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Influences on GP coping and resilience: a qualitative study in primary care

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Abstract

Background: 'Neoliberal' work policies, austerity, NHS restructuring and increased GP consultation rates provide the backdrop against increasing reports of GP burnout and a looming shortage of GPs.

Aim: To explore GPs' experiences of workplace challenges and stresses and their coping strategies, particularly focusing on understanding the impact of NHS workplace change.

Design: Study design was qualitative, with data collected from two focus groups and seven one-to-one telephone interviews.

Method: Focus groups (n=15) and interviews (n=7) explored the experiences of currently practicing GPs in England, recruited through convenience sampling. Data were collected using a semi-structured interview approach and analysed using thematic analysis.

Results: Interviewees understood GPs to be under intense and historically unprecedented pressures, which were tied to the contexts in which they work; with important moral implications for 'good' doctoring. Many reported that being a full-time GP was too stressful: work-related stress led to mood changes, sleep disruption, increases in anxiety and tensions with loved ones. Some had subsequently sought ways to downsize their clinical workload. Workplace change resulted in little time for the things that helped GP resilience: a good work life balance and better contact with colleagues. Whilst some GPs were coping better than others, GPs acknowledged that there was only so much an individual GP could do to manage their stress, given the external work issues they faced.

Conclusion: GPs grasp their emotional lives and stresses as being meaningfully shaped by NHS factors; resilience building should move beyond the individual to include systemic work issues.

Keywords: primary health care, general practitioners, professional burnout, coping skills, psychological resilience, political factors

How this fits in

- **Primary care is currently facing unprecedented challenges including increasing GP burnout and staff shortages.**
- **GPs report being under intense and historically unprecedented pressures that are tied to the contexts in which they currently work.**
- **In the intense, micromanaged, competitive NHS 'marketplace' our participants were conscious of the potential damage to relationships (to self and others) the current system engenders.**
- **At the individual level, resilience training may be of benefit to GPs, yet an exclusive focus on improving individual coping risks sidestepping the systemic challenges shaping primary care.**

INTRODUCTION

Contemporary General Practice

Post-1970s, western governments have pursued 'neoliberal' policies (1, 2) prioritising employee productivity and flexibility, alongside increasing insecurity and unpaid overtime (3, 4). Subsequently, there was commodification of NHS healthcare, increasingly conceptualised as a competitive marketplace (5). Cost, value and privatisation were prioritised (6), creating variation in access to healthcare (7). NHS policies have reduced GPs' autonomy too (8). The 2004 General Medical Services (GMS) contract, while initially helpful (10) increased the authority of Primary Care Trusts (9) and created a market for resources (10). The cycle of performance management, monitoring and competition for scarcer resources has resulted in NHS savings (11), but created a focus on cost-effective healthcare; competition for funding against quality standards; increased primary care workload for conditions previously managed in secondary care (12); and growing responsibility for delivering quality with fewer resources (13, 14).

As well as neoliberalism, austerity and NHS restructuring, GPs face cultural changes with increased patient demand and expertise (12, 15), and new care technologies to administer and provide clinical care (8). While these trends may add to quality and patient centred-ness (16), they also present challenges for the profession (8).

Links to GP wellbeing

Research suggests that uncertainty at work contributes to distress and dysfunction amongst healthy adults (17), although links between rapid change and worker wellbeing are unclear (20, 21). UK GPs face cognitively and emotionally challenging environments with high workloads and long hours (18). While many cope successfully (19) reports of distress and burnout, and related negative job performance are increasing (20-22). Burnout is a descriptive measure (rather than a clinical diagnosis) of feelings of emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment primarily driven by workplace stressors (20, 22). One in three UK and European GPs are experiencing burnout (22); UK GPs report lower levels of work satisfaction than other Western countries (23), 16% report unmanageable distress (24). Doctor distress increases professional morbidity, depression and alcohol and substance abuse (25-27), and is linked to medication errors, lower patient satisfaction, and non-adherence to treatment (28-30). Stress also reduces productivity (37), increasing absenteeism, presenteeism, job turnover, clinical errors and early retirement (31, 32). UK GP vacancy rates are at their highest levels (33), with more planning to leave (34). The desire to leave general practice is linked to high stress levels (23). Government plans for routine seven-day GP working will create further challenges (35).

