980), Medical Council protocols (Irish Medical Council 2015, 2024a) and the Health Service Executive (HSE), which employs primary carers and negotiates their terms of employment (HSE 2018). All medical doctors are obliged to have professional medical indemnity.

³⁵ Without the presence of a Medical Officer, many local sporting events cannot proceed. Rural GPs provide such cover on a voluntary basis for maritime sporting events, equestrian events, GAA football, hurling and camogie and rugby and soccer.

2.6.2 The workload of caring for marginalised people

Provision of primary care for marginalised people brings an augmented workload to each consultation, such are the many and varied disadvantages in their lives. Structural violence (Farmer et al. 2006; Farmer 2010), poverty (O'Sullivan 2023), inequality and inequity (Burke 2009; Curtis 2003; Tudor Hart 1971; Marmot 2002; McGinnity 2021) wrongfoot underserved patients at every step. Blighted by Adverse Childhood Experiences (ACEs) (Felitti et al. 1998; Felitti 2019), burdened by hardship (van der Kolk 2015), they require more primary care support than people with good social capital. Wiles draws upon the concept of 'slow violence' (Nixon 2011) to explain how marginalised people suffer so much more from 'climate change, deforestation and the environmental aftermath of war' (Wiles 2024, 372) and applies this to the effects of the COVID-19 pandemic (ibid. p. 373). She also includes 'third places' as care sites, a subject often raised by GPs in this research who had helped construct them for the benefit of their community (ibid. p. 375). Familial caring for people with intellectual disabilities is framed by Power as a relational and ethical practice: participants in this research construe their caring likewise (Power 2016). Greenhalgh goes even further, asserting that in healthcare research, 'without values, complexity is reduced to mathematics' (2025, 1–5) an edict that deserves our attention as the spectre of AI hovers with intent.

Appropriate allocation of resources according to need may be seen as healthcare (Daniels 1985). National Census data, taken every four years, provide an accurate dataset on the state of the nation's health, both self-interpreted and classified (CSO 2016, 2022a). The Haase-Pratschke Deprivation index is compiled from census data and may be viewed by Electoral District or Small Area (100 households or thereabouts) (Haase and Pratschke 2016).

Resources may then be allocated according to need, depending on the ideology of the incumbent government.

2.6.3 Case histories, not anecdotes

If the testimonies of GPs given at interview for this research consisted solely of anecdotes, they would make nice fireside tales. But no anecdotes were told: every quotation from every GP in this work is the case history of a patient, a family or a cohort who came to them seeking healthcare. A landscape of care is what a caring GP and their primary care team create wherever they locate their Practice and their practice.

2.7 COVID-19 and the (temporary) annihilation of place

This section came into being when COVID-19 irrupted our lives in the spring of 2020, causing a degree of morbidity and mortality that frightened us all and rendered us more compliant with harsh restrictions of mobility that almost annihilated our individual and collective sense of place (Bissell 2021; Scott 2020). The practices of everyday life were suspended, including my research, so I turned to the therapeutic practice of journalling my experience (Ellis, Adams, and Bochner 2011, 7) which subsequently became an (auto)ethnography³⁶ of COVID-19.

³⁶ I bracket (auto) because of a positionality that made me both insider and outsider while I experienced the restrictions of the COVID-19 pandemic as a citizen and worked for the HSE as a Clinical Contact Tracer.

2.7.1 Writing ethnography

Autoethnography is hard to write (Wall 2008). Personal reflections may be drawn on to illuminate the text but may not flood it. In this respect I drew on the writings of anthropologists introduced to me during my BA in Anthropology (2013–2016), some of whom, like Malinowski (1922, 2014), found themselves in circumstances beyond their control or comprehension, others whose research was part of a colonial project, such as Evans-Pritchard (1937), and writers whose academic curiosity drove them, like Taussig (1986), Scheper-Hughes (1979) and Tsing (2015). Bourgois' exemplary account of 'selling crack in El Barrio' is written with unrelenting respect for people who live in appalling circumstances (Bourgois 2003). These and numerous others reminded me that the bizarre is quotidian, a point made by John Van Maanen (1988) when I heard him speak at an ethnography conference in 2019. Human geographers use autoethnography too. Till's work mapping spectral traces in Germany and Cape Town reminds us how painful are the visceral resonances of what we research (Till 2005, 2009; Jonker and Till 2009). When autoethnographic practices are properly carried out, with due regard to reflexivity and its learnings, useful insights may occur without collateral self-harm to the writer (Liggins, Kearns, and Adams 2013; Butz and Besio 2009; Moss and Besio 2019). All of the body's senses are recruited as preliminary sketches for an autoethnography (DeLyser 2015; Pink 2009). Documenting, reflecting, coding and synthesising then build with these raw materials.

The work of writing ethnography and its discipline are well documented (Emerson, Fretz, and Shaw 2011; Clifford 1986b; Butz and Besio 2009; Reed-Danahay 1997; Bochner and Ellis 2016). Although fieldwork was no longer

available to me once lockdown³⁷ began in March 2020, my own emotional implosion needed to be earthed daily via ‘thick description’ with pen and paper (Geertz 1973, 6). Typing on a keyboard did not ground the electrical circuits in my head. During medical training I had been drilled in the importance of contemporaneous note taking, but unless clinical uncertainty needed to be logged, personal or reflexive observations were contra-indicated.³⁸ Comfortable with uncertainty, the political scientist Pachirat scuppers that approach:

... ethnography forces us to confront the question of how we as researchers are implicated in the social worlds we study, to confront the ways we actually co-generate rather than simply collect data, and to confront the ways the knowledge we produce with these data travels back and alters the very social worlds it purports to explain (Pachirat 2018, 18).

Feminist geographers remind us that there is no such thing as a neutral observer (England 1994; Rose 1997; Till 2005). My identities as socially isolated citizen, retired GP, stymied researcher, Clinical Contact Tracer, and ethnographer of the ‘Advocates of the Poor’ were sedimentary, sequential, and recursive.

Since the cultural turn, autoethnography has become more acceptable in its many and varied forms, each with its own ethical imperatives (Ellis, Adams, and Bochner 2011; Butz and Besio 2009). Chapter 6 might be classified as ‘personal experience narrative’ (Butz and Besio 2009, p. 1665), ‘reflexive ethnography’ (ibid. p. 1666) or ‘insider research’ (ibid. p. 1669); what unites them is that

³⁷ Officials prefer that we refer to it as ‘pandemic restrictions. I take the liberty of calling it ‘lockdown’ because that was how I experienced it.

³⁸ SOAP is an acronym for how doctors might record a consultation. S = subjective findings, O = objective findings, A = assessment, P = plan.

they all strive in some way to collapse the conventional distinction between researchers as agents of signification and a separate category of research subjects as objects of signification (Butz and Besio 2009, 1671).

2.7.2 COVID-19 news feed

But my ethnographic journalling was not done in isolation. Newspapers, radio, television, Twitter (before Elon Musk bought it in October 2022) brought into my kitchen daily updates of the SARS-CoV-2 virus and its effects. I followed the National Public Health Emergency Team (NPHE) daily briefings, I listened to experts being interviewed on the radio, I followed representatives of government, the Department of Health and the HSE as they updated us. The Irish College of General Practitioners (ICGP) hosted weekly webinars which, as a former member, I attended, and it updated its COVID-19 hub twice daily, such was the speed of new scientific information becoming available.

Behavioural scientist Pete Lunn of the ESRI kept us informed about the levels of public compliance with restrictions (Lunn et al. 2020; Lunn et al. 2024). Once recruited as a healthcare worker I had access to the updates and educational refresher courses on the Health Service Executive's portal www.HSELand.ie. Trisha Greenhalgh, an English academic GP, became an inspiration, applying her and her colleagues' rigour to every aspect of the pandemic (Barry and Greenhalgh 2019; Greenhalgh, Koh, and Car 2020; Greenhalgh, Ozbilgin, and Contandriopoulos 2021; Jimenez et al. 2022).

2.7.3 Digital space

Before the pandemic, Kitchin and his fellow writers had written about how digital communications were capable of deterritorialising time and space; it was interesting to witness in real time the collapse of healthcare provided over physical time and space into an online practice mediated by visual and auditory

data exchange (Kitchin and Dodge 2011; Kitchin 2014, 2017; Kitchin and Lazarotto 2023). Without the online capacity of the government and its instruments, healthcare would have been stymied; one need only read Camus' *The Plague* to imagine it (Camus 1947, 1998). Data gathering, trend forecasting, policy formation and contact tracing were enabled by digital communications. Those who have written about it after the event have recorded high level policy meetings and the differences of opinions that were hard fought between politicians, statisticians, epidemiologists, public health experts, immunologists, police and many others (Holohan 2023; Horgan-Jones and O'Connell 2022). The UK's pandemic management is critically evaluated by Boyle et al. (2023), a stark reminder to Irish people of the advantages of living in a republic.

Although we reside on an island, we are well connected to cyberspace. Consumer research in March 2024 indicated that 96% of adults aged 18–75 years own a smartphone (Deloitte 2024). While 'Dr Google' has been used by many for a preliminary medical query, large language models (LLMs) are now freely available as Chat-GPT or Microsoft Copilot. Charlotte Blease, a philosopher of medicine, makes the case that in the face of rising rates of medical error, doctor burnout, the impossibility of keeping up to date with new therapeutics and the likelihood that the most marginalised patients suffer most from these factors, AI (artificial intelligence) has a role to play in healthcare delivery (Blease 2025). GPs may resist this, but my RPs say that their patients use it anyway. Used judiciously, AI could help with equitable distribution of healthcare resources, human and material, and with diagnosis.

2.7.4 Telemedicine

Telemedicine represented a challenge to Irish GPs, accustomed as they were to all the data transfer about a patient's complaint that is picked up merely by

being in their presence. Before the pandemic, the HSE had provided training videos on online consulting, its decorum and ethics, as a resource. Studies done after vaccination had made the world safer showed that both patients and doctors adopted it with varying success and returned to pre-pandemic practices after the pandemic (Walley et al. 2024; O’Callaghan and Glynn 2024; McHugh and Connolly 2025; Homeniuk and Collins 2021; Humphrey et al. 2025). The HSE provided all GPs with a practice terminal for their homes along with Healthmail and Healthlink, software for e-mailing prescriptions to pharmacists, letters of referral to secondary care services and sickness certificates to employers.

2.7.5 Principles of government response

2017 had seen the publication of the policy document Sláintecare (Shortall 2017). While COVID-19 interrupted its implementation, research has judged that the government’s pandemic response remained faithful to the principles of Sláintecare in all its decisions and actions (Burke et al. 2021). The Irish response in the context of other European countries is favourably evaluated (Kennelly et al. 2020; Al-Salem et al. 2021) with the exception of Long Covid and mental health (Kelly 2020). As time goes on, the long-term mental harms done by social restrictions become ever more apparent and will be factored into managing whatever pandemic comes next.

2.7.6 Syndemic

Those who suffered most were the ‘underserved’ (O’Carroll 2022). The word ‘syndemic’ describes what occurs when people are affected by poverty, inequality and inequity and an epidemic of infectious disease (Bambra et al. 2020; Bambra, Lynch, and Smith 2021; McGowan and Bambra 2022; Devlin, Whelan, and McGuinness 2024). Deep End GPs work with these people every

day and recognise their greater needs on every front (Deep End GPs 2025). Lessons learned from the COVID-19 pandemic by Willems et al. (2024) can be summed up in the word 'respect': the authors recommend that every part of the continuum of healthcare delivery be properly resourced with a view to providing safety for patients and avoiding burnout in practitioners. Maybe the pandemic, in this respect, was a 'portal' after all (Roy 2020)? The commodification of primary healthcare for profit (Mercille 2019; Mercille, Turner, and Lucey 2022; Mercille 2023) is beyond the remit of this research, but since profit for investors always means cutting the cost of salaries and supplies for workers, the model proposed by Willems et al is outside the capitalist model and would have to be constituted as such. It serves as a reminder that Sláintecare is founded on that egalitarian ethos and will continue to be implemented accordingly, however slowly.

2.7.7 Contact tracing and vaccination services

The setting up of a contact tracing service and a mass vaccination services on a scale never before seen in Ireland required energetic participation from all stakeholders. Both were considered a success; the contact tracing service saved many people from becoming infected and its model is ready to go for any future pandemic (Martin, Carroll, and Khurshid 2022; Fulham-McQuillan et al. 2024). Most of the COVID-19 vaccinations in Ireland were done very quickly (and joyfully, according to RPs) by GPs and GP nurses (Healy 2021; Ni Aodha 2021). While hospital doctors came under unprecedented stress that often led to burnout and COVID-19 infection (Byrne et al. 2021; Creese et al. 2021; Claponea et al. 2022), GPs in this research only reported fatigue, the worry of 'missing anything' in an online consultation, and the pressure to stay up to date. Whether online or in-person, the GP's duty of care prevails (O'Malley, O'Connor, and Lydon 2024).

From the onset of the COVID-19 pandemic, primary care services pivoted nimbly to telemedicine, supported by the government and all of their professional organisations. Penchansky's 'five As' were woven into every initiative to curb the spread of the virus before an infected person could transmit it to others (Penchansky and Thomas 1981): (see section 2.2 above). But, apart from vaccination, all were conducted without the sense of touch, without which all of us were deprived and disorientated (Dodge and Paterson 2012; Field 2010).

2.8 Summary

This chapter has been a synopsis of material I have read that led me to research the lived experience of general practitioners who care for marginalised people. Exposure to the anglophone literary canon in my teenage years left me perplexed as texts were taught without historiographical context. Immersion in the patriarchal culture of UCD medical school in the 1970s led me to question the 'givens' and buy a copy of Illich's 'Medical Nemesis' in 1975. I read second-wave feminism in the 1970s and brought it to bear on my practice. Meeting patients on the wards, hearing their stories first-hand, then becoming a GP who cared for marginalised people in a conservative country expanded my lived experience. Only after 2010 was I exposed to theorists such as Foucault who crystallised society's unfairness for me. The study of human geography, the transition from medical to health geography, reading idealised accounts of patient-care policies while counterbalancing them with narrative accounts of former colleagues who struggled with overwork and burnout made me wonder what constituted a kind of patient care that would enhance both patient and doctor, and what were its impediments. The COVID-19 epidemic up-ended everything but provided an opportunity to appreciate what we had had by its absence. It is worth mentioning that this dissertation expresses views that

would, in contemporary international right-wing ideology, be classified and dismissed as 'woke'. Not only do I reject that binary polarity, but it makes me cling even faster to the concept of human dignity and fundamental human rights. Having presented the relevant literature in this chapter, I now turn to the research practices used for this project and why I chose them.

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Chapter Three: Methodology

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time (Eliot 1942).

Preamble

It surprised me to find myself beginning fieldwork in July 2020, researching the lived experience of Irish General Practitioners who provide primary care for marginalised patients. But I had done an M.A in Geography, part-time, from 2016-2018 and had researched the same subject for my thesis, travelling all over rural Ireland to visit ten GPs for a dissertation that took its title from Rudolf Virchow's 'Attorneys of the Poor'³⁹ (Virchow 2006 [1848]), an ethnographic study of a selection of General Practitioners in rural Ireland. My principal finding in 2018 was that GPs were alienated from their work and from their own 'vital activity' (Marx 2000 [1844], 90–91) by austerity measures such as FEMPI (Financial Emergency Measures in the Public Interest) imposed on them by government after the 2008 economic collapse. This sense of alienation has almost disappeared from the current research: FEMPI provisions in respect of GPs were reversed to a great extent in 2019. Those that remain have more of an impact in rural than in urban areas, and the COVID-19 pandemic interrupted

³⁹ 'Physicians, surely, are the natural attorneys of the poor and social problems fall, to a large extent, within their jurisdiction' (Virchow 1985 [1848], 4; Virchow 1848). I now prefer to use the translation 'advocate' than 'attorney'.

general practice in every way from March 2020 onwards. However, the 2018 project left many questions unanswered, begging further research.

Much is written, spoken and documented in the mainstream and academic media about general practitioners (GPs). It would be accurate to note that, particularly within lived-experience narratives and other critical accounts, the general practitioner is frequently portrayed in markedly negative terms and positioned as an active perpetrator of inequality. Occasionally, a GP spokesman is interviewed who either speaks to a public health issue or complains about their conditions of employment, but their lived experience remains relatively unknown in public discourse, shrouded, as it must be, by the obligation of patient confidentiality, and the time-honoured duty of GPs to present themselves as worthy of patients' trust, both by their actions and by their reputations. In order to find out about their lived experience I decided to ask them in person, so this dissertation is the outcome. In Chapter 2, I have already outlined the state of research in Health Geography into the lived experience of GPs, especially the almost complete absence of their voice. The disciplines of Primary Healthcare and Health Geography have much to lose by standing tall in their respective siloes. I hope this research may extend an invitation to collaboration.

3.1 Introduction

As outlined in Chapter 1, in this research I asked a group of Irish general practitioners (GPs) about their lived experience, attempting to divine what creates meaning in their lifeworld. Bearing in mind the two-tier structure of Irish healthcare, its particular focus is on GPs who provide primary care for marginalised and underserved people in both urban and rural settings. In the face of high, and rising, national expenditure on healthcare, the government's

ongoing commitment to implementing Sláintecare (see section 1.2.3 above), the relentless creep of privatisation of primary healthcare and regular reports of GP shortage due to emigration and an ageing workforce, I wanted to know how GPs in practice discern and feel these, and other vectors, bearing down on them. Fieldwork was scheduled to begin in Spring 2020 but was halted by the arrival of COVID-19. Once pandemic restrictions abated, and face-to-face interviews became possible again I began requesting interviews from GPs. While many research projects pivoted nimbly to the online space, I resisted this idea from the outset. Having experienced the warm welcome from GPs when I visited them during MA research, their proud tour of their surgery premises and/or their practice hinterland, the breadth and depth of their engagement when they answered my questions, I was not prepared to forego the embodied encounter, so I parked fieldwork *pro tempore*. This was expedient since it transpired that the GP workload increased hugely during the pandemic so participant recruitment would have been much more difficult, and less fruitful. Two interviews were done in Summer 2020, fourteen between July and December 2021 and seventeen between April and June 2022. I avoided asking for interviews when COVID-19 case numbers were rising and, once vaccination allayed people's fears from January 2021 onwards, during the winter months when GPs are busy with common respiratory viruses and their complications, on top of their regular workload.

This chapter shows how I designed and carried out my fieldwork and analysis.

Section 3.2 elaborates the philosophical underpinnings of the thesis. Before exploring the ontological and epistemological stance I took from a health geographer's perspective, it details those stances as taken by GPs in their everyday lifeworld with decorum ever present. Section 3.3 describes the study design and key methods under ten headings, factoring in how I responded to

and used the momentous changes wrought by the pandemic for this research. Section 3.3.1 explores ethnography and how I conducted it. My positionality is explained in 3.3.2 as retired GP, researcher, Clinical Contact Tracer (CCT) and the blend of all three in my embodied persona. How the fieldwork was planned (3.3.3), how sampling was done (3.3.4), and how Research Participants (RPs) were recruited (3.3.5) is outlined next, followed by my interview preparation (3.3.6). The questionnaire I devised for semi-structured interviews takes up section 3.3.7 and Appendix B. Section 3.3.8 is about the interview itself and 3.3.9 about research practices I used afterwards. Section 3.10 details how I tidied up my messy experience of the pandemic and found a way to write it in an autoethnography. I move on to Analysis in 3.4 and describe the process of editing and anonymising transcripts in 3.4.1, and coding transcripts and memos in 3.4.2. The matter of ethics is in section 3.5; both the ethical requirements made of me by Maynooth University and the extra precautions I took to put my own conscience at ease. Section 3.9 concludes the Methodology chapter.

3.2 Philosophical underpinnings of the thesis

There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy (Hamlet Act 1, Scene 5) (Shakespeare 1987 [1603], 950)

Ontology is the study of being. Epistemology is the way or ways of knowing. How do we know what we know? How does a GP know what they know and how can they diagnose the causes of a patient's ill-health? How can a GP untangle and discern the societal vectors at play in a patient's clinical presentation? Doctors in training are consistently reminded, at every level, how important it is to 'know what you do not know' and ask for a second opinion. How can a researcher articulate both their explicit and tacit knowledge concerning their own lived experience? How much of their relative worldviews

come together in the common area of a Venn diagram and can be faithfully represented in a text?

The practice of medicine is replete with time-bounded, epistemological conundrums and researching it is fraught with the possibility of misinterpretation and cultural relativism. Cartesian dualism has its place in any discipline with a value on scientific accuracy. Positivism, likewise, provides comforting mathematical perspectives. Both are transcended, however, by the relational nature of general practice and of an ethnography conducted by a former GP. Latour's Actor-Network Theory obviates the easy conceit of identifying components of GP lifeworld a priori, since it requires a nimble, kinetic perspective that concentrates on flows between actors such as doctor and patient and inanimate objects such as new drugs and therapeutic procedures, new regulations and protocols (Latour 2005, 236–238). Political philosophy is instrumentalised in people's everyday lives too, made invisible by time and custom. GPs know, nowadays, to interrogate what websites and influencers a patient has consulted online that motivated them to book a consultation about their symptoms.

3.2.1 Medical epistemology

As outlined in Chapter 2, the development of the science of medical practice accelerated over the period of the Enlightenment. Foucault explored the genealogy and shifting landscape of power at that time (Foucault 2003 [1963], 2001 [1961]). Contemporary medical practice is shaped by both art and science, and, with rare exceptions, is only conducted with the patient's consent. To research GP lifeworld requires an understanding of the tapestry woven by these strands and more, an appreciation of how the biomechanical and social worlds shape each other. The ontology of a GP's lifeworld is multi-faceted, messy and

relational; during training, GPs are taught to become comfortable with this. Uncertainty is a constant in their world. Their quest to make meaning of their patients' healthcare concerns persists throughout the clinical relationship, perhaps over decades.

Epistemology comprises a set of beliefs and arguments about how we can reliably acquire knowledge about those things we take to exist or be real. Khushf (2013) provides a detailed, atomised exploration of medical epistemology and how its components came into being sequentially. He lists epistemic practices such as history taking and physical exam; pattern recognition and expert knowledge; heuristics and biases and their role in clinical reasoning; differential diagnosis; Bayesian, causal and mechanistic reasoning; how best to use information systems; justification and use of guidelines and clinical pathways, systems-based approaches to eliminating error and advancing quality and theories and practices of measurement and testing- their use and abuse. He concludes with the over-arching precept: 'knowing patients as persons, rather than just regarding them as instances of diseases' (Khushf 2013, 486). Any or all of these practices, and more, are factored into GPs' everyday consultation and I deployed most of them in my attempt to make meaning of my Research Participants' interviews. Writing in 2013, when Khushf mentioned 'patient testimony' (ibid. p476) he did not foresee the momentum of those who consult Dr Google before consulting a doctor. Nor did his 'extrusion of perception, rationality and values into the social sphere' (ibid. p. 481) envisage Artificial Intelligence, one of whose champions, Demis Hassabis, won the Nobel Prize in Chemistry in October 2024. Khushf reminds us that

Although the positive goods of health and knowledge are ontically first things, epistemologically they are the last, and perhaps we never will have anything more than a partial, explicit grasp of them (ibid. p. 482).

He thereby brings us back to the starting point of this chapter, from T. S. Eliot. Recursivity, relationality, continuity of care and the endurance required either to care for a patient or to search for meaning through research underpin the never-ending epistemological question 'how do we know what we know?'

The practice of medicine is highly regulated and although epistemology is not mentioned in the Irish Medical Council's codes of practice, any GP's curriculum vitae must list all educational modules and all exams they have ever taken. A researcher of the GP lifeworld must be appraised of the academic and statutory requirements of their speciality, the conditions of possibility pertaining to their work and vernacular discourse which describes their role and contribution to society. Relations and processes integral to their work must be revealed by abstraction. If I interview a selection of GPs, how can I believe what they tell me? How can I analyse the data to do justice to their individual and collective accounts? I must respect their account, critically evaluate it, and apply the highest standards of contemporary qualitative research to such data as I may gather.

3.2.2 Epistemology in human geography

Whereas a general practitioner's work brings them into direct awareness of individual patients' presenting complaints and obliges them to work outwards through concentric spirals of precipitating factors, human geographers work from the outside inwards. A GP's initial object of interest is an unwell patient, a geographer's, a phenomenon worthy of enquiry. Geo-graphy means to write the earth. Vermeer's image of *The Geographer* (1669) represents Dutch exploration and colonialism at its wealthy apogee, when sailors navigated by dead reckoning, a century before Harrison devised a means of measuring longitude (Sobel 1995). Geographers at that time measured land and sea

masses, mapping the best routes for profitable voyages. The mapping of people, their habitations and practices followed, helped by impeccable military notetaking that can still be viewed in libraries and private collections.

Alexander Von Humboldt (1769–1859) travelled extensively, documenting how human habitation has shaped the earth (Wulf 2016). Auguste Comte's (1798–1857) positivism, a philosophy based on observing and counting came in the wake of Adam Smith's (1723–1790) thinking on political economy (Comte 1974 [1877]; Smith 1976 [1778], 1976 [1759]), both of which have persisted to this day, preferred as an analytic lens by those who reckon that everything that matters can be counted. At a time before Pasteur's germ theory was proposed in 1861, geographers mapped diseases such as the cholera epidemic in London (Gilbert 1958). John Snow mapped the spread of *Vibrio cholerae* in London twenty-nine years before Robert Koch identified it under a microscope in 1883.

Before the mid-twentieth century, not only did the masculinist perspective prevail in academic literature, but it embodied the top-down hegemony of white, heterosexual, well-off males who claimed the high ground of objectivity. Since then their lexicon has been decolonised firstly, by Marxist geographers who believed that unequal economic growth, wealth distribution and social conditions predicated poverty and secondly, by feminist geographers who dismantled the masculinist lexicon, giving voice to women, people of colour, people of all ethnicities, genders and abilities (Wengrow 2008; Harvey 1985; McDowell 1999a; Massey 1984; Massey 1993). Earlier, in France, Georges Canguilhem (1804–1995) and his pupil, Michel Foucault (1926–1984), had begun interrogating the histories and geographies of medicine (Canguilhem 1978; Foucault 2002 [1969], 1991 [1975], 2001 [1961], 2003 [1963]). Canguilhem, a medical doctor and philosopher, splintered the binaries of health and illness, describing them as value-laden concepts, while challenging the conventional biomedical model (Canguilhem 1978, 11–17). The move to a bio-psycho-social

perspective was under way. According to Philo, Canguilhem asks whether a shift from 'medical geography' to 'health geography, is worthwhile:

One goal of this new formulation has been to rescue the human being – the living, experiencing, thinking, feeling, often anxious, perhaps suffering, maybe dying human being – that conventional medicine (and older medical geography) risks obliterating by converting these embodied bits of troublesome humanity into the abstractions of 'patients', presentations of disease entities, figures in graphs or dots on maps (Philo 2007, 83).

The idea of 'patient as abstraction' sits uneasily with me, having been taught as an undergraduate in UCD that we were never to refer to 'the diabetic in bed 7', but always by her title and surname – 'Miss or Mrs. Bloggs in bed 7, who has/suffers from diabetes'. Our teachers insisted that we never write a patient's full name on our notes and that we never discuss patients or their cases in public places where we could be overheard. Our discursive training always framed the patient's case, signs and symptoms within their humanity.⁴⁰

3.2.3 In search of respect

But diseases occur in populations and must be enumerated to understand them. Ideally a researcher would cultivate the respect due to persons participating in research while developing skill in statistical analysis. Quantitative research, improving constantly with new technologies, is praised by Rosenberg for its capabilities such as 'multi-level modelling and network analysis using GIS platforms' (Rosenberg 2016, 547), whereas 'if the goal is a deeper understanding about aesthetics and cultural norms, a qualitative approach is more likely to yield those insights' (ibid. p. 550). The Irish pandemic experience saw Quant. and Qual. working productively together, in a vibrant and responsive mycelium of new scientific knowledge. The era of experts on pedestals

⁴⁰ This describes best practice. I have often heard people describe how they felt like meat on a butcher's slab after being physically examined by a disengaged doctor.

preaching their own gospel ended, to everybody's benefit. Having read Sheldrake's book on how fungi make our worlds during the first lockdown, I see how we can all move towards mutually respectful assemblages in which quant. and qual. synergise (Sheldrake 2020).

While I was being taught the rudiments of doctor-patient decorum on ward rounds in the 1970s, Buttimer, Seamon and others were midwifing humanistic geography into the discipline.

Humanistic approaches focused attention on contingency, variability of interpretation, and contextualized human agency. Rather than theorising away or seeking to eliminate the subjectivity and contextual difference, they made meaning, values and intention central to geography (Sothorn and Reid 2018, 95).

Whereas 'medical geography' concerned itself with 'disease ecology [...] and welfarist and largely empiricist studies of health care provision' (R.A. Kearns and Moon 2002, 607), from around the year 2000 onwards, the 'geography of health' showed 'an increased interest in well-being and broader models of health and health care' (ibid., p.606). Drawing on lived experience as philosophised by phenomenologists such as Husserl, Heidegger and Merleau-Ponty, and existentialists such as Nietzsche, Kierkegaard and Sartre, humanistic geographers 'opened up ontological, epistemological and above all, political questions about materiality, language and representation (Sothorn and Reid 2018, 95). GPs know that the human patient is at the centre of their work; at their peril do they lose sight of this focus. Contemporary humanistic geography has adopted a similar perspective (Brown et al. 2017; Sothorn and Reid 2018; Agarwal 2009; Andrews and Crooks 2016).

3.3 Study design and key methods

3.3.1 Ethnography

During my B.A. Anthropology, 2013–2016, I attended lectures and read ethnographies by anthropologists who had immersed themselves in the cultures they studied for several months at a time. To call my research ‘an ethnography’ might, in their terms, be considered a stretch of the imagination. Etymologically, ‘ethnography is the recording of an *ethnos*- a way of life of a person or group of people’ (Rapport 2014, 12). Having its origins in (for profit) colonial projects, exemplified by Evans-Pritchard who was embedded in South Sudan with the British army for the purpose of explaining the ‘natives’ and their ways to their coloniser (Evans-Pritchard 1937), ethnography has since then trained its lens on itself and on its practitioners. Clifford and Marcus worried in 1986 that ‘ethnography is in the midst of a political and epistemological crisis’ and went on to suggest that

the essays in this volume help us imagine a fully dialectical ethnography acting powerfully in the postmodern world system. They challenge all writers in the humanities and social sciences to rethink the poetics and politics of cultural invention (Clifford 1986a, 2)

The world they imagined then is the world in which I did an ethnographic study of GPs, first in 2018, then four years later. Clifford presaged the different outcomes of the two projects:

Ethnography’s disappearing object is, then, in significant degree, a rhetorical construct legitimating a representational practice: salvage “ethnography” in its widest sense. The other is lost, in disintegrating time and space, but saved in the text (Clifford 1986b, 112).

Such saved texts as have waxed and waned in influence during the emergence of health geography as an academic sub-speciality have been documented in Chapter 2.

3.3.2 Researcher positionality

The matter of researcher positionality is addressed here under two headings: firstly, that which pertained to interviewing GPs for this research as it was originally conceived, before the COVID-19 pandemic and secondly, in my role as a Clinical Contact Tracer (CCT) with the HSE from December 2020 to May 2021.

As a consequence of the humanist turn in geography, the notion of researcher neutrality has been debunked as an illusion. 'Neutrality is itself a role enactment and the meaning of such a role to people will, most assuredly, not be neutral' (Van Maanen 1991). I knew I was conducting this research from an insider position and as time went on, it became clear to me that without this position it was unlikely that I would have secured any interviews at all.

In an earlier career I had worked as a GP, caring for patients in a disadvantaged suburb of Dublin and in the female wing of Mountjoy Prison. To anyone who would listen, I would say that during these years I learned the greatest lessons of my life, that accident of birth was what placed me outside bars, not inside them. "There but for the grace of God go I", a common Irish expression, expressed my feelings, every time a prison officer unlocked a series of gates to release me, after 'doctor's parade' to use Victorian prison nomenclature, back to morning surgery at my Practice. I disclosed my positionality to Research Participants in the first letter of invitation and again when some of them made further enquiries about my past before we began the interview (see Appendix A for letter of introduction and consent form). I qualified as a medical doctor in 1979, worked in hospital jobs and GP practices for five years then 'put up my plate' in 1984 and practised as a GP in a marginalised suburb of Dublin until I retired in 2000. Like so many contemporary GPs I had a 'portfolio career' at

first, which included doing sessions in the Well Woman Centre, 1981–1983, providing contraception and abortion referral for women before it was legal in Ireland, working on the Sexual Assault Treatment Unit in the Rotunda Hospital, 1984–1986, and providing round-the-clock primary care for women prisoners in Mountjoy prison, 1986–1992. In retrospect, others called me a feminist activist, but at the time, I attached no such moniker to merely doing work that presented itself to me. It seemed manifestly unjust to me that women patients could not access reproductive healthcare from their own GPs. These jobs demanded more than routine medical care; advocacy was the component that gilded the lily and made a difference to my patients. To try to adopt researcher neutrality would be to deny what I experienced during those years that gave my work meaning.

I have also been on the receiving end of primary care, both as a patient and as the person who accompanied my children, my ageing parents and my friends to doctor visits. This experience taught me to read both staff in reception and a waiting room, to discern how busy or hectic the day's workload was in that practice. Insights like these sharpened my researcher antennae and eroded any conceit of neutrality on my part. This researcher was doubly embodied: first by having practised as a GP 1984–2000, second by acknowledging to RPs that so much had changed since then. Although I spoke their vernacular, disclosing my positionality to GPs and conceding that my medical experience was rusty made me either an anomaly or a novice, or both in their world.

It was quite different in the contact tracing world: (a) only qualified clinicians were hired as Clinical Contact Tracers (CCT) and (b), CCTs suffered more than our colleagues who were tasked with collecting people's contact details rather than compassionately hearing them out in a phone call overlaid with terror and anguish. An auto-ethnographic account of my experience as a CCT is detailed in Chapter 6.

3.3.3 Planning fieldwork

I began by consulting the Pobal HP deprivation index to find areas in Ireland that qualified as marginalised or very marginalised (Haase and Pratschke 2016). The criteria have already been discussed in Chapter Two. While some GP practices are located at the heart of the marginalised communities that they serve, others may have a more peripheral location, served, perhaps, by a good local public transport system. I then consulted the HSE website 'Find a GP'⁴¹ which enables one to search for a GP by their name, townland or address and gives a list of nearby GPs with their practice phone number, address, Eircode, telephone number, e-mail address and a link to directions on Google Maps. It does not state whether the GP sees GMS patients or whether they work in a group or single-handed practice. If a practice had a website, a search would lead me to it. Some GP practices have a rudimentary website with little information, not often updated. The larger practices tended to have well-kept, up to the minute websites with all the information I needed. Since the beginning of this research, I had kept a list of all GPs whom I had heard speaking on radio, writing articles in or letters to the newspapers or posting on Twitter in their capacity as advocates for the poor. Another group of GPs has public profile in their capacity as GP representatives, and I included their names on the list as they often complained publicly about structural factors that interfered with GPs' delivery of adequate primary care. I triangulated names and addresses on these lists against the map of deprivation. Rather than seek the views of accomplished media performers I was keen to interview GPs who spend most or all of their working day and week consulting with marginalised patients and doing the relevant advocacy. I wanted to hear their account of their lived experience, what gave them satisfaction in their work and what drained

⁴¹ <https://www2.hse.ie/services/find-a-gp/>

them, sometimes to the point of illness and exhaustion. I wanted to sit in their presence in a room furnished by them for comfort and confidentiality, to ask them questions and to hear and to witness their answers. I decided to begin fieldwork in Dublin city, where I live, and then to move out to other cities, towns and villages further afield. Knowing, from my MA experience, how difficult it was to make contact with a GP and to persuade them to grant me an interview and knowing also how much busier they were during and after the pandemic, I decided to send out no more than three invitations at a time, since my earlier experience had been that appointments sometimes had to be broken and re-made.

3.3.4 Sample size

Sample size in this research is very small, but adequate. As I have already mentioned, there is no accurate account of the number of GPs in Ireland. The Irish Medical Council's Medical Workforce Intelligence Report on 2021 states that 4,461 doctors on the medical register reported that they were working as GPs during that year (Irish Medical Council 2021b). Therefore, research that includes thirty-one participants represents 0.7% of the working GP population that year. Qualitative research characteristically involves small sample sizes (Kitchin and Tate 2013, 40). An article in the *European Journal of General Practice* suggests that 'that ethnographic research should require 25–50 interviews and observations, including about four-to-six focus group discussions' (Moser and Korstjens 2017, 11). Given the difficulty of GPs making time for interviews, the notion of creating focus groups with multiple GPs all available at the same was unrealistic and, indeed, was rendered impossible by pandemic restrictions that prevailed, in varying degree, throughout my fieldwork. Denzin and Lincoln, in their *SAGE Handbook of Qualitative Research* make no comment or recommendation on sample size (Denzin and Lincoln

2018); nor does Till (Till 2009). But since it was never the intention of this research to provide a definitive report that faithfully represented all Irish GPs, the breadth and depth of RPs' lived experiences describe here serves to represent a significant constituency. The picture presented here represents the experience of a number of GPs working in deprived areas. 'Thick description' was accomplished (Geertz 1973, 6). Kitchin cites Oppenheim, who 'suggests that the interview is really a precursor to a larger questionnaire survey' (ibid. p. 213). This was part of the plan before COVID-19 forced me to change course. With hindsight, I am not convinced that a survey could reliably access the experiential material elicited by these in-person interviews.

The table that follows gives an account of how Research Participants were represented by gender, when they graduated from medical school and how I recruited them. It also roughly describes where they work. I have not mapped their practices because I was obliged to anonymise them completely. It is important to mention at this stage that all my participants were white Irish, so there was no racial diversity in the sample.

Table 0-1: Characteristics of Research Participants

Characteristics	Details
Gende	Male (n=15) Female (n=16)
Decade of basic medical qualification (BMQ)	1970–'80 (n=3) 1980–'90 (n=11) 1990–2000 (n=6) 2000–2010 (n=6) 2010–2020 (n=5)

Characteristics	Details
Source of contact	Letter of invitation/ cold call (n=6) Media presence (n=2) Known to me already (n=6) Snowballed (n=17)
Geographical location of practice ⁴² (See Appendix E)	City (n=18) Satellite Urban Town (n=3) Independent Rural Town (n=3) Rural areas with high urban influence (n=1) Rural areas with moderate urban influence (n=2) Highly rural/remote areas (n=4)

3.3.5 Recruitment

Every GP practice has a forensic protocol for processing the day's post, e-mails and telephone calls. Items are opened, scanned by a designated staff member, then routed to the intended recipient. Incoming letters are stamped with the date on which they were received. I wrote a letter of invitation to each GP on my list, introducing myself and my research and asking them for a semi-structured interview lasting an hour or so, in a place of their choosing, and appended my contact details (see Appendix A for letter of introduction). A consent form was included (Appendix A) along with a draft questionnaire (Appendix B). In view of the likelihood of my letter's finding its way to the

⁴² This categorisation is taken from the CSO's 'Six-Way Urban-Rural Classification' in 'Urban and Rural Life in Ireland, 2019 (Central Statistics Office 2025).

<https://www.cso.ie/en/releasesandpublications/ep/p-urli/urbanandrurallifeinireland2019/introduction/>

bottom of a GP's in-tray, I mentioned that if I did not hear from them within two weeks, I would contact their practice by telephone. Very few GPs responded to me in person, as I expected. A phone call to the practice administrator expedited a speedy reply, whether yes or no, and in the case of a yes, an appointment within a few weeks' time. Once I identified myself as a retired GP, I was offered a return phone call after consultation hours and always received it. The most useful tactic of all was snowballing, which secured a GP's personal contact details. One early Research Participant e-mailed colleagues, yielding four interviews. One of these RPs snowballed a further six. And one GP whose name I had found in mainstream media snowballed a further five. Four GPs who had given me an interview for the MA project agreed to see me again and two later recruits each snowballed one GP for the research. One GP brought his trainee to the interview; I always carried copies of letters of invitation, consent forms⁴³ and questionnaires, so they signed these on the spot. Only five responded directly to my letter. Without snowballing and insider positionality, this research would very likely have been stillborn.

3.3.6 Interview preparation

In all cases I conducted an academic search on participants, found their published work, if any, and read it. A Google search led me to their media appearances, articles in local rural newspapers and Twitter accounts. The Irish Medical Council provides a publicly accessible database of the dates of graduation and specialisation of all registered Irish doctors which saved time-wasting at interview. In presenting myself to my Research Participants in their GP surgery, McDowell's axiom that 'Bodies have a material existence' came to mind (McDowell 1999b, 41). While academia deals with abstraction, no GP

⁴³ See section 3.5.1 for details of ethical approval for this research (see also Appendix 3 and Appendix 1 for a copy of the letters of introduction and consent forms).

needs to be reminded of the corporeality of their work. I was aware that GPs worked within 'an embodied time-space grid' (Parr 1998, 30). Their consulting room is where they invite their patients to make themselves comfortable, to describe their symptoms and to consent to physical examination. It's where they are very much in charge. Except that having granted me an interview, the power geometry would be somewhat inverted (Massey 1993) as I would be asking the questions and interrogating them, asking them to sign a consent form and turning on a voice recorder. Taking a lead from Erving Goffman, I presented myself as anonymously as possible, with no distinguishing or objectionable features (Goffman 1990). Good grooming, no make-up, jewellery or perfume, since Parr suggests that 'to dress appropriately may help the interactive process' (Parr 1998, 31). I wore muted, clean, pressed inoffensive clothing. I also wore an FFP2 face mask, in accordance with the conventions of the pandemic. Most GPs wore one too, and I found that I had to focus very hard on their eyes to discern their facial expressions. If I drove to the interview I made time to go for a walk to stretch myself rather than engage their trained, eagle-eyed gaze to detect the 'body ballet' of someone who gets stiff after sitting for a while (Seamon 1980). It mattered to me that at no time would they have any reason to construe me in the role of patient.

Informed by perspectives on investigator's body as an instrument (already cited in literature review), I decluttered my senses before interviews, wrote reflexive field notes before leaving home and again, near the site of the interview, on how I experienced the locale. This was particularly important either when visiting a GP's marginalised city suburb or a rural GP some 250 km from home, or more. When interviewing RPs from Dublin, I drove to the suburb where they practiced during the week before the interview, walked around, and appraised myself of the urban fabric of their hinterland. I took photographs on my iPhone as an aide-memoire for my reflexive memos. While RP anonymity precludes the

use of any such photos in this research, the images signify areas of poverty, high unemployment, low material comfort, rundown public amenities and, following Fanon and Beaumont, I often discerned an oppressed gait in the people I saw nearby (Fanon 1961; Beaumont 2024).

For interviews further away from home I tried to arrange them so that I would have two on two consecutive days, necessitating one night in a local B&B, but sometimes GPs had to reschedule at short notice, so I had two interviews in one day on four occasions. This was very tiring and required writing a reflexive memo after one interview before driving 80–120 kilometres to the next interview. B&B hosts were chatty and interested in why I was there. While I never asked them about the GP I was visiting, they often painted a picture of their locality that was accurately reflected in Census 2022 data, for example, commuting patterns in Donegal or rural emigration. Impressions that have necessarily been omitted include the profile of lazy beds in areas that depended on potatoes before the 1847 famine, suggesting a legacy of structural violence; boarded up buildings on the main streets and abandoned ‘ghost estates’ on the periphery of rural towns and villages signifying a failure to recover from the 2008 economic crash, and heavy postering advising a Pieta House fund-raiser for suicide prevention in one town.

Altogether, I drove 2,891 km for twelve interviews. I did not record the distance travelled for interviews in Dublin, nor did I ask one GP how far we travelled by boat to an offshore island. In most cases, I baked cake or cookies the day before the interview and presented it to the RP at the start, as a token of my appreciation. It was always well received; most RPs said they’d share it with their team over coffee the next day, indicating the extent of their attachment to their co-workers.

3.3.7 The questionnaire

This research aimed to elicit the lived experience of a selection of Irish general practitioners as told by themselves. A semi-structured interview format was adopted with twelve questions, eleven of which were similar to the questions I asked at my MA interviews with one extra about how COVID-19 had irrupted general practice; see Appendix B for the questionnaire. Seidman reminds us that

The purpose of in-depth interviewing is not to get answers to questions, nor to test hypotheses, and not to “evaluate” as the term is normally used. At the root of interviewing is an interest in understanding the lived experience of other people and the meaning they make of that experience (Seidman 2005, 9).

In some interviews I asked the questions in numerical order, ticking them off on my paper copy as we proceeded. A handful of GPs had printed off the copy I had sent them and written their own notes alongside; these GPs took charge of the interview, and I intervened only to ask supplementary questions or request further clarification. In most cases, however, the questions were asked and answered in an iterative ‘stream of consciousness’ manner. Apart from four RPs who were under time pressure, I was aware that RPs were answering all questions and encouraged them to speak freely once we hit a topic that animated them, as evidenced by their brighter manner of speaking and more energetic body language. GPs are accustomed to explaining complex medical and scientific concepts to their patients and often use stories to illustrate a point. This skill was evident throughout all RP transcripts. As already mentioned, many case histories were redacted but at no loss to the research as I had sat and listened; they knew they had been heard (a) at the interview and (b) when they received a copy of their edited and anonymised transcript. Triangulation of redacted data enabled me to factor the impressions they made into my writing. Witnessing their sometimes emotional narratives drew my attention to the

‘political and power relations that are embedded in the everyday, the way it is experienced’ (Pink 2009, 16) and mandated me to code it appropriately later on.

3.3.8 The interview

Fourteen interviews took place in the GP’s consulting room at their practice and four in a consulting room of a clinic where they worked on a sessional basis. Seven were held in a hotel lobby or café and two online. In three cases the GP invited me to their home and in one case, the GP came to my home.

About 45 minutes before the interview, I arrived in the Practice car park, settled in for 15 minutes to get a sense of the place, then presented myself at reception to let them know I had arrived. Waiting rooms were largely empty due to pandemic restrictions. Noticeboards, however, gave a great sense of the Practice engagement with their public. Most were very informative and targeted at different patient groups; some were friendly, a few were strident. In the practices where the waiting rooms were occupied by patients, I overheard some of the banter and found it very reassuring and warm.

GPs who saw me at their workplace collected me from the waiting room, escorted me to their own room while making general conversation, closed the door and made me comfortable, then got down to business, assuredly efficient while putting me at my ease. Either they had already signed the consent form⁴⁴, or we signed two copies of it there and then, one for their records and one for mine. I turned on my Sony voice recorder, and the interview began. Owing to the semi-structured format, I took cues from their tone of voice and ‘body ballet’ as they moved about in their chair while speaking. This created a widely

⁴⁴ Ethics approval was granted to me for this research on 4 April 2019. The Reference number is SRESC-2019-020. See Appendix 3.

differing set of interviews whose range was subsequently captured by the coding process. It also meant that at no point during analysis could I assert what percentage of RPs spoke for or against a subject. All of them were just describing their own lived experience and illustrating it with case histories, many of which, necessarily, had to be redacted. Several RPs also asked me to redact text where they gave vent to annoyance or anger about structural issues concerning the HSE, TUSLA, CAMHS⁴⁵ and the shortcomings of secondary care services for their patients. One was so exercised about the social injustice suffered by their patients that they stood up and paced to and fro while angrily spelling it out. While I had assured all RPs of confidentiality, they did not want to be identified as the source of these complaints.

In the circumstances when a GP invited me to their practice premises to interview them in their consulting room I sat in the patient's chair, alongside the desk. Social distancing was being observed so both GP and I were masked, and I sat a distance from the desk. From where I sat, I often noticed photographs of their children, a pinboard or shelf with 'thank you' cards from patients and framed pictures of photos that clearly had meaning for the GP who worked in this room. Some had framed certificates on the walls. One had abstract art which patients found appealing.

What struck me in the consulting rooms of GPs who had been in practice for several decades was how their chair bore material witness to hours, days and years of sitting, listening to patients. One RP had a swivel chair with well-worn leather upholstery. At one stage during our interview, they stood up to leave the room briefly and I paid great attention to the state of the chair, the

⁴⁵ HSE is the Health Service Executive. TUSLA is the Irish Child and Family Agency, established in 2014. It takes name from the Irish words Tús (=beginning or start) and Lá (=day). CAMHS is the Child and Adolescent Mental Health Services.

distribution of the worn upholstery. When they returned and resumed their lengthy and generous interview, I noticed how they moved in the chair and leaned forward and back as they told stories; how they leaned on the arm rests as they asked me to clarify a question. This chair could tell its own stories if it could speak. This GP recounted a one-person effort to deal with the rising incidence of depression in young men by offering them lengthy consultations at a quiet time of day. Their consulting room furnishings coded their work.

Interviews varied from thirty-three to one hundred and ten minutes in duration. I did not record the time during which GPs showed me around their practice premises or their neighbourhood. While some GPs were pressed for time, and said so at the outset, others were happy to talk until interrupted by the phone or a knock on the door.

3.3.9 After the interview

Directly after the interview I got up and left, walked or drove to a nearby café and wrote my post-field memo in longhand on my jotter. I place great value on writing contemporaneous notes to capture my impressions as soon as possible. I would have my mobile phone turned off during the interview and would not turn it on again until the memo was written. Only then would I check messages or return calls. Once, half-way back from a GP interview 280 km from home, I realised that my post-field memo was incomplete, so I pulled into a large motorway service station to write up some observations that had occurred to me while driving. Since a family gathering was underway at home, I knew that if I didn't capture my reflections *stat*, they would be lost. Emerson, Fretz and Shaw, and Till would have approved (Emerson, Fretz, and Shaw 2011, 74; Till 2009, 626). And once a family member or friend would ask 'how did it go?' the

story I told would be concretised, shorn of the richness of confidential data that I could not disclose.

3.3.10 Design and methods of an (auto)ethnography of the COVID-19 pandemic

In Chapter 6 I write an autoethnography of the Covid-19 pandemic under three sections: (i) from the first reports of a pandemic in January 2020 to when I began working for the HSE as a Clinical Contact Tracer in November, 2020: (ii) the period during which I worked as a contact tracer, 13th November 2020 to 6th May, 2021 and (iii): Interviews with Research Participants: 7th May 2021- 8th June 2022. I kept a personal diary during that time in order to anchor my discombobulated self in time and space. At the beginning it included personal streams of consciousness, comments on the daily news cycle, especially NPHE briefings, memos on ICGP webinars which I attended almost every Wednesday evening and news of family, friends and neighbours. Once I volunteered for 'Be On Call for Ireland', it became a chronologue of the requirements to have my name restored to the medical register and mandatory items for HSE employment such as Garda vetting and vaccination status with regard to infectious diseases. When interviews began, my memos take on the character of research journalling rather than a personal diary. I took photos on my iPhone of empty thoroughfares and boarded up shops to remind me of how bleak it was. Events during the COVID-19 pandemic are thoroughly recorded on mainstream media and I have drawn on these to write my account.

The autoethnography has long been deployed as a heuristic device. Reed-Danahay describes it as 'a form of self-narrative that places the self within a social context' (Reed-Danahay 1997, 9). However, the absence of an embodied social context is what my early diaries best describe, when the first Irish

lockdown made me and my husband feel like we were in joint solitary confinement. My initial ruminations verge on ‘confessional tales’ which take the author or knower as subject matter and by and large bypass what it is that the author knows because of fieldwork’ (Van Maanen 1988, 96). Once I began to engage with the outside world again, through the process of applying to the HSE, it became possible to represent the world in which I found myself, and to choose a positionality from among those described in the literature (Butz and Besio 2009; Butz 2010; Bochner and Ellis 2016; Ellis, Adams, and Bochner 2011; Pachirat 2018). Butz describes ‘three main orientations an authoethnographer may have to the production of authorised academic knowledge: inside, outside, or at the margins (Butz 2010, 3/28). As I mentioned in the section on positionality, I am not an outsider because I have worked as a GP in the past: I speak the *lingua franca* of GPs and understand their lifeworld. Nor am I a complete insider, as over twenty years have elapsed since I was a GP, and I have no binding relationships with any of my Research Participants. The best fit for my positionality is fluid version of ‘on the margins’, asking for interviews from the standpoint of an academic researcher and triangulating findings via my own lived experience, the discourse around the pandemic and the extant literature. Butz’ description rings true:

The most familiar autoethnographic orientation is the academic ethnographer – the researcher. This narrating subject is positioned within academic knowledge, claims a degree of academic authority, and is therefore necessarily preoccupied with the epistemological and methodological implications of positionality, experiential knowledge and narrative voice (Butz 2010, 3/28).

To experience the COVID-19 pandemic as a citizen, a former GP and a contact tracer, gave me a sense of solidarity with my fellow citizens, an understanding of how GPs pivoted to continue to care for their patients and the satisfaction of being able to do something useful for others. Shaped by these sedimentary

experiences, I reckoned that semi-structured, in-person interviews would best answer my research questions.

