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Professional resilience in GPs working in areas of socioeconomic deprivation:

a qualitative study in primary care

Abstract

Background
GPs working in areas of high socioeconomic deprivation face particular challenges, and are at increased risk of professional burnout. Understanding how GPs working in such areas perceive professional resilience is important in order to recruit and retain a GP workforce in these areas.

Aim
To understand how GPs working in areas of high socioeconomic deprivation consider professional resilience.

Design and setting
A qualitative study of GPs practising in deprived areas within one primary care region of England.

Method
In total, 14 individual interviews and one focus group of eight participants were undertaken, with sampling to data saturation. A framework approach was used for data analysis.

Results
Participants described three key themes relating to resilience. First, resilience was seen as involving flexibility and adaptability. This involved making trade-offs in order to keep going, even if this was imperfect. Second, resilience was enacted through teams rather than through individual strength. Third, resilience required the integration of personal and professional values rather than keeping the two separate. This dynamic adaptive view, with an emphasis on the importance of individuals within teams rather than in isolation, contrasts with the discourse of resilience as a personal characteristic, which should be strengthened at the individual level.

Conclusion
Professional resilience is about more than individual strength. Policies to promote professional resilience, particularly in settings such as areas of high socioeconomic deprivation, must recognise the importance of flexibility, adaptability, working as teams, and successful integration between work and personal values.

Keywords
burnout; general practitioners; primary health care; qualitative research; socioeconomic factors.

INTRODUCTION

GPs commonly find managing the complex healthcare needs of patients in areas of socioeconomic deprivation a challenge.[1] Patients in the most deprived areas in the UK experience a 17-year difference in disability-free life expectancy compared with the least deprived.[2] Many more patients in deprived areas suffer from several medical conditions simultaneously[3] and consultation rates are 20% higher than in the least deprived areas.[4] Consultations in deprived areas are regularly dominated by psychosocial issues[5–7] and limited resources mean GPs feel unable to effectively tackle social problems.[8] In order to address the inverse care law,[9] there is a need to recruit GPs to work in areas of high socioeconomic deprivation and to support them to thrive.

The 'endless struggle'[1] of working in deprived areas is associated with twice the rate of GP burnout compared to affluent areas.[10] While various policy and financial incentives have been applied to attract GPs to work in underserved areas, such as the GP Retainer Scheme and the Targeted Enhanced Recruitment Scheme, these do not support doctors to thrive in such areas. Additional support for GPs has recently been proposed in the UK within the GP Forward View.[11] This extensive programme of initiatives includes a specialist mental health service aimed to support GPs suffering from burnout and stress. Over 1200 GPs have accessed this service since its launch in January 2017. Of the service users who responded to a 2018 survey, *'78% of GPs stated the service had a positive impact on their ability to work or train. 93% are likely to recommend this service.'*[12]

Resilience of services, practitioners, and patients has recently been the subject of attention both in policy[11] and research.[13–15] In a study of Australian GPs working with marginalised populations, resilience was deemed the result of individual processes, such as engaging with work intellectually, intrinsic motivations to do good, and adopting strategies to prevent burnout, such as control over work organisation;[15] while a study of Scottish primary care professionals working in highly deprived areas identified key traits of the individual and of their personal and professional networks that work synergistically to facilitate adaptability.[13] A recent review of resilience in primary care practitioners concluded that resilience was a multifactorial and evolutionary process resulting in positive adaptation.[14] In order to understand how practitioners working in areas of high socioeconomic deprivation saw themselves as resilient, the present authors conducted a qualitative study with GPs working in Yorkshire and Humber Deep End (Y and HDE) network: an informal network of practices serving 10% of the most deprived practice populations of this region.[16]

METHOD

This qualitative study was undertaken from February 2017 to April 2017 and involved

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How this fits in

GPs working in areas of high deprivation are at particular risk of stress and burnout: this was the first study specifically focusing on resilience in this group of GPs. Resilience strategies included flexibility and adaptability rather than simply bouncing back, and were enacted through teams rather than through individual strength. Efforts to protect practitioners must allow professionals flexibility — rather than enforcing conformity — support teams, and foster the integration of personal and professional values rather than enforcing systems that set them against each other.

semi-structured interviews and a focus group.