In the context of these complex changes in the GP workplace, and their links to wider political changes, we used a qualitative interpretative approach in order to address: What are GPs' experiences of core workplace challenges and stresses, and their preferred coping strategies.

METHODS

Design

Focus groups allowed GP discussions about their experiences in the 'austerity NHS'. GPs are busy (12), thus more flexible telephone interviews (covering the same topics) were offered to those unable to attend a focus group. The interview topic guide was additionally informed by themes emerging from the group discussions (36).

Participants and recruitment

Recruitment packs including participant information sheets were made available to GPs at the resilience talk delivered at the RCGP 2015 Annual Conference. Additionally, a study flyer was placed on the RCGP website and sent to local RCGP faculties and medical committees. We exploited our extensive primary care contacts targeting GP gatekeepers, asking them to distribute our flyer to their contacts, and using snowballing - with those recruited asked to contact colleagues about the study.

Inclusion criteria were; currently practicing as a GP in England. GPs who expressed an interest were emailed a participant information sheet and consent form, and invited to a focus group in London or Bournemouth or a telephone interview. Participants received no financial reimbursement for participation.

Twenty-two GPs participated in the study (January to March 2016): two focus groups (Bournemouth, n=8; London, n=7) and seven telephone interviews. We recruited a wide demographic in terms of age, sex, type of GP, practice type and working hours (Table 1).

<Insert Table 1 about here>

Data collection

We adopted a semi-structured approach to data collection. Topics covered current sources of GP stress, coping strategies and barriers/facilitators to successful coping. Focus groups lasted 37 and 77 minutes, interviews 35-65 minutes, all were conducted by an experienced qualitative researcher. Discussions in focus groups flowed easily and, once the facilitator raised a topic, minimal facilitation was required. Focus groups allowed debate and drawing out of issues, whilst interviews explored underlying issues and in depth individual experiences (37). The point of data saturation (38) – no new themes of interest were emerging – was debated between the first authors, and determined to be 22 participants. Interviews and groups were recorded and transcribed verbatim; transcripts were checked for accuracy and anonymised.

Analysis

A constructivist epistemological approach was adopted. The study was approached from the position that "data do not provide a window on reality, rather, the 'discovered' reality arises from the interactive process and its temporal, cultural, and structural contexts" (39). Data were analysed inductively (40), using thematic analysis (41). Two researchers immersed themselves in the data, repeatedly reading the transcripts to understand participants' experiences. Key issues, concepts and themes arising from the data were identified and debated, creating a draft-coding framework that was discussed with the research team, to

construct the final conceptual framework. Transcripts were coded and explored in NVivo (42) and findings were written up into a draft which was then debated and finalised by all authors.

RESULTS

Our findings explore core workplace challenges discussed by GPs, their experiences of workplace stress, and how they are coping. Findings are presented around the following broad themes: Work intensification and morality issues therein; Intensification and links to patient complexities; and GP coping, work life balance and downsizing (see Table 2 for summary).

Insert Table 2 about here

Work intensification and morality: “It’s becoming very Big Brother”

Interviewees felt GPs to be under intense and historically unprecedented pressures suggesting these issues were tied to work contexts, with important moral implications. NHS factors were considered particularly important in understanding GP stress. Participants overwhelmingly believed that linking the Quality & Outcomes Framework (QOF) directly to GP funding was detrimental to GP wellbeing and patient-centred care. In particular, some participants argued that QOF made unreasonable demands on a 10-minute consultation, and had more to do with allocating funding than good use of evidence based practice:

‘To be a good GP you need to think about these things, but in order to obtain your funding you need to run through your little hoops. So it might be that your computer’s saying, needs this check and that check and this check. And you think, oh no, I haven’t got time to do all that.’ FG1F

Participants agreed their human connection with patients was important, and worried that they were less able to connect because of conflicting time demands. The imperative to collect and record patient indicators during consultations and the need to work within a new NHS marketplace for resources, risked undermining the ‘art’ of medicine and ‘good’ care by impinging on GPs’ ability to authentically engage with patients. Primary care seemed to be functioning in more detached ways, ‘like secondary care’, while being micromanaged and professionally deskilled. Care Quality Commission (CQC) inspections also were seen as increasing the intensity - and external scrutiny - of GP work.