3.4 Analysis

3.4.1 Editing and anonymising transcripts

Once back at base I downloaded each interview recording onto my computer and saved it to the Maynooth University cloud. My laptop is password protected; logging on requires two-stage authentication and all documents are stored on the Maynooth University cloud. Paper documents such as RPs' signed consent forms were stored in a locked cabinet in my office in the university. A document with RP names and the codes I gave them were also stored in a locked cabinet to which I alone had access. All interviews were sent for transcription to an academic typist who had undertaken a confidentiality agreement and returned them within several days. Familiarisation with the data required that I read the transcript in its raw state while at the same time, writing yet another reflexive memo recording any thoughts or feelings arising from that RP interview. Within a few days I read it again, this time, listening to the recording at the same time. I listened out for errors where the typist had misunderstood medical language or acronyms and for emotional interludes where the RP had changed their pitch of voice or their pace of speech. On the third revision of the transcript, I listened for linguistic fillers and counted them before removing those that were superfluous. Expressions such as 'like', 'sort of', 'you know', 'kind of', 'I suppose' were whittled down. Intensifiers particular to the Hiberno-English vernacular (mistakenly construed in other anglophone lexicons as cursing or swearing), while colourful, were also removed.

I attempted to give each RP a pseudonym, knowing that it would read better in the finished thesis, but that confused me completely, so I numbered them sequentially and used that nomenclature instead. Numbers also removed gender from RPs' research identity, enabling me to use the pronouns 'they' and 'them' when quoting them below, further masking their identity. The GP world is very small and most of them know each other either from their training, from social encounters or from their public persona. Advocates of the Poor tend to be vocal, and their turn of phrase would be well known to their colleagues. Once I was satisfied that the transcript was adequately anonymised, I imported it to NVivo, version 14, for coding. I also anonymised and tidied up my pre-field memos, post-field memos, memos written while auditing and editing the transcript and memos written while coding the transcript. Some of the content resonated deeply with experiences I had had during my own career as a GP and required articulation before I could move on with the work.

3.4.2 Coding transcripts and memos

I chose NVivo 14 software for coding because I had used it for the MA and found it manageable. My trainer promised back-up for the duration of the PhD and has always been available when needed, an important support for this digital immigrant researcher. NVivo is a Computer Assisted Qualitative Data Analysis software programme (CAQDAS) that has been in development since 1981 (Jackson and Bazeley 2019, 4). It is capable of handling text data 'via coding, writing, linking, adding demographics, searching for patterns, and reporting or exporting data' (ibid.). Health geographers have made diverse uses of NVivo software: the organisation, coding and meaning-making of textual data is its most frequent use (Dreidger and Garvin 2016, 201–203; Curtis and Riva 2010, 221; Kwiringira et al. 2021, 2; Zhou et al. 2025, 4; Parr and Philo 2003, 474). NVivo software has been used effectively to code artworks and

photography (Coleman 2016, 42; Castleden, Morgan, and Franks 2016, 183; Fenton and Baxter 2016, 201). A confidentiality imperative forbade the inclusion of my photos in this research, but they served me to contextualise and frame interview data. Babbel et al. used NVivo to code Glaswegian GPs' views of inequality in their city (Babbel et al. 2019, 5). Both Hawthorne and Kwiringira have emphasised the importance of multiple rounds of coding, a practice integral to qualitative research (Hawthorne and Kwan 2013, 100; Kwiringira et al. 2021, 2). Citing Strauss and Corbin (1998) Hawthorne declares that 'such methods allow researchers to "obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods"' (Hawthorne and Kwan 2013, 100; Corbin and Strauss 1998, 11). I found this to be true and created an affective *mille-feuille* of my Research Participants' emotions and my own, in response to what they said at interview. Collaborative coding is used in multi-researcher projects, earning respect and repeated use by health geographers and medical doctors alike (Crooks, Casey, and Whitmore 2016, 248; Skinner et al. 2018, 142; O'Brien et al. 2023, 3). While collaboration between researchers and authors may enrich insights during multiple rounds of coding, Braun and Clarke insist that 'a single coder is normal - and good -practice in reflexive TA':

Having only one person coding – usually the researcher – is normal practice, and indeed good practice, for reflexive TA. Where multiple coders can be useful is in developing richer and more complex insights into the data. But it is not essential, or even more desirable than having a single coder (Braun and Clarke 2022, 55).

Once edited and anonymised, I imported each interview transcript and its associated memos into NVivo and began coding it promptly. Whereas Charmaz' Grounded Theory requires line by line coding, Braun and Clarke's Reflexive TA allows the researcher to select text-bytes of any length as a single coded unit (Charmaz 2014; Braun and Clarke 2022). They advise that

Coding can capture a range of meaning abstraction, from the semantic or manifest content of the data, to latent or underlying meaning (Braun and Clarke 2022, 52)

While I had provided Research Participants with a 'Sample Questionnaire' including twelve questions (see Appendix B), I had also advised them that the format of the interview was semi-structured and that they could stray from one question to another if they wished because I would ultimately code their utterances in a way that revealed their true meaning, as I discerned it. Contrary to what some might think, Braun and Clarke advise that

For reflexive TA, we do not advocate line-by-line coding in the traditional, grounded theory- developed sense of coding each single line of text (Glaser 1978). Instead, you only need to code data relevant to the research question – broadly framed (Braun and Clarke 2022, 53).

In reflexive TA, the researcher can choose between theoretical and inductive analysis. A theoretical approach 'is more explicitly analyst driven' (ibid. p. 84) and more likely to shoehorn data into the researcher's chosen framework. I preferred an inductive approach where I would read the text, listen to the recording and deduce the speaker's meaning from what they said, how they said it. The data they provided along with the memos I wrote thereby created the codes in an organic manner. Preliminary coding in Phase One yielded 3,999 codes. Braun and Clarke's Reflexive TA proposes six stages of coding, summarised below (Braun and Clarke 2022, 22).

Phase 1: Familiarising yourself with the dataset.

Read the text, listen to the recordings, make notes, then do it all again, several times.

Phase 2: Coding

Read through the text slowly, coding segments as you go. Create a new code label as required or code a segment to a code you created earlier. If a segment warrants inclusion in two or more codes, then do that. Each code aims to capture single meanings or concepts. On conclusion, review the coding to make sure that all segments are appropriately coded and to visualise patterns that have become evident.

Phase 3: Generating initial themes

Here, Braun & Clarke warn against the idea that ‘themes emerge’, stating that ‘if themes reside anywhere, they reside in our heads from our thinking about our data and creating links as we understand them’ (Braun and Clarke 2022, 80). This is where the researcher clusters the codes with shared meaning into super-ordinate groups.

Phase 4: Developing and reviewing themes

Development and review involves checking that themes make sense in relation to both the coded extracts, and then, the full dataset’ (ibid. p.35). Each candidate theme must have the integrity to stand alone and to play its part in the shared meaning of the project. And these must take their place within the wider context of the research area.

Phase 5: Refining, defining and naming themes

By this stage, each theme ought to be able to tell a story about an aspect of the research. Re-naming themes might happen here.

Phase 6: Writing Up

Whereas writing has been ongoing since the start of coding, by means of memos, notes, queries, reminders, Phase 6 is when you ‘weave together your analytic narrative and compelling, vivid data extracts, to tell your reader a

coherent and persuasive story about the dataset that addresses your research question' (ibid. p. 36). Figure 3-1 is a screenshot of part of the Phase 2 codes.

Figure 0-1: Summary of Braun and Clarke's six stages of coding in reflexive thematic analysis

Name	Files	References	Created on	Created by	Modified on	Modified by
Advocacy	40	227	21/11/2023 14:01	M	15/01/2024 12:12	M
Becoming	38	243	21/11/2023 14:03	M	15/01/2024 12:12	M
Burnout	27	64	21/11/2023 13:53	M	15/01/2024 11:26	M
Care	47	386	21/11/2023 14:05	M	26/07/2024 14:57	CH
Career Expectation	31	68	21/11/2023 14:20	M	15/01/2024 12:13	M
Covid-19- changes in General Practice	37	264	21/11/2023 14:13	M	26/07/2024 10:42	CH
Drain Factors	40	326	21/11/2023 13:54	M	15/01/2024 12:19	M
Healthcare Policy	20	76	07/12/2023 10:43	M	15/01/2024 12:05	M
Identity	42	153	21/11/2023 14:18	M	15/01/2024 12:22	M
Negative feelings	40	168	21/11/2023 14:14	M	15/01/2024 12:13	M
Place-making	45	208	21/11/2023 14:28	M	16/03/2024 13:02	M
Positive Feelings	41	119	21/11/2023 14:16	M	28/05/2024 20:25	CH
Power	35	167	21/11/2023 14:08	M	15/01/2024 12:12	M
Powerless	30	133	21/11/2023 13:56	M	15/01/2024 11:21	M
Practice Logistics	55	520	21/11/2023 14:23	M	26/07/2024 11:48	CH

Figure 0-2: Screenshot of preliminary coding, Phase 2

I did Phase 3 without realising it. In an early, sensory approach to the later phase when themes are generated, I had applied a colour to the codes (see Figures 3-2 and 3-3). Purple, the colour of power, denoted higher purpose and altruism; blue denoted the organisational orthodoxies of practice, when an RP referred to sine qua non items such as statutory regulations and mandatory CME. Green signified growth. Pink, conventionally the colour of the heart, represents what GPs love and enjoy, positive feelings they expressed and their identity in their communities. Yellow, the colour of the sun, was assigned to placemaking, the (geographic) concept that GPs enact, mostly without articulating it. Brown is composed of the three primary colours, yellow, red and blue, but is less than the sum of its parts and signifies things that drain GPs such as being powerless to access secondary care for sick patients. The image that follows is a screenshot of preliminary coding, Phase 3.

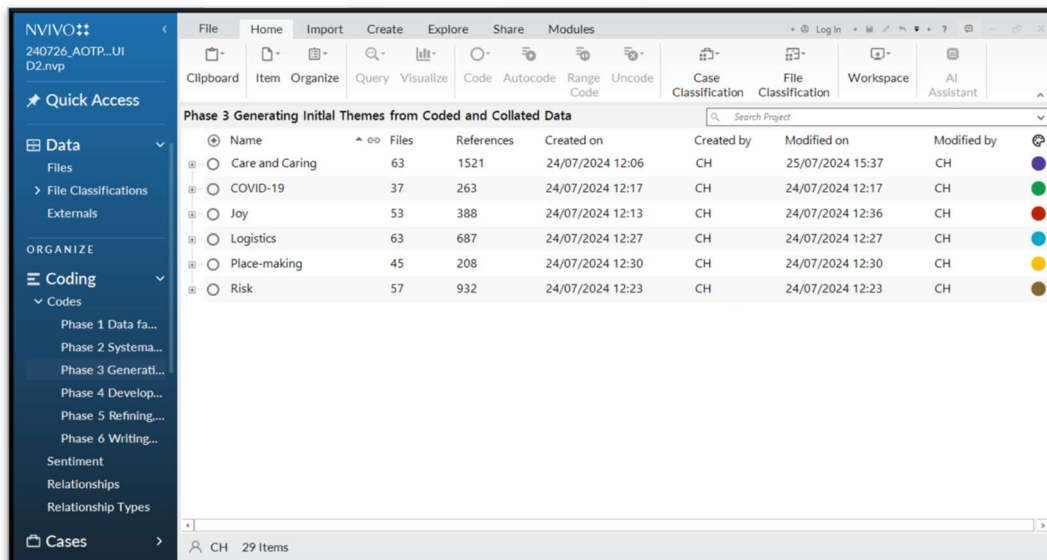


Figure 0-3: Screenshot of Phase 3 codes

The process of coding is slow, but gratifying. NVivo provides visualisation tools that afford the researcher different perspectives on how the dataset is shaping up at any stage. After eight months, Stages 1 and 2 of coding were completed, only to be deleted when my computer developed a fault, because I had unknowingly been backing up my daily work to a desktop folder, rather than an online one or a hard drive. So, I started over, edited and anonymised the RP transcripts, imported them, along with memos into NVivo 14 again, and recoded the entire dataset. This took a further four months and was faster because I knew the data well. Braun and Clarke's injunction to 'familiarise yourself with your data' was well and truly accomplished. As a descriptive adjective for thematic analysis, the word 'iterative' had never been more apt. I reckoned the coding was better the second time even though I had nothing to compare it with, since I had never printed off the first time. On neither iteration was saturation reached: whereas data saturation was a useful measure for ideal sample size in the past, Braun and Clarke now find it 'deeply problematic' (Braun and Clarke 2022, 28) as it is 'a key consideration in positivist-empiricist research' but not in reflexive TA. Their position resonated deeply with me especially when I arrived at coding my last interview, RP31. Unbeknownst to myself I had been looking forward to resolution of the perfect cadence, but it

was not to be as RP31 introduced a whole new practice of advocacy. When Syrian people arrived in their rural hinterland in 2017⁴⁶ and the HSE recruited them to provide primary healthcare services, they set up the service de novo and improved it in tandem with the HSE and their funding. Cultural learning and translation services soon led to an efficient service. So, when the Ukrainian invasion displaced people to Ireland in 2022, they had prior experience of setting up a service and did so this time with greater speed. Other RPs had mentioned working with migrant patients, but none had described setting up the service. RP31's account of their nimble response to need, characterised the entrepreneurial, 'can-do' approach taken by other RPs to providing various services such as primary abortion care, services for homeless people, for drug and alcohol users and, generally, for people who are poor. Although preliminary coding ended without the fanfare of a saturation Q.E.D., it gave me the overview that all my RPs had engaged energetically in rising to the challenge of whatever problems their patients presented them with. I realised that it was likely that any sample size would continue to deliver new accounts of GP lived experience. It also became clear to me that this 'can-do' attitude is possible because GPs defend valiantly their right to be independent contractors to the HSE rather than direct employees, a matter that has policy implications for the provision of primary care. Irish GPs have always valued and valorised their autonomy; a move to sessional work that begins and ends by the clock is likely to erode this position.

Phases 4 and 5 came together quite quickly. Were I to proceed to condense the entire thesis into one piece of work, I would have continued as Braun and Clarke suggest and distilled the data into the three most prominent themes. The

⁴⁶Voices of Syrians: Resettled Refugees in Ireland

<https://www.gov.ie/pdf/?file=https://assets.gov.ie/231237/5826c0d7-0bd7-410a-af18-e0c24702d7b6.pdf#page=null>

COVID-19 pandemic changed this plan so I selected three aspects of the data that would best answer my research questions. This approach required leaving out codes that were laden with meaning, some of them negative, but I preferred to highlight aspects of the data which are not well represented in the literature. The following figure is a screenshot of Phase 3 themes from which I chose three, GPs and placemaking, an autoethnography of the COVID-19 pandemic, and GPs and landscapes of care and caring.

3.5 Ethical considerations

3.5.1 Ethical approval for research

Ethical approval for PhD research in Maynooth University is the responsibility of the Social Research Ethics Subcommittee (SRESC). I began preparing my application in February 2019 and received approval for this research on 04 April 2019 (Reference SRESC-2019-020). See Appendix C for letter of approval. This research required Tier 2-3 approval as it might involve pregnant women (there was one, who disclosed it after the interview). There was also the possibility that a Research Participant might be vulnerable, for example, that a GP might be on the brink of burnout without being aware of it. I was aware of another feature of the research that applied to interviews, also experienced by Gerada, who wrote:

Forty years on, I am still in awe how, within seconds of a stranger meeting me, they are willing to disclose the most personal parts of their minds and bodies, parts that are forbidden in all other human encounters, even those nearest and closest to them (Gerada 2021, 23)

Most GPs of my acquaintance have had this experience, and I have had it too. While GPs are guarded in this respect, I could not anticipate what they might disclose. My stint in general practice in a previous career stood to me in this

regard: I have cultivated a habit of observing confidentiality and, in company, 'knowing nothing'.

The research practices required of me by SRESC included the following:

- Devise questions in such a way that I know what I expect to glean from each one.
- Explain the research in detail to each RP and get their written consent before proceeding with the interview.
- File the signed consent forms under lock and key in Maynooth University.
- Write and record all documents and audio files on an encrypted computer.
- Use only a laptop computer or tablet that has been adequately securitised by the Maynooth University I.T. department.
- Back up to an encrypted hard drive that is kept under lock and key at the university.
- Observe all stipulations of the General Data Protection Act 2018 and its precursors in 1988 and 2003. [This requires that personalised data are collected for a specific purpose only, that RPs are informed of how the data will be managed and that RPs are assured of confidentiality].
- Anonymise all Research Participants, remove all identifiers and re-name them with a key or pseudonym, the key and data to be stored separately.

I complied with all of this and, in addition to these recommendations, I added more to ensure that RPs were at ease with what they had told me. Once the interview had been transcribed, I reviewed it carefully for typographical errors and removed linguistic fillers. I deleted all sections that the GP had requested and anonymised all identifiers. Then I sent them the transcript, mostly by e-mail, but in one case, in printed form, as the RP had requested. It was returned to me with further edits which I incorporated into the finished document. Only when the RP had endorsed the transcript did I import it into NVivo for coding. Within a few days of all interviews, I wrote to the RP to thank them for their courtesy and their time. I have not met or contacted any RPs since their interview but will send the finished dissertation to those who have requested it.

When I visited GPs at their place of work, I did not know if they had given me an appointment outside surgery hours or during consultation time. On arrival, if there were patients in the waiting room, I knew the interview would be shorter. One GP had suggested a time when they had 'protected time' for dealing with paperwork, but their colleague and the main receptionist had got flu, and they were single-handedly trying to do it all. I suggested that I would leave, and we could re-schedule anon, but they insisted on completing the interview. I thought I had an ethical dilemma, assuming that this created extra stress for them, but I was mistaken. Patients in the waiting area were aware of their challenges that day and were unhurried, supporting them in doing whatever they needed to do. The respect and affection in which they were obviously held by their marginalised patients said more than words. It distilled, for me, the reciprocal relationality of a general practitioner's lifeworld.

One GP described a harrowing experience of burnout the previous year (before the start of this research) and went on to explain that this was why they were curtailing the interview rather than miss their lunch break. Morning

consultations had over-run, a common event in general practice. Again, this vignette flagged an ethical dilemma for me which was easily solved by wrapping up the interview promptly. A researcher does not want to be a cause of stress to a Research Participant. The Hippocratic axiom 'first, do no harm' applies to research too.

There were times, during about six of the interviews, when I thought I perceived that the GP was quite stressed and that I could corroborate my observation by their narrative. But I had not met most of them beforehand and reckoned that I might just have discerned the turbo-charged energy that GPs summon to get through a busy surgery. Since Irish GPs have a significant incidence of emotional exhaustion, depersonalisation and low levels of personal achievement, all being constituents of burnout (O'Dea et al. 2017), it is important to mention that at no time during any interview did I sense that any RP was currently struggling with these issues.

3.5.2 Ethics of COVID-19 autoethnography

When ethical approval for this research was given to me by the university's Social Research Ethics Subcommittee (SRESC) on 4 April 2019, the COVID-19 pandemic and its contingencies were not anticipated. As already mentioned, the first case of COVID-19 occurred in Ireland on 29 February 2020 and social restrictions began on 12 March 2020. I responded to the 'Be On Call for Ireland' campaign to recruit retired medical and paramedical practitioners, and the Irish Medical Council restored my name to the medical register on 1 April 2020. On 17 November 2020 I signed a contract of employment with the HSE to work for them as a part-time Clinical Contact Tracer and retired from that job on 6 May 2021.

Three different but overlapping codes of conduct mandated my ethical behaviour during that period. In chronological order, SRESC had, at first, authorised this research. Secondly, the 'Medical Council Guide to Professional Conduct and Ethics' (eighth edition) took effect once I re-registered as a medical practitioner. It is specific about standards of confidentiality (Irish Medical Council 2016, 25–26), and I include its provisions hereunder:

Irish Medical Council Guidelines on Confidentiality

29. Confidentiality

29.1 Confidentiality is central to the trust between you and your patients and a core element of the doctor/patient relationship. However, sharing information, in appropriate circumstances, is also important, both for patient care and for the safety of the patient and others.

29.2 You should protect your patients' privacy by keeping records and other information about patients securely. You should guard against accidental disclosures.

29.3 Before sharing or disclosing any identifiable information about patients, you must take into account the Freedom of Information (FOI) principles. You must be clear about the purpose of the disclosure and that you have the patient's consent or other legal basis for disclosing information. You must also be satisfied that:

- you have considered using anonymised information (information that does not identify the patient), and you are certain that it is necessary to use identifiable information.

- you are disclosing the minimum information to the minimum number of people necessary; and
- the person or people to whom you are disclosing the information know that it is confidential and that they have their own duty of confidentiality.

Figure 0-4: Extract from Irish Medical Council Guide on Confidentiality: Source: Irish Medical Council. "Guide to Professional Conduct and Ethics." Dublin: Medical Council of Ireland, 2016

Third, the contract of employment presented by recruiters CPL Healthcare (the Company) on behalf of the HSE (the Client), which I signed on 17 November 2020, is equally specific about confidentiality:

HSE contract of employment with Clinical Contact Tracers

21. Confidentiality

You will not, except as authorised or required in the course of your duties. Reveal any information of a confidential or proprietary nature relating to any material information concerning any matters affecting or relating to the Company or the client including without limitation to the generality of the foregoing, the names of any of its patients: private information about people; and information that is provided to the Company or Client on condition that it is kept confidential, such as patient information or any other information of, about, or concerning the business of the Company or client, its manner of operation, or its plans, which may come to your knowledge during the period of your employment with the Company ("Confidential Information").

You will keep all Confidential information entrusted to you completely confidential. This restriction will continue to apply after the termination of your employment without limit in point of time but will cease to apply to information or knowledge which may reasonably be said to have come into the public domain other than by reason of breach of the provisions of this Agreement.

You will not during your employment with the Company make or compile otherwise than for the benefit of the Company or any Associated Company any notes or memoranda relating to any matter within the scope of the business of the Company, its Associated Companies or their existing or potential customers or concerning any of the dealings or affairs of any such company.

All such notes or memoranda made by you will be the property of the Company and left at its - the Client's - offices upon the termination of your employment with the Company

Figure 0-5: Excerpt from HSE contract on confidentiality. Source: Contract of Employment between the HSE and myself, transcribed by researcher, not available online

As contract tracers, we were made aware of our obligations regarding social media in an e-mail on 15 January 2021. Each of us was instructed to read the HSE's 'Social Media Staff Use Guidelines' and its 'Electronic Communications Policy' and to confirm our understanding of these in a Google form that we were obliged to sign and return within one day.

Accordingly, within this thesis, I have used no identifiers whatsoever and have omitted material from transcripts that identifies where a GP is in practice. While working as a contact tracer, I used a jotter to take notes while making calls and listening to what people said; all data was then uploaded to the HSE's Covid tracking system and, at the end of each shift, a supervisor patrolled the floor, carrying a paper bin, asking all contact tracers to put their notes in it, for safe disposal. In this thesis, I use terms like 'a young man from Syria' or 'a farmer from the Midlands' in the knowledge that there were many such individuals who received contact tracing calls at the time. When I write in the autoethnographic chapter about members of my family and their pandemic experiences, I have sought and received their permission to do so. Stories about pandemic surges in named localities all first came to my attention via radio, television, newspapers and Twitter. They were reported in the public domain and unknown to me through my work. I have cited national and local mainstream media as sources of this information.

3.6 Summary

Research practices adopted for this research followed guidelines for qualitative analysis best suited to answering the research question i.e. 'what is the lived experience of Irish GPs who provide primary care for marginalised people?'. As researcher I had to be mindful of working with human subjects who, despite a high degree of training and infrastructural support, provide continuity of care for vulnerable people and might be vulnerable themselves. I also had to be aware of my own vulnerabilities. Repeated coding enabled me to discern patterns in Research Participants utterances and latent meanings. I now turn to three thematic chapters to present the empirical findings of this research.

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Chapter Four: General Practitioners and Placemaking

Palimpsest

Making house calls was one of the daily features of my work as a General Practitioner (GP) in the Dublin 11 area in the 1980s and 1990s. At the end of morning ‘surgery’⁴⁷, the Practice receptionist would hand me a list of house calls that had been requested by phone during the morning, or that I had deemed necessary for a house-bound patient. House calls were then organised in priority order of clinical need and ergonomic travel by car. I drove a small, second-hand Toyota Starlet whose appearance belied the presence in the boot of a doctor’s bag full of syringes and needles, injectable opiate, tranquilliser and antipsychotic drugs. Among the many house calls I made to patients in their

⁴⁷ Surgery: GPs and Practice staff refer to a working session as ‘surgery’, either morning, afternoon or evening surgery. A surgery session is proclaimed on the Practice signage and website as being time-bounded e.g. 10am-12pm, 2pm-4pm. Before COVID-19 pandemic restrictions, many GPs had ‘walk-in’ surgeries. Now, most are ‘by appointment only’ or ‘strictly by appointment only’ which suggests that some patients were still arriving without an appointment. During surgery hours the Practice doors are open. Outside these hours, doors are closed to facilitate clerical and administrative work, the hidden work that backs up and completes clinical work done during patient-facing consultations. When GPs worked from rooms attached to the family home the word ‘surgery’ was used to distinguish public Practice premises from private family quarters

homes⁴⁸, there were some which made me aware, without articulating it, of my role as placemaker, and of the social relations that were strengthened by every visit. One such involved a visit to a house in a marginalised suburb after dark on 30 October. The patient's mother apologised for calling me out so late, but her son had a terminal condition and had 'taken bad'. She asked what time I would arrive so that she could post her older son outside to mind my car. 'Your car would be perfect for a Hallowe'en bonfire, and they'll have it gone in two minutes, so my older son will guard it while you're here'. Driving home after the visit, I felt very much cared for by this lovely family. This was reciprocation at its best: I delivered primary medical care to make them feel whole and safe in their homes (Cresswell 2004; Tuan 1979; Relph 2015); they delivered protection to me in a way that came to characterise our relationship (Kleinman and Van der Geest 2009; Mauss 1925,2011). I could draw a three-dimensional map of the places where I made house calls then, including the top floor of the Ballymun flats before the tower blocks were demolished. So could every other GP who worked in that neighbourhood and all would have warm recollections of how courteously they were received when making house calls. 'Patients appreciate home visits and feel that their relationship with their GP improves as a result' (Mitchell et al. 2020, 306).

⁴⁸ Patients: GPs and Practice staff usually refer to those who use their services as 'patients'. Just as patients often refer to 'my GP' or 'my sister's GP'. GPs often refer to those in their care as 'my patient' or 'a patient of mine'. The possessive adjective, rejected by those who prefer the descriptor 'service users' usually signifies a bond of care, a taking of responsibility by the speaker. All of my Research Participants (RPs) used the term 'patient' along with the possessive adjective, so I will use their syntax. 'Client' or 'service user' were never used by participants in this research, being the language of the marketplace.

4.1 Introduction

The consultation is the core of general practice. Whether it occurs within a consulting room at the GP's Practice or where the patient dwells, it's an encounter to which the patient brings their symptoms and the GP, their professional capabilities. Both parties hope that it makes a difference in the patient's life. In their 2021 study of general practice in the Republic of Ireland, Collins and Homeniuk set out their findings as follows:

507 practices reported an estimated 21,353,731 GP consultations every year, along with 7,749,615 Practice Nurse (PN) consultations occur in Ireland annually. An Irish person visits their GP an estimated 4.34 times a year and the average consultation time is 13.7 min. This study shows that over 29.1 million consultations take place in Irish general practice every year (Collins and Homeniuk 2021, 1).

Whenever a GP travels out from the Practice to where the patient dwells, they make place centrifugally, but whenever patients travel from their homes to the Practice, GPs make place centripetally. Whereas house calls are still made in rural Ireland and city suburbs, mostly to house-bound patients, they are increasingly rare in city centres. Crosbie et al. found that 'GPs over fifty-five years of age spent more time doing house calls than younger GPs and that both rural and male GPs spent a greater proportion of time on house calls than their urban and female counterparts' (Crosbie et al. 2020, 4). Logistics of where the consultation occurs depend on multiple factors, all of which are discussed between team members of a Practice and clearly agreed as policy. Ownership of cars and/or access to public transport to the practice make it easier for patients to travel. Patients with mobility issues, patients who require palliative care and patients who may have infectious diseases are better visited at home. When a GP takes on responsibility for caring for marginalised people, they go to wherever those people dwell; homeless people who sleep rough, prisoners in prison cells.

However, GP surgeries are better equipped nowadays to deal with very ill patients at the Practice premises. Appointment protocols are set up to enable acutely ill patients to be seen⁴⁹ by the next available GP as soon as they arrive at the Practice. Continuity of the caring relationship with patients empowers receptionists to know them and to gauge the urgency of their case and alert Practice Nurses (PNs) and GPs that they're on their way. Patients who are poor, marginalised, homeless, addicted or otherwise disadvantaged often lack the transport, the social relationships, the know-how of conventional behaviour to navigate an appointment and a period of waiting quietly in a waiting room. According to thirteen Research Participants (RPs) the practice team knows these individuals and is trained to anticipate and manage their needs: instances are cited throughout this dissertation. While participants in this research were selected because of their service to marginalised populations, several cared for mixed income groups. Research Participants identified a variety of off-site locations for primary care consultations including nursing homes for elderly people, home visits for people receiving palliative care, homeless shelters, step-down facilities for homeless people, drug addiction clinics, facilities for gay men who wanted anonymity, Safetynet facilities and residential facilities for displaced Syrian and Ukrainian people. One RP has an occupational health role at a local meat factory. Eleven RPs are members of the Deep End Ireland Group.

So, why does place matter to general practitioners? Because, having been sculpted by it themselves, they make it for others. A Google search for 'GP

⁴⁹ Seen: When a GP 'sees' a patient this transitive verb is loaded with implicit power relations and serves as a metonym for all the capabilities deployed by the GP in discerning the patient's clinical status: smell, hearing, touch, sight, previous knowledge of this patient by ongoing, continuous care, and up-to-the-minute training to the level of professional excellence. Whereas Foucault interrogates the power dynamics of the medical gaze, as in Charcôt's clinic in 1887, GPs consider their clinical 'gaze' to be necessary for accurate diagnosis (Foucault 2003 [1963], 108–109).

shortage in rural Ireland’ returns hundreds of thousands of newspaper articles, radio and TV references and debates in Dáil Éireann, lamenting the problems people experience when they cannot access GP care either in a timely manner or at all. On 1 April 2024, a GP speaker from the floor at the Irish Medical Organisation (IMO) AGM in Killarney said, ‘there just aren’t enough of us.’ The presence of a GP service in a rural area reassures people that primary healthcare is available without delay to diagnose and treat sudden illness, to perform minor surgical repairs for farming and other occupational injuries, to triage patients who might need urgent referral to hospital, to visit patients in their homes who have terminal illness and many other clinical presentations. ‘GPs are deeply embedded in the communities that they serve’ (Government of Ireland 2021, 62). In all of these situations the patient has relatives, friends and neighbours who need reassurance and professional support in their caring role. The relational component of the visit often outweighs the medical one.

In February 2016, Dr Michael Harty, the only GP in Kilmihil, Co. Clare and founder member of the campaign ‘No Doctor, No Village,’ was elected to represent the Clare constituency as an independent TD in the 32nd Dáil (O’Muircheartaigh 2016). At that time, many single-handed GPs who wished to retire found that they could not find a successor to take over their practice. They blamed the Health Service Executive (HSE) for failing to advertise the post in a timely and effective manner and for failing to make the contract sufficiently attractive for applicants. Their dilemma was that they might either continue to work or that they might retire from practice, leaving their patients, who were also friends and neighbours, without a primary care service in the locality. Dr Harty said that his patients and constituents conflated the threat to GP services with similar threats to local post offices, banks, credit unions and schools, saying ‘the fabric of local communities is unravelling, and GPs are part of that’, a lament echoed in online newspaper *The Journal* (Hochschild 1979; Russell

2017). 'Place attachment, place identity and place dependence' of both the GP and the people whom they serve are thereby disrupted (Christiaanse and Haartsen 2017, 328). Dr Harty finally managed to retire from general practice in 2022 at the age of seventy. Citing Mohan (2000), Crooks and Andrews underline these relations: the overriding goal of the geographies of health and healthcare is to 'construct accounts of why place matters' (Mohan 2000; Agarwal 2009, 1). In this chapter, I argue that GPs are placemakers by virtue of the clinical work they do, the care they give to their patient population, the security they confer on individuals and groups who know they are accessible locally and by the decades of continuous care they provide to members of their communities.

As outlined in Chapter 3, Methodology, I coded RP interview transcripts and reflexive memos using Reflexive Thematic Analysis. I produced 10,524 references, coded into two hundred and eight codes from forty-five files (Braun and Clarke 2022). Having coded thirty-one GP interviews it became clear to me that in the text-bytes I had coded to place and placemaking, GPs rarely uttered the word 'place' nor the concept 'placemaking' as they are used in Geography. I then conducted a word search of the interview transcripts and associated memos, looking for 'place' and found one hundred and six mentions in thirty-one files. Analysis reveals scant overlap between the two categories, and this led me to discern that where GPs use the word place, they refer mostly to what influenced them in their professional development, whereas I code their utterances to the geographical concept of 'place' and refer to the act of placemaking as an inference from their narrative. However, placemaking is relational and arises from the intersubjectivity between doctor and patient/community that is inherently geographical. This relational aspect is recursive, grows deeper over years and, according to RPs in this research, constitutes one of the great joys of general practice. Although the Routledge Handbook of Placemaking (Courage 2020) has no chapters on healthcare, and a

word search for health, healthcare, doctor, GP, medical etc. yields those words only when hyphenated or as root of another word e.g. “doctor-al studies” (Courage 2020), this research uses the construct of place fundamental to human geography to make meaning of GPs’ work beyond bare primary healthcare.

4.2 What is place?

In his seminal text, *Place: An Introduction* (Cresswell 2015), Cresswell begins his exploration of place with the ancient Greeks who held place to be the fundamental basis of existence for anything else:

for something to exist it had to be somewhere. ... In this sense place (in the limited sense of location and container) has to come first ontologically – it is the ground for existence itself. For something to exist it has to be some place – so place, necessarily, provides the basis for existence (Cresswell 2015, 26).

Cresswell goes on to cite the political geographer John Agnew, who outlined three major elements of place:

locale, the settings in which social relations are constituted; location, the geographical area encompassing the settings for social interaction as defined by social and economic processes operating at a wider scale; and sense of place, the local ‘structure of feeling’ (Agnew 1987, 28)

Locale refers to the material setting for social relations’ (ibid.). Location can be defined in Euclidean terms and given co-ordinates of latitude and longitude. In a GP practice this might include how the building appears, the car park and accessibility, the reception area and waiting room, and the consulting rooms. Sense of place evokes feelings: how a GP experiences working there and how patients experience visiting the practice. Bearing in mind that patients visit a practice because they are sick or unwell and that GPs work there to provide healthcare, their respective appreciation of its location, locale and sense of place are laid down over time in a subjective and sedimentary fashion. Ideally, place is where one feels ‘at home’ or ‘safe’ (Browne and Bakshi 2013, 56–58; Till 2008,

104, 106; Tuan 1979, 403; Buttimer 1976, 284) although GPs, particularly those who care for marginalised people, are all too familiar with households where their patients do not feel safe and are not safe from their commensals. Likewise, people who identify as lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA) may fear coming out to their families, and may or may not consult their GP for advice. Place may provide the conditions of possibility for living a good life and for self-actualisation at all stages of life (Buttimer 1976, 284; Lewicka 2011). And elderly patients place great value on living out their last years in a place with the prospect of a happy death (Grove 2020; Guzmán et al. 2023; May et al. 2020). Insofar as a GP Practice in a town or village makes place for its residents, the absence of a primary care facility renders patients more vulnerable to the precarities of poor health and to higher morbidity associated with infancy and ageing.

Place is not a static container, it is kinetic; it changes, being subject to flows of time and time-space compression. Yi Fu Tuan describes how space becomes place:

What begins as undifferentiated space becomes place as we get to know it better and endow it with value ...The ideas 'space' and 'place' require each other for definition. From the security and stability of place we are aware of the openness, freedom, and threat of space, and vice versa. Furthermore, if we think of space as that which allows movement, then place is pause; each pause in movement makes it possible for location to be transformed into place (Tuan 1977, 15).

Place is always in a state of becoming (Pred 1984, 287–290) – more or less economically wealthy, more or less salutogenic (Antonovsky 1996), more or less vulnerable to weather events wrought by climate change. Local vectors shape place for its inhabitants: good land rewards hard agricultural work and creates prosperity, proximity to the sea enables healthier lifestyles in myriad ways (Foley and Kistemann 2015, 160–161). Networks of communication such as

rivers, ports, canals, railroads, road networks and airports globalise even the smallest towns by making possible flows of family members, tourists, and trade. Economic factors such as the crash of 2008 were written large in boarded up shops and ghost estates throughout rural Ireland in its aftermath. But after the upturn, remote working, which had begun before COVID-19 restrictions were imposed in March 2020, became much more popular as entire (nuclear) families moved out of cities and back to their rural origins near their extended families. ‘Geographic landscapes of digital labour’ attract people from other countries to work online from rural Ireland and thereby become digital placemakers (Graham and Anwar 2019, 185; Maciej 2024, 2). Irish government policy to encourage foreign direct investment (FDI) has created ‘1600 overseas company operations that directly employ over 250,000 people ... in sectors such as ICT, life sciences, financial services, engineering and business services’ (Department of Enterprise 2021). ‘Big Pharma’ companies such as Allergan in Westport, Co. Mayo and Pfizer in Ringaskiddy, Co. Cork have changed these respective places significantly. Doreen Massey’s description of place and placemaking in Kilburn would resonate with GPs who work in these localities (Massey 1994). However, the ebbs and flows of capitalism materialise not only in plant, high local employment and profitable exports, but also in a significant rise in the quantity of illegal drugs being imported, consumed and trafficked via our 3,172 kilometres of coastline. Since the foundation of the Republic of Ireland in 1922, Ireland has become quite wealthy, reflecting a strong economic performance relative to its population size.⁵⁰ Inequality, measured by the GINI coefficient⁵¹, has fallen steadily in Ireland over recent decades, indicating a more equitable income distribution compared to some other developed countries.

⁵⁰ Ireland had the eleventh highest Gross National Income (GNI) in the EU27 in 2022 at €363.6bn and the ninth highest Gross Domestic Product (GDP) at €506.3bn (CSO 2022b).

⁵¹ The GINI coefficient measures income inequality within a country, with 0 representing perfect equality and 1 representing perfect inequality.

TASC⁵² attributes this to various social policies and economic factors that aim to reduce income inequality. In a recent TASC report on inequality, Ireland's GINI coefficient was given as 27.9 in 2022/22, a figure 'well below the European average' (Sweeney 2023, 11). Walsh's 2023 survey of income distribution and redistribution in Ireland concludes that 'fostering regional strengths' and 'valuing and connecting communities' must be added by the state planning apparatus to bald economic considerations (Walsh 2023, 113). Citizens have the capacity to effect change too:

Demeterova et al. (2020) realise two dimensions of spatial justice: horizontal aspects of justice that address issues of access to and provision of resources such as institutions, services, markets and infrastructure and vertical aspects that relate to participative capabilities in power relations 'to avoid dependency, dominance and oppression' (Mahon et al. 2023, 686).

GPs who care for marginalised and underserved patients experience daily how the structural violence of poverty, drug, alcohol and gambling addiction and homelessness or poor housing bear down on them. Whether by design or neglect, these factors make place in a manner that compounds the healthcare issues with which patients present to their GP.

4.3 How place shapes General Practitioners

To the non-geographer the word place hardly warrants interpretation. It seems to act as a synonym or metonym for locations known to people with shared experience. 'My place or yours?' does not require further explanation when the speakers in a conversation are familiar with each other's lives and movements. However, GPs arrive at being placemakers for others after many years of being shaped by place. While my interview questions did not specifically include a question about place, I asked each RP how they came to be a GP [RQ1]. Their

⁵² TASC stands for the Irish Think-tank for Action on Social Change, founded in 2001. <https://www.tasc.ie/>

answers ranged from the formative influence of growing up as the son or daughter of a GP [5RPs] and learning social justice from their parents' outlook on life [2RPs] to having their home bombed during the Troubles in Northern Ireland [1RP]. Only one recalled any particular influence in secondary school: they attended a Jesuit school with social justice as a core value in the co-curriculum. Once in medical school, some began to question the compartmentalisation of medicine as practised in hospitals. Before the first GP training scheme began in Galway in 1971, four older RPs had to go abroad for a formal training in general practice while those who stayed in Ireland moved through the hospital specialities in self-directed training. GPs who qualified in the 1970s and 1980s described doing holiday locums early in their career and loving the holism of general practice as opposed to the atomised hospital experience where you cared for a patient's presenting complaint, discharged them from your care and never saw them again.⁵³ The GPs who participated in this research wove the geographical concept of place into their accounts of seemingly random placements in various locations in Ireland and abroad. Their narratives crescendoed to where they settled ultimately, once they found a job and lifestyle that offered the conditions of possibility for their work and self-actualisation. Protracted training confronts medical students and doctors not only with work that appeals to them and suits their natural talents, but also with its opposite⁵⁴.

⁵³ When a hospital doctor consults with a patient who has been referred by a GP, he/she has a duty of care to that patient. Once the course of treatment is concluded, the doctor discharges the patient back to the care of their GP and writes a letter to the GP stating what happened, what procedures were done, what medication was prescribed and any contingent advice. The duty of care is legally binding and is made clear by the Irish Medical Council.

⁵⁴ For example, those with poor dexterity would not be drawn to a surgical or obstetric speciality.

4.3.1 The word 'place' as used by Research Participants during interview

The word 'place' was uttered only one hundred and six times by thirty-one Research Participants during interview. It was used as noun and transitive verb. However, I extracted the utterances of 'place' and found that at 5,200 words the section was far too long for inclusion in this chapter. 'Place' was uttered by RPs to signify a point of time in their career, for example, when they got a place on a training scheme, got a place to practise, got a job. When modified by adjectives or descriptive clauses it was often disparaging, especially when describing a hospital experience during training.

To 'put in place' a practice protocol was to try to bring order to chaos, particularly at the outset of the COVID-19 pandemic when mortality and morbidity figures were high, and scientific research had not yet yielded an understanding of how the virus spread. It was also a clinical response to a presenting complaint, when a GP 'put in place' a treatment plan, in consultation with the patient. 'All over the place' is a term that two RPs used to describe how they feel when their workload of clinical and associated clerical duties is too heavy. Twelve RPs mention 'workplace' in the context of trying to create a happy working environment for the practice team in the knowledge that marginalised people bring multiple problems to every interaction which take their toll on staff members. Two RPs had left Ireland early in their careers 'this unkind place' [RP13] because of the political climate on abortion and divorce, only to return years later to work with marginalised patients and advocate publicly for constitutional change. 'Place' was also used to describe a mental state or a state of agency in the case of either the speaker or their patient 'getting to the right place' [RP14]; 'A very difficult place for them to go back to' [RP17].

In her book 'Beneath the White Coat: Doctors, Their Minds and Mental Health' Dr Claire Gerada explores the multitude of factors that lead people to decide to become a doctor, the transformation of the individual into the 'medical self' and then, the 'collective self' where 'the individual and the doctor become indistinguishable from each other' (Gerada 2021, 3–7, 22—31). These were recited in varying combinations by all RPs to trace their vocational formation. However, I trace a 'geographical formation' and will now quote a selection of examples here as RPs move from family home through university to training schemes in general practice (G.Kearns 2015).

4.3.2 Early life influences

Research Participants' accounts criss-crossed from where they grew up, to where they were schooled, educated and where they received their professional formation. Some had been shaped by an ethic of social justice in their early lives at home;

My grandmother was born in 1886; she lived through two world wars. And my father was a public servant. My mother is a teacher, so I come from a long line of people with extremely profound sense of civic duty and service. And one's education and one's intellectual prowess was definitely what mattered [RP12].

My dad used to work in what's called the Free Legal Aid system, where you are on call, and you see people whose income is below a certain threshold [...] it takes the money out of it [...] It's the same, the way I view health is, I don't view it as a commodity I view it as a right that's so important that it's too important to put a price on [RP17].

RP12 and RP17 had their place in the world mapped out for them by their family's ethical code.

Two RPs recalled going on home visits with their GP father:

My dad used to bring me on house calls with him, it was in the country, in *Named County Town* when it was a small town. And so, I would go on house calls with him, and I would hold the torch when he was trying to take something out of somebody's eye [RP05].

Two others had experienced ill-health of self or a close family member in a formative way:

My mother died when I was in Second Med ... of breast cancer, and she was palliated at home, and our GP was a very formative person for me and was a wonderful influence [RP23].

In this case, the GP escorted the patient and family through a harrowing terminal illness, at the same time modelling good primary care for a vulnerable young person.

One RP had their social conscience formed while growing up in Northern Ireland:

Our shop was bombed when I was fourteen ... only years later did I realise in retrospect that I was really traumatised by that ... it was very sudden and very shocking. Happened ... you know, five minutes to get out, father and everybody scattered around the village because we were at a T-junction And I've often thought that was connected to why I ended up in *Satellite Town* which is a traumatic place of its own [RP10].

Five RPs were sons and daughters of GPs who always knew they would go on to do medicine and worked hard in secondary school to get the necessary grades. Twenty-nine RPs who studied medicine as their primary degree

described working hard to get the marks in the Leaving Cert⁵⁵ that would secure a place in medical school.

4.3.3 Influences during undergraduate education

During six years of undergraduate study, all RPs attended a named university for academic studies and attached university hospitals for clinical training. Placements on clinical rotations in hospital were most commonly described by my RPs as experiences that made them aware that rather than treating a specific illness, they wanted to provide continuous care for ‘the whole patient’ and thus to work in general practice. Some disliked the hierarchy and depersonalisation in hospitals:

I did medicine. Didn’t really enjoy it, particularly lots of the stuff, the hierarchy [...]. I managed fine but found the whole set up really quite adversarial [RP13].

Others realised that they wanted to be their own boss:

You are your own boss, and you can choose how you work; you can work to your own standards [RP05].

You are your own boss, which has its huge positives but also a few negatives. [RP26].

⁵⁵ Irish education is formalised in the Primary school system, which a student leaves at around 12 years old, and the Secondary school system, which they leave five or six years later. On completion of Secondary school, they sit the Leaving Certificate Examination. Until 2009, the marks they got in this exam alone determined their access to medical school; in 2009 the HPAT (Higher Professions Admissions Test) was introduced to examine logical reasoning and problem solving, interpersonal understanding and non-verbal reasoning. Entry to all college courses is by competition and is managed by the CAO or central applications office. Many students who want to study medicine, should they fall short of the required ‘points for medicine’ sit the exam more than once.

Only eight RPs said that they had had GP placements as undergraduates but in all cases, they had found these enlightening.

We had great teachers deliver Social Medicine in Fourth Med. It was the first time we had learning in a small group, formatting questions and answers and scenarios. [...] We could all easily identify and sympathise with the person, the woman with no money ... but when the GP was looking for a termination for the woman who had everything it was very different ... interesting ... how we had to think differently. So, thinking about whole people and their whole circumstance that was the first time and so that was really exciting as an undergraduate. And we saw the first cases of HIV on the ward. So that was very ... you know '84/'85-was ... this whole social side of illness ... because it was such a social demographic ... [RP07].

Six RPs who graduated from Trinity College, Dublin in the 1970s and 80s had the highest praise for James McCormick (McCormick 1979) and Peter Skrabanek (Skrabanek and McCormick 1998) who gave them a social conscience and taught them how to think. These men lectured in Trinity College, Dublin in the 1970s and 1980s (Skrabanek and McCormick 1998). McCormick, a GP and professor of community health introduced a course on social medicine to first year medical students that broadened their insight into the social causes of physical and mental illness (Houston 2007). Skrabanek, a Czechoslovakian-born epidemiologist, was a rigorous thinker who 'with the spirit of European iconoclasm kept the medical evangelists in their hot boxes' (O'Brien 2012, 111). No other undergraduate teachers were named in this way although I reckon that the next generation of GPs will record their respect for some participants in this research, who have inspired them during their undergraduate learning and postgraduate training.

4.3.4 Influences during postgraduate training

As outlined earlier, a GP's sense of place is fluid during training. The apparent randomness of their six-month postings makes them more malleable in preparation for the unpredictability of a GP's caseload. Not only did RPs

experience practising across the spectrum of urban/rural, wealthy/poor practice populations, but they also learned the art of general practice from experienced GPs who had chosen to put down their roots in a variety of locations and scenarios. RPs warmly recalled what their GP trainer had taught them and how it helped them configure their career path.

I realised when I was working in various disciplines for a few years that there was an awful lot of over-medicalisation. That holistic concerns for patients weren't addressed, there were too many tests happening, it was very fragmented. No one understood patients. I didn't really like that when you are doing surgery you consulted someone else to look after someone's blood pressure: when you are doing nephrology or there was a liver problem you consulted someone else. This is all the stuff you learned in med school - why couldn't you do comprehensive care? Why isn't there continuity? And without knowing it ... I didn't know that's what GP was ... I realised that I wanted to do GP [RP14].

And going through medicine I think you're exposed much more to the hospital specialities [...] I could also see that by the time patients arrive into the Emergency Department, half the time the game is lost. Because they're left sitting on a trolley and they're getting dehydrated and delirious and everything. And I was thinking -Gosh if you just had a really good GP maybe you could really make more of an impact. And make more of a difference [RP18].

And it was halfway through my time in Oncology I had the epiphany - what the hell am I at? In general practice I'll have everything, I'll have the Medicine, I'll have the Obstetrics, I'll have the Palliative Care. And it was literally like an epiphany. And then I said – that's it [RP21].

Several RPs mentioned that the most popular training scheme (among applicants) in the Republic of Ireland is the North Dublin City GP Training Programme. Founded in 2009, its founding mission and continuing vision is to train GPs to work in areas of deprivation and with marginalised groups, widening their perspective on social injustice. Younger GPs gave accounts of applying for postgraduate training schemes: while they hoped to get their first preference of place, they took whatever they were offered. One RP works in a rural coastal location and considered themselves very lucky that their spouse, also

a GP registrar, had found a position in the same town; some colleagues were not so fortunate. The role of GP trainer and co-ordinator of a regional GP training scheme had been undertaken and enjoyed by fifteen RPs.

GP trainers are experienced GPs who, along with being a principal in a general practice, take on the job of training, mentoring and supervising GP trainees. In order to qualify as a trainer, a GP must be registered on the Specialist Division of the Irish Medical Council as a General Practitioner, must have passed the MICGP exams and have at least three years' experience working as a GP in Ireland. Their Practice premises must provide adequate facilities for training and they must complete the ICGP trainer induction programme. Trainers attend regular targeted CME meetings and trainer workshops organised by the ICGP. Trainers say that this role adds a significant workload to their lives but that its rewards outweigh the downsides. Three RPs who were trainers introduced me to their GP registrar and, in each case, were full of praise for the qualities the younger, trainee doctor brought to the Practice. The network of GP Trainers is an important support system for those who participate. Apart from being well remunerated, they say that it acts as a kind of continuity of care, as they teach the art, craft and science of doctoring to a new generation. Trainers from all over Ireland meet formally on a regular basis; as they network with each other they also act as placemakers for their trainee GPs.

4.3.5 Influences after postgraduate training

One RP undertook a Masters in Global Health after GP training with the intention of working abroad. They were radicalised as they walked into college by passing people sleeping rough:

The thing that struck me about the Masters was even though it was focused on lower to middle income countries, a lot of the lectures and a lot

of the examples, a lot of the case studies that they used were actually from the Irish health context, looking at inequity in the Irish context or in the European context. So, I suppose what it did was it highlighted to me that there was a huge amount of inequity and unfairness in Ireland [RP17].

The morning walk into college re-orientated their career; they went on to become a full-time GP and advocate for the poor in Ireland.

4.3.6 GPs who studied medicine at postgraduate level

Two RPs studied medicine at postgraduate level. One began studies in postgraduate medicine at the age of 34, having worked overseas as a development worker. Exposure to shortcomings of healthcare in other countries sharpened their awareness of the Irish situation. They looked forward to making a final payment on their student loan at the end of 2021. Their place in medical school had cost tens of thousands of euros but they had no regrets.

Another GP worked as a schoolteacher in a marginalised city suburb before deciding that they could make more of a difference to this cohort if they became a GP:

I just seemed to get more enjoyment out of working with people who were a bit more marginalised or a bit more vulnerable. And I think that's probably stuck with me when I entered medicine then and it was always in the back of my mind to work in a more deprived area. It was just something that I was attracted to, I don't know why [RP22].

In both of these instances, place shaped the nascent GP who undertook an expensive and demanding course of education with the sole objective of being a GP for marginalised people.

4.3.7 How place made GPs in the 1970s and 1980s

Ten GPs near retirement age described working all over Ireland and the UK in different practices, either as *locum tenens* to cover a GP's holiday leave or as

‘assistant-with-a-view-to-partnership’. GPs of this vintage applied for and competed for a GMS position or ‘list’ wherever one was advertised and moved to whatever place they were appointed to. One RP recounted enlightening training in the NHS system in the UK:

When I went to *Named UK City* to do my registrar year because you couldn't get in in Ireland, I did all the interviews. I suddenly realised this is great, I was in a different jurisdiction, different culture in *Named UK City*, a can-do ... the negativity wasn't there. Very welcoming to Irish graduates, and an incredibly positive experience. And it was like shedding my armour, I didn't have to have my medieval armour and spear anymore to just get through the day which I had to have to survive in hospital medicine in Ireland, which was to me a system of ritualistic humiliation and intimidation and degradation. That was my professional training ... it sounds negative, but it came from a culture of didactic monoculture Catholicism and a paternalism ... and that was male dominated, and it was rife. And it took a long time for Ireland to come out of that [RP12].

