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Unpromising Futures: Early-Career GPs' Narrative Accounts of Meaningful Work during a Professional Workforce Crisis

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Abstract

Over the past few decades, the intensification and reorganisation of work have led to growing precarity, insecurity and uncertainty for employees, affecting even professionals tied to traditionally model employers. Doctors, in particular, have seen substantial changes to their work: having to work harder, longer and more intensely with reductions in expected autonomy, deference and respect. This article focuses on how early-career GPs make sense of and navigate meaningful work in the context of a current workforce crisis. Drawing on 15 narrative interviews and 10 focus groups with early-career GPs, the findings show that meaningful work during a crisis is understood temporally, with imagined futures perceived as increasingly impossible due to changes to the structure and orientation of medical work, leading to different career plans. Utilising Adam and Groves' approach to futures as a conceptual lens, the article focuses on how multiple, often clashing, future orientations impact meaningful work.

Keywords

futures, meaningfulness, medical work, temporality

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Introduction

Sociological debates on the transformation of work over the past few decades centre on the shift in the forms of work, and attitudes towards employment, as a result of societal change (Beck and Beck-Gernsheim, 2002; Sennett, 2006). In particular, there has been a focus on how increased insecurity, mobility and intensity of work have impacted the meaningfulness of work and in turn how individuals plan and negotiate careers (Thompson and Smith, 2009). In the UK, the National Health Service (NHS) has been traditionally regarded as a 'model employer' due to the high levels of job security and mutually recognised values of the organisation but there is evidence that this is under threat (Fielden and Whiting, 2007). A developing workforce crisis affecting medical and nursing professions alike (Imison and Bohmer, 2013) is attributed to the combination of the reorganisation, redistribution and reorientation of medical work (Charles-Jones et al., 2003; Fenwick, 2013; Rich et al., 2016).

General practice has experienced significant reform over the past few decades, with changes to the structure of practices leading to rising patient volume (Forbes et al., 2019), increasing patient complexity, new tasks from secondary care (Charles-Jones et al., 2003) and a greater focus on productivity, efficiency and regulation (Fenwick, 2013). Workforce survey statistics show that close to 40% of general practitioners (GPs) plan to quit the profession within the next 5 years as a result of stress, burnout and disillusionment (Gibson et al., 2019). This workforce crisis is likely to continue with experienced GPs retiring early and newer GPs eschewing traditional, secure, partnership posts for short-term salaried or locum positions that have been described as '"half inside, half outside" the profession' (Ferguson et al., 2021: 160). There is a need, therefore, to examine how early-career GPs navigate their careers and understand their work as meaningful when entering a profession in crisis and the implications for their future work.

This article is interested in examining the role of the future in how meaningful work is anticipated, understood and experienced, particularly under the conditions of a workforce crisis. Utilising Adam and Groves' (2007) approach to the future, which foregrounds the need to treat the future as living and already in action rather than abstract, this article offers a novel perspective to explore how meaningful work is understood temporally. Drawing on narrative interviews and focus groups of early-career GPs, it is argued that meaningful work, entangled with perceptions and actions of the past and present, is a crucial part of an imagined future. The findings highlight that in times of crisis there is a focus on the present at the expense of futures, that in turn can make imagined futures unfeasible. In what follows, the framework for the article is developed in three parts. First, the literature on meaningful work and medical professionalism is outlined to show how anomie can set in due to changes in the social contract of medicine, which shapes mutual understandings of the value and worth of work. Second, it integrates earlier work on the temporal nature of meaningful work to argue that anomie in the present is constructed with the past and future. Third, it outlines key concepts on temporality and the future that will be applied to the findings.

Meaningful work and changes to medical professionalism

To look at how professionals make sense of their work, the literature often turns to the role of meaningful work. Yeoman (2020) regards meaningful work as an orientation

towards taking care of significant things of independent value and that offers autonomy, freedom and dignity. In turn, this work is experienced as worthwhile. Meaningful work relies on mutuality, with shared ethics and appropriate structural enablers needed to allow people to contribute with dignity and autonomy (Laaser and Karlsson, 2022) around a common goal. Yeoman's approach is particularly appropriate to the current study given that it reflects what is known as the social contract of medicine. The social contract is a metaphor used to reflect the relationships between workers, employers and society. For Yeoman (2020), the traditional social contract reflects what she considers as values, the public promises that set out what parties can expect of each other. Harris (2017) suggests that in healthcare this involves an implicit agreement that doctors will act in the public's best interest by being devoted, competent and moral physicians in return for social recognition and financial rewards from society (Cruess and Cruess, 2008). In other words, doctors will engage in morally worthy work in exchange for autonomy, freedom and dignity from the state and public.

On paper then, the work of GPs should be meaningful: they are highly skilled professionals with a large degree of control over their work (Frenkle et al., 1995) recognised as contributing to helping others. The disconnection between the characteristics of meaningful work and experiences of meaningful work requires further thought. In the UK, the social contract between medicine and society has changed drastically over the past few decades (Dixon-Woods et al., 2011; Edwards et al., 2002). The traditional social contract promised security and gainful employment in a morally worthy organisation (the NHS) that provides the conditions for meaningful work (Hunter, 2015). However, changes to the organisation of care, declining trust in medical expertise, and disputes between doctors and governments have left the social contract broken – or at best undefined and uncertain (Imison and Bohmer, 2013; Royal College of Physicians, 2005). Lepisto and Pratt (2016) theorise that professionals may experience 'anomie' (feelings of pointlessness or alienation) when there is uncertainty or change in priorities within the working context that conflict with their subjective experience and expectations of their work.