Purposive sampling was undertaken to recruit GPs who worked in areas of high socioeconomic deprivation through the Y and HDE network. This is a group of practices selected based on their 2015 index of multiple deprivation (IMD) scores, obtained through Public Health England's National General Practice Profiles database.[17] The network comprises 117 practices in Yorkshire and Humber with the highest IMD scores in the region. This group of practices provide care for 585 904 patients (10.4%) from a total population of 5.63 million. An initial letter of invitation was sent to all Y and HDE practice managers (N = 117) and the Y and HDE email list (N = 566). Snowball sampling through one participant was also used. Responders who replied after data saturation were not recruited. The researchers recognised the need to reflect diversity within the sample and devised a framework before recruitment, which included the following demographic information: GP characteristics (sex, role, hours, and years working in a Deep End practice) and practice characteristics (IMD score and practice population size). As recruitment progressed the researchers monitored the range of participants to ensure diversity of the sample. Recruitment continued until data saturation of themes was reached.

Data were collected in two stages. First, participants took part in a one-to-one, in-depth interview (n = 14) to generate themes, which were then checked for transferability with a focus group (n = 8). Both methods were used, as interviews allow for more in-depth exploration of a question, while focus groups stimulate wider discussion. Interviews were held at the participants' choice of location, which was usually in the GP practice (n = 8), but two took place over the phone and four in other locations. The focus group was held in a meeting room at a practice.

All the discussions that took place at the interview and the focus group were digitally recorded and transcribed verbatim. Also, field notes were made throughout. After weekly training during supervisions with two research supervisors for 5 months, the interviews and focus group were conducted by one researcher who was a medical/BMedSci student. Throughout the project, weekly supervisions allowed for discussion about research methods and quality assurance of findings.

An interview topic guide was developed to include various aspects of both maintaining factors and challenges to resilience as well as aspects that would aid overcoming these challenges. The focus group was conducted after preliminary analysis of the interviews to test the validity of emerging themes and establish data saturation. During data collection, resilience was defined as a psychological capacity to rebound or bounce back despite an adverse encounter; this definition was formed from an amalgamation of several resources arising in the literature search.[18–22]

Analysis was conducted from an interpretivist theoretical perspective[23] with coding conducted using the framework approach.[24] This comprises five stages: data familiarisation, identifying a thematic framework, indexing, charting and mapping, and interpretation. Using a framework approach allowed both pre-specified and emergent themes to be tabulated and compared across individual participants. All transcripts were initially read and coded by one researcher, with independent coding carried out by two others, and by peers on eight different transcripts for verification of coding constructs before a thematic framework was identified. Another author joined the project after data collection and took part in the later stages of thematic analysis. Analysis was conducted using NVivo (version 11) software.

RESULTS

From an initial letter of invitation sent to all Y and HDE practice managers (N = 117), four practice managers responded expressing interest from their GPs and this led to 15 participants recruited to the study. An invitation was also sent to the Y and HDE email list (N = 566). This led to 11 expressions of interest from the email list; responders who replied after data saturation were not recruited (n = 2); two

GPs expressed interest but were unable to attend an interview or the focus group; and one responder did not fit the inclusion criteria as they were not a GP. This left six participants who were recruited from the email list; a further participant was recruited by snowballing from one of these participants. In total, 14 participants undertook in-depth interviews and eight took part in the focus group, giving a total of 22 participants.

Nine interviews were held in GP practices, three in other locations and two by phone. All interviewees were established GPs (three partners in practices, 11 salaried or locums). The focus group contained three established GPs and five GP specialty trainees.

Response rates to invitations to participate were low. Despite this the sample of participants working in the most deprived areas of Yorkshire and Humber demonstrated diversity in relation to personal and practice characteristics, except with respect to sex (17 females; five males). Owing to time constraints and low response rates the researchers interviewed all responders who were able to arrange an interview or attend the focus group (22 in total). A range of GP roles were represented (salaried and locum = 11; partners = 5; GPs in training = 6; full-time = 8; part-time = 14; >5 years at practice = 9; <5 years at practice = 13). Practices also showed a range of characteristics (IMD scores ranged 45–57; practice population sizes ranged 3407–11 901. A detailed table of characteristics of participants has not been provided as the authors were conscious of maintaining confidentiality, as with local knowledge participants could possibly be identified.

Three major themes relating to resilience among GPs working in areas of high socioeconomic deprivation were identified. Each theme is described as a summary statement. The three themes were:

- resilience arises through flexibility and adaptability — involving adaptive trade-offs;
- resilience is dependent on others and on the system — it is not just a property of the individual; and
- resilience at work requires integration between work and life — both in terms of activities and values.

Resilience arises through flexibility and adaptability — involving adaptive trade-offs

Participants viewed their work as constantly changing. Patient populations in areas of high socioeconomic deprivation were fluid, both with new migrant populations and with frequent relocation of individuals and families in social and privately rented housing. GPs recognised the need to understand and respond to differing health and cultural beliefs as well as to manage the evolving expectations of existing populations.

