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GPs' perceptions of resilience training:

a qualitative study

Abstract

Background
GPs are reporting increasing levels of burnout, stress, and job dissatisfaction, and there is a looming GP shortage. Promoting resilience is a key strategy for enhancing the sustainability of the healthcare workforce and improving patient care.

Aim
To explore GPs' perspectives on the content, context, and acceptability of resilience training programmes in general practice, in order to build more effective GP resilience programmes.

Design and setting
This was a qualitative study of the perspectives of GPs currently practising in England.

Method
GPs were recruited through convenience sampling, and data were collected from two focus groups (n = 15) and one-to-one telephone interviews (n = 7). A semi-structured interview approach was used and data were analysed using thematic analysis.

Results
Participants perceived resilience training to be potentially of value in ameliorating workplace stresses. Nevertheless, uncertainty was expressed regarding how best to provide training for stressed GPs who have limited time. Participants suspected that GPs most likely to benefit from resilience training were the least likely to engage, as stress and being busy worked against engagement. Conflicting views were expressed about the most suitable training delivery method for promoting better engagement. Participants also emphasised that training should not only place the focus on the individual, but also focus on organisation issues.

Conclusion
A multimodal, flexible approach based on individual needs and learning aims, including resilience workshops within undergraduate training and in individual practices, is likely to be the optimal way to promote resilience.

Keywords
burnout, professional; coping skills; general practitioners; primary health care; resilience, psychological; training.

INTRODUCTION

Primary care delivers 90% of NHS activity through GPs.[1,2] At present, however, GPs describe a highly demanding and stressful work environment. Issues include high workloads,[3] lengthy working hours,[4] and sustained cognitive and emotional challenges.[5] Although many derive joy, meaning, and satisfaction from their work,[6,7] many also report high levels of stress and job dissatisfaction, and up to 50% experience burnout. There are serious implications for GPs themselves, service delivery, and the quality of patient care.[8–11] Recruitment of medical trainees to general practice at below-target levels and low retention rates of qualified GPs are key factors contributing to a workforce crisis.[11–13]

Promoting resilience is a key strategy for enhancing sustainability of the healthcare workforce and improving patient care.[14] Resilience is an individual's ability to adapt and manage stress and adversity; it is not a static trait but varies with circumstances, knowledge, skills, and attitudes.[15] Resilience has the potential to improve physician wellness by mitigating distress, especially when used for prevention rather than as a response to existing problems.[16,17]

Evidence suggests that resilient doctors deliver higher-quality care, and are less prone to medication errors and becoming sick or leaving practice, all of which reduce costs for the NHS.[14,15] Approaches to promoting resilience in clinicians are increasingly viewed as 'multifaceted', requiring a combination of personal, social, and workplace features.[18] Recent evidence suggests that physician resilience is a shared responsibility of the individual and the healthcare organisation:[19,20] organisational and multicomponent interventions are more effective at reducing burnout and improving resilience compared with those solely targeting the individual.[15,17] Tangible improvements in general practice are more likely with the application of practice-wide resilience programmes to promote not just personal wellbeing, but also relationships among the whole team.[17]

A core prerequisite for improving resilience in general practice is to understand the needs of GPs and tailor resilience programmes accordingly. A number of international studies have found useful GP approaches to dealing with stress include mindful self-compassion and self-awareness, optimism, adaptability and prioritisation, teamwork and supportive relationships, and job-related gratification.[6,18,21,22] In the UK, two recent qualitative studies concurred that the emotional lives and stresses of GPs

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How this fits in

Resilience training is one potential tool for tackling current challenges in primary care. Although resilience training is acceptable to GPs, improvements are required to increase access to training for those most in need. A multimodal, flexible approach based on individual and practice needs/learning aims would be ideal. In addition, organisation-wide approaches to resilience are vital.

are largely shaped by NHS factors and that resilience consists of a synergy of personal characteristics (self-worth, flexibility, organisational skills, assertiveness, and humour) and professional and organisational promoters (strong management support, teamwork, workplace buffers, and resources).[23,24] The King's Fund report *Understanding Pressures in General Practice* offers a useful insight on ways of more effectively helping practitioners with growing pressures,[25] but the exact content and the acceptability of these propositions to GPs remain unclear.

