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Qualitative study exploring the reasons why GP's  
leave practice early in their careers and the  
barriers to their return

Final Report

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July 2014

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# 1. Summary of findings

## Recruitment and methodology

- At the time of starting this qualitative phase, 121 early GP leavers (aged under 50 at time of leaving practice) had responded to our on-line survey.
- Of those, 21 consented to be interviewed. They took part in semi-structured telephone interviews lasting between 40 and 60 minutes.
- The participants represented a maximum variation sample in terms of age, number of years as practising GPs, and geographical location.
- Thematic analysis techniques were used to generate a description of the dataset themes. These were grouped to construct an interpretative narrative.

## Reasons for leaving

*"I think it's so multi-factorial, I don't think there's any one thing. I think it's that combination of increased work with decreasing income with high patient expectation with continuous media negativity and no support from the government, just all of those things." (GP5)*

- For most participants, general practice had been their first career choice.
- They had been attracted to GP work in the expectation that it would offer patient continuity of care, professional autonomy, flexibility in working hours and teamwork, along with the intellectual challenge inherent in problem solving.
- However, participants described a set of conditions that were systematically eroding what they saw as the heart of general practice.

## Organisational changes

- Participants described a radically altered working environment brought on by an unprecedented increase in organisational changes. They felt that many of these were made without any long-term vision and for little health gain.
- Such was the onslaught of change that participants had felt worn down and frustrated. They reported that the job that they eventually came to leave bore little resemblance to the role that they had initially signed up to.
- Interviewees thought that the mass of changes actively inhibited their ability to connect with and care for their patients.
- They came to feel more controlled and constrained in professional practice.
- As referral systems became more complex and hospitals more specialised, interviewees came to experience a more fragmented and depersonalised healthcare system that was becoming increasingly challenging for them to navigate.

## Increased workload

- Management targets, regulations and guidelines were felt to have impinged on participants' day-to-day work in general practice, increasing their workload. This left

many feeling professionally compromised as they juggled with conflicting priorities in the consulting room.

- The GPs also had to manage a rise in patient expectations and demands.
- The higher workload meant that they could spend less time with their patients, leading to a fundamental change in the doctor-patient relationship.
- Participants began to feel more burdened and time-pressured by the additional workload and expectations placed upon them.

### **Anxiety and reduced confidence**

- Time pressure and conflicting priorities meant that participants felt the need to “cut corners”. As a result, they felt that the care they were giving was sub-standard.
- These pressures, along with what participants saw as a move towards a “blame culture”, led to disillusionment and a raised anxiety about the risk of making a mistake.
- Combined with a feeling of isolation, this impacted participants’ confidence to practice.

### **Lack of support and workplace issues**

- Several participants described a “bullying culture”, which they felt had come to permeate the NHS from the top down.
- They were unable to identify any organisation that could provide true advocacy for them, so that they could in turn provide advocacy for their patients.
- They lacked a collegiate environment in their practices, with no time during their working days for more informal support or "catch up" with colleagues. This led to a feeling of isolation.
- Views on NHS annual appraisals were mixed. Some saw it as an opportunity to learn from and engage with a more senior colleague, while others dreaded it and felt that it undermined their sense of professional competency and worth.
- A third of the sample experienced ill health, including stress, anxiety disorder and burnout. They perceived a lack of professional support both within and outside their practices, which led to a loss of confidence.
- Participants called for a more robust occupational health service for GPs.

### **The changing role of the GP and its impact on job satisfaction**

- Participants were unanimous in their descriptions of a rapidly changing working environment: from one in which they initially enjoyed professional autonomy with the time to reflect and practice more patient-centred continuity of care, to an increasingly pressurised working one where more was expected of GPs without the necessary resources or support mechanisms in place.
- These factors came to impact participants’ job satisfaction and overall wellbeing, leaving them vulnerable to ill health, feelings of demoralisation, stress and burnout.

### **Negative media portrayal**

- Instead of feeling supported in their efforts to meet patient demands, or having their efforts to cope with the pressures inherent in a high-risk working environment recognised, participants felt increasingly worn down by negative media stories and political “spin”.
- Some, but not all, felt that this was beginning to undermine their relationship and rapport with their own patients.

### **Burnout**

- For some participants, diminishing job satisfaction led them to self-diagnose the early symptoms of burnout.
- In some cases, the conditions were such that participants came to hate their job.

### **Coping mechanisms**

- Measures taken to cope included:
  - reducing hours and going part-time;
  - taking on more managerial roles;
  - developing external roles and interests.
- However, these did not offset the stresses of a rapidly changing working environment: many reported that going part-time led to increased stress, due to the pressures of keeping up-to-date with organisational policy changes and new treatments.

## **Barriers to returning to work as a GP in England**

*“I think there would need to be a complete management and cultural change whereby the GPs were permitted to simply do their job.” (GP15)*

- Interviewees felt that there was no point in returning to NHS general practice, as the problems that had made them leave had not resolved.
- Those who now work as GPs in other countries with equivalent systems of primary care feel that this should be taken into account when deciding whether, or how much, retraining is needed. They resent what they perceive to be the unnecessary imposition of a prolonged period of retraining.
- For some, the need to work for weeks or months without payment during their training was a considerable barrier.
- Some found it difficult to find clear and reliable information about the Induction and Refresher Scheme.

## 2. Introduction

Over a decade ago the BMJ ran a series of articles on the low morale and diminishing job satisfaction among doctors with articles entitled: "Why are doctors so unhappy?" (Smith, 2001), and "Unhappy doctors: what are the causes and what can be done" (Edwards, Kornacki, & Silversin, 2002). Much research has been carried out on the factors associated with stress, anxiety, depression and burnout among doctors in the UK and abroad (Firth-Cozens, 1998; Harvey, Laird, Henderson, & Hotopf, 2009; McManus, Winder, & Gordon, 2002; Vedsted, Sokolowski, & Olesen, 2013).

More recently, policy initiatives have emphasised the importance of health and wellbeing among medical staff in the workplace (Boorman, 2009). There has also been a renewed focus in the research literature upon educational initiatives, preventative measures and therapeutic interventions which could be taken to help combat what is perceived to be a growing malaise within the health care profession (Beckman et al., 2012; Bullock et al., 2013; Kjeldmand & Holmstrom, 2008; Krasner et al., 2009; Lown & Manning, 2010).

Although current evidence points to an impending crisis in the recruitment and retention of general practitioners in the UK (Adams, 2013; BMA, 2014a, 2014c), this is by no means a new phenomenon (Evans, Lambert, & Goldacre, 2002; Lambert, Evans, & Goldacre, 2002; Young & Leese, 1999), nor one which is unique to the UK workforce (Heponiemi, Manderbacka, Vanska, & Elovainio, 2013; Sumanen et al., 2012; Van Greuningen, Heiligers, & Van der Velden, 2012). In 2001, a survey carried out by the BMA revealed that a quarter of General Practitioners (GPs) wanted to quit (Kmietowicz, 2001b), while a number of surveys, carried out prior and since, have continued to monitor GP training, retention and recruitment, particularly in relation to contractual reforms, job satisfaction and burnout (Sibbald, Bojke, & Gravelle, 2003; Sibbald, Enzer, Cooper, Rout, & Sutherland, 2000; Van Ham, Verhoeven, Groenier, Groothoff, & De Haan, 2006; Watson, Humphrey, Peters-Klimm, & Hamilton, 2011; Whalley, Bojke, Gravelle, & Sibbald, 2006; Young & Leese, 1999).

So why are we currently witnessing a renewed crisis in UK general practice? The medical profession does not exist in a vacuum, but rather it is part of the wider culture and as such, it is subjected to broader societal factors including changes in consumer demographics, demand and expectations, as well as technological advances, economic constraints and a growing trend towards targets, accountability and managed care.

Against this backdrop, UK general practice in particular has undergone a series of policy changes, some initially well received - such as the changes to GPs out-of-hours-commitments in the 2004 contract (Rose, 2013) - and others which have served to heighten a disparity between doctors' expectations, professional values and priorities, with those of the government and wider public. For example, contractual changes have in the past led GPs to close their surgeries in protest at government targets, threaten to quit and more recently, to confront ministers over the mounting pressures of a workload which has



become increasingly viewed as unsustainable (BMA, 2014b; Ham & Alberti, 2002; Iacobucci, 2013; Kmietowicz, 2001a). This is illustrated by recent media headlines such as: "Family doctor service on brink of extinction", says new GP leader" (Campbell, 2014); "Doctors in fight against cuts to GP funding" (Harris D, 2014); and "Tens of Thousands of GPs on brink of early retirement, BMA finds" (Duffin, 2014).

In the past ten years the GP workforce has grown; however, this has amounted to only half the rate of other medical specialties and not been in line with population growth. It is estimated that patient demand for GP services in England alone, represents an annual total of 340 million patient consultations (up 40 million since 2008), while an increase in part – time work among both male and female GPs, is thought to be adding more "longer term sustainability pressures" (NHS England, 2013).

Given the growing reports relating to GP workforce pressures and the current crises in recruitment and retention, an online national survey was commissioned by NHS England in order to explore the extent and nature of the problem. Following on from the survey (Harris M, 2014), this qualitative study was devised in order to better understand the experiences and perceptions of GPs who decided to leave UK practice early in their careers and to explore the possible barriers to their returning to practice.

### 3. Background

There are many reasons why doctors may not wish to commit fully to a lifetime's work in the National Health Service (NHS). However, the early loss of General Practitioners (GPs) is contributing to the impending GP recruitment and retention crisis.

The Department of Health (DH) has set a target that half of all UK medical graduates entering postgraduate specialty training should go into GP training (NHS Careers, 2013). However, according to the Centre for Workforce Intelligence (CfWI) (Centre for Workforce Intelligence, 2011), measured against this target we are under-training GPs by 550, approximately 18% per year.