GPs described a number of strategies to manage the demands they faced. To stay resilient, GPs learnt to navigate unpredictable working environments allowing them to duck and weave from adversity:

'I've asked to change my days … I'm [going to do] *4 half days and 1 full day … I've recognised that I get really tired in the afternoon so I'm putting things in place to mitigate that.'* (female GP [F], <5 years [time working in deprived area])

Being able to mould to the environment and to flexibly work *with* challenges, rather than *against* them also strengthened resilience:

'Because of the loss of funding and the loss of doctors we've now got a 4-week wait for an appointment … so you've got to be creative about thinking how can I manage this particular issue without them waiting 5 weeks to come and see me.' (F, ≥5 years)

However, constantly adapting to the circumstances in this way was recognised as wearing, and some GPs acknowledged the need to spend time away from such an environment:

'I found that working with the university has been really really helpful just to give me another outlet … I think I'd find it too much working in a practice where it's incredibly challenging patients.' (F, <5 years)

Some of the more experienced GPs described a learning process, where with time and experience, challenges were perceived to be more manageable. Experience also allowed GPs to exceed their previous thresholds for coping with adversity. This suggested that resilience is a process of positive adaptation, where personal skills and resources develop and accumulate:

'When I came here I found it incredibly difficult to work in this area, people were so sick … The only way I could cope with that was to see less people … So at first it was

hard but you learn to adapt and you get, I get more knowledgeable and better at your job and that helps your resilience.' (F, ≥5 years)

This finding was broadly similar to the findings by Matheson *et al*, that resilient individuals understood that the ability to be flexible and adaptable are essential for the resilient health professional.[13]

Resilience is dependent on others and on the system — it is not just a property of the individual

Resilience was seen as dependent on others and therefore context-specific, rather than individually determined. One participant had experienced feelings of burnout and an inability to cope in a previous practice, but in a new environment felt able to function and maintain their wellbeing. While the clinical aspects of the work at both practices remained virtually identical, new-found resilience came from knowing there was support from the team:

I had a massive sense of relief for leaving where I was because I knew that I was at a point where if there was a big complaint or I had made a mistake I couldn't have coped with it … They hadn't realised the importance of team work and being part of a team … [Now] *when I'm in* [work] *I really like it and I'm really happy and I feel really part of the team.'* (F, <5 years)

Having a supportive team was seen as a buffer and support for practitioners, who otherwise might not cope on their own. Supportive teams allowed the margins of individual resilience to be stretched:

'If everyone had been just in just their own little worlds and stayed in their rooms, and not wanted to chat about things, or happy to listen to me when I wanted some advice I definitely wouldn't have stuck around.' (F, ≥5 years)

Routines that brought GPs together were seen as beneficial to resilience because they allowed practitioners to feel like part of a supportive team:

'[We] *have lunch together … I think that's probably a massive, massive contribution to resilience because it's just a chance to have a chat, have a moan.'* (male GP [M], ≥5 years)

A team is a dynamic body, where there are individuals requiring support and others with sufficient personal resources to provide it; whether an individual is providing support, or requiring it, a team changes with context and circumstance:

'Helping each other out, if someone's duty doctor and they're drowning and someone else has finished surgery earlier, they join in to help them sort it out.' (M, ≥5 years)

Finally, the importance of all healthcare professionals being involved in the team was acknowledged by GPs:

'It's not just doctors obviously, we've got our practice managers, our nurses, we're all here to just, you know chip in and say oh did you see that patient last week what did you think? And I think that's the most important thing about resilience at a DE practice.' (F, ≥5 years)

Resilience at work requires integration between work and life — both in terms of activities and values

Several studies on resilience in professionals have highlighted the importance of boundaries between work and the rest of life. For example, physicians working in Germany described how leisure time maintained resilience because of the change in mental focus from work; effectively, 'switching-off'.[25] However, the views of participants in the present study suggested that the boundaries between work and personal life are more complex. Personal and professional fulfilment were not seen as mutually exclusive entities; rather, resilience at work required the integration of these two things:

'You have to enjoy your life to enjoy your work.' (F, <5 years)

'There's a sense of your own values as well … There's something that keeps some people working in these sorts of places, it's a sense of doing something valuable, or worthwhile.' (F, <5 years)

This integration of personal and professional values was seen when GPs deliberately chose to work in the areas they did:

'I actively chose an inner-city practice because having trained in [an affluent area] *I kind of felt like I needed more of a challenge, so it was a positive decision to come and work here.'* (F, ≥5 years)

This preference arose from personal beliefs and values, and to be able to align

work with these satisfied their personal aspirations:

'I was driven by a desire to redress some of the evils of society … I think that's probably quite an important contributor to resilience … the majority of people who work in deep end, deprived areas are … wanting to work in those areas.' (M, ≥5 years)

Acting on professional objectives also contributed to personal fulfilment. The degree to which these two factors are intertwined is a balance unique to each individual, however, getting this balance wrong can have significant impacts on resilience:

'I think for me resilience is bound up with feeling quite strongly that you're doing it properly. So, things that get in the way of doing it properly challenge my resilience. Because I like to come home feeling like I've done a good job.' (M, <5 years)

DISCUSSION

Summary

The present study found that GPs working in areas of high socioeconomic deprivation had a view of resilience that was more complex than the simplistic notion of personal strength and bouncing back from adversity. Resilience was seen as requiring flexibility and adaptability, it was enacted through teams rather than by individuals, and involved integration between work and personal values.