In the present study, qualitative data were collected to elicit GPs' perspectives on the content, context, and acceptability of resilience training programmes in general practice. The study aimed at gaining an insight into GPs' personal experience in resilience and identifying the attractive elements of resilience programmes and participating challenges, to build more effective GP resilience programmes.

METHOD

Design

Focus groups allowed GP discussions regarding what GPs needed to support and build their resilience. GPs are busy,[25] 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.[26] The study uses an existing qualitative dataset.[24]

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. The present authors' extensive primary care contacts were also exploited, targeting GP gatekeepers, asking them to distribute the flyer to their contacts, and using snowballing, with those recruited asked to contact colleagues about the study.

The inclusion criterion was currently working as a GP in England. GPs who expressed an interest were e-mailed 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 (which took place from January to March 2016): two focus groups (Bournemouth, $n = 8$; London, $n = 7$) and seven telephone interviews. A wide demographic was recruited in terms of age, sex, type of GP, practice type, and working hours (Table 1).

Data collection

A semi-structured approach was adopted to data collection. GPs were asked what they needed to support and build their resilience including type of support, format of delivery, improving accessibility of support, and their perceptions of resilience training. Focus groups lasted 37 and 77 minutes, with interviews lasting 35–65 minutes, and 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, whereas interviews explored underlying issues and in-depth individual experiences.[27] The point of data saturation[28] — no new themes of interest 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. Constructivism acknowledges that there is not one objective 'reality'. Rather, reality will be experienced depending on the varying interpretations that each individual brings to a situation. Thus, the position was taken that different subjective GP experiences and perceptions would be prioritised.[29] Data were analysed inductively:[30] no specific hypothesis was tested, and findings on resilience were instead developed based on important issues as stated by participants, that is, research themes were teased out of the data using thematic analysis.[31] Two researchers immersed themselves in the data, repeatedly reading the transcripts to understand participants' experiences. Key issues, concepts, and themes arising

Table 1. Participant demographics

	N (%)
Age, years	
20–29	1 (4.5)
30–39	10 (45.5)
40–49	3 (13.6)
50–59	6 (27.3)
Missing	2 (9.1)
Sex	
Female	18 (81.8)
Male	4 (18.2)
Type of GP	
Salaried	10 (45.5)
Partner	6 (27.3)
Trainee	4 (18.2)
Locum	1 (4.5)
Rapid response	1 (4.5)
Working hours	
Full time	14 (63.6)
Part time	8 (36.4)
Type of practice	
Urban	16 (72.7)
Rural	5 (22.7)
Mixed	1 (4.5)

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 9, and findings were written up into a draft that was then debated and finalised by all authors. Previous similar approaches to analysis by the present study group have been successful.[24]

RESULTS

Findings on GPs' perceptions of what kind of support GPs need to build resilience are presented below under the following themes: perceptions of resilience training, resilience training course content, and delivery of resilience training (Box 1).

Perceptions of resilience training

All participants spoke at length about what they perceived to be key challenges associated with the GP role, as described in a previous article.[24] Participants perceived resilience training to be potentially valuable in ameliorating workplace stresses. Those who had undertaken resilience training themselves, or knew of colleagues who had, spoke favourably of this approach:

'As I said, there's a couple of people that I've heard have been on the resilience say it's quite good.' (P14, female [F], 57 years, full time [FT])

'Improving the way that people manage their own stress is certainly valuable.' (P25, male [M], 38 years, part time [PT])

'Oh I think it's desperately needed yeah [resilience training]*.'* (P3, F, 59 years, FT)

There was an appreciation, however, that resilience training would differentially benefit GPs. It was noted that some GPs already possessed good resilience skills and techniques for coping with workplace stress. Participants suspected GPs whose current stress levels were highest would be most likely to benefit from resilience training. This group were considered least likely to partake in training, however, as, ironically, their stress levels were seen as impinging on their ability to engage:

'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, so I think that can be trained.' (P3, F, 59 years, FT)

'My concern would be that the people who are the most stressed, who would benefit the best from them, are probably the least likely to access them. And still possibly they end up at the stage where they actually become unwell.' (P25, M, 38 years, PT)