It is possible to increase the number of UK GPs by

- Increasing the number of students in UK medical schools and GP training
- Raising the number of medical graduates who go through GP training

These two options have significant time and cost implications. It costs £488,730 for a student to complete undergraduate medical school and then GP training (Curtis, 2012), while the cost of a GP training programme for a medical graduate is £196,500: £11,600 per subsequent working year using peak joiner and median retirement ages calculated from NHS Information Centre data (NHS Information Centre for Health & Social Care, 2012).

More cost-effective options are to:

- Reduce the number of GPs who leave their work before the usual retirement age
- Retain more GPs who, principally because of domestic commitments, can only undertake a small amount of paid professional work
- Encourage more GPs to return to practice after a career break

In order to achieve a reduction in early leavers and encourage retention of GPs after career breaks, it is necessary to understand the factors that prevent and facilitate their continued work as GPs. The current study sought to address these issues.

## **4. Research Aim**

To explore the factors causing GPs to leave practice early and the barriers to their return.

### **Objectives:**

- To investigate why doctors leave general practice early.
- To establish what they do after leaving GP practice.
- To explore what the barriers are to returning to GP practice.

## 5. Methods

In order to explore the reasons why general practitioners left UK practice early in their careers, as well as the barriers to their returning to practice, we undertook a qualitative study involving audio recordings of interviews with 21 general practitioners who had volunteered to take part following their participation in a national on-line survey. Interviews were carried out by telephone and lasted between 40 and 60 minutes in length.

In our online survey (Harris M, 2014), 38 participants volunteered to take part in a telephone interview. They were therefore contacted by e-mail and provided with consent forms and information sheets explaining the purpose of the qualitative research and what their participation would involve. Of these, 21 returned completed and signed consent forms (see appendix 1) before being contacted by follow-up phone call to take part in the study.

Interviews were semi-structured and were based upon an interview schedule that was designed by the research team to act as a guide to the topic area (see appendix 2). Interviewees were asked about their reasons for choosing to work in primary care; whether their GP training prepared them for the reality of life as a GP; to describe their experiences of working in general practice and whether it met or fell short of their expectations. They were asked what changes they had witnessed during their time in practice (at either a local or organisational level) and what impact this had on their day-to-day role as a GP. They were then asked to describe the circumstances surrounding their leaving UK general practice and whether they intended to return, and what the main barriers were to their returning to UK general practice. They were also asked about their overall perceptions of the annual NHS appraisals and revalidation scheme and how familiar they were with the processes of getting back into practice. Finally they were asked to state, in order of importance, their main reasons for leaving GP practice and their main reasons for not returning.

The semi-structured nature of the interview meant that the GP participants determined the order, as well as the extent to which any predefined themes were discussed.

Following the interview, participants were asked if they would like to receive a copy of their interview transcript to pre-approve prior to inclusion in the study. Out of 21 participants, six requested to pre-approve their interview transcripts. These were later returned unchanged and fully approved.

Ethical approval for this research was granted by the Research Ethics Approval Committee for Health (REACH) at the University of Bath.

## **6. Data Analysis**

Interviews were audio recorded, transcribed verbatim and audio quality checked to include the removal of all identifying information. Fieldwork notes were kept in order to contextualise the data and detailed summaries of each interview were produced. Thematic analysis techniques were then used to generate a description of themes both within and across the dataset (Braun & Clarke, 2006). The phases of analysis included coding, followed by the identification and clustering of themes and sub themes and the production of a descriptive thematic summary.

Three members of the team (ND, FF, KR), all with expertise in qualitative analysis, each independently coded three transcripts before comparing their analyses through group discussion for any inconsistencies as well as areas of agreement. Finally the themes and sub themes were grouped in order to construct a more interpretative narrative across the whole dataset.

## **7. Findings**

Participants in this study were located in the following geographical areas: Australia (n=2), New Zealand (n=1), Canada (n=1), Switzerland (n=1) and the UK. Of the 21 interviews that were carried out, 14 participants were females and seven were males, with an age range at point of interview of 32 to 54 years. They had been practising GPs in the UK for between 2.5 and 20 years and their age range when they left general practice in the UK ranged from 29 to 50 years. Although participants were randomly selected from the first group of volunteers to return completed consent forms, they represent a maximum variation sample in terms of age, number of years as practising GPs and geographical location.

In the subsequent section, the major themes and sub-themes that have been refined through the analysis (see Appendix 4) are summarised and illustrated with verbatim quotes.

## Reasons for going into general practice

For some participants, general practice was not their first career choice, but an option which they chose either because they felt it would offer them “more flexibility” in raising a family (n3), or more “work/life balance” compared to hospital-based medicine (n4). Indeed one participant described taking this option following a severe illness episode during his hospital-based training, having previously maintained: "I will never be a GP" (GP19).

However, for the majority of participants who took part in this qualitative study, general practice had been their first career choice, with some describing how they had wanted to be a GP since childhood:

"I'd wanted to be a doctor ever since I was 12 or younger and my vision of that was always general practice." (GP15)

"I always wanted to be a GP just because you sort of covered everything [...] and had to know bits about everything and was always on the front line with the patient's [...] I liked the way in general practice, you had the breadth of everything and you were the gatekeeper and the advocate for the patient." (GP17)

"I'd always been interested in the family aspect of medicine and being part of the community and seeing people on a continual basis." (GP2)

Among those for whom it was their first career choice, what attracted them to general practice was the expectation that it would offer patient continuity of care, professional autonomy, flexibility in working hours and teamwork, along with the intellectual challenge inherent in problem solving:

"The continuity of care and being part of a team that you work with for more than six months at a time [...] getting to know my patients and being able to follow them up and be a little bit more autonomous." (GP16)

"Just that continuity of care, the ability to build up a relationship with a patient and not be too specialised, so a generalist view, to be able to be involved in the physical, psychological and social, all within the whole package." (GP5)

"I'd always planned to do that right through medical school because I initially just liked the idea of seeing everybody and a range of unfiltered, undifferentiated problems that was always appealing. And I always liked the idea of the continuity of care that went with general practice." (GP18)

## Changing role of general practice and its impact

In this section, the main theme: 'Changing role of general practice and its impact' is discussed in relation to the following sub themes:

- a) Political/organisational changes
- b) Clash of values GP's versus system
- c) Increased workload
- d) Negative media portrayal
- e) Workplace issues and lack of support

### a) Political/organisational changes

- Shift to evidence-based practice
- More complex systems/hospitals becoming more specialised
- Changes to methods of referral, more complex communication channels across services
- Funding cuts
- More bureaucracy - management targets, regulations and guidelines
- More of a "machine" (centralised, standardised, depersonalised, fragmented patient care)

### 'Shuffling deck chairs on the Titanic'

"I've been in the NHS in a very interesting time, from when it basically worked, to when it has become pretty dysfunctional and everyone is shuffling deck chairs on the Titanic because no one has actually really got a grip of what we are there to do."  
(GP13)

Participants to this study were able to paint a picture of general practice from a myriad of vantage points. Some reported on their experiences of being in partnership posts in one geographical area, others took on salaried or locum posts in a number of practices across the UK, while others took career breaks to raise a family, or work abroad at various times throughout their career, returning to the UK in order to meet the minimum requirements to maintain their licence to practice. Across the sample, the variation in the amount of time spent working in general practice meant that some could provide a more longitudinal perspective on the changing nature of the role of general practice over the past 10 to 20 years, while others provided the perspective of having practiced in the UK for a relatively short duration of time (2.5 to 5 years). However, what all participants had in common, were the shared feelings of being worn down and frustrated by constant organisational changes to their profession, as the following participants described:

"It's really hard because it's done nothing but change since sort of starting." (GP1)



"This washing machine affair of being in constant change, goalposts moving every year... this feeling of helplessness, this feeling of 'we are powerless'." (GP13)

"I felt less empowered, I felt less professionally responsible [...] The endless micromanagement of general practice I found demoralising and frustrating." (GP15)

Such was the onslaught of change that many came to feel that the job, which they eventually came to leave, bore little resemblance to the role which they had initially signed up to. As one participant stated:

"Cases were getting more complicated, more was being transferred from the responsibility of the hospital to the responsibility of GPs and I found that even in the short time I had, I was spending more and more time doing administrative things and less and less time being able to devote my mental attention to the patients in front of me. I just felt more and more stretched." (GP3)

Having predominantly chosen to go into general practice in order to practice more patient centered continuity of care, participants described a set of conditions which were systematically eroding what they saw as the heart of general practice:

"I think general practice of old was very patient focused, not necessarily evidence based and it was all about the sort of patient and that doctor/patient relationship [...] I think it's become much more of a machine really that's, you know, evidence based." (GP1)

Whilst broader socio-economic and cultural factors such as globalisation have inevitably contributed to the growing demise of the family doctor who knew their patients 'from cradle to grave,' participants described a radically altered working environment brought on by organisational changes which at grassroots, actively inhibited their ability to connect with and care for their patients:

"It [general practice] became an exercise in futility that all you were doing was just sitting there and punching out a few boxes and making a few notes without really having the opportunity to think on the bigger picture. Also the time pressures of the job had got to be that there was no reflection time; the majority of benefit that you actually brought to the consultation was not face-to-face, but it was afterwards, when you had the opportunity to replay and think it through and consider the possibilities – those days have gone. I just felt under pressure." (GP9)

Such were the changes at systems level that participants expressed difficulties in finding the time to reflect on their clinical caseloads, and to effectively communicate with fellow healthcare professionals. As hospitals became more specialised and methods of referral between primary and secondary care changed, participants began to encounter a growing complexity that hampered vital communication channels between services:

"You have to refer in a certain manner and if you've got something that you're a bit concerned with, it's much more difficult to pick up the phone to someone and you know, to consult them and say 'This is going on, what do you think?'" (GP1)

"You can't actually talk to anyone, number one; there's always a pathway, so you can't just ring and say 'what shall I do? What do you think I should do?' There's always a pathway that has to be followed [...] It's supposedly superefficient now, but it's not [...] You cannot communicate anymore!" (GP19)

Having previously experienced a more collegiate working environment which was both personable and informal, participants were now describing a climate whereby: "everything was constrained and controlled" (GP9) resulting in them feeling more isolated:

"Because general practice is ultimately quite lonely, you sit there in a room on your own, you've got no one else to ask; other people, other GPs may be present, but are equally up to their eyeballs in it and sometimes it's actually something that you do need to talk to someone in the hospital, someone who is doing that specialty and you used to be able to do that, and then after a while you became known as a GP in an area, you became known by the hospital doctors etc. and they were colleagues effectively, but that has gone." (GP19)

Another participant, who had worked in general practice for 10 years with a short career break, compared working in the 90s to returning to work in 2004:

"The constant change that there is now. Even as little as how you refer somebody somewhere [...] In the '90s, they all went to the one hospital and you just did your little letter, you know, to the respiratory person [...] Now it doesn't work like that, there's a referral form for every Tom, Dick and Harry and it changes, you know, monthly, yearly and again that's all added stress." (GP11)

As referral systems became more complex and hospitals more specialised, participants came to experience a more fragmented and depersonalised healthcare system, which was becoming increasingly challenging for them to navigate:

"One of the problems with hospital medicine is it's very fragmented and everyone is so super specialist that they aren't the generalists that they used to be, so if you sent somebody in with one thing, they have that sorted, but they don't look at the bigger picture, so they'd come back out and there'd be another thing that was developing so you'd have to refer them to somewhere else, so the fragmented nature of hospital medicine makes general practice quite difficult." (GP4)

Furthermore, being part of a National Health Service that was becoming increasingly fragmented and depersonalised meant that participants witnessed the adverse consequences this was having on patient care:

"I do see it now in hospitals [patients] see so many different people now and I think that's becoming true in general practice now as well, they don't see the same partners so they don't – nobody ever seems fully responsible for the patient anymore." (GP21)

According to one participant who had worked in general practice for 18 years:

"The NHS started to really badly go downhill I would say round about the millennium. I had been working since 1990, yes I mean it really started to go downhill when we started getting extra contractual referrals, you know, that kind of money following patients, fund holding." (GP13)

Other participants expressed their disillusionment at what they saw as: "cost-cutting at the expense of patient care":

"District Nursing Services got revamped and you seem to end up with fewer district nursing hours and the Mental Health Services got revamped [...] Changes were made not solely to improve patient care, but I think a lot of it was cost-cutting and it was always sort of disguised as 'we are revamping the service'." (GP6)

"The government changes, emphasis on money suddenly really started to rear its head and efficiency and all this kind of stuff and the juggernauts started rolling from then." (GP13)

Participants who worked abroad intermittently throughout their careers, were in a more unique position to reflect on the changes they witnessed each time they returned to the UK. In particular, they noted that general practice had become "a lot more pressured" with a lot more "rigid guidelines" and "shifting priorities". (GP19)

Whether in general practice for two years or 20 years, participants had experienced an unprecedented increase in organisational changes to their profession, many of which they perceived to be created without any "long-term vision" and for "little health gain," as the following quotes reveal:

"It [general practice] doesn't seem to have any structure anymore [...] There is no common sense and it's become part of the political football now and of course politicians want to get elected [...] and everything therefore is short-term, there is no long-term vision." (GP19)

"It just became about [...] managers which have bloated out of all recognition since the early 90s, and their interference in the day-to-day business of general practice, for what I can see as very little health gain." (GP15)

"I'm very angry with how the goalposts were moved for everybody. At the end of the day it's not the GPs necessarily that suffer, but the patients who suffer. The care has deteriorated dramatically." (GP13)

## b) Clash of values GPs vs. system

- Reduced to "government clerks"/ "QOF monkeys"
- Impossible targets
- Unrealistic appointment times
- Less patient centred

### From professional autonomy to 'QOF Monkeys'

"In the 90s, it was much more of 'a GP does what a GP does' and I think the initial 1990 contract was problematic in terms of the way it started to constrain general practice. But I would say from the introduction of the new GP contract in 2004 where we became QOF monkeys. It just became about running after management targets." (GP15)

According to participants, a major consequence of the continual organisational changes was the extent to which bureaucracy, in the form of new management targets, regulations and guidelines came to impinge upon their day-to-day work in general practice. Most participants and particularly those who had been in practice for ten years or more, felt that their professional role was being reduced to a "service provision role;" a "government clerk;" or a "data clerk for public health and for management." (GP15) The influx of more administrative tasks not only increased their workload, but also left many feeling professionally compromised as they came to face conflicting priorities in the consulting room. One participant described the challenges she faced in trying to balance "getting through a bureaucratic exercise" with maintaining quality patient care:

"It's very difficult not to lose the sort of relationship you have with patients to try and make them better [...] You've got to change the way you work to try and cope with that pressure, but still get the job done, but without compromising that relationship." (GP1)

Although some administrative tasks were viewed as necessary, they still intruded upon the doctor-patient relationship, in what were already viewed as time stretched consultations:

"Some of it was helpful, but some of it was just administrative for administrative sake. You spent more time ticking boxes than you did talking to the patients sometimes [...] that put more stress on me and I felt it affected my rapport with the patients." (GP2)

For most participants, the introduction of the Quality Outline Framework (QOF) marked a defining point where "modern medicine" became a "more target driven culture" (GP12):

"I think when QOF came in, it suddenly became quite a 'tick box exercise'." (GP1)

"We were actually very, very good at generic targets, but it got ridiculous [...] When QOF came in, and all the targets came in, although you see the need, some of them were frustrating and silly." (GP21)

Responses to QOF were mixed across the sample with one participant seeing it in a more positive light:

"On the whole QOF I suppose I didn't know any different really, but actually it seemed in my perception there was a huge variation in the standard of some of this, what should be preventative care and measurements and actually QOF did on the whole I think, did hugely good steps in terms of changing that. So in general it was a very positive experience." (GP17)

Another viewed it in more pragmatic terms, as a facet, or an inevitable by-product, of modern culture:

"I think you can take it [QOF] on different levels... So yes, it is a tick box exercise to a certain degree to get money into the surgery and stuff, but it is evidence based and [...] targets or whatever, I think having a points mean prizes money system, it's how the rest of the world's businesses work." (GP16)

Nevertheless, for the majority of the sample, attempts to juggle what they saw as "impossible targets" with unrealistic appointment times "did detract from the core business of actually just looking after sick people" (GP12). As one participant described:

"The partner would come in before I started surgery and say, 'Oh don't forget to do all the QOFs, you know, we've got QOFs on target, if any boxes pop up make sure you get all the stuff...' you know? And that was more important than actually focusing on the patient and talking to them and trying to sort out their problem." (GP11)

Another participant who worked in UK general practice for 2 ½ years before relocating abroad, held a more "philosophical objection" to what he saw as "unnecessary and potentially distracting work that changed your focus from the patient" (GP18):

"I felt increasingly irritated by the encroachment of what appeared to be fairly unproductive work, but work that generated income for the practice so it was therefore important. And I was a bit sort of disillusioned about that I suppose, I hadn't really been anticipating that that would be a big part of my work and it seemed that it increasingly would be." (GP18)

Similarly another participant who had worked in general practice for ten years commented:

“You know, with busier and busier surgeries with more and more extras. Something has to go and I think what ends up going when you’re under pressure to get all the QOFs and the money in, is the actual patient relationship.” (GP11)

### c) Increased workload

- Conflicting priorities in the consulting room
- More work shifting from hospital to primary care
- Change in patient population and demand
- Time pressures
- Constant change at systems level

#### Conflicting priorities in the consulting room

With this change in emphasis towards a more target driven culture in general practice, came a fundamental change to the doctor-patient relationship as participants found they had less time with their patients:

"I didn't have the time to pursue issues and problems that I would like to have had with patients. I think that more time with patients would have given me the potential to have done more things with them, more things to help to be supportive." (GP15)

This was a particular issue when it came to addressing the psychosocial needs of their patients:

"When somebody comes in and they're just unhappy and miserable and really what they need is you to spend ten minutes having a chat with them and, you know, doing a little bit of cognitive work or a little bit of, you know, behavioural suggestions [...] And that's where you start to get stressed then, because they go out and you feel, 'Well, I didn't really deal with their problem' [...] And there isn't that job satisfaction." (GP11)

Conflicting priorities amidst time pressures meant having to cut corners, which left participants feeling they could not provide a good enough service:

"I felt I was cutting corners, I felt I wasn't offering a good service unfortunately. The test is would I want a family member to be treated this way and I thought no, I wouldn't really." (GP6)

One participant, who had left general practice twice, compared working as a GP in the 1990s to when she came back in 2004:

"It was much more bitty when I came back [...] you just couldn't remember who you'd seen one week to the next to be honest, because you were just moving so fast [...] It's hard to say whether it's the patients or the working environment [...] You see it does change the doctor/patient relationship because it changes how you react to people and how you interact with people. I mean it's obvious stuff, but when you're



really stressed and you've still got fifteen people to see, you don't have the time for people, you don't have the interest. It's the old fashioned burnout, isn't it? [...] you just want to get them in and out and I never used to feel like that." (GP11)

As more work began to shift from hospitals to primary care:

"There was a definite push, the sort of pushing more work out from secondary care into primary care." (GP6)

Participants began to feel more burdened and time pressured by the additional work load and expectations placed upon them:

"The consultation's length didn't change, but what you were expected to do in a consultation changed." (GP11)

One participant who had worked in general practice for 18 years and was also an appraiser was able to see the impact this was having on a number of GPs:

"The GPs I was appraising were very low in morale, exhausted actually, a lot of them genuinely exhausted, emotionally, physically by the demands of the job, increasing demands of patients within the consultation, increasing complexity, the shift of complexity of case-loads from secondary care to primary care which I think a lot of GPs that I met felt hadn't been addressed, that they were just being expected to manage these really quite complicated, multifactorial cases which, in the old days, the physicians in the hospitals, good old general physicians used to care for, were now being shunted into primary care." (GP13)

In addition to this shift of workload, participants had to manage a notable rise in patient expectations and demands that were characteristic of a more consumerist society:

"There's much more patient demand, there's a much bigger expectation of what they [medical professionals] can deliver ... patients are much less forgiving of, you know, what's going on and I don't necessarily think that's bad but you have to adapt and look at that a bit ... you don't want to lose that sort of personal relationship." (GP1)