‘It’s becoming very Big Brother, the whole of the NHS and especially general practice about what we have to do in order to earn money and look after people. It’s becoming more, obviously guidelines and protocols are really useful and we need those, especially as things become more complex. But that’s squeezing out just the relational aspect of general practice, which is a lot of the time what people need and where help and healing really happens I think.’ P24F, 36, PT

‘You want me to put them on a tablet just to get the money in? This is not what I signed myself up for. ... So the other obstacle is trying to get these other GPs on board who have moved onto the ‘other side’, which is, we must get QOF, we must get QOF, we must get QOF.’ P26

A perceived negative portrayal of GPs by the UK media and politicians particularly concerned participants: the public prestige/esteem of the profession seemed to be under threat, affecting morale. Others felt the coverage negatively influenced the patients' trust in GPs, which could in turn affect consultations and their sense of being a 'good' doctor.

'Negative portrayal of the profession in the press I think, is a strong demotivator. It actually impacts quite significantly on the doctor patient relationship as well. ... When they walk into the consulting room, that wariness is very, very difficult to overcome, to gain a rapport.' P25M, 38, PT

GPs endorsed patient empowerment and favoured patients making formal complaints where medical care was genuinely compromised. However, there was a perception that trivial complaints were being normalised within a "complaints culture". Consequently doctors practiced more defensively by increasing their paper trails or making referrals they felt were probably unwarranted.

'I feel the need increasingly to be defensive about the way that one practices because of the increased levels of complaints and increased empowerment really, the complaints that one receives, this takes an immense amount of time and emotional energy to respond to.' P25

Intensification and patient complexities

GPs tried in various ways to convey the competing demands that they had to balance in their work, emphasising the unrelenting 'pressure of time'.

"The thing that is most stressful I think is the relentless nature of it a lot of the time. It seems a lot of the time like a constant race against the clock from half eight in the morning or before to seven at night." FG1M

GPs saw consultations with patients as their 'bread and butter'. But day-to-day administrative duties, phone calls to patients and 'surprise work' (e.g. working with social services or paramedics on behalf of specific patients) inevitably increased their workload. GPs perceived that the complexity of their work was increasing without additional resource. An ageing population needing more consultations was presenting with more complex multi-morbidities. Additionally, GPs were taking on the management of chronic conditions previously referred to secondary care. They were concerned about being out of their depth

'Patients are getting much more complex and they're getting much more demanding.' FG1F

'It's what secondary care is putting back into primary care, it's very complex because they're reducing mental health services and pushing patients back on to us, we have to deal with. We are not properly trained to deal with them, they are taking a lot more time. We try to refer them, they get bounced back at us.' FG1F

or 'set up to fail'.

Changes to practice management such as GPs not having their own personal lists, were thought to contribute to a lack of continuity of care, with less ability to develop long-term patient relationships. This tended to reduce the efficiency and effectiveness of consultations, because GPs had to 'go back to square one' with unfamiliar patients.

"I don't have a list. ... I may never have met them [patient] and not know anything about the issue, but in order to safeguard them I do have to go back to square one to find out where we are, before we then decide how we move forward. So it's not like a follow up, it's like a new consultation which takes more time." P14F, 57, FT

Ten minutes for each patient was unanimously perceived as inadequate for treating increasingly empowered patients with complex issues: Clinics routinely ran late, GPs often felt unable to take adequate working breaks. They universally worked longer hours than contracted, and were uneasy about the impact of the proposed Government seven-day working week.