Additionally, GPs highlighted that organisational factors also needed to be considered in relation to GP stress. Here, it was considered that there was only so much an individual GP could do to manage stress, given the extent of work pressures they faced:

'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 cause you get nowhere.' (focus group [FG]2, M)

Resilience training course content

There was considerable agreement among participating GPs regarding what should be included in resilience training. Participants often drew on personal experiences of what had helped them, or cited approaches for which they felt a strong evidence base existed. Many had successfully used mindfulness/meditation or yoga/breathing exercises, and these were viewed as effective techniques. Additional techniques and topics suggested for inclusion were lifestyle advice (including exercise and dietary advice), general stress management advice (including relaxation/self-care techniques), and better understanding of the physiology of the stress response:

'Acceptance and commitment training ... is like a third wave of behavioural therapy, beyond CBT [cognitive behavioural therapy]*, but it's very much about reconnecting with your values, but using mindfulness alongside reconnecting with your values.'* (P30, F, 41 years, FT)

Box 1. Participant themes and sub-themes

Theme	Sub-themes within narratives
Perceptions of resilience training	Resilience training as having potential value
	Resilience training as having differential benefit for different GPs
	Access to training for those who most need it
	Limitations of resilience training
Resilience training course content	What should be included in resilience training
	The language of resilience
Delivery of resilience training	Format of resilience training
	How do you provide training for busy and stressed GPs?
	The multimodal approach
	Using mentoring/buddies

'I'm a little bit biased and seeing the value of meditation and deep breathing and yoga and stuff like that. Yeah, just a little bit of office yoga to stretch out your body at your desk. Just some deep breathing techniques which are really simple but really powerful. And, yeah, I think everyone should learn how to meditate and I think GPs probably as much as or more, need it more than anyone. Because you can take 2 minutes out and re-centre yourself when you're feeling super stressed in the middle of things just by doing those things. And so I think those techniques are very useful.' (P24, F, 36 years, PT)

'Just try to re-encourage my colleagues about the absolute basics of their own health and wellbeing self care, so I know there are loads of people who eat junk food to get through the day, or don't eat at all. So one of the things which I would think would be really key would be finding ways of encouraging people, to just remind them that they're not gods, or different from other human beings. And that they need some basics in terms of food and exercise and fresh air and a break, if it's at all possible, every day.' (P30, F, 41 years, FT)

Some participants highlighted that it would be beneficial to include practical approaches to reducing stressors in the GP workplace. Training here could include advice to address some of the challenges faced in a practice and/or at local level, including improving communication and support among work colleagues, and simple, practical approaches to improving workplace efficiency:

'So in a GP surgery, if you have an approach where the patient demand is never met, helping the practice establish the best system to manage the work on the day seems like a practical solution.' (P4, F, 58 years, PT)

'A lot of the solutions need to be either local or almost practice based ... the practices that are coping better have a better sense of team.' (P25, M, 38 years, PT)

Others highlighted that being able to share experiences with peers was particularly therapeutic, engendering support and problem solving among colleagues. There were suggestions, however, that skilled facilitation could ensure that forums did not become a detrimental 'moan fest':

'I think being in a group setting where other people say, yes I find that really hard too ... I think knowing that other people feel like that too is comforting and that it's not just you feeling that you're going off the boil and you can't do this anymore.' (P14, F, 57 years, FT)

'It's important to have that space to decompress but there's something around making sure it doesn't get depressing and just a moan fest.' (P24, F, 36 years, PT)

Others discussed how resilience training was useful in providing the language for GPs to discuss evidence-based resilience concepts and ideas, and how this was important in itself.