Faced with the combination of an ageing population and the need for more mental health and chronic disease management, this evident increase in patient expectations and demands was proving difficult to meet:

"patient expectations, they wanted, not unreasonably, they wanted good care, but sometimes you just weren't able to offer them anything like that." (GP2)

One participant who had enjoyed working with more complex patients, including refugees and asylum seekers, in a particularly deprived area of the UK, felt that the work she was

doing and the time she was needing to give to her patients, was neither appreciated nor valued by her practice colleagues who were beginning to judge work output by numbers, as she described:

“To my mind it’s not possible to give them [complex patients] anything like a basic, sensible, quality level of service if you’ve only got eight minutes with them [...] GPs shouldn’t quantify their work based on how many patients they see. They should base it on lots of other multi-factorial issues. [...] That was always my biggest struggle, was that they [practice partners] wanted to quantify things numerically. I just don’t feel that as GPs, as self-respecting GPs we should be measuring what we do by numbers because it just encourages you to work sloppily and quickly and just do the basic thing you have to do to get them out the room.” (GP7)

Participants described taking various measures to cope with their workload, which included staying on at work late, taking work home with them, or changing their appointment times:

“I changed my work patterns because I kept getting migraine headaches, because I was getting stressed because of time pressures [...] I found it very stressful, having patients just waiting, because I was running late on a regular basis, so I changed my appointment times [...] it meant it stopped me running late in the surgery.” (GP2)

Overall the conditions by which both doctors and patients were expected to function were inevitably compromising their ability to practice more holistic patient centred care:

“Patients are dissatisfied and they’re not actually getting treated in the way that they want to be treated – which is why they keep going for different opinions [...] because they’re not being given sufficient time to give their history properly and be investigated at the primary care level [...] there isn’t that reflective quality that allows differential diagnosis, use of time, the use of your personal knowledge of the individual and their social circumstances to be applied.” (GP9)

Where patient care was felt to be sub-standard, participants were left feeling professionally compromised:

"I think all doctors should be allowed to practice so that they give their best and the conditions that my colleagues were being asked to work in, did not allow them to practice at their best." (GP13)

### **From tick box culture to blame culture**

According to one participant who had worked as a GP for nine years, there was a distinct change in society towards what he described as a “blame culture” during his time in practice:

"In my short-ish career [...] It always felt more of a battle and that public perception, there was a change towards general practice, or just in society, it's slightly more of a blame culture [...] I certainly felt worn down by it, and I think the whole profession does really." (GP17)

Another participant who worked as a GP for three years, described how disillusioned she felt with this "culture to sue your doctor" and how it affected both her training experience and practice:

"At the beginning it was very much, you know, this is how you treat this, that and the other. And then towards the end it was all teaching was based on 'this is how you are treating this, okay make sure you don't get sued,' so it was all very much covering your back [...] If there was less of a culture to sue your doctor, [...] if there was less of a culture of, you know, 'I am going to sue you if you get it wrong,' then I think I could have put up with everything else." (GP20)

Participants recognised that the practice of medicine can never be risk free:

"There's no doubt in general practice you have the potential for either making a big mistake [...] or the potential for generating a complaint." (GP6)

However the working conditions which participants were describing, such as increased workload, time pressures and having to cut corners, left many feeling increasingly anxious about the potential for making a mistake:

"I found that I was increasingly anxious about the patients that I was seeing. I think because I was so often quite time strapped with all the things that I was trying to fit in during the day. But I felt conscious that I was worried that I ran the risk of missing things and that made me really worried and anxious." (GP3)

This led to increased anxieties about being sued:

"I knew that I was getting more and more stressed [with] the responsibility and [...] with the uncertainty [...] There is no black-and-white and you are living with the potential of making a mistake all the time, and the consequences of that became overwhelming [...] There's a constant fear of being complained about and being sued, about being charged and going to jail, that became a real issue for me, because I didn't trust any system to support me." (GP4)

"I think it was because I couldn't switch off from it, so I would see patients and I would be forced to not do the job properly and then I would worry about that because I just didn't feel comfortable with it. And I couldn't really get rid of those worries and I think those worries turned into anxiety [...] I'd just be worrying about work all the time and, you know, waiting for someone to sue me basically." (GP20)

The high-risk nature of their work, combined with this perceived shift in society towards more of a 'blame culture,' meant participants felt they needed to:

"practice quite defensively. You know cover your back, extremely good note keeping, visit if people are going to complain, because it's easier to visit them then deal with a complaint, that sort of thing." (GP5)

For many participants, feeling so isolated in practice only served to exacerbate their worries and concerns:

"It's quite frightening sometimes about how isolated you feel and that weight of responsibility." (GP17)

This was particularly so if their patients presented with more complex and diffuse conditions:

"There's always some people that you would worry about [...] or you know, had a diagnosis that was unexpected and you always worry, 'Is there something I could have done wrong?' and you can often feel quite isolated even though you're in a group practice, actually you just see patients on your own and you often see the same ones so you don't see anybody else." (GP1)

In several cases, the weight of such responsibility, combined with a feeling of isolation and escalating work pressures, impacted their confidence to practice:

"I think I'd started to lose my nerve a bit [...] I didn't want ever to be in a position where I could miss something for anyone." (GP21)

For one participant, such pressured working conditions led to the development of a severe anxiety disorder:

"Well, it was the beginning of the end of my general practice career, actually. I became very anxious and developed a significant anxiety disorder regarding work only. It was only focused on work, but I was kind of becoming obsessive, double-checking everything, taking 20 minutes to leave the practice, going to the car, going back in, checking again, ringing patients at home, doing home visits, going back. I was just checking and rechecking things over and over and over again." (GP4)

According to this participant, had she received more support, she felt things may not have escalated to the point where she had to take sick leave with a "work-related anxiety disorder" as she commented: "I think if I'd had a different support network around me, it might not have got that bad". (GP4)

#### d) Negative media portrayal

- Fear of "political spin"
- Portrayed as "overpaid and underworked"
- Undermining/demoralising/unsupportive

Rather than feeling supported in their efforts to meet patient demands, or being rewarded for their endeavours to cope with the pressures inherent in a high-risk working environment, participants instead felt increasingly worn down by negative media representations. Some GP's described this as a "political spin" to undermine their "hard work and professionalism":

"One of the frustrations is that I think there was definitely a political spin against general practice [...] It doesn't help when you've had a bad day at work and you come home and watch the ten o'clock news and you see somebody on the telly saying 'Oh these GPs aren't working very hard and patients can never get appointments' and things like that [...] Just constant criticism in the press about the fact that GPs were getting paid an awful lot of money and they weren't having to do the out-of-hours and they weren't working nights and weekends and all the rest of it." (GP6)

For many participants, being portrayed as "overpaid and under delivering" was tantamount to "media battering":

"The press that we get as a profession does not help at all, because it's really difficult to read those headlines and think but you're not doing this job and we're not paid that, and the conditions are poor and the training, people forget it takes years of sacrifice and commitment to get there. So the media battering doesn't help." (GP4)

Not only did participants feel misrepresented, but they were also frustrated that the more positive aspects of their hard work and professionalism went largely unreported:

"They [media] were absolutely ridiculous about doctors earning £600,000 a year and living in the Bahamas and employing other people to do the work and stuff. From that moment on really we were open season – it was open season for GPs, you could just say what you like and that was it; there was never anything positive, never any positive health stories related to the improvement in cardiac mortality, reductions in cancer deaths, earlier diagnosis – any of the positives that we'd achieved were just ignored." (GP9)

Becoming the subject of an on-going and negative media campaign felt both demoralising and stressful:

"I was very conscious of the negative image of general practice in the media and I found it quite stressful [...] Every day there was something in the paper about

overpaid GPs taking advantage, although that wasn't necessarily how I felt perceived by the patients that I saw, I didn't feel that perception on the ground so much, but I did find it quite frustrating to read that in the media a lot." (GP3)

The extent to which this negative media portrayal impacted the doctor-patient relationship varied across the sample, with some confident that it had no direct influence:

"I still believe we are valued by the general public, held in high esteem." (GP13)

While others felt it was beginning to undermine their relationship and rapport with patients:

"Patients taking a jab at you as if you were sort of public property really; if you took a holiday it was – as soon as you got back, there was no sort of remarks about glad you are back, it was always that people had been waiting for you and 'I suppose you've been off spending your millions' or – we were targeted in a completely unsympathetic light [...] without any recognition of what as a profession we gave to the public really and it did, over time, become very wearing, especially as it was just open season for anyone to talk about the sort of pay that we got and also the fact that the perception amongst the public was that we were pretty lousy at what we were doing and that we weren't working hard enough. Whereas the reality was that, certainly in my practice, people were working well over a 40 hour week and were highly committed to what they were doing." (GP9)

For several participants this negative media portrayal not only undermined their professionalism, but also helped to fuel a culture of complaint and a far more critical approach to medical help seeking:

"I think it's much more critical than it used to be, yeah, and maybe that feeds into the way patients sort of react to their doctors now a little bit perhaps. You know it becomes more of a fair game to sort of have a go and everyone's encouraged to complain all the time, aren't they?" (GP11)

Participants also expressed concern that the profession was being undermined through the media's propensity to raise public expectations:

"Increased patient expectations which has been driven, in my opinion it's been driven by press, media, government, rather than particularly patients." (GP5)

This happened to such an extent that some felt the profession was being 'de-professionalised':

"I think most of the time you just feel like you're more of a pizza delivery service than a doctor [...] There is no boundary anymore; there's absolutely no limit to what the expectation is and the expectation is outstripped by far what you're able to deliver, even as a human being, never mind as a doctor [...] The expectation is there, but you're never ever supported from above!" (GP19)

## e) Workplace issues and lack of support

### **Lack of support**

- Government - more expected of GPs with less financial resources and support in place
- NHS/other professional bodies - no “true advocacy” for GPs
- Colleagues - less time for informal support or "catch up"
- Need for a more “robust” occupational health service

### **Workplace issues**

- Partnership conflicts
- Bullying/unfair constructive dismissal
- NHS appraisals and revalidation

### **A call for culture change**

According to participants, in order to cope with the increasing demands and stresses inherent in their job role, not only were more support mechanisms needed at systems level, such as “a more robust occupational health service” for doctors (GP13), but they needed to feel that politically they were fully represented, valued and supported from “on high” (GP5). Instead participants reported struggling to identify any system or sector that could provide true advocacy for them, so that they could in turn provide advocacy for their patients:

“One always thinks that when people get to positions of authority like presidents or secretary of the RCGP or whatever, that you are fighting on behalf of your members. Sometimes it came across, but I think another reason why people got disillusioned, and didn’t feel represented, was because they were actually representing their own political career within the medical/political world and they weren’t there as advocates for the profession and I think this is where vocation has gone. We need to get more people back at the top with real vocation.” (GP13)

Not only were participants experiencing a lack of support at systems level and through the media, but their working conditions were further exacerbated by the lack of time left available to them for more informal support or "catch up" with colleagues.

