What are the barriers, facilitators and survival strategies for GPs seeking treatment for distress? A qualitative study

Abstract

Background: General Practitioners (GPs) are under increasing pressure due to a lack of resources, a diminishing workforce and rising patient demand. As a result, they may feel stressed, burnt out, anxious or depressed.
Aim: To establish what might help or hinder GPs experiencing mental distress as they consider seeking help for their symptoms, and to explore potential survival strategies.
Design and setting: We recruited 47 GP participants via emails to doctors attending a specialist service, adverts to Local Medical Committees (LMCs) nationally and in GP publications, social media and snowballing. Participants self-identified as 1) currently living with mental distress, 2) returning to work following treatment, 3) off sick or retired early as a result of mental distress or 4) without experience of mental distress. Interviews were conducted face to face or over the telephone.
Method: Transcripts were uploaded to NVivo 11 and analysed using Thematic Analysis.
Results: Barriers and facilitators were related to work, symptoms or access to support. GPs also talked about cutting down or varying work content, or asserting boundaries to protect themselves.
Conclusion: We suggest that systemic changes are needed to support individual GPs and protect the profession from further damage.

Keywords: Anxiety; Burnout, professional; Depression; General Practice; Mental Health Services; Self-care.

How this fits in

We know General Practitioners (GPs) are currently working in an environment of rising pressures and diminishing resources. Their satisfaction with their work is lessening whilst stress levels rise, and GPs may have difficulty seeking help when they are experiencing mental distress. This study makes explicit the barriers and facilitators that face GPs as they consider seeking treatment for mental illness, as well as exploring ways in which they may protect themselves from their workplace stresses.

Introduction

General Practitioners (GPs) are operating under significant workload pressures and with diminishing resources (1, 2). Funding has been cut for primary care while expenses have risen (3). Workload for GPs has increased by 16% in the past seven years (4) while less than one in five UK F2 doctors went into general practice in 2015 (5). The patient population is growing faster than the GP workforce, with rising demands due to an ageing population and increase in multi-morbidity (6, 7). Additional pressures for GPs in the UK come from sources such as Quality and Outcomes Frameworks (QoF) and the implications of future cuts in NHS funding (6).

Reports of GPs feeling dissatisfied (6), distressed, anxious (7, 8) and suicidal (9) are rising. Some GPs report misuse of substances (7), while others feel exhausted, 'grumpy', and have feelings of hatred towards their work (10). It has been suggested that personality traits such as perfectionism and workaholism, with which many GPs may identify, can contribute to anxiety, depression and eating disorders for physicians (7). Additionally, several authors cite concerns for patient safety as a result of GP distress (8). Low levels of personally reported physician personal accomplishment have correlated with emotional exhaustion and depersonalisation (11), and high levels of pressure may lead to decision fatigue (3). However, findings have shown that patients did not change their ratings of burnt out doctors as opposed to healthy ones (11), suggesting that unwell GPs continue to deliver a high standard of care, and maintain a balance between emotional contagion and professionalism, even if they do not feel that this is the case.

Despite this negative picture, it may be noted that one GP in a qualitative study reported the extra pressure as a benefit as it can result in more strategic thinking (6). In addition, emotional labour such as that faced by GPs on the frontline has been found to be valued over other aspects of work, and may lead to increased job satisfaction (12).

GPs may lack support (13), and there are barriers to help-seeking for distressed doctors, such as concerns about confidentiality (7), presenteeism (attendance at work despite ill health) (7), long working hours (14) and stigma around mental illness (15). Research about ways of lessening the distress experienced has tended to explore short term interventions geared towards increasing resilience (16, 17). In addition, much previous work has focused on the impact of physician wellbeing on patient outcomes, meaning the emphasis is not on the needs of GPs themselves (8, 18, 19). We would suggest that the concept of resilience is problematic, as it places the responsibility for

managing pressure with the individual, rather than the organisation (20), and we highlight the need for research into health practitioner wellbeing to value that wellbeing for its own sake.

This study aimed to explore the barriers and facilitators to help-seeking for GPs living with distress.