'I suppose one of the things that's useful about the work that's being done at the moment is that there's a language which is developing to describe what resilience means and how we've become a bit more resilient to the stressors in our lives. And there's a bit more out there. There's a bit more of an evidence base. There's a bit more of an ability and an expertise to talk about it.' (P25, M, 38 years, PT)

Delivery of resilience training

When discussing the *mode* of resilience training, views were much more conflicted and a key challenge was highlighted: how to provide training for busy and stressed GPs who find it difficult to allocate time for training? Most felt that a one-off group workshop, ideally half a day in length, would be optimal — not taking up too much time yet providing a valued group experience. Some participants warned, however, that a one-off workshop could be 'pointless'; effective training requires continuous learning. These participants preferred approaches such as autonomous resilience groups responsible for their own continuing education, despite challenges involved for GPs in attending regular groups:

'Yeah, I guess a half-day course is good because it just requires a one-off time commitment whereas weekly courses are a little bit more of an investment.' (P24, F, 36 years, PT)

'I think if they're going to be just one-off activities, that's pointless, absolutely pointless. And I really think this has to be a continuing thing ... So I would say, if you're going to do resilience training, it can't be just one-off events, it's got to be something that can be continuous and done again and again, and perhaps little groups can be autonomous in training themselves rather than getting people in all the way to provide

the training. Fair enough about getting people to start off the training, but certainly to create autonomous groups who could then train themselves.' (P26, M, 45 years, PT)

'Schwartz rounds, the Balint group, or even just slightly less formal peer learning groups.' (P30, F, 41 years, FT) [Schwartz rounds aim to support staff in their work to promote compassionate patient care. They are structured groups in which healthcare staff (clinical and non-clinical) come together to discuss the emotional and social aspects of their work. A Balint group is for clinicians to present case studies from their own practice to discuss with the group; discussion has a particular focus on the clinician–patient relationship.]

Online training and forums were favoured by some GPs, allowing busy GPs to access resources at a time and place convenient for them. Others disagreed, however, suggesting that GPs already spent too much time on their own at a computer:

'I do think face-to-face forums are really good too, but I suppose the thing about the online is just the reach, because I know one of the massive limiting factors is just time and logistics, so that's where I think online would come into their own ... I could imagine it being like an online module, with different aspects of wellbeing, with all sorts of links to things and some will inspire some people and some won't. But it might be that some sort of real basics, like how to look after your health, what sorts of exercise is important, what food, then let's think about your psychology, mindfulness is one option, other sorts of relaxation exercises are another, but I also think another sort of sub-module would be about relating, so actually really trying to make sure you've got space to connect with other people.' (P30, F, 41 years, FT)

Thus, a multimodal approach/flexible approach based on individual needs and learning aims was considered to be ideal. Others suggested supplementary material to support one-off training groups including apps or an online toolkit:

'I guess probably the way that I would work it is that it is supposed to be multimodal. Different people like things different ways.' (P25, M, 38 years, PT)

'But the other thing I was thinking about when you were first talking about it, was an app or something. Because you know things like Headspace and just to have a change in the way that you approach your day which is needed and so having just an app popping up and going, have you done ten breaths today? Or whatever it is or, yeah, have you exercised this week?' (P24, F, 36 years, PT)

'A toolkit or a check kit that people can go online, a website, and say, these are some ideas that different GPs have found have helped them, why don't you give these a go, like a tick box.' (FG1, M)

Some highlighted that the inclusion of mentoring from more senior colleagues as part of resilience training or a 'buddy' could be beneficial to the long-term resilience of GPs. Similarly, a training approach whereby GPs undergoing resilience training were expected to bring the skills they learnt back into their practice was seen as a useful approach to disseminating the benefits from the training:

'And then different people can join and leave whenever they want, the idea being those people who actually attend the meetings learn how to become resilient and learn how, and then start feeling positive about life again. And the idea is then that would cascade to the practices they go back to.' (P26, M, 45 years, PT)

'The other idea I'd had was a buddying up programme, through the college, so just finding somebody in your area that you might touch base with once a month.' (P30, F, 41 years, FT)

Given that feeling part of a team within your own practice and offering mutual support was seen as bolstering GP resilience, some participants felt that it may be of benefit for resilience workshops to be conducted within their practice, or with a population of local GPs. Others suggested building resilience training into university medical training:

'I think, a team is the most important thing. So I don't know, I think, yeah, within practices or local groups maybe.' (P24, F, 36 years, PT)

DISCUSSION

Summary

Participants believed resilience training could be of value in ameliorating the impact of workplace stress. They suggested that resilience training should focus on mindfulness/meditation, yoga/breathing exercises, lifestyle advice (exercise and dietary

advice), general stress management advice (relaxation/self-care techniques), providing information on physiological mechanisms of stress, and how to manage practical issues causing stress. They also felt that organised sharing of concerns with peers would be helpful. Participants emphasised, however, that resilience training should not only focus on individual factors, but also take into account organisational issues to reduce stress.