While all participants were in agreement that they felt supported during their training and registrar year, once fully qualified they came to feel more isolated in practice:

“I did sometimes feel quite isolated at the practice [...] I think the thing that possibly my training hadn’t prepared me for was sort of feeling like a lone worker in many ways, particularly in comparison to working in a hospital where you were always part of a team.” (GP3)

“I think in medicine you can very easily get quite isolated.” (GP17)

The extent to which participants felt supported by their practice colleagues varied across the sample with some reporting:

"I had good support among my colleagues, [...] But I don't think good colleagues can overcome the whole system." (GP5)

While others experienced a distinct lack of support:

"I didn't really have much colleague support really [...] and I found that lack of support very draining." (GP11)

However it was in those instances where participants came to experience ill-health including stress, anxiety disorders and burnout (a third of our sample) that a lack of support was most keenly felt:

"I didn't actually think they were trying to help me get back to work. I felt they were actually trying to get rid of me, and I did speak to the BMA at the time about unfair dismissal, whatever the word is, but... they said you've got to prove and that's going to be very difficult. I really feel if you're that unwell at the moment, it's not something to pursue, so I didn't [...] I was quite vulnerable at that time, and it was a very unsupportive meeting." (GP4)

In another case, a participant tried reducing her working hours following her diagnosis, in order to accommodate her illness in the workplace:

"I think I would have stayed a bit longer. I mean I could even do some work now, if I did small sessions and things like that [...] But I couldn't reduce my hours and didn't get a lot of support from anything really. Occupational health weren't any use to me [...] there was no support, both psychologically or practically available, at least as far as I could find out." (GP2)

In several cases this perceived lack of support led to a loss of confidence as the following participant described:

"I lost my confidence. I lost my faith in the system. I lost my faith in my profession [...] I think once you've lost your confidence, then I don't think there's any structure within the profession that helps that come back, and I don't think the GMC are particularly supportive." (GP4)

In other instances, participants described conflicts within their practices over funding; career progression; flexible hours and workload distribution, as the following participants described:

"The thing I probably found most difficult was the partnership relationships and those sort of 'in-house' politics." (GP17)



"[Practice partners] trying to push me to have smaller percentage share and do more work. You know, trying to force me to do more things that I don't want to do. So I've always had to watch my back in that practice. I mean, dysfunction is its middle name in terms of the partners." (GP7)

Such conflicts led some participants to feel that:

"the move into this 'employer of other GPs model,' I think in the long run has been bad for the profession, it has been divisive amongst practitioners." (GP18)

"I don't think that doctors are terribly good employers particularly of other doctors. I don't think they treat them terribly well." (GP11)

Not all participants within the sample were in agreement on this matter, as some maintained the view that general practice should be returned to a vocation (GP13) - run by professionals for professionals - with an emphasis placed on fostering a more collegiate working environment (GP15; GP18). However where participants were in agreement, was that there remains an urgent need, post mid Staffordshire, for culture change within the NHS.

Several participants described a bullying culture that they felt had come to permeate the NHS from the top down, as one participant described witnessing:

"Managers [who] would be quite shell shocked after being shouted at by the people at NHS London who would be shell shocked after being shouted at by the people at the Department of Health, there is a really aggressive, vicious, bullying culture that permeates management in the National Health Service. That then flows all the way down to whoever your locality middle managers are. It's a dreadful, awful, bullying culture and to shift from that to a non-overseeing, facilitative, hands-off, trusting culture is, ... I don't know if people are capable of that cultural shift." (GP15)

## Annual NHS appraisals and getting revalidated – A Sword of Damocles?

“I absolutely firmly believe that it is a method of [...] political control over general practitioners and it is a weapon that is basically held, it’s like a Sword of Damocles, which is basically hanging there the whole time, and rather than being able to actually do your job, you are not only not able to do your job because you’re dictated to on how to do your job, you’re also told that unless you do your job in a certain way, ‘And by the way we’re going to be making sure that you do it in a certain way, by ensuring that you conform to X, Y and Z which is by the way going to make you a better doctor,’ of which they have no proof at all. Then you could in fact lose your job and lose your career.” (GP19)

Attitudes towards annual appraisals and revalidation were mixed across the sample. With some viewing it as a "fairly painless process:"

“I’ve just been revalidated actually and it’s a fairly painless process. I didn’t have a problem with it [...] I was quite happy to do all the stuff [...] I quite liked feeding it all into computers and all the rest of it, it sort of feeds into my obsessional streak I think. I didn’t mind that at all and I don’t have any strong objection to it. I don’t know that it does what it’s supposed to do. I don’t know if it’s particularly good at rooting out bad doctors, but on a personal level I didn’t mind doing it.” (GP11)

Others expressed their frustration that unless things were recorded it was assumed they were not doing their job correctly:

“The appraisal system drove me nuts [...] If you didn't record it correctly and you weren't seen to be doing the right thing, then it was assumed that you hadn't done the right thing!” (GP21)

In one case, the appraisal was viewed in more positive terms, as an opportunity to learn from and engage with a more senior colleague:

"I always felt quite positive about the whole appraisal process [...] My first appraisal was with a GP. He was just about to retire, he was fantastic. You feel quite isolated as a GP [...] especially when you first start, so it was hugely valuable going outside of my practice, talking to another GP who was very enthusiastic, and also just reflecting for a time." (GP17)

However the majority of participants viewed appraisals and the revalidation process more negatively, describing it as "a waste of time;" "costly;" "onerous;" and in one case even "threatening," as the following quotes reveal:

“I think it’s rubbish and it’s another reason why it made it easy for me to leave. The appraisal is a bit of a tick-box exercise, it doesn’t really achieve very much, and the idea of having to revalidate [...] I don’t want to have to keep proving that I am good at my job, just because a few people don’t do a very good job.” (GP4)

“it really was a waste of time and quite expensive, because I think it was an afternoon of locum pay for me and locum pay for the very nice colleague who I didn't know, who did my appraisal. And it was fairly unproductive really I don't think it really improved my practice.” (GP18)

“The straw that broke the camels’ back was revalidation and appraisal [...] I’d jumped through all the little hoops I had to jump through, but the appraisal system drives me crazy. I mean, there is no more ridiculous system. It could be such a wonderful support mechanism for doctors and instead it’s just this threat and this weapon and it’s just, it’s so unpleasant and such a shame.” (GP7)

By and large most participants felt that a vital opportunity was being missed through the appraisal process, to more fully participate in career progression through mutual support. Instead the majority of participants described feelings of “dread” and of having to prove their competency, all of which served to undermine their sense of professional competency and worth. By comparison one participant who relocated to Australia described an appraisal system whereby he felt “actively supported” to achieve his career aspirations and objectives:

“Whereas in Britain, rather than a facilitative relationship, it feels like a policing relationship.” (GP15)

## **'Boiling Frogs' - the changing role of the GP and its impact on job satisfaction**

"If you take a frog and you stick it in some very hot water it will jump out, it won't like it. If you take the same frog and you stick it in a pan full of water and you just very, very slowly warm it up, it will adapt to the change, to the point that [...] you can actually boil the water and [...] because it's so well used to adapting, it won't realise that it's actually dying!" (GP6)

All participants who took part in this study to share their experiences and perceptions of working in UK general practice were unanimous in their descriptions of a rapidly changing working environment: from one in which they initially enjoyed professional autonomy with the time to reflect and practice more patient-centred continuity of care, to an increasingly pressurised working environment where more was expected of GPs without the necessary resources or support mechanisms in place. One participant, who had worked in general practice for 14 years, described how his colleagues used to refer to this as "boiling frogs:"

"A lot of GP meetings that I used to go to they used to go on about 'boiling frogs' and they said they keep on increasing the workload on GPs who are adapting to the point where they all crack and then say 'That's it, I've had enough!' " (GP6)

Participants described a series of conditions that they felt contributed to this increasingly pressurised working environment. These included organisational changes; diminishing professional autonomy resulting in a clash of values as health-care became more centralised, standardised and effectively depersonalised; an unprecedented increase in workload; and a lack of support not only from government, but across services, among practice colleagues and the wider community due to an on-going negative media campaign. All of these factors came to impact participants' job satisfaction and overall wellbeing, leaving them vulnerable to ill health including feelings of demoralisation, stress and burnout:

"There was this kind of malaise growing within the profession that I could see as an appraiser. As GP's got more and more exhausted and burnt out, there was this 'I don't want to know,' there was this disassociation, there was this lack of will to fight to get what patients needed." (GP13)

"I just saw people, doctors, falling apart and just misery really, even though they were nice practices and this was not kind of dysfunctional practices with lots of dysfunction, they weren't unhappy practices [...] It was the misery, it was the misery, I think burnout, overwork, constant change with shifting sands all the time; everything always changing [...] And I think patients' dissatisfaction." (GP19)

## Job not meeting expectations

- More time pressure, stress and administrative tasks
- Continuity of patient care not as expected
- Less intellectual challenge
- Less opportunity for innovation and career progression
- More isolated, controlled and constrained
- Erosion of professional autonomy and values
- Current job unrecognisable from the professional role they took on

As participants came to encounter more administrative tasks amidst mounting time pressures, they began to feel the strain, as the following participants described:

“As a GP [...] you never felt like you had time [...] you're always firefighting all the time, and the capacity was being stretched and stretched without any increase in resource.” (GP17)

“I mean, I didn't enjoy constantly feeling under pressure. I felt under pressure all the time to be doing more and achieving more and hitting more targets and seeing more patients and, you know, balancing keeping patients happy with saving money. It was really stressful. I was stressed all the time.” (GP14)

Measures taken to cope included reducing their hours, going part-time or taking on more managerial roles, or other external roles and interests. However such measures could not offset the stresses of a rapidly changing working environment, as many reported that going part-time often led to increased stress with the pressures to keep up-to-date with organisational policy changes in the form of changing referral patterns, administrative procedures and medications:

"Names of drugs were changing, everything seemed to just be changing. As a part-time GP, it's very difficult to keep on top of that because things seemed to literally change from one week to the next." (GP4)

For many, going part-time represented a pay cut in order to achieve a degree of flexibility with no reduction in stress, responsibility and accountability:

"Working part-time was quite hard, and I think that's not an easy thing to manage at all on any level because you're not there half the week, but you're often expected to be by your patients, so their expectations were quite high." (GP4)

Constantly having to play "catch up" led many to reflect that part-time really meant full-time and full-time amounted to two jobs.

