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Professional resilience in GPs working in areas of socio-economic deprivation: a qualitative study.

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ABSTRACT

Background

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

Aims

To understand the ways that GPs working in areas of high socio-economic deprivation consider professional resilience

Design and setting

Qualitative study of GPs practising in deprived areas within one region of England.

Method

14 individual interviews and one focus group of 8 participants were undertaken, with sampling to data saturation. Data analysis used a framework approach.

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 being a matter of individual strength. Third, resilience involved 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 level of the individual.

Conclusion

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

How it fits in

GPs working in areas of high deprivation are at particular risk of stress and burnout: we conducted 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 which set them against each other.

INTRODUCTION

General practitioners (GPs) commonly find managing the complex health care 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 richest (2). Many more patients in deprived areas suffer from several medical conditions simultaneously (3) and consultation rates are 20% greater 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 socio-economic 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. The uptake has been high, reflecting demand, however NHS England are yet in a position to publish official outcomes of the programme.

Resilience of services, practitioners and patients has recently been the subject of attention both in policy (11) and research (12–14). 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 (14); 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 (12). A recent review of resilience in primary care practitioners concluded that resilience was a multifactorial and evolutionary process resulting in positive adaptation (13). In order to understand how practitioners working in areas of high socioeconomic deprivation saw themselves as resilient, we conducted a qualitative study with GPs working in the Yorkshire and Humber Deep End: an informal network of practices serving 10% of the most deprived practice populations of this region (15).

METHODS

The study took part between February and April 2017 and involved semi-structured interviews and a focus group. Research ethical permission was granted by Sheffield's University of Research Ethics committee on 14/11/2016 and all participants gave informed consent

Purposive sampling was undertaken to recruit GPs who work in areas of high socio-economic deprivation through the Yorkshire and Humber Deep End (Y&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. 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 of all Y&HDE practice managers (N=117) and the Y&HDE email list (N=566). Snowball sampling through one participant was also used. Responders who replied after data saturation were not recruited. We recognised the need to reflect diversity within the sample and devised a framework before recruitment which included the following demographic information: GP characteristics (gender, role, hours, years working in a Deep End Practice) and Practice characteristics (IMD score, practice population size). As recruitment progressed we monitored the range of participants to ensure diversity of the sample. Recruitment continued until data saturation of themes was reached.

We collected data in two stages. Firstly, 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). We used both methods, as interviews allow for more in-depth exploration of a question, while focus groups stimulate wider discussion. Interviews were held at a location of participants' choice, which was usually in the GP practice (N=8), but 2 took place over the phone and 4 in other locations. The focus group was held in a meeting room at a Practice.

All discussions at interview and the focus group were digitally recorded and transcribed verbatim. Also field notes were made throughout. After weekly training during supervisions with research supervisors (EW and BJ) for five months, the interviews and the focus group were conducted by EE (medical/BMedSci student). Throughout the project, weekly supervisions allowed for discussion about research methods and quality assurance of findings.

A interview topic guide was developed to include various aspects of both maintaining factors and challenges to resilience as well as what would aide 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 (16–20).

Analysis was conducted from an interpretivist theoretical perspective (21) with coding conducted using the Framework approach (22). 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 EE, with independent coding carried out by LW, BJ, and peers on eight different transcripts for verification of coding constructs before a thematic framework was identified. One author (CB) joined the project after data collection but took part in the later stages of thematic analysis. Analysis was conducted using NVivo 11 software.

RESULTS

From an initial letter of invitation sent to of all Y&HDE practice managers (N=117) 4 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&HDE email list (N=566). This led

to 11 expressions of interest and the recruitment of 6 participants; a further participant was recruited by snowballing from one of these participants. Responders who replied after data saturation were not recruited (N=2); 2 GPs expressed interest but were unable to attend an interview or the focus group and one respondent did not fit the inclusion criteria as they were not a GP. In total 14 participants undertook in-depth interviews and 8 took part in the focus group (Total participants=22).

Interviews were held in GP practices (9), in other locations (3) or by phone (2). All interviewees were established GPs (3 partners in practices, 11 salaried or locums). The focus group involved 3 established GPs and five GP Specialty Trainees.