Method

Given our focus on the experience of GPs, we employed a qualitative approach. Existing qualitative work has tended to use smaller samples (6, 21, 22) or examine the experiences of GPs in different parts of the world (17). We aimed to address these limitations by eliciting a larger group of English GPs' feelings concerning what helps and hinders them from receiving support for their chronic stress or distress, hence giving greater weight to the intrinsic - rather than extrinsic - value of GP wellbeing.

Interviews with 47 GPs from around England were conducted. Potential participants were contacted via emails to doctors attending a specialist service, as well as adverts to Local Medical Committees (LMCs) nationally, in GP publications and on social media. A total of 122 GPs got in touch, although 18 of these did not send a second response after receiving an information sheet.

Potential participants were asked which of these categories they most strongly identified with:

1. Living with mental distress (defined as anxiety, depression, stress and/or burnout)
2. Returning to work following treatment for such problems
3. Off sick or retired early because of mental distress
4. No lived experience of mental distress

Interested GPs were purposively sampled to represent a relatively even spread across these four groups, although the largest number of participants were in group 1. Once each group was well-represented, further GPs who expressed an interest in participation were politely thanked and turned away. We intended to purposively sample approximately 10 participants per group. However, the majority of GPs who contacted us self-selected into group one and due to the emergent rich data, continued recruitment to this group was considered justified. We endeavored to recruit more participants into groups two and four using targeted publicity information but due to time constraints, those groups remained marginally under-recruited. In the event, many GPs who

identified as living with no stress reported having had experiences of work-related stress and distress at some juncture in their career.

Data collection took place face to face or by telephone, between February and August 2016. Semi-structured interviews consisted of questions exploring wellbeing, stress management and help seeking, as shown in the topic guide (box 1). The analysis process began while interviewing was ongoing. The interview schedule was updated based on early analysis to include additional questions on topics, including the impact of distress on practice and the impact of early retirement on finances. Interviews lasted between 27 and 126 minutes (mean = 69 minutes), were recorded and transcribed verbatim.

>>>> insert box 1 around here<<<<<

Transcripts were uploaded to NVivo 11 and analysed using thematic analysis (23). Each transcript led to emergent codes being added to and refined. Emerging themes were discussed and agreed among all authors. A code book of key points from all interviews was drawn up. This was audited by two of the authors (RR, MB), both experienced qualitative researchers. The multi-disciplinary research team independently analysed a sub-set of transcripts, contributing to the refinement of codes, and maximising rigour. Emergent themes were discussed by the whole team.

Tables of themes were drawn up for the major codes. Analysis continued into the writing process, when adjustments were made to ensure that each theme was explored optimally.

Results

A total of 122 GPs responded to recruitment advertisements, of whom 47 were purposively selected to ensure a relatively even split across the four groups mentioned above. Participant demographics are shown in table 1, below.

>>>>Insert table one around here<<<<<

Findings were identified across all groups, including Group 4, who had identified as having no mental health concerns. The themes also applied to participants irrespective of seniority/role in the practice, age and gender.

Data were divided into two main themes and corresponding sub-themes:

- ***Barriers and facilitators to help seeking for distress*** *- work related, symptom related, and access to support*
- ***Survival strategies*** *- Cutting down or varying workload and asserting boundaries*

Note […] within quotations indicates editorial elision.

Barriers and facilitators to help seeking for distress

Work related barriers and facilitators

i. Need to attend work

Participants talked about a perceived need to go to work even when unwell as a barrier to seeking support. Such 'presenteeism' was compounded by workforce shortages and difficulty accessing locum cover, in addition to guilt at letting down patients and colleagues:

> *I fought and fought and fought not to go off sick because the guilt associated with going off sick is so huge. […] Everybody's struggling, so if I go off sick I will just make everybody else's struggle even more. But it got to the point where it was making me quite ill.* (P24, Female Partner)

> *If you don't go in, no one else covers you. […] And your workload doesn't disappear, so whoever is there has to take it on.* (P3, Female salaried)

ii. Stigma associated with mental illness

Mental illness is stigmatised in the UK. Several participants perceived that there was a specific stigma attached to being a GP experiencing such ill health:

> *There is a sort of an unwritten rule that you don't admit to mental illness in any way in general practice, I think. Even though everybody knows that everybody has it, it's just not talked about.* (P9, Male Partner)

For others, stigma was internalised, meaning illness itself was framed as failure:

You're not groomed to be ill, are you? You're not groomed to be a failure (P36, Male Partner).