The feeling of having no control over their work-load, while having to cut corners at the expense of patient care, left participants vulnerable to feelings of demoralisation and diminishing job satisfaction:

“Worsening pressures, feeling like I was doing a bad job and therefore lacking job satisfaction [...] I didn't really want to feel like that, but I did sort of feel like I just wanted to get through each day and get home [...] So that's part of the reason that I left because I felt that it's not only doing me a disservice, but it's doing the patients a disservice, because I didn't feel I was really getting involved in the way that I wanted to. I just felt like I wanted to get through the day and get home.” (GP3)

“It was just lack of job satisfaction; I just didn't feel – I was getting no satisfaction out of the job at all [...] I didn't think that we were – that I was offering a particularly good service; I think I got fed up with it all really.” (GP6)

For others it was an inability to follow through with their patients and to thereby exercise their intellectual capabilities in order to reach a resolution, which came to impact on their job satisfaction as the following participants described:

“You were lucky if you saw a patient more than once. I think it made it much less satisfying, because you didn't often get to see the patients working through their illness and you know, the resolution [...] In general practice now, you have to have [...] appointments that are 24-hour access and 48-hour access, so they [patients] can't book in advance, and then 24 hours before their appointment they try and book you and they can't because you're full. So you don't get that follow-up and that continuity of care.” (GP14)

“I just felt it wasn't fulfilling what I wanted. I wasn't having that continuity and enjoyable relationship with patients that I'd really wanted to get from general practice and the negatives just started to outweigh the positives I think.” (GP3)

In several cases, participants reported that their role, as general practitioner, was beginning to offer less of an intellectual challenge:

“I also started to feel that the challenge had gone out of it really, the intellectual challenge, the stress and strains and all of that were still there, but the intellectual challenge had gone and I wanted to do something that would stretch me a little more.” (GP12)

Indeed several participants described feeling more "controlled and constrained" (GP9; GP11; GP13; GP15) in their working practice, as policy initiatives sought to standardise patient care in the name of quality care:

“I suppose part of the problem is that the definition of quality is very often defined in terms of the reductions in variability, but the opportunities to innovate and to do

things differently also come down to variability and those were being very quietly pushed out of the system, so that you couldn't try anything new." (GP9)

A participant who described feeling no job satisfaction as a general practitioner, was asked what constituted job satisfaction for her. She commented:

"I think getting to the end of the day and feeling you have made a positive difference in somebody's life." (GP20)

While another participant described job satisfaction as the following:

"So clinically it is having a high degree of clinical autonomy, continuity of care and working in an organised network of practice. So it is not feeling isolated and on my own in a practice but feeling that I am well supported in a practice and that the practice is part of a broader robust network of primary care. So working in an area of organised primary care that has got strong representation within the health system and beyond, that has become quite important to me." (GP18)

Rather than being able to exercise their clinical autonomy and judgement within a supportive and collegiate "network of practice" (GP18), participants were describing a "reduction in job satisfaction and being treated like an automaton and feeling helpless to do anything about it" (GP13), with potentially adverse consequences for patient care:

"In the latter years [...] I found that the emphasis had changed. I found that initially you could use your judgement, you were able to be a real patient advocate and certainly in the last year [...], I did feel, you know, you just, your voice didn't count so much and you had to shout louder and harder to get things for patients and the role of the advocate was going really." (GP13)

In some cases, the conditions were such that participants came "to hate" their job:

"I think I got to the point where I hated it and, that's a really strong word. But I absolutely hated it and I used to wake up on a Friday morning feeling sick at the thought of going in at 12 o'clock and as I say I'd get there and I'd sit in the car park and think, 'Oh God, I don't want to get out,' you know? And it was a huge decision to give up because ... you know, actually to phone up and say, 'Take me off the Performers List.' I just thought, you know, I'd done all this training and then I'd gone back and, you know, retrained a little bit and it was a huge, huge decision, but I was so relieved when I actually did it and put the phone down and thought, 'That's it, gone, I'm not doing any more GP work ever again'." (GP11)

In other cases, it was not so much the job, but "everything around the job" which they came to "hate" as another participant described:

“Passionately adoring my work and my patients, I mean, really I can’t tell you how much I miss them. Absolutely loved the actual job, but everything around the job I hated.” (GP7)

For some participants, diminishing job satisfaction led them to self-diagnose the early symptoms of burnout:

“I don’t think I was medically ill, but I was certainly quite grumpy and I was quite fed up and I just wasn’t enjoying work and I got to the stage when I was driving to work and I used to have this sort of sense of dread the nearer I got to the practice and I thought ‘Oh no, another day is coming’. I thought this isn’t right, I shouldn’t be feeling like this! So I’ve done a bit of occupational medicine and I sort of tried to stand back from it all and think well what would I advise if somebody came to me and said ‘this is what my job is making me feel like, what would I do?’ And I thought well I would probably say ‘go and talk to your managers and see what you can do and what you can change.’ I thought, well, there is no point, because we all felt the same in the practice and I just got the feeling that the higher up organisations there’s, for whatever political reasons, they weren’t interested either, so I thought I don’t think there is any way that I can change general practice per se.” (GP6)

And to act upon these early warning signs:

“Before getting to the point where I really thought I was going to burnout and really hit a very low point mentally and psychologically, I thought actually, I think I recognised those warning signs and I thought it better to go do something different at this point whilst I still have the wherewithal to go and do it.” (GP12)

According to another participant who had worked in UK general practice for 17 years, his main reason for relocating abroad was due to what he described as the erosion of his professional role, autonomy and values:

“the professional autonomy because the actual role, the holistic, professional role of a general practitioner in Britain, the erosion of that role over the last couple of decades, I mean [...] I found myself becoming less holistically satisfied with the life and role of a GP in Britain [...] I’ve been very disappointed by the way I’ve seen the role of a GP change and the professionals’ leaders have been complicit in that [...] things really aren’t what they used to be and the job that I went into, it’s not that job anymore. Actually it’s not that more things are being asked of you, because actually that’s the interesting bit, it’s that less is permitted of you.” (GP15)

For several participants, the model of general practice that they came to leave was:

“no longer interesting or stimulating [...] the opportunities to change and the flexibility in healthcare had really gone”. (GP9)



As another participant reflected:

"You're not a professional in the UK anymore, that's gone." (GP19)

## Summary of interviewees' recommendations

Factors identified by interviewees that could help improve GP recruitment and retention:

- more supportive system in place
- more control over workload
- more interface and dialogue between secondary care and primary care
- more flexible hours
- more time with patients
- more clinical and professional autonomy
- less bureaucracy and contractual targets
- more supportive collegiate environment
- more opportunities for career progression
- to be appreciated and valued as a professional - within system and through a more positive media campaign
- returning the profession to a vocation
- professional yet informal support network
- a return to patient advocacy
- the confidence and the ability to question colleagues
- more robust occupational health service for GP's
- a culture change: away from "an aggressive, vicious, bullying culture towards a non-overseeing, facilitative, hands off, trusting culture" (GP15)
- Returner (I & R) scheme: more consideration of individual circumstances such as returning from having worked as GP abroad

## 8. Summary

This study has revealed a very different picture from that portrayed by the media, one in which GPs are overworked, taking pay cuts either to support partnership practices, or through going part-time to cope. Participants described a series of conditions that they felt contributed to this increasingly pressurised working environment. These included organisational changes; diminishing professional autonomy resulting in a clash of values as health-care became more centralised, standardised and depersonalised; an increase in workload, with more work shifting from hospitals to primary care; and a perceived lack of support from government, across health-care services, and the media.

The working conditions in general practice have been further exacerbated by a changing patient population where the demographics have shifted to an ageing population, more chronic disease management and mental health care needs, as well as more complex care needs generated by a recent influx of asylum seekers and refugees in key geographical areas. According to participants, many of these patients are difficult to care for within the funded criteria of 8 to 10 min consultations, leading them to have to "cut corners" within a system which prioritises "numbers through door" rather than the ability to provide "holistic patient-centred care." (GP7)

Diminishing job satisfaction combined with work pressures, are leaving GPs vulnerable to demoralisation, stress, burnout, anxiety disorders and other illnesses, resulting in their decision to take early retirement on medical grounds, or to relocate abroad, or to change career direction entirely.

## 9. Conclusion

This qualitative study investigating why GPs leave practice early in their careers and the possible barriers to their return, shows reasons that are both cumulative and multifactorial (appendix 3). There is a growing feeling among GPs that the very essence of their professional role has been so altered over the years, that it is no longer recognisable from the role which they initially signed up to. Previously, GPs occupied a central role as both diagnostician and expert generalists who could take a more global view of the whole patient and thus enjoy professional autonomy as gatekeepers to more specialist knowledge and care. This has reportedly been compromised by a number of factors including: technological advancements, a more complex and growing population placing increasing demands on primary care, all against the backdrop of a succession of new policy initiatives leading to changing priorities and escalating work pressures. Each of these can be seen to impact on GPs job satisfaction as they report having to "cut corners" rendering them unable to offer a service which reflects their true capabilities, intellect and commitment to patient care.