Strengths and limitations

This study is the first to explore resilience exclusively among GPs working in areas of high deprivation. The participants were diverse in age, experience, practice locations, and work patterns (part-time, full-time, and portfolio). While several of the interviewees were female or had <5 years' experience, the views expressed were broadly similar across the range of ages and experience, and data saturation was achieved on key themes. However, the participants were enthusiastic about addressing inequalities in health and they may have had greater resilience at work than other colleagues working in deprived areas.

Comparisons with existing literature

Participants in the current study demonstrated resilience by mitigating adversity, rather than by simply relieving symptoms of stressors and challenges, by adopting flexibility and adaptability. These were both identified as traits of a resilient practitioner by GPs in Aberdeen.[13] A systematic review found that being adaptable was key to primary healthcare professional resilience, and concluded that resilience combines such traits with experience, leading to positive adaptation.[14] Flexibility, in combination with a supportive work environment, has also been named to further professional reflection. Such reflection acts as a catalyst for personal development, and may be key to positive adaptation.[26]

The need for supportive colleagues within a team has often been noted in maintaining resilience for GPs.[13,15,27,28] In these studies, colleagues were seen as supportive aides that either helped to build resilience capacity, or act as shock absorbers to mitigate the need for individual resilience.

In the present study, resilience did not appear to be a matter of individual capability. Participants without supportive colleagues who engaged with several 'resilience strategies' aimed at building personal capacity, still experienced feelings of burnout. However, working in supportive teams provided the right context for participants to demonstrate resilience, so was a prerequisite rather than a promoter of it. Given greater numbers of salaried, part-time, and locum GPs, it is harder and less automatic to build a strong team. New doctors struggling with resilience should look to how their team functions, instead of battling their own inabilities to cope single-handedly. Likewise, more senior and permanent staff can learn that resilience is dependent on their efforts in creating and ensuring a supportive multidisciplinary team, especially when working in deprived areas.

Setting limits and leaving the work day behind was a way of maintaining control over working lives for GPs with reputations for resilience in Canada.[27] Although protecting personal time to rest and recuperate was important for this current study's participants, much of what sustained their practice was an integration of work and life. These findings are consistent with theories of wellbeing that occur *'… when people's life activities are most congruent or meshing with deeply held values and are holistically or fully engaged'*[29] and allows one to exist authentically. When the work and life values of mental health practitioners in Australia were identified, a moderate degree of congruence between them was associated with self-acceptance and perceived personal accomplishment at work, both factors thought to reduce burnout. The

researchers suggest that linking values with professional behavioural actions can help practitioners to align their personal values with their professional work.[30] This would strengthen both personal and professional fulfilment, and in turn promote wellbeing and increase resilience. However, unlike other research in Australia,[15] the role of the physician–patient relationship in building resilience was not found to be a central theme in this study. It is possible that the interview topic guide did not draw out discussion around this theme as the authors assumed this as implicit for GPs working in deprived areas. Or it may be that cultural differences between GPs in the UK and Australia could have affected participants in this study; not raising the importance of relationships with patients in relation to their resilience.

Findings in this study highlight the importance of having a flexible and adaptable approach to work with a healthy integration of work and personal life, reflecting the previous literature. However, reliance on resilience derived from having team support emerged more strongly in this study than previously described.

Implications for research and practice

This study has provided a new perspective of practitioner resilience, highlighting that resilience is context specific, and not only limited to individual capabilities but includes professional networks and personal values also. Therefore, future interventions to target practitioner resilience, particularly in highly-deprived areas, must appreciate the multidimensional nature of resilience and nurture teams. In addition to doctors working at the front line, this is relevant for commissioners responsible for overseeing NHS resilience funds and GP retention.

Efforts to protect practitioners must allow professionals flexibility rather than enforcing conformity, support teams to support themselves, and foster the integration of personal and professional values rather than enforcing systems that set them against each other.

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Ethical approval

Research ethical permission was granted by Sheffield's University of Research Ethics Committee on 14 November 2016 (reference number: 011254) and all participants gave informed consent.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have no competing interest to declare.

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