Reaching and engaging GPs with busy time schedules in resilience training was uncovered as a core challenge. Participants suspected that GPs most likely to benefit from resilience training were the least likely to engage, as their stress levels and sense of time pressure mitigated against engagement. There were conflicting views about how to encourage engagement (for example, online versus in person, one-off versus ongoing sessions). Overall, a multimodal, flexible approach based on individual needs and learning aims was considered to be ideal. Others suggested that resilience training should be built into undergraduate medical education and that developing resilience workshops within practices could increase access.

Strengths and limitations

The study sample included a range of demographics, practices, and roles. There were more females, salaried GPs than partners, and GPs from urban practices;[32,33] however, the proportion of full- and part-time GPs was consistent with national figures.[32] The sample size ($n = 22$) was adequate for this type of qualitative study, and data reached saturation for the issues relevant to the study.[34] Sampling methods may have attracted GPs with an interest in resilience and time to participate. Interviews and focus groups provided a helpful combination of data collection methods.

Comparison with existing literature

This research, like other projects, cautions against viewing the problem of GPs' stress as an issue only to be tackled at the individual level, emphasising that organisational factors are a crucial determinant of stress,[23,24] which continually impact on the individual.[35] Further, recent systematic reviews and meta-analyses have found that intervention programmes for burnout in physicians can be significantly enhanced by adoption of organisation-directed (as opposed to physician-directed) approaches.[19,20] Resilience is a shared responsibility of the whole healthcare organisation.

There was consistency among the present study participants about the content they would like to see included in training. A number of participants practised mindfulness, meditation, or yoga, and proposed these self-regulation activities as part of resilience training. Current research and opinion suggests that, in medicine, resilience calls for more than just coping with stress; rather than merely bouncing back from adversity, doctors' resilience is associated with a set of positive characteristics that support self-care, wellbeing, and flourishing in practice.[18,23] It has been suggested that resilience training should promote deeper self-awareness for lasting benefit.[36] A 2016 review noted that research on improving GP wellbeing has been limited by its predominant focus on stressors, rather than on development of positive mental health.[37]

Although GP burnout and support needed for GPs are increasingly acknowledged,[38] GPs most in need of support are those who are least likely to access it. This suggests that any support offered to GPs should take into account how to promote access to those most in need.

Implications for research and practice

The implications for practice are clear: when delivering resilience training, 'one size fits all' approaches are unlikely to be acceptable or effective. Although participants broadly agreed on the core content for resilience training, a wide variety of topics was suggested. Therefore, programmes most likely to appeal are those based around a 'core curriculum' delivered in various formats (including blended learning online options), augmented by optional content exploring certain topics in depth. Training must cover ways of promoting wellbeing, self-awareness, and better practice organisation, as well as dealing with individual stress.

To meet GPs' diverse requirements, access to training should be convenient, multimodal, flexible, and responsive to personal learning needs. Training is promoted, or conversely may be undermined, at both personal and practice levels. Thus practice-based resilience training could be an effective way of addressing individual *and* local organisational issues. There is, however, a growing recognition that primary care is at breaking point.[25,39] Thus, systemic and organisational changes to the work environment of primary care alongside physician training[14,40,41] are necessary for improving resilience and retaining the primary care workforce. Further research is warranted to examine efficient organisational strategies to complement physician resilience training.

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Ethical approval

Ethical approval for the study was obtained through the University of Westminster Ethics Committee. It was confirmed (using the HRA decision tool and telephone/e-mail correspondence with a local clinical research network) that NHS ethical approval was not required for this study (VRE 1516-0054).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors declare the following competing interests: David Peters runs the Westminster Centre for Resilience, which delivers resilience training to doctors. Chantal Simon commissions training courses (including resilience training) for the Royal College of General Practitioners, including their continuing professional development portfolio. Anna Cheshire, John Hughes, Maria Panagioti, and Damien Ridge declare no competing interests.

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