The practice of medical doctors in all specialities going abroad to broaden their education and experience before returning home to Ireland is well known in the contemporary medical vernacular and historically grounded in our being a colonised island nation.⁵⁶ RP02 recalled being a partner in a fund-holding practice in the UK in the 1980s when GPs could commission the operations their patients needed from surgeons with whom they negotiated terms and conditions. They returned to Ireland buoyed up by this experience of what had become possible. RP27, likewise, had their horizons broadened by working in the NHS at that time. Five RPs did training in Australia; RP31 might have stayed there but they had always wanted to set up their own practice in Ireland, and so they returned just before the 2008 economic crash. In the 1970s and 1980s, locum work was popular among doctors who hadn't got a permanent

⁵⁶ Ireland had no university in the late mediaeval period, so they travelled by sea and overland to Europe for further medical education. This practice, accentuated by the Penal Laws from 1695 onwards, exposed Irish doctors to ‘the clinical, teaching and diagnostic methods of the hospitals of Paris and Vienna’ (McGeachie 1999, 86).

job. Eleven RPs spoke of how locum jobs all over Ireland made them more and more certain that they wanted to work in general practice. They loved the varied case load, the unpredictability of the work and how the local practice team and community looked after them, even during a brief stint. Witnessing needs that their home life would not have exposed them to, knowing that they had the skillset from training and toolkit from contemporary therapeutic advances empowered them to choose how and where they wanted to work.

4.3.8 Getting a job

It is self-evident that no matter when a person qualifies as a general medical practitioner or as a GP, what they want next is a job to earn an income, to find a satisfactory way of making a living and, in many cases, to be able to settle down with their life partner with the prospect of raising a family. At times of economic uncertainty in the past, most medical graduates emigrated from Ireland and made their careers abroad. Doctor retention has become a deepening problem for the Irish health services (Humphries et al. 2015; Humphries, McDermott, et al. 2019; Humphries, Connell, et al. 2019; Humphries et al. 2020; Humphries, Crowe, and Brugha 2018).

Finding a job in a practice that suits one's life choices can be challenging. Setting up a practice from scratch as one RP did with partners involves incurring significant debt. Evidence suggests that those who opt to work in rural general practice are more likely to have grown up in a rural area (Glynn et al. 2023; Stanley et al. 2023). RP29 mentioned a recently devised postgraduate training scheme in University of Limerick that places trainees in rural and urban practices contiguously (Glynn 2024). One RP has chosen to practice in a marginalised city-centre area despite having had job offers that might appeal more to others:

... it's technically social enterprise so the idea is that the charity sets up a practice in an area where it's not financially viable to do it and then that we would work here and so the GPs work here and eventually we become a full partner. Now it's not very financially successful working in a deprived area, so I've opted to remain salaried. I think it's a bit risky to be a full equity partner [RP09].

The financial aspects of general practice are beyond the remit of this research. However, in a similar project done for my MA in 2018, most GPs complained of the income cuts imposed by FEMPI⁵⁷ after the 2008 economic crash. In the current research, FEMPI restrictions had been reversed, and RPs' main complaint was the workload that interfered with their capacity to deliver quality care for their patients and maintain their own wellbeing.

4.3.9 Political placemaking: Brexit.

When the UK voted to leave the EU in 2016, RP08 knew that they must leave the UK. RP08 was born in an EU country and had met their spouse (a dual Irish and UK citizen) during training. They had settled down in a scenic part of rural England, had children and worked as GPs for almost twenty years. They moved to rural Ireland in 2019 and took a series of part-time GP positions to try to work their way into permanent jobs. When pandemic restrictions were introduced, RP08 was assigned a part-time job teleconsulting in the practice and found it very lonely. Before long a position in a homeless support agency was advertised and they got the job. A seventy mile commute each way presented no problems now that they were seeing people, many of whom were newly arrived in Ireland, and knowing their skills were making a difference in the lives of their patients. Place was made for RP08 by politics; they went on to make it for others.

⁵⁷ FEMPI: Financial Emergency Measures in the Public Interest Act 2010

4.4 The GP as placemaker: how GPs design and enact place in their working lives

In his book *A Fortunate Man: The Story of a Country Doctor*, John Berger writes movingly about a rural English GP responding to a call out for a woodman who had been trapped under a tree, sometime in the 1960s.

As he drove through the lanes he kept his thumb on the horn the whole time, partly to warn oncoming traffic, partly so that the man under the tree might hear it and know that the doctor was coming (Berger and Mohr 1969, 23).

This GP was caring not only for the patient, but also for the entire community.

While Cresswell's definition of place provides a start in identifying how GPs make place, a more expansive account is necessary to do justice to the role of GPs, especially in rural areas. In the next section I draw on what RPs said at interview that signified how they make place through their work. I have framed their practices according to the location where they work. Although the framing may seem like nested scales of activity it is not, since GPs' work at off-site locations resists any such bounded and layered classification (Sayre 2009, 99). The forcefield of their personal knowledge of their patients accompanies GPs everywhere, to the point that four RPs said they are very careful where they socialise and absolutely disciplined about where and with whom they consume alcohol. Marston, citing Schatzki, proposes the more useful 'site ontology' (Marston, Jones, and Woodward 2005), brought humorously to light by RP29 saying that patients ask them about clinical and confidential matters in the most inappropriate public places, such as the crush leaving Sunday Mass. They must practise 'culturally sensitive care' (Parr 2003, 480) and ask patients to ring them 'at the surgery'; three other rural GPs told similar stories. Sometimes a GP makes place by conscientiously doing nothing.

4.4.1 Practice premises

Practice premises are easily located by co-ordinates on a map, or nowadays, a postal Eircode intelligible to Google maps. Older GPs described 'putting up the plate' on the family home and living 'over the shop'. As the practice grew and they had children, they moved the practice to a larger premises, sometimes in a different location. By contrast, younger GPs have the opportunity to work in large, primary care centres, purpose-built by the HSE, where there are several GP partners along with ancillary clinical and clerical staff. Whereas urban GPs can commute to work using public transport, patients in rural areas can tell who is on duty by scanning the car park to see if their doctor's car is there. Locale includes the fabric of the Practice building, whether it is warm enough, adequately ventilated, whether sound insulation can protect confidential disclosures or emotional outbursts. A nearby pharmacy adds to the locale since many consultations yield a prescription for acute presentations or as repeat prescriptions for chronic illness. Access for disabled persons and clean, spacious toilets are essential to include all members of a community. Good public transport renders urban Practices more accessible to the public. COVID-19 restrictions bequeathed an immediate legacy of scantily furnished waiting-rooms and car parks populated by patients who waited in their cars until called by the receptionist; with the rise of COVID-19 vaccination rates, this has returned to normal.

Fourteen GPs invited me to interview them in their consulting rooms, eight in modern, newly built or modified facilities and six in more traditional premises. A further four met me at a clinic designated to provide a particular service to marginalised people, such as clinics for the homeless, for drug misuse, for HIV+ gay men. Those who met me elsewhere, three at their own homes, one at my home, seven in hotel lobbies and two online, did so in order to create

undisturbed space for the interview; they said that once they were on the Practice premises, even if time was protected, our interview would be interrupted. On every occasion, when I arrived, I was greeted by a Practice team member or the GP themselves. Any little delay suited me well as it allowed me to acclimatise to my surroundings and to notice how busy they all were, even when it was out-of-hours.

RP02 had worked with Practice partners in an old building in an outlying, deprived city suburb, using a small house in a neighbouring housing estate as a second Practice premises. They had long dreamed of a purpose-built premises, and it was realised, quite perversely, by the economic crash of 2008. Construction halted on a large building in a well-served location and its market price fell significantly. The partners approached the HSE *inter alia*, to re-purpose this building as a Primary Care Centre. It now hosts a pharmacy on the ground floor, various healthcare agencies on other floors, and a beautifully lit and decorated GP practice premises accessible by lift on an upper floor. At the official opening of the Practice, awe-struck patients asked; 'is this place for us?'.

When we were designing this place, the builder wanted to have a corridor that the doctors could go up and down the corridor and not be seen by the patient. And I said no, I didn't want that. I wanted to come out and to be a presence in the waiting room. We never have any trouble in the waiting room because they know if there's a doctor in there, they're doing something. Not that they've gone and forgotten them [RP02].

In this way, this GP and their partners have designed a respectful architecture that puts patients in this marginalised population at their ease while waiting (Shove 2007). Patients in RP02's practice also have their confidentiality protected by staff procedures:

RP02: The one group we are very cagey about is guards [police] coming in here.

CH: Do they sometimes have reason to come in in uniform?

RP02: ... In uniform ... if we can meet them anywhere else, we will. We don't want any of that. We'd be very, very careful about that. Confidentiality is ... you know ... now they assume it, but they didn't always assume it.

Conventions like this augment the conditions of possibility for a patient's feeling safe at the GP Practice. Trust like this is socially constructed and must be safeguarded. It transforms the building from an arid 'healthcare facility' into a relational space (Cummins et al. 2007, 1835) where the intersubjectivity of GP and patient is prioritised to the extent that it enables effective primary care to occur.

RP 12 works in a modern, purpose-built primary care centre in a deprived city suburb which, although bright and efficient, took time to recommend itself to the practice team:

We moved in 2018, and we went from a very friendly building that was totally wrong, old and everything, but a terribly friendly place where we knew all the staff and we moved into a new building where everybody was in different floors and there was no central meeting place anymore.

But interestingly, in the pandemic the old building would have been totally inappropriate, at least we now have these really big rooms where we could ventilate, we could leave the doors open, have two metres, we were well able to be two metres from each other. So yeah, I've come to appreciate the building [RP12].

RP12's description of the 'throwntogetherness' (Massey 2005) feeling that gives such strength to a practice team was echoed heartily by RP10 and RP11, and in an ambient way by twelve other RPs. The theme of assemblage; (Duff 2023; Barnard et al. 2024) , introduced in section 2.1.4 above can be discerned in their narratives where they explicitly valorise the importance of a happy, committed practice team.

When a patient finds that the GP they have chosen has a full list and will not take on any new patients, where do they turn? Two urban GPs keep their lists open, as long as someone lives locally. They also continue to give appointments to patients who have moved to a rural area and cannot get a local GP. Two city-based and two GPs in medium sized towns see any patients who live in Direct Provision although one city-based GP laments the long distances these patients must travel to consult with GPs in their practice.

A GP who works in a multi-partner practice in rural Ireland gave a joyous account of how their premises facilitated rapid vaccination of their patient population during the first roll out of COVID-19 vaccines in January 2021.

Our primary care centre was turned into a clinical hub and the HSE did that really quickly ... we're lucky we've a very big premises ...it was very impressive ... when the HSE want to do something, they do it really well. When the first lockdown eased, we were very careful, we'd bring them in one by one, make sure that they weren't exposed, we'd bring them in from the car and we'd everything done [...] a few of them did say thank you so much for bringing me in and for taking my blood pressure, looking at my medication. But interestingly, each tranche ... the first tranche of the very elderly ... they were coming on Zimmer frames and then as each 10 years went down ... and then by the time you got to the 50s and 40s they were bouncing in. But it was interesting, every decade told its tale [RP30].

Five other RPs gave similar accounts of how their Practice car park, once a warehousing space for empty cars, became an animated relational space for staff and patients alike during pandemic restrictions and the first wave of COVID-19 vaccination.

And I remember one afternoon three cousins, elderly gents who hadn't seen each other for fifteen months even though they lived within a thirty-mile radius...They met in the car park, and we had photographs taken and a bit of a ... I won't say party, but people were happy [RP29].

These elderly gentlemen experienced space turned into joyful and therapeutic place as they had social contact after protracted isolation (Gesler 1992).

Reflecting the pioneering spirit of independent GPs who created their practices from very modest beginnings, RP31 did it all alone when he took over a small, rural, single-handed practice:

It was tricky at the time because it was actually an old-style GP surgery. It was based out of the [retiring] GP's house. He had no secretary, he had no nurse, it wasn't computerised. So, it was a big step to take but I went for it, I actually bought this building, converted it and computerised the practice, hired a practice nurse, hired admin staff and then it just grew and grew [RP31].

RP31's intrepid spirit enabled them to rise to the challenge of providing primary care for Syrian and Ukrainian refugees a few years later.

Seventeen other RPs narrated a similar experience that required vision, entrepreneurship, undertaking debt and hard work. GPs' practice premises manifest temporal and spatial vectors, apparently random, which converge to distil their personal and professional formation and become instrumentalised in their place-specific health-caring persona.

4.4.2 The consulting room

GPs spend long hours in their consulting room. Those GPs who invited me there had a choreography of entry and exit. They showed me great courtesy, made me comfortable, put me at ease and ended the interview with friendly banter. Three RPs who saw me after hours gave me an unhurried tour of their Practice premises, proudly explaining the events that had caused them to make various changes. This is their *locus operandi*, where they consult with patients who are in pain, troubled, sick children brought by their anxious parent or insouciant elderly people ... the unworried unwell ... who wonder why their adult son or daughter is 'dragging' them to the doctor, 'wasting the doctor's time'. Some patients describe their symptoms with great verbal clarity, their hands mapping the diagnosis over their bodies as they speak. Some carry a

burden of ongoing stress that causes the presenting complaint but just want it fixed without addressing the underlying cause. In all cases, the GP must use their listening and communication skills to attempt to unravel the patient's presenting complaint and treat them appropriately.

All consulting rooms contain standard equipment for physical examination. It may seem to the reader that this description is superfluous, but the material culture of a doctor's consulting room signifies the range of pathologies to which they must be alert at all times. There is no hospital consultant's room or suite that contains the range of diagnostic equipment essential to a GP's work. And the next patient must have no inkling of what transpired directly before their consultation. Sturdy chairs are provided for patient and accompanying person, coat hooks, an examination couch with hinged back rest and an instruments trolley alongside, a curtain hung on a rail or a screen for patient modesty. Windows have blinds or curtains for two reasons: to darken the room if the eyes need to be examined and more importantly, to reassure the patient that they cannot be seen in this room by a passer-by, and that if clinical examination is warranted, their modesty is respected. Whether wall-mounted alongside the examining couch or lying on the desk, there's always a sphygmomanometer or blood-pressure measuring device, a thermometer, an auriscope to inspect eardrums, a torch to inspect throats and sometimes an angled light to help inspect ambiguous rashes, although most skin complaints are best diagnosed by daylight. An ophthalmoscope is used to examine eyes. Should the patient's clinical presentation require it, the GP can pivot rapidly to doing internal pelvic examinations; they already have the skill and the equipment, all they need is the patient's consent and a chaperone from the practice team. A box of tissues is always within reach for an unanticipated emotional outburst.

A stethoscope is used to listen to heart and lungs: RP29 said that his elderly patients often ask, 'would you sound my chest' and although the particular clinical presentation does not require it, it provides an opportunity for the 'laying on of hands' which some patients find reassuring. Touch, 'our most vital sense' (Kearney 2021), takes time and is becoming increasingly obsolete in medical consultations. In some practices the PN sees the patient before the GP and takes their 'obs' or observations as required by their clinical presentation: temperature, pulse, blood pressure, respiratory rate, height and weight, urinalysis. In this way, the patient history is taken twice. As one GP said, 'they'll say stuff to her that they'll never say to me'.

The days of handwritten clinical notes are gone⁵⁸, so all GP practices now use a networked computer system with a terminal on every healthcare worker's desk and, since pandemic restrictions in early 2020, the option of a monitor at their home where they can log on to the practice if on-call, or when doing paperwork after hours. GPs consider it a great advantage to be able to touch-type so that they can maintain eye contact with a patient while typing in their narrative verbatim. Printers are required for printing off letters of referral to hand to patients. The dot-matrix printer, once the bane of every GP's working soundscape [nine RPs], is gone, banished by the rapid introduction of Healthmail and Healthlink in the early months of COVID-19. Healthmail enables GPs to write a prescription online and e-mail it directly to a named pharmacy. Healthlink is the National Health Messaging broker and provides a web-based messaging service which allows the secure transmission of clinical patient information between hospitals and GPs and vice versa. Aside from the clinical equipment, there's usually a side table piled high with paperwork that

⁵⁸ One RP said that their local county hospital still uses paper files and case notes.

awaits attention. The consulting room is often personalised by the display of artwork, family photos and thank-you cards.

Despite the presence and use of all this essential hardware and software, the GP's job is to focus on the patient, to elicit their symptoms, discern their signs, diagnose their condition and treat them in a way that makes a difference.

Patients from marginalised populations frequently manifest signs of structural forces beyond their own agency and require extra support and advocacy from their healthcare providers. 'I think the deprivation adds a whole other layer' RP11 said, echoing ten Deep End RP Colleagues. RP10 showed me 'the iceberg of general practice' which depicted the workload on an NHS GP who cared for a marginalised population (see Figure 4-1).



Figure 0-1: The iceberg of General Practice (2022)

Source: Thorpe Road Surgery, Peterborough, Cambridgeshire, UK. Available at: <https://www.thorperoadsurgery.nhs.uk/news/the-iceberg-of-general-practice>

Safety-netting and safeguarding have come to be intrinsic to the consultation as the GP ticks all possible clinical and social boxes before the patient leaves, ensuring their safety insofar as is possible and alerting them to what might prompt them to seek further advice promptly. One RP explicitly stated that they had suffered from burnout. Three more came close but were able to make changes to their work before it engulfed them. The iceberg image reflects not

only the GP workload but also their life. It also signifies the balance of met and unmet healthcare needs in a marginalised population (Joseph and Phillips 1984).

4.4.3 The consultation

Whether working full- or part-time, the GP usually has a fixed consulting room in the Practice, the 'holy of holies' [RP28] where they practice their profession. Unless it's a clerical matter such as collecting a sick cert. or a doctor's letter, the focus of every patient's visit to a Practice is a consultation with the GP or Practice Nurse (PN). At the appointed time (or later), the patient is called from the waiting room or waiting area and goes or is escorted to their GP's consulting room. Once the door is closed behind them, the consultation may begin. GPs invite patients to sit down either across a desk from them, or around the corner of their desk; fifteen RPs who had worked as GP trainers referred to teaching trainees how to position themselves. While the patient is making themselves comfortable, leaving down a bag or undoing a coat, the GP observes them carefully. In the context of continuing care which may have gone on for decades, the GP has an intimate knowledge of this person and of their ongoing illnesses and social situation.

I don't see it as a patient having one consultation with you. I see consultations that have gone on for 30 years. The one life. And they come to see you and ... bits and pieces. It's not a ... it's not seeing a patient five times a year or whatever. Seeing them once, but at five different times [RP02].

In a long-term relationship of continuing care, the GP waits to hear whether the patient has a new presenting complaint or wishes to review an ongoing one. Although the stated reason for the consultation is listed in the Practice appointments diary, this is often a decoy for a deeper, more troubling matter. In a relatively new, or a once-off clinical relationship, the GP has much more

supplementary information to gather. (These decoys were narrated by RPs and redacted at their request). But the GP must not guide the consultation, so they'll open with a broad enquiry, inviting the patient to say why they came to the GP today – known as 'taking a history'. It's a well-known Osler-ism⁵⁹, a maxim among experienced GPs to 'Listen to the patient, he is telling you the diagnosis' (Stanford Medicine 2014). If a patient is clearly unwell and a careful history and examination fail to yield a satisfactory diagnosis the GP may ask the PN or a GP colleague for a second opinion, allowing them to re-take the history and repeat the physical examination.

I think that's one of the most powerful things that a GP can do, to make a difference in people's lives. When they're at a very low ebb in their life [...] we're in a position to say – look, I know what to do here, I can help you, leave this with me [...] and when you meet six months or a year afterwards, they acknowledge that and say look when I was back there - thank you so much for that. You see a few thank you cards over your shoulder there ... [RP31].

While the patient speaks, they transmit important clinical information on every sensory level, olfactory, visual, tactile, auditory and emotional. Their breath may signal the keto-acidosis of diabetes or anorexia nervosa. A deterioration in their level of personal grooming or hygiene may point to a deepening depression or inability to cope. Their tone of voice may alert the GP to a state of anxiety or a flat affect. Their gestures and appearance give emphasis to their words, helping the GP to take in what they are saying, known as the 'presenting complaint', to process it through their many diagnostic lenses and lead them to a line of enquiry which begins when the patient has finished speaking. If the patient is a minor or has brought an accompanying person, the GP will, with the patient's consent, 'take a collateral history' from them to add more context and detail. Much can be discerned by observing the interaction between the

⁵⁹ Sir William Osler (1849–1919), Canadian physician.

dependent person and their companion. Should the presenting complaint require it, the GP invites the patient to consent to a physical examination. This is a time-honoured sequence of practices following the ancient routine of inspection, palpation, percussion and auscultation. Contemporary evidence-based medicine continues to add to the requirements of best practice. Continuity of care builds 'accumulated knowledge' to provide a reliable baseline (Pereira Gray et al. 2018, 2). Continuity of interpersonal GP care also acts as a proxy for placemaking.

Routine ante-natal care visits have great value in placemaking, especially in a marginalised community where young women may have few supports when their first baby is born:

You build a bridge giving ante-natal care. We do far too many ante-natal visits, but you get the mother right, then you get the child, the family, all kinds of things. They know then that they can come back when they're struggling in the first two weeks. It's all, it's therapeutic, really [RP02].

And GPs love doing routine ante-natal consultations that offset more difficult ones:

It's even better now twenty-two years in because the babies that were coming out of the womb when I started are now going to college, becoming productive young people in the community and I do love that [RP30].

Once the patient has dressed, the GP tells the patient what they have found on examination and initiates discussion of the treatment plan, ensuring that the patient understands what they say and whether they are in agreement with what is being proposed. Outcomes from a GP consultation may include prescription of medication, ordering blood tests, X-rays or other tests, referral to a secondary specialist service in a hospital or in the community, social prescribing of exercise or moderation of tobacco, alcohol or high-calorie food consumption. Safety-netting covers the uncertainty inherent in many disease

presentations, especially at an early stage. Telling bad news is part of a GP's job and the skill to do it well is woven throughout their entire training. It's one of the skills required to escort people from cradle to grave:

And sometimes people, in this day and age, people still ask me - I'm going to tell you something, you're not going to tell anyone, will you? it won't leave this room? And I say -of course, you know, what we say in this room is sacrosanct, it doesn't leave. And often you actually physically see the load leaving them, it's almost like a catharsis [RP31].

As the consultation ends, contingencies for follow-up are discussed. Once coats are buttoned up, tears dried up, children's toys tidied away, the GP changes the conversational register to small chat before they open the door, and the patient leaves this liminal place to re-enter the world. A world where the GP's placemaking skills fall well short of effecting structural change in a timely manner:

You can also feel powerless when you have at-risk children, still at risk, and deprived parents and fractured families. And violence and criminality, when you know the people are victims of violence and criminality when they leave your room. They go back out into that world, so you are powerless to influence their milieu of deprivation and victimhood. Because the society and the environment is full of threats for them and you are powerless to protect them or maybe you feel powerless, you feel you are powerless in protecting or offering them a way out or a solution [RP12].

These comments valorise the GP consultation room as a 'safe' node within a potentially unsafe set of relations outside that space.

RP02 began prescribing methadone⁶⁰ to patients in the mid-1980s and had enormous success in weaning patients off illegal drugs and onto prescription medicine. While the mothers of many of their patients expressed their gratitude, those who profited from the sale and distribution of illegal drugs were very unhappy about it. RP02 got feedback that they had single-handedly ruined the illegal drug dealing market in their area. This is a great example of how an action taken by a GP in consultation becomes a practice, then a protocol, then a life-changing intervention for individuals and communities whose lives are ravaged by the illegal drug trade. RP02 made their locality a safer place for their patients and all their community:

When we opened up ... the gangs started. We'd got a very successful methadone programme going, all that took the market away. I was the first doctor in *Named Suburb* to prescribe methadone. The IMO rang me up and told me I was giving bad example. I thought it was terrible⁶¹ [RP02].

This comment reflects observations made by five other RPs who have a sizeable cohort of patients who are addicted to intravenous drugs. The slow

⁶⁰ Methadone is a synthetic opioid, developed in the 1950s, specifically as a substitute for heroin (Nutt 2012, 164). It is used to support people with opiate dependency to withdraw from heroin. The Medico-Social Research Board and Garda Síochána identify 1979–1983 as the beginning of an epidemic of heroin abuse in Dublin (Dean et al. 1985, 108). Because of its side-effects, methadone had to be prescribed and dispensed in regulated settings; I prescribed it regularly for my patients in the female wing of Mountjoy Prison when I worked there 1986–1992. In 1998 the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations came into operation in Ireland (Butler 2002) which confined prescribing of methadone to doctors trained for that purpose. Ireland's first medically supervised injecting centre opened in December 2024. The long wait for this service occurred because of ongoing objections from members of the public.

⁶¹ RP02 named the high-ranking public figures (more than one) who telephoned to discourage them from prescribing methadone for patients and redacted their identities from the transcript. Their efforts served only to highlight the stigma attached to drug addiction; notwithstanding this, the GP carried on fulfilling their clinical duty to their patients.

development of services for people who inject drugs is well catalogued (Delargy, Crowley, and Van Hout 2019).

Over time, GPs develop a unique consulting style that adapts immediately to a patient and their presenting complaint and circumstances. All GPs have a 'body-ballet' by which they choreograph the consultation (Seamon 1980, 2018). RPs mentioned the Calgary-Cambridge model (Papageorgiou 2015), Starfield (1994), Balint (1955), Pendleton (2003), Charon (2006), Launer (2023)) and other renowned theorists of the consultation. In training, they learn to mirror the patient's movements to encourage disclosure. They lean back in their chairs to listen, lean forward to say something, they make full eye contact and use appropriate humour to make the consultation easier. As an interviewer seated in the patient's chair, I observed this 'body-ballet' at work during sixteen interviews in GP consulting rooms. It was all the more engaging when some GPs produced the interview questions I had sent them in advance, printed out and annotated with their considered responses. Some interview questions evoked a cross-questioning where they asked me ... 'what do you mean by that?' that led to an interesting discussion. I felt that they had made it worth my while to travel long distances to interview them, sometimes staying overnight, and when I said so, two of them volleyed the courtesy and thanked me for visiting them rather than 'asking for yet another meaningless Zoom chat or survey' [RP27].

4.4.3.1 *Touch*

RP29 values touch to the extent that they make a point of always making physical contact with a patient, even to pat them on the shoulder as they leave the room. RP12 lamented the loss of touch in the consultation during pandemic restrictions, stating that the poor and marginalised patients in their practice often had terrible personal histories to narrate and that a reassuring holding of

hands gave them great support. To balance the dynamics of power in the consultation, RP21 lowers their chair so that the patient's head is slightly above the GPs. This is done in an attempt to enable a patient who has been brutalised by structural violence and might display deference to the GP to give a clearer account of their symptoms and thereby expedite an accurate diagnosis. RP06 likes to take a history from patients while the practice nurse is dressing their wounds; they've already told the PN their story. It helps to remember every detail and to triangulate the narrative in a three-way consultation atmosphere. That one cannot touch without being touched is a version of Newton's Third Law of Motion:⁶².

In the oldest stories of the wisdom traditions- from Jacob and Jesus to Chiron and Asclepius- the double sensation of healer and healed entailed the double sensation of touching and being touched (Kearney 2021, 139).

In an unusual concession to the importance of placemaking, RP21 never takes blood samples from children at their remote rural practice:

... I really try not to do much paediatric phlebotomy despite the hospital wanting to transfer, -Oh doctor can you do this because you're closer. Because it changes this from being a place where people come, from being a safe haven to being just another place where people take out needles and 'come at me' [RP21].

Touch prefigures speech in the ancient art of healing and haptic sensing is another means for a GP to arrive at or corroborate a clinical diagnosis. Professional access to touch is amenable to abuse so medical practitioners learn to deploy it with great expertise and caution. The case of Michael Shine, a former consultant surgeon found guilty in 2017 of the sexual abuse of boys in

⁶² Sir Isaac Newton's Third Law of Motion (1686) states that 'for every action in nature there is an equal and opposite reaction' (Escudier and Atkins 2019).

his care and in 2019 of indecent assault, serves as one reminder of proper decorum and the importance of consent (McGarrigle 2024).

4.4.3.2 *Gaming the system*

GPs have various strategies for supporting their patients in the face of inequity. RP02 always invites the patient to ‘help me fill out the form’ if they are making a claim against the Department of Social Welfare or an insurance body. A marginalised patient may well have an unrealistic expectation of claim benefits so it’s useful to let them articulate it and say ‘Oh, they won’t buy that’. Or to make it clear that the GP must be truthful. A partnership approach works best for both⁶³. RP01 describes consultations with people who have been subjected to so much repeated structural violence that they trust neither the GP nor any figure of authority. This GP has had to develop a different skill set to persuade patients of the value of going to hospital when their clinical needs require it. RP29 has helped raise funds to build a small residential facility for people who left Ireland in the poverty-stricken 1940s and worked in low-paid occupations all their lives. A small, happy community of elderly, repatriated Irish men and women now live out their lives, home at last, among their own people.

Faced with an inadequate secondary care system in the local hospital, RP21 must ‘be cruel to be kind’. Knowing that an elderly man with acute urinary retention needs surgical intervention but will not be able to get an appointment for at least two years, he does a ‘partial intervention’. He showed me drawers with sterile urinary catheters of every size and said, ‘if I keep fixing them, no letter of mine will get them an appointment’. So, he calculates the intervention that will last 90 minutes while a relative drives them over the bumpy road to

⁶³ Watch the film *I, Daniel Blake* to see how marginalised people who lack digital skills are humiliated by online form-filling (Loach 2016).

hospital, and, with their agreement, sends them to A&E. When they arrive there, the junior doctors treat them appropriately and immediately give them an appointment for the next urology clinic. Gaming the system is necessary for GMS patients; private patients get private appointments without delay.

These co-constructed consultations are more advocacy than medical skill. Patients who experience this kind of respect appreciate it and feel more at home in the world, cared for by a personal doctor.

4.4.3.3 Laughter

Laughter, or 'having the craic' is valorised by six RPs. RP27 said that 'black humour' characterised patients in their remote part of rural Ireland: 'the worse their pains and aches, the blacker their humour'. RP02 invites people who need their weight measured to 'hop up on the lie-detector there'. RP03 asserts that they could not imagine general practice without 'the craic' and RP11 says they know the laughter they overhear in the corridor, as their colleagues escort patients out, belies a difficult consultation that has just ended. The absence of direct patient contact during the first pandemic lockdown took all the joy out of general practice [RP03, RP07, RP21]. This is not surprising since almost all RPs identified 'the patients' as their chief source of satisfaction in their work. Intersubjectivity between doctor and patient/community gives meaning to their work and their lives, since the two are not easily separated.

In terms of the Irish primary healthcare system, the thirty million consultations between GP and patient each year (Collins and Homeniuk 2021) are the smallest of transactions and arguably, the most important. The variety of consultations that constitute a GP's daily workload encompasses all aspects of human life (Crosbie et al. 2020, 4). Whether the consultation is about acute illness, particularly in small children or elderly people, about maintenance and

troubleshooting of chronic conditions or about bewilderment when a patient does not know where to turn for advice or advocacy, in each case, the GP makes place for the patient, sometimes by throwing light on their presenting complaint, often by relieving their symptoms, usually by listening. While no RPs in this research mentioned placemaking explicitly, all spoke about how they and their practice teams strive to make the Practice a welcoming and safe space for their patients, yet another unarticulated plank in their placemaking scaffold.

4.4.4 Digital placemaking

Over recent decades GP consultations have moved beyond the consulting room in the surgery, the sick bed in the patient's home and other places where patients live. The advent of the internet, smartphones and algorithms has enabled many communications to occur online. Before the arrival of this technology GPs facilitated walk-in surgeries, without appointment. House calls were arranged by their nurse/receptionist; two RPs described how their GP father relied on their (retired) nurse mother to take the phone calls, triage them and hand him a list of visits to make after morning or evening surgery. Before the advent of COVID-19 in January 2020, online consulting had begun in the UK and was being offered by private health insurance companies in Ireland. The way it worked in Ireland was that a person rang their insurer to request a consultation. They were put through to a doctor employed by the insurer who took a history and asked them to show any demonstrable signs of their presenting complaint on the camera of their phone. I have heard people describing shining a phone light in their own throat and saying "Ah" for the online doctor. Rashes are sometimes inspected in this way. Irish GPs hardly ever consulted online until the pandemic when social isolation was mandatory and, before vaccines were rolled out in January 2021, a visit to a doctor's

surgery might have carried undue risk of infection. Then in April 2020 the HSE produced guidelines for online consulting (HSE 2020a) which conformed to the Irish Medical Council's stipulations on professional conduct and ethics (Irish Medical Council 2019). The ICGP offered webinars to its members to guide them through the risks and benefits, and so it began. Appointments were required, just like in-person consultations, as the patient record had to be opened up on screen by the GP and the usual standards of consent and confidentiality had to be observed. When a GP felt that they could not satisfactorily diagnose and treat the patient online, they asked them to come into the Practice, and donned full PPE (personal protective equipment) for the encounter.

While there were some useful online consultations, most RPs found the experience quite frustrating, saying that they frequently failed to reach closure in a consultation. They had to recalibrate their safety-netting practice so that the patient got a proper opinion, and they were satisfied they had adequately informed the patient about what to do if symptoms persisted or disimproved (Jones et al. 2019; Murphy 2022). RPs described consultations that were adequate while wondering how difficult it might have been if they did not have an ongoing clinical relationship with the patient. Some described not being able to sleep at night before they got proficient in online consulting. RP07 said 'it's not safe or sustainable to work remotely in drug misuse'. Five other RPs agreed. Then, echoing Claire Gerada who wrote that she never ceased to be amazed by how total strangers were prepared to confide their innermost secrets, and to disrobe and display signs of illness to her (Gerada 2021, 23), RPs experienced dissonant intimacy of the consultation as broadcast by the patient from a public place. Accustomed to the decorum of the consulting room, several GPs recounted their shock when a patient who was ringing them from a public place would begin to undress to show them the evidence of their complaint. Online

clinical engagement with disadvantaged patients generally failed to achieve any useful outcome; those who had dropped the filters of clinical decorum due to pain, worry or chronic disadvantage were encouraged to visit the surgery for an in-person consultation.

However, GPs themselves went online for mutual support once the COVID-19 pandemic loomed in early 2020. The ICGP provided weekly educational webinars at 8pm on Wednesday evenings with formal clinical updates and Q&A to follow. As a retired member of the ICGP I attended several of these excellent webinars along with over two thousand other ICGP members. RPs mentioned how various WhatsApp groups were formed at that time and RP11 recounted a better engagement online at the GP trainers' group:

Whenever Covid happened ...it became more of a supportive place for people because I was very aware that there were people who were working single-handedly and there were people who were on their own at home, you know single people [RP11].

In this way, GPs who are usually quite isolated from each other by the nature of their work, seeing one individual after another, all in absolute confidence, were able to connect in a digital place and experience the relational bonds of community. Shorn by pandemic restrictions of the embodied encounters that characterise most consultations, they turned, energetically, to a digital geography populated by their colleagues, all with shared purpose. These online CME meetings, facilitated by the ICGP, had the highest standards of confidentiality and communication. 'The ethics of digital care' (Kitchin and Fraser 2020, 175) turned cyberspace into a safe place for all participating GPs.

4.4.5 The off-site consultation

4.4.5.1 House calls and on-call duty

House calls are relatively uncommon nowadays. A report on NHS doctors calculated that in 1953, British GPs did, on average, between 12 and 30 house calls per day (Kmietowicz 2006). A recent survey of general practice in Ireland found that

The majority of consultations provided were face-to-face (87.8%), with telemedicine, home visits and nursing home visits making up 10.0, 1.3 and 0.9% of appointments respectively (Collins and Homeniuk 2021, 3).

This states that Irish GPs do c. 277,600 house calls per annum and c.192,200 visits to patients in nursing homes. It would be misleading to compute an average by dividing this by 3,378, the number of GPs who were members of the ICGP then, such is the wide variety between patterns of practice in different demographics and geographies.

Older doctors recall doing ‘on-call’ duty when they covered for their GP colleagues at weekends and through the night. They described colleagues with remote practices who were on-call every night – ‘one-in-one’. As towns grow in population with the need for more GPs, ‘one-in-three’ up to ‘one-in-twelve’ becomes possible and gives a much better quality of life to the GP. Although it is now quite common for the Practice phone to be switched over to an on-call GP Co-op at the end of the day’s surgery, GPs that I interviewed in city areas still do their share of On-Call; they go to an Out-Of-Hours (OOH) hub and work a clinical session consulting with patients unknown to them, who attend other GP practices:

... I go to D-Doc, and I see sixteen patients in four hours and I come home fresh as a daisy. I see ten patients in my own practice in the morning, and I'm fit for nothing [RP10].

RP10 implies here that the burden of social determinants of health is excessively high in their practice population. The Hasse-Pratschke deprivation index (Haase and Pratschke 2016) bears this out, as did my drive around their practice hinterland.

Co-ops in large cities hire part-time GPs to work through the night and weekends and hire a driver to collect the GP from home and bring them to the patient. Rural GPs have a similar arrangement and can visit patients up to c.80 km away when on call. All RPs visit patients who are receiving palliative care in their homes. RP26 finds they can get to see a patient faster if they come in:

I actually only do house calls to my palliative patients because I find that if people hear you'll do house calls it's being requested all the time [RP26].

Although there's plenty of deprivation in RP26's practice catchment area, the agricultural land is good, and this RP refers here to people who are well off enough to own or have access to a car.

RP03 and RP04, who work in a city, use the person's address as a criterion for agreeing to take them on as patients:

I think the best example of that was years ago, we decided any new patients that we had, particularly GMS patients. We said that you're too far away. We do our house calls walking. Or cycling. And because the traffic's so bad. And we stuck to that for a long time, and it became our absolute norm [RP04].

RP09 likewise does house calls on foot and has a worn-out backpack as their doctor's bag so that they draw no unwelcome attention as they move through a disadvantaged city area.

By contrast, RP29 does up to five house calls a day in their rural practice. While they say that 'requests for house calls are always valid' they sometimes call in

on patients they're worried about. RP21 serves a part of rural Ireland ravaged by emigration, where they have a significant number of elderly patients who live alone. They brought me on their calls; the first visit was to the local supermarket which is run by people who are their patients. There they made general enquiries about the neighbours before proceeding on their rounds; Christiaanse et al. construed this apparently casual chatter as a key feature of placemaking (2017). Three visits were made to seem more like social calls than doctor visits, but by the time they left they had determined the patient's healthcare status, that the patients and their carers understood and were complying with their prescribed medications and that their mood was '*in status quo*'. They also reassured the carer, in one case, that she was doing everything right. RP27 visits their palliative care patients daily, two other rural RPs visit theirs several times a week:

The biggest thing I can do as a GP is keep people in their homes and they want it too. I think that's a huge part of my job, knowing when to send someone on or knowing when to keep someone at home. I think it's one of the most important parts of our job remit is to know the patients and to know what's going on in people's lives [RP31].

The commitment to provide this level of complex care challenges GPs to skill up to a specialist level that they would have neither anticipated nor trained for.

And sometimes the anger comes back at me and then I get grumpy. But in their hearts, they are not really angry with me, but I am the face of this. I keep saying I've nothing to do with the HSE, we muddle along here as best we can for the things I'm responsible for. Somebody of eighty who needs a hip done and it would really improve the quality of their life, and they would get an extra two or three years out of it; no way they can afford that privately [RP27].

Urban practice has different house-call patterns. RP05 visited a poor asylum seeker at her home in the city. Test results had arrived that morning that needed to be communicated to their patient and a treatment plan agreed. Since the patient was newly arrived in Ireland and did not speak English, RP05 visited

her at her home with her extended family. At interview, RP05 described the very poor material circumstances and overcrowding of that home and how they had difficulty computing how all were so happy there. One of the group who spoke English told them that it was 'home' compared with what they had escaped from and thanked them profusely for making the patient feel at home too.

Involuntary committal of patients to psychiatric care is one of a GP's least favoured jobs. Before the Mental Health Act 2001, GPs had to visit the patient at home along with a team who would remove them to hospital:

It was horrible before; you had to nearly batter down the door and then wait for the police who then did batter down the door [RP11].

RP11 states, yet again, the challenges of caring for a marginalised patient population. Involuntary committal is usually required for the safety of the patient and for those who live with them.

In all of these stories, the GP is a placemaker for their patient and those who care for the patient, commensals, family, kinship groups, neighbours and friends. While most presenting complaints can be dealt with at a GP surgery, some patients are too sick or immobile to travel to the surgery. In the case of a palliative care patient, a GP satisfies both the patient and themselves by making a home visit. The presence of a GP service in a rural area serves to make it into a place where people feel safe as they age or if they have precarious health. Effectively, the work of the GP creates a version of the 'right to stay put' (Huse 2014). On the contrary, the 2016 campaign in West Clare 'No Doctor, No Village', already referred to, maintains that the lack of a local GP renders a townland unsafe and turns marginalised people into a precariat.

4.4.5.2 Visits to homeless patients

Not every GP wishes to or is prepared to provide primary care for homeless people whose lives are chaotic. As RP09 said: ‘... I think you have to be comfortable with a certain degree of chaos to work in a place like this’. I have already detailed the formation, both personal and professional, of a person who feels able to do this work. Once committed, they give it their all. Eleven of the GPs I interviewed work with homeless people and have worked with Safetynet in some capacity, whether as trainee or fully qualified GPs. Safetynet was set up by Dr Austin O’Carroll in 2007 to provide healthcare to homeless people wherever their need arose. The Safetynet website provides the following information:

‘The service is funded by HSE Social Inclusion and adopts an approach to bring health services close to where people are. This approach is based on the evidence that homeless people have different consulting behaviours than the general housed population and a very high burden of ill health. This service has been specifically tailored to the needs of this vulnerable group’ (Safetynet 2019).

Patients can attend clinics in the city centre in Dublin, Cork and Limerick. A ‘Mobile Health Unit’ is operated in Dublin on three nights a week by Safetynet and the Dublin Simon Community /Peter McVerry Housing First. Using a converted ambulance, the Unit is staffed by GP Registrars from some of the Dublin based GP Training Programmes and a panel of experienced Safetynet Nurses.

So, we have a bus, a mobile bus that goes out to people who are rough sleeping, who aren’t necessarily engaging with services. The outreach teams identify those in need and then we go, the bus goes to the people. Maybe people mightn’t be there, or they might be there and tell you to f-off and say come back to me in half an hour. Grand, so you go see someone else and then you come back. I only do a few shifts on that bus, but I’m the clinical supervisor to the GP Reg.s (*sic*) so if they see anybody on that bus that they are worried about, they ring me and also if they want to follow up the next day, I follow up with the clinical nurse manager [RP06].

An RP in Galway does a walkabout every Thursday morning, visiting places where homeless people are to be found and encouraging them to come to the Thursday clinic in an anonymous premises. Another RP does sessional work in A&E in a major Galway hospital with a brief to care mainly for homeless people. Whereas two Dublin hospitals have an Inclusion Health department that facilitates fast-tracking of homeless people into hospital care, none such facility exists yet in Galway. Should the GP form the opinion that the patient requires admission to hospital, there are no protocols, only the grace and favour of hospital staff who are well disposed towards homeless people.

RPs gave me several descriptions of consultations with homeless people and in all cases, requested that they be redacted from the transcripts. I was quite taken by the GPs' narrative style, recounting very difficult clinical encounters with ease, understanding the social and psychological conditions that had led to the patient's current situation. GPs knew their patients by name as well as by situation. One RP had consulted with a couple in a park the previous night, in the early hours of the morning, and said that once they had dealt satisfactorily with the issues, they returned home and fell asleep easily. When I enquired whether RPs felt angry about inequity, all but five said they were powerless, a matter for discussion anon.

4.4.5.3 Activism

The GPs who do this work could be called activists. They perceive a need, discuss it with kindred spirits, generate the evidence, lobby for funding, and provide continuing care for the patients. Patient and GPs in this microcosm get to know each other over time. A medical recording system used by Safetynet organises patient data so that, for example, it is immediately clear to any

treating doctor that a patient might be allergic to penicillin, their list of regular medications, whether they're on a course of methadone etc. Continuous care is thereby provided by a committed team and their tech support. RP13 described the frustration when secondary hospital services are not available:

Your GP has nothing in his tool belt to deal with it. That would be the big powerlessness you would feel. The social determinants of health ... I suppose at some level I've come to the place where I can only do what I can do [RP13].

RP10 'refuses to believe the system cannot be changed' and lobbies hard at every opportunity to represent the needs of their underserved patient population.

Activism manifested itself in diverse ways throughout the interviews. RP19 is a strong advocate of lifestyle change for health improvement and a marathon runner, like most of their Practice colleagues. They often include a jog through their local medium-sized rural town as part of their daily running circuit to model good wellbeing practice. RP14 declares that they're proud they stayed in Ireland after the 2008 crash, to work as a GP with disadvantaged people while undertaking a Ph.D. that gave them more clout in terms of advocacy and policy making. They became an active participant in medical politics. Likewise, RP17 undertook a Ph.D.:

The main reason I did a PhD was to be able to walk into that room ... and say – Well, actually I work clinically; I have a PhD which means I know and understand research. Here's what I have to say, here's what I think needs to change [RP17].

Six RPs spoke about providing primary abortion care to patients as soon as the Eighth Amendment to the Constitution was repealed in 2018. RP18 and RP20 had regular visits from protestors who said the rosary and sang hymns outside the surgery premises for several hours at a time. Rather than feeling

beleaguered by them, they felt sorry for patients who had to pass through that protest to have their consultation. Women who already feared an unwanted pregnancy experienced their GP practice transform from a centre of 'primary care' to a landscape of fear, to borrow Yi-Fu Tuan's term (2013). Widespread reports of such protests galvanized the government to enact legislation that would introduce 100 metre exclusion zones around all hospitals, GP practices and family planning clinics, in October 2024 (Government of Ireland 2024).

Several RPs have taken up leadership roles in their GP representative bodies, the IMO, ICGP, Irish Medical Council, Deep End Ireland, liaison committees, the HSE and local services, and as elected representatives to Dáil Éireann. One RP does a weekly medical broadcast on local radio to communicate mainstream medical evidence and best practice to local people. RP02 made a formal complaint against the local hospital that led to a statutory enquiry which vindicated the GP. A four-year-old boy had lost the sight of one eye permanently, while waiting for an appointment to be seen for a routine squint. RP02 complained that GP letters of referral were not being dealt with in a timely manner and that this constituted neglect. It transpired that the GP letters were not even being opened by hospital staff. After the enquiry, policies and procedures changed.

Finally, RP21 made the most radical statement of all: 'I believe that the CDM has turned the Inverse Care Law on its head'⁶⁴ [RP21]. The HSE Chronic Disease Management Programme aims to prevent and manage patient chronic disease using a population-approach. It helps identify and manage GMS and GP Visit card patients at risk of chronic disease or who have been diagnosed with one or

⁶⁴ Hart, J.T. (1971) 'The Inverse Care Law' states that "the availability of good medical care tends to vary inversely with the need for it in the population served".

more specified chronic diseases. These include Type 2 diabetes, asthma, chronic obstructive pulmonary disease (COPD) and cardiovascular disease, including heart failure, heart attack, angina, stroke and irregular heartbeat (atrial fibrillation)'. RP21's remote, rural practice population has a very high number of elderly people, all of whom have now been processed through CDM where their chronic diseases are actively managed. Three RPs stated that they felt sorry for the people who didn't qualify for the scheme because, either their means placed them above the threshold for GMS eligibility, or, their disposable income was too low to afford preventive medical care, since they pay 'out-of-pocket' for each visit (The Lancet Editorial 2025). One rural GP looks forward to the day when their entire practice is on the GMS, and everyone is entitled to the best care they and their team can give. Navigating the interstices of patients' public/private healthcare entitlement takes a lot of Irish GPs' time, effort and energy, as this research demonstrates.

4.4.5.4 Off-site clinics and professional commitments

GPs in this research like to leave the practice premises to work off-site if it is practical and useful to do so. With masterly understatement, RP28 described such ancillary commitments as 'bits and pieces', for example, a part-time commitment to occupational health at a local factory, a lecturing commitment in a local university, a clinical commitment to a centre for survivors of torture. HSE and TUSLA case conferences concerning children at risk warrant GP attendance but since attendance is not remunerated, many GPs are reluctant to ask their practice colleagues to double up in their stead and so, they miss them. Only RP10 stated explicitly that their practice is organised in such a way as to enable the GP to attend as a key advocate, but it could be deduced from nineteen other interviews. As already mentioned, RPs in this research have a variety of commitments outside their Practice:

General practice is so overwhelming that you couldn't do it five days a week, four weeks a month, 365 days a year. You just couldn't. You need a break from it, but you also need your colleagues [RP28].

The term 'portfolio career' was used by seven RPs to signify a career with several part-time commitments. Older GPs used the term disparagingly, lamenting the fact that many newly qualified GPs prefer it to the old model of working in one practice only. One RP said 'said it's a job where you work two or three days in a General Practice, two days doing something else, and the main feature is that there's no loyalty or commitment. You finish on time and that's it' [RP12]. But it suits parents of young children, one of whom said that they will probably not take up a partnership until their last child is in National School [RP15].

Five RPs stated that a portfolio career enabled them to provide the kind of care they valued, working in organisations where administration was done centrally, and they could focus on good doctoring in a multidisciplinary team. Three RPs visit bespoke clinics for asylum seekers near their Practices. Satellite surgeries are a historical feature of some practices. RP02 said that theirs was closed during pandemic restrictions but that it had its own regular clientele who needed GP service and would reopen as soon as possible. RP24 travels once a week to an offshore island by boat, to do a clinic and house calls, and brought me with them on the day I visited. Residents were very appreciative of their service, backed up by two nurses who live on the island. Seasonal tourist traffic makes this GP busier during the summer and their round-the-clock support for the local RNLI made them a placemaker for all sailors off the local Irish coastline.

4.4.5.5 Nursing home visits

All residents in any nursing home require GP care. Most are elderly and have between one and five chronic conditions with associated polypharmacy. If a patient moves from their home to a nursing home nearby the same GP can continue caring for them at their new address. Sometimes they move a good distance away and must enrol with a new GP. Any given nursing home can therefore have several visiting GPs although two RPs told me that they visit nursing homes where all resident patients are on their books, and patient-care protocols can be streamlined. RP28 has agreed case management protocols with patients who are fit to participate in their own healthcare decisions, along with their relatives, management and staff.

The very last place you want a geriatric patient is in the hospital. The very last place you want them is in an A&E department, it's not dementia friendly, it's very frightening and I bend over backwards in my nursing home work to make sure that there are absolute instructions about what the patient and the family want – And while I was on holidays one was shunted off and that really p**d me off. The doctor who was called from ... he didn't ask the question, didn't ask to look at POLST forms, Position Ordering Life Sustaining Treatment, and every patient has one done and it's signed by me and by the family or by the patient themselves, if they're with it. And it had clear instruction on it: Not For Transfer. She was ninety-five and she died within 48 hours of transfer. How was that for her? She wanted to die at home; the nursing home was her home [RP28].

It's the opposite of what end-of-life primary care is meant to be. Happily, it rarely occurs where protocols are robust.

4.5 The Primary Care Team

All of the foregoing would be impossible without assemblage, the messy, seemingly random, thrown-together mix of human beings who align with each other to provide healthcare, whose efficacy is far more than the sum of their parts (Barnard et al. 2024; Duff 2023). Single-handed GPs of yore did their work

backed up by un-named and un-accredited doctors' wives, receptionists, and occasional clerical assistants. However, contemporary general practice flourishes in a milieu where doctors, practice nurses, receptionists, physiotherapists, psychologists, speech and language therapists, technical support staff, security staff and cleaners share the workload in a manner that delivers the best service to patients while still allowing them to take sick leave, holiday leave and exceptional leave without compromising patient care. They liaise externally with the Public Health Nurse, local pharmacists and specialist clinics and agencies to create a thorough and streamlined patient experience. When asked about where they get their supports, all RPs named their practice team first. A happy workplace is valued by GPs who work to create it. RP02 said that they try to create a happy workplace while still valuing 'doctors who worry about patients'. RP10 commented on a very low staff turnover in their practice: during the early stages of the COVID-19 pandemic they adopted a new mutual support ritual:

one of the things we started doing was having a team huddle every morning at ten to nine. The whole team, all the admin, because things were changing so fast, and we are still doing that. So, we have the admin there, and they can say this happened, that happened, what are we going to do when this happens? It gives you a great sense of collegiality in the Practice [RP10].

As retirement approaches, RP13 recited their own professional epitaph, smiling broadly as they spoke:

And one of the things I would feel I achieved would be of running a small business, of having staff who, on the whole, stayed and didn't want to leave and were happy at their workplace. Of a place where GPs loved to train, and where the patients were treated with respect [...] Where there was people, lots of really good people but harnessing with other people ...it wasn't just me now but as a team harnessing a lot of the strengths of working in teamwork, helping patients [RP13].