'There are mornings where I think, oh dear, is this going to be a two wee day or a one wee day?' FG1F

'We were all thinking, we can't cope with five days at the moment, how on earth are they going to get us doing seven days!' FG1M

GP coping, work life balance and downsizing

Some GPs are coping better than others, although reports of coping often came with caveats (e.g. working longer hours to cope)

'Sometimes you just stay late or you come in another day and you do your extra work. I find actually I'd rather do that than cope with that feeling of being overwhelmed really.' FG1F

'Well I think some people innately can always look at the cup half full can't they, and I probably have that personality or I wouldn't have survived this long' P3F, 59, FT

However, most GPs were adamant that being a full-time GP was now 'too stressful'. For some, their current role was perceived as undermining their ability to function effectively, or even safely. Cognitively stressed GPs felt unable to handle the levels of incoming information, and were worried they might make errors. Work-related stress led to changes in mood, disruptions to sleep patterns and increases in anxiety.

'I felt unsafe in my practice because my head was too full and there was too much going on and I didn't feel I was able to think clearly, rationally.' P24

'You're constantly worried and the more stressed you are the more worried that, oh my God, I'm definitely missing something now.' FG1F

Many participants said that being a full-time GP was incompatible with an adequate work-life balance. Female GPs with children experienced this issue most acutely. Childcare forced some GPs to 'down tools' earlier, but then meant working overtime to catch up. Even if partners and families were supportive, many GPs still lamented the stress they experienced, with limited time for loved ones.

'Then there's the stress, we're talking about stressors, the stress of not knowing that you're not going to get home for bed time with the kids or to have a bit of a row with the other half because you've been late leaving yet again.' P25

GPs also highlighted the lack of time to pursue hobbies or leisure activities. Yet a good work/life balance was widely considered to increase GPs' resilience and better equip them to deal with the stresses associated with their role.

'I think an understanding that you have a right to have a life outside your job. ... And that actually the richer that is probably the more resilient a GP you could be I think.' FG1F

All participants spoke about the strategies they employed to mitigate work stress. These included meditation/mindfulness, stress management techniques, taking regular exercise and eating well. Participants also adapted practical aspects of their day-to-day working routine in an effort to ease their workload and/or make their work more efficient.

'I think one of my ways of coping is to do blocks of work in chunks, so different modalities of work. So say results, so try and not switch over to documents say, to go through my block of blood results before I move on to the next thing like phone calls.' FG1F

'And mindfulness isn't just meditating, it's lots of other things as well. And that just helps me, it helps keep me in check.' P26

'I mean just lifestyle things, making sure you've slept enough and you haven't drunk too much alcohol the night before, and that you eat regularly and you exercise, all of those things.' P24

Other participants reported focusing on what they enjoyed about their job which helped with their stress, and included helping patients and having a supportive and friendly practice. Space for meeting and debriefing with the team was perceived as having a positive impact on stress levels. Increasing work demands meant GPs had less time to connect with colleagues.

'There's been nothing official, but I have felt supported, appreciated and been able to talk about stuff when I needed to with my colleagues, but that is changing or has changed a lot. Because one of the biggest differences from when I started in the practice where I'm in now, is that I now arrive at work half an hour early to get all the login and look at my path links and things like that, so I go in and I shut my door. And then I can possibly be in there for about 11 hours without much opportunity to talk to anybody.' P14

'We all love our job, we work for the patients, that's why we do this job' FG1F

Participants emphasised that no matter how good they were at coping with external factors and work stressors, there was only so much individual GPs could do to cope. Many factors such as 10-minute consultations and QOF, were considered unlikely to change imminently. A number of participants had implemented far-reaching changes having come to a gradual awareness (or a defining moment) of the limits of their ability to cope full-time. Participants talked about colleagues who had left the profession. A surprisingly high number of participants had reduced their working hours or changed their role (e.g. to salaried or locum) to enable them to downsize, better cope and regain some work/life balance.