Response rates were low to our invitations to participate. 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 gender (F=17; M=5). Due to time constraints and low response rates we interviewed all respondents 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 from 45 to 57; practice population sizes ranged from 3,407 to 11,901. A detailed table of characteristics of participants has not been provided as the authors are conscious to maintain confidentiality, as with local knowledge participants could possibly be identified.

Three major themes relating to resilience among GPs working in areas of high socio-economic deprivation were identified. Each theme is described as a summary statement. The three themes were: (1) resilience arises through flexibility and adaptability - it involves adaptive trade-offs; (2) resilience is dependent on others and on the system – it is not just a property of the individual; and (3) resilience at work requires integration between work and life – both in terms of activities and values.

1) Resilience requires flexibility and adaptability – it involves adaptive trade-offs

Participants viewed their work as constantly changing. Patient populations in areas of high socioeconomic deprivation are 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 learned 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, <5 years working in a 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" (female GP, >=5 years)*

However, constantly adapting to the circumstances in this way was recognised as wearing, and some GPs recognised the need 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" (female GP, <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 suggests 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" (female GP, >=5 years)*

This finding was broadly similar to Matheson's (2016) finding that resilient individuals understood that the ability to be flexible and adaptable are essential for the resilient health professional.

2) Resilience is dependent on teams and on the system (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 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" (female GP, <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." (female GP, >=5 years)*

Routines which 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, >=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, 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" (male GP, >=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, were 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" (female GP, >=5 years)*

3) Resilience at work involves integration between work and life

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' (23). However, the views of participants in our 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" (female GP, <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" (female GP, <5 years)*

This integration of personal and professional values was seen in GPs deliberately choosing 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" (female GP, >=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" (male GP, >=5 years)*

Acting upon professional objectives also contributed to personal fulfilment. The degree to which one intertwines these two factors is a balance unique to that individual, however to get 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" (male GP, <5 years)*

DISCUSSION

Summary

We found that GPs working in areas of high socio-economic deprivation had a view of resilience which 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 amongst GPs working in areas of high deprivation. The participants were diverse in age, experience, practice locations and work patterns (part-time, fulltime, portfolio). While several of the interviewees were female or had less than 5 years' experience, the views expressed were broadly similar across the range of ages and experience, and we achieved data saturation on key themes. However, the participants were enthusiastic about addressing inequalities and they may have had greater resilience at work than some colleagues working in deprived areas.

Comparisons with existing literature

Participants in this 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 (12). 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 (13). 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 (24)

The need for supportive colleagues within a team has often been noted in maintaining resilience for GPs (12,14,25,26). 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. However, from this study, resilience does 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 singlehandedly. 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. In addition to doctors working at the front line, this is relevant for commissioners responsible for overseeing NHS resilience funds and GP retention.

Setting limits and leaving the working day behind was a way of maintaining control over working lives for GPs with reputations for resilience in Canada (25). 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 eudaimonic wellbeing which occurs "when people's life activities are most congruent or meshing with deeply held values and are holistically or fully engaged" (27) 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 (28). This would strengthen both personal and professional fulfilment, and in turn promote wellbeing and increase resilience**.** However, unlike other research in Australia (14), 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 topic guide didn't 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 contributed to participants in this study not raising the importance of relationships with patients in relation to their resilience.

Our findings highlighting importance of having a flexible and adaptable approach to work with a healthy integration of work and personal life, reflects previous literature. However, the reliance of resilience on the team emerged much more strongly in our study than previously described.

Implications for research and /or 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. 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 which set them against each other.

Conclusion

Professional resilience is about more than individual strength and "bouncing back". It requires flexibility and adaptability, it is enacted through teams rather than by individuals, and involves integration between work and personal values.