Where once patient continuity of care with time to reflect constituted the hallmark of general practice, participants reported that this is being replaced by an insidious encroachment of micromanagement. This has left many feeling that they have been reduced to a "government clerk" or "service provision role," being incentivised to meet contractual targets in the name of quality patient-centred care, but possibly at the expense of it. The GPs ability to act as patient advocate is considered to be under threat, as they report feeling a lack of support at systems level. The conditions are such that GPs have become increasingly vulnerable to demoralisation, stress, burnout and bullying in the workplace. This, combined with a lack of support from the media; feeling isolated in practice; as well as the need for a more supportive and collegiate working environment, has resulted in greater numbers of GPs either choosing to relocate abroad, or, as we are currently witnessing, to retire early from UK general practice on health grounds, for family reasons, or to pursue another career option entirely.

## **10. Appendices**

## Appendix 1 Information sheets and consent form

### Severn School of Primary Care

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[n.doran@bath.ac.uk](mailto:n.doran@bath.ac.uk)

### Invitation to take part in a research study

Dear Doctor,

NHS data suggest that 50% of the GPs that left general practice in England in the past ten years were under the age of 50. Researchers at the University of Bath and Severn School of Primary Care are exploring why this is, and the barriers that prevent those GPs returning.

To help with this, we would like to do some telephone interviews with GPs who have left English general practice. You kindly indicated on our on-line survey that we could contact you with more information.

A telephone interview would last about 45 minutes and would be at a time of your choosing.

We would like to explore the answers to your survey questions in more detail:

- why you left English general practice;
- what your experiences were of working in general practice;
- why you do/don't intend to return to being a GP in England;
- what barriers, if any, there are to your returning to general practice;
- what you think the NHS should learn from this, and what changes it should make to keep GPs in practice.

If you would like to take part, please complete the attached consent form and send it (either by email or by post) to the address given on the consent form.

If you do decide to take part, the interview and any correspondence will be with the social science researcher. Your data will be anonymised and will remain confidential. No identifiable information will be given to NHS England, the RCGP, the Severn School of Primary Care, the Health Education Executive or medical colleagues.

If you would like more information before deciding whether or not to take part in the telephone interview, please contact:

Dr Natasha J. Doran

Tel: +44(0)7905 105511

Email: [n.doran@bath.ac.uk](mailto:n.doran@bath.ac.uk)

Best wishes,

Dr Natasha Doran, University of Bath      Dr Michael Harris, Severn School of Primary Care

## **A qualitative study exploring why GPs leave practice early and what are the possible barriers, if any, to their return.**

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully. If there is anything that is not clear, or if you would like more information, please contact us. Take time to decide whether or not you wish to take part.

### **What is the purpose of the study?**

This study aims to explore the factors causing GPs to leave practice early and the barriers to their return. The research team anticipates that the results will help to inform policy and practice regarding retaining GPs in practice and supporting their return after a career break.

### **Why have I been approached?**

You have been approached as a search of the medical performers list indicates that you have not been active in General Practice for at least 2 years.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to take part in a telephone interview. If you decide to take part you are still free to withdraw at any time without giving a reason.

### **What will happen to me if I take part?**

Your involvement in the study will be a telephone interview with an experienced researcher that we estimate will take up to 45 minutes of your time. You will be asked about your current occupational status, your reasons for having left GP practice and the barriers to your return to practice. The interview will be recorded and transcribed, although all identifying information will be removed to ensure anonymity.

### **What are the possible benefits of taking part?**

While there is unlikely to be any direct benefit to taking part in this research, some individuals value being able to explore their experiences in a confidential setting. However, we do hope that the results of this research will help to inform policy and practice regarding retaining GPs in practice and supporting their return after a career break.

### **What if I wish to make a complaint?**

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study then Dr Michael Harris would be very happy to discuss this with you. In the event that this does not resolve your complaint then Anthony Curtis, Associate Postgraduate Dean for Research and Evaluation, Severn Deanery is available to take the matter further. Their contact details are provided at the end of this document.

### **Will my taking part in this study be kept confidential?**

Your interview data will be anonymous, will be securely stored and it will remain confidential. No identifiable information will be given to the Severn School of Primary Care, NHS England, the



RCGP, the Health Education Executive or to medical colleagues. The only reason we might have to consider passing on confidential information without your permission would be to protect you or someone else from serious harm, for example if serious malpractice was disclosed. In the unlikely event of this happening, we would contact you to discuss this first.

### **What will happen to the results of the research study?**

After all interviews are completed and transcribed they will be analysed for common themes. The findings will be published in peer-reviewed journals, a written report and presentations. You can request to be sent an outline of the results.

### **Who is organising and funding the research?**

The study is being organised by a group of researchers from the Severn School of Primary Care and The University of Bath. The research is funded by the Health Education Executive and NHS England

### **Who has reviewed the study?**

The study was reviewed for scientific integrity by the Severn School of Primary Care and for ethical integrity by the Research Ethics Advisory Committee for Health at The University of Bath.

### **Contact for further information**

If you require any further information about the project or have any questions that you would like answered please contact either Dr Natasha Doran or Dr Michael Harris:

Dr Natasha J. Doran  
Tel: +44 (0) 7905 105511  
Email: n.doran@bath.ac.uk

Dr Michael Harris  
Tel: +44 (0) 1761 241366  
Email: michaelharris681@btinternet.com

In the event that you wish to make a complaint please contact Anthony Curtis,

Anthony Curtis, Associate Postgraduate Dean for Research and Evaluation, Severn Deanery  
Tel: 01454 252667  
Email: Anthony.Curtis@southwest.hee.nhs.uk

**Severn School of Primary Care**  
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## CONSENT FORM

**Title of project:** A qualitative study exploring why GPs leave practice early and what are the possible barriers, if any, to their return.

**Name of researchers:** Dr Michael Harris, Dr Natasha Doran, Dr Fiona Fox, Dr Gordon Taylor, Dr Karen Rodham.

	Tick in this column or type "yes"
I have read and understand the information document for this study and have had the opportunity to ask questions.	
I understand that the interview will be recorded and that This information will subsequently be transcribed.	
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
I would like to have the opportunity to review and agree the transcribed interview before it is used in the research. (If "yes", please return the approved transcript within 1 week of receiving it.)	Yes/No

I agree to take part in the above qualitative study:

Signature.....

If returning this form electronically, please **either** add a digital signature **or** type your name:

Name ..... Date.....

**Please send this form either by email to [n.doran@bath.ac.uk](mailto:n.doran@bath.ac.uk)**

**Or by post to:**

F. Fox, 1 West 5, Department for Health, University of Bath, Claverton Down,  
 Bath, BA2 7AY

*Name of researcher taking consent:* Dr Natasha Doran.

*Signature*                      *Date* .....

## Appendix 2 Interview schedule

### GP Leavers Project

#### Semi-Structured Interview Schedule

Open ended Question	Prompts (use if not covered by initial response)
<b>General demographics and background info</b>	
Age Gender Where did you graduate as a doctor? In which year did you graduate? How many years did you work as a GP in England? At what age did you leave general practice? What work are you currently engaged in?	United Kingdom, another country in the EU, outside the EU
<b>Perception of general practice</b>	Prompt
Why did you decide to become a GP? How do you feel that your GP training prepared you for the reality of life as a GP? Can you tell me about your experience working in general practice? Did working in general practice meet or fall short of your expectations? What changes to your role as a GP and/or organisational changes in general practice did you witness? What could have been improved?	In what way? Personal life, life in a GP practice, patients, the NHS in general, politicians, media, What impact did these changes have on your day-to-day life what was your perception of these changes? What changes would you have liked to have seen?

<p><b>Reflecting on past experience as a general practitioner</b></p> <p>Reflecting back on your time working in general practice. How did you find the work?</p> <p>What do you feel could have been done to improve your work life balance?</p> <p>How was your health during those years?</p>	<p>Prompt</p> <p>Stressful/manageable</p>
<p><b>Reasons for leaving general practice</b></p>	<p>Prompt</p>
<p>Can you tell me why you came to leave general practice?</p> <p>Was there anything about the working environment or demands of the job that caused you to leave?</p> <p>Were there any family reasons for leaving general practice?</p> <p>What changes would you have liked to have seen that may have influenced your decision to leave?</p> <p>Is there anything that would have stopped you leaving work as a GP [in England]?</p> <p>At the time that you left, did you intend to return to practice?</p>	<p>What were the circumstances surrounding your leaving?</p> <p>(Workload/colleagues/finances/complaints/patients)</p>
<p><b>Current circumstances/lifestyle /employment</b></p> <p>What did you do after you left GP?</p> <p>Can you tell me about your current circumstances:</p> <p>What are you doing now?</p> <p>How do you find your current work /life balance?</p> <p>How does it compare to when you were a GP [in England]?</p>	<p>Did you change to a different specialty or non-medical employment?</p>
<p><b>Returning to practice</b></p> <p>Have you considered returning to general practice [in England]?</p> <p>What stops you returning to being a GP?</p> <p>What changes, if any, would help you to start work as a GP [in England] again?</p>	<p>What would have to change for you to consider starting work as a GP [in England] again?</p> <p>Prompts: personal life, life in a GP practice, patients, the NHS in general, politicians/media</p>

How do you feel about the annual NHS appraisals and getting revalidated?	How confident do you feel about returning to practice?
<b>The Induction and Refresher (I&amp;R) scheme</b>	Prompt
How familiar are you with the processes of getting back into practice?  Is there anything about the I&R scheme that could be changed to make it more attractive to you?	In terms of the entry requirements, assessments, refresher work?  How do you feel about this process?
<b>Final questions</b>	
Finally could you state most important reasons for:  a) Leaving GP practice and  b) Not returning  Is there anything else that you'd like to share about your experience working in general practice?	