The perceived stigmatising attitudes of colleagues to patients with mental illness may also work as a barrier to help-seeking:

It was about all the voices I've heard from GPs saying, you know, "They just need to pull themselves together," or, you know, "all they ever want is pills." (P20, Male Partner)

In contrast, participants discussed how openness around distress could ease help-seeking:

I have got a colleague here with mental health problems. And I have to say, she's fantastic. She's absolutely brilliant about telling you how she is, how she's feeling, medication she's taking. And that degree of openness is really refreshing. (P22, Male Salaried)

Participants also took the opportunity to combat stigma by speaking out to colleagues and patients about the realities of GP distress and experience:

I try and act as a bit of an advocate, really, within the practice, and within medical circles. I haven't - I haven't hidden any of it. (P24, Female Partner)

All the stuff in the papers […] definitely feels quite demoralising. When we talk about it in our VTS group we're just like, "Yeah, because we're rubbish and we're overpaid." […] If patients come in and say something like that, I will – you know, something like, "I've been reading this in the Daily Mail" - will, where I am able, refute it and explain (pause) the alternative viewpoint. (P43, Female on sick leave)

iii. Confidentiality, time and identity

Privacy and confidentiality were cited as impediments to help-seeking. Many feared their patients might find out about their mental health concerns:

If you went to like a counselling group, you'd be worried you'd bump into one of your patients. (P26, Female Salaried)

Also prevalent were concerns around the impact of relationships with colleagues on confidentiality:

> *I knew all these GPs in [location], and it was a close-knit community. And suddenly all my colleagues that were training to be GPs were training in all the different practices in [location], which potentially had – could have – wherever I was registered would have access to my notes and know exactly what was going on with me.* (P5, Female Locum and Salaried)

Participants found lack of time to be an impediment to both help-seeking and self-care:

> *Never mind reflective practice and Balint groups and all of this, people are just, you know, nose to the grindstone absolutely all of the time.* (P7, Female Locum)

GPs talked about the difficulty of moving between doctor and patient identity to accept help:

> *Whether it's being a doctor as a patient that's difficult or the fact that, you're being a patient and seeing the room from, you know, a very familiar situation from another viewpoint.* (P47, Female on sick leave)

Symptom related barriers and facilitators

Acknowledging that they had a mental health problem was difficult for many participants:

> *The hardest thing is to acknowledge that you've got a problem.* (P30, Female Salaried)

Inertia resulting from depression could also act as a barrier:

> *If you're that exhausted you can't see a way out because to try and see a way out requires some effort.* (P29, Female Partner)

However, for some participants, reaching crisis point spurred them into action:

The trigger for me was that I could not stop thinking that I wanted to kill myself. (P20, Male Partner)

I think I just had to be ill enough. I didn't realise how ill I was until I was off work and then it became quite clear to me I was seriously quite unwell and needed, you know, I needed to do something fairly serious. (P36, Male Partner)

Access to support

i. Quality of treatment

Participants reported a perceived inadequacy of psychological treatments as a difficulty when they were seeking effective help. One GP reported an inadequate response despite her suicidal feelings:

I saw her for the first couple of sessions and then she said, "Oh, I can't see you for another two weeks." And I was quite suicidal at the time. (P4, Female on sick leave)

One found that his status as a GP appeared to negatively impact the quality of help he received:

She [GP] said, "Well, what do you do?" "I'm a GP." "Well, we're all stressed, aren't we?" was the answer. (P45, Male Salaried)

A good relationship with one's own GP helped secure effective treatment:

I feel that I've been very lucky that both the GPs who I've seen over this problem have been very understanding and sympathetic. (P28, Male on sick leave)

ii. Accessing information about relevant resources

Some participants felt unsure where to turn if they decided to seek help:

I did a burnout score around that time, and the RCGP website, and it said, oh, you're at risk of burnout. And then it had no suggestions of what to do. (P46, Female Partner)

However, one GP gave an example of best practice; her surgery disseminated helpful information about services for GPs:

> *My practice has just recently produced a document, like an A4 document with online help for GPs and the local support agencies. So they've just laminated that and they're just putting it in the doctors' runs […] I think probably having something there and a number makes it a bit more accessible.* (P3, Female Salaried)

iii. Availability of a specialist, confidential service

Participants talked enthusiastically about the benefits of going to a specialist, confidential treatment facility:

> *People who are treating doctors need to treat them like patients. That is a very skilled job. Because it's so easy to collude, it's so easy to see your stuff in them. It's an incredibly hard job to do well. And so it needs to be specialised.* (P31, Female Locum)

> *As a doctor you can cover it up for a lot longer till you're in a much worse state, and (pause) you need experienced people that are not going to be flannelled by that. And if you go to your GP you've only got a ten-minute appointment, and I can pretend I'm fine in a ten-minute appointment, but I couldn't for an hour and a half.* (P43 Female on sick leave)

The confidential nature of specialised services was of importance:

> *The LMC thing was completely confidential, it was outside of the area so I thought that was fine, so that seemed to make sense.* (P27, Female Partner)

Most users of specialised services spoke of them highly:

> *I just thought was really fantastic because — they're used to having doctors. And they take everything seriously. They've got time to kind of go through things.* (P48, Female Registrar)

However, a small number had reservations:

If I were to have what I thought was a sexually transmitted infection, I'd probably go to my GP rather than go to the sexual health centre. Because if I'm going to the sexual health centre, everyone will think, "She's got an STI." Whereas if I go to my GP I can get exactly the same service. […] If I went I'd bump into colleagues and it might be a bit awkward because we'd all know that we were there for the same reason. (P3, Female Salaried)

iv. Influence of work environment on access to support

An unsupportive environment at work could impede self-care:

My role as senior partner, oddly enough, had been just to sort of keep my head down and keep going. So if anything happened to me, it sort of destabilises them and then they would react very badly to the fact that I was off. (P49, Female Retired)

However, participants reported emotional support from colleagues as helpful:

One of my colleagues came in and said, "You've got to phone someone." I'll never forget that, you know, she insisted. I'd been talking about it for weeks to my wife and to colleagues here. And she came in and said, "You'd better do something." And she'd probably seen something in the way I was that I hadn't seen myself. (P19, Male Partner)

Practical support was also reported:

I'd said how stressful I'd been, to these two female partners of mine, and we'd had a meeting and talked about it. And they tried to find some ways of helping. I said things like, it would be nice, if I get lots of extras, if someone from the staff could make a cup of tea? (P35, Female Retired)

Survival strategies

Participants discussed a wide range of survival strategies, many of which have been documented extensively elsewhere (6, 24-26). Due to this existing extensive literature, we made the decision to focus on those strategies that are less widely reported, or which have particular relevance for GPs within this paper.

i. Cutting down or varying work content

Some participants had resigned or retired due to distress.

> *I'm just thoroughly enjoying myself. I've never had time to myself in my life. So I'm seeing friends, I'm going for runs, I'm walking the dog, I'm interested in cooking and, yeah, for the first time in my life I'm actually relaxed and happy.* (P49, Female Retired)

However, others considered resigning as a possible last resort:

> *I really don't want to go. But if things get worse, I would go.* (P30, Female Salaried)

Participants often felt that working fewer sessions was necessary to stay healthy:

> *I've actually always worked part-time since I've been a GP. And I think that is the essence of good mental health. I don't think people should be allowed (laughs) to work full-time really.* (P1, Female Partner)

Lessening workload could mean working as a locum, which some perceived as offering additional control:

> *You pretty much don't get any admin, so it's all just see patients, go home on time.* (P26, Female Salaried)

Participants talked about planning for longer consultations with patients than the standard 10 minutes, a strategy designed to make the day less stressful:

> *Patients booked in at fifteen minute intervals. Which is bliss.* (P35, Female Locum)

Participants sometimes restructured their working lives to maintain good mental health. For many, this involved cultivating a portfolio career. Other roles taken on included training, committee work and consultancy.