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References:

1. O'Brien R, Wyke S, Guthrie B, Watt G, Mercer S. An 'endless struggle': a qualitative study of general practitioners' and practice nurses' experiences of managing multimorbidity in socio-economically deprived areas of Scotland. Chronic illness. 2011 Mar;7(1):45-59.
2. Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, Geddes I. Fair society, healthy lives: the Marmot review. 2010. The Marmot Review. 2014.
3. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. The Lancet. 2012;380(9836):37–43.
4. Mclean G, Guthrie B, Mercer SW, Watt GCM. General practice funding underpins the persistence of the inverse care law: Br J Gen Pract. 2015;(Dec.):799–805.
5. Mercer SW et al. The Inverse Care Law: Clinical Primary Care Encounters in Deprived and Affluent Areas of Scotland. Ann Fam Med. 2007;5(6)(Nov.):503–10.
6. Mercer SW, Higgins M, Bikker AM, Fitzpatrick B, McConnachie A, Lloyd SM, et al. General practitioners' empathy and health outcomes: A prospective observational study of consultations in areas of high and low deprivation. Ann Fam Med. 2016;14(2):117–24.
7. Stirling AM, Wilson P, McConnachie A. Deprivation, psychological distress, and consultation length in general practice. Br J Gen Pract. 2001;51(467):456–60.
8. Watt G. General Practitioners at the Deep End: The experience and views of general. Occas Pap R Coll Gen Pract. 2012;89(i–viii):1–40.
9. Tudor Hart J. the Inverse Care Law. The Lancet. 1971;297(7696):405–12.
10. Pedersen AF, Vedsted P. Understanding the inverse care law: a register and survey-based study of patient deprivation and burnout in general practice. Int J Equity Health. 2014;13:121.
11. NHS England. GP Forward View. London: NHSE. 2016.
12. Matheson C, Robertson HD, Elliott AM, Iversen L, Murchie P. Resilience of primary healthcare professionals working in challenging environments: Br J Gen Pract. 2016;(July):1–9.
13. Robertson HD, Elliott AM, Burton C, Iversen L, Murchie P. Resilience of primary healthcare professionals: 2016;(June).
14. Stevenson AD, Phillips CB, Anderson KJ. Resilience among doctors who work in challenging areas: A qualitative study. Br J Gen Pract. 2011;61(588):404–10.
15. Walton L, Ratcliffe T, Jackson BE, Patterson D. Mining for Deep End GPs: a group forged with steel in Yorkshire and Humber. Br J Gen Pract. 2017 Jan 1;67(654):36-7.
16. Jackson D, Firtko A, Edenborough M. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: A literature review. J Adv Nurs. 2007;60(1):1–9.
17. Tugade MM, Fredrickson BL, Barrett LF. Psychological resilience and positive emotional granularity: Examining the benefits of positive emotions on coping and health. Vol. 72, Journal of Personality. 2004:1161–90.
18. Rutter M. Resilience in the face of diversity: Protective factors and resistance to psychiatric disturbance. Br J Psychiatry. 1985;147:598–611.
19. Carver CS. Resilience and thriving: Issues, models, and linkages. Journal of social issues. 1998 Jul 1;54(2):245-66.
20. Bonanno GA. Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events?. American psychologist. 2004 Jan;59(1):20.
21. Crotty M. The foundations of social research: Meaning and perspective in the research process. Sage; 1998 Oct 15.
22. Mays N, Pope C. Quality in qualitative health research. Qualitative Research in Health Care, Third Edition. 2007: 115
23. Zwack J, Schweitzer J. If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. Academic Medicine. 2013 Mar 1;88(3):382-9.
24. Reich J, Zautra A, Hall J. Handbook of Adult Resilience. New York, London, Guilford; 2010: 117.
25. Jensen PM, Trollope-Kumar K, Waters H, Everson J. Building physician resilience. Can Fam Physician. 2008;54(5):722–9.
26. Walters L, Laurence CO, Dollard J, Elliott T, Eley DS. Exploring resilience in rural GP registrars–implications for training. BMC medical education. 2015 Dec;15(1):110.
27. Ryan RM, Deci EL. On Happiness and Human Potentials: A Review of Research on Hedonic and Eudaimonic Well-Being. Annu Rev Psychol. 2001 Feb 1;52(1):141–66.

28. Veage S, Ciarrochi J, Deane FP, Andresen R, Oades LG, Crowe TP. Value congruence, importance and success and in the workplace: Links with well-being and burnout amongst mental health practitioners. J Context Behav Sci. 2014;3(4):258–64.