## Appendix 3 Reasons for leaving general practice

GP	Reasons for leaving	Barriers returning to practice
GP1	<ul style="list-style-type: none"> <li>• Lack of support from partners</li> <li>• Long hours/long days</li> <li>• “Tick box culture” – challenges balancing bureaucracy with quality patient care</li> <li>• Risk averse</li> <li>• Stress</li> </ul>	<p><b>What changes may have influenced decision to leave</b></p> <ul style="list-style-type: none"> <li>• More flexible hours</li> <li>• More supportive system in place</li> <li>• If her more managerial type work had been acknowledged and supported</li> <li>• If her practice partners had been "prepared to look at different ways of working to try and relieve that pressure because everybody felt it. It wasn't just me"</li> </ul> <p><b>Barriers to returning to practice:</b></p> <ul style="list-style-type: none"> <li>• Patient safety/risk averse</li> </ul>
GP2	<ul style="list-style-type: none"> <li>• Ill health (retired early on medical grounds)</li> </ul> <p>Though she would not have retired early had it not been for her health, she listed a series of factors that contributed to her leaving:</p> <ul style="list-style-type: none"> <li>• Stress (migraine/headaches)</li> <li>• Paperwork and administration</li> <li>• Working longer hours</li> <li>• Patient expectations</li> </ul>	<ul style="list-style-type: none"> <li>• Would have stayed longer if her job had accommodated her illness.</li> </ul> <p>"I was getting a bit disillusioned before then [illness onset] really, but it was just general moans and groans of work really"... "I enjoyed my job basically and I was sorry to leave it, but I hadn't got any choice"</p>
GP3	<ul style="list-style-type: none"> <li>• Worsening pressures</li> <li>• Feeling like she was doing a bad job</li> <li>• Lack of job satisfaction</li> <li>• Inability to see this was ever likely to change.</li> <li>• Feeling isolated</li> </ul>	<p>Not considering returning to practice but conditions that may affect decision making:</p> <ul style="list-style-type: none"> <li>• More contact with colleagues/professional yet informal support network</li> <li>• More continuity of care</li> <li>• Organisational changes at systems level</li> <li>• Quality patient-centered care</li> </ul>
GP4	<ul style="list-style-type: none"> <li>• Developed a work related anxiety disorder/panic attacks</li> <li>• Lack of support (from practice partners and systems level)</li> <li>• Feeling isolated</li> <li>• Bullying</li> <li>• Disillusioned with the profession</li> <li>• Always wanted to be a doctor since childhood but came to realise “I don't think it suited my personality very well.” Problems regarding responsibility and uncertainty inherent in medical practice.</li> <li>• Risk averse/prescribing</li> </ul>	<ul style="list-style-type: none"> <li>• No support to stay or to return to practice (offered 8 week phased return with no practical or financial support to enable this)</li> <li>• Bullying/constructive dismissal felt too ill and vulnerable to fight this</li> <li>• It became apparent that illness was long-term. “It became very clear that it wasn't going to go away very quickly, I couldn't even have the BMJ in the house [...] because if I saw it, it would bring on a panic attack. It was quite severe but it was only regarding work"</li> </ul>

	<ul style="list-style-type: none"> <li>• Patient expectations</li> <li>• Tick box culture</li> <li>• Revalidation process</li> <li>• Negative medial portrayal/media battering</li> <li>• Working longer hours/more pressure</li> <li>• Patient complaints</li> </ul>	<ul style="list-style-type: none"> <li>• Now works as tribunal doctor for the Ministry of Justice. She finds this ideal, as it is a clinical role that requires no clinical responsibility.</li> </ul>
GP5	<p>Reasons for leaving UK general practice:</p> <ul style="list-style-type: none"> <li>• Feeling undervalued</li> <li>• Increased patient expectations</li> <li>• Increased work load (more secondary care moving into general practice without funding streams following it)</li> <li>• Financial stresses</li> <li>• Stress with the job</li> <li>• Negative media portrayal</li> <li>• “Having to practice quite defensively”</li> <li>• General practice changed too much</li> <li>• Lack of support (from government)</li> <li>• Longer hours/lack of flexibility</li> <li>• Taking work home</li> <li>• Work/life balance “too much for too little”</li> </ul>	<p>Now works as a GP three days a week in Australia.</p> <ul style="list-style-type: none"> <li>• Initially intended to return to UK general practice after four years but having been there six months she now has no intention returning.</li> <li>• Sees entry requirements and assessments as “potentially quite onerous”</li> <li>• Quality of life/work life balance</li> <li>• She wishes that the entry requirements could differentiate between those who were returning having worked abroad compared to those returning after a career break.</li> </ul>
GP6	<ul style="list-style-type: none"> <li>• Lack of job satisfaction</li> <li>• Cutting corners</li> <li>• No longer offering a good service</li> <li>• Workload/Busier/More pressure</li> <li>• Concerns for the next generation of GP’s/Impending crisis in recruitment</li> <li>• Organisational changes/funding problems</li> <li>• Bureaucracy</li> <li>• Partnership stresses</li> <li>• Negative media portrayal/political spin</li> <li>• No continuity of care</li> <li>• Pre-emptive signs of burnout</li> </ul>	<p>GP6 left general practice twice. In 2001 he left and returned in 2006 once the following changes came in:</p> <ul style="list-style-type: none"> <li>• positive changes to General Practice (i.e. new contract, out of hours change, salary increase)</li> </ul> <p>When he left for a second time, he had no intention of returning and took his name off the Performers list</p> <ul style="list-style-type: none"> <li>• Changes needed perceived to be too vast.</li> <li>• Feeling powerless</li> </ul> <p>“I don’t think the job will have changed and I can’t see that – I know quite a lot of my friends are GPs and I don’t think I know any happy GPs at the moment.”</p>
GP7	<ul style="list-style-type: none"> <li>• Partnership stresses/ conflicts/sexism/racism</li> <li>• Feeling isolated (lone female worker among 3 male practice partners)</li> <li>• Funding issues</li> <li>• Job satisfaction</li> </ul>	<p><b>What changes may have influenced decision to leave</b></p> <ul style="list-style-type: none"> <li>• Having another female colleague</li> <li>• Having another part time colleague</li> </ul>

	<ul style="list-style-type: none"> <li>• Workload</li> <li>• Lack of support</li> <li>• Organisational changes</li> <li>• Bureaucracy and paperwork</li> <li>• Tick box culture (value “based upon numbers through door” rather than “holistic patient care”)</li> <li>• Not appreciated by partners/government</li> <li>• Work stress “I'd get to breaking point”</li> <li>• Revalidation and appraisal</li> </ul>	<ul style="list-style-type: none"> <li>• Better working relationship and communication between practice partners</li> <li>• Feeling appreciated and supported for the loan work she did helping a complex patient population</li> <li>• Shorter working hours/more flexibility</li> </ul> <p><b>Returning to Practice</b></p> <p>She may return to practice once her children are older (in two years time): “Financially our finances would certainly be better if I could earn [...] I'm going to need retraining that doesn't feel judgemental and make me feel stupid [...] You'd have to swallow your pride to go through any kind of retraining process”</p> <ul style="list-style-type: none"> <li>• Finding a job [GP practice] where she could feel respected</li> </ul>
GP8	<ul style="list-style-type: none"> <li>• Ill-health</li> </ul> <p>“I was forced to come off the performers list”</p> <p>“It wasn't ever an active decision to leave... I'm now in a situation where I have had to leave because of the illness”</p> <ul style="list-style-type: none"> <li>• Stress of the job</li> </ul> <p>“There was a stress related element to the [illness]... I did find general practice stressful”</p> <ul style="list-style-type: none"> <li>• Work life balance</li> <li>• Patient demand/workload</li> <li>• Time pressure</li> <li>• Taking work home</li> <li>• Bureaucracy “ever expanding paperwork”</li> </ul>	<ul style="list-style-type: none"> <li>• Induction and refresher scheme: “I didn't realise the criteria was so strict and that after two years I would have to come off [relinquish license to practice]”... “so many hoops to jump through. For me it is just not practical at the moment to do that, financially or time wise”</li> <li>• Managing long-term health problem</li> <li>• Perception that “things have really got worse in general practice, the working environment”... “Lack of attractiveness of the career at the moment”</li> <li>• Negative media portrayal</li> <li>• Currently enjoys far better work/life balance</li> </ul> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• Properly fund refresher course with less hoops to jump through</li> <li>• Changes at systems level to better meet patient demand</li> </ul>
GP9	<ul style="list-style-type: none"> <li>• Changes to GP role “managing short term complaints rather than long term conditions”</li> <li>• QOF target driven agenda</li> <li>• “The attitude of newer appointed GPs...they hadn't got the historical perspective on how general practice had been and the sort of long term patient to grave commitment to the individuals that we gave”</li> </ul>	<ul style="list-style-type: none"> <li>• Meeting minimum requirements to maintain licence to practice was not possible with other work commitments</li> <li>• Very happy in new job role - more opportunity for “personal development and longer term job satisfaction”</li> <li>• Prefers working at a more strategic systems level to implement change</li> </ul>



	<ul style="list-style-type: none"> <li>• Bullying</li> <li>• Burnout</li> <li>• Partnership stresses</li> <li>• No flexibility</li> <li>• Time pressure/No time for reflection – pivotal to GP role as diagnostician</li> <li>• Better job opportunity came up</li> </ul>	<ul style="list-style-type: none"> <li>• Current model of general practice "no longer interested or stimulated me in the way that it had previously, the opportunities to change and the flexibility in healthcare had really gone... everything was constrained and controlled"</li> </ul>
GP10	<ul style="list-style-type: none"> <li>• Family work/life balance</li> <li>• Job satisfaction</li> <li>• Extended hours/workload</li> <li>• Changes to practice agreement</li> </ul>	<ul style="list-style-type: none"> <li>• Enjoying new job in medical education</li> <li>• Returner scheme</li> <li>• Changes to GP role/"busier and moral is lower"</li> <li>• Feeling rusty</li> </