Commensality gives great support too: practice teams often have coffee and/or lunch together once the doors are locked and relish the exchanges this allows (Douglas 1997; Lupton 1996). RP11's team lunch off their laps in the waiting room and find it very important. RP10 insists that trainees stay for lunch:

When the trainees come and we say -You are expected to stay here through lunch, and they give out - they want to clear their head, they want to go over to the shopping centre and we say -No, this is part of your training. And you've got to see us, and you got to see us struggling and you see that we don't always have the answers. And that's how we do it here [RP10].

In this manner, RP10's trainees learn to contend with uncertainty and with the risks inherent in medical practice, as counselled by Prof. Martin Cormican in section 6.3.2.

Most RPs to whom I brought home-made cake as a token of my gratitude said it would be much appreciated by the staff with coffee the following day. Where there is continuity of care and good professional relationships, the practice staff know the patients well and are better placed to gauge and grade an emergency presentation.

In the spirit of *Quis custodiet ipsos custodes?*⁶⁵ staff members need care too. During the early stages of the COVID-19 pandemic RP30 had to insist that a valued staff member take a step back from patient-facing care in the practice because they had a chronic underlying condition. They recalled insisting that "if you're admitted to hospital, you won't even get a ventilator because you're too young" before the staff member complied and took up working-from-home

⁶⁵ This Latin phrase means 'Who oversees the overseers?' and is used metaphorically in contemporary medical parlance, particularly with regard to oversight, accountability and healthcare for medical practitioners, to ask Who cares for the carers?

clerical duties. Once vaccinated, this healthcare worker (HCW) could resume their regular job.

RP09 gave great credit to local politicians in their marginalised area even though they had rarely met or spoken to any of them. RP27 praised the HSE for providing GPs and patients with the CDM programme. Seven GPs who work in modern HSE buildings sang the praises of their material circumstances. But the built environment and government policies are only as good as the healthcare they deliver. The recurring obstacle in all RP narratives, as elicited by direct research questions (RQ3, RQ6, RQ9)⁶⁶ was secondary and tertiary care services, hospitals, CAMHS, to which I will return in Chapter Five.

So much of a GP's working life is tightly regulated and yet the contours of their influence are fluid, ever-changing and defy Euclidean contouring. Here, I turn to Allen's 'Powerful Assemblages' to help frame my RPs' placemaking.

For much of the time, the geography of this or that is made up of relationships and things that jostle, co-exist, interfere and entangle one another (Allen 2011, 154).

Every day, GPs face a cascade of the unpredictable, even though their appointment diaries look quite mundane. What gets them to the end of the day without causing any harm is the concentric webs of social relationships within which they work. As the anthropologist, Clifford Geertz wrote:

⁶⁶ Research Question (RQ) 3: What aspects of your everyday practice drain you?

RQ6: Can you give me an example of where you feel powerless?

RQ9: Who or what undermines you?

Man⁶⁷ is an animal suspended in webs of significance he himself has spun (Geertz 1973, 5).

These 'webs of significance' are relational; GPs work as independent contractors to the HSE rather than being employees. Such is their value on their independence, clinical and otherwise, that they consistently maintain this position. Their relationships with trusted, long-standing practice team members buttress their capacity to care for their patients. They depend on other healthcare workers such as public health nurses and the pharmacists for recursive loops of feedback on patient care. In caring for marginalised patients, they rely on a wide network of NGOs and volunteers to alert them to where need arises. Allen asks us to contemplate that 'heterogeneous elements can hold together without actually forming a coherent whole' and then explains that 'the way that things hold together in assemblages is down to their relatedness' (Allen 2011, 154, 156). The human condition is messy but GPs, in concert with their colleagues, bring a degree of hope, and order, to chaos. Mutual regard plays a large part in the ongoing relationship:

Once you've been in general practice for thirty, thirty-five years you've got a fan base there. People who don't like you have moved on a long time ago [RP03].

Placemaking is relational, not only between people but 'a mutually reinforcing and reciprocal relationship between people and place' (Cummins et al. 2007). No matter what a GP's route was towards where they finally dwell, all RPs asserted their deep attachment to place (Lewicka 2011), to whose role in the making of community I now turn.

⁶⁷ In 1973 it was acceptable to use the generic term 'man' to refer to all humankind. This is no longer the case, particularly in this research, where women GPs were 50% of the Research Participants.

4.6 Community

All RPs expressed their affection for and appreciation of their practice population. Whereas GPs nearing retirement had lived ‘over the shop’ at the start of their careers, none of the participants in this research lived on their practice premises at the time of interview.

Two said they loved being ‘owned’ by the local inner-city community:

In general practice you are owned by your community in the inner city ... you’re their property ... and I love that, you’re part of it ... they shout at you in the street, and I loved that. I’ve no time for the separation [RP01].

I really enjoy just being a member of the community; not just being a doctor in the community, I’m honestly seen just as a member of the community. Oh, you are one of us, fair play. It’s not even being a GP – I’m in the area so much I’m out getting coffees and sandwiches and seeing people and you are privy to the gossip and all that stuff [RP14].

GPs who drive about visiting patients off-site see plenty ‘out of the car window’ that triangulates the knowledge they already hold. RP25 said they could ‘tell you every house in this town where heroin is sold’. They see who is out walking, following their social prescription to take more exercise, and who is smoking outside the pub, despite advice to the contrary.

I would think that you can probably, at this stage, speaking to me for this long, see how much value I put into the GP as being part of the community. And I do think that’s really at risk. And I see why, because sometimes GPs more and more want to be anonymous. But I think there’s a lot of value with being part of any community and not just being somebody who works away but actually being side by side with the butcher, the baker and the candlestick maker [RP30].

The mutuality of being between rural doctor and community is evident here:

So *Named Person* out there who is the foreman on the Council scheme and mortified me during one of the snows a few years ago because [...] he cleared [...] with sand and grit from the main road up to my house which is

about a mile. So, I was just completely embarrassed, but anyway it was very good [RP27].

A second rural GP who lives two hundred miles away from RP27 told the same story.

One said that as they approached retirement ...

... it's more important to me that I leave some kind of legacy for the people that I love, really ...the patients that I've worried over for years. That they have a good medical service [RP02].

In these instances, Agnew's (1987) 'sense of place' is co-produced by the giving and taking of meaningful primary care incorporating relentless advocacy. The future of general practice was a recurring theme through all interviews as RPs expressed their anxiety about the privatisation of primary healthcare by 'for-profit' companies such as Centric, the difficulty in making rural practice attractive enough for young GPs, and the concern of older GPs that when they retire, their practice population will be left with no GP service. I will leave this for discussion in a later chapter.

4.7 The death certificate

GPs tend not to go to patients' funerals. 'If you went to one, you'd have to go to them all and you don't have the time'. When a patient dies at the end of a terminal illness, the coroner will not require a post-mortem, so the GP can sign the death certificate. In these situations, a rural GP usually visits the relatives of the deceased to extend their condolences and makes an appointment for the signing of the death certificate at another date. Urban GPs expect hospitals to inform them if their patient has died in hospital so that they may pay their respects before hearing the sudden news on the local grapevine. Two rural GPs spoke movingly about their death certification practice as the last act of care for the patient. RP25 was shocked when I asked if he would ever leave the certificate in an envelope at the reception desk.

There's some things you have to come in and sit down with. There really are some things you have to sit down and look them in the eye and that would be definitely one of them. You want to make sure there's nothing left unsaid. And I want a bit of indication that I did take care of him. That they are happy with that [RP25].

RP29 had spent half-an-hour with a bereft patient the day before our interview, explaining the death certificate of her adult son (not their patient) who had died suddenly abroad. RP29 knew she'd be back again 'because she could only take in so much at a time'.

4.8 Placemaking finale

I end this chapter with the text of an e-mail received from a GP I visited about 270 km from my home in Dublin. We finished the interview late in the evening and they asked me to let them know I had got home safely. Their spiral of care encircled my life too. Their reply to mine when I got home distils elements of their placemaking practice into an essence of relational primary healthcare:

Catherine,

it was me that kept you late with my blather.

I hope that you weren't collapsing at the wheel on the way home.

Thank you for coming out to bear witness. It was wonderful to be able to bring you to the few people that we saw, and yourself being on the medical register still, meant that we could plough ahead as colleagues with the patients understanding that, and knowing that you were a doctor helped the patients also feel appropriate that the two of us were visiting in tandem.

It was great that you could bear witness also, as I cannot write these patients' stories, as even if I anonymise myself, and the patient, and the location, everything is identifiable, and their stories go unwritten and die with them.

I suppose, like all GPs, I carry a graveyard in my head, some of it haunting, some of it happy. We tend to unhealthily gravitate to the sections of that graveyard that might have cause to stir regret or self-questioning, and visit the joyful sections less often, unless prompted to by those left behind.

Your visit gave me a lift, as rural GPs often feel inconsequential to the bigger world out there, but I wouldn't have it any other way as underneath it all, we know that being there is the most important thing we can offer patients.

Clever doctoring, clever diagnosing, clever prescribing is much overrated. A hand on the shoulder, and a laugh or a cry, or a hug where appropriate, keeps this GP mullarkey as a human transaction, rather than a series of perfunctory exchanges.

Thanks again for coming Catherine.

RP21

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Chapter Five: Landscapes of Care and Caregiving

I think the consultation is the kernel to everything. That very interactive and very unknowing ... not knowing what's going to emerge on a day to day. The variety and the curiosity is constantly tweaked and the pursuit of diagnosis and forging relationships on an ongoing basis both with the team and with your client and patients and their loved ones and their families. So, you are part of a vibrant neural network within the community and within the delivery of healthcare and care. Delivery of care to the community that you serve.

I consider general practice a humanitarian endeavour ... that's what I say to students that if you haven't, if you don't think you have a mandate for humanitarianism, you're in the wrong job. It's not just about diagnostics it's not just about how you consult or learning to speak or learning cues it's about a real sense of service and really, excavation of problems. It's not enough to provide the service. The HSE go on about service providers, that to me is so narrow and does not in any way describe what primary care clinicians, physicians and admin support do. They are excavating need, they are attempting on a daily basis, and changing in response all the time, they are not stuck. They are fluid, to me it's like they are small units that are like flying columns. That are constantly scanning and surveying each other and surveying the various people and persons who come every day and it's a relationship; it's a constant negotiation. And it has to be two way otherwise it becomes didactic, and it becomes irrelevant in deprivation. If you go in every day with an agenda that is rigidly in place you will become alienated from the group. Because they don't, it's chaotic. But equally if you let the chaos in the door and permeate through the team you also are in trouble [RP12].

5.1 Introduction

At a time of seismic technological advances in medicine alongside the unstoppable march of AI (artificial intelligence) and the relentless thrust of Silicon Valley companies such as Palantir, Amazon, Meta, Apple and Microsoft to insinuate themselves into the private healthcare marketplace, this chapter might well be construed as a salvage ethnography, a Proustian 'remembrance of things past'. This thesis argues, however, that in their diagnostic and

therapeutic role, GPs have traditionally had unique and privileged access to patients, granted or withheld at every consultation. By doing their job well, by bringing their full, professional attention to every patient they see, they are reinforcing time-honoured practices of GP care, bringing to bear on each person's complaint the full range of skills already outlined. Nimble ways of thinking detailed in Section 3.2.1 on medical epistemology are learned by all trainee GPs and ought to be a key component of their everyday practice. Careful history taking and careful physical examination not only diminish the risk of making mistakes but also, borrowing from RP21's letter, build a web of 'human transactions rather than perfunctory exchanges' [RP21].

Within this chapter, I switch lens from the role of GPs as placemakers to discern how care and caring give meaning to their lifeworlds as they care for marginalised people. According to Milligan and Wiles, 'Care entails a complex network of actors and actions involving multidirectional flows and connections' (2010, 739). Whereas doctors formerly had only their own counsel, skills and prescriptions to give to patients, nowadays they have modern science and therapeutics, mandatory CME, statutory protocols, multi-disciplinary primary care teams, support from government and healthcare algorithms to buttress them in their engagement with patients. Automation has the capacity to reduce GPs' face-to-face time with a patient but not to replace them as humanitarian healers. Algorithms may promise greater efficiency in healthcare but if deployed without intersubjectivity, they carry the high cost of shearing both patient and doctor of their humanity and alienating the doctor from their craft, resulting in poorer diagnosis and treatment. This chapter gives a perspective on how GPs care (transitive verb); how they deliver care (noun) and how their caregiving recursively affects and shapes them. It demonstrates the relational nature of personalised primary care and queries what healthcare would look like without it. Contrary to convention, concentric spirals and circles of care are

sketched with the GP at the epicentre; while ‘patient-centred care’ is what they perform, this thesis explores GPs’ lived experience and therefore, places them at the centre. This research sought GPs who take care of marginalised people and is particular to their lifeworld. Although disadvantage manifests quite differently in inner-city and remote rural populations, in both situations and in every scenario in between, GPs are called on to provide primary care, to advocate for those who cannot advocate for themselves, and to find the wherewithal to continue doing it in the face of structural failings. Milligan and Wiles’ *Landscapes of Care* provide a theoretical framework within which to map GPs’ utterances about care and caregiving.

Whereas place is made by GPs on the ground and in the flesh, landscapes of care are borne aloft to a different plane by the eddies, tides and maelstroms of multiple varieties of capital – social capital within communities, political capital when a district has an elected representative in Dáil Éireann or in the European Parliament, ideological capital when a government expedites the redistribution of wealth (or does not) and financial capital when a new FDI (Foreign Direct Investment) initiative materialises as a factory with hundreds of jobs and the infrastructure to sustain it. As outlined in section 2.7 above, Milligan and Wiles (2010) and Wiles (2023, 2024) focus upon landscapes of care:

Landscapes of care encapsulate the spatial manifestation of care within and across interconnected scales and the ways in which care is woven through the fabric of particular social spaces. As the complex embodied and organizational spatialities within and across which care and care relationships take place, and as an emphasis on the contextual and located nature of care, we see landscapes of care as a helpful analytical framework (Milligan and Wiles 2010, 749).

Wiles (2023) goes on to explore the importance of resilience as process and outcome in the struggle to fight inequity and in 2024, she interrogates care as ‘more than clinical’ (ibid. p. 371) and as a transformative event for both giver and receiver. Participants in this research have witnessed general practice

transform from delivery by a single-handed GP, working as a contractor to the Department of Health, to a multidisciplinary team collaboration housed in a built-for-purpose building, with both contracted and salaried GPs. Should Sláintecare (2017) materialise in its entirety, primary care will be free at the point of access to all Irish citizens, and all GPs will work in primary care teams. In such a scenario, 'Landscapes of Care' becomes the only possible framework.

In Phase 2 of coding, care was coded to three hundred and ninety text-bytes in forty-seven files, thirty-one interview transcripts and sixteen fieldwork memos. A word search for 'care' as noun, prefix or suffix was not done because the word 'care' occurs so often in the logistics of healthcare that it would confuse the matter. The questionnaire did not include an explicit question about care, so all coding was inductive. In Phase 3, I aggregated the Phase 2 codes of Advocacy, Becoming, Power, Satisfaction and Support along with Care to a Theme called 'Care and Caring'; all of these are subsumed into this chapter.

In section 5.1.1, I define 'care' as the term is used in the Irish vernacular. Then, in 5.2.2, I describe a GP's 'duty of care', that sword of Damocles under which all doctors practise. Care as identified and described by my Research Participants comes next in section 5.2, followed by Section 5.3 in which they recount stories of the extra burden of caring that accrues to marginalised patients. Section 5.4 gives an insight into protocols which assist and sustain GPs in delivering care and 5.5 considers their advocacy, the *sine qua non* of caring for a deprived population. Self-care as a fundamental strategy for GP wellbeing is discussed in 5.6, followed by 5.7 which deals with how RPs handle the lure of becoming politicised. This chapter concludes with section 5.8.

5.1.1 Defining care

Writing in English, I look to the Oxford English Dictionary (OED) for definitions of care. Having lived all my life in Ireland, however, I speak and think in Hiberno-English, as do most of my Research Participants.

The Oxford English Dictionary defines care as:

Care; (noun) 1. the provision of what is necessary for the health, welfare, maintenance and protection of someone or something. 2. Serious attention or consideration applied to doing something correctly or to avoid damage or risk (Pearsall 1998, 275).

Care; (verb): feel concern or interest: attach importance to something; feel affection or liking for.

Care for; look after and provide for the needs of (ibid., 275).

In the Irish language, care is expressed either as cúram or aire.⁶⁸ Cúram, on the one hand, translates as above in the OED. Aire, on the other hand implies responsibility and a duty of care. For example, the Minister for Health is ‘An t-Aire Sláinte’. In feudal times when a nobleman took responsibility for those who worked for him, he was called an Aire (De Bháldraithe 2009). In the Irish language, care invokes a duty: ‘How’s all your care?’ is widely used along the western seaboard as a colloquial enquiry about someone’s family or household (Dolan 1998, 84). ‘Aire’ is the military command in the Irish army that translates as ‘Attention’ in English. And the Liverpooldian valediction ‘Ta-Ra’ is derived from the Irish ‘Tabhair aire’, meaning ‘Take care’ (Birtill 2020). Citing Tronto (1989), Milligan and Wiles believe this too: ‘care is ‘necessarily relational’ in that it involves ongoing responsibility and commitment to an object (or subject) of care’ (Milligan and Wiles 2010, 737). Gesler classifies language in medical

⁶⁸ I do not italicise the Irish language here since it is our first, official and native language which takes precedence over English in Irish law. ‘Aire’ is pronounced ‘arra’ with a rolling R sound.

encounters in terms of ‘the four ms, metaphor, model, metonymy and myth’ and goes on to state that ‘metonyms structure a domain of thought in terms of one of its elements’ (Gesler 1999, 17). The metonym of care pervades all of the text-bytes that I have coded to the category ‘care’; the nuance of taking care, personally or through practice protocols, is evident. I have already referred, in an earlier chapter, to how all RPs used a vernacular of responsibility.

HSE: The Primary Care Strategy defined primary care as being

An approach to care that includes a range of services designed to keep people well, from the promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible by self-referral and have a strong emphasis on working with communities and individuals to improve their health and social wellbeing (HSE 2024a).

The HSE’s primary care contractors include 7,007 General Practitioners (GPs), Pharmacists, Dentists and Optometrists / Ophthalmologists who provide care to 3.4 m people in the community (ibid.). Only GPs will be mentioned in this thesis.

Health geographers, Duff and Hill, referred to care in the following terms:

Care may [...] be understood as a practice of maintenance and repair, as an ongoing labour of restoring access to a community and all the social and material resources it avails, while also helping individuals find ways to themselves nourish this commons by finding ways to contribute to the life of their community (Duff and Hill 2022, 6).

While all of the definitions given above nest comfortably within Milligan and Wiles’ 2010 framework, their landscapes of care focus mainly on care given and received beyond the professional relationship between doctor and patient. This research shows how the care given by contemporary GPs is informed not only by their training and statutory obligations but also by the relational nature of their engagement with patients that enriches all and makes care-giving sustainable in the face of life’s vicissitudes.

5.1.2 Duty of care

All registered medical doctors are obliged to act in accordance with ‘The Guide to Professional Conduct and Ethics for Registered Medical Practitioners’, ninth edition, 2024 (Irish Medical Council 2024b) and at the time of fieldwork, from the 2019 edition. Taking its authority from the Medical Practitioners Act 2007 (Government of Ireland 2007), it details the duty of care governing every possible interaction between doctors and patients – in the consultation, in record-keeping, communicating with colleagues; their obligations to patients’ families and communities; their responsibility to co-operate well with others on their healthcare team; their legal obligations and the requirement that they maintain confidentiality, decorum, clinical competence and scholarship. If a doctor is accused of dereliction of duty, this is the instrument by which they are judged in law.

5.2 Emplacing continuity of care

Continuity of care was mentioned explicitly by eighteen RPs and spoken about by thirteen of these. GPs value knowing their patients and reckon that a long-standing, trusting relationship enhances their therapeutic interventions. Increased continuity of care by doctors is associated with lower mortality rates from all causes and is ‘potentially a matter of life and death’ (Pereira Gray et al. 2018, 11). The absence of continuity of care is regarded as ‘a significant predictor of mortality, acute hospitalisation and use of out-of-hours care’ in Norway (Sandvik et al. 2021, 1). Baker et al. identify the mechanisms by which continuity of care is instrumentalised and, while finding that it decreases patient mortality, it is in decline: ‘More qualitative work is needed on how continuity is achieved in modern practices with part-time clinicians; how patients achieve continuity and how practices, and receptionists in particular,

can enhance it (Baker et al. 2020, e609). The GPs get a lot out of it too. Continuity of care implies continuity of relationship; ‘I think patients who don’t like you move on. You get fans after thirty years, but you have to click and if you don’t click, they move on’ [RP04]. Trust grows over time and intersubjectivity creates the conditions of possibility for humour. A GP in an ‘independent urban town’⁶⁹ spoke about social prescribing:

I love the social prescribing, I love it. And because I suppose I’m so rooted in the community I wouldn’t say – ‘Go lose weight, go to the gym,’ I would say ‘If you go to the gym now – Hold on and I’ll ring a fella in the gym.’ and say – ‘I’ve a pal Tom here now would you show him around the gym?’ – ‘Oh, I will of course Doctor, no problem,’ and I’d say, ‘Tom will be there, and he’s there and he’s the fella with the curly hair or something.’ Or I’d say ‘AA,’⁷⁰ you see, I have to be a bit careful with AA because you can’t be giving names and things [RP25].

They went on to mention prescribing buying a dog, joining a book club, or joining amateur dramatics when they knew their patients well enough to make suggestions that might be acceptable to them. ‘There’s a lot of lonely people,’ they said before explaining why they look the other way when they see their patients smoking outside a pub. In this way, RP25 harnesses the ecological, social and economic capabilities of arts and culture to make life liveable in their medium-sized town (Kroismayr et al. 2025).

RP02 expanded on this when they explained why they believe their patients:

If a patient wants to take a doctor in or deceive a doctor, I think is quite easy to do. And it should be because you really want to think the best of people. You want to give them a fair chance. You don’t need to be a fool. But you do want to kind of say well, they may do this once or twice or

⁶⁹ Towns/settlements with populations between 1,500 and 49,999, where less than 20 percent of the usually resident employed population’s workplace address is in ‘Cities’. Source: Central Statistics Office. “Urban and Rural Life in Ireland, 2019.” Cork: CSO, 2025.

⁷⁰ Alcoholics Anonymous.

whatever it is. So, you have to ... I think you almost set a standard that you say I'm believing you. If you say -I'm believing you and you know you shouldn't be believed. You'd find it very difficult to derive the same satisfaction from that in the future. I don't care who you are. I suppose morality is more about behaviour, isn't it, than belief? [RP02].

'Making a difference' was mentioned one hundred and six times by all thirty-one RPs as an important source of satisfaction. While GPs have a range of therapeutic interventions that can offer immediate care, these were only referred to in order to illustrate a point. The joy of working as a GP, for them, arose out of the range of differences they can make in patients' lives by their medical and social care and advocacy, the *sine qua non* being continuity of care.

5.2.1 Continuity of care in city and suburban areas.

Continuity of care becomes much more important when a patient who has been brutalised by the social determinants of health has difficulty forming trusting relationships. Gesler's account of places where people were shunned because of leprosy or psychiatric illness presages a more subtle contemporary form of social exclusion (Gesler 1992, 738). Marginalised patients have higher incidences of psychiatric illness, drug and alcohol dependency and poor general health, leading not only to homelessness, but to borrow Relph's term, placelessness (Relph 2015; Relph 1976). According to Biehl, some places function 'by exclusion, nonrecognition and abandonment' (Biehl 2013 [2005], 38). Those who are homeless or rough sleepers may not seek healthcare. The Safetynet primary care service, already outlined in Chapter 4, has a fully equipped and staffed bus which travels to wherever a homeless person needs healthcare. On the night before our interview, one RP had been on a call out to a couple in a park after midnight, both in an altered state of mind. They described the patient's injuries and their underlying risk factors (redacted) and how the consultation was fraught by the patient's unwillingness to go to hospital for necessary care. The GP had a longstanding familiarity with this couple and

their addictions. They described how they had to gauge the tone of their intervention so as not to alienate them but to negotiate a salutogenic intervention. Another RP told me how their homeless patients, the ‘unworried unwell’ could give a class on the Wells Criteria for DVT; DVT is an acronym for deep venous thrombosis, a blood clot that, if it moves from the leg to the lung, can cause a fatal pulmonary embolism.

... I would say half the people I see with DVTs would have big swollen legs, don’t want to go to A&E. They’ll just say – ‘Oh just give me the Inohep,’⁷¹ they’ve been there before, they don’t want to be referred. They don’t want to be seen; it’s not a priority for them and I don’t mean that dismissively. It’s because they have other awful things going on in their lives by and large that understandably their perspective ... I don’t agree with it ... but as they look at it, they say actually going to A&E is not a priority. I suspect a third of the patients I see have had a DVT at some stage. And if they haven’t, their boyfriend or girlfriend, they will have seen people giving themselves Inohep [RP16].

A GP who works in a very marginalised city suburb takes care of very complex, troubled patients:

So, what happened was I became the niche person in the practice, when there was only two of us, for the difficult families and the people that were struggling. And when we moved [premises], we got more doctors, we got more patients but then there were a lot more difficult people in there and they all landed on me. It is different in the Deep End⁷² there’s a bigger volume; there’s more sick people for a given population [RP10].

Patients who have been traumatised need a higher level of understanding from every member of the practice team:

⁷¹ Inohep is an anticoagulant medicine that affects how the blood clots. It is administered by subcutaneous injection, the dose titrated against response shown by blood tests that measure blood clotting indices.

⁷² Deep End was explained above, section 2.2.8.

We have trained all the receptionists; we send them on training for trauma-centred care. A huge number of ours are traumatised people. Waiting is very traumatic for them – it triggers them ... so they can become quite aggressive. Now it's become much better over the years, because they know that we are consistently providing care for them. We care what happens to them. We are looking after them. We understand where they are coming from [RP13].

GPs who care for marginalised patients know that they rely on their practice team to embody the practice ethos in how they receive and greet patients and manage their queries and expectations.

Commensality enhances relationships in the practice team; it strengthens them to contend with their chaotic patients:

There's a lot to be said for the small, the small close-knit aspect of it (the practice team and premises). And the connection, like the family practice part of the practice. As in not just the patients and families but us being a family almost. The dining room, for example, in these big places is miles away so people tend to, they might eat in their room. Whereas we are always in and out to the reception, always making cups of tea and having chats. We do try and make an effort to have lunch for fifteen minutes together in the waiting room. So, I think that is very important. I just think that they are so loyal. I think if any one of them has missed a day in the years that they've been with us; it's hardly been a single day. Only if they had pneumonia or COVID. But yeah, I think that inspires me [RP11].

Caring for patients with chaotic lifeworlds obliges GPs to do everything they can in one consultation in case patients do not keep follow-up appointments. Careful record keeping on shared software enables a team of GPs to provide continuity of care:

They come in in a terrible state. They might be coming in drug-seeking – 'I can't sleep, doctor.' So you have to try and manage that aspect of it, but then while you are doing that, try and make sure that- 'OK, well, let me just figure out what is your past medical history and are you on the right medications?' And 'if you are on the right medication, where do you get those medications? Do you have a GP? When were you last seen by your GP?' Well, 'if you are a drug user, - are you doing harm-reduction stuff' and then obviously make sure that, well, have they had a recent BPD

(borderline personality disorder) screening? And if they had, what was the outcome of that? 'Are you HIV positive?' If they are, do you have to have them in for Hepatitis C treatment? Then the mental health stuff: have they lost contact with their mental health team? And therefore, they are kind of – their drug use is central to me trying to manage their mental health. So, there's that whole interweb that happens. All the GPs in Inclusion Health use Socrates [computer software programme] ...so I have a consultation checklist that I go through to make sure that if they are not seen for another three months that the next doctor who sees them goes – 'OK, here are the priority issues' [RP06].

It hardly needs to be emphasised that RP06's consultation, described above, takes much longer than the standard ten or fifteen minutes. Not only is the patient free to raise multiple concerns, but the doctor is prepared to deal with all of them, and to raise further issues to which the patient may be oblivious. A health economist studying doctor productivity could have difficulty with this consultation style, but factoring in Pickett and Wilkinson's axiom that 'equality is better for everyone' might reframe the matter (2010). This research did not enquire about RPs' income streams but RP06 was explicit about their choices. They had chosen a portfolio of salaried jobs in order to work neither as an employer nor a manager, but as a clinician. Two other inner-city GPs declared the same positionality.

In all of the examples given above, GPs not only respond and react to a patient's presenting, looking for care, but they also pro-actively seek out those patients, knowing the risks that accrue to their lifeworld. In the cosmology of homelessness and rough sleeping, GPs frequently consult alongside a nurse practitioner who may also be known to the patient. Twenty-six RPs stated that good relationships are key to achieving good outcomes.

5.2.2 Continuity of care in rural areas

As I have described already in Chapter 3, the profile of marginalised people in remote rural areas differs markedly from that in the city. Liam Glynn, Professor

of General Practice at the University of Limerick is a strong advocate for rural healthcare. In the comprehensive 'Limerick Declaration on Rural Health Care', 2022, Glynn et al. have proposed mechanisms to ensure continuing delivery of healthcare to '1.6 million people: one of the highest rurally based populations in Europe' (Glynn et al. 2023, 5). The recommendations had four major themes: 'rural healthcare needs and delivery, rural workforce, advocacy and policy, and research for rural health care' (ibid. p. 5). Noting the gradual decline of GP numbers in rural Ireland over the past twenty years, the authors propose that all university medical schools ought to provide 'longitudinal integrated clerkships in general practice' (ibid. p. 5) to provide the workforce for rural primary care. At present only one of six Irish medical schools provides this education. I have already noted, in Chapter 4, that twenty-eight of the thirty-one GPs I met chose to become GPs after being exposed to general practice during their upbringing, their undergraduate rotations, postgraduate placements or GP locum work.

Remote rural areas that I visited scored highly on the Haase-Pratschke deprivation index for deprivation by having more elderly, dependent people, many of whom lived alone, with low educational achievement and high unemployment (Haase and Pratschke 2017). Satisfaction in delivery of continuing care was expressed:

... the continuity of care, that you have an opportunity to follow people almost throughout their lives or at least through your working life. So, I would have looked after grandparents, parents, their children and their grandchildren. So that level of knowledge and that level of continuity of care is quite unique to general practice. [RP29].

Newly qualified doctors can have difficulty deciding what speciality they want to train in. Seven RPs told me that they found their purpose only after they left

hospital medicine and did a training module with a GP. This city-born GP had their epiphany in a remote rural area:

I had a notion of what GP was, which turned out to be incorrect. [...] But I liked the tribe. I liked, I liked ... they got it, you know? They got what healthcare was, that it was more than just a few tests and treatment. It wasn't for us it was for them; there was that marriage of providing important care but also looking after yourself. The community context and again going back to the over-medicalisation piece. Which is probably the biggest problem in medicine, the solution to that is more continuity of care and less fragmentation of care [RP14].

In the foregoing quotation, RP14 distils the essence of the 2017 Sláintecare report's thrust to move more healthcare into the primary care arena. Some incremental changes have been made to this end.

The evidence on the benefits of continuity of care is well-known by GPs:

When I was in med school, continuity of care was talked about all the time and actually I think that's even more important now with the arrival of commercial entrants into the general practice market. And there's a real risk of taxi stop medicine with that, where the next person that comes along, whatever taxi comes along you jump into it, well whatever doctor comes along that you jump into that. The outcomes when there isn't continuity of care are worse than when there is continuity of care [RP19].

Ireland's carceral era when young women were locked up for pregnancy outside wedlock and young men were imprisoned for petty crime has left a legacy of traumatised people with multiple care needs (O'Rourke 2011):

We have lots of generations of people ... So, you have the elderly guy who's been in industrial schools, and you can see the alcoholism. And then you can see the impact on the generations after. It's really interesting, trying to piece them all together ... [RP18].

5.2.3 From ante-natal care to end-of-life care

In all primary care practices, continuity of care begins with ante-natal care visits, usually light-hearted and joyful, the kind of consultation that leavens a GP's working day. Seven RPs spoke about how it lays a foundation for a good doctor-patient relationship as the cycle of life plays out in their daily workload. End of life care can be equally joyful when elderly people die at home after a life well lived. This GP respects their 'stoic' mountainy patients and mourns their passing:

So, I've just been up to see somebody, who keeps trying to die, she's as happy as can be, but one of these days she will successfully die. [...] I've said goodbye to her so many times at this stage it's going to be a huge shock. But that's fine, that's completely easy to me. I mean ... if she died tonight and I hadn't been up there I'd have felt I hadn't quite done the journey properly [RP27].

End-of-life care gives great satisfaction to GPs when it concerns an elderly patient who has lived a full life, or when a patient who has had a terminal illness comes to the end of their suffering. RP03 lamented the passing of a time when most people in these situations died at home, surrounded by their family and friends, supported by family and friends, district health nurses, palliative care nurses and their GP. They reckon that nowadays, 'people ring an ambulance at a lower threshold'. In an address at the Royal College of Physicians in Ireland in 2016, Arthur Kleinman, renowned American psychiatrist and anthropologist, recounted a similar experience. He told the gathering that despite a decades-long career as a clinician, he only really understood care and caring once his wife got Alzheimer's disease and he, in tandem with a supportive team, provided her terminal care at home (Kleinman 2009). In like manner, Virginia Lawson shared her experience of delivering domiciliary terminal care to her husband over two years, when she gave her

presidential address to the AAG (Association of American Geographers) in 2007:

My experience in caregiving, with all its personal and professional costs, also stimulated my thinking about care ethics and geography and so suggests the situatedness of our work – in our lives, our emotions, our caring commitments and our politics (Lawson 2007, 4).

In this research, two rural GPs gave heartfelt accounts of making ‘up to five house calls after surgery every day’ to elderly patients, including those who were terminally ill. RP21 brought me to visit a patient with a terminal illness who had spent the previous two weeks in a hospice and had now come home to die. The patient’s main carer asked the GP to stocktake and check the dose of all of his medications and supplies. Then RP21 told him the local news, cheered him up and we left. I received an e-mail within two days to tell me that he had died peacefully. RP21 had already mentioned that once the patient died, they would ‘keep a close eye’ on his carer:

It’s all about the carers. With the population, the aged population, it’s all about caring for the carers. Once the carers get burned out it’s very hard for them to get back on track and then the situation can collapse. And it’s not just Machiavellian to keep a situation going for somebody who needs care, but it goes back to the actual health of the carer [RP21].

I remember from my father-in-law’s death in our home in 1994, following a terminal illness, how our home became a ‘landscape of care ...to accommodate the performance and paraphernalia of care’ (Milligan and Wiles 2010, 739). After seeing the hospital bed, hoist and miscellaneous other terminal care equipment in a cottage on the Wild Atlantic Way, I knew that the HSE would come and remove it, as they did in our case, once the early pains of bereavement abate.

5.2.4 Chronic disease management

The Chronic Disease Management Programme, introduced in 2019 as part of Sláintecare, represents the apogee of preventive care. The Irish population is ageing.

Year	Males over 65y	Males over 75y	Males over 85y	Females over 65y	Females over 75y	Females over 85y
2002	177252	66872	10570	246848	118252	29240
2006	207095	79660	14845	260831	125718	33183
2011	243314	93540	18486	292079	137025	39930
2016	296837	112375	23000	340730	151684	44400
2022	641100	149400	31600	704300	186700	52800

Table 0-1: Numbers of males and females over 65, 75 and 85 years according to Census 2002 to Census 2022.

Source: Irish Census returns 2002, 2006, 2011, 2016, 2022.

Currently 15.5% of the population is aged over 65 and it is predicted that by 2027, 915,800 people will be aged over 65 (CSO 2023). Data from Irish census returns in 2002, 2006, 2022, 2016 and 2022 reveal an ever-rising cohort of ageing

people. In Table 5-1 above, numbers of males and females aged over 65, 75 and 85 years are cumulative.

Table 5-2 shows the cumulative percentage of males and females in older age categories as a percentage of the total population in the five most recent census returns.

Census Year	%M>65 y	%M>75 y	%M>85 y	%F>65y	%F>75y	%F>85y
2002	4.50	1.70	0.27	6.30	3.00	0.74
2006	4.90	1.88	0.35	6.15	2.97	0.78
2011	5.30	2.04	0.40	6.37	2.99	0.87
2016	6.23	2.34	0.48	7.16	3.19	0.93
2022	12.00	2.90	0.61	13.70	3.62	1.03

Table 0-2: The cumulative percentage of males and females in older age categories as a percentage of the total population in the five most recent census returns.

Source: Irish Census returns 2002, 2006, 2011, 2016, 2022

Figure 5-1 indicates the upward trend in graphic form.

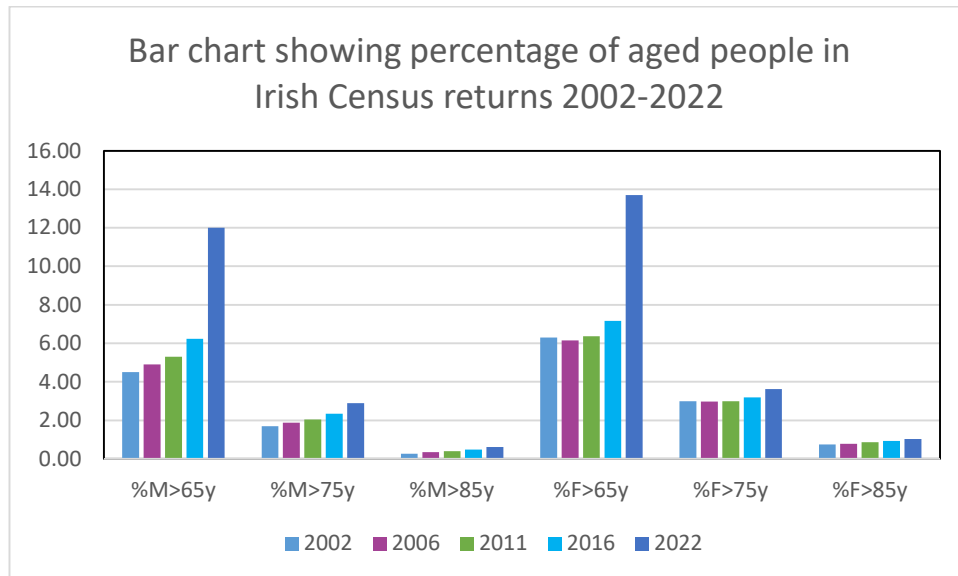


Figure 0-1: Aged people in Ireland as a percentage of the population, 2002–2022.

Source: Irish Census returns 2002, 2006, 2011, 2016, 2022

The trend is steadily upward and spikes in 2022. This may be explained by the fact that the Irish population fell steadily from the 1840s to 1962 due to emigration. Those aged 65 or over in the 2022 Census were born in 1957 or afterwards, a time characterised by a wave of prosperity from 1959 to 1966.

The distinction is drawn, nowadays, between lifespan and healthspan, a focus not only upon years of life but, also, upon years of living healthily (Olshansky 2018; Gold et al. 2002). Population health measures these as HALYs (health-adjusted life years), DALYs (disability-adjusted life years) and QALYs (quality-adjusted life years) in which expected years of healthy life are compared with those lost due to a disease or disability or gained due to a medical intervention (Moreno-Ternero, Platz, and Osterdal. L.P. 2023). Lifespan estimates the number of years an individual can expect to live and healthspan, or healthy life expectancy, the number of years they may expect to live independently, with

good health. Both lifespan and healthspan have increased in Ireland since the foundation of the state. However, a tacit memory persists of retirement into passivity at 65, while retirement age ratchets steadily upwards. The Irish Longitudinal Study on Ageing (TILDA) has shown that

Far from being a time characterised by decline and increased dependency, older adults aged 70 years and over continue to make valuable contributions to society, with many characterised by active citizenship and participation in the lives of their families and their communities (McGarrigle et al. 2020, 18) .

Those with ill-health cannot participate in the workforce and concerns arise throughout the developed world about how a smaller population of taxpayers will fund a growing population of dependent older people in the future.

An acute presentation may lead to a diagnosis of a chronic condition:

Most of the illnesses that people come in with are self-limiting. If we don't see people face-to-face, we miss an opportunity to pick stuff up that we know exists out there. Our success is measured in non-events. So, the success of keeping diabetes well controlled is that bad things don't happen [RP04].

The CDM programme requires significant input from all team members in a practice, especially for a patient's early visits:

So, the way we tend to do it is that either the nurse or the intern does the first visit, so, where the blood tests are taken, and the height and weight are measured and – 'Do you smoke? Do you exercise?' – some of the parameters being taken. And then there's a follow up phone appointment a week later, with the GP, to go through everything. The precedent is established with diabetes and works well with diabetes care. So those patients probably understand the system. But maybe for other things it requires more explanation, let's say at the first visit. You won't have to go to the hospital every six months; it's like an out-patient appointment but it's in your GP practice. Most of them are very grateful and you have repeated chances to chat about different things rather than trying to tackle everything at the one visit. It's a great service. [RP15]

They are really being looked after very well with it. So, the diabetics are getting their bloods done and we are really religious about it, we have a call

back system so that if people are due to come in this June the girls have a list of who is due in for their bloods this month. And if they are not in, they'll be on the phone to them going – 'Where are you, Johnny? You were due in this week for your bloods.' And also, what we are doing is we are doing a huge volume of ECGs and blood pressure monitors. And we are picking up a lot more uncontrolled hypertension or, A-fib⁷³ or anyway, we are picking up stuff. The patients are being well minded, and they are loving it [RP25].

When GPs signed up to the CDM contract they found the early workload overwhelming. Some practices hired extra clerical and nursing staff to implement the protocols and to manage returns to the HSE; the CDM is well-funded, and GPs acknowledge that they are well paid to provide the service. With the passage of time, however, everybody has accommodated to the workload, patients and primary healthcare workers alike; GPs in this research serenade its benefits for all:

There has been change into Chronic Disease Management and it is being facilitated by our software modules, it actually makes it easy to do. [...] In between [the] twice-yearly visits, chaotic care has diminished. Because if somebody comes in sick or unwell you can just have a quick look at the file and say – 'Well, d'you know what? Two months ago, your blood count was perfect, so you're not anaemic.' So, you're actually able to deal with the problem at hand knowing that the housekeeping is done [RP25].

As already mentioned in Chapter 4 above, RP21 also stated that in their remote, rural practice, the CDM programme had 'turned the Inverse Care Law on its head'. When they mentioned this, we were walking back to their car from visiting four elderly patients who live alone in small cottages along the Atlantic seaboard. They had invited me to accompany them on home visits since my medical registration was in order. Consultations were conducted in a mix of Irish and English over a cup of tea, and all patients were happy that all their medical needs were met. The GP's valediction was 'An bhfuil aon ní eile de dhíth ort?' (translated as: *is there anything else lacking to you?*), and the answer in

⁷³ Atrial fibrillation, a cardiac arrhythmia that can lead to premature death.

all cases was 'Nil' (*There is not*). As we walked across the causeway, I saw the truth of what his patients said and felt that the CDM protocol had instrumentalised the best possible end-of-life care for people in their own, remote, rural homes.

5.3 Disadvantage generates more work

In her autobiography about being born to and growing up as the child of parents addicted to alcohol and heroin, academic and clinical psychologist Katriona O'Sullivan spells out the depth and breadth of how disadvantage becomes inscribed on the body and mind:

Being poor affects everything you do and everything you are. Thinking of poverty, we picture barefoot children in rags on the street. Of course, it is the lack of money and material possessions. For me, it was those things; for so much of my life I literally had nothing. But 'poor' for me was also feeling like I had no worth. It was poverty of mind, poverty of stimulation, poverty of safety and poverty of relationships. Being poor controls how you see yourself, how you trust and speak, how you see the world and how you dream (O'Sullivan 2023, 274).

Patients who are poor, homeless, addicted, disadvantaged, marginalised and/or underserved require more healthcare support than those whose material needs are met. Multiple layers of disadvantage sediment in their lives and oppress them, often leading to hopelessness. All the GPs whom I interviewed gave case histories (mostly redacted) of situations where, to their satisfaction, they were able to make a difference. They also recounted stories where they felt 'the system' had failed their patients and frequently became animated and expressed anger about it. 'Landscapes of despair' were implicit (Dear and Wolch 2014); 'interdependency, reciprocity and multidirectionality' of care (Milligan and Wiles 2010, 737) were a *sine qua non*.

5.3.1 'Paperwork' aka 'hidden work'

'Paperwork' is the term used by GPs to describe the work they do behind the scenes once patients have left the surgery. Nowadays, very little paper is involved but time is spent making telephone calls, e-mailing, searching for results of discharge letters, writing referral letters and filling in forms (Barnard et al. 2024). Whether a GP works in a single-handed or group practice, much of this work cannot be delegated, and until it is done, the GP cannot have a clear head. The amount of 'paperwork' accruing to each patient is significant:

Every week and at the end of every day, there would be at least one or two DCA – which is a domiciliary care allowance – forms or the carer's allowance or something. Assessment of need, referral to the EIT (HSE's childhood Early Intervention Team), so there's really, feels like a disproportionate amount of patients that we have their children – all have special needs. So, they all need the domiciliary care form filled out, then what's happening is you send that off and then it comes back, and they have been rejected, so they need a letter of appeal. And so that's the extra work on top of the day-to-day that has to be done [RP11].

In their work with asylum seekers and homeless people, RP05 declares that there are clerical services needed by marginalised people which only a doctor is entitled to provide:

(The power is in) opening doors and not opening doors for people. So, a lot of the things that are not really medical that people come to us for, and we have the ability to make it happen or not happen for them because we are doctors. So, things like illness benefit or disability allowance or accessing services, whether it's educational services for their child or letters for child benefit ... somebody comes in and says this is my child, this is their passport, they are living here in Ireland with me, and I give them a letter to say that, then they get an income for the next eighteen years. If they didn't have a doctor to do that for them, they wouldn't get that. ... and accommodation letters, and clothing grants ...[RP05].

Interventions like this create resilience (Wiles 2023) and represent real advocacy for the poor.

5.3.2 Involuntary admission

Two GPs spoke about involuntary admission of patients to psychiatric care. One reminded me of what a violent transgression of human rights it had been when I was in practice, before the Mental Health Act 2001 (Government of Ireland 2001) made the process more humane.

We do several a year, at least. It changed with the new Mental Health Act a few years ago. The difference meant that in fact once we sign the forms that's our job done essentially. Previously – you might remember this⁷⁴ – you might have to go to somebody's house and literally had to wait there until the police came or somebody came to keep them there so that they could be taken in. [...] It was a violation yeah, so I feel that has hugely changed. So, I don't get stressed about it anymore [RP11].

RP11's account of doing an involuntary admission in 2022, by comparison with doing one before 2002, exemplifies the ways that the state, through its laws, can provide the means of keeping people safe: the patient from themselves, their kinsfolk from the unwell patient and the GP from the distress of it all. 'Sociocultural norms and the specific nature and values of state regimes' (Milligan and Wiles 2010, 744) determine procedures in this scenario. A 'care convoy or situated network of care' (Wiles 2024, 371), instrumentalised in this way, inscribes 'a care-ful or compassionate geography' (Milligan and Wiles 2010, 741) on a community.

The one that does concern me is making an involuntary admission. We have a lot of them [...]. It's because patients with schizophrenia tend to drift towards homelessness so then tend to end up in this kind of area. And you want to make sure you obviously are doing them for the right circumstances. ... that's the only time where you feel like I'm really removing somebody's civil liberties and it's something to be taken very seriously [RP09].

⁷⁴ I recall some very upsetting committals during my time as a GP.

Although the removal of a citizen's civil liberties may be an infringement of their human rights, it is only done when two medical practitioners, one a consultant psychiatrist, diagnose a mental illness which puts the patient in a situation of being 'at risk' to themselves or to others (Government of Ireland 2001). When done in the best interests of the patient, it is an act of care. However, the laws and practices of psychiatric care spring from repressive political ideologies, well traced through time by Foucault, Fanon, Scheper-Hughes and Kelly (Scheper-Hughes 1979; Foucault 2001 [1961]; Fanon 1961; Kelly 2016). Women's experience is more easily understood through feminist analysis (Federici 2014; Gilligan 2003 (1982)). While Ireland had inherited its laws and practices from British rule over several centuries and only began to create its own after Independence in 1922, the female body and its reproductive rights were proscribed for decades by a patriarchal, Catholic state (Ferriter 2012). Austin O'Carroll, who founded the Safetynet service for homeless people, argues that in the cases of those most disabled by poverty, it is misleading, harmful and dehumanising to diagnose them with 'borderline and antisocial personality disorders' (O'Carroll 2022). In applying a diagnosis to the person, he argues, 'we deflect society's attention from the most likely causes of these behaviours including the effects of trauma, sexism and social inequity' (ibid), a view widely corroborated in health geography (Crooks and Andrews 2009; Pearce 2014; Pearce and Dorling 2009; Rigby et al. 2017).

5.3.3 Perseverance

Perseverance is required to effect change. Milligan and Wiles suggest that 'caregivers do not simply do things for people; they also support them with encouragement, personal attention, and communication in ways that endorse a mutual sense of identity and self-worth' (Milligan and Wiles 2010, 738).

I find that work very rewarding because you can make a big difference ... and our patients have such little expectations for life and of getting helped that – and I’m really interested in the whole childhood trauma thing and the impact on adult life. And the impact on physical illness, not just mental illness. And the business of being stubborn with a patient. So being stubborn about the services, about getting things for people, not giving up on services but also not giving up on patients, who have been given up on by everybody and often behave very badly in the expectation that that’s what people expect of them. And the power of saying – ‘Well, you behaved disgracefully last week but I want to see you next week anyway’ [RP10].

All of the GPs in this research referred, repeatedly, to the importance of trust in the relationship between doctor and patient, and continuously wove into their narratives the efforts, personal, professional, structural and systematic, that they and their teams put into caring for their disadvantaged patients through the continuum of acute medical care, preventive care, chronic care and advocacy. In both urban and rural situations, RPs said that local shopkeepers keep them informed, in a non-intrusive way, about how some vulnerable patients are faring, and sometimes alert them to a need they had not been aware of. Triangulation of this kind of data requires subtle social skills; while the GP may hear stories, they may not trade them.

5.3.4 Multi-disciplinary team meetings

Multi-disciplinary team (MDT) meetings are required in certain cases. When a child seems to be at risk, an MDT meeting is convened to determine what services can be provided and whether that child needs to be taken into care. Whereas HSE and TUSLA workers factor these into their day’s calendar, GPs must find a colleague or locum to replace them for half a day’s clinical work to attend. Several GPs said that MDT meetings had fallen by the wayside during the pandemic and were slow to resume. While some complained that they were a waste of time, one said that the move to online meetings during the pandemic had made it easier to attend. One Deep End GP said that they will always attend in their capacity as the patient’s advocate, stating ‘That’s the work’.

GPs abandon their patients to the case conference process by not showing up. [... We] are the only professionals who have a therapeutic relationship with the mother and the child. Everybody else is there for the child, they don't give a shite about the mother. [...] The young mother who comes to you – the GP does not want to go to a case conference where that mother is being put on trial. [...] So, the mother has no advocate then. So, the GP to keep their relationship with the patient pure and – 'I'm on your side I'm not getting involved with those awful social workers- yeah, they are terrible aren't they? I'll write a report, and I'll stay out of it.' Because you can be contaminated when you are there with them, but you *have* to stand up to them. Because they [the social workers] are a juggernaut who need to be pushed back regularly. And it's our job to do that [RP10].

This GP insists that trainee GPs stay on-site to have lunch with the practice team 'so that they can see how we struggle too'. Haraway calls it 'staying with the trouble' (2016). To me it's the perennial 'crouch, touch, engage' of patient advocacy.

5.3.5 Caring with humour

GPs use humour as a tool to mitigate the hardship of people's lives and as a leveller in the consultation. Four RPs said they teach their trainees how to deploy it. A further fourteen mentioned 'having the craic with patients' despite difficult living circumstances. While I waited for one inner city GP to see me at the end of a busy surgery, I noticed the light-hearted engagement of the regular patients with staff at the reception desk and heard peals of laughter coming from consulting rooms down the corridor, since all doors were still kept open to ventilate the premises in late 2021. RP13 interrupted our interview to engage with a patient who arrived unexpectedly to collect a letter and afterwards, gave a moving account about how, in their practice with a large population of marginalised people, joking and laughter between patients and staff is common currency. I wondered if they remembered Portia in *The Merchant of Venice* speaking about '*the quality of mercy ... it blesseth him that gives ...*' (Act IV, Scene 1) (Shakespeare 1987 [1596], 228). Smiling broadly, RP13 concluded the

quotation with emphasis: '*and him that takes*'. I had just witnessed the humorous banter between them and the patient, and we both knew that what 'blesseth' the giving and receiving of care is the ongoing relationship between doctor and patient.

5.4 Consultation protocols that help GPs

During GP training, doctors are taught the art of communication, how to impart bad news, how to listen and hear what patients are saying. Research Participants wove into their narratives theoretical and practical dogmas about the consultation learned during their training or later on, during their career. It behoves one to remember that not long ago, medicine was practised in a patriarchal manner with no concept of partnership between doctor and patient. Over the past twenty years, however, the advent of the internet and smart phones has banished this approach (Kitchin et al. 2013; Hearne, Kitchin, and O'Callaghan 2014; Garvey and Miller 2021; Kitchin 2014). Demographic change, the decline of the Catholic church's paternalism, education and the rise of everyday feminism have empowered patients to query both expertise and authority. Contemporary GPs interact with the patient as subject rather than object and approach the consultation accordingly. Bearing in mind that GPs are professional carers, paid by individuals or by the state to care for their patients, they cannot switch off their caring when fatigued or preoccupied. Therefore, they must incorporate strategies in their daily practice that stand to them at all times. Research Participants referred to consultation models that they have incorporated into their practice, and I expand on some of these below since these are the learnings that underpin provision of a landscape of primary care as it is currently delivered by one human being to another.

5.4.1 Balint

The 'Balint' model (Balint 1955) may be summarised as the doctor using themselves as an instrument or as a drug in a doctor-patient relationship in a manner that foregrounds good communication. During my time in practice, I knew several colleagues who participated in loosely formatted Balint groups and did so myself. A formal Balint group has been running in Sligo since 2013, with GPs meeting in small groups to work on improving their consultation communication skills. Twelve RPs say they use this technique to some extent or other.

5.4.2 Pendleton

Pendleton's model appeared in 1984 (Pendleton et al. 2003) and was mentioned by two RPs. It names seven tasks that the doctor and patient must accomplish in the consultation; 'establishing the reason for the patient's attendance and their health beliefs; exploring the social context of the patient's life; choosing an appropriate management plan for each of the problems, discussing them as a dyad and the patient taking responsibility for whatever they can do; using time and resources efficiently and promoting a relationship that builds long-term trust' (Denness 2013, 593).

5.4.3 Starfield

Three GPs mentioned Starfield's framework for primary care (Starfield 1994), which articulated the four pillars of primary care practice: first-contact care, continuity of care, comprehensive care and co-ordination of care.

5.4.4 Calgary-Cambridge

The Calgary-Cambridge communication skills model (1996) includes five steps: initiating the consultation; gathering information; building relationships; explanation and planning and closing the session. Three RPs spoke about Calgary-Cambridge.

5.4.5 Narrative medicine

In 2001, Rita Charon, New York doctor and Professor of Medical Humanities and Ethics at Columbia University published her first book about Narrative Medicine. She defined it as ‘medicine practiced with the skills of recognizing, absorbing, interpreting, and being moved by the stories of illness’ (Charon 2013, 2006, 2001). Attention must be paid to intersubjectivity, relationality, personhood and embodiment, action toward justice, close reading (or slow looking) and creativity. Two RPs have been guided by Charon’s approach.

5.4.6 Conversations inviting change

Dr John Launer, an English GP, theorised ‘Conversations inviting change’ or CIC, in 2018 (Launer 2023). RP11 took an online course in CIC during pandemic restrictions and explained it as follows:

... it was less didactic it was less, you know, ‘I’m the doctor you are the patient – I’m telling you what to do.’ It was much more to try and find a common place where we would meet in the middle and share decisions and understanding. [...] You just listen and you are looking for cues and then you pick up on a question maybe on what somebody has said. And then you don’t give advice, or you don’t interpret, or you don’t reframe stuff that is all useful in its place. If you do feel you want to give advice [then] you ask ... ‘Would you like me to explain that?’ Or ‘Have you ever heard of this before? Will I explain it to you?’ Or just ... ‘listening to you there something strikes me, would you like me to give you a bit of advice or whatever.’ So, it’s a much more equal relationship [RP13].

The keyword in all these medical consultation models is 'relationship', foregrounded through the lens of human geography by Milligan and Wiles; 'the complex social, embodied and organizational spatialities that emerge from and through relationships of care' (Milligan and Wiles 2010, 736). I will now turn to how Research Participants describe relationship, what it is, how they cultivate it, how they build on it.

5.5 Advocacy

This chapter has already described the manifold ways in which GPs care for marginalised patients. Whereas a middle-class patient might present with a straightforward pain, ache or minor illness along with the social capital to comprehend it and do something about it, a similar presentation in a poor patient is usually complicated by a lack of the wherewithal to recover their health. GPs can diagnose an ailment and prescribe a treatment but in cases where social determinants of health are at the root of the problem, their care withers on the vine unless they engage in advocacy. 'You must dig where you stand,' according to Prof. Susan Smith, at her Inaugural lecture as Professor of General Practice in TCD (2024). Although advocacy is not one of Pechansky's five As, Availability, Accessibility, Accommodation, Affordability and Acceptability, it underpins them as some or all may be absent from a patient's care unless a GP specifically advocates for them (Penchansky and Thomas 1981). Some RPs in this research have specialised in primary care for a niche group with whom they have sympathy. One male GP works in the Gay Men's Health Project where he not only cares for the individual patients but also researches their clinical needs and feeds the outcomes into policy. Three women GPs expressed fellow feeling for women patients who need contraception and abortion healthcare:

Deprivation exposes the working poor so much – women who will never ever prioritise their own healthcare needs because there's always a schoolbook, there's always a trip, a birthday. And they will not prioritise and then they get caught. And it's going to be the straw that breaks the camel's back because they might have four kids, that means they have to get a bigger car; they've just started a new job because the kids are now all in primary school or whatever; and you think of these women having to get transport to the UK [RP30].

Homeless people require a great deal of advocacy along with all the services that a multi-disciplinary team can provide. RP17 teaches this to their medical students, synthesising their roles as clinician, educator and activist:

So, the student will come in and I'll say to them – 'Welcome, and I know you think you are here today because you think I'm an expert, I'm actually not an expert on homelessness or addiction, I've never had an addiction and never slept under a bridge. So, it's useless me telling you about it how that feels. So, here's the patient, and the patient is going to teach you and me today about how that feels.' It's disconcerting for the students [... but] the patients love it [RP17].

Although they've done it throughout their careers, GPs express amazement at how effective letter-writing can be. They write letters for housing assistance, clothing grants, back to school allowances, carer's allowances and when the patient's request is rejected by the authorities, they do it again. According to one GP, 'Dublin City Council (DCC) states that the more support you get, the more likely you are to move up the housing list' [RP09].

I have already explained Deep End GPs and their commitment to underserved people in section 2.2.8 above. One RP is a member of the Deep End sub-group that specialises in advocacy for children; another Deep End member says they see people who experienced hardship in their childhood, go on to inflict it on their own children, and that advocating for children is important to try and 'break the cycle'. 'Adverse Childhood Experiences' (ACEs) have been proved to be strongly related to psychiatric ill health in adulthood (Felitti et al. 1998; van

der Kolk 2015). Several GPs recounted harrowing case histories to illustrate their advocacy, all redacted from this text.

The prescription of methadone has been an immense help to opiate addicts, doctors and communities since its introduction in Ireland in 1971. Only in 1998 was legislation passed to allow GPs to prescribe it (Delargy, Crowley, and Van Hout 2019; Government of Ireland 1998). GPs who prescribe methadone examine the patient's urine for opiates at each repeat visit:

When the methadone patients come in and TUSLA is on their back, and they need supervised urines.... that whole aspect, which is really so degrading for them. [...] Somebody comes in with a dirty urine and they can't explain it and I say well I can't explain it either, but it has to go down on the chart and when TUSLA come looking it will be there. So, I suppose it's that kind of a ..., so I do my best to just you know have a relationship with them that's equal in every other way [RP11].

Another GP praised the Inclusion Health Service for its nimble and far-reaching services to drug addicts, and got a lot more satisfaction from working as a team member than as a solitary GP:

I could do the medical bit, but it would be far less satisfying. [...] There's much more to intervention than the methadone. But it's better than, it's certainly miles better than nothing but it's not as good as it could be, by itself [RP16].

Here, RP16 emphasises the importance of relational care, asserting that while methadone is a very useful drug in treating opiate addiction, its effectiveness is greatly augmented if prescribed by an engaged, caring healthcare practitioner.

In a medium-sized rural town, an ageing patient population requires a different kind of advocacy. Eight rural GPs spoke about caring for elderly people in their practices. Ageing-in-place is the goal of most healthcare systems. Not only does

it cost less to the exchequer, but it's what ageing people want (Grove 2020; Finlay et al. 2015):

I would like to think that the letters that I provided down the years, seeking grants – for example, home improvements are huge around here, because the *Named Region* is traditionally quite poor compared to *Elsewhere*. [...] So elderly patients will often look for things that maybe others take for granted, like downstairs toilets or downstairs showers or maybe extra access to their homes [RP31].

5.5.1 Primary carer providing secondary care services

GPs complain that in the absence of timely access to secondary care services, GPs must 'up their game' and try to provide medical care that would usually only be provided by a hospital specialist. The existence of a team of Clinical Leads in the ICGP suggests a tacit understanding of such need. In Chapter 4 I quoted RP21 and their dilemma about relieving acute urinary retention in elderly men in a remote rural area. In this instance, if the GP relieves the patient's discomfort, they thereby becomes their urologist. They gave other examples about where failure to get hospital appointments for public patients with varying conditions turned this GP and their rural colleagues into a rheumatologist or a psychologist. RP24 had a similar complaint, saying that they had begun doing skin biopsies for patients with lesions that looked suspiciously like malignant melanoma. This malignant skin tumour metastasises quickly and if not diagnosed and treated early, may have a fatal outcome. Rather than have the patient wait months or years for an out-patient appointment, RP24 does a surgical excision biopsy, sends the sample to pathology services in the local hospital 60 kilometres away and on receiving the result, can write an urgent letter to the hospital service with the diagnosis already made. RP27 expressed astonishment that they now regularly provide complex care for diabetic patients who may be taking up to four drugs for their illness.

Although most GPs in this research only treat a small number of private patients, those who do railed against the inequity of access to secondary care. RP28 told me what comes between them and their sleep:

The injustice, and it's the patient not being seen because they can't afford it, that drives me insane. [...] People who can't afford private care are paying for it because they can't get it any other way. That comes between me and my sleep, it's just unjust and it's morally wrong [RP28].

In 2024, the Minister for Health investigated doctor productivity in hospitals at a granular level. Historical precedent had allowed consultants holding a public contract to divide their time between their public patients and their private patients without accountability. In 2023, however, he introduced a 'Public-only Consultant Contract'; by March 2024, '1,923 consultants (45%) had signed the new contract' (Department of Health 2024). This 'enables the move towards universal, single-tiered healthcare, where patients are treated on medical need rather than ability to pay' (ibid.). It is hoped that this initiative will free up hospital resources – beds, staff, plant and services – for patients in the public sector and reduce waiting times. The landscape of secondary care ought to improve accordingly.

5.5.2 Child psychiatry services

The care of children who required psychiatrists' care elicited the most distressed responses from GPs. They recounted harrowing case histories of child patients who had been brought to them by worried parents. Their upset was caused by knowing that the patient needed immediate access to psychiatric evaluation and treatment and their concern that this would not be available in a timely manner, or at all. Cases they described included childhood autism, developmental delay, learning difficulties, ADHD (attention deficit

hyperactivity disorder), anorexia in older children and suicidal ideation, mostly in teenagers.

CAMHS is the HSE's Child and Adolescent Mental Health Service which 'applies specifically to services that provide specialist mental health treatment and care to young people up to 18 years of age through a multidisciplinary team. To access CAMHS you need to be referred by your GP' (HSE 2024b)

Eleven GPs complained about the failure of CAMHS to provide adequate service. Two said that their comprehensive letter of referral to CAMHS was rejected, citing the specific reasons they had given for referral in their letter as the reasons why CAMHS would not take on the patient. I have already quoted GPs who say that in their practice, with a high prevalence of marginalised patients, the incidence of children needing psychiatric care is above normal. When secondary psychiatric care is not available, the GP must ramp up their advocacy in the hope that a solution can be found for the patient and their family. NEPS (National Educational Psychological Services) is the psychological service of the Department of Education, not available to GP referral:

They won't see anybody over the age of six, they refuse to see anybody beyond the age of three and a half. Because they weren't going to get to see them on the list anyway. And they won't see anybody before the age of two, so they had their window down to ..., it was just awful. [...] NEPS doesn't speak to us. [...] The school principal is the pathway. But by the time we've reached January, February the school has usually used all its slots, and your child could be swinging out of the ceiling and isn't going to get seen [RP27].

So at the moment I just see these parents with children who have some kind of behavioural abnormality which may or may not be on the autistic spectrum. May or may not be ADHD, would almost certainly benefit from an SNA at school. And the CAMHS won't see them. [...] 'No, no, we are not seeing your patient and we are not going to help you because your patient doesn't fit our criteria.' You know, I could count on one hand the number of CAMHS referrals that have been accepted in my twenty-five years [RP10].

Two rural GPs said that the CAMHS service in their counties was relatively good and praised the psychiatric team leaders by name. Two other rural GPs construed the problem of access as being due to manpower shortage:

RP 29: They have difficulty recruiting psychiatric nurses, social workers, occupational nurses. So, the team is never full. So, a team that only has sixty percent of its staff struggles to supply service.

CH: Meanwhile you have the little patient.

RP29: Yeah, and what happens, which happened in Co. Kerry (*where there was a publicly aired problem*) was that junior staff are unsupervised (Phelan 2022). They can't get a psychologist. They can't get talk therapy. So, they are pressurised into prescribing. And as GPs you're a gatekeeper to prescribing, so another aspect of general practice is ninety-five percent of prescriptions [...] end up travelling through my surgery. So, I would be very conscious of teenagers being over-prescribed. If that was the case, I'd be aware of it because I now have to write the next prescription and when I sign that prescription it's my prescription.⁷⁵

All of the above illustrate where a GP's attempts to use established referral pathways for secondary care see the unfortunate patient volleyed back into primary care, requiring turbo-charged GP advocacy. Parr and Philo made this observation in rural Scotland in 2003; little has changed since then (Parr and Philo 2003, 477).

RP29 explains a double-edged doctor's dilemma here: they know the secondary service is inadequate, but their primary care service cannot provide the necessary specialist care for the patient. Then, when an inappropriate prescription is given to the patient and the GP transcribes it in accordance with GMS rules, they take a risk and become responsible for it.

⁷⁵ RP29 refers here to how a GMS patient must bring a hospital prescription to their GP to have it transcribed onto their GMS record. Once this is done, the state pays for GMS prescription medications.

5.5.3 Transitional care

In an ideal world, every doctor who treats a patient would be privy to the details of their medical history. This would save a series of healthcare professionals having to take a patient's history repeatedly and would avoid the potential calamity of a patient, who is sick, forgetting to mention that they have a drug allergy, have had an adverse drug reaction, or forgetting the names of their tablets or previous procedures. Conventional professional courtesy requires that when a patient goes from the care of one doctor to another, they carry a letter of referral which details their case. GPs complained that when their patient goes to hospital, has procedures done and is prescribed new medication, they frequently leave without a 'discharge letter' which ought to inform the GP of changes.⁷⁶ Then, patients who are not medically literate arrive at the GP's, asking the GP to rewrite the prescription on a GMS form, so that their medications are paid for by the state. GPs need to be alert to the possibility of a hospital doctor's not being aware of a patient's foregoing medications:

Transitional care, the transfer of the patient from primary to secondary care and back again, [... causes] problems with *Named Hospital* ... Their discharge letters are poor. [... Seeking an explanation for] a horrendous prescription [...] for a patient [...], I got this junior HD⁷⁷ on the other end of the phone ... – 'What do you expect me to do? I don't have time' ... and I said – 'Well what do you expect me to do? You're asking me to prescribe massive doses of morphine to a patient who's well known to have an addictive personality and has a history of drug abuse.' – 'Oh!' And she said – 'Well I don't have time,' and I said, 'Well I think you're going to have to make time,' and she said, 'I just don't have time, and I said 'Look, don't take this personally,' I said, 'I can't do this prescription until you tell me what's wrong with my patient.' And she said, 'Oh my God,' she said, 'You're working in the dark.' And I said, 'Pinnnnngggg!' So, she did tell me over the phone what the story was and why and, yes, they were going to keep a

⁷⁶ I have already referred to the problem with discharge letters in section 4.4.1.

⁷⁷ HD: house doctor. Non-consultant hospital doctors are colloquially referred to a Junior House Doctors or Senior House Doctors, depending on where they are on their postgraduate training schedule.

really close eye on this. But it was ... that is the worst thing, absolutely [RP28].

Transitional care, although not identified as such, is spoken about among patients who have recently been discharged from hospital and among their carers. Irish GPs who await the patient's discharge summary after they have been treated in hospital frequently have to 'work in the dark'. In other European countries every citizen has a unique patient identification number and an online file on which their medical history is entered. The NHS in the UK has used this kind of record keeping since systems were digitised. The French Carte Vitale affords the same accessibility. Before a patient leaves the care of one doctor to go to another, the first doctor must enter all significant medical, surgical, psychiatric and obstetric events on their record along with any changes in prescribed medication and the reason why the prescription was changed. Should the patient have a medical emergency when away from home, any doctor in the country can log on and see their entire history. This prevents duplication of tests, long delays in diagnosis and dangerous drug interactions.

Continuity of care is registered by a terminology that incorporates legal as well as medical considerations. In our contemporary climate of individualism, people speak in the first person about their health and healthcare and may reject the idea of being somebody's 'patient'. But the term 'my patient' signifies a doctor's legal duty of care. The contemporary use of terms such as 'service provider' and 'service user' in the place of the traditional 'doctor' and 'patient' belies the legal duty of care incumbent on a treating doctor at any time. If, for example, a patient has an acute appendicitis and is admitted for emergency surgery, that patient is temporarily 'under the care of' the operating surgeon. Once discharged from hospital, the patient is given a follow-up appointment for review by the surgeon six weeks later, this being the conventional time period for full recovery after uncomplicated surgery. If the surgeon is satisfied

that the patient has recovered fully, they then 'discharge the patient back to the care of their GP' and write to the GP to inform them of this fact. One RP described how, when they did their post-graduate training in Edinburgh, all discharge letters were written by the consultant. They complained that discharge letters are now written by the newest doctor in training. While this may be adequate in the case of a person who has an uncomplicated appendectomy, it is worse than useless in the case of a patient with multimorbidity. GPs in this research understood how overworked junior hospital doctors are but need the patient's discharge letter so that they're not 'working in the dark' [RP28]. Humphries et al. have described the onerous working conditions of hospital doctors (Humphries, McDermott, et al. 2019; Humphries et al. 2020; Humphries et al. 2022). RP21 illuminates the GP perspective:

RP21: And it's not that it's necessarily being facilitated by the consultants, because the consultants, if you bring it to their attention, they cringe when they see some of the letters being sent by their SHOs (Senior House Officers). It's being done by people who don't know the nature and the effect of what's being done in general practice.

CH: Well, they need to be taught, aren't they in a teaching post?

RP21: Yeah.

CH: Shouldn't they be taught?

RP21: I've a feeling that the teaching is not happening. There's a disintegration of teams in hospital. With the working time directive being brought in, the identity of an NCHD (non-consultant hospital doctor) being part of a team or being an SHO2 or a registrar 2, that's gone. They're now becoming the SHO who is on tonight. They cover anything and everything. They'll do the acute admissions, and they don't actually have any longitudinal responsibility to that patient [...]. The patient will then get nominally admitted under a consultant, but [... the consultant's team] has to be gone once their 39 hours (per week) are up. So, we're getting discharge letters out with nobody's name as the responsible consultant on the discharge letters.

CH: So, you have nobody to get back to?

RP21: We don't. And it always appears to be the issue when there's something to be got back about, can we not find out who was the actual responsible clinician.

This lament by RP21 refers back to their own training when a doctor in training belonged to a team led by a consultant who taught, modelled and required specific modes of best practice. The directive they refer to is the European Working Time Directive (2014) which was implemented to ensure that no doctor would have to work a single shift longer than 24 hours (HSE 2017). It also serves as a reminder of the type of clerical work that GPs must do outside their consultation hours.

This is yet another example of how regulatory change has unforeseen consequences that irrupt continuity and butcher the landscape of patient care.

5.6 Self-care

Before the 1980s, the traditional model of a GP was a male doctor, married with children, often to a nurse whom he had met while doing his undergraduate hospital training. He bought a house and 'put up his plate' at the front, indicating to all that he was now in practice as a GP. His surgery was either in the converted sitting room at the front of the house or in a converted garage to the side. In due course, he and his family would buy another house to use as the family home while the first house was modified into a general practice building. Four RPs grew up in such a family home and followed their fathers into general practice. The concept of self-care was not articulated at the time: the GP's wife answered the phone around the clock, triaged the patients if she was a nurse, ran the house and raised the family. In these four cases, their mother did not work outside the home even though one was a qualified doctor. These women cared for their husband in his working life which entailed being on-call between

every night and weekend and one in three or four, if neighbouring GPs could be found to agree an on-call rota. Demographic changes now produce more women doctors who, if they marry and have children, have a two-career household. Nine RPs in this research have spouses who are doctors; three work in the same practice as their spouse. One RP stated that ‘at the height of our childcare needs we were buying in fifty-six hours of labour (per week) into the house’ [RP30].

Morbidity in doctors is well documented. For many practitioners, suffering, whether it is personal or witnessing it in others, is the origin of their motivation to pursue a career in medicine. It sadly can also be the reason, if left unchecked, that doctors are more vulnerable to the stressors inherent to medical practice (Gerada 2021, 80).

Gerada also sought professional help, recruited peer support, learned mindfulness and meditation and spoke out publicly about her illness, becoming an advocate for other sick doctors. She also introduces the concept of the ‘wounded healer’, a physician identity that may be conflated with martyrdom, a term used by three RPs:

The idea of the ‘Wounded Healer’ dates back to antiquity. Plato, the founder of Western philosophy, considered the most skilful clinicians to be those who had suffered from all sorts of illnesses. The psychoanalyst Carl Jung considered the wounded to be one of the human archetypes (Gerada 2021, 72)

Every year, the Irish Medical Council is made aware of doctors who have become psychiatrically ill and have developed alcohol or other drug misuse. It recommends that, long before ill health occurs, every doctor ought to have their own GP. This advice is based on the research finding that 40% of doctors in Ireland do not have their own GP and thereby, miss out on all the preventive care available in a continuing doctor/patient relationship (Bowers 2021). The

IMC provides a confidential service to those who need it, through the Practitioner Health programme (Practitioner Health 2023). In 1985, the Sick Doctor Scheme was founded by the IMO, ICGP, Irish College of Psychiatrists and GP Wives' Association to help doctors in practice who were victims of substance abuse. Dr Andrée Rochfort has been the Director of the Health in Practice Programme at the Irish College of General Practitioners (ICGP) since 2000. A newspaper article in 2005 highlighted her views on GP illness 'They tended to deny their own symptoms and illnesses, and delay seeking help or advice as well as self-diagnosing, self-investigating, self-prescribing and self-treating' (Shanahan 2005). During my time as a GP, 1984–2000, I was aware of several cases of colleagues who treated themselves with adverse outcomes, including the death of one colleague in mid-career.

Research questions in this project did not include any direct questions about GPs' health. However, ten RPs mentioned burnout in response to questions about quality of life or what drains them. One had experienced it in the recent past and had completely reconfigured their working life in order to prevent its reoccurrence. Three said they had 'not yet' had burnout. In response to research question 3: 'What aspects of your everyday practice drain you?' one RP gave vent to their feelings in the following stream of consciousness:

An awful lot drains me. The work hours drain me. I would often have to work twelve-hour days and go home to walk the dog and cook dinner with my partner and then apologise and go back to work. That's a normal day for me. This weekend I spent all day Sunday working and on Saturday I did an out-of-hours shift and I did about three hours of work. It's enormous, the workload as a GP. I wasn't a GP twenty years ago, but I gather medicine has changed significantly. Our computer systems and our electronic health records which are great in some levels have made us slaves to work. And to make sure that there's continuity and that everything is documented in the right way and the multitude of pathways and guidelines and then medications that are new that all require their own monitoring and blood monitoring and hospitals that mandate blood monitoring and that all funnels, as it should do, into where patients present in the community. And

that multimorbidity and polypharmacy that we generated as a discipline, as a profession over the past thirty years is managed, that continuity is managed in general practice and with the complexity of social problems, COVID and homelessness that's funnelled into general practice. And organisations and systems and HR around all that complexity and the staff and the problems with staff that happen around that and the more administrative staff that now come because we have e-mail and text messages and phone calls and a medicolegal system that mandates, and a complaint culture and Google reviews it means that ... I wasn't a GP twenty years ago and GP has always been challenging but it is a completely different and utterly changed job that is brutal and cruel in its hours. And what it mandates from the GP to be a good GP, to have that continuity of care and access. So, setting up a practice in the past few years is great, and I'm so proud but it's not without massive cost. And massive cost to my personal life and my free time, my physical health and probably my mental health. So, I don't like that about the job, how bleak it can be. And I say that as a resilient ... this terrible word ... a resilient person who half thrives in this thing which I have to sort out in my own head [RP14].

This account meets several of the criteria for incipient burnout in the Maslach Burnout Inventory; excessive workload, lack of control, diminished reward, and failure to manifest values (Montgomery et al. 2019, 4). The other two criteria, not mentioned above, are lack of fairness (from employer) and lack of community support. Since GPs are self-employed doctors who contract their services to the HSE, neither RP14 nor any other RPs complained about their employer. Elsewhere in the interview, RP14 explicitly praises the practice team for their support. It follows, therefore, that exhausted GPs blame themselves and self-stigmatise, as Gerada suggests:

The shame doctors feel when they are unable to meet targets is compounded by them being blamed for not being resilient enough, thereby shifting the blame and shame to the individual rather than addressing the working conditions that caused their distress (Gerada 2021, 67).

Eleven RPs said that they rely on regular exercise, running, cycling, dancing or yoga to maintain their physical and mental health. One rural GP said that every GP in their practice had run a marathon. One takes refuge in music and the arts and three take solace from mindfulness meditation. According to one RP 'everyone should have a supervisor'; this GP sees their supervisor every four

weeks to ‘process things’ and finds these meetings very supportive. In what follows I include clinical workload, portfolio careers and supports received by GPs under the heading of self-care because, following Goffman, in order to present themselves as the best GP they can be, these are the forces they must contend with (Goffman 1990).

5.6.1 Clinical workload

This section is necessarily brief because GPs did not focus on it at interview. Answering research question no.2: ‘What aspects of your everyday practice give you satisfaction?’ they mentioned making a difference, doing procedures and continuity of care. Occasionally they would light up when describing making the diagnosis of a patient’s illness. Consulting with patients is what they like to do most: it’s why they chose to be a GP, it’s what they’re trained for, it’s where they experience ‘flow’ (Csikszentmihalyi 1997). Apart from recounting case histories (mostly redacted) to illustrate a point, they generally spoke about the other work that had to be done to arrive at the consultation with a clear head. In order to ensure that patients receive proper care and that all the follow-up ‘paperwork’ is completed satisfactorily, GPs attempt to tailor their working hours to balance their personal and professional lives. Crosbie et al. surveyed Irish GPs in 2019 and found that

The mean duration of a two-session day (excluding break-time) was 9.9 hours. Of this time, 64% was spent on clinical consultations. In total, 25.4% of activity was recorded outside the hours of 9.00 am and 5.00 pm. An average of 12.4 face-to-face consultations were completed per session of activity. The mean duration of a 10-session week was greatest for the partner and >55-year-old demographics, relative to their respective colleagues (Crosbie et al. 2020, 1).

In a 2023 study, Johansson et al. found that ‘to apply all guidelines for preventive care, chronic disease care and acute care ... US primary care physicians would require up to 27 hours in a working day’ (Johansson, Guyatt, and Montori 2023, 1). In this research, RPs spoke consistently about the

demands on their time made by 'paperwork'. At the time of writing, Blease suggests that only the judicious deployment of AI will make it possible for doctors to stay up to date and still provide good clinical care (Blease 2025). In order to maintain the humanity of the consultation in the future, GPs must deploy AI as a tool while foregrounding their own, human agency.

RPs employ varying strategies to cope with their workload. Only one GP worked nine clinical sessions per week, taking a half-day mid-week which was often taken up with clerical work. ten work eight clinical sessions per week, twelve work seven. In group practices, GPs often work equivalent numbers of clinical sessions and use the other sessions in the week to work outside the practice.

5.6.2 Portfolio careers

Off-site activities mentioned by RPs include research, academic teaching, seeing patients in a niche group at a different location, representation on a GP body such as the IMO, ICGP or Medical Council, representation to the Houses of the Oireachtas, managing an out-of-hours GP service, formal advocacy at groups such as Safetynet or Deep End, medical journalism and broadcasting on local and national radio. Rural GPs involved in representation travel long distances to meetings, but none complained: they find that meeting their 'tribe', discussing problems and forging solutions recursively empowers their day-to-day practice. The term 'portfolio career' (already referred to in Section 4.4.5.4) is usually applied to young GPs who choose how many sessions they work per week and where. It works well for women GPs in their childbearing years when they want to work part-time and are not yet prepared to commit to full-time GP work or to becoming a partner in a GP practice. Six RPs spoke about portfolio careers. Two early-career women GPs mentioned it; one, to say that it suited her

lifestyle at the time and the other, to say that she had considered it but reckoned that a GP partnership gave her enough variety in her working life and provided more continuity for her patients. Four end-career GPs mentioned it to say that towards the end of one's career, everybody does a portfolio of jobs if they can. Three others lamented the perceived lack of commitment to general practice by young GPs. RP27 found that assistants and locums were prepared to consult with the patients but not to do the follow-up paperwork:

Many of our assistants [...] won't touch any of that work. They saw it on the [training] scheme [...] and they said – 'No way am I ever doing that. We [...] will do half-days, portfolio careers.' [...] I see my five-man practice colleagues dreading each other's holidays [RP27].

An end-career rural GP praised a young woman GP who sometimes provided locum cover for themselves and their neighbouring colleagues:

There's a GP in *Nearby Town* and she does three days in the practice, and she does CME in university for two days. She's supplying an excellent service but she's not doing what we did. I wouldn't do it again [RP29].

One GP was scathing in how they observed well-trained GPs from reputable post-graduate training schemes opting for part-time work and declining to become principals in a practice and gave examples of young GPs declining to do follow-up paperwork on patients they had seen, saying 'young doctors have a narcissistic, self-serving culture now' [RP12]. This GP has given their all to the marginalised people in their career over four decades; other GPs, like RP29, cited above have done so too, but would not do it all over again. General Practice has changed significantly from the 'single-handed' model of the 1950s and '60s. This research has shown that late career GPs who gave their all to their professional commitments realise that it took its toll on their personal lives. One rural GP said, 'none of our children have gone into medicine, doesn't that tell you everything?' Trainee GPs witness these working practices and abrogate them by walking away from offers of partnership. The implications for

the primary care workforce of these findings are significant and will be discussed further in the concluding chapter.

5.6.3 Supports received by GPs

Up to this point, I have given an account of the care given by GPs to their patients and communities. In this section I describe the supports that GPs receive, without which they could not deliver primary care. Question No, 8 asked each RP 'Working on the front line of patient care in the community, who gives you support?'. Thirty-one RPs gave full and varied replies that depict a scaffolding of their work, their person and their commitment to patients. Two hundred and ninety-two codes in thirty-six files (thirty-one interview transcripts and five fieldwork memos) detailed their supports. Their anecdotes, told to emphasise a point, wove further acknowledgment and appreciation of their supporters into the research. Milligan's term 'landscapes of care' captures RPs' lived experiences very well. Whether their marginalised patients dwell in urban or rural locales, they need a primary care service from cradle to grave, at home and at work, for therapeutic and preventive purposes.

Landscapes of care are multilayered in that they are shaped by issues of responsibility, ethics and morals, and by the social, emotional, symbolic, physical and material aspects of caring referred to above. This includes support, services and the spatial politics of care (Milligan and Wiles 2010, 740).

While some late career RPs identified their practice as 'single-handed', they all went on to use the pronoun 'we' when discussing their practice. The 'I' narrative, formerly the aria of all single-handed GPs has been replaced, in their telling, by the collective chorus. Gilligan's 'inevitable challenge to a patriarchal order that can remain in place only through the continuing eclipse of women's experience' has been wrought, over time, by the feminisation of medicine (Gilligan 2003 (1982), xxiv). Contemporary GPs know they depend on their

supports and valorise them. Credit, in this research, has been given by RPs where credit is due.

All RPs praised their practice teams in superlative terms, identifying them by role, receptionist, practice manager, practice nurses, doctors, and often by name. 'I couldn't manage without them,' was amplified by saying that most of their staff had worked there for as long as the GP could remember [RP11]. Then they paid tribute to their spouses, partners and families. Beyond the practice building, community healthcare workers such as the public health nurses, social workers, the community mental health nurse and local pharmacists were identified as great supports. Some Nursing Home staff were singled out, but not all. GPs who worked in organisations like Safetynet, Merchant's Quay, the Simon Community, the Capuchin Clinic and other facilities for homeless or substance dependent patients, or who collaborated with hospital-based Inclusion Medicine services sang the praises of their co-workers in these organisations. NGOs who work in care for homeless persons were mentioned in glowing terms, always with a comment about how caregiving to marginalised patients was teamwork and couldn't happen any other way. RP10 glowed when describing how they found their 'tribe' among the Deep End GPs, Glasgow, and went about setting up Deep End Ireland. Ten other GPs are members of Deep End Ireland, and it is at these bi-monthly meetings that they can discuss cases among kindred spirits, forge relationships and plan their advocacy. Fifteen GPs are or have been GP trainers and name the GP Trainers' group as one of their main supports. 'Care-ful geographies' and 'geographies of caregiving' thrive more in a teamwork environment than in single-handed practice (Milligan and Wiles 2010, 749).

Mandatory CME provides the impetus for all GPs to meet their colleagues at least once a month. These meetings occur in the evening, sometimes near home,

sometimes up to an hour's drive away, in rural Ireland. While there is usually an academic focus, the social aspect is very important to people who work in silo-like conditions all day. It also provides a forum for asking a colleague's opinion about a case: 'What would you do?' While the Irish Medical Council is responsible for accrediting the registration of doctors every year, based on their CME returns, among other things, the CME programme is organised and run by the ICGP. Each faculty has a tutor and many RPs in this research named the CME tutor's group as a great support.

WhatsApp groups have become very popular among GPs over recent years. The campaign to 'Repeal the Eighth' (article of the Irish Constitution) and legalise abortion galvanised GPs in favour of it to begin communicating with each other via WhatsApp. The group had members from all over Ireland who are still in touch. The COVID-19 pandemic drove most lines of communication online. RP07 joined a WhatsApp group of GPs who wanted to try to stay abreast of newly evolving scientific information and was astonished at some of their colleagues' capacity for reading. The trophy for online support during the pandemic went, however, to the ICGP's weekly webinars. It is worth reiterating that over two thousand GPs regularly logged on to the weekly Zoom webinar after a full day's consulting. They also relied on the College website, updated twice a day. The IMO received plaudits too, for its excellent representation of GPs when negotiating terms with the HSE for extra COVID-19 related services, such as vaccination.

Hospital doctors and consultants received scant mention in reply to a question about GP support. Inclusion Health staff are the exception. Dr Clíona Ní Cheallaigh, a consultant in St. James' Hospital, Dublin explains:

People who are homeless or in addiction are often excluded from society and are much sicker than the general population. As a healthcare system, we're not great at

dealing with this vulnerable group. Inclusion medicine takes the view that it's the healthcare providers' responsibility to make sure that everybody feels included, can come into clinic, and that we're not leaving the responsibility on the person (Merchants Quay Ireland 2019).

RPs who work in Dublin feel they have access to the secondary care their patients need through the Inclusion Health services. Other cities are not so lucky.

HSE services that have made a difference in areas of deprivation include the HSE Winter initiative, the Covid initiatives, GP access to diagnostics during the pandemic, the Grant for Areas of Deprivation and the Drugs Task Force. One GP gave fulsome praise to HSE staff members in these areas; a small number of GPs had formed working relationships with named HSE personnel and found them exceptionally helpful, lamenting the fact that the 'good ones' always got promoted away from patient care. The Chronic Disease Management programme has already been described and is valorised by all RPs. In a comment about how they missed meeting their GP colleagues during pandemic restrictions, one RP described GPs as 'a feisty, eccentric bunch'. A thread that ran through all the interviews where RPs told a story of perceiving need, perceiving the obstacles to serving those with needs and recruiting a team that would care for those in need could be named as social entrepreneurship. In such a situation, several GPs found kindred spirits among HSE workers, civil servants and named elected representatives with whom they worked tirelessly and who will never be adequately acknowledged for the work they do.

Among the other, personal supports that GPs rely on are friends from college, extended family, friends, neighbours, mothers of their school going children's friends. Help in their home, provided by childminders and housekeepers is a *sine qua non* for RPs who are parents. In the local community, GPs find great support, vocal and tacit, from shopkeepers and residents. While visiting a local

supermarket with RP21, the owners discussed 'the news of the parish' with him, telling the GP who was well, who was not, who was in hospital or had lately been discharged from hospital, and what their home carers were saying. This conversation served to determine the order of RP21's home visits that day, and probably always. It was a moving example of a living landscape of care, sensing, pulsing, communicating, responding, manifesting the relational nature of general practice. Although I did not witness it, I heard similar stories from five inner city GPs who go looking for their marginalised patients, to prevent them from 'falling through the cracks'. The patients regularly show their appreciation of GPs' care too, by thoughtful courtesies and gestures as their paths cross in everyday life. In all the doctor's surgeries I visited, there were Thank You cards pinned to a cork board or standing on a shelf.

Lest this appear like a hagiography of GPs, I refer the reader to the design of this research in which I sought only GPs who provide primary care for marginalised people. As I have already mentioned, five RPs in this research have felt quite alienated from their GP peers in common settings such as CME and local groups because when they raise the concerns accruing to their patient population, colleagues lack the lived experience and capacity to understand that lifeworld. So, they find GP support groups such as Deep End Ireland or a like-minded CME group for support. An alternative research focus on, perhaps, GPs who care for middle-class patients, would elicit very different narratives. Writing these words causes me to ask what is the opposite of marginalised? Legitimised? And if so, have we unknowingly carried and perpetuated the Victorian ethos that drafted the 1834 Poor Law in England and Wales, which created the binary opposition of deserving and undeserving poor? I will attempt to answer this in the concluding chapter.

5.7 'Care politicises you'

GPs do have different politics and values like the rest of society, and I think even there's something about doctors who want to look after more vulnerable groups that's really satisfying and challenging. And if that doesn't politicise you [...] I wonder if people are really listening to the patients [RP14].

RP14 went on to say that they supported political positions conventionally interpreted as left-leaning. Dr Michael Harty, a GP and TD from West Clare, is the most recent medical doctor elected to Dáil Éireann. The history of Irish medical practice is replete with doctors who distinguished themselves as advocates for the poor, too many to include comprehensively here, some documented in the literature review chapter.

Following the worldwide economic crash in 2008, austerity measures known as FEMPI⁷⁸ were introduced across all sectors. Two particular measures had severe impact on the viability of rural practice: removal of the Distance Code which remunerated GPs for travelling to visit people at home, and removal of the Rural Practice Allowance. Estimates of the income deficit varied between 24%-38% (Ring 2018). As the Irish economy recovered, GPs noticed that FEMPI was reversed gradually in the pay and allowances for civil servants while they waited till 2022 for reversal. The non-replacement of rural GPs on retirement is another workforce issue which exercises GPs who 'don't know what will happen to my patients when I'm gone'. This shows the degree of relationship with a community that GPs develop over decades of practice.

I asked all RPs to what extent they concerned themselves with the social determinants of health (SDH). Twelve said that they were powerless to deal with anything outside the one-on-one consultation, that after allowing

⁷⁸ Financial Emergency Measures in the Public Interest.

themselves to get upset or angry in the past, they had decided that this was counter-productive and to channel their energies into the patient in front of them. In the burnout literature, this is known as depersonalisation, 'an adaptive response to intolerable situations' (Gerada 2021, 51) and, if chronic, can be a factor for the development of caring neglect (Montgomery et al. 2019, 2). Three RPs were ambivalent about their role in the SDH whereas sixteen engaged actively with lobbying, writing letters, joining activist groups and setting up services that would make a difference. I have already referred to RP02's prescription of methadone as activism, and these sixteen RPs gave accounts of working with others to set up services for homeless and substance addicted people in the cities, and residential facilities for older, retired people in rural Ireland. To a great extent, GPs who care for marginalised people are full-time, professional advocates since advocacy is woven into every consultation, every day. Despite contending with social determinants of health embodied in their underserved patients, most RPs are not inclined to take a public political positionality. Having heard the extent of their care and advocacy for their patients, I struggle to see where they would find the time without compromising their own wellbeing.

GPs get quite exercised about the prospect of their patients being left without primary care when they retire. One suburban GP had undertaken a twenty-year plan to organise succession in their group practice 'to take care of these people that I love' [RP02]. Rural GPs take the lack of their replacement as a slap in the face, an undervaluing of their life's work. If primary care is transferred to a large, purpose-built primary care, some ten or twenty miles away, who will do the home visits? Will all the patients currently ageing-in-place with the support of family and community have to go into residential care? Recent years have seen private, for-profit companies buy up group practices and replace the

retiring GP with a series of part-time GPs. RP12 explained how this might happen:

We are a family practice, it's becoming corporate, taken over by corporate Ireland. So, the structure of health and general practice in Ireland went from single handed sole practitioners to partnerships and group practices. But they were very much in the heart of the community, they knew their community well and they were known, and they were of the community. And as the complexity has increased, the need to have the support admin, the practice managers, and bigger team has made that financially complex and that has meant that it's not possible really to be in the modern world as a solo, even in a two partner without that complex team. That brings on financial challenges and the private sector has just been swooping in on that. [...]

CH: Are you referring to companies like Centric⁷⁹?

RP12: Yeah, yeah, buying up and people are retiring and seeing that as understandably a nest egg ... and here because we don't have universal healthcare, the private sector is seeing it as easy pickings. And I think the family practice will be gone because the clinician won't be a family practitioner, they will be a general practitioner. They won't know anything about the family, and they won't know anything about the extended family. [...] I think they will be in a big fancy building, and they will have very good hours, and they will have lots of fancy stuff, but they won't necessarily know where or how people live around that fancy building [RP12].

RP12 went on to say that no private investment company would be interested in their practice since it's in a deprived area with hardly any private fee income. Although their practice is in a well-appointed HSE facility, it still worried them that their successors might be under-committed part-time GPs. These observations, once again, lead to the consideration of providing a primary care workforce in the future. The Medical Council's 2023 Workforce Intelligence Report corroborates the findings of this research:

Increasing pressure on GPs is a result of a growing and ageing population, increased patient multi-morbidity, GP retirement, poor morale and burnout (Collins and O'Riordan 2015). There is an urgent need for effective action to tackle Ireland's shortage of GPs, which can potentially impact the core elements of general practice,

⁷⁹ <https://www.centrichealth.ie/>

namely, continuity of care, the doctor-patient relationship and person-centred care (Irish Medical Council 2024b, 8).

Perusal of the financial pages of Irish daily newspapers over the past year provides convincing evidence that the business of private healthcare is now seen as a goldmine for investors. Mercille has alerted us to this trend too (2019; 2023). In her book *Automating Inequality*, Eubanks paints a dystopian picture:

The parallels between the county poorhouse and the digital poorhouse are striking. Both divert the poor from public benefits, contain their mobility, enforce work, split up families, lead to a loss of political rights, use the poor as experimental subjects, criminalise survival, construct suspect moral classifications, create ethical distance for the middle class, and reproduce racist and classist hierarchies of human value and worth (Eubanks 2017, 183).

Just as desertification can happen to land, termination of a primary care service can wither a community. Like landscapes of soil, river and lake, landscapes of care need our attention and our action.

5.8 Summary

The landscape of primary care is being reconfigured on several fronts. People are more likely, nowadays, to consult 'Dr Google' on their smartphone or laptop at the onset of a pain or ache and to use non-evidence-based remedies for their complaints. When they do consult a healthcare practitioner in person, they have usually 'done their research' and do not want to feel rushed by a harassed GP (Garvey and Miller 2021). With the changing demography of general practitioners, older, mostly male, single-handed GPs are giving way to younger, female GPs, some of whom who are reluctant to take the responsibilities of having their own GMS list. A recent ICGP survey highlights the multiple caring responsibilities for children and older relatives self-declared in 2021 by Research Participants, and their consequent preference for a portfolio career (Keenan et al. 2024). Insinuating itself into the workforce deficit between these two cohorts comes the for-profit sector, buying up general practices with a

high number of private patients and financially strong audited accounts (Mercille 2023). Centric-owned practices are staffed in the early days by the GP partners who are working till retirement, who are then replaced mainly by sessional doctors who consult with patients during a defined number of hours with no obligation to stay late. Such continuity of care as may be possible resides in the affordances of the patient's digital medical record, not in relationship between members of the practice team and the patient in their family and social context. Primary medical care is thereby shorn down to its diagnostic and therapeutic rudiments, transactional but not relational. RP12 was confident that 'they won't be interested in buying my practice' since it's in an area of deprivation. But they also lamented that the next generation of GPs is unwilling to work the hours that they and their contemporaries did, and this will negatively affect all the marginalised patients in theirs and in others' practices.

Milligan and Wiles distinguish between *caring about* and *caring for* (Milligan and Wiles 2010, 741–742). The testimonies given by GPs in this research conflate the two, particularly when they give accounts of what comes between them and their sleep: always patient-related, always asking if they could have done more. Nowhere does caregiving become more embodied than when it keeps a person awake at night.

This chapter has drawn on interviews given by thirty-one GPs in which they speak about delivering primary care and their care-giving practices. It gives voice to GPs whose work is often only evaluated by government audit, or by the conversation of patients. It demonstrates the toll that caring for marginalised patients takes on them, how they feel about it, and their concerns about general practice in the future.

Long hours of consulting, of 'paperwork', of advocacy as detailed by Crosbie et al. conflict with work-life balance and are not sustainable (Crosbie et al. 2020). In order for GPs to be able to provide primary care in a relational way, along with the self-care that mitigates burnout, and the family and social life that nourishes them, we need to reconfigure the current model in which a doctor who acquires a GMS list takes on full-time 24/7/365 responsibility for patients but can still get to know patients and their lifeworlds. While policy and financial considerations of this order are beyond the remit of this research, I invite the reader to contemplate the kind of primary care service they have experienced in their own lives, and what they would value in the future. I also invite GPs who despair of the future of general practice as it is currently known to become evangelists for what they know to be best practice primary care.

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Chapter Six: (Auto)ethnography of COVID-19

“May the grass grow before your door”.

Old Irish curse (Carleton 1865, 127–128). This malevolent invocation wishes a lifetime of social isolation on the recipient. Grass grows on a doorstep if there are no visitors.



Figure 0-1: Photo of the front door of No. 15 Usher's Island, Dublin 8. James Joyce wrote his short story 'The Dead' about events around a party here on 6 January, the Feast of the Epiphany, 1904 (Joyce 2000 [1914]). Photo taken by author on 19 February 2021.

6.2 Introduction

The COVID-19 pandemic irrupted all our lives and caused most of my fieldwork to be delayed for sixteen months. General Practice was altered drastically by a novel coronavirus that represented a risk to the lives and wellbeing not only of patients, but of GPs themselves. While it is conventional to observe and record a GP service, such as that which played out in Ireland before the pandemic arrived, it is useful to observe and record what can be learned from the absence of such a service and from its nimble adaptation to an enormous challenge. What was General Practice like for GPs without their regular face-to-face caseload? How did the pandemic change their ways of practising? In order to find out, I asked them.

The WHO declared the outbreak of SARS-CoV-2, the virus responsible for COVID-19, as a pandemic on March 11, 2020. This declaration marked the recognition of the global scale and severity of the disease.

On 5 May 2023, more than three years into the pandemic, the WHO Emergency Committee on COVID-19 recommended to the Director-General, who accepted the recommendation, that given the disease was by now well established and ongoing, it no longer fit the definition of a PHEIC (Public Health Emergency of International Concern). This does not mean the pandemic itself is over, but the global emergency it caused is – for now. Since the COVID-19 pandemic started, over 2 million people in the European Region have died from the disease (WHO 2023).

As demonstrated in Chapter 4, general practitioners become placemakers in several ways: by dwelling in an area, by establishing a healthcare service there, by making themselves available to their community in a known and understood manner and through eliciting stories from their patients. Chapter 4 showed GPs transforming space into place by making people feel safe. Traditionally, their *modus operandi* has played out through face-to-face consultations in their surgeries, in patients' homes, in local nursing homes and factories, in facilities for asylum seekers and in emergencies, wherever these arise. Chapter 5

depicted a landscape of Irish primary care delivered by GPs and their teams. It interrogated the many and varied elements of what it takes to enact primary healthcare such that it benefits the patient and rewards the doctor when they do a good job. The COVID-19 pandemic disrupted all of these regular, time-honoured practices and drove primary healthcare services almost entirely online. In atomising the elements of primary healthcare, the pandemic mandated serial recalibration and allowed us to see what healthcare without personal contact looks like. Whereas it had been my intention to research qualitatively the lived experience of GPs who care for marginalised people and communities in ordinary times, the pandemic and its restrictions interrupted all normality. Isolation drove me into the memory bank of my own earlier but comparable lived experience, providing primary care for prisoners and other marginalised people, eliciting a reverberating moral injury as I witnessed TV accounts of people who died from COVID-19 because they could not get the healthcare they needed. My embodiment as citizen, materfamilias, neighbour, retired medical practitioner and doctoral student imploded and compelled me to *do something*.

At first, pandemic restrictions catapulted me into a state of relative anomie. Greg, my husband, and I have been empty nesters for many years. Like everybody else, we were thrust on each other's company and shorn of all other social scaffolding, family, neighbours, friends, colleagues and the delightful random interactions that enhance our days. The outdoors became our refuge, and, as the days got longer, long walks or daily cycles our Xanadu (Coleridge 2000, 102–104). But my sleep pattern became disturbed: I took to writing long diary entries, committing my observations and feelings to the page in an attempt to earth increasingly frenzied circuits in my head. I now draw on these musings to write an (auto)ethnographic account of the COVID-19 pandemic. Writing during 2020 and 2021 was not only 'therapeutic'; it was both 'process

and product' (Ellis, Adams, and Bochner 2011). Real-time description spilled onto the page. Some reflexivity occurred then; much more, later, when I reviewed diary entries. Analysis supervened as I went through the stages of re-enrolling on the Medical Register, being re-trained (online) as a healthcare worker, meeting Research Participants who worked on the front line, witnessing both the harms done by COVID-19 and the valiant work to curtail its progress, working as a Clinical Contact Tracer and finally, writing this chapter. I have attempted to avoid the 'confessional' style (Van Maanen 1988, 74–81) while remaining true to my discombobulated feelings at that time.

Before fieldwork began, I re-drew my fieldwork questions to include one about how GPs experienced new modes of practice brought about by the COVID-19 pandemic. While I am bound by confidentiality not to identify anybody I engaged with as a contact tracer, I use my reflections on that period as one way to identify the effects of the recalibration of personal care. This chapter, then, is in three parts. First, I describe how the COVID-19 pandemic in Ireland evolved, drawing on my contemporary reflections at a time when I was still a doctoral student, considering the embodied dimensions of primary care. Then, I reflect on what was impressed upon me during my time as a CCT. The focus here is on how an attenuated form of healthcare that is, online consultation, was developed from a rudimentary tool to a nimble, responsive, networked protocol and set of practices. These applied both in the work of contact tracing for the HSE and in general practice as narrated by RPs. Finally, I report on what my interviews with GPs disclosed about healthcare adaptations in their own practices, their affective responses, and the broader ramifications of remote primary healthcare during the public health emergency.

6.3 (Auto)ethnography: January–November 2020

In this section I outline how the COVID-19 pandemic imploded on my awareness, informed the practices of my daily life, restricted my range of movement in space and forced me to reactivate my GP worldview. Whereas my fieldwork was due to begin in Spring 2020, the pandemic not only delayed it but also changed the lived experience of GPs whom I set out to research. However, healthcare was irrupted by COVID-19's capacity for rapid spread with its high morbidity and mortality. GPs, already over-burdened by their regular caseload, winter viruses and manpower shortage would struggle to provide patient care. All I could do was watch and wait, powerlessly.

After Christmas 2019, normal life resumed, both at home and in public. COVID-19 had broken out in Wuhan, China in December 2019 and seemed very remote. A general election on 8 February 2020 returned the thirty-third Dáil. No party could form a majority government, so outgoing ministers continued working in an 'acting' capacity for almost five months. The National Public Health Emergency Team (NPHET) was established on 27 January 2020, and the first case of COVID-19 was confirmed in Ireland on 29 February 2020. The World Health Organisation (WHO) declared a pandemic on 11 March 2020 and the following day, acting Taoiseach, Leo Varadkar, ordered the first lockdown.⁸⁰ Media reporting of rising deaths from COVID-19 across the world alongside scientific ignorance about how this novel virus operated frightened us all into submission. Our acting government stayed in place until 27 June 2020, when a coalition government was formed. From the outset, public compliance with pandemic restrictions was high, as detailed in the Chief Medical Officer (CMO),

⁸⁰ 'Lockdown' is a term disavowed by the authorities, who preferred 'pandemic restrictions'. Since this is an (auto)ethnography I use the term 'lockdown' to describe how I experienced it.

Dr Tony Holohan's memoir (Holohan 2023), the journalistic account *Pandemonium: Power, Politics and Ireland's Pandemic* (Horgan-Jones and O'Connell 2022), and the opinion polling of Amárach (Amárach 2022).

Figures 6.2 and 6.3 below depict respectively the number of daily confirmed cases of COVID-19 in Ireland in 2020 and the number of confirmed deaths from COVID-19 in the same period. The first wave, from March to July 2020, shows a rapid rise to 936 new cases per day on 23 April 2020 and a fall as pandemic restrictions such as social distancing took effect. Restrictions were relaxed in Summer 2020 and as autumn arrived, the second wave, from August to November 2020, showed a rise to 1283 new daily cases on 18 October 2020 that was mitigated by the introduction of harsher restrictions. A third spike in December 2020 represents a high incidence of cases due to social mingling at Christmas, exceeding the peak of new daily cases from the second wave in October and reaching 1720 new daily cases on 30 December 2020. The third wave ran from late November 2020 to June 2021. The chronology of deaths (see Figure 6-4) shows the same three peaks, but deaths were at their worst during the first wave, reaching seventy-seven on 20 April 2020, a little over seven weeks after identification of the first Irish case on 29 February 2020. Our friend and neighbour died from COVID-19 on 19 April 2020. It was a sorry occasion as his funeral cortège drove past his home, friends and neighbours lining the streets while observing two metre social distancing, chanting the Gaelic lament 'Mo ghile mear'.⁸¹ COVID had robbed us of a wonderful man, and of the chance

⁸¹ 'Mo ghile mear' is a lament, written after the defeat of Bonnie Prince Charlie at the Battle of Culloden, 1746 <https://www.youtube.com/watch?v=zxjvNUNXhkU> . Translating from Irish to English, 'Mo' = my; 'ghile' is the vocative case of 'geal', meaning brightness; 'mear' = swift. I was taught in National School that this song was an ode/love song to Bonnie Prince Charlie, envisioning his return, by sea, to wrest Scotland from English rule.

properly to wake, bury and mourn him. Returning to our carceral homes we were bereft and frightened.

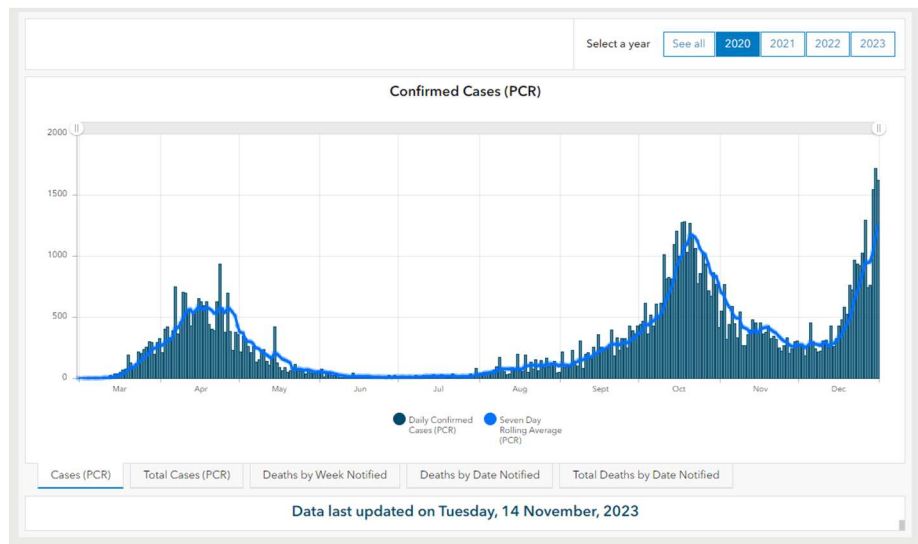


Figure 0-2: Graph of confirmed cases of COVID-19 in the Republic of Ireland, March-December 2020.

Source: covid19ireland-geohive.hub. Available at: <https://covid19ireland-geohive.hub.arcgis.com/>

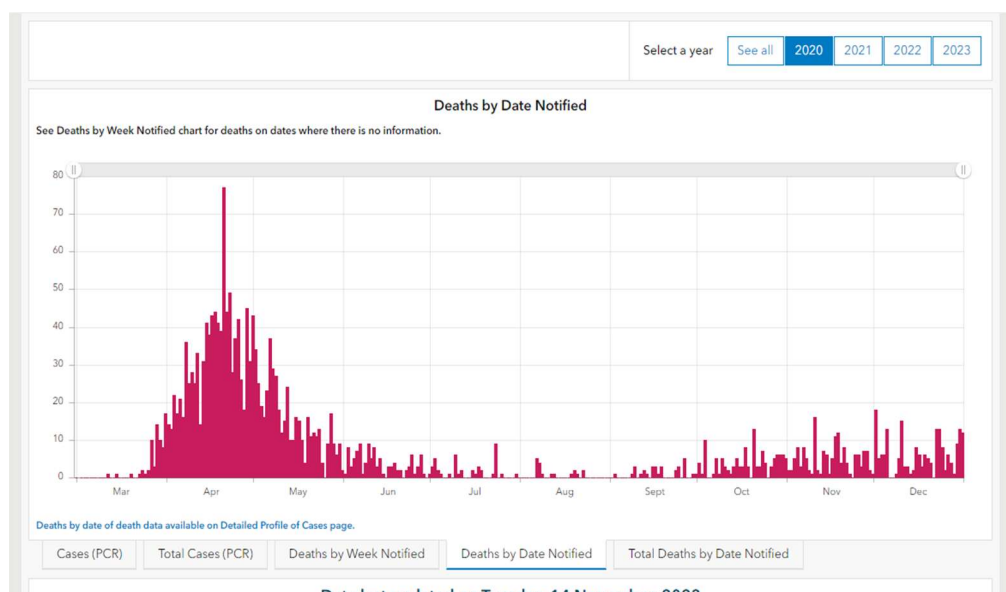


Figure 0-3: Graph of confirmed deaths from COVID-19 in the Republic of Ireland, March-December 2020.

Source: covid19ireland-geohive.hub. Available at: <https://covid19ireland-geohive.hub.arcgis.com/>

6.3.1 Two sick daughters, abroad

Two of my daughters became ill in the third week of March 2020: Alannah, in London, got COVID-19 and Eimear, in Brussels, got mumps. I was worried and powerless: both were very unwell, and I could not travel to take care of them. The importance of face-to-face care was starkly highlighted for me by its being forbidden. Since none of my adult children have followed a medical or paramedical career, I have always preferred to show up in their presence when they're not well; being in the room and sensing their wellbeing gives me far more insight than words on a phone, e-mail or video call. Help was at hand, however. An article in the *British Journal of General Practice* provided a protocol for evaluation of breathlessness over the phone (Greenhalgh, Koh, and Car 2020) and the HSE published a flow chart for the evaluation of patients suspected to have COVID-19 (Figure 6-4). These proved very useful.

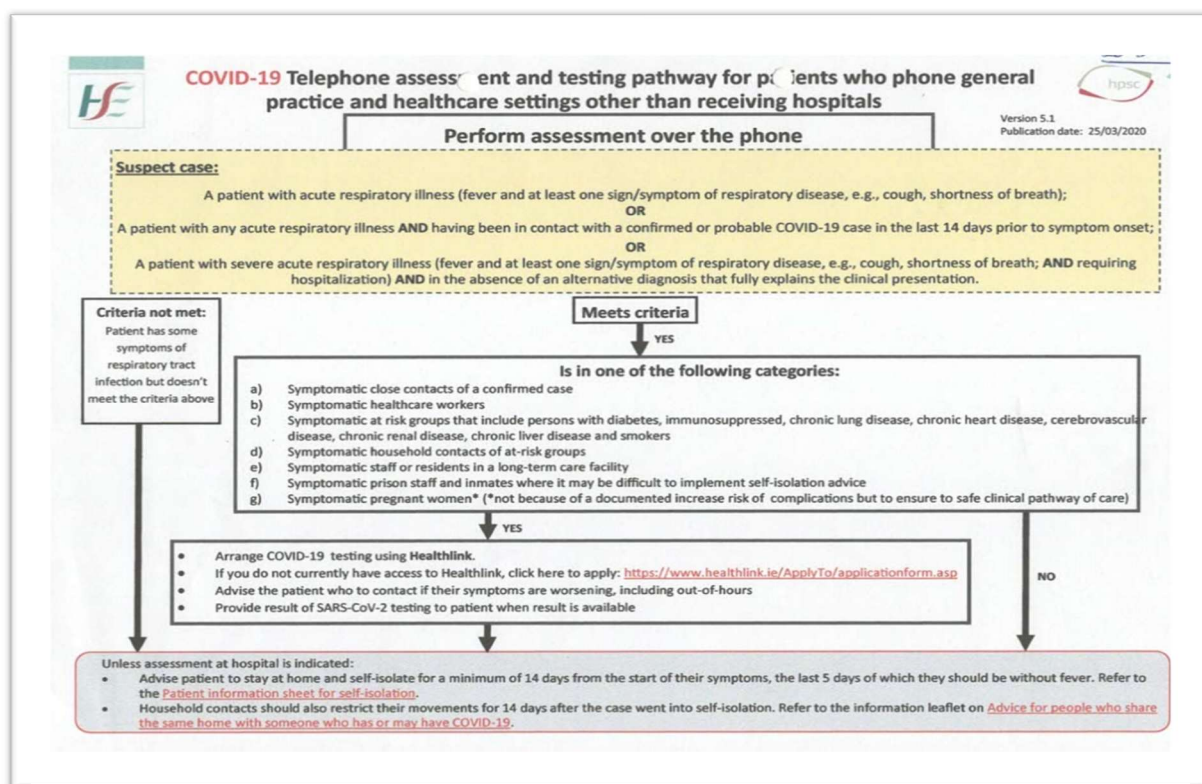


Figure 0-2: HSE protocol for COVID-19 telephone assessment and testing pathway for patients who phone general practice. Version 5.1 Publication date 25/03/2020

I advised both my daughters to buy a pulse oximeter⁸² and thermometer immediately and to record their measurements and send them to me several times a day, so that with the help of the HSE diagnostic flow chart (see Figure 6.4) and Greenhalgh et al.'s COVID remote assessment tool (Greenhalgh, Koh, and Car 2020) I could discern whether they needed to seek further medical assistance. They both recovered by the fourth week of March. Meanwhile, public health advice on mainstream media and via posterage kept Irish people apprised of the importance of social distancing and hand sanitising in order to 'flatten the curve' and 'not to overwhelm the health services'. By 31 March 2020, seventy-one people had died in Ireland from COVID-19.

⁸² A pulse oximeter is a small, inexpensive, non-invasive device, that when clipped onto a fingertip tells the oxygen saturation level of the blood and the pulse rate.

6.3.2 Restoral⁸³ of medical registration

On 17 March 2020, the government had launched a call for all retired HCWs to volunteer to return to work through the initiative “Be on-call for Ireland”. I applied immediately, along with 73,000 others. At the beginning it was not clear what the government wanted retired HCWs to do, but the work of contact tracing and, from January 2020, vaccination, required a huge, skilled workforce. Ultimately, less than 1% of applicants were hired on this initiative (Brennan and McConnell 2021). A rigorous evaluation process required me to restore my registration with the Irish Medical Council and to be Garda vetted. Anybody aged over 65 years was deemed ineligible for patient-facing work, so my CV was forwarded to a recruiting agency to await establishment of the contact tracing service. The HSE sent me login details to their online learning portal www.HSEland.ie to provide access to learning modules with credits. As a retired member of the Irish College of General Practitioners I also had access to its weekly Wednesday evening webinars. Along with c. 2,000 other attendees, I was educated on the latest scientific knowledge on COVID-19 and its application in general practice. A team of indefatigable experts gave presentations and answered questions on Zoom. Members were reminded to check the ICGP’s Covid Hub twice daily or oftener, such was the speed of change in scientific knowledge. I was delighted to have a job to do.

My re-education as a medical practitioner was challenging because I did it alone, online. The loneliness of isolation caused by pandemic restrictions was amplified by a lack of intersubjectivity. Living at home with my husband, our duty was to stay safe and not to contract COVID-19. It seemed like such a small, self-serving focus in the context of the maelstrom of morbidity and mortality

⁸³ ‘Restoral’ was the term used by the Irish Medical Council for the process of re-registering retired medical practitioners to work in the COVID-19 pandemic.

around us. Postgraduate GP training is delivered to individuals and to groups so that while the trainee learns clinical and communication skills, they also form bonds of attachment with their peers who provide support at a time of need. Nobody can predict which patient or illness will trigger a doctor's emotional reaction. Structures of training and the mentorship of an individual GP trainer provides scaffolding before it is required. The networks of colleagues available to me while I was a practising GP were not only defunct, but all the individuals still working as GPs were now overworked, contending with a novel coronavirus epidemic along with their regular clinical workload. Throughout May 2020, as the number of cases and deaths fell dramatically, I took great courage from weekly ICGP webinars. Clinical updates were up-to-the-minute, new initiatives such as the COVID-19 Tracker App and the development of contact tracing services were fully explained and self-care and care for colleagues was valorised. All of the speakers were lively, engaged and answered all questions with competency. Much of the content of these webinars concerned the evaluation, triage, and treatment of patients layered over a continuum of handling patients' regular clinical presentations. At the webinar on 14th April, 2020, Prof. Martin Cormican, Consultant Microbiologist and Professor of Medicine at University Hospital, Galway finished by reminding us that:

We all joined the profession knowing we'd look after sick people. That comes with risk. Deal with it.

This was the gauntlet thrown down before every medical doctor during the pandemic and picked up by most. My Research Participants' comments on this subject, cited later in this chapter, show that, apart from a few anecdotal exceptions, they did.

The HSE had already stated that I would not be hired in a patient-facing role; nevertheless, these sessions left me astonished at the amount of new clinical information that GPs had to bring to each consultation. I continued to do online HSE training and still didn't know if, how or when I would be deployed. I experienced great solidarity with those taking online training and looked forward to working purposefully with others again.

My personal diaries record how much I missed regular contact with my family and friends and ambient contact with neighbours and others. GPs occasionally remarked on ICGP webinars that they missed the patients. By now, many of my friends had tuned out of the daily press briefings and taken to exchanging recipes for banana bread, and to sea-swimming. However, I felt obliged to stay tuned, so that I would be informed when the HSE decided to assign me to a role, and I became a devotee of NPHE's daily bulletin and the weekly ICGP webinars.

6.3.3 Deaths, monotony and sharpened focus

Despite measures being taken to restrict the spread of COVID-19, the incidence of cases and deaths from COVID-19 continued to rise inexorably, as shown in Figures 6-2 and 6-3 above. In March 2020 the HSE established c.50 COVID-19 community hubs for assessment and triage of possible cases. 439 GPs and 156 GP Registrars were trained to work in these hubs and 'reported high levels of satisfaction with the training and with the preparation they received' (Bury et al. 2020), 479). GPs directed all possible cases of COVID-19 to these hubs where they could be evaluated and referred for Covid testing. All Covid-related services were free to every patient and paid for by the HSE. From 6 March 2020, Nursing Homes Ireland, a representative body for providers of almost 400 nursing homes, decided to restrict nursing home visits to its residents (HIQA

2020, 12). At the same time, government moved elderly people out of acute hospitals to nursing homes to clear beds for the coming surge. Private companies owned and managed 80% of these facilities and had not been subject to mandatory inspection by the Health Information and Quality Authority (HIQA 2020, 10); this only changed in 2024. GPs, wearing full PPE, continued to visit their patients in nursing homes during the pandemic. Supplies of PPE were difficult to source, staffing and care were compromised by staff members falling ill and testing positive for COVID-19. These events were reported and contested on the airwaves during March and April 2020, causing great distress to patients, their relatives, their healthcare workers, and to all of us. Window visits to grandparents became the norm. The mortality was high:

Just under one thousand deaths in nursing homes were linked to COVID-19 during the first wave of the pandemic. ... And, in less than a year, it (Covid) would do so again, with another one thousand lives lost in the third wave in January and February 2021 (Horgan-Jones and O'Connell 2022, 71).

By Easter Sunday, 12 April 2020, three hundred and fifty eight people had died from COVID-19 and cases numbered about eighteen thousand (HPSC 2020).

Domestic violence was also rising: 'the number of protection and interim barring orders granted to victims of domestic violence in Dublin between July and September last year increased by 40% from the same time in 2019' (RTE 2021). My journal entry on 3 April quotes a check-out operative at the local supermarket who said she was at work because she was 'cracking up at home, alone'; 'Mark my words, there'll be a lot of mental health problems around when this is all over' she said, unknowingly prescient, less than one month into Europe's longest lockdown.

The weather in March and April 2020 was unusually dry and sunny. Cherry-blossoms had never been lovelier. One warm day, 5 May 2020, Greg and I walked through Mountjoy Square in central Dublin and were alarmed by large

gatherings of people of multiple ethnicities seated close together on the grass. Looking upwards, however, we could see the sash windows of some Georgian buildings opened fully and beyond them, tiers of small bunk beds going all the way up to the high ceilings. This area has a mix of large houses occupied by private families and others let out to tenants, mostly newly arrived asylum seekers. It was zoned as marginally above average in the 2016 Haase-Pratschke deprivation index (Haase and Pratschke 2016). This afforded a sharp insight into the inequality that, of itself, raised the risk of infection among those who had poor access to green space and lived in overcrowded housing (McGowan and Bambra 2022). On 18 May 2020, Ireland commenced Phase 1 of easing COVID-19 restrictions as part of the Roadmap for Reopening Society and Business. We were allowed to exercise within five kilometres of home and to convene outdoors in groups of no more than four. Our first trip to the seaside, at Dollymount Beach, was ecstatic. Visiting our extended family in Cabra on Sunday, 31 May was emotional ... three generations of us, all in floods of tears as we hugged for the first time in nearly twelve weeks.

6.3.4 Summer respite

Phase 1 introduced the summer respite with falling numbers of cases and deaths as we all moved outdoors. With the transition to Phase 2 of relaxing restrictions on Monday, 8 June, we could travel up to 20 kilometres, meet in groups of six outdoors and all retail outlets were opened. Air travel had almost completely ceased so on sunny days, Dollymount Beach was crammed with swimmers and sunbathers. Phase 3 was scheduled for 20 July and would allow us to travel further afield. We rented a house near the beach on the Atlantic coastline for all our extended family for the last week of July. Fieldwork for my research began again with two GP interviews scheduled for that summer, each of which was cancelled and rearranged several times. I wrote field notes and

began transcribing the interviews, hoping to get them finished before the HSE made contact.

6.3.5 Never let a crisis go to waste

Almost five months after the general election, a new government was sworn in on 27 June 2020. Stephen Donnelly became Minister for Health, replacing Simon Harris, who had held the brief since 2016. Sláintecare, a cross-party healthcare strategy agreed in 2017, seemed to have been thrown off course by the pandemic (Shortall 2017). Its equity-based principles, however, were upheld by each of the two Ministers for Health who held office during the pandemic and woven into Ireland's response to COVID-19. Burke et al. analyse national Irish government health system and budgetary policy documents from March 2020 to May 2021 and assert that the Sláintecare mission was central to Ireland's pandemic response (Burke et al. 2021, 3–4):

The government implemented universal, free care at the point of delivery for all COVID-related diagnosis and care early in the pandemic. COVID-19 also allowed the long-awaited introduction of Independent Health Identifiers (IHI) in Ireland with anyone who received a COVID-19 test, was contact traced or signed up for a vaccine being allocated an IHI. The progress of IHIs had been recommended for over 15 years in Ireland but progress on actual implementation was extremely slow prior to COVID-19⁸⁴ (ibid. p. 5).

The shift to telemedicine practice was rapid. The HSE supplied GPs with a modem connected to the practice computer so they could access practice data from home. They could e-mail prescriptions to pharmacies and e-mail letters of referral to hospital consultants, a facility they had been requesting for several years without success. New contracts were agreed between the HSE and

⁸⁴ Stephen Donnelly, Minister for Health, announced in May 2024 his intention to begin introducing a national health identifier within the term of office of this government, which ended in February 2025. This was not accomplished in his tenure but his successor has committed to it.

hospital doctors, and the HSE and GPs, progressing the move towards universal healthcare, an explicit goal of Sláintecare (2017), as already described. All of this would become clear to me in due course, when I began working as a contact tracer.

6.3.6 Transition to contact tracing

Academic life resumed in September 2020. I knew that as winter approached, COVID-19 numbers would rise again with the likelihood of further, stringent lockdowns. This would mean that, once again, GPs would be far too busy with their clinical workload to give me the time for a research interview; I would have to wait until Spring 2021. A recruiter rang on 14 October to offer me a job as a Clinical Contact Tracer. On my supervisor's advice, I opted for the part-time position, 2x12 hour shifts and one four-hour shift per week, to leave time for my academic work. On 21 October 2020, Ireland was put on Level 5 restrictions until December. It was reported that a vaccine against COVID-19 had been developed (in an extraordinarily short time) and that it might be available to the public in a matter of months. I was excited at the prospect of working as a contact tracer, the training, the work, the structuring of my daily life and being 'On Call for Ireland'. I reckoned the Irish state and all its healthcare agencies were taking great care of its citizens and looked forward to beginning work on 13 November 2020.

6.4 Section 2: Contact tracing: 13 November 2020–6 May 2021

6.4.1 COVID-19's spatial reach

From the outset, COVID-19 demonstrated that it could travel well, and once again epidemic disease provoked our collective geographical imagination (Gilbert 1958). The SARS-CoV-2's distinguishing lethal weapon was that it

could infect a human host who would transmit it and infect others for up to five days before they experienced any symptoms of the disease. Writing about the pandemic in his memoir, Dr Tony Holohan, Chief Medical Officer at the Department of Health explained:

Our aim was to maximise the likelihood of picking up a case⁸⁵ as soon as it arose, putting in place effective measures to stop that case infecting other people, tracking the contacts of that case and limiting their possibility of becoming cases and transmitting the disease further. The approach at that point was one of so-called containment (Holohan 2023, 159).

At the outset, COVID-19 seemed to have plutocratic preferences, moving along travel routes used by up-market holidaymakers and traders. However, once it moved into the lives of marginalised people with precarious health in overcrowded housing, it infected and killed at a faster rate (Devlin, Whelan, and McGuinness 2024, 4, 23). Public health authorities realised early that suppression of the pandemic required a skilled, diverse, nimble, well-managed workforce of contact tracers so they created it. Martin et al. have reviewed the first year of the Contact Management Programme (CMP) in Ireland and found that

246,666 positive cases were recorded using the CMP between 17th March 2020 and 30th April 2021 with contact tracing successfully completed for 237,759 cases (Martin, Carroll, and Khurshid 2022, 1–2).

They report that 3,834 contact tracers were trained between March 2020 and March 2021 (ibid. p. 7) and detail the ethos and process of setting up the system and making it adaptable to changing need. Figure 6-5 illustrates activity in the CMP, and I draw attention to the surge from Christmas 2020 to New Year 2020/2021. People missed each other terribly; the high number of close contacts

⁸⁵ When referring to a person who tested for COVID-19 I choose to capitalise the word 'Case', as a proper noun. I use lower case 'case' when the word is a common noun.

for each case shows how much they were prepared to risk for social contact. The two peak weeks were those ending 3 and 10 January.

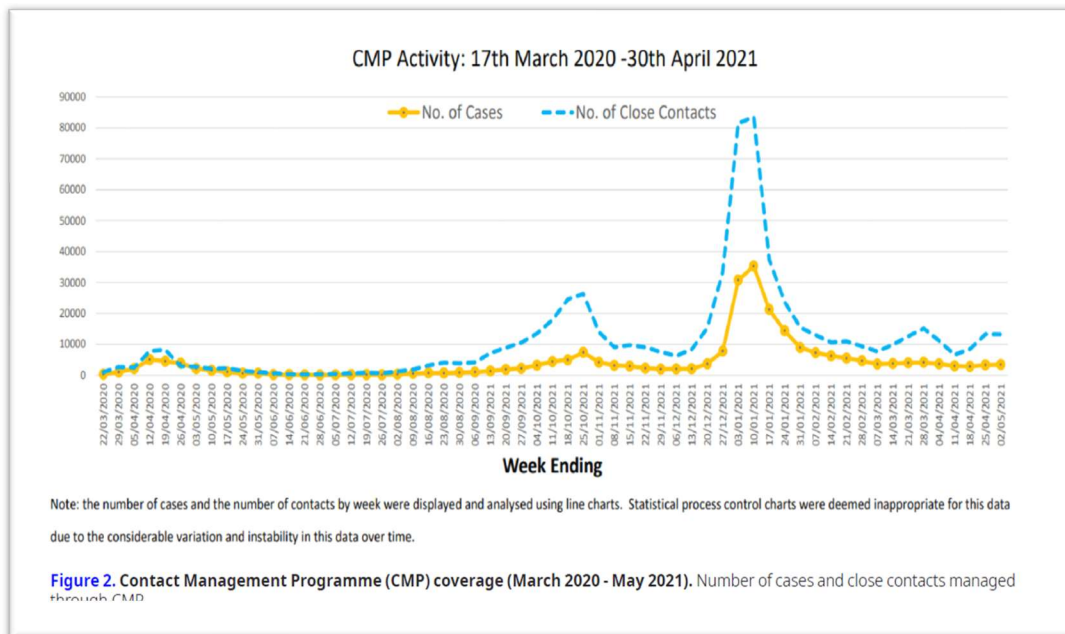


Figure 0-3: Contact Management Programme coverage March 2020–April 2021.

Author: Martin et al. Source: <https://hrbopenresearch.org/articles/5-12>

6.4.2 COVID-19 contact tracing in Ireland

Informal contact tracing has a long history in Ireland, beginning when Ireland was under British rule before independence in 1922. Prior to the development of modern antibiotics in the twentieth century, the only means of preventing the spread of infectious disease was to isolate patient(s) and maintain hygiene. Then, as now, economic factors tilted the balance between recovery of good health and moribund deterioration once infectious disease visited a household.

Horgan-Jones and O’Connell devote the first five chapters of their book *Pandemonium: Power, Politics and Ireland’s Pandemic* to recounting the who, why, when, where and how of assembling the groups that led the Irish response (Horgan-Jones and O’Connell 2022, 1–48). Government and healthcare authorities knew that the pandemic could only be suppressed by recruiting a

post-colonial Irish population as co-operative participants. In order properly to trace and treat all cases of COVID-19, the Irish government's approach to ethical decision-making in a pandemic was outlined in a document published in March 2020, based on the principles of 'Minimising Harm, Proportionality, Solidarity, Fairness, Duty to Provide Care, Reciprocity and Privacy' (Department of Health 2020). It became clear to me as I watched daily news coverage on RTÉ and the BBC and spoke to my daughter who lives in England that our approach was very different to that of our nearest neighbour. Whereas we were treated like citizens of a republic, British people were treated like subjects. When Meade and Earickson explored the transmission of disease in 2000 their ideas were rooted in positivist medical geography (Meade and Earickson 2000): trust, for example, is not mentioned in this text. The OECD proposes that 'certain indicators of trust in institutions and interpersonal trust are associated with lower COVID-19 and excess mortality rates' (James et al. 2022). More recently, the ESRI has published a series of papers on how behavioural science was used to coax the Irish population into compliance with public health measures (Lunn et al. 2020, 16–17; Lunn et al. 2024, 681). Boyle et al. later highlighted the UK's approach, stating that 'the corrosive effect that neoliberal insouciance towards inequality has had on the UK's resilience to crisis has been starkly highlighted by the pandemic' (Boyle, Hickson, and Gomez 2023, 187). Irish results were better than the UK's (Al-Salem et al. 2021, 387–388). OECD figures show that in 2020–2021, Ireland recorded 1,186 deaths per million people while the UK recorded 2,636 (James et al. 2022). As detailed in Kennelly's review of how the Irish Government tackled the pandemic, development of an effective contact tracing service was a crucial element of suppressing spread of the virus in Ireland (Kennelly et al. 2020, 426–427).

6.4.3 Induction to COVID-19 contact tracing.

Training as a CCT began online, at home, then one week later, I cycled to the office before dawn. We were a very mixed group that assembled in HSE offices in Parkgate Street, Dublin 7, alongside the Liffey, on Friday, 13 November 2020. Meet and greet was enthusiastic and perfunctory, such was the urgency of our work. The managers who ‘onboarded’⁸⁶ us made it clear that contact tracing on this scale was new in Ireland, had never been done before, and couldn’t matter more. Systems and protocols had been put in place over the eight months since the pandemic was announced but new science and new learnings from the Irish population were being factored in as fast as was practicable and we were required to stay abreast of all the educational material sent our way and the new directives arriving daily by e-mail. Contact tracers were divided into two groups: Clinical Contact Tracers who would ring the ‘Case’ and inform them that they had tested positive for COVID-19 (Call 1) and Non-clinical Contact Tracers (CTs) who would ring the Case after the first call and gather the names and phone numbers of those with whom they had been in contact during their incubation period (Call 2). CTs would also ring the Case’s ‘Close Contacts’ to invite them to get tested for COVID-19 and to make the appropriate arrangements (Call 3). CCTs were doctors, dentists, nurses, midwives, physiotherapists, pharmacists, speech and language therapists, occupational therapists, opticians and radiographers. Some had retired from clinical work on reaching the age of retirement; more had just completed their professional training and, since pandemic restrictions had shut down all non-essential healthcare services, they had no job to go to. The HSE reckoned that all clinical

⁸⁶ ‘Onboarded’ was one of many corporate words and phrases in the vernacular at our contact tracing centre that were new to me but familiar to our team leads, men and women in their late twenties and early thirties. An American term in common usage in corporate language, it is a synonym for ‘inducted’.

workers had been trained in delivering bad news with empathy and professionalism and that Call 1, breaking the bad news of a positive test result, should only ever be made by a Clinical Contact Tracer. This practice was changed once vaccination began to take effect in March 2021 as numbers of cases and deaths fell significantly.

On the day I began working at the HSE, none of us could have anticipated the surge of COVID-19 cases that would come to define Christmas 2020, as depicted in the graph below. Case numbers began to rise in the weeks before Christmas and surged in early January 2021, due to increased social contact. Fourteen people died from Covid on 27 November 2020. Fifteen died on 23 December, then eighteen on 31 December. The daily numbers rose rapidly to seventy-seven deaths on 1 February 2021 and then fell steadily to fourteen on 2 March 2021. Two thousand, seven hundred and sixty-seven people died from COVID-19 in Ireland between 1 December 2020 and 31 March, 2021, in this, the third wave of the pandemic (Figure 6-6).

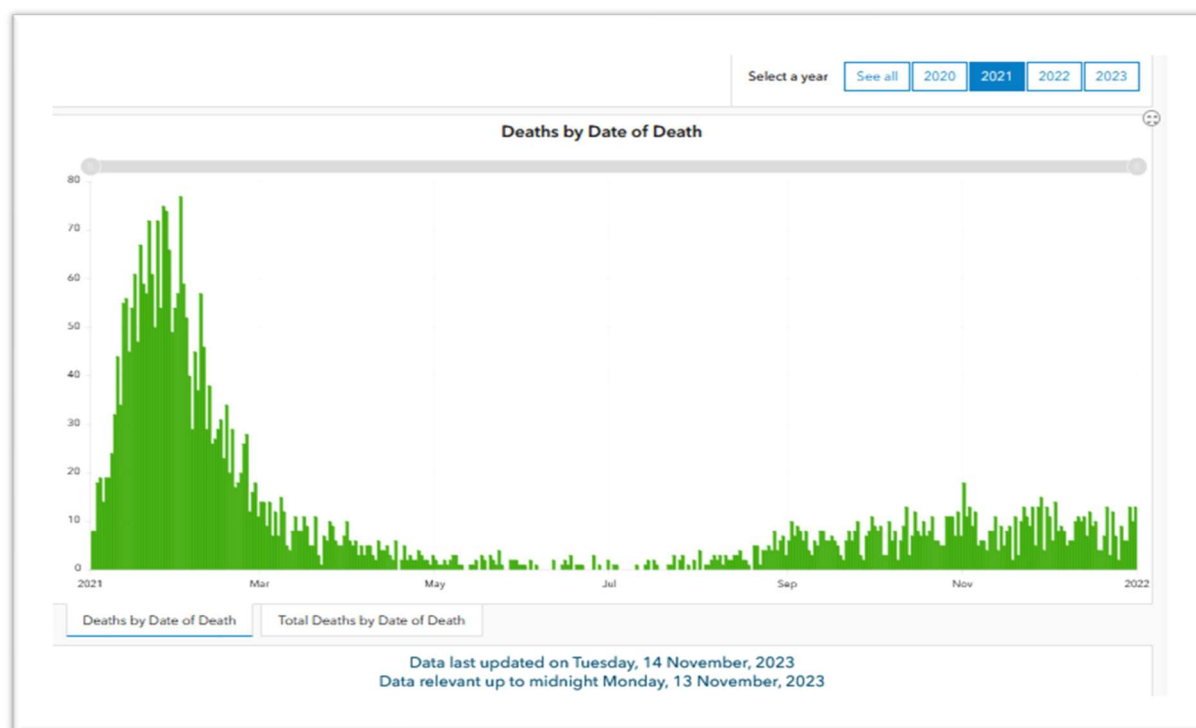


Figure 0-4: Graph of deaths from COVID-19 in Ireland in 2021.

Source: COVID-19 Ireland Geohive Hub. Available at:

<https://covid19irelandgeohive.hub.arcgis.com/pages/17dad985d0534ca093ed69920b7658a2>

We took up our places at workstations that each had a laptop and a pair of screens, a hand sanitising gel dispenser and a pack of sanitising wipes for our desks and computer equipment. Each of us was given a headset with microphone for making calls. We were given login details for several websites and asked to choose usernames and passwords. In order to make a call, each contact tracer had to activate the following:

- Login to contact tracer's personal HSE account; this gave access to all other software.
- Locate Scenario Manual, Script Manual and User Manual and drag them to the right-hand screen:
- Scenarios: This was a databank of all known scenarios in which a Case might find themselves with advice on how the contact tracer might answer their questions.

- Scripts: a list of the questions to be asked of each Case.
- User Manual: technical information about software.
- Login to RCSI Moodle, for educational purposes.
- Login to Covidcare Tracker: This is where we would enter the answers given to us by the Case during a call.
- Login to Google Chrome, incognito: Miscellaneous purposes. For example, if a Case did not know their Eircode, Eircode Finder could be opened on Chrome, the Case's address typed in and the Eircode would be provided along with an aerial view of the address.
- Login to Agent Portal: used to ring Case and to ring the designated translation company who had translators in every language.

6.4.4 Training as a Clinical Contact Tracer

During the first week we had facilitated virtual training via webinars from the HSE and online modules from the Royal College of Surgeons in Ireland (RCSI). An online 'sandbox' was where we made practice calls. Safety was a high priority: talks were given on protecting ourselves from COVID-19 at work and at home. If any contact tracer either tested positive or was named as a contact, we must stay home and isolate for fourteen days. A HSE psychologist visited to advise us about self-care strategies and provided a list of online supports along with her contact details. None of us knew how much we would come to need her advice when the surge happened. But the HSE did; they provided a 'Time-Out room' in case it would be needed and indeed it was. Fulham-McQuillan et al. did qualitative analysis of contact tracers' needs and experiences at three

points in 2021 and give a good account of the HSE's anticipation of and response to our needs (Fulham-McQuillan et al. 2024). At the start and end of our work shift we spent ten minutes cleaning our work station. Masks were provided and were to be worn at all times. By the fifth day everyone made their first live call, with our 'Team Lead' walking around the floor, available to advise over our shoulders if necessary. Tea-, coffee- and lunch-breaks were rostered as was a daily walk in the nearby Phoenix Park or the grounds of Royal Hospital, Kilmainham. Logistics of car-parking, shift working, the dress code and social distancing at work were explained. Everyone was given a travel consent letter to show to Garda checkpoints when commuting to and from work; some contact tracers commuted from towns 100 to 140 km from the Dublin office. At no stage did any contact tracer have the option of working from home. Finally, our reporting format was explained. At the end of each day, we would enter on a spreadsheet the Case Number of each call we had made, the call type and the outcome – resolved or not resolved. Key performance indicators were explained: Clinical Contact Tracers were expected to make ten 'Call-1's per day when the incidence of cases was low and up to twenty 'Call-1's during a surge. Although contact tracing had been in development at the UCD site since March 2020, it was being rolled out to Cork, Galway and other Dublin locations just in time for the expected surge at Christmas. The RTE News clip below (Figure 6-7, 2 mins 43 secs) illustrates the work practices of HSE CCTs.



Figure 0-5: Video clip from an RTÉ News Item on 5 February 2021, depicting the work of contact tracers (News 2021).

Available at: <https://www.rte.ie/news/2021/0205/1195393-contact-tracing-update/>

6.4.5 The daily rhythm

On Saturday, 19 December our team moved to a large, modern, purpose-built, glassy, climate-controlled office block in Dublin 8. The contact tracing service operated from 08:00 to 20:00, seven days a week including public holidays. Everyone was required to be at their desk by eight o'clock (or on time if working a four-hour shift). In the new building people were assigned to groups divided into pods with desks all two metres apart, as shown in Figure 6-8 below.

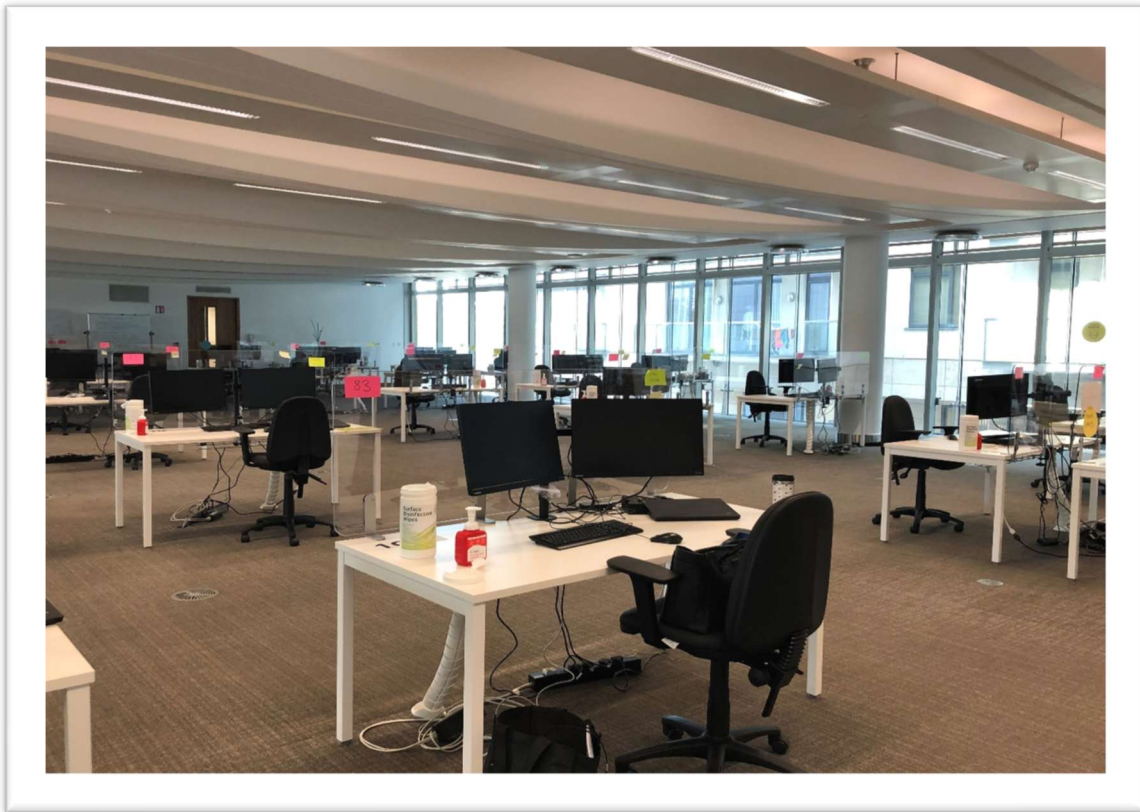


Figure 0-6: Photograph of contact tracing workspace in HSQ building, Dublin 8 with my desk in the foreground.

Photograph taken by author.

Once logged on to the various mandatory sites there would be a socially distanced ‘team huddle’ at around 08:30 at which our Team Lead would inform us of any new developments, changes to scripts or scenarios, trends in how the disease was spreading and feedback from the HSE and Public Health experts. She would then take questions, answer them, and inform us of what progress had been made on questions asked or matters that had arisen during the previous 24 hours. In keeping with the ethos of dignity that pervaded our work, we were told that it was considered both rude and counter-productive to ring a Case before 09:00 a.m. The daily huddle created a sense of common purpose, a rare experience during those atomised days. Once it ended, we all donned our headsets, collected our cases and prepared for the first call of the day. A congregational start to the day reminded us all why we were there, and how

our work mattered so much in the national effort to ‘suppress the virus’. It engendered in all of us a sense of belonging to something bigger than ourselves. After nine months of social isolation and self-absorption, this gave us both relief and purpose.

During the previous night, the Virus Reference Laboratory (VRL) had posted all COVID-19 test results on its database. Those who tested negative would get a text message to inform them of the fact, advise them how to stay safe and that they would receive a contact tracing call in a matter of hours; Cases with positive tests would appear on our database. We collected these Cases, one at a time and took them into our ‘work items’ to prepare to make a call. Each Case had already given their name, address and date of birth when they enrolled for their COVID-19 test and at that point they had been assigned an individual health identifier (IHI). People making Call 1 would collect cases from the VRL database and prepare to make the call. Once you collected a Case it became your responsibility. Sometimes people failed to answer so the call was made again, twice. On each occasion the attempt was logged. After three failed attempts the call was returned to the VRL database as ‘unresolved’ to be attempted again on the next shift or handed over to a local Public Health team if the person resided in a Nursing Home, was very elderly or there was any reason to expect that they might not be contactable. Call 1’s could take from fifteen minutes if the Case was straightforward to over an hour if they were distressed. Clinical Leads were always present to answer any clinical questions or, if they did not have answers, to feed the question up the chain to UCD. Their nimble response made all of us feel very well supported.

At the end of each twelve-hour shift, we would compile a worksheet of the calls we had made and their outcomes. Team Leads would walk the floor, available for queries so that every query was answered and all data available to the

software people who would work through the night to discern trends and consider necessary modifications to software and work practices. We cleaned our workstations then trooped out at 8:00 pm. Team Leads stayed later, feeding back data to the contact tracing 'mothership' at UCD.

6.4.6 Working as a Clinical Contact Tracer

Apart from socially distanced ice-breaker sessions and daily walks, contact tracers had little opportunity to socialise. But we got to know each other quite well by overhearing each other's calls. The period before making the call and after finishing the call was taken up with sitting in silence, reading the file, familiarising with every possible detail in order to prepare oneself to give very upsetting news to somebody one had never met before, then after the call, entering data, routing the Case appropriately, making sure that the file was properly 'resolved' and suitably configured for the public health database authorities. My GP experience of duty of care served me well while speaking with distraught people, and I witnessed it in other CCTs too. During silences between calls, neighbouring contact tracers could be heard going through the scripts in an orderly, respectful manner; articulating clearly if the Case was hard of hearing, speaking empathetically if the news of a positive test was a shock to them. Occasionally we became aghast as we witnessed a colleague's professionalism, followed by their emotional collapse after the call. On one occasion everyone stood up out of respect and applauded silently, after a colleague had a particularly harrowing call. The yearning for human contact had become unbearable: all of us contact tracers experienced it in our own lives and understood it in theirs. However, we were well trained and protected; I often heard colleagues say, 'I'd crack up if I didn't have work to come to'. Cocooned, in a way, from how the public mindset was changing outside our contact tracing centre, we just did our work.

The Irish population had, however, grown fed up with lockdown. In January 2021, schools were now closed, again; not only were parents tired of trying to home-school while working remotely, but they were increasingly concerned with the harm done to their children by social isolation.

6.4.7 A 'meaningful' Christmas

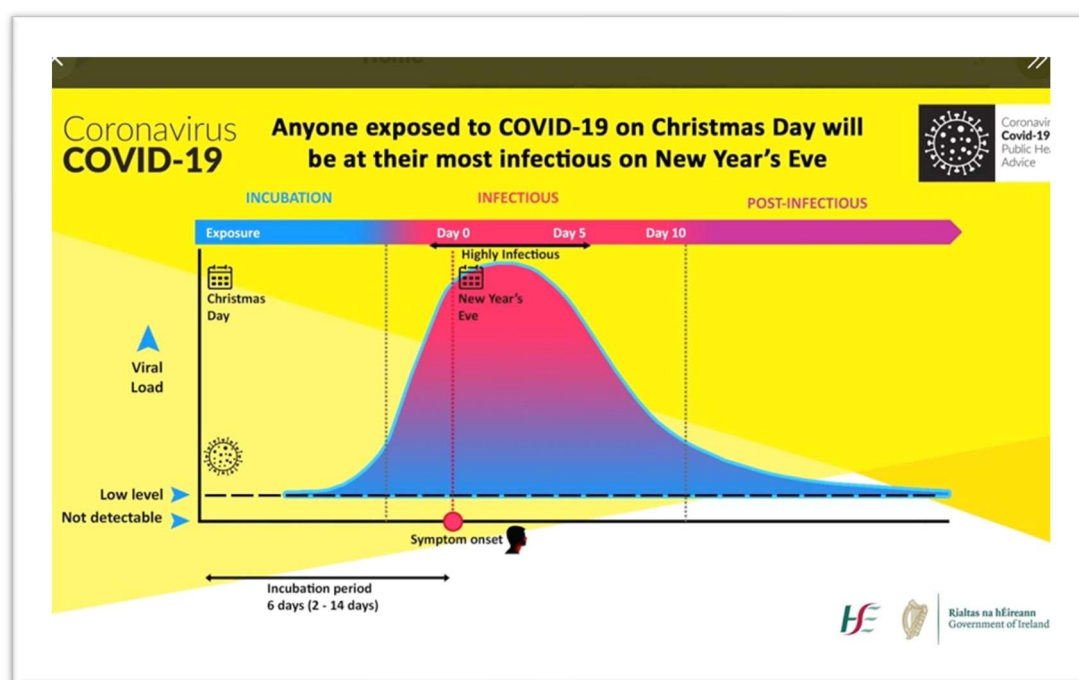


Figure 0-7: HSE public information warning the public about the risks of COVID-19 over Christmas 2020. Photograph taken by author

In December 2020, the image above (Figure 6-9) was widely circulated on all Irish media to remind the public of the risks of socialising over the Christmas period. The Taoiseach, Micheál Martin urged us all to have a 'meaningful' Christmas. Behind the scenes, NPHET and the Government wrestled with what kind of restrictions would be necessary to prevent the hospital services from being overwhelmed. Weekly briefing from Amárach Research kept them informed about how much the Irish people would bear (Amárach 2022). Three superspreader events created local surges that exemplified behavioural trends

across the country. On 13 December 2020, Limerick played Waterford in the (postponed) All-Ireland Hurling final and won. Call-1's to Limerick in its wake all told the same story: people chose carefully where to watch the match and with whom, but when their team began to win, they got excited: "we were all jumping around the place shouting and roaring and hugging each other" according to one Case that I rang. The HSE's weekly report on the epidemiology of COVID-19 in Ireland for 29/12/2020 confirmed the high incidence of cases in Limerick (HSE 2020b, Slide 16).

A widely reported funeral on 4 December 2020 in Ramsgrange, Co. Wexford contravened all COVID-19 restrictions in place at the time according to a local radio report (Beat News 2020). An old friend who lives nearby told me that the family erected marquees and provided hospitality for all visiting mourners (personal communication). Case incidence and death rates spiked in the vicinity during the two weeks following the event. My last remaining, and much-loved uncle had died, in his nineties, in October 2020 and I will never forget the effort it took to resist the physical yearning to hug my cousins in sympathy. After Christmas 2020, celebrations at a hotel in Belmullet, Co. Mayo that went on for several days before and after Christmas drove the incidence of COVID-19 to three times the national average, in the weeks following the events. A national newspaper reported that 'Infection rates rose 10-fold from 182.5 cases per 100,000 population on December 28 to 2,111.1 cases per 100,000 population on January 4' (Fagan 2021). People were missing each other's company and infection rates rose so rapidly that the government reinstated full restrictions again shortly after Christmas.

6.4.8 After the post-Christmas surge

In late December 2020, all the windows in our new building were opened fully to ventilate our work environment. It was freezing; all my colleagues were muffled up in a variety of fleeces, ponchos, duvet coats, UGG boots, Aran sweaters, woollen hats, scarves and fingerless gloves. Some even had hot water bottles on their laps, refilled regularly from the Burco water heater at the tea and coffee station. But nobody complained. Although the WHO did not confirm that COVID-19 was spread by aerosol until April 2021 (Jimenez et al. 2022) the HSE managed all its workplaces in accordance with an airborne aetiology. Several contact tracers had been close contacts of a Case at work, and nobody wanted to contract COVID-19, particularly since vaccination was imminent. Several Clinical Contact Tracers felt that the work had been transformed into a commercial call centre with KPIs (key performance indicators) rather than a caring centre where each Case got the care they needed, an observation later validated by Fulham-McQuillan et al. (Fulham-McQuillan et al. 2024, 12). But at peak, we had to make over seven thousand contact tracing calls a day. All of us in the contact tracing team were *in the zone*, trying to get ahead of Covid.

6.5 COVID-19 vaccination

As case numbers began to fall in mid-January 2021, people became optimistic. Research centres in Mannheim, Germany and Oxford, UK had developed vaccines within a year of the onset of the pandemic. Governments in the developed world invested heavily in rolling out vaccination programmes to all their citizens; the Irish vaccination scheme was deemed very effective: eight months after its inception, 87.8% of the population had been fully vaccinated (Ni Aodha 2021). On 29 December 2020 the first vaccine was administered in Ireland: by 6 March, 2021, over half a million vaccines had been given in Ireland

(HSE 2024c). Front-line healthcare workers were prioritised along with elderly people and patients with underlying health conditions such as heart disease, lung disease, kidney disease, liver disease, neurological disease, or immune deficiency. Alongside mass vaccination centres, GPs were recruited to administer vaccines (Healy 2021). Knowing their patients through continuity of care and having computerised patient records that could classify those at risk by age and risk profile expedited rapid and widespread vaccination. Contact tracers in our office received our first vaccine on 23 March 2021. As case numbers fell, the numbers of calls to be made dropped accordingly and my nurse and doctor contact tracing colleagues began to leave to go to work in the vaccination centres. This was never an option in my case as a return to academic life beckoned once restrictions were lifted. The frenzied and ever-changing, albeit well-remunerated workload accomplished by GPs during the pandemic would abate somewhat, allowing them to give consideration to my request for in-person interviews.

6.6 COVID-19 contacts who signified population trends

Although contact tracers worked twelve-hour shifts without accessing mainstream media, we had our fingers on the pulse of the pandemic. We missed the daily press conferences given by Dr Tony Holohan, CMO of the DoH, Dr Ronan Glynn, his deputy, Prof. Philip Nolan, Chair of NPHE's Irish Epidemiological Modelling Advisory Group and a host of other experts. But as we made our calls, the people we called told us what was going on and what they thought about it. In this respect, I found working as a CCT quite similar to working as a GP. In both cases one must try to find out as much as possible about the Case before engaging. On the one hand, the contact tracer works in a highly circumscribed and scripted space with one task – compassionately to inform the Case of a positive result, to give healthcare advice for them and their

commensals and to record all their clinical data appropriately. The GP, on the other hand must handle whatever the patient brings to the consultation – their ongoing chronic conditions, their new presenting complaint and all the pathologies that accrue to their lifeworld, even though the patient may be unaware of them. Active listening is a GP's first tool. In this section I begin by recounting how I prepared to make a Call 1 and then give examples of how Cases responded in my calls, that signified trends in the pandemic. All the cases I refer to are described in my contemporaneous memos and anonymised; other contact tracers had similar calls on the same shifts.

6.6.1 Preparation to make Call 1

Call 1 might take an hour or more, so I would make sure I was comfortable and refreshed before dialling the number. Automated SMS messaging of a positive result to a COVID-19 test would have been sent once the software was designed for this; the idea was that the Case would receive it, have time to accommodate to the bad news and to begin recalling whom they had met during their infectious period and gathering their phone numbers in preparation for Call 2. The time of the SMS was logged on the Case's file and contact tracers were instructed to allow one hour to elapse before ringing them. The Case's name, address of residence and date of birth were on the first page along with the date of their test and its result. Their name alerted me to their ethnicity (but not always). The numbers of eastern European names reminded me of the data from Census 2016 which indicated that 810,406 people in Ireland on 24 April 2016 were born outside Ireland – 17.3% of the population (CSO 2016). At the outset, we were instructed not to call any Case with a surname or address (e.g. *SuchAndSuch* Halting Site) that suggested membership of the Traveller population. A specialised division of contact tracers, experienced in working with Travellers, would handle their exposure. We asked every Case to name

their GP or GP practice and entered this with the practice contact details on the Case's file. I was astonished at the number of GP practices staffed mainly by doctors with, say, Polish or Arabic names.⁸⁷

As time went on and more expertise on contact tracing was developed, many more teams were formed who had expertise in particular cultures; this became important as Covid denial and vaccine resistance crept into public discourse in early 2021. Date of birth indicated if the case was a minor, in which case a parent or guardian would take the call. Any person over sixty-five might live in a residential facility such as a nursing home or might have a healthcare worker visiting regularly. Scripts and scenarios were available on our screen for all these eventualities. Eircode Finder was useful to identify where the Case lived. Whereas farmers often live quite remotely, overcrowded urban housing offered no opportunity for a Case to self-isolate. When Covid spread to the workforce in the meat factories, contact tracers were delighted to be able to ring a translation service where competent translators could enable foreign nationals on minimum wage to communicate with us immediately. As with all other services for tracking and tracing COVID-19 cases, translation services were free to the Case and paid for by the state.

6.6.2 Examples of Cases

Elderly people: Before Christmas 2020, many of my calls were to elderly men and women in isolation in healthcare facilities. If they were well enough to talk, they complained of being very lonely. Repeated accounts of well-meaning healthcare staff arriving at their bedside in full PPE painted a grim picture.

⁸⁷ Unfortunately, I was unable to get interviews from any such GPs. Since Census 2022 shows that 17% of people enumerated on that night were born outside Ireland, the omission in this research is significant.

Most were stoical; one expressed the wish 'that God would take me'. This was not suicidal ideation but an expression that life like this was not worth living. Some of these elderly people kept us on the phone as long as they could, quite candidly stating that 'you're the only person I'll be talking to today'. When I interviewed GPs fifteen months later, two referred to the stoicism of their elderly patients in remote rural areas.

Muslim families: in two cases, Muslim families expressed how grateful they were for the Irish approach to the pandemic. One father in the south of the country took a call in December 2020 on behalf of his young son. Having gone through the lengthy script and gathered all his clinical detail I added a query – 'Will you be going to the mosque tomorrow?' 'Oh no', came the reply – 'our Imam takes great care of us, he has closed the mosque already'. Another young man, a college student in the south of Ireland said that he had rung his mother as soon as news of his positive test arrived by SMS. She told him to come home immediately, that she and her husband would vacate their bedroom with its en-suite bathroom and put a ladder against the wall so he could climb up into it and isolate there for the next fourteen days.

By contrast, early in December 2020 I rang an eighteen-year-old Syrian man with good English, on behalf of his younger sister. His courtesy evaporated rapidly when I began asking the relevant questions. He was fed-up. He told me that he had several younger siblings and that his mother did not speak English. All of them had tested positive and he was sick of taking their calls. My heart broke for him when he said that his father had been killed in the Syrian conflict earlier that year, making him the 'man-of-the-house' and that the family had fled Syria in a hurry. Unfortunately for him, and for many others who had several family members who tested positive, it had been decided at the outset of contact tracing that each Case would receive a personal call. This would confer

on everyone the dignity of being a person rather than just a number, as described in the government's ethical framework (Department of Health 2020). It was one of many examples where world demographic shifts and cultural anomalies were distilled in a contact tracer's daily work.

Christmas 2020: I have already referred to surges in case numbers in discrete parts of Ireland. These surges, put great pressure on the contact tracing system and we were reminded at our daily huddles to conduct the call without any judgement. The reminder was apt, but all of us contact tracers understood the yearning for contact, for company, for touch, for laughter, for *the craic*, and how alcohol, which acts mainly as a disinhibitor, would scupper people's best intentions to stay socially distanced. Limerick's All-Ireland victory caused a surge in Eircode V94, as already mentioned, and the mood among most contact tracers, guardedly expressed, was 'could you blame them?'

Inequality: Most of these calls were quite upbeat in that the Case would recount the social gathering they attended and readily name their Close Contacts. 'I'll put you on speaker now so while we're talking, my husband can call out the numbers of the contacts' was a regular comment. Many of these calls brought the contact tracer into the family sitting room, fire blazing, Christmas tree twinkling, several members of family testing positive but nobody sick. One woman happily declared that her family were having their best Christmas ever (all tested positive): 'we knew it was coming so we stocked up and once the 'Man in Red' (code for Santa Claus while her children were listening) was organised, we had nothing to worry about'. Quite often, ringing people with good housing, visualised on the Eircode map, and with comfortable means, disclosed by their conversation, I was struck by how different the experience of COVID-19 was for well-off people, compared with those who were marginalised. The effects of health inequalities in pandemics are championed

by Bambra (Bambra et al. 2020; Bambra, Lynch, and Smith 2021). The word ‘syndemic’ was as yet unknown to me (Bambra et al. 2020; Singer et al. 2017). Contact tracing calls to non-nationals who worked in meat factories and needed translation services because of lack of fluency in English, painted a different picture of overcrowding and low income. We contact tracers often chatted about how people from all over the world were manning the services that sustained our everyday lives: my own cases included supermarket workers, international truck drivers, taxi drivers, healthcare workers, refuse collectors, meat factory workers and agricultural workers. New syndemic spaces and their Eircodes were mapped out in my consciousness daily. Some geographical patterns of case incidences perplexed the specialist teams. An early cluster took weeks to interpret: a barber was doing home visits at night, by car, in a remote area of rural Ireland: all his clients concealed his existence until one finally told the truth to a contact tracer. Being well coiffed in 2020 was a rarity but some people just could not bear the lack of personal grooming.

Unable to say No: During the post-Christmas surge in cases, I made a call to a man in his early twenties who had had thirty-two close contacts – the highest number recorded in our centre that day. He had delivered the family’s gifts to relatives’ houses and on each occasion was invited in, and couldn’t bear to say no.

Deniers: While most Cases appreciated a call from a contact tracer, resistance and denial became evident in January 2021. On 15 January, I rang a Romanian man who declined to take the call, saying “I don’t believe in Covid”. As instructed by a scenario sheet, I noted the details of the call and routed it to a specialist team. Other contact tracers had similar experiences with Cases from many different countries. From the outset, the government provided adequate sick leave cover through the PUP (pandemic unemployment payment) so that

people could isolate without losing income. Therefore, when people declined to engage with us, we knew this was ideologically driven.

Schools reopening: Phased reopening of schools began in February 2021 and was accompanied by widespread outbreaks of COVID-19. Although vaccination had begun, it would be a long time before children were offered vaccines, and it was still winter, with short, cold days and everybody indoors. Parents of young children were trying to work from home and home-school their children simultaneously; I knew from my daughter's household nearby how some teachers had pivoted and engaged in the challenge of providing remote education while others had not. I made a call in February to a dad who told me he'd been 'crunching the numbers' himself, having expertise in data management. He refused to accept that his household had to isolate and asked to speak to a manager, so I offered him a call with my Team Lead who dealt with the matter. Frustration was rife.

A farmer's story: In spring, 2021, I made a call to a farmer. While preparing for the call I looked at his Eircode in a part of Ireland renowned for high-quality dairy produce, then inspected the aerial view of his address – a house with out-buildings, surrounded by acres of green pasture. Knowing that one never asks a farmer how many cattle he has (since it's like asking his income), I wondered how to ask the relevant questions tactfully. Early in the call he told me that he was very sick and had several symptoms of COVID-19. I was happy that he was not at risk of serious illness and enquired about what kind of farming he did. As expected, he was a dairy farmer with a significantly big herd that required milking twice a day. He had no help and no access to help. 'Herself is worse than I am' he said of his wife. His tone was desperate. Knowing that every year, people are trodden to death by cattle (Teagasc 2020), I helped him explore every option of how he would source help if, in different circumstances, he was going

to, say, a family wedding. Then he remembered people who had dairying skill and might help him out, and said he'd contact them. I finished the call with the usual safety-netting. He expressed his fulsome thanks before we finished. As usual in a contact tracer's work, I never spoke to him or any other Cases again and I wondered how he fared. This wondering raised for me again the spectre of harrowed hospital healthcare workers who perform a service for a patient on a one-off basis and never see or hear from them again while GPs, embedded in their community will either see the patient out-and-about, or hear from their neighbours and family how they are getting on. In my experience, both as GP and CCT, the circle of care in a GP's cosmology carries immense personal rewards.

I cite these calls as examples of the interactions we contact tracers had with members of the public during lockdowns. While the work was demanding, we worked in a network of care and, for the most part, felt supported.

Unbeknownst to us, while we did our work, exercising compassion and empathy, those who were isolated at home experienced varying degrees of personal and social implosion, the results of which are now evident in the high rates of mental health problems throughout society, now that pandemic restrictions have ended (Kelly 2020). These issues are beyond the remit of this research but will continue to affect patients who consult my Research Participants. Life is already difficult enough for marginalised people; a scaled-up incidence of their problems is more than well-disposed GPs can handle. Siersbaek et al. suggest that fragmentation of care for marginalised people thrusts an unbearable load on individual carers and that integration of resources at every level is the only sustainable approach (Siersbaek et al. 2021, 16), a view endorsed by many GPs I interviewed when I left contact tracing after six months and resumed research at Maynooth University.

6.7 Section 3: Interviews with Research Participants: 7 May 2021–8 June 2022

6.7.1 Timing of interviews

Fieldwork for this research was delayed by the COVID-19 pandemic and its restrictions and interrupted by the workload it thrust on GPs especially at the outset and predictably, during two consecutive winters. As I have already detailed in Chapter 3 on methodology, I intended to begin fieldwork in Spring 2020, reckoning that it was pointless to approach GPs for interview during winter when there is a high incidence of respiratory illness in the population and a heavy workload. Two GPs gave me interviews during Summer 2020, one in a well-ventilated public healthcare facility and one in their modern, well-ventilated and lit consulting room. Their lived experience referred to their decades of general practice and only to the first five months of the pandemic. With the arrival of Autumn 2020, case numbers of COVID-19 began to rise again, culminating in a spike as Christmas 2020 was celebrated. COVID-19 vaccination began in January 2021 and was an early and significant success. Case numbers fell vertiginously as vaccine efficacy kicked in in Spring 2021. Once I finished working as a CCT in May 2021, I began writing to GPs for interviews and as I have already detailed in Chapter 3: Methodology, I interviewed thirty-one RPs over three summers.

6.8 Research Participant utterances about COVID-19

Among the twelve questions that sought to elicit their reflections on their lived experience working as GPs providing primary care to marginalised people, question number 4 asked specifically about COVID-19: 'How do you feel about new modes of practice brought about by the COVID-19 pandemic?' While GPs

gave specific answers to this question, they also referred to the pandemic and its exigencies throughout the interview. I have therefore extracted two sets of data from interview transcripts and memos:

- Text bytes that refer specifically to the COVID-19 pandemic, changes it wrought in their personal practice and their observations: 263 references in 37 files.
- Word search for 'COVID-19' and for 'pandemic': 310 references in 49 files.

6.9 The Covid 'thing/bit'

Your word choice betrays your thinking. RP02 had said 'the Covid thing' twice in their interview recording before I adverted to it and then searched for it in the transcript. They said it a few more times and also invoked it without being explicit. RP06, likewise, called it 'the Covid bit'. Covid had become a proper noun in the vernacular; people referred to it as 'The Covid'. Now here were two GPs referring to 'the Covid thing/bit'. In so doing they turned the word Covid into a descriptive adjective, a modifier, which fit perfectly into Latour's Actor-Network Theory (Latour 2005). The thing/bit was the entity that came to impact on their practice, curtail their regular ways of engaging with patients, their ability to offer care that was not only responsive but pro-active and preventive, the kind of care that a good GP gives, where they and everyone working in their practice knows the patient, knows their social circumstances, knows their medical, surgical, obstetric and psychiatric history, knows their family history - not only the hereditary conditions that carry risks for, say, atherosclerotic disease, but also the family narrative: "everybody in our family has always had a bad back". A good GP knows how to take a history from a person who may

not be a good historian, for a multiplicity of reasons, and how to give tailor-made advice that has some chance of making a difference. They have been trained to create levity in a consultation, to brighten someone's day, and how to give bad news in a sensitive and empathic way. They know how to treat – and RP02 lamented losing their skills because the pandemic advised people to seek GP appointments only if absolutely necessary:

I inject joints and I do minor surgery and all that kind of useful stuff that I'm now losing, of course, because of this damn COVID. Because you have to use what you have to keep doing it [RP02].

Good GPs know how to safety-net – to communicate clearly to a patient what they must do if matters do not improve within a given time frame (Neighbour 2018). A focus on safety distinguishes excellent GP care (O'Malley, O'Connor, and Lydon 2024, 2). If the patient is not satisfied with how a GP treats them and complains of the GP to the Fitness to Practice Committee of the Medical Council, that GP will be subject to an enquiry and judged by contemporary standards, by the practice of the day. It is in this context that a GP regards 'The Covid Thing' as just another mandatory layer of new science to learn, new practices to adopt, new arrangements with which to manage practice procedures and unforeseen suffering borne by their patients. The sense of coherence valorised by GPs in this research had a speed wobble at the onset of the pandemic and was regained by collective effort. Antonovsky's concept of 'salutogenesis', constituted to a great extent by sense of coherence in family, community, at work and at a national level (Antonovsky 1996; Foley and Kistemann 2015, 159) was what RPs aimed to recapture in their practice for themselves, their practice team and their patients.

At a very early stage of the pandemic, it was clear that Covid and its associated matters would prevail over every other healthcare concern, preoccupying as it did, the minds of members of the public, healthcare workers, policy makers and

government officials alike. As we citizens were reminded constantly, our job was to stay safe, not to get infected and not to infect each other. “We’re all in this together” was the mantra. Except that GPs couldn’t get to provide the kind of holistic care they were accustomed to providing and were duly unsettled.

Covid wrecked an awful lot of our protocols and really wrecked a lot of our work that we had done over the years around protocols, around team meetings and around social time with each other. It was one of the real challenges of Covid because how to be cohesive and how to have ongoing interaction within the team [...] I don’t think the authorities have any idea of how difficult that was in a practice like ours [RP12].

A large part of caring for deprived persons is encouraging them to seek help:

They are the unworried, the unwell, they are much more preoccupied about their child who is suspended from school. Or their benefit being stopped or their sick mother or whatever [RP10].

This intensive care was particularly imperilled by social distancing. GPs with marginalised practice populations struggled to care for their patients in accordance with the high standards they had developed before the pandemic.

Our practice is face-to-face ... no-one wants to be doing video consultations, and we phone patients as we have always done, when it’s needed. And that summarises it – nothing has really changed. Nothing has changed. I do think that there’s a little bit of extra workload in terms of these Covid calls and triages and that represents an absolute minority of work that we do in GP. It’s just all the bulk of comprehensive general practice is what’s happening. Covid is just a parallel or a background context that’s important and it shapes how we work. Covid has changed our waiting rooms ... now we all wear masks. Sometimes a staff member has to go home because they are ... their kid has a temperature or something. There’s that context that’s different, but the care itself is the same’ [RP14].

When RP14 asserted that ‘the care itself is the same’ they did not factor in the multiplicity of new protocols and procedures GPs were obliged to bring to each consultation after March 2020. Johansson et al. reckon that every new protocol introduced to medical doctors’ workloads ought to be audited and costed in

terms of ‘time taken to treat’ lest the highest price of all – burnout – be paid by doctors themselves (Johansson, Guyatt, and Montori 2023).

In response to Research Question 4: ‘How do you feel about new modes of practice brought about by the COVID-19 pandemic?’ GPs were quick to applaud the rapid introduction of technological fixes such as online prescribing and online communication about patients with hospitals by the HSE. Online consultations had limited value while the provision of a computer terminal at their homes facilitated remote access to patient files after surgery hours.

Temporary recruitment of Irish private hospitals for patient diagnostics was seen as a great help. GPs acknowledge that they were well paid for their extra work during the pandemic. Once COVID-19 vaccines became available in January 2021, GPs were invited to ‘have a key role in delivering the COVID-19 Vaccination Programme to persons aged 70 years and over as well as high-risk patients in the medical priority groups’, as outlined in a HSE circular to GPs (Healy 2021), as well as doing sessional work at mass HSE-run vaccination clinics. Research Participants extolled the professional support they received from their practice teams, their colleagues and their professional support organisations such as the ICGP, the IMO and the Irish Medical Council.

Such complaints as RPs voiced came under two categories: (i) the care they were unable to provide to patients; (ii) the deterioration in their own quality of life during the pandemic. But the people I met at interview and the contributions they made to my research bore scant resemblance to what hospital doctors were going through, as reported by mainstream news media, on social media in TV drama reconstructions⁸⁸ and subsequently in published academic papers (Creese et al. 2021; Humphries et al. 2022; Byrne et al. 2021).

⁸⁸ ‘Breathtaking’ (2024), four-part series made by ITV.

This perplexed me at first, but recursive analysis of the data yielded the fundamental truth of GP life: continuity of care benefits not only the patient but also the doctor. Intersubjectivity gives meaning to their life's work, a case I allow my RPs to make throughout this thesis.

6.10 Doctor burnout in this research?

Before the advent of COVID-19 GPs already complained of being too busy. General Practices now commonly gave appointments only to patients who were already 'on their books' and many refused to see new patients. Single-handed practitioners in remote rural areas with sizeable GMS lists found, on reaching the age of retirement, that the HSE had failed to appoint a doctor to take over their list. Doctor retention had become a significant problem with large numbers of newly specialised Irish doctors going abroad, some, never to return. Humphries et al. have researched the large-scale emigration of hospital doctors and concluded that structural factors such as conditions of employment are responsible (Humphries, Crowe, and Brugha 2018; Humphries, McDermott, et al. 2019; Humphries, Connell, et al. 2019; Humphries et al. 2020). In a 2019 survey of Irish hospital doctors, Hayes et al. found evidence of burnout in 29.7% of participants (Hayes et al. 2019). No such research has been done on Irish GPs, but their workload has been evaluated and found to be demanding (Crosbie et al. 2020; Collins and Homeniuk 2021). The COVID-19 pandemic piled extra layers of work and work-related stress on all healthcare workers. Humphries' team have published harrowing accounts of hospital doctors' experiences while working during the pandemic (Byrne et al. 2021; Byrne et al. 2023; Creese et al. 2021; Humphries et al. 2022). So, it surprised me that these narratives were absent from my RPs' accounts with the single exception of one GP who had had burnout before the pandemic. The 'Covid Thing' framing permeated their responses to my questions about practice during the pandemic

and their other ambient mentions. A rural GP proudly stated that nobody in his practice died from Covid. A city GP who works with populations experiencing homelessness said the same of their practice population. GPs worked hard but were not ground down. Bury et al. suggest that they are 'motivated by altruism to work during pandemics despite the high personal risk, and they are enthusiastic about further training and information' (Bury et al. 2020, 196). Their accounts of working with marginalised people suggested that this level of crisis care provision was not new to them and perhaps required little more than an affective attunement. Moral injury⁸⁹ was entirely absent from interviews given by this group of GPs. I will now recount their responses to Q4 and will draw conclusions at the end of this chapter.

6.11 New modes of practice brought about by the COVID-19 pandemic

6.11.1 Healthmail and Healthlink

Research Participants said that GPs had been asking the HSE repeatedly, for years, to roll out Healthmail and Healthlink but that it took the pandemic to shock them into action. Healthmail has been in operation since 2014 with the original purpose of providing safe email communication between GPs and hospitals. In April 2020, COVID Emergency Legislative Provisions recognised Healthmail as the national electronic prescription transfer service, permitting

⁸⁹ Moral injury is 'distress experienced when an individual witnesses or engages in acts that contradict their moral and ethical beliefs. This has traditionally been studied in military populations exposed to combat but severe difficulties in providing optimal care during a pandemic could provoke similar reactions in healthcare workers. Surveys of US hospital workers have demonstrated high levels of moral injury over the course of the COVID-19 pandemic (Brady et al. 2022, 2). Kelly, an Irish consultant psychiatrist, asserts that healthcare workers have experienced a raised incidence of psychiatric illness since the pandemic, due in some measure to moral injury (Kelly 2020).

the transfer of a prescription between the prescriber and dispensing pharmacy by electronic means, removing the need for a paper equivalent. This has led to phenomenal increases in usage of the system in terms of message throughput, volume, and user logins (HSE 2024d).

Only three of thirty-one RPs did not refer to e-prescribing in their response to Q4. Twenty-eight used superlatives to describe its efficacy and efficiency along with its capacity to safeguard vulnerable patients. Five RPs happily referred to the demise of the 'background music' [RP13] of dot-matrix printers, now made redundant forever. Both urban and rural GPs loved the e-prescribing facility, Healthmail. Rural GPs who care for marginalised populations have large numbers of elderly, low-income patients who live alone and depend on kinsfolk and neighbours to collect the monthly prescriptions that help manage their multiple medical conditions. The quotations that follow illustrate how frictionless Healthmail has made this core task of general practice:

Fantastic, couldn't be better. It's not just e-prescribing but the electronic sending of PDFs of prescriptions to pharmacies and the fact that for the first time the nature and structure of how we work in general practice was prioritised to facilitate our work. So, everybody, for years, would have said – 'Oh we can't do that because we've never done it before, we need that actual paper signed in triplicate,' and all this kind of stuff. That went out the window and we will never revert to handwriting prescriptions [RP21].

Healthmail reduced the number of people who needed to come to the surgery just even to pick up a prescription. And that, overnight, changed the dynamic in our interaction with the pharmacy. And I think the pharmacists thought it was fantastic as well so ...huge improvement. Say, now, they got a repeat prescription on Monday afternoon they'd ring the patient on Wednesday ...everything is here, ready. You can come and pick it up. So, the waiting time in the pharmacy was reduced. And patients got used to it as well and they'd ring in advance, a week or ten days before. So, there was no more ... 'I've run out of my pills doctor' ... [RP29].

RPs said that they had long complained to the HSE about old-fashioned, inefficient prescribing and dispensing practices. COVID-19 created a contingency that improved flows of healthcare to the benefit of doctor, pharmacist and patient alike.

All prescription drugs are regulated with regard to how often their prescription can be repeated and whether GPs must see the patient before issuing a repeat prescription. RP03 and RP04 say that local pharmacists issue timely reminders to visit the GP for a checkup and that the patients come to the visit, happy that they're being taken care of.

In the city environment, marginalised people are more likely to be homeless and may have an addiction to drugs and/or alcohol. Their GPs need to be sure that they have the medication they need on a daily basis with no possibility of trading the written prescription:

E-prescribing is great. I mean, the amount of drug prescription tampering I had to deal with prior to that was always a struggle. [RP22].

E-prescriptions- fantastic. That we can send methadone scripts digitally is great [RP23].

The e-prescribing has been very helpful and has made prescribing much safer and much more efficient. [...] When there's a will there is a way. Things can change [RP15].

RP06 took Covid in their clinical stride as they dispensed rather than prescribed medicine during the first waves of the pandemic:

We have our own Covid assessment unit. Effectively what it was, was anybody that was homeless and were identified as having symptoms, they could come to us for a full respiratory assessment and a test but also within that you were just ... you were never just consulting on the one case. So, you were doing Covid assessment and then making sure that they were on their medication and that they had their medications: if they were on methadone that they had methadone. If they were on diazepam and they

were using street tranquillisers and they needed to go into isolation, then we needed to give them at least 30mg of diazepam to make sure they weren't going to have any seizures or withdrawal seizures. If they were using alcohol, to make sure that they would start on the Librium detox because obviously you don't want them to have seizures when they are in isolation. If they are off their HIV meds you have to make sure they get back on them. So, it was like ... all those other things ... the Covid bit was the easy bit ... [RP06].

A written prescription traditionally began with the symbol Rx, shorthand for the Latin imperative '*Recipe*', translated as 'Take thou'. The writing of a prescription is one of the final acts in a consultation when a GP, having taken a history, examined the patient, and discussed possible diagnoses, gives the patient something to make them better. When a patient requires referral to a hospital service either for diagnostic tests such as X-ray or blood tests, or evaluation by a specialist, the GP writes a letter of referral. These request letters or forms are now sent by Healthlink, another online technology made available to GPs at the outset of the pandemic. Should a patient's illness make them unfit to work, the GP fills out an electronic sick certificate and sends it to the Department of Employment and Social Protection (DEASP) via Healthlink. RPs are delighted with this efficient technology as expressed here:

There are a few places like *Named Local Hospital A&E* that are still taking FAX referrals which is just beyond thinking about in this day and age. But they are. So, we are emailing most of our referrals for things now and it's great because you always have proof that it was received – 'Oh we never got that letter' – they can't say that anymore. It has also made dealing with nursing homes much easier because the nursing home nurses are able to email us if they just have a simple request to add something to a prescription [RP26].

RP26's comment provides yet another example of how hospitals make it difficult for GPs to get secondary care for their patients; another example of blockage and reverse flow⁹⁰ in healthcare.

6.11.2 Tele-consultation

Telephone consultation was rarely used by GPs prior to COVID-19. It might have been used for cursory check-in as a patient recovered, but rarely for a full consultation. The move to online consultation was urged by policy makers and explicitly encouraged in the Sláintecare document (Shortall 2017, 101). Covid's high morbidity and mortality rates during the first wave drove most consultations online. GP surgeries remained open but waiting rooms were decommissioned and in rural practices, patients were requested to wait in their car until called by a receptionist. Urban practices do not usually have spacious car parks so patients who got a lift from a neighbour or friend parked nearby and those without private transport had to wait outside, no matter what the weather. All requests for a doctor or practice nurse visit were triaged by telephone and only if the presenting complaint could not be thoroughly and safely dealt with over the phone was the patient invited to attend physically at the practice. All practice personnel wore full PPE for the first nine months, before vaccination became effective. ICGP webinars introduced GPs to all

⁹⁰ From their earliest days as medical students, doctors are taught about fluid dynamics ... the flow of blood through the circulatory system, air through respiratory tubules and tissues etc. Any obstruction to normal flows leads to pathology, and may, for example when a deep venous thrombosis (DVT) in the leg moves to smaller vessels in the lung, cause a fatal pulmonary embolism (PE) (see section 6.2.1). Modern healthcare systems are designed so that patients who need secondary care can flow from the periphery to the hospital or centre of excellence. Just as GPs diagnose blockages and reverse flows within the body's systems at primary care level, they experience systemic blockages and reverse flows when they cannot get their patients treated in hospital in a timely manner, and as narrated by RP21 in section 4.4.3.2, must try to provide specialist care themselves.

aspects of providing primary care during the pandemic, for example donning and doffing of PPE, telephone triage, and updates from ICGP Clinical Leads. The HSE provided online training for tele-consultation in its training platform, HSELand. I took this training while working as a Clinical Contact Tracer and revised the key elements of providing confidential patient consultations online:

Privacy and Security:

How to engage with and disengage from the patient

Ensure secure platforms for patient–doctor communication.

Protect patient data and comply with GDPR⁹¹ regulations.

Informed Consent:

Clearly explain the process of online consultations to patients.

Obtain their informed consent for telemedicine services.

Clinical Assessment:

Conduct thorough assessments, even remotely.

Use video calls for visual cues and accurate diagnosis.

Documentation:

⁹¹ GDPR is General Data Protection Regulation (2016), a European Union regulation on information privacy in the European Union (European Union 2016).

Maintain detailed records of online consultations.

Document prescriptions, advice, and follow-up plans.

Safety-netting

Give information to a patient or their carer during a consultation about actions to take if their condition fails to improve, changes or if they have further concerns.

Homeniuk and Collins found that between February and June 2020, during the first wave of the pandemic, 'face-to-face consultations decreased to one third from a median of 26 to a median of 8; GP telemedicine consultations increased from a median of 2.4 to a median of 11.3' (per GP per day) (Homeniuk and Collins 2021, 4). RPs in this research say they find tele-consulting exhausting, that it is freighted with the possibility of 'missing things' causing them to feel anxious after patient interactions were finished. As they became more accustomed to telephone consultation, some, but not all, became more comfortable with it. They said that their history-taking was not good enough, non-verbal cues were easily missed, and that physical examination was not possible. A rural GP said that

75% of the work, certainly in the first year of the pandemic, was over the phone, and you could bring them in if necessary. ...I would have found it very difficult if I didn't know the patients. And I did out-of-hours consulting during the pandemic and I found that much more difficult because I was dealing with people that I didn't know [RP30].

This comment, foregrounding the importance to GPs of continuity of care, is the quintessence of primary healthcare.

Continuity of care in general practice expedited tele-consulting but not with marginalised people:

A lot of our patients struggle over the phone in terms of regular phone numbers and language ability and literacy. So, it's not been easy for the patients [RP17].

When there's a mental health issue, all GPs with marginalised patients say that telephone consultation is almost useless:

It wouldn't have worked in the homeless sector. Most of them have phones but it takes up a lot of time getting the thing right. ... It's totally unsatisfactory for mental health services. You just can't pick up a feeling or they can't; a lot of what you are doing is empathy and just letting them know I have an idea of how awful things are for you at the moment. That might be as much as you can do but that just doesn't work [RP16].

Video consultation was abandoned by all RPs, even those who had purchased the equipment for it. GPs who had hoped that it might help diagnose rashes found it dangerously misleading. Whereas one RP had used telephone consultation in the UK during fifteen years working in the NHS, even this GP lamented 'missing the patients'. GPs take great solace from the variety of general practice; the contrapuntal daily case load that intersperses minor and routine medical conditions with significant and life-threatening ones. Two RPs declared that they missed seeing children and watching them grow. That Covid had siphoned all the joy out of general practice by taking away face-to-face contact with patients was stated explicitly by three RPs and tacitly by all the others. Loneliness was a common experience during the long working days.

One RP was on maternity leave when the pandemic began:

So, I missed a lot of the time where it was almost exclusively tele-medicine. I went back in late summer, so I dodged the extreme stress that I think doctors were under at that time. Our practice is in an area of deprivation where health literacy can be a real barrier and the stories – somebody

complaining of a pain in their foot and then – Oh gosh, their toes are necrotic. Or someone had a patient who was saying -I’m falling a lot- and it turned out it was a vision problem; he was going blind [RP15].

RP15 said that their colleagues described this in terms of a GP’s nightmare – missing signs and symptoms that, if diagnosed in a timely manner, could have been treated early. There were some unforeseen consequences to teleconsulting. RP04 described the shift in power when the old model of patients assembling and waiting in the waiting room was abandoned at the beginning of the pandemic. From then on, patients were given timed appointments for either a phone call or an in-person consultation, and quite often, if they were delayed, the doctor had to wait. RP04 commented on the reversal of power relations that accompanied this change. Two RPs said that their patients had had online consultations with hospital specialists and told them about it. In both cases they were upset, on the one hand, that they only got a phone consultation after a two year wait for a hospital appointment. On the other hand, both patients had recounted calling the hospital consultant to account because the medium of telephone stripped him of the power of his rank.

All RPs reckon that, despite their efforts to return their practice to face-to-face consultations, tele-consultation is here to stay. It offers more convenience with no need for the patient to take time off work or school to go to the doctor’s surgery. It enables GPs to dial in to a multidisciplinary team meeting without having to travel through traffic. Some RPs have adapted to it, others declare they never will. The examples given above highlight the need for active listening, focused attention and care-ful safety- netting on the part of all GPs in all consultations.

6.11.3 Unanticipated upsides of COVID-19

At the outset of the pandemic a decision was made to make available whatever funds and resources were required to suppress spread of the SARS CoV-2 virus (Burke et al. 2021). Not only was the technology for Healthlink, Healthmail and remote work made available, but all primary care for people with signs or symptoms of COVID-19 was funded by the state. A cohort of patients who had heretofore rarely consulted a doctor because they couldn't afford it thereby presented themselves for primary care.

During the pandemic we came in contact with a lot of the working poor⁹² who didn't have medical cards but were contacting us because they thought they had symptoms of Covid. [...] But it turned out they had unmanaged asthma or something ... and these are the people who actually die with asthma ... so it was an opportunity then to try and get them educated and sorted ... there's a lot of working poor out there [RP18].

A recent Lancet editorial castigated Ireland for its inadequate provision of primary care that is free at the point of access: '58% of residents do not have access to free primary health care' (The Lancet Editorial 2025). But during the pandemic,

Suddenly money and resources came to set up all the PCR testing, all the contact tracing, all the vaccination clinics [RP15].

GPs noticed that bureaucracy was eroded and that they became much less conscious of litigation:

The whole health service to me seems to work. [...] I think a lot of people decided that actually it's more important to get the job done than to protect their patch ...entirely because of Covid [RP16].

⁹² Working poor: a term used by GPs to refer to people who, although employed, neither have enough disposable income to pay 'out-of-pocket' for private medical care nor little enough income to qualify for a GMS card or Doctor Visit Card.

Nursing homes were a real pain in the neck pre-Covid. Because they were the ones that I was getting called out for all sorts of things. And really you were spending more time making sure you'd written everything down than the time you were with the patient. All that evaporated with Covid [RP04].

Nurses are now qualified to pronounce death. A few thousand nurses have done the course [RP04].

As members of the public watched case and fatality numbers rising during the first wave, they expressed more appreciation of the service offered by their GP:

Of course, they don't want to go to the hospital now ... all that whinging and whining and complaining, all that's gone. And replaced by gratitude [RP02].

We got really good feedback from the community. They would regularly thank us for being there with them [RP30].

GPs working in urban Deep End practices were impressed by the commitment of their practice team members during the pandemic. RP10 and RP12 had a team huddle in their respective Practices morning and described it as 'a kind of army meeting', presaging a 2024 study which found that good teamwork was an essential component of 'exceptionally good patient care in general practice' (O'Malley, O'Connor, and Lydon 2024, 9–10). GPs found their practice team members to be nimble, versatile and willing to rise to the challenges posed by the pandemic, a fact endorsed by Dr Tony Holohan, Chief Medical Officer of Ireland in his memoir (Holohan 2023, 201). COVID-19 vaccination was often done on Saturdays and Sundays and required all practice staff to be at work:

We adapted when the pandemic hit – I don't know of any practice in the country that didn't roll in and vaccinate. [...] We have vaccinated the overwhelming majority of people in this country – it wasn't vaccine clinics, it wasn't pharmacies, it wasn't hospitals, it was GPs. And we did the elderly ... we were able to locate those patients pretty fast, bring them in, park them in the car, remain with them afterwards, implement a system where they were on the premises for 15 minutes. At that time get their cert out to them, their piece of paper, put it all on the software, send that information back to the HSE so they know who has been vaccinated with what vaccine and when [RP31].

6.11.4 Continuity of care

Regular primary care continued, regardless of the pandemic, in so far as GPs could deliver it:

We stayed open all through the pandemic as in we were open for all of our antenatal care, all of our childhood vaccines [RP26].

But before vaccination it was tough, it was tough doing Mirenas and Implanons, our group badly needed their LARCs and we felt we had to keep it going⁹³ [RP12].

Chronic Disease Management continued. It has put on a solid footing good, structured care for the vulnerable, as the research project would say, the poor, in essence people who have medical cards. And in the middle of that, in between those twice-yearly visits, chaotic care has diminished [RP21].

Knowing the patients of a practice made it possible to contact people with a chronic condition who were afraid to leave their homes and invite them to have a check-up. In this way, continuity of care enabled the GP to offer care and the patient to trust them sufficiently to accept it. RP29 visited their housebound patients at home to vaccinate them against Covid. People experiencing homelessness were sought out and offered appropriate care. Like any other GP practice population, the healthcare workers and patients know each other well and this relationship facilitates the delivery of targeted care. Collaboration between these healthcare professionals delivered an early, focussed, patient centred response to the pandemic with excellent outcomes (O'Carroll 2020).

⁹³ These are all contraceptive implants.

6.11.5 Downsides of the COVID-19 pandemic according to Research Participants

GPs interviewed in this research divided the disadvantages of the COVID-19 pandemic into what affected patients and patient care and what affected themselves. During the first wave, everybody was confined to their homes, and most people were very frightened of exposure to the virus. Patients only consulted their GPs in extreme cases, so the ambient investigation and diagnosis of signs and symptoms of chronic disease escalated rapidly.

The problem is at the moment people have not been seen for such a long period of time and so when they come in you are picking up lots of stuff and I've had three or four I can think of off the top of my head with blood pressures of 200/120 and not having them checked out⁹⁴. They had stopped their medication [RP13].

While hospitals and other secondary care facilities were shut down for routine admissions, waiting lists grew exponentially. Research Participants said that mental healthcare services were among the first to withdraw from face-to-face interactions with patients:

I think things are particularly bad since Covid, that's my sense. People weren't providing much of a service in TUSLA ... teachers would report things ... I think things got quite bad in people's homes and in relationships [RP07].

I think it's a big shame that during the COVID that the mental health services were one of the first people to actually withdraw and to say – Oh I can't do face-to-face consultations. [RP16 in December 2020].

I would say that's one of the things COVID has done, people have become ... there's a lot of mental health issues out there at the moment, and people have a very short fuse [RP13].

⁹⁴ Blood pressure readings of this order indicate significant cardiovascular risk to the patient and require immediate intervention.

Two GPs interviewed in Summer 2022 said that many of their patients were reluctant to return to work after receiving the Pandemic Unemployment Payment for over a year; ‘work-shy’ being the courteous rural Irish term they used.

Jobs like Care Assistants and things like that – people just don’t want to do it [RP26].

RP26 went on to describe the case history of an elderly woman with perfect cognition and poor mobility who needed a Care Assistant at home. Nobody was available either via the HSE services or private payment by her family. This woman had to go into a nursing home and would probably never come out. When I asked if Care Assistants are adequately paid⁹⁵, RP26 said ‘probably not’. This observation calls to mind Arundhati Roy’s musings on ‘the pandemic as a portal’ (Roy 2020) and reminds one of TV images of the UK public clapping their support for healthcare workers while black and ethnic minority healthcare workers died in larger numbers than their white colleagues (Rimmer 2020). Roy suggested that ‘historically, pandemics have forced humans to break with the past and imagine their world anew’, inviting us to forsake capitalism. Instead, the world order has become even more focused on economic growth than before the pandemic.

The prohibition of touch presented a major disruption to doctor-patient engagement in the face-to-face consultation. From the outset of the pandemic, public debate raged about how COVID-19 was transmitted and what measures might curtail its spread. The WHO did not acknowledge that COVID-19 is airborne until December 2021 (Jimenez et al. 2022, 2–3). During the early, uncertain days, it was presumed that it was droplet-borne and rested on

⁹⁵ Health and social care assistants are currently paid €35,434–€44,539 per annum (March 2025), about 25% above the minimum wage.

surfaces, on hands, on doorknobs etc. During the first wave, when people were frightened, ambient gestures used by GPs to explain diagnoses, to recruit co-operation, to reassure and encourage were decommissioned. Once masks became mandatory, elderly patients had great difficulty processing GP speech in the absence of lip-reading and facial expression. Empathetic and compassionate disposition was difficult for GPs to convey:

You can't sit and hold on to somebody's hand anymore. ... and that feels like a terrible deprivation for both our patients and for us as clinicians. I think the laying-on of hands is such an ancient part of healing; it's done in religion, and it's done in health. I think they miss it, and I miss it. [...] And touch creates that connection of equality [RP12].

While all RPs felt galvanised by the momentum of the COVID-19 vaccination programme from January 2021 onwards, at a personal level, they found the pandemic workload very onerous, and several said that it had caused a deterioration in their own physical and/or mental health. It was 'astronomically busier' [RP05] once Covid arrived. GPs who had held or were newly appointed to leadership roles such as 'Clinical Lead' or 'GP Trainer' or 'Convenor of the Out-of-hours Service' scrambled to create and implement new practices and protocols that would help 'suppress the virus'. New scientific information became available more than once daily, creating the obligation to stay abreast of all updates. Practice buildings had to be reconfigured, waiting rooms decommissioned and signage erected throughout. Primary healthcare teams needed training and upskilling to work with new technology and PPE. Practice teams had to observe the public health guidelines too: if any one of them tested positive for Covid before the vaccination programme took effect, they had to go home and isolate for fourteen days, adding to their colleagues' workloads. Routine primary care had to be continued while the burden of COVID-19 related care prevailed in terms of worried patients ringing the practice, unaccustomed to the new etiquette of making appointments for a phone call

with a clinician. Marginalised patients who were chaotic required extra levels of care and accommodation.

Safety-netting had to be ramped up to compensate for the lack of face-to-face consultations. After an online consultation, GPs sometimes found themselves still worried about a patient. They felt that they worked in siloes, missing the mutual support that is a feature of group practices [RP08], having a bigger caseload of marginalised patients who preferred to see a particular doctor with whom they had formed a therapeutic relationship.

It's difficult to convey how much extra work we have had. Like the changes in the pandemic not just the mode, it's the volume of all this COVID related work. So, when the pandemic is high there's ten or fifteen calls about COVID per day and the person with chest pain isn't getting spoken to. Or you do it all and you are there till 9 o'clock. Then patients ring up asking -Is Dr RP10 annoyed with me because I haven't seen them for so long. These were just people I had seen every three or four months for the last ten years. And I know them inside out. And they are hurt. I don't know how you get around that [RP10].

Multidisciplinary team meetings ceased immediately, withdrawing an essential level of support for children in marginalised families at a time when rates of domestic violence rose significantly. In an aside, two GPs mentioned that they were so busy that they had no time to make returns and claim expenses for some Covid-related work and for some Chronic Disease Management work. Another GP who works near the Northern Ireland border said that their workload was augmented by having to support distraught patients whose relatives suffered and died from the shortcomings of pandemic healthcare in the UK.

Weight gain was mentioned by four GPs, deterioration in personal fitness and signs of mild depression were remarked on by a further two GPs. Five referred to a generalised disintegration of their quality of life while associating it with

their workload. One GP lamented that their GP Registrar had worked for two years in a pandemic and that they had to consistently remind him that this did not reflect normal practice.

It is worth mentioning that the phenomenon of Covid denial received only one mention throughout this research. During the summer of 2020, before vaccination was available, RP04 triaged a patient and invited her to come in for examination on condition that she took a Covid test. She said that she did not believe in Covid and declined the invitation. This was, for RP04, a harbinger of Covid denial and vaccine hesitancy that flourished from 2021 onwards and yet another example of how each GP's working life is a microcosm of global trends.

6.11.6 Professional support for GPs

In March 2020, GPs scrambled to find ways of staying connected. WhatsApp groups were set up for mutual clinical and educational support. As I have mentioned already, the ICGP began a series of weekly webinars to keep its members informed on all aspects of the COVID-19 pandemic; early in the week the topics and speakers were e-mailed to members who could register online. Over two thousand GPs attended regularly, and CME credits could be claimed afterwards. Research Participants in this research said that they took great strength from people like Mary Favier, President of the ICGP and Nuala O'Connor, COVID-19 Clinical Lead, who, while admitting that their workload was heavy, remained upbeat and optimistic throughout the pandemic. In this research, one RP who is close to retirement age described how his practice team over-ruled him and devised a work schedule that removed him from patient-facing work. Another told a story about a hospital consultant colleague who was protected in like manner by his team. Three RPs complained of GP colleagues who used the pandemic to withdraw from face-to-face consultations

and were slow to return. Another story concerned the reluctance of some GP practices to agree to see new patients, even though the HSE was underwriting their fees. In several cases, RPs complained bitterly of hospital doctors blithely writing to them instructing them to have tests carried out on patients; “I’m not your intern” said RP25, reflecting the annoyance of GPs who struggled to keep up with their own primary care workload. One surprising finding was the handful of GPs who work mainly with marginalised people and say that they have stopped attending their CME group because colleagues with more privileged practice populations have nothing in common with them and no support to offer. The Deep End Group offers mutual support to GPs who do this work, a fact mentioned by RPs who belong to that group.

Although the burden of patient care was heavy during the three waves of the pandemic, GPs, without exception, felt supported, appreciated and well remunerated by the state, the Department of Health and the HSE. All RPs were visibly pleased when recounting gratitude expressed by their patients for the work they did during the pandemic.

6.12 Summary

Before the COVID-19 pandemic erupted in early 2020, Irish GPs contended with their regular workload with its balance of clinical and administrative responsibilities. A survey of 507 practices done in February 2020 indicates that ‘over 29.1 million consultations take place in Irish general practice every year, that an Irish person visits their GP an estimated 4.34 times a year and the average consultation time is 13.7 minutes’ (Collins and Homeniuk 2021, 1). A mean working day of 9.9 hours has already been cited (Crosbie et al. 2020, 1). The COVID-19 pandemic spread fast with huge morbidity and mortality, catapulting most citizens into a state of shocked quasi-paralysis. To contend

with the new modes of practice thrust upon them, GPs adapted rapidly in order to continue to provide care for their patients. Support came from every quarter and was widely incorporated: the Irish state, the Department of Health, newly constituted bodies such as NPHET supplied them with knowledge, funds and support in every possible way. Professional bodies such as the IMC, IMO and ICGP worked proactively and energetically to provide guidance, targeted scientific knowledge and to enhance GP expertise. GPs set up WhatsApp groups with their own peers for rapid peer-to-peer consultation. Not only did they have to provide regular primary care for their patients, but they also had to continue the management of chronic disease in an ageing population. Those with a cohort of patients in marginalised areas had to search out their patients whom they knew to be more at risk of ill health and the sequelae of poverty.

Having retired from the practice of medicine in 2000, I re-registered with the Irish Medical Council and was employed by the HSE as a Clinical Contact Tracer in 2020. Training for this role reawakened my rusty medical education and the affective dimensions of caring for patients that are so intrinsically embodied in being a GP. I give an account here of the training, then, the six months of working as a contact tracer, then, my return to academic work when travel was allowed. I interviewed thirty-one GPs who spoke about how the pandemic and its restrictions impacted on their practice and on their own wellbeing. During the interviews, during the transcription and coding, something continued to elude me, and it took time before I identified it. It was the absence of accounts of disabling burnout and moral injury that were woven through the accounts given by hospital doctors both in academic literature (Creese et al. 2021) and in mainstream media. While it is one of the disadvantages of this small research sample that I found scant evidence of mental illness arising from the COVID-19 pandemic, when I interviewed ten GPs for my MA research in 2018, two spoke about colleagues who had taken

their own lives, one, after being complained to the Fitness to Practice Committee of the Medical Council. Reviewing the transcripts of this research project through a linguistic lens offered an explanation: as they spoke, GPs used active, transitive verbs when describing patient care. The passive voice was absent. Continuity of care brings them into a relationship with their patients that reciprocally benefits both. This is a major finding of this research confirmed in this striking manner even during the public health crisis of the pandemic.

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Chapter Seven: Discussion and Conclusion

7.1 Introduction

This thesis is political. It did not set out to be, but the personal is political, and GPs who participated in this research shared personal stories of and reflections on their lived experience which signalled a deeply engaged, relational commitment to their marginalised, underserved patients. It is political because it highlights what matters to GPs, what gives meaning to their life's work, what makes them keep on caring. It also suggests the mirror image of this kind of general practice - what primary healthcare could be like if delivered by highly trained, algorithmically driven, disengaged clock-watchers. The thesis is political with a large P because healthcare and social care consume such a large proportion of government spending (Government of Ireland 2025)⁹⁶ and yet, so many people remain underserved. As Chapter 2 has shown, geographies of health are replete with studies about inequality and caregiving, but deficient in accounts of GPs' emotional and relational experiences. The concept of GPs as placemakers is absent, a critical theoretical lacuna in which I place this research. While the forces of poverty, structural violence and health inequalities play out in both everyday and academic discourse, the literature rarely studies how general practitioners encounter, mediate and negotiate them in their daily work.

The overall aim of this research was to discern the lived experience of Irish general practitioners who provide primary care for marginalised people.

⁹⁶ In 2025 from its total expenditure of €120bn, the Irish government allocated €26bn to healthcare (21.5%) (Government of Ireland 2025).

Although the term ‘marginalised’ defies rigid geographical categorisation or delineation, patients who fall into this group reside in areas of deprivation, mapped on the Pobal HP maps (Haase and Pratschke 2017, 2023) and it is here that I found their primary healthcare centres and the GPs who serve them.

Within this framework, I aimed to detect how GPs act as placemakers in the communities where they work and to draw them out on how care and care-giving create meaning in their life-worlds. I also sought to understand how GPs contend with structural inequalities and power relations while delivering primary healthcare. Once the COVID-19 pandemic had disrupted the quotidian practices of primary care, I sought to discover what it had changed, how GPs had adapted, and how they felt about the reconfiguration it mandated both during and after the event. All of the lived, felt, textured experience that GPs spoke about in person was largely absent from the academic literature and it seemed worthwhile to find a way ethically to elicit their stories in a manner that rendered them capable of being told and synthesised. This thesis, ‘Advocates of the Poor’, finds its niche and makes its contribution to knowledge by giving voice to GPs’ lived experience; this chapter interprets the findings in the context of the research questions and extant literature. It concludes by proposing elements of the scaffolding of primary caregiving that will sustain GPs and patients into the future.

7.1.1 Geography with a small or a big G?

Participants in this research frequently invoke geography (with a small G) when they speak. They give vivid accounts of patients’ living circumstances, how to get to their homes in different weather, why one hospital is easier to access than another. They speak of rural emigration, and inward migration, economic shocks to a neighbourhood, ageing-in-place and homelessness. They facilitate

patients with long commutes to work and specific occupational hazards. Yet, the discipline of Geography hardly troubles their busy lifeworld. This led me to query GPs' roles as placemakers, one that is implicit in their narratives but unarticulated by them, although they enact it daily:

With respect to 'intentionality', it is posited that through human presence, perception and judgment, places are ascribed meaning (Andrews 2021, 73).

Research Questions outlined in the introductory chapter were answered within the frames of placemaking, care-giving and what was lost and re-gained due to the COVID-19 pandemic.

7.1.1.1 Placemaking

In Chapter 4 I have shown that while they say that 'nobody knows what we do' (Gannon 2019), GPs are placemakers in thought, word and action (Conradson 2005; Dyck et al. 2005; Cummins et al. 2007). They are shaped by place during their medical and geographic formation and then go on to make place for others (Gerada 2021; G.Kearns 2015; McCormack 2009). In Chapter 4, I also explored how GPs enact placemaking by the architectural design of their practice premises and the codes of practice observed by everyone on their practice teams in order to create the ideal conditions of possibility for patients to disclose personal information and consent to physical examination. I detailed the many and varied sites where they visit patients away from their practice premises and regretted that my ethical research mandate prohibited mapping the pathways they carve on their landscapes of care. The idea of digital placemaking was studied too, having become more commonplace by the accelerated introduction of digital technologies during the pandemic. GPs who care for marginalised people are embedded in their communities; the physical and human geography of patients' lifeworlds shapes them too.

7.1.1.2 Landscapes of care and care-giving

In Chapter 5, I interrogated the caring practices used by my research participants that go a long way beyond basic clinical diagnosis and treatment. In this chapter the focus was on GP advocacy and the work it requires, often hidden, often unacknowledged. Since primary care is only one node on a chain of healthcare modalities, this chapter focussed on communications with providers of secondary care, such as hospitals and community psychiatric services. GP relationships with the HSE and Government are important and are frequently commented on by GPs in this research. However, a Foucauldian analysis of power enquired about how they articulate their own power and powerlessness and how they positioned themselves on that axis. The thesis also focussed on the practice of self-care; GPs said little about it when they had worked it out in their own lives but said a lot more when describing adverse events in the lives of some of their colleagues. At their request, I redacted many of their Case Histories and confidential narratives from the text but remained moved by the spectral trace of what they had told me. Such accounts as were redacted by some RPs but were re-iterated and not redacted by others enabled me to triangulate their narratives without breach of confidentiality.

7.1.1.3 The COVID-19 pandemic as disruptor

In Chapter 6, rather than extracting further themes from participant narratives, I focussed on the COVID-19 pandemic from the perspective of citizen, former GP and clinical contact tracer. While we all reeled from the sudden shock and disruption of our regular lifestyles, government's approach to suppressing the SARS-CoV-2 virus took the principles of Sláintecare and incorporated them in each new measure (Burke et al. 2021). As place was annihilated in our lives, it was reconfigured online in medical care. Only the sickest patients were seen in person as GPs learned to consult in full PPE and masks, struggling to discern

the gravity of a patient's history in the absence of facial expressions known to them from years of continuous care. Despite these challenges, and the lingering fear, described by RPs of 'Did I miss anything?', by July 2020 (five months after the first Irish case), one RP described COVID-19 as 'the Covid-thing', reducing it to the status of just another job to be factored into the consultation. Rather than reporting burnout, GPs gave exhilarated accounts of vaccine roll-out, revelling in seeing their patients again in person, and providing a protocol-driven service to all citizens, irrespective of ability to pay, that genuinely saved lives. They knew they had been instrumental in the efficient delivery of vaccinations and were pleased to be duly acknowledged by politicians and the CMO. Having had their embodied, face-to-face consultations prohibited, they rejoiced in their return, with a sharpened appreciation for the intersubjectivity that drew them to general practice in the first place. This is a salutary reminder that as telemedicine and AI advance, face-to-face consultations ought to remain the default, for the good of both patient and doctor.

7.2 Summary of key findings

7.2.1 General Practitioners derive great joy and meaning from caring for their patients

The main conclusion of this research is that general practitioners who provide primary care for marginalised people engage deeply with their patients in an intersubjective, in-person manner that goes on for decades. The relational nature of GPs' professional commitment grows, over time, to include all aspects of their patient's personal life, family situation, work and community involvement, celebrations and crises. Since GPs often provide primary care to more than one member of a family in more than one generation, GPs develop an embodied, sensing appreciation of a person's lifeworld during a career of continuous caring. Before the cultural turn, GPs might have asserted that they

do all the giving in the doctor–patient relationship, giving care, giving advice on risk avoidance, giving emergency support at unsocial hours. But if general practice were to be a one-way transaction, remunerated only by income and expenses, why would anybody keep on doing it? There are easier ways to earn a living and in our buoyant Irish economy, a GP's transferable skills could find them another well-paid job. The joy lies in the life-affirming intersubjectivity between doctor and patient. This research foregrounds what it feels like to be a GP. Three hundred and eighty-eight references in fifty-three files (interview transcripts and memos) were coded to the heading 'Joy' (see Figure 3-3). In response to interview questions about satisfaction at work, positive feelings about their career, their identity and their quality of life, they enthused using expressions like 'joy', 'enjoy', 'laughter', 'having the craic', 'having a laugh', 'black humour', 'respect', 'treasured interactions', 'GPs are affirmation junkies', 'love', 'happy', 'satisfactory'. They described the joys of consultations in the practice across the life course, doing house calls, visiting patients with no fixed abode, taking time with nursing home visits, educating patients in preventive healthcare, teaching medical students, training GP trainees, participating in policy making, mass vaccinating against COVID-19, making a difference, and peppered their spoken accounts with smiles and laughter. 'The best job in the world', 'I'd encourage anyone to do it' were uttered by two RPs and echoed by all. The expressed joys of being⁹⁷ a GP were an overture to the symphony of placemaking, the consequence of their life's work that is unseen by them, but a *sine qua non* for all their patients.

⁹⁷ Recall Gerada's comment that one 'becomes a GP' in every aspect of one's life.

7.2.2 General Practitioners act as placemakers

‘No doctor, no village’, Dr Michael Harty’s election slogan in 2016, portends clearly the vacuum caused by the absence of a primary healthcare presence and/or service that transfigures space into place. I have already stated that placemaking is relational and arises from the intersubjectivity between doctor and patient/community that is inherently geographical. Everybody needs a GP. People with acute and chronic illnesses require and deserve prompt access to diagnosis and treatment. Babies and children need developmental checkups and vaccinations. Mothers need ante-natal and perinatal care. Teenagers with mental health issues need a primary carer they can trust; sexually active people need contraceptive and sexual health advice and prescriptions. In adulthood, patients need diagnosis and treatment for the vast range of illnesses acquired by genetic predisposition, lifestyle, occupational hazard and mere happenstance. Older people want to stay in their homes rather than go into a nursing home (Grove 2021; Finlay et al. 2022); they require a higher frequency of doctor visits and more advocacy with financial leverage to equip their homes safely. Poor people get sicker younger and have worse outcomes (Pearce 2014; Watt 2019). Some patients want to die at home, in the bosom of their family and friends. Every kilometre driven, walked or cycled by a GP en route to a patient makes place for them both: the patient gets medical care and the GP feels useful [RP02], respected [RP03, RP14, RP25] and knows they’ve made a difference [RPs 05, 09, 16, 17, 19, 22, 26, 28, 30, 31]. Rather than feeling burdened by the variety in their clinical caseload, GPs love the unpredictable nature of general practice, and love solving a clinical dilemma by persevering at it with their full range of clinical skills.

Sláintecare (2017) concluded

that our healthcare system must be re-orientated to ensure equitable access to a universal single tier system, and that the vast majority of care takes place in the primary and social care settings (p. 14).

The structure of the Irish healthcare system has been described in the introductory chapter to this thesis which clarifies its inequality and inequity of access. Place is made structurally by the system in terms of geographical distribution of healthcare facilities. Uneven access to disability services (p.45), palliative care (p. 49), hospitals (p. 87) and primary care (pp. 40, 129) were noted in the Future of Sláintecare report and have yet to be remedied (Shortall 2017). In the meantime, GPs must strive to fill the gaps in patient care by going beyond their remit in terms of skill and advocacy, becoming not only placemaker but place-router. Participants in this research state repeatedly that what drains them is not consultations with patients. They feel worn down firstly, by the volume of administrative work (paperwork/hidden work) arising from consultations and secondly, by the systemic inequities that make them unable to access timely secondary care for their ailing patients, sometimes with catastrophic consequences.

The word 'privilege' is used frequently by participants in this research when describing how it felt to be trusted by their patients. GPs enter the lifeworlds of individual patients; lifeworlds shaped by patients' own personal experiences, by their families and their communities. Family and community life are an interwoven mesh of seasonal rhythms, locally influenced events, joys and sorrows which together, co-construct a sense of place. Intersubjectivity is described by Buttmer as

the inherited situation which surrounds everyday life. It can also be understood as an ongoing process whereby individuals continue to create their social worlds (Buttimer 1976, 286).

I conceive intersubjectivity as a protracted process of reciprocal carving and moulding where, over years, those in the relationship sculpt each other by their

relationships and mutual regard. RPs described events where they were able, variously, to provide service and care immediately, and meaningfully alter an outcome. The majority of participants have been at public events where somebody collapses and their prompt, skilled intervention not only saves a life, but also gives those present the gift of not having their occasion ruined by a tragedy, and the security of knowing that somebody with those skills is one of their own⁹⁸. Women patients frequently travel a long way to see a female GP. A doctor/patient personality clash can undermine a timely clinical outcome⁹⁹. In an ideal scenario, patients choose their GPs, a situation that becomes more unlikely with every GP that emigrates and/or retires. An embedded, local GP may reasonably be said to be capable of fulfilling any or all of Seamon's generative processes of place: interaction, identity, release, realisation, intensification and creation (Seamon 2018). 'No Doctor, No Village' indeed.

7.2.3 Landscapes of primary healthcare

This thesis has contributed to an understanding of the lived experience of GPs who care for marginalised people. The age range of participants in this research was between 29 y and 73 y, with an equal number of males and females. Much research has been done into the working practices of Irish GPs, the problems associated with GP emigration and the ageing-out of a cohort of GPs nearing retirement whose practices were viable because of economic realities that no longer prevail. Ireland is not alone in facing these problems; other developed

⁹⁸ I can identify with these accounts, having been called on as a GP during and after my medical career. Only in the USA where litigation is a concern, do doctors decline to step in and assist.

⁹⁹ GMS patients have a 'Choice of Doctor' scheme. If they do not like their local doctor, and if another one has capacity, they can request that their medical records and their healthcare arrangements are transferred.

countries have great difficulty staffing primary care, particularly in remote rural areas. I argue that the kernel of GP attrition in certain areas is to be found in their feelings about their lifeworld (Buttimer 1976; Seamon 2018). GPs in this research have described their formation, the various crossroads in their training where they took the road less travelled and why, what supports them and drains them in their work and how they make meaning of it.

I have already recounted how GPs who qualified in the 1970s–80s set up single-handed practice with a GMS list. At interview, many of these late-career GPs said that they ‘would not do it all over again’ because they made so many sacrifices. On the other hand, contemporary GPs are trained that self-care is the foundation of being able to care for others (Gerada 2021). Humphries et al. profile participants in different age cohorts with a view to understating their differing value systems.

The role of doctor has been shaped by the Baby Boomer generation whose approach to medicine was characterised by long working hours and the assumption that ‘the answer to every problem was to work harder, no matter what the sacrifice’ (Humphries, Crowe, and Brugha 2018, 2).

A new generation sees it differently;

[they] have begun to reject the workaholic values of an earlier generation [...] they want to pursue purposeful work in medicine alongside a rich personal life (ibid. p. 3).

Three younger participants in this research have described taking a salaried role in a practice with no administrative responsibilities, in order to work hard as a medical doctor, and go home on time. Four end-career participants told me about the difficulties finding younger GPs to work in their practices, ensuring succession for the patients. In two cases, the practices are located in very remote rural areas with low population density. The majority of the practice income would come from the GMS list as private income was scant. One GP said that

many of the well-trained young GPs had studied medicine at postgraduate level and therefore, had to pay fees for their degree. With five or six figure debts hanging over them, they needed to begin earning good income to repay the bank, an unlikely possibility in that GP's remote practice. Financial challenges faced by graduating GPs ought not to be a limiting factor in staffing rural healthcare. Mahon et al. argue that

‘in top-down, urban-centric and growth-driven notions of success [...] the rural would always tend to underperform’ (Mahon et al. 2023, 698).

A place-centred policy imperative might make a difference in this situation (Burnham 2025). ESRI reports have considered this issue in all its economic aspects (Smith et al. 2019; Walsh and Hill 2024), but omitted the concept of placemaking. The model of large, centripetally focused health centres with skilled doctors and healthcare workers in-situ cannot possibly enable older people to age-in-place. A more centrifugal variety of care, such as that recounted by RPs who do plenty of home visits, would be more beneficial to ageing patients and those with terminal illnesses (Glynn et al. 2023). And the ‘hidden’ work, so essential to patient care and done after in-person consultation must always be factored in.

7.2.4 Self-maintenance and repair

In order to take care of themselves, participants used the kind of tactics that all GPs would suggest to their patients, but that the older ones would not have prioritised at an early stage of their career. They use the blue and green spaces on their doorstep to great effect (Foley and Kistemann 2015; Conradson 2005; Foley et al. 2019). Running, marathon running, Shirin yoku (a Japanese term for forest bathing), walking the dog, walking the local beach, making music alone or with others, frequenting the theatre and manual crafting were enthusiastically described by RPs. Some see a counsellor on a regular basis: one

said, 'I tell everyone they should do it'. One partner in a very deprived inner city area practice always finishes on time to have dinner and bedtime with their children and said that once the HSE gave everyone a practice computer terminal at home, they found they could catch up on paperwork at home, if they had to [RP09]. I found it salutary to reflect on how these accounts of the 'maintenance and repair' of a GP's own health counterpointed the harrowing case histories they recounted.

The Practice Team is cited by all GPs as their chief support and mainstay during at all times. They praise their team's devotion to duty [RP11, RP30], their work as receptionists,¹⁰⁰ practice nurses and practice managers over years and decades of continuous care [RP12, RP13, RP21, RP27, RP29]. Their co-workers' clinical skills, are a given, mentioned only *en passant*, and they refer to sending staff on training courses to help them contend with the chaotic lives of disadvantaged people. Mutual support and teamwork were valorised in terms of patient care and caring for each other. RPs who had trained young GPs were gratified when excellent trainees, 'who could get a job anywhere' wanted to stay in their practice after graduation.

GPs give and receive mutual support at their CME and Deep End meetings. They undertake portfolio careers to moderate the intensity of their clinical workload and diversify their skillset into membership of professional organisations and policy making. Throughout their training and practice they cultivate and maintain a sense of humour that lightens a patient's burden and helps re-frame illness within the human condition.

¹⁰⁰ Over years of accompanying my elderly relatives on doctor visits I have come to know that the practice receptionist usually has a similar demeanour to the doctor and gives a foretaste of the clinical consultation.

7.2.5 Primary care is best accomplished as an assemblage

Contemporary GPs require a well-trained, nimble and responsive primary care team to work effectively. The concept of ‘assemblage’ presents itself (Anderson and McFarlane 2011, 124–127), since the agency of the GP incorporates a range of diverse components beyond their personal capacities. Practice Receptionist, Practice Nurse, Practice Manager, Practice Cleaner and others collaborate with GPs in the interest of patients. Into each consultation, a contemporary GP carries a corpus of such knowledge as is currently ratified by the law and by peer-evaluated best practice. All of the above is parked, however, as the GP invites the patient to say why they have come to the doctor today, and allows them to set the terms of engagement of the consultation. This is a feature particular to general practice and unique to the speciality; by contrast, all secondary care doctors know that the patient in front of them has been referred for their specific skills. GPs rehearse their listening skills over their lifetimes so that they pick up every clue given or leaked by the patient in front of them¹⁰¹. General practice thereby becomes ‘bottom-up’ rather than ‘top-down’. Items that matter on the GP’s agenda will have to wait until the patient’s presenting complaint has been thoroughly heard and evaluated. Preventive health behaviours such as quitting smoking, taking more exercise and many others are included at the end of the consultation, or referred to a colleague on the healthcare team, depending on whether the patient has the valency for them on that occasion. It all sounds quite random, but in their consistent ‘becoming’, GPs take it in their stride, as long as their workload is manageable.

¹⁰¹ All GPs are familiar with the ‘hand-on-the-door’ moment when a patient, at the end of a consultation, suddenly says something that reveals the kernel of their presenting complaint to the examining doctor, and often, to themselves. This scuppers a GP’s time-keeping but if managed well, can illuminate the path to recovery.

7.2.6 The COVID-19 pandemic showed General Practice to be the fulcrum of Irish healthcare

The pandemic made visible much of the hidden work routinely done by GPs. When the HSE required Covid hubs for safe assessment of patients away from hospitals, GPs donned PPE and staffed them. Some GP practices with large premises were taken over as hubs until vaccination curtailed spread of the virus. When vaccination was to be rolled out by age and morbidity cohort, GPs had patient registers that organized rapid and efficient ordering of priority. Along with their practice teams, GPs worked ‘every hour God gave’ to vaccinate their patients¹⁰². GPs had long and repeatedly begged the HSE to supply digital services such as Healthmail and Healthlink to increase safety and efficiency; these were provided at speed once the pandemic took hold. It thereby became clear that such GP requests were not ‘whining’ but reasonable and grounded in the experience of providing primary care. GPs now found themselves being respected by government and the HSE for their dynamic response to pandemic requirements, rather than being the object of thinly veiled institutional contempt. RP narratives provided some genuine insights into syndemic spaces and the provision of primary healthcare on the ground in such spaces.

¹⁰² RPs acknowledge that they were well remunerated for all this work.

7.2.7 Without my dual researcher positionality, this research would have been stillborn

7.2.7.1 Access to Research Participants

It is conventional practice to address as a penultimate consideration the matter of access to research participants, when considering strengths and weaknesses of a project. However, access was so difficult in this research that the matter deserves to be discussed as a preliminary finding and factored into any future research on the GP experience. In the Methodology chapter I described how I went about recruiting RPs, what worked, what did not and how the COVID-19 pandemic shifted the tectonic plates of General Practice before fieldwork even began. I have detailed how most of my letters of request for an interview went unanswered until either of two things happened: (i) a GP who had given me an interview saw the value in my research and agreed to snowball colleagues; (ii) following an unanswered letter of request, I rang the Practice, spoke to a receptionist and promptly identified myself as a retired GP.¹⁰³ A third outcome was that the receptionist took my message, discussed it with the GP and rang me back to say that the GP could not oblige me because of time commitments, but wished me well. In the first and second instances the GP returned my call within 24 hours, agreed to meet me and provided me with their personal contact details. Interviews were arranged and rearranged to fit into their schedules. Researching the emigration of Irish doctors in 2018, Humphries et al. stated that 'Recruiting respondents was more challenging than anticipated. For those who gave a reason for their non-participation in the interview process, a shortage of time and the challenging logistics of scheduling an interview around work commitments played a significant role' (Humphries, Crowe, and Brugha 2018, 4). Conflating the difficulty of access to GPs along with their view

¹⁰³ Once I identified myself as a former GP I was addressed with the honorific "Doctor".

that ‘nobody knows what we do’ suggests that GPs’ working lives are a series of siloed confidential encounters amenable to quantitative measuring while hardly available at all to qualitative evaluation. Therefore, I argue that, in the face of a GP manpower crisis, interview teams researching general practice ought to include experienced GPs. I believe that GPs have difficulty making themselves available to researchers because their well-documented high ‘productivity’, high daily consultation numbers and large volume of ‘paperwork’ (Crosbie et al. 2020; Collins and Homeniuk 2021) leave them exhausted at the end of a working day in the maelstrom of inequity, with no disposable time.

7.2.7.2 The vernacular

Like any highly trained professional or trades person, GPs speak to colleagues in a specific register and use a vernacular laced with acronyms and medical proper nouns. An entirely different lexicon is used when speaking to people with no medical training. Evidence-based medicine requires the communication of many accurate facts in a short time frame and during training, doctors become expert at it. Research participants told me that they found it easy to speak freely because I was a retired GP. Once the recording was switched on, participants in this research relaxed very quickly into a medical vernacular, checking occasionally by glance or pause that I understood. While two interviews were conducted online for logistical expediency, they equalled the in-person dialogues for depth of engagement and forthrightness. I believe that it was my positionality as retired GP turned qualitative researcher that unlocked participants’ rich contributions.

The affective atmosphere in the room left no doubt about the joy GPs get from their working lives, counterpointed by an equivalent frustration when they cannot access the services their patients need. Accustomed as I am to the

disrespectful tone of populist narratives about marginalised people, I was struck by the unremitting positivity of these GPs' discourse. There was not a single instance of speech that could not be included verbatim in this dissertation, once the everyday Hiberno-Irish 'intensifiers' were removed, and confidences were redacted. Intemperate rants were redacted too: whenever an RP gave vent to their feelings about injustice or inequality, they doubled back immediately and requested redaction. Many of these diatribes were aimed at the secondary healthcare structures that had failed specific patients and the professional power hierarchies that enabled the presenteeism of hospital colleagues whose main focus was their private practice. Their language betrayed their thinking and made a deep impression on me about what drained them. While GPs in this research, especially Deep End GPs, are exceptionally humanitarian in thought, word and deed, individual effort can merely palliate the effects of structural violence and slow violence in their patients' lives. Inequality and inequity incarnate in patients, firstly, and then, as RP28 said, in the 'second victim', their GP.

7.2.7.3 Quant. V. qual.

GPs are accustomed to having their views sought by survey. One remote rural GP indicated a pile of paper on a side table, saying that it was all surveys that he would never reply to, then thanking me profusely for making the long journey to visit him in person. Another urban GP enquired if I had sought out academic GPs for this research; when I said No, he was not surprised, saying that they would be much more interested in quant than qual. An ICGP Member Survey on 'The Future of General Practice' had a 30.4% response rate 'which may be considered marginally low by some standards [but] is in fact relatively high for online surveys to Irish general practitioners' (Collins and O'Riordan 2015). A survey on hospital doctors' stress had a higher response rate of 55%

(Hayes et al. 2019). Collins and Homeniuk had a 32% response rate to a survey of workload in general practice (2021). In contrast, academic and practising physician David Snadden reports the value of travelling in person in Western Canada to visit GPs where they worked (Snadden and Kunzli 2017), arguing that not only did the interviews yield rich data, but that the geography of his journeys gave him an appreciation of GPs' respective life-worlds. My travels gave me similar insights; one RP took me to their local Atlantic beach to inhale the ozone after a storm and told me that their patients use this as a mood enhancer (Foley and Kistemann 2015). No Zoom call could give an equivalent sensory 'hit' to any researcher.

It is appropriate that the Irish healthcare service, which consumes 21.5% of government expenditure be subject to rigorous audit and planning (Government of Ireland 2025). However, in view of the relatively high number of trained GPs who planned in 2019 to emigrate (a) for improved quality of life (30%) and (b) because of concerns for the future of general practice (26.6%) (Collins et al. 2019, 8), I propose that only qualitative research done by teams that include insiders will plumb the depths of GP disaffection. Late career participants in this research all worried about and wondered what would happen to their patients when they were gone, especially if their rural post was not being filled by the HSE. Fourteen RPs spoke joyfully about spending time in a rural practice, whether as a locum or trainee: three had had their 'epiphany' (RP21) to become a GP during that time. Further research needs to establish what must be done to make general practice a sustainable career again.

7.3 Contribution to knowledge

The lived experience of General Practitioners is under-theorised in health geography; this thesis renders it visible, untangling the affective, relational and

caring components of their working lives and lifeworlds, usually invisible to public and governmental discourse. It situates general practice within a geographical framework that construes place not only as a set of Euclidean coordinates, but as an entity actively produced by continuity of primary care. The academic framing of GP as placemaker is proposed as a useful, cross disciplinary theory with real world application.

This research places GPs at the centre of community making, especially when their practice population is marginalised, needing not just clinical acumen but unrelenting advocacy. It valorises the voice of GPs who, by way of representing their patients, tell government explicitly what supports they need in order to provide best practice primary care and urges government to listen, to staunch the ebb tide of newly qualified GPs from our country.

Several research participants described an epiphany when they realised that they wanted to train and work as GPs; these epiphanies all occurred during or after a clinical attachment to a General Practitioner during undergraduate or postgraduate training. In all cases, the humanity of the GP/patient interaction catalysed this realisation. Not computers, not tech, not algorithms, not fancy buildings. These RPs felt that they had discovered what would give meaning to their years of study and accomplishment of skills. None of them regretted it. This thesis asserts that if primary care in marginalised areas in cities and remote rural areas is to be staffed, that all medical students should have a lengthy placement in more than one general practice.

7.4 Implications of research

7.4.1 Inequality and inequity

This research has highlighted that GPs who care for marginalised people find that inequality and inequity underpin their patients' experience of illness and their own additional workload. Their patients have lower health literacy, less social capital, higher morbidity and earlier mortality (Fleitas Alfonzo et al. 2022; Burke 2009; O'Carroll 2022; Roantree, Maître, and Russell 2024). Structural violence is historically mediated (Farmer et al. 2006). Slow violence, 'the incremental, "invisible," accretive violence and staggered harm, with repercussions, playing out across a range of temporal scales' (Wiles 2024, 372) insinuates itself in the lives of people who have been incarcerated in Ireland's reformatories and Magdalen laundries (Wiles 2024; Gilmartin 2013), migrated to Ireland as refugees or asylum seekers, or who have been born into families ravaged by substance addiction (O'Sullivan 2023). Pathologies arising from structural violence, mediated by historical and economic narratives and norms, make poor people sick. GPs' affective attunement to this powerless suffering is what inspires them to become 'advocates for the poor' (Virchow 2006 [1848]).

All participants in this research gave examples of how inequality and inequity stymied their patients' access to timely healthcare. Eight RPs referred specifically to inequality and how it upset them. These are the concerns that, in answer to a research question, come between GPs and their sleep.

The COVID-19 pandemic provided a respite from Ireland's two-tier health system when all cases were given free healthcare, housing for isolation, tests and vaccination (Ni Bhuachalla et al. 2020; Horgan-Jones and O'Connell 2022). The government temporarily appropriated all private Irish hospitals for public use, to manage the surge in cases. Unlike their hospital colleagues, GPs had a

more satisfactory working experience, being able to re-kindle the embodied patient care that gives meaning to their lifeworld.

Sláintecare (2017) aims to eliminate inequality and inequity in healthcare for all Irish citizens. Its implementation continues to proceed steadily, but slowly under three different Ministers for Health since 2017, all with a congruent right of centre ideology who, nevertheless, have shown their commitment to Sláintecare and its mission. This research urges the government to progress the implementation of Sláintecare to bring our healthcare service up to the level of other developed countries and to allow all GPs in the public system to be able to treat all patients without any financial considerations.

7.5.2 Rural and urban inequality

In reflecting upon the placemaking by my sample of rural and urban GPs, it is worth reiterating briefly that inequality manifests differently in rural and urban areas and across the spectrum in between. These differences frame GPs' care for their patients.

Irish cities and large towns have old centres and newer suburbs. A cursory glance at the HP map of any city or large town reveals the areas or suburbs where people are affluent or poor. City GPs may choose to work in an area predominantly inhabited by affluent people and may know nothing of the realities of their colleagues who work with marginalised people (as already stated). Homelessness is said by city RPs to be the greatest impediment to good health; this is well corroborated by research (Hearne and McMahon 2016; Hearne 2020; CSO 2017a; Dorling 2014; Walsh 2023). Lone parenthood is strongly correlated with poverty (Roantree, Maître, and Russell 2024). Addiction to alcohol and illegal drugs is frequently associated with psychiatric illness (Butler 2002; Delargy, Crowley, and Van Hout 2019). Government needs

to address the blight of homelessness in order to exterminate this cause of morbidity in our current and future societies.

GPs in large towns experience a mix of the city and rural demographics and develop their expertise accordingly. Those who provide empathic healthcare for groups such as travelling people, asylum seekers in direct provision and immigrants working in low-paid occupation such as meat factories reach a mutual understanding of their patients' lives and culture over time. GPs in small country towns provide care for commuting workers (CSO 2017b) and a hinterland dotted with retired small farmers who want to 'age-in-place' rather than end their days in a nursing home. GPs in extremely remote rural areas reported in this research that they care for lonely, elderly people whose families have emigrated and who depend on them to do regular house calls. In all of these cases, GPs willingly provide primary care, complaining only about the inadequacy of secondary care when their patients need it. The provision of an Inclusion Medicine speciality in city hospitals (MQI 2019) and the proposed roll out of the Limerick Rural Declaration on Healthcare (Glynn et al. 2023) offer a possible means to provide continuous primary care to the neediest people in our society. These measures must be expedited without delay.

7.5.3 Power struggle between hospitals and community medicine

The structure of the Irish healthcare service has been outlined in the introductory chapter. Its politics have been alluded to throughout the thematic chapters, but not always explicitly, as RPs preferred to redact opinions that might identify them. Since the foundation of the state, general practice has been both constructed and perceived as the poor relative of hospital medicine. Results of this research bears this out as participants repeatedly give instances of how hospital consultants demean them verbally in front of trainees and

decline to answer or return their phone calls when they ring to discuss the case of a mutual patient¹⁰⁴. Sláintecare aims to rebalance resource allocation in favour of primary care, redirecting funding from hospitals into the community. While this will be welcomed by GP and community services, it may be resisted by some in the hospital sector who fear that the democratisation of healthcare will threaten their private practices.

One of the more powerful lobby groups in medicine has been hospital doctors with access to significant prestige and wealth through their private practices. Historical precedent highlights their priorities: I have already referred to their stance during the 1847 Famine in Ireland and to the debacle of the 1950 'Mother and Child Scheme' tug o' war between vested interests. According to participants in this research in 2020–2022, the status quo had not changed. In 2023, however, Stephen Donnelly, Minister for Health introduced a 'Public Only Consultant Contract' (Department of Health 2024). Aligning with the vision of Sláintecare, consultants who sign it may no longer treat their private patients in public hospitals. By June 2024, however, 45% of hospital consultants had signed it. Many of these are younger women: it is likely that, as in general practice, they are making choices that prioritise their work-life balance. RPs expressed the hope that this initiative would free up hospital consultants and patient beds for GMS patients.

¹⁰⁴ One late-career GP who started out in practice near the Richmond Hospital in Dublin 7, in the early 1970s told how if they had a (public) patient at morning surgery whose case perplexed them, they would drop in to the Richmond to discuss it with their consultant colleague. Consultants were always on the wards in those days and you could always guess what time they would finish their operating session in theatre or their ward rounds. They were delighted to discuss a challenging case and would immediately agree to see the patient at their next weekly out-patient clinic or before that if the GP requested it. This practice changed with the growth of private healthcare both within the public hospital and at other private hospitals.

7.5.4 Advent of digitally mediated healthcare

Whereas the binary of public versus private healthcare characterised service delivery in the past, the advent of online/digital healthcare has added another vector. People now routinely consult Google or Chat-GPT at the first onset of a symptom, and are likely to post an enquiry to their peer groups on social media such as WhatsApp, Instagram and Facebook (Garvey and Miller 2021). Klein's 'Doppelganger' describes a cosmology of anti-vaxxers, pandemic deniers and conspiracy theorists who hold views contrary to orthodox medical practice (2023). RPs say they often have to counter false information at the outset of a consultation before inviting the patient (or their parent, if it's a child) to consent to history-taking and examination.

Online primary care consultations became the norm during pandemic restrictions and abated once face-to-face consultations could resume safely (section 4.5.4). However, private health insurance companies have begun providing in-app consultations with doctors, physiotherapists and dietitians and demand for this service is thriving, normalising the service. Participants in this research declare that they not only enjoyed the return to in-person consulting but that they found online consulting with their marginalised patients unsafe, and unlikely to deliver a satisfactory outcome. Whereas affluent people may choose their doctor or insurer, poor people only have their GMS doctor and primary care team. For reasons given by RPs, these clinical relationships are founded on mutual knowing and trust engendered by continuity of care.

Artificial Intelligence and the use of algorithms render healthcare management and some aspects of diagnosis much more efficient. However, at our peril do we

allow them to reduce or eliminate personal GP service. These tools must remain tools at the disposal of the examining doctor who knows the whole patient.

7.5.5 Privatisation of healthcare

Privatisation of healthcare has the capacity radically to change the doctor/patient interface. In 2020, Palantir Technologies, co-founded and chaired by Peter Thiel, was awarded a £23 million contract by the UK government to process sensitive NHS health data as part of the COVID-19 response, an example of what Naomi Klein (2007) calls 'disaster capitalism' (Boyle, Hickson, and Gomez 2023, 33). With the advance of new technologies, private healthcare has become an enormously profitable frontier for private investors. As RP12 said:

I think that the private sector will only go where it's profitable. So, places that are unprofitable will not be thought worth going to. It's very hard for us to recruit doctors, they do not see working in the deprivation area attractive, it's not financially attractive. It's extremely hard work. So, I'm fearful for the future of family practice, I think family practice is almost gone and I'm fearful for the future of general practice.

Whereas GPs formerly borrowed to buy a premises or 'bought in' to a practice by working as an assistant-with-a-view on a sliding income scale, now a large healthcare centre is built or bought either by the HSE or the HSE in a public/private partnership (Mercille 2019; Mercille 2023). End-career GPs who sell their practices to private companies such as Centric work to retirement and are then replaced by sessional doctors who only do clinical work.¹⁰⁵ Despite the

¹⁰⁵ Centric is a private, for profit, equity-backed healthcare company which buys up general practices and continues to run them after the former owners have retired. In 2023 it operated 76 GP clinics across Ireland.

obvious attractions to young GPs of a good work/life balance, I struggle to see how continuity of care is sustained by such an arrangement.

7.5.6 Universal Patient Record

I have already shown how the universal patient record or IHI (Independent Health Identifier) was assigned to every patient who used COVID-19 testing, vaccination or other pandemic healthcare measures. While this will streamline transitional care as a patient goes from GP to hospital doctor (and possibly a few more hospital doctors) and back, it would also facilitate a Fordist approach to patient care by those who might reduce care to its barest rudiments. Eubanks predicts that under a new regime of algorithmic inequality, only affluent people who consult doctors privately will have face-to-face consultations and continuity of care. The remainder will be consigned to the ‘digital poor house’ (Eubanks 2017, 174–217). In such circumstances, GPs like those who participated in this research will require exceptional state contracts and arrangements to enable them to continue providing the exceptional care they do (Watt 2014; Watt 2019). Whereas the rudiments of biomedical primary care may easily be driven by an algorithmic patient record assisted by artificial intelligence, best practice bio-psycho-social care requires the input of empathic GPs and other primary healthcare professionals. As RP21 wrote in section 4.9, ‘perfunctory exchanges’ fall short of ‘human transaction’. Patients of Deep End doctors are deeply traumatised in multiple ways (Felitti et al. 1998; Pearce et al. 2018). At times, their GP is powerless to effect material change in their situation and can only dignify them by listening to them, by hearing and accompanying them. One very traumatised patient of RP02’s said ‘you’re the only one that remembers’; that meant a lot to them both.

Whether the state should pay primary carers for this work depends on ideology. The Proclamation of the Irish Republic in 2016 stated that the state would ‘cherish all the children of the nation equally’ (Government of Ireland 1916, 2013). Numerous case histories told by RPs, along with caregiving practices I witnessed during fieldwork, persuaded me that this is happening, but in patchy distribution. To date, successive governments have striven to move healthcare towards equality, but public perception suggests there is still a long way to travel.¹⁰⁶

7.6 Limitations of this research

As detailed in the methodology chapter, this was a very small sample. However, GPs were generous with their time and generated rich qualitative data to give an insight into their lived experience. All of my RPs but one were Irish-born and Caucasian. Since almost 20% of citizens enumerated in Census 2022 were born outside Ireland, this represents a significant gap, not only in numbers but also in cultural diversity.¹⁰⁷ Since I was enriched by travelling through and in the landscapes where GPs work, I regret that conditions of ethical approval and (necessary) anonymity did not allow me to share descriptions, images or maps. Describing GPs’ placemaking capacity in words alone gave only a glimpse of the sensory experience of landscape; it certainly understated my shock at seeing the poverty of some people’s circumstances. I

¹⁰⁶ One recent survey found that 54% of Irish people surveyed considered their healthcare system unfair, compared to an average of 44% among respondents in 22 mostly European countries (McHale 2025).

¹⁰⁷ White Irish (excluding Travellers) were 73.5% of the labour force according to the Census of 2022; and 76.2% of those in the sector comprising Human Health and Social Work Activities (CSO 2025).

have tried to do justice to the GPs who wade into these lifeworlds and continue to make a difference.

The literature I consulted was predominantly anglophone, written in English in developed European, American, Canadian, Australian and New Zealand regions where the legacy of colonialism continues to produce societal inequalities. Primary care for marginalised people, as provided in China, Russia, India and Sub-Saharan Africa goes unrepresented in this research.

7.7 Conclusion

This thesis shows primary care given by participating GPs in all its dimensions. Firstly, spatial: length, breadth, depth of care; design of practice premises to accommodate all comers; range of visits made on foot, on bicycle, by car, by boat or on a Safetynet bus to visit patients who cannot come to them. RPs also cared across borders, for example, RP27 supported their patients who grieved their relatives who suffered inadequate care in Northern Ireland¹⁰⁸ during the COVID-19 pandemic; RP31 cared for asylum seekers from Syria and Ukraine. Secondly, time: care is given during surgery hours in face-to-face and online consultations; care continues behind closed doors as GPs conclude the hidden work and advocacy accruing to each consultation. GPs do regular on-call shifts with their local GP co-op at weekends and holidays to cover their colleagues. They spend some of their evenings attending continuing medical education meetings and/or educational webinars and commit to representing their peers on professional and academic organisations over evenings and weekends. They act as honorary medical officer for local sporting events. They provide primary

¹⁰⁸ Northern Ireland is part of the United Kingdom.

care for the duration of their professional lives, sometimes over four or five decades.

Care [can be thought of] in terms of interdependency, reciprocity and multidirectionality (Milligan and Wiles 2010, 737).

While GPs are providers of healthcare, they left me in no doubt, at interview, that they enjoyed and valued their work, mainly because of their relationships with their patients which I take to 'endorse a mutual sense of identity and self-worth' (ibid., p.738). They 'care for and care about' (ibid p.40) their patients, their colleagues and co-workers, and in the case of the late career GPs, they care about ensuring succession so that their patients will be well cared for when they retire.

7.7.1 There is enough

At the time of writing, there is enough money in the exchequer to fund universal healthcare for all. There are enough medical graduates adequately to staff a primary healthcare system that serves urban and rural citizens alike. There is enough goodwill among current general practitioners to train the next generation in the art and profession of primary care. In a country where people rate GPs as among the people, they would trust the most (O'Dowd 2022), there is a will to have an accessible, country-wide primary care service. Policies have been written and agreed; numbers have been crunched; budgets have been set, and yet progress is slow. Part of the problem that beset the implementation of Sláintecare before the onset of the COVID-19 pandemic, was the cultural dissonance between career civil servants and new project leaders from the world of business. Had Leo Varadkar, the Taoiseach at the time and a former GP, taken the Sláintecare project into the Department of the Taoiseach, it is likely that it would have made more progress.

7.7.2 Proposals arising from this research

I conclude with a model of how General Practice can build upon the positive dimensions of older GP lifeworlds, while looking forward to ways of properly supporting compassion, care, advocacy and placemaking as core values of future primary care practice. While healthcare is a very expensive component of government expenditure, those who deliver it and those who receive it are humans, and the human condition is messy.

I propose that a geographical, population-based survey of the Irish people, based on recent censuses, be done to establish the extent of need in our country. This can be calibrated against existing primary care services and decisions made about where workforce deficiencies need to be addressed and made good. To date, GPs have been free to choose where to locate their practice, able to decide what proportion of public/private practice they would prefer in our hybrid system, at liberty to balance their income sources between state subvention and private fee income. With the incremental implementation of Sláintecare and the growth of private practice in wealthy areas, the state must undertake adequately to remunerate those who practise in areas of deprivation.

In addition, I propose that GPs step out from the subaltern position they have occupied in the past and proclaim their contribution to placemaking, to community and to healthcare in public discourse, in every forum. RPs in this research know and value their own work. So do policy makers and opinion makers, who may just need to be reminded. Rather than rely on colleagues to represent them, GPs would do well to evangelise for general practice at every opportunity.

Medical school curricula can be structured to include mandatory placement of students in both urban and rural general practices, particularly in areas of deprivation. Training of students must include a large proportion of shadowing an experienced GP, learning not only the science, but also the art of general practice. The financing of medical education could be re-calculated so that students would not incur huge loans which would compromise their career options as newly graduated GPs.

Learning from the COVID-19 pandemic and anticipating the next one, government must hasten the roll-out of the IHI or individual healthcare identifier. This would also streamline transitional patient care between primary and hospital levels, eliminate duplication of tests and iatrogenic errors in prescription. Hospitals which still use paper patient records must be encouraged to digitise them.

Secondary care services for adult and child psychiatry must be reviewed and reorganised adequately to provide access for patients in need. And their restructuring must include a provision that, in a future healthcare emergency such as a pandemic, they cannot unilaterally withdraw from patient care.

Since cities act as a magnet for mobile marginalised people, an Inclusion Health service ought to be established in every Irish city.

Every GP ought to have a personal GP, recalling that 'A physician who treats himself has a fool for a patient' (Stanford Medicine 2014). While CME provides peer support, nothing can match the experience of presenting as a patient to a trusted colleague and benefitting from their clinical acumen and support.

This research has shown that GP independence is vital in excavating need and devising service delivery for marginalised people. I have referred throughout this dissertation to how RPs' language deployed active, transitive verbs, corroborated by their accounts of interventions on behalf of patients that went far beyond their clinical obligations. A democratically elected government would do well to listen to GPs who, although (mostly) not elected, are chosen and trusted in over twenty-nine million consultations per annum by people who find that their healthcare and advocacy make a difference in their lives.

This research shows clearly a congruence of the practice of primary care and the discipline of health geography and calls for more widespread interdisciplinary collaboration. It unmaskes the huge workload, clinical, affective and relational, carried out by GPs, especially for marginalised patients. And it reminds us that we live in a republic whose foundational principles are to 'cherish all the children of the nation equally'. Policy makers and politicians would do well to include GPs in this mantle of state care (or cúram or aire), to valorise their contributions not only in word, but also in deed. The kind of primary healthcare we all want and need is at hand. We only need to value it and those who provide it.

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Appendix A: Letter of Invitation and Consent Form



10th June 2020

Information Form

'Advocates of the Poor'¹⁰⁹: an ethnographic study of the lived experience of a selection of Irish General Practitioners.

Allow me to introduce myself. My name is Catherine Hayes; I am a retired GP and a postgraduate student at the Department of Geography, Maynooth University, Co. Kildare. In 2018 I did qualitative research on the lived experiences of rural Irish GPs for an MA in Human Geography. Now my focus moves to urban Irish GPs, especially those who care for marginalised people. As a GP I provided primary care for people in Dublin 11 (1984-2000), worked in the first Sexual Assault Treatment Unit in the Rotunda Hospital (1984-1986) and as the first woman GP in Mountjoy Female Prison (1986-1992).

Much has been written about healthcare from the perspectives of patients, specialities and management, economics and politics. However, the voice of GPs is less well represented in mainstream discourse. Before the Covid-19 pandemic Irish general practice was characterised by an ageing workforce and a high emigration rate among newly trained GPs. The robust response to the pandemic in Ireland has been mediated in no small measure by nimble, hard-working GP individuals, practices and professional organisations. Now, delivery of primary care is increasingly mediated by online platforms, requiring significant flexibility from doctors who are already overstretched. At a time of such great change, I hope you will share with me your observations and feelings about what constitutes, for you, a good quality of life, and what undermines it. I hope to explore the highs and lows of a lifetime delivering primary care and how this has changed since you began working as a GP.

In the first instance I hope to do semi-structured interviews with between thirty and forty GPs who serve patients living in areas of deprivation as identified by the Pobal HP Deprivation Index (Haase and Pratschke, 2016)¹¹⁰. I will travel to the place where you work and hope you can afford me approximately an hour of your time during which I will interview you in a place

¹⁰⁹ [Virchow, Rudolf \(1848\)](#)

¹¹⁰ [Haase, T and Pratschke, J \(2016\) 'The Pobal HP Deprivation Index'](#)

of your choosing...either a café or perhaps, your surgery, where we will not be overheard. Appropriate social distancing must be observed, and I will be guided by your requirements. I attach a sample of the interview questions I may ask on the day as a guide to my research. You may wish to address other matters, and these will be included. I will record the interview digitally and will transcribe it myself. I will send the transcript to you so that you may indicate if it is a fair representation of what you said. Then the transcript will be coded by me and included in my research. Your participation is entirely voluntary, and you have the right to withdraw any or all of your contribution at all stages of the research, without consequences. I will anonymise/mask your name and place of practice in accordance with standard academic practice.

Once the interviews are completed and coded, matters may arise that require further enquiry. It may be worthwhile to do a survey, to conduct focus groups or to re-visit participating GPs. Any or all of these research steps will require supplementary approval from the Ethics Committee at Maynooth University. When that time comes, I will make the appropriate application to the committee. In the meantime, I ask for your permission to keep your contact details for the next phase of the research.

I will do my best to maintain the highest standard of confidentiality during the research process and subsequent research outputs. All interviewees will be anonymised in accordance with the Ethics Policy at Maynooth University ¹¹¹. I will keep the data in an encrypted format in a secure place at the Maynooth University Department of Geography for ten years following the end of this study. If I wish to use the data for comparative studies or follow-up projects, I will request your permission anew and you can decide whether to allow me to use the data generated from your interview or not.

It must be recognized that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by lawful authority. In such circumstances, the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent. Since your registration with the Irish Medical Council (Article 54.3)¹¹² is contingent on your not incurring any criminal conviction, I would suggest that discussion of any matter that might interfere with your annual declaration to the Medical Council is outside the remit of this research.

All interview transcripts will be used in the completion of my Ph.D. thesis, as well as other publications, scholarly articles, presentations, map exhibitions and for teaching purposes. I am happy to send you a digital copy of these outcomes if you provide me with your email address.

If during your participation in this study you feel the information and guidelines that I have given you have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@nuim.ie or +353 (0)1 708 6019. Please be assured that your concerns will be dealt with in a sensitive manner. You may also contact my supervisors, Prof. Gerry Kearns, at gerry.kearns@mu.ie, Dr Ronan Foley, at Ronan.Foley@mu.ie, or at the Department of

¹¹¹ <https://www.maynoothuniversity.ie/research/research-development-office/research-ethics>

¹¹² <https://medicalcouncil.ie/News-and-Publications/Reports/Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf>

Geography, Maynooth University, Maynooth, Co. Kildare. You may contact me at any time (catherine.hayes@mu.ie).

When we meet, I will ask you to sign two copies of the consent form below, one for your own records and one for mine.

Yours sincerely,

Catherine Hayes

PhD Candidate

John & Pat Hume Postgraduate Scholar

Dept. of Geography,

Maynooth University

E: catherine.hayes@mu.ie

M: 087 2930640

Consent Form

'Advocates of the Poor': an ethnographic study of the lived experience of a selection of Irish General Practitioners

1. I agree to give the researcher an interview: Yes ☐ No ☐
2. I agree to have the interview digitally recorded: Yes ☐ No ☐
3. I understand that the researcher will mask my identity: Yes ☐ No ☐
4. I understand that the researcher will send me a copy of my interview transcript and that I may withdraw or change any or all of the content without consequence: Yes ☐ No ☐
5. I understand that I can withdraw up to the point of full anonymisation or submission of the thesis, whichever comes first. Yes ☐ No ☐
6. I agree to allow the researcher to keep my contact details so that she may communicate with me for the next phase of this research: Yes ☐ No ☐
7. I give my permission for secondary use of the data for other research projects
Yes ☐ No ☐
8. I understand that data will be retained for 10 years and then destroyed by being overwritten. Yes ☐ No ☐
9. I understand that the researcher will take photos of the practice hinterland but not of the practice premises, its patients, its staff or their vehicles: Yes ☐ No ☐

I have read the information form provided and agree to participate in this research.

Name (printed): _____

Name (signature): _____

Date: _____

Appendix B: Sample Interview Questions

Interview Questions

1. How did you come to be a general practitioner?
2. What aspects of your everyday practice give you satisfaction?
3. What aspects of your everyday practice drain you?
4. How do you feel about new modes of practice brought about by the Covid-19 pandemic?
5. In what way does a general practitioner experience being powerful?
6. Can you give me an example of where you feel powerless?
7. What comes between you and your sleep?
8. Working on the front line of patient care in the community, who gives you support?
9. Who or what undermines you?
10. How do you identify as a general practitioner/healthcare provider? Does it differ from a GP's role five, ten or fifteen years ago?
11. How would you rate your quality of life over the past five years?
12. How does it compare with what you expected at the outset of your career?

Appendix C: Ethical Approval

MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND



Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

04 April 2019

Catherine Hayes
Department of Geography
Maynooth University

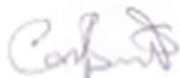
RE: Application for Ethical Approval for a project entitled: *Attorneys of the Poor*: an ethnographic study of the lived experience of a selection of Irish General Practitioners

Dear Catherine,

The Ethics Committee evaluated the above project and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 30 April 2023.

Kind Regards,

A handwritten signature in blue ink, appearing to read "Carol Barrett".

Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

C.c. Professor Gerry Keams, Department of Geography, Maynooth University

Reference Number SRESC-2019-020

Appendix D: Glossary

Glossary

A&E.....Accident and Emergency Department.

ADHD Attention Deficit Hyperactivity Disorder.

AI Artificial Intelligence.

BMQ Basic Medical Qualification.

BPD Borderline Personality Disorder.

BST Basic Specialist Training.

CAMHS..... Child and Adolescent Mental Health Services.

CAO..... Central Applications Office.

CCT Clinical Contact Tracer.

CDM..... Chronic Disease Management.

CME Continuing Medical Education.

CMO..... Chief Medical Officer.

Coroner's Report: In the event of a sudden, violent or unexplained death, a coroner is legally responsible for investigating the cause of death and reporting their findings.

COVID-19 A contagious respiratory illness caused by the SARS-CoV-2 virus which was identified in late 2019 and led to a global pandemic.

CSCST Criteria for Satisfactory Completion of Specialist Training

DCA..... Domiciliary Care Allowance.

Deep End Ireland A network of GPs who care for the most marginalised patients in Ireland.

Direct Provision: A system introduced in 2000 to receive people seeking asylum.

Doctor in this thesis, a person who has graduated from medical school and is registered with the Irish Medical Council to work as a medical doctor.

DoH..... Department of Health.

DPS Drugs Payment Scheme.

Duty of Care: A legal and ethical obligation incumbent on medical doctors to provide patients with safe, competent and appropriate medical treatment. This duty is governed by law and overseen by the Irish Medical Council.

DVC..... Doctor Visit Card.

ESRI..... Economic and Social Research Institute.

FDI Foreign Direct Investment.

GDPR General Data Protection Regulation.

GIS Geographic Information Systems.

GP General Practitioner.

GP Registrar..... A medical doctor in specialist training to become a GP.

GPVC..... GP Visit Card.

Group practice: A primary care practice with more than one GP.

Healthlink Ireland's national electronic health messaging service.

Healthmail..... Ireland's secure clinical e-mail service that allows healthcare professionals to send and receive patient related data safely and efficiently.

HIQA Health Information and Quality Authority.

HPAT.....	Higher Professions Admission Test.
HSE	Health Services Executive.
HST	Higher Specialist Training.
ICGP	Irish College of General Practitioners.
IMC	Irish Medical Council.
IMO.....	Irish Medical Organisation.
ITU	Intensive Therapy Unit.
KPI.....	Key Performance Indicators.
LARC	Long-acting Reversible Contraception.
LGBTQIA.....	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual.
M.B., B.Ch., B.A.O:	MB= Medicinae Baccalaureat (Bachelor of Medicine): BCh = Bachelor Chirurgiae (Bachelor of Surgery) and BAO= Bachelor in the Art of Obstetrics.
MICGP.....	Membership of the Irish College of General Practitioners.
Mirena	a brand of hormonal Intra Uterine Device (IUD).
MQI.....	Merchants' Quay Ireland: a voluntary organisation that cares for people who are homeless, addicted and socially excluded.
MDT	Multi-disciplinary team; a co-ordinated group of healthcare professionals from different disciplines who care for patients.
NAGP	National Association of General Practitioners.
North of Ireland: a contested description for the six counties of Ulster that are under UK rule.	
NPHET.....	National Public Health Emergency Team, advised the government during the COVID-19 pandemic.

NRT	Non-representational theory: a theory that emphasises practices, embodied experiences and affective engagements with the world.
OED.....	Oxford English Dictionary.
OOH.....	Out of hours.
Paperwork	The hidden, clerical and invisible work of advocacy done by GPs outside patient-facing time. Also known as Hidden Work.
Patient	A person who presents to a medical doctor for healthcare.
PCP	Primary Care Professional.
PHEIC.....	Public Health Emergency of international Concern.
PMAs	Personal Medical Attendant's reports. If an insurer requires information on a person's health status, they ask their client to provide their GP's contact details and to consent to their providing a report. This report is referred to by GPs as a PMA.
POLST	Physician Orders for Life-Sustaining Treatment: a protocol agreed between doctor and patient for the latter's end-of-life healthcare.
practice (small p)..	a routine activity or set of actions.
Practice Nurse	a registered nurse who works in a general practice setting.
Primary Care.....	Health and primary care services provided in the community.
RCSI.....	Royal College of Surgeons in Ireland.
Republic of Ireland:	a sovereign state which gained independence from the UK in 1921 and became a republic in 1949.
RIDDGP	Rural, Island and Dispensing Doctors of Ireland.
RNLI	Royal National Lifeboat Institution.
RP	Research participants in this research.

RQ.....	Research Question.
Safetynet	A medical charity that provides free, accessible healthcare to marginalised people in Irish cities.
Safety-netting	A clinical strategy used to manage uncertainty and ensure patient safety in an unfolding clinical situation.
SDH	Social Determinants of Health.
Secondary care ...	Any healthcare service to which a patient is referred by a primary carer, usually a hospital service.
Session.....	A block of patient-facing time, usually three hours.
SHO.....	Senior House Officer.
Sign	An objective indication of a disease observed by a diagnosing healthcare practitioner.
Single-handed GP	: A GP who is the only doctor in a primary care practice.
SMS.....	Short message service.
SNA	Special Needs Assistant: a person who assists students with significant care needs.
Specialist.....	A doctor who has undergone specialist training in a discipline and fulfilled the qualifying criteria.
Specialist Register:	A register of all doctors who are duly qualified and accredited within their chosen speciality, e.g dermatology, general practice.
Surgery	Usually a vernacular description of where a GP works rather than the act of operating on a patient.
Symptom	A subjective experience of illness.
TASC.....	Think-tank for Action on Social Change.

Tertiary care Specialised medical treatment provided to patients referred from primary or secondary healthcare services.

The Practice..... The term used to describe the building and its environs which accommodate the work of a primary healthcare team.

UCC..... University College Cork.

UCD University College Dublin.

UL University of Limerick.

VRL..... Virus Reference Laboratory.

WHO World Health Organisation.

WTE Whole time equivalent.

Appendix E: Urban and rural classification rules – CSO

Type		Definition
Cities		Towns/settlements with populations greater than 50,000 - using Census 2016 definitions/breakdowns.
Urban areas	Satellite Urban Towns	Towns/settlements with populations between 1,500 and 49,999, where 20 percent or more of the usually resident employed population's workplace address is in 'Cities'.
	Independent urban towns	Towns/settlements with populations between 1,500 and 49,999, where less than 20 percent of the usually resident employed population's workplace address is in 'Cities'.
Rural Areas	Rural areas with high urban influence	Rural areas (themselves defined as having an area type with a population less than 1,500 persons, as per Census 2016) are allocated to one of three sub-categories, based on their dependence on urban areas. Again, employment location is the defining variable. The allocation is based on a weighted percentage of resident employed adults of a rural Small Area who work in the three standard categories of urban area (for simplicity the methodology uses main, secondary and minor urban area). The percentages working in each urban area were weighted through the use of multipliers. The multipliers allowed for the increasing urbanisation for different sized urban areas. For example, the percentage of rural people working in a main urban area had double the impact of the same percentage working in a minor urban area. The weighting acknowledges the impact that a large urban centre has on its surrounding area. The adopted weights for: Main Urban areas is 2 Satellite urban communities is 1.5 Independent urban communities is 1 The weighted percentages is divided into tertials to assign one of the three rural breakdowns

Rural areas with moderate urban influence	As above
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Highly rural/remote areas	As above
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Source: Central Statistics Office. "Urban and Rural Life in Ireland, 2019." Cork: CSO, 2025. <https://www.cso.ie/en/releasesandpublications/ep/p-uri/urbanandrurallifeinireland2025/backgroundnotes/>