I worked at the Sally Army helping the homeless with drug problems. […] And that was nice, because a day a week I was doing that. […] If you still want to work four or five days a week, you can. But if for one or two of those days you're not doing just GP-ing, it's a break. (P37, Female on sick leave)

ii. Asserting boundaries

The importance of saying no to extra work was emphasised by GPs, either for themselves or colleagues:

Establishing boundaries, understanding what your limitations are, you know, saying no, just not for the sake of saying no, but learning to say no and don't feel guilty. (P41, Female Locum)

So I think really that in a partnership you should acknowledge that and actually say no to people that want to take on what's obviously too much. (P1, Female Partner)

Boundaries could be established by finding ways to cut down hours or roles.

We have started being a training practice deliberately to kind of, take the pressure off us a little bit. (P17, Female Partner)

Participants also talked about knowing when to stop work.

I never put the computer back on when I go home. (P46, Female Partner)

I'll say, "I'm doing that tomorrow," because it's 7 o'clock and I want to see my children before they go to bed. (P18, Male Partner)

Discussion

Summary

This paper reports barriers and facilitators to help-seeking for GPs living with mental ill health and/or chronic stress. Workload barriers included guilt-induced presenteeism, internalised and perceived

stigma and concerns about privacy and confidentiality. A lack of time and inability to move between doctor and patient identities also made help-seeking challenging. Distressed GPs often found it difficult to overcome their feelings of inertia or did not always acknowledge their own illness to themselves. In contrast, some GPs found that reaching crisis point spurred them on to seek help. A lack of access to adequate treatment was reported by many, although confidential services for practitioners were reported to be useful by others. Some striking examples of openness around mental ill health between colleagues were also given and these had clearly worked to facilitate getting support or access to professional help. Findings around potential survival strategies, including cutting down or varying workload, and asserting boundaries were also reported.

Strengths and limitations

This research is timely, focusing as it does on the GP experience of distress, and adds to a growing cohort of recent papers concerned with this topic (6, 7). This research provides insights into GPs' perspectives of barriers and facilitators to help-seeking. We interviewed a range of GPs from different geographical areas and in different roles (that is, partners, salaried or locums), offering a balanced view of GPs in need of effective support.

A potential limitation is that our sample was self-selected, meaning we spoke to GPs who felt able to communicate with us. It may be that the most vulnerable GPs were too distressed to respond to advertisements or feel able to talk. However, given the large number of GPs who got in touch and the range of views expressed, it is hoped that we spoke to a representative sample.

Comparison with existing literature

Continued attendance at work whilst unwell has been reported previously (7, 14, 27, 28), and it has been suggested that this lack of self-care may result in longer periods of time off sick further down the line (29). Our findings add depth to this information around 'presenteeism,' by showing the degree of guilt associated with the pressure to stay at work that can drive this unhealthy practice. Participants also confirm the continued perceived stigma around mental illness (14, 15, 30). Our findings suggest this may be a particular problem for those working in general practice.

Existing work highlights the difficulty in acknowledging symptoms of mental ill health, (31) and denial or avoidance (7), as barriers to help-seeking amongst clinicians in general. Some GPs in our study who recognised the importance of their symptoms were, however, prompted by this to seek help. Given the high rates of suicide among doctors in general and GPs in particular (9), it is

imperative that UK GPs are given the support they need so that they can access appropriate help before they reach this crisis point.

Treatment for doctors in distress can be inadequate (32-35). The positive value of a good relationship with a GP was emphasised, while participants also confirmed the importance of offering specialist services for doctors (27, 35). A particular feature of specialist services is that they emphasise confidentiality and are available outside usual local care, hence minimising the aforementioned barrier of concerns around privacy. It is hoped that the new NHS GP Health service (36) will provide an accessible, specialised service for GPs.

It is noteworthy that some participants highlighted the emotional and practical support they had received within their practice as facilitators to help seeking, although this was by no means universal, with some practices being perceived as very unsupportive environments. The proactive examples of good practice at work cited by our participants are encouraging, and demonstrate the importance of supportive partnerships. The need for doctors to develop good teamwork strategies has previously been emphasised (37), and our findings also support this recommendation.