'Since qualifying I've really been doing a regular six session week, so that means three days, I've been doing some locum shifts as and when. But it just means that if I know that those three days I'm always in work twelve hours at least and then I have a long drive home at the moment, so actually that's thirty-six hours a week so that's full-time work. That's really helped me. At the moment I'm now going to a regular yoga class, I've got a bit fitter, I can see my friends. ... Which is not great for the GP workforce on the whole because if it was more manageable I could do five days, no problem, but because it's not manageable.' FG1F

'I'd say even amongst my cohort of ST3s, I would say probably half of us are thinking of just working part time.' FG2F

'What you've got to be careful to do is not ignore the fact that actually, maybe, for most of us, we are not coping with the stressors because there's too much stress, not because we're not resilient enough. And therefore if you don't solve the root course you get nowhere.' FG2M

DISCUSSION

Summary

GP work is shaped by the policy agendas affecting other public services. The profound impact of increasing workload, and demand on the way GPs relate to themselves, their colleagues and patients needs highlighting. The development of the NHS as a marketplace, with intense regulation but under resourcing, is perceived as detracting from high quality patient-centred care. The moral implications of work intensification are enhanced disconnection from patients and fears about bad doctoring. GPs increasingly feel the need to practice more defensively, whilst at the same time may be too busy to connect with their peers to adequately debrief.

Some GPs had found ways to cope with conflicts between work- and home-life but others simply looked to reduce their workload. Concurrently an ageing population, increasing patient contact, relocation of secondary care services into the community, and rising public expectations have intensified GP workload. Participants acknowledged the need to build personal resilience but also recognised that organisational change is needed to improve their wellbeing and job satisfaction.

Strengths and limitations

Our sample were from a range of demographics, practices and roles but with a larger number of females, more salaried GPs than partners, and more participants from urban practices (43, 44); yet our proportions of full- and part- time GPs were consistent with national figures (43). Our sample size (n=22) is adequate for this type of qualitative study, and our data reached saturation (45).

Our sampling methods may have attracted GPs who were interested in resilience and had time to participate. These GPs may be coping better than others. Nevertheless, a number of our participants reported that they were not – or had not previously been – coping well. We did not interview GPs who had left the profession nor focus our questions on the positive aspects of GPs' careers (46, 47). Interviews and focus groups provided a helpful combination of data collection methods.

Comparison with existing literature

Others have described similar pressures on GPs (12, 14) including dissatisfaction with appointment length (23), increasing patient expectation and demand (12, 46), negative media portrayals and a reduced ability to practice patient-centred care (46). While the proportion of NHS funding for primary care has declined, consultation rates and workload have increased dramatically (12, 14), thus creating a 'feeling of crisis' in primary care (12). Research has identified similar trends across Europe (48).

We identified a contradiction between Government rhetoric that puts patients 'at the centre of everything the NHS does' (49) and current policy. The NHS as 'marketplace' limits high quality individualised care (50). Previous research has found neoliberal ideas encourage

a ‘specific way of being, acting, and understanding the world, which is highly individualistic’ (51); we found that NHS marketisation promotes a kind of individualism – an atomization - where GPs feel increasingly removed from meaningful interactions with patients and colleagues, even loved ones. While some doctors cope better in the new NHS than others (59), there is a growing recognition that primary care is at breaking point (12, 14). Early indicators of change may be Government proposals to cut bureaucracy (52) and abandon the QOF (53), and the BMA’s call to increase GP consultation time (54).

Implications for research and practice

Resilient doctors are better at caring for others, and are less likely to commit errors, get sick or leave practice (55, 56). Systemic changes to the work environment (55, 57, 58) and educational and organisational interventions that could increase physician resilience are key to more effective primary care. Resilience training should be a preventative strategy rather than a response to overwhelming systemic problems (59). Mindful self-compassion, optimism, adaptability and prioritization, teamwork, supportive relationships and job-related satisfaction all enhance resilience (60-62). Yet resilience building requires a synergy between personal characteristics, management support, teamwork and workplace/social buffers (63). Our findings suggest that NHS organisational factors and wider government policy impacts directly on GPs’ emotional lives in predictable ways. Further research should address how organizational change can best promote both individual and systemic resilience (56). We must be wary though of how neoliberal ideas could turn resilience-building into a project of the self, with a focus on individual choice and the pursuit of individual wellbeing, while neglecting the systemic realities facing GPs in the NHS (51, 64).

ADDITIONAL INFORMATION

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