The notion of a professional crisis in medicine is not new, with the threat to professional dominance providing a rich seam of literature. Freidson (1986) observed early evidence of a shift in professional power in the 1980s and this has been further explored in work arguing that there is an erosion of doctors' monopoly over medical knowledge and authority over decisions alongside a rise in regulatory constraints, described as 'deprofessionalization' (Haug, 1988). McKinlay and Arches (1985) have pointed to the problem of 'proletarianization', which highlights the role of financial and industrial forces that have reduced doctors' control over their work. Within the UK, threats to medical professionalism have been linked to the rise of managerialism and new public management (Bolton et al., 2011; Harrison S and Dowswell, 2002). More recently, systemic underfunding of the NHS (Gershlick et al., 2019), contract disputes with junior doctors (Iliffe, 2017), and rising media attacks on the profession are all likely to have deepened the crisis (Doran et al., 2016). In summary, there has lately been a change in doctors' working activities, context and external support.

The changing nature of professional dynamics in the context of wider societal, political and organisational change is likely to impact doctors' subjective experiences of work (Yeoman, 2014). Qualitative studies examining doctors' and GPs' perceptions of

work in the UK over the past decade have found similar themes: that there are high rates of low morale (Mazhar and Rashid, 2016; Rich et al., 2016), stress (Marchand and Peckham, 2017; Rich et al., 2016) and disillusionment (Spooner et al., 2017). Furthermore, uncertainty about the future of working conditions and the profession is leading to anxiety (Doran et al., 2016) and regret about their career choice (Mazhar and Rashid, 2016). This points to evidence for Lepisto and Pratt's (2016) proposal of anomie. The erosion of the working conditions and external validation of doctoring coupled with low morale and uncertainty in personal experiences of work may lead to meaninglessness at work. When this happens, it can make an emotional engagement to work – to continue to care, act and persevere – more difficult (Yeoman, 2014). Emotional engagement is reciprocally tied to the future, with the understanding that present effort will have an impact on the future. It is to the literature on the temporal nature of meaningfulness that the next section turns, to position the article's novel use of Adam and Groves' (2007) future perspective.

Temporality, futures and the meaningfulness of work

This article is particularly interested in how the future may shape experiences of meaningful work and will be using Adam and Groves' (2007) work as an organising lens. To do this, it is important to first set out the theoretical positions on time and temporality that underline this work. Sociological approaches to temporalities consider the experience of time as contextual, institutionally structured and bound within social relationships (Adam, 2013; Wajcman, 2014). These theories challenge assumptions of time as objective, external, ahistorical and disembodied (Adam, 2013; Wajcman, 2014). In doing so, they expose how much of the norms around time have been developed in response to work. Adam (2003), for example, has described how the idea of clock-time (as uniform, measurable and controllable), a key component of modern industrial societies, emerged with the demand for greater work efficiency. Initially, this was externally driven by organisations; however, the need to be productive has increasingly become internalised and individualised by workers (Gregg, 2018). This is evident in work discourses that foreground individualised solutions for workers to regain control of their time, such as better work–life balance, managing time conflicts and slowing down the pace of work (Webster and Ballard, 2009).

There are two veins of research where temporality has been established as a key facet of meaningful and meaningless work (Bailey and Madden, 2017; Bailey et al., 2019; Tommasi et al., 2020). The first is the role of time in people's working lives, often focusing on the time pressures resulting from the convergence of increasing volumes of work, intensification of work and a loss of workplace proximity (Wajcman, 2014). The loss of control because of time pressures features in the literature as leading to meaninglessness at work. This includes research showing that the lack of external recognition when time sacrifices made by workers are not acknowledged (Simpson et al., 2014) can lead to anomie; or disillusionment as control over autonomy and pacing of work is lost (Bailey and Madden, 2017). Relevantly, studies with GPs have found that commodified time is now a key way in which they talk about their work (MacBride-Stewart, 2013) due to the loss of control over appointment times, the challenges of juggling administrative and caring tasks, and the need to work within decreasing time

resources (Horobin and McIntosh, 1983; MacBride-Stewart, 2013). The control of time, therefore, is positioned as both the problem and solution for more meaningfulness at work (Adam, 2003).

The second vein of research examines how meaningful work is constructed over time. Temporality has been used to move beyond seeing meaningfulness in work as static and instead examine it as partial and episodic as well as stable and subject to change (Bailey and Madden, 2017; Tommasi et al., 2020). Of relevance here, is how meaningfulness is located regarding the past, present and future (Adam, 2003). For example, studies suggest that meaningfulness is experienced strongly during significant moments that allow workers to reflect on past achievements and look to the future (Bailey and Madden, 2017). Following this, De Boeck et al. (2019) found that employees need to have the opportunity to imagine and realise future selves for work to be meaningful. Looking at how individuals view their future work, perhaps exploring if and how meaningfulness is constructed in relation to the future, may be a useful avenue that has yet to be explicitly examined.

The future is often conceptualised in contemporary western societies as an abstract and open space that is full of limitless possibilities. This has been critically analysed by Adam and Groves (2007) who argue that this perspective of the future as empty and disconnected from the present can result in the future being exploited in a variety of ways. They describe how empty futures can be commodified for the benefit of the present, a process they call *present futures*, that strips away responsibility for the potential outcomes (Adam and Groves, 2007). A *present futures* approach is more likely in times of uncertainty, as the future becomes ever more distant, making it difficult to invest in long-term futures (Leccardi, 2008). An alternative orientation, one of *future presents*, treats the future as real and already in motion (although it may not have yet materialised) by past and present action that motivates an ethic of responsibility. This links to Yeoman's (2014) focus on having an ethic of care for meaningful work – that active engagement must require thinking about and acting on futures. If futures are disregarded and uncertain, some individuals will likely struggle to find meaningfulness in the present. Indeed, Berlant (2011) proposes that when an expected and hoped-for future becomes unachievable it forces individuals to adapt, stall, or give up in the present. This qualitative study of early-career GPs, then, aims to address the question of how meaningful work is understood by adopting this futures approach and addressing the following research questions:

- How do past and present experiences of meaningful work shape the imagined future of early-career GPs?
- In a time of crisis, how is meaningful work understood and experienced by early-career GPs?

Methods

A qualitative biographical narrative approach was used to understand how trainees and newly qualified GPs made sense of and accounted for their work and careers temporally. Doctors in their final year of a GP specialist training programme (trainee GPs) or within 5 years of qualifying (new GPs) in England were recruited to take part in interviews or

focus groups. Participants were recruited through training programme organisers, peer groups for newly qualified GPs, as well as open invitations on social media and word of mouth among contacts from June 2017 to June 2018. A total of 15 in-depth interviews (six trainees, nine new GPs) and 10 focus groups (seven trainee focus groups involving 50 participants, three new GP focus groups involving 13 participants) were conducted across seven English regions. Participants reported a range of ethnic backgrounds, were mainly female (60%), had an average age of 32 and around half reported having parents in the medical profession.

An adapted Biographical Narrative Interpretative Method (BNIM) (Wengraf, 2001) approach was adopted, which aims to explore life histories, lived situations and personal meanings. In BNIM interviews, the researcher gives an initial narrative to encourage a response from the participant with minimal subsequent intervention. It allows participants to construct their accounts and determine what is important from their experience. For this study, the researcher asked:

> We are interested in exploring GPs' career transitions and the decisions that have led you to this point. We would like you to reflect on the factors that have been important to you and have influenced your career into general practice and how you imagine it in the future. I'm not going to interrupt; I'm just going to take some notes. You can start wherever you feel is important.

At the end of the opening narrative, the researcher follows up on the topics mentioned, in the order mentioned, to explore the account in more detail and to clarify any uncertainty. Finally, any remaining topics (from the topic guide developed below) not covered are explored. The advantage of biographical methods is that they allow participants to share their experiences as well as their interpretations and understandings of the experiences placed in context (Wengraf, 2001). Narratives can reveal how participants connect their experiences to produce a meaningful account of their decisions. Also, narratives from a group of similar individuals can illustrate common standpoints as well as differences (Gubrium and Holstein, 2009).

Focus groups took place at a range of NHS sites and were facilitated by a GP Clinical Academic Lecturer (SS) and a medical sociologist (LL). At the start of each group, there was a discussion of consent and group rules around confidentiality before written consent was taken. A topic guide was developed based on existing literature and iteratively developed during fieldwork. The resulting topic guide covered what were the doctors' expectations of general practice, experiences of training, working practices, career intentions and the perceived future of general practice. The categories were open to allow participants to contribute topics they considered important. The focus groups ranged in length from 40 to 180 minutes (an average of 65 minutes).

Interviews and focus groups were audio-recorded on an encrypted device, with consent, and then transcribed verbatim and stored on password-protected MS Word files in a secure server at the university. Interviews took place at the venue of the participants' choosing, mostly occurring at participants' homes, places of work, or a public space with a private area for the interview. Ethical approval was gained from the NHS Health Research Authority and The University of Manchester Research Ethics Committee 5

(ref: 2017-0773-2586). Pseudonyms are used throughout to protect the anonymity of the participants, and cohorts are identified as trainee GPs or new GPs.

The analysis drew on thematic (Braun and Clarke, 2006) and narrative (Gubrium and Holstein, 2009) analysis approaches to be able to focus on how accounts about work and meaningfulness were understood and constructed from the past, present and imagined futures. The analysis was ongoing and iterative. The transcripts were stored and managed in NVivo (QSR v12) and were closely read to gain familiarity before coding. Initial coding was conducted by one author (LL) and shared with the other researchers (SS, KC) who provided context and analytic insights. The team then revised and defined the final inductive themes.

Analysis

There was a common thread across the accounts and discussions. Namely, that early-career GPs perceived that the environment needed for meaningful work has changed, making meaningful work less likely than it had been in the past. Attachment to the NHS as a morally worthy organisation, however, remained a stable source of value, although concerns about privatisation were adding to uncertainty about the future. To manage and navigate future uncertainty, early-career GPs were adopting a range of individual strategies and approaches to work. These collective and individual narratives will be explored in more depth in the following themes.

Lamenting the past

The trainees and new GPs (mainly in their late 20s and early 30s) frequently drew on their perceptions of what general practice used to be when describing what they expected from their current and future work. General practice of the past was seen as desirable and meaningful predominantly because the work environment was perceived as contained, focused and morally significant. In terms of containment, this was characterised by the size of practices, viewing small or single-handed local practices as enabling a volume of work that could be managed within the confines of a 9-to-5 job. For example, Jenna's (ST3) expectations of general practice were based on work experience in a local 'nice, small practice where it was a single-handed GP' where 'the patients all knew us really well, there was a patient who used to bring us all a bottle of wine every Christmas . . . and really sort of respected the GP'. However, the organisation of general practice has seen a movement away from single-handed practices to new collaborations with other geographically proximate health services (Forbes et al., 2019). This was ongoing, with participants observing the end of small practices throughout their training.

Contained work within small practices was perceived to allow a focus on care-related tasks. The new GPs believed that older GPs were familiar with all of their patients and had autonomy and freedom from many of the bureaucratic restraints they now faced. Participants expressed frustration that having to multi-task administrative work, complex referrals, follow-ups and additional clinical tasks from hospitals (Charles-Jones et al., 2003) took them away from patient-facing work and left them feeling stretched and unable to work in the way they want:

> I just want to feel like when people come to see you, you think if it was you or your relative or anyone else, you want to look after them the best you can and I hate feeling, like, I can't do that. (Daria (new GP), interview)

It was the belief of participants that contained and focused work in the past allowed GPs to see the outcome of their clinical work in the relationships and gratitude from patients – they received external recognition that their work was of value. The new GPs, in contrast, reported that the relationship with patients has become less reciprocal. Many participants were concerned about a rising complaint culture and demands outwith traditional doctoring work, as expectations of GPs have shifted. For example, new GP Harry (interview) recounted an incident where he felt he had gone out of his way to help a patient, only to receive a complaint:

> I brought this patient in at the end of my surgery as an extra, I'd spoken to her on the phone and said, come down and I'll check you out, we'll see if you need antibiotics or not. I saw her, a nice normal conversation in the consultation, examined her. I was like, on balance, I think you've got the flu, I don't think antibiotics are going to help here. Paracetamol, ibuprofen, stay hydrated, sleep when you feel tired. And, she put in a complaint.

From these early-career GPs' perspectives, the previous generations had it good. Their perception of past work was that the environment was controllable and manageable and the mutual understanding of roles with the public was reciprocal. In choosing general practice as a specialism, then, this is what the participants signed up for and expected in their future work. It was their *imagined future*. Instead, what they are observing is that components of general practice that they imagined would lead to meaningful work, such as autonomy and shared values, are evaporating – the promise cannot be met. Participants were reconciled that these changes would be permanent; for example, a trainee in one of the focus groups recalled a conversation with an older GP:

> I met one of the GPs who I was working with, he was saying he doesn't think the sort of general practice that he loved doing, and the sort of general practice that I saw and really liked, is all that common anymore . . . they knew the regulars very, very well, and they knew all the families, locally, as well. And I really loved that, and I think that is just disappearing, and I think that will continue to disappear. (Focus Group 2, trainee GPs)

The present experience for trainees and new GPs was one of accelerating pressure with increasing volumes of work, intensification of multiple work tasks and loss of workplace security, resulting in an embodied experience of being harried (Wajcman, 2014). These pressures are perceived to have accelerated over the past decade and did not have an end in sight:

> A combination of much more work and less staff, so that the balance has tipped – from happy GPs that have gone, and the sort of overworked GPs are left. And I suppose that situation keeps getting worse, doesn't it, because people try it out and then it's not a very happy environment. And then it just gets worse and worse. (Lydia (new GP), interview)

Crisis and the present future

The participants recognised that the current crisis in general practice was the result of multiple past failings in the system: decades of political disinvestment, policy and contract changes, population variations and patient expectations. However, some went further by explicitly linking how their present and future work has been made precarious by previous generations of GPs. As Adam and Groves (2007) write, our present is the created and desired future of our predecessors. The concept of *present futures* argues that the future can be, and is often, commodified for the benefit of the present (Adam and Groves, 2007). Here, several participants felt that previous generations had taken their share of benefits in their present but did not consider the longer-term future:

> We haven't got older people ahead of us now, they're all retiring, so then what's going to happen in the next five years? The workforce is going to be decimated . . . To be honest, I think our age, our generation, we've been shafted. Costs of living are higher, house prices are higher. I get really frustrated at the older generation for not protecting the profession. They have better pay, better pensions, paid off their mortgage on their reasonably priced houses, free university fees . . . They've left things in a mess. The least you can do is improve it and pass it on – not clean up our mess, we're off. (Harry (new GP), interview)

Other participants recognised that the current older generation were also suffering the same work pressures, but blamed them for being too negative about the challenges of primary care and putting off future generations. Mutuality between the generations, the shared ethics and values of the profession that allow collective action, was lacking (Yeoman, 2020). This follows previous research that highlighted that negativity about general practice is felt from multiple sources: medical school, hospital consultants, peers and the media (Dale et al., 2017; Nicholson et al., 2016). The low morale observed in practices led even those within the training programme to question their career:

> So I applied to GP training, started on my first day of GP training and my trainer said, 'Oh, I just can't wait to retire now because it's so awful that I just don't want to do the job anymore'. So I'd sort of bounced into GP training being like, yeah, I'm doing what I always wanted to do, and felt a bit knocked down at the first hurdle . . . So I actually thought about quitting at that point. (Jenna (new GP), interview)

For the participants, desired *imagined* futures came from the perceived work of past generations. At the same time, there was a recognition that the current crisis was a result of a *present future* approach that prioritised short-term activities rather than protecting the long-term future of the profession. For some, it was the previous generation of GPs that were blamed for discounting the future of the next generation.

The discounting of the future also featured in accounts of episodic experiences of meaninglessness that arose from situations in which the present needs of the system were prioritised over the doctors' long-term future needs and well-being. These most frequently occurred within their foundation training[1] where, as junior doctors, they had little freedom and say over where, what and when their work was. Doctors described their training as a temporal sacrifice (Jemielniak, 2009; Simpson et al., 2014): that they had

missed out on their 20s and lost time with family and friends through long training programmes that expected them to devote their lives to their work. However, the GPs often felt they were only there to fill the rota – to bulk up the workforce to meet the current demands on services (Rich et al., 2016). This was seen to be to the detriment of their training needs, such as not being permitted time to gain particular experiences, 'I've asked if I can do these sort of things (get some specialist experience) and they said, "No, he's not doing it, you're there to see patients"' (Focus Group 1, trainee GPs), and their dignity and well-being:

> My rota was so bad, it was when I was on A&E and I just couldn't get time off and it never happened. I think I got ill a few times because we were just worked so hard and there were loads of gaps in the rota and I was under the impression from the registrars that it was the same in most jobs. I felt it, on my first day in the job, I ended up having to do, I think, a 20-hour shift because no-one turned up for the night shift and they, sort of, guilted me into it and I felt because it was my first day, I couldn't really say no. (Martha (new GP), interview)

The participants described feeling like the sacrifices they had had to make were not valued or cared about. Their dignity had been compromised. Yeoman (2020) refers to dignity as a core aspect of meaningfulness – that individuals have to be recognised as people with lives to lead and that to care for others they need to have the capacity to care for themselves. Instead, in these hospital settings, they were treated as a commodity for the current needs of the organisation rather than for their benefit as the next generation of doctors. This had a direct impact on the doctors in the immediate aftermath of foundation training – many described experiencing burnout, and others took a break to re-evaluate if they wanted to continue. These episodic moments of meaninglessness give rise to the uncertainty that stretches into present actions and decisions about the future.

Unpromising futures

The participants generally talked about the future of general practice as uncertain, with some holding stronger anxieties that it was going to change beyond all recognition. The discussions of uncertainty were tied up with concerns about how the future of general practice could continue within the structures of the NHS. Institutions play an important role in providing a source of stability and security in the face of uncertainty (Selin, 2008) and the NHS has been long held up as a morally worthy organisation. The doctors described a strong commitment to the public values of the NHS as a source of meaningfulness that was a strong motivator for both deciding to become a doctor and to stay. For many participants, continuing in medicine was contingent on the NHS: 'It sounds, probably, a bit too ideological, but I mean, I do like working in the NHS and if the NHS was to crumble, then I'd have a real good reason to leave' (Focus Group 4, new GPs). For others, their desire to uphold the values of the NHS jarred with their experiences of working within it. Lydia, who has moved away from general practice, for example, states: 'I feel a loyalty to the NHS . . . I want the NHS to work. And I want to work for the NHS.' The ideological values of the NHS as an institution were an important source of meaningfulness and buffer to uncertainty for participants, although personal

experiences within the structures of the institution differed. In other words, the values of the NHS were a relatively stable source of meaningfulness despite the working environment (the loss of autonomy, dignity and freedom) making meaningful work less possible. The loss of this security, then, could have detrimental impacts on meaningful work now and in the future.

Concerns about the long-term future of general practice were not simply theoretical. As has been previously described, the participants recognised that their anticipated general practice no longer existed with the significant reform to the primary care system over the past few decades. They were witness to *lived futures* (Adam and Groves, 2007), and saw the future of general practice as something already underway and set in motion:

> I think we're in trouble, I think recruitment's at an all-time low, I think there's less and fewer and fewer GPs trying to do a bigger and bigger workload and at some point that will fail. (Adam (new GP), interview)

The result of these *lived futures* was unclear. There were concerns that the UK Government would take advantage of the crisis to force a transformation in care: 'The current government are doing their best to privatise it in an underhand backdoor way' (Craig, new GP). Some believed that general practices would be taken over by private healthcare providers in big merged practices or that GPs would become salaried employees working directly for the NHS instead of independent contractors. Some participants saw the pressures currently on general practice as an indicator of wider problems within the NHS. The end of general practice, and the NHS, was not an inconceivable thought:

> I think primary care is absorbing a lot of this and it's a floodgate really. If primary care fell, then I think the rest of the NHS would fall within weeks. (Focus Group 3, new GPs)

The participants perceived that there was overwhelming uncertainty about the future. When this occurs, the future can press onto the present, making it difficult to see the long-term outcomes (Adam and Groves, 2007), and in turn, can make decision-making about the future challenging. When discussing their plans, the participants could be split into three groups. The first group were actively seeking to leave the profession to regain autonomy, freedom and dignity (Yeoman, 2014) in their work, recognising that the sacrifice of their time and well-being was not likely to be acknowledged in general practice. The second group were interested in actively changing general practice for the future. This group saw themselves as having a different outlook on general practice and wanting to bring a more hopeful collective approach that would encourage others to join the profession. The third, and the largest, group were planning on continuing in general practice with an important caveat: to continue in general practice they had to get sovereignty over their time and prioritise their well-being. Part-time flexible work was seen as the only viable working option for all participants, men and women, as it allowed them to: (a) repay the time debt accumulated during training, by having some free time to connect with friends and family; (b) reduce the pressure of GP clinical work, in particular – occupying other days with breaks or other types of work such as teaching or working in a specialist area; and (c) protect their future self from burnout and to be able to continue

long-term. It could be argued then that these doctors are treating the *lived future* as one in which the current workforce crisis will continue and get worse, and thus is in need of action in the present.

Discussion

This article examines how early-career GPs account for their experiences and expectations of meaningful work in the face of a professional crisis by focusing on the role of the future. Previous research on meaningful work and temporality has often focused on retrospective forms of sensemaking, such as reflecting on the past to make sense of the present, while treating futures as abstract and open (cf Muzzetto, 2006). The novel approach taken here, adopting Adam and Groves' (2007) theoretical work on futures, shows that there are multiple fluid future orientations that may impact how individuals, and organisations, construct and anticipate meaningful work. This opens up interesting avenues for which to understand meaningful work, particularly under conditions of uncertainty and crisis. In the current study, two conflicting future orientations impact meaningful work during a professional crisis. In what follows, the current study findings will be situated with the theoretical approach and literature to illustrate the contribution to current knowledge on temporality and meaningfulness.

The findings show that there is a mismatch between *imagined futures* and *lived futures* as a result of reforms that have led to changes in the workplace environment. In the recent past, general practice was perceived to provide meaningful work through the traditional social contract. Morally significant activities, a work environment that allowed autonomy, freedom and dignity, in a profession that was respected (Laaser and Karlsson, 2022). In other words, components that fulfil Yeoman's (2014) definitions of meaningful work. These perceptions of general practice shaped the *imagined futures* of junior doctors choosing to train as GPs. The *lived future* these GPs were faced with, however, was a work environment characterised by accelerating work pressures and intensity, uncontained and changing work environments, alongside a loss of public respect (Charles-Jones et al., 2003; Fenwick, 2013; Rich et al., 2016). This mismatch leads to anomie, evident in the lamenting over the past and a realisation that the changes to the organisation, structure and conditions of general practice and the NHS mean that the imagined futures, and thus meaningful work, would not be possible for them (Lepisto and Pratt, 2016). Exploring the tensions between *imagined* and *lived futures*, then, provides a useful lens to examine how meaningful work is navigated under changing working conditions.

The second clash in future orientations occurs between *present future* and *future present* approaches that privilege the present to the detriment of the future (Adam and Groves, 2007). The previous generation of GPs are blamed by some participants for not adequately future-proofing the profession, while others recognised the fault of policymakers and healthcare leaders who prioritised tackling current needs in the system rather than considering long-term solutions. The timescapes of government policy are short-term, fast and often temporary, which makes learning from the past and thinking long-term about the future difficult (Graham, 2010). The irony is, as a result of these future orientation clashes, participants were also forced to take a *present future* approach to

their plans. Upon realising their *imagined future* is not possible, participants responded in different ways: (a) by leaving and seeking that future elsewhere, (b) working to transform the present to achieve that future, or (c) making do by altering their *present future* and hoping things turn out better in the end. As Adam and Groves (2007) state, uncertainty can make it hard for individuals to envisage futures. In other words, it is difficult to convince individuals to focus on long-term solutions when they are busy bailing water out of a sinking boat. *Present future* solutions (e.g. reducing working days) then, make more sense to individuals than investing in *future present* solutions (such as taking up partnerships) given the uncertainty. These solutions reflect what Chaudhry et al. (2021) have referred to as depersonalisation and detachment strategies in medical work during crises. It is, currently, unclear whether these individual strategies can support meaningful work and further research exploring these temporal clashes could prove fruitful.

In applying the theoretical work of Adam and Groves (2007), this article proposes that meaningful work is impacted by multiple, and often conflicting, future orientations. Meaningful work, for these early-career professionals, was situated in imagined futures that can act as a form of cruel optimism (Berlant, 2011). This refers to an enduring attachment to an idea, for example, that meaningful work is achievable within a working environment that is maintained even when it becomes clear that it may not be possible. As such, it becomes an obstacle to moving forward (Berlant, 2011), and indeed many participants described a sunk-cost fallacy – that they had sacrificed too much to quit despite their unhappiness.

Meaningful work is also likely to be impacted when there is a focus on *present futures*. To move forward, there needs to be a move towards *future presents* where there is a recognition that futures are already in the making, and that current actions have consequences for the near and distant future (Adam and Groves, 2007). There needs to be system-based responsibility and obligation for the next generations to help reshape and reimagine what the future can and should be. To take a caring approach to futures. For general practice, a new social contract will likely need to be defined to manage the expectations of all parties. This applies to other professions and industries, such as academia (Gill, 2010), experiencing widespread uncertainty and insecurity that result in short-term *present future* approaches. By using these insights and approaches, it is possible to look at what is being set in motion in the present and to understand how these tendrils construct and dismantle certain close and distant futures.

Conclusion

Widespread precarity in work and society has made understanding the role of meaningful work increasingly important. As such, there has been an increasing focus on examining how meaningful work is made and managed over time. This article highlights that a futures approach is useful to comprehend how meaningfulness is located and imagined through different temporal dimensions. Conflicting *imagined* and *lived* futures, and approaches that prioritise the present over future needs, can be particularly impactful in how people construct meaning in work. Further research might look to examine if and how new *imagined futures* can be made and how meaningfulness may be recovered by different orientations towards the present and future.

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Note

1. Two years of on-the-job training after medical school and before specialist training.

References

Adam B (2003) When time is money: contested rationalities of time in the theory and practice of work. *Theoria* 50(102): 94–125.

Adam B (2013) *Timewatch: The Social Analysis of Time*. Hoboken, NJ: John Wiley & Sons.

Adam B and Groves C (2007) *Future Matters: Action, Knowledge, Ethics*. Leiden: Brill.

Bailey C and Madden A (2017) Time reclaimed: temporality and the experience of meaningful work. *Work, Employment and Society* 31(1): 3–18.

Bailey C, Lips-Wiersma M, Madden A, et al. (2019) The five paradoxes of meaningful work: introduction to the special issue 'meaningful work: prospects for the 21st century'. *Journal of Management Studies* 56(3): 481–499.

Beck U and Beck-Gernsheim E (2002) *Individualization: Institutional Individualism and Its Social and Political Consequences*. London: SAGE.

Berlant L (2011) *Cruel Optimism*. Durham, NC: Duke University Press.

Bolton S, Muzio D and Boyd-Quinn C (2011) Making sense of modern medical careers: the case of the UK's National Health Service. *Sociology* 45(4): 682–699.

Braun V and Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.

Charles-Jones H, Latimer J and May C (2003) Transforming general practice: the redistribution of medical work in primary care. *Sociology of Health and Illness* 25(1): 71–92.

Chaudhry S, Yarrow E, Aldossari M, et al. (2021) An NHS doctor's lived experience of burnout during the first wave of Covid-19. *Work, Employment and Society* 35(6): 1133–1143.

Cruess RL and Cruess SR (2008) Expectations and obligations: professionalism and medicine's social contract with society. *Perspectives in Biology and Medicine* 51(4): 579–598.

Dale J, Russell R, Scott E, et al. (2017) Factors influencing career intentions on completion of general practice vocational training in England: a cross-sectional study. *BMJ Open* 7(8): e017143.

De Boeck G, Dries N and Tierens H (2019) The experience of untapped potential: towards a subjective temporal understanding of work meaningfulness. *Journal of Management Studies* 56(3): 529–557.

Dixon-Woods M, Yeung K and Bosk CL (2011) Why is UK medicine no longer a self-regulating profession? The role of scandals involving 'bad apple' doctors. *Social Science & Medicine* 73(10): 1452–1459.

Doran N, Fox F, Rodham K, et al. (2016) Lost to the NHS: a mixed methods study of why GPs leave practice early in England. *British Journal of General Practice* 66(643): e128.

Edwards N, Kornacki MJ and Silversin J (2002) Unhappy doctors: what are the causes and what can be done? *BMJ* 324(7341): 835.

Fenwick T (2013) Understanding transitions in professional practice and learning: towards new questions for research. *Journal of Workplace Learning* 25(6): 352–367.

Ferguson J, Tazzyman A, Walshe K et al. (2021) 'You're just a locum': professional identity and temporary workers in the medical profession. *Sociology of Health and Illness* 43(1): 149–166.

Fielden S and Whiting F (2007) The psychological contract: is the UK National Health Service a model employer? *Health Services Management Research* 20(2): 94–104.

Forbes L, Forbes H, Sutton M, et al. (2019) How widespread is working at scale in English general practice? An observational study. *British Journal of General Practice* 69(687): e682.

Freidson E (1986) *Professional Powers: A Study of the Institutionalization of Formal Knowledge*. Chicago, IL: University of Chicago Press.

Frenkle S, Korczynski M, Donoghue L, et al. (1995) Re-constituting work: trends towards knowledge work and info-normative control. *Work, Employment and Society* 9(4): 773–796.

Gershlick B, Kraindler J, Idriss O, et al. (2019) *Health and Social Care Funding: Priorities for the Next Government*. London: Health Foundation.

Gibson J, Spooner S, Hawthorne KJ, et al. (2019) An investigation into the early career intentions and training experiences of newly qualified GPs. *British Journal of General Practice* 69(suppl 1): bjgp19X703469.

Gill R (2010) Breaking the silence: the hidden injuries of the neoliberal university. In: Ryan-Flood R and Gill R (eds) *Secrecy and Silence in the Research Process: Feminist Reflections*. New York: Routledge, 228–244.

Graham H (2010) Where is the future in public health? *Milbank Quarterly* 88(2): 149–168.

Gregg M (2018) *Counterproductive: Time Management in the Knowledge Economy*. Durham, NC: Duke University Press.

Gubrium J and Holstein J (2009) *Analyzing Narrative Reality*. Thousand Oaks, CA: SAGE.

Harris JM (2017) It is time to cancel medicine's social contract metaphor. *Academic Medicine* 92(9): 1236–1240.

Harrison S and Dowswell G (2002) Autonomy and bureaucratic accountability in primary care: what English general practitioners say. *Sociology of Health & Illness* 24(2): 208–226.

Haug M (1988) A re-examination of the hypothesis of physician deprofessionalization. *The Milbank Quarterly* 66: 48–56.

Horobin G and McIntosh J (1983) Time, risk and routine in general practice. *Sociology of Health and Illness* 5(3): 312–331.

Hunter DJ (2015) Wider political context underlying the NHS junior doctors' dispute. *BMJ* 351: h6317.

Iliffe S (2017) A tale of three disputes: junior doctors against the government 2015–2016. *Soundings* 64(64): 128–142.

Imison C and Bohmer R (2013) NHS and social care workforce: meeting our needs now and in the future? Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf (accessed 11 October 2021).

Jemielniak D (2009) Time as symbolic currency in knowledge work. *Information and Organization* 19(4): 277–293.

Laaser K and Karlsson JC (2022) Towards a sociology of meaningful work. *Work, Employment and Society* 36(5): 798–815.
Leccardi C (2008) New biographies in the 'risk society'? About future and planning. *Twenty-First Century Society* 3(2): 119–129.
Lepisto D and Pratt M (2016) Meaningful work as realization and justification: toward a dual conceptualization. *Organizational Psychology Review* 7(2): 99–121.
MacBride-Stewart S (2013) The effort to control time in the 'new' general practice. *Sociology of Health and Illness* 35(4): 560–574.
McKinlay J and Arches J (1985) Towards the proletarianization of physicians. *International Journal of Health Services* 15(2): 161–195.
Marchand C and Peckham S (2017) Addressing the crisis of GP recruitment and retention: a systematic review. *British Journal of General Practice* 67(657): e227–e237.
Mazhar K and Rashid A (2016) What are the career plans of GP trainees and newly qualified general practitioners in the UK? A national online survey. *Journal of General Practice* 4: 1000216.
Muzzetto L (2006) Time and meaning in Alfred Schutz. *Time & Society* 15(1): 5–31.
Nicholson S, Hastings A and McKinley R (2016) Influences on students' career decisions concerning general practice: a focus group study. *British Journal of General Practice* 66(651): e768–e775.
Rich A, Viney R, Needleman, S. et al. (2016) 'You can't be a person and a doctor': the work–life balance of doctors in training – a qualitative study. *BMJ Open* 6(12): e013897.
Royal College of Physicians (2005) Doctors in society: medical professionalism in a changing world. *Report of a Working Party of the Royal College of Physicians of London*. London: RCP.
Selin C (2008) The sociology of the future: tracing stories of technology and time. *Sociology Compass* 2(6): 1878–1895.
Sennett R (2006) *The Culture of the New Capitalism*. New Haven, CT: Yale University Press.
Simpson R, Hughes J, Slutskaya N, et al. (2014) Sacrifice and distinction in dirty work: men's construction of meaning in the butcher trade. *Work, Employment and Society* 28(5): 754–770.
Spooner S, Gibson J, Rigby D, et al. (2017) Stick or twist? Career decision-making during contractual uncertainty for NHS junior doctors. *BMJ Open* 7: e013756.
Thompson P and Smith C (2009) Labour power and labour process: contesting the marginality of the sociology of work. *Sociology* 43(5): 913–930.
Tommasi F, Ceschi A and Sartori R (2020) Viewing meaningful work through the lens of time. *Frontiers in Psychology* 11: 585274.
Wajcman J (2014) *Pressed for Time*. Chicago, IL: University of Chicago Press.
Webster S and Ballard D (2009) Time and time again: the search for meaning/fulness through popular discourse on the time and timing of work. *Kronoscope* 8(2): 131–145.
Wengraf T (2001) *Qualitative Research Interviewing: Biographic Narrative and Semi-Structured Methods*. Thousand Oaks, CA: SAGE.
Yeoman R (2014) Conceptualising meaningful work as a fundamental human need. *Journal of Business Ethics* 125(2): 235–251.
Yeoman R (2020) *Ethics, Meaningfulness, and Mutuality*. Abingdon: Routledge.

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