Participants discussed a wide range of potential survival strategies, some of which have been cited elsewhere, such as exercise (25, 26), mindfulness and meditation (38), and support groups such as Balint groups (24, 39). A recent article found that many GPs have reduced their sessions in order to cope with the stress of increasing workload (22). Our findings build on this by adding detail to the ways in which GPs might vary their working days or assert their boundaries, demonstrating ways in which individual GPs may protect themselves within the current general practice structure. However, while these may be beneficial strategies for the individual, they could have damaging consequences for patients and the profession unless there are resources available to recruit more GPs.

Implications for research and practice

Our findings demonstrate the concerning extent of the crisis point that many GPs reach before they seek help for stress-related or mental health difficulties. There needs to be a cultural shift within the medical profession and the NHS, so that the ongoing stigma of mental illness is confronted, making it easier for GPs to recognise and speak out about their difficulties before they reach such a crisis. One systematic review has argued that systemic barriers to help seeking are more important - and more difficult to overcome - than individual ones (33). We agree, and recommend that systemic stigma

around mental ill health within healthcare organisations is a key area needing to be addressed by researchers and policy makers.

In line with our findings, previous authors have reported that doctors and medical students often do not know about existing specialist mental health services (27, 30). We recommend that individual practices, the RCGP, Deaneries, CCGs, LMCs and the Department of Health do more to advertise these services, such as the new NHS GP Health service. We also suggest that GPs are offered specific training about how to effectively support and treat their GP and other medical colleagues when they attend as patients, since effective primary care may be an essential lifeline for doctors in distress.

Finally, we recommend that researchers and policy makers respond to research such as ours and others (6, 7) as well as the General Practice Forward View (40), by investigating and developing organisational changes that will enable the workload stresses experienced by GPs to become more manageable for individuals (22, 41, 42), whilst ensuring sufficient resource and practitioners for the delivery of good medical care for all. These strategies must emphasise both the mental and physical health of GPs by putting in place measures both to prevent distress and provide support should it arise, so that the profession may continue to thrive and grow.

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Box 1: Topic guide

Current well-being

- Describe average working day in practice (hours, surgery, home-visits) and any additional responsibilities
- Explore current well-being, feelings about work, levels of stress, work-life balance
- Explore causes of stress/distress (work load, hours, admin, clinical caseloads, organisational issues, lack of support, personal issues, pre-existing mental health symptoms)
- Explore reasons for early retirement/sickness (if relevant)

Managing stress

- Explore how GPs manage their workload/stress in their day-to-day work life, what they do to relax, to look after themselves (self-care strategies: supportive relationships, sport, exercise relaxation techniques)
- Explore relationship with colleagues and whether/how/if concerns are raised, how they are responded
- Explore if receive informal/formal supervision or mentor (1:1 or group) and experience/value of group
- Explore thoughts/feelings about seeking help, barriers to seeking help (stigma/shame, fears about confidentiality, uncertainty of where to go)
-

Experience of help-seeking (where relevant)

- *E*xplore experience of help seeking for reduced well-being and/or mental health symptoms (friends, colleagues, family, GP, specialist service (PHP), mental health professional, counsellor, therapist)
- If primarily of specialist service, explore how heard, contacted, experience of service, feelings about seeking help, what support offered
- Explore what helped/how benefited from the service
- Explore suggestions for improving the service/anything done differently
- Any difficulties accessing the service

Any other issues

- Any other issues the participant would like to raise

Table 1: Participant demographics

	N
Sex (female)	33
Age	
20-29	1
30-39	12
40-49	20
50-59	14
Group	
1	19
2	9
3	11
4	8
Years since qualified	
<10	19
No of sessions contracted per week	
<5 sessions (mean actual hours worked)	12 (15)
>5 sessions (mean actual hours worked)	32 (38)
Fully retired	3
Mean size of practice	12624
Range	3,600 – 37,000
Employment status	
Partner	17
Salaried	11
Locum	5
Registrar	4
Retired	3
Sick leave	5
More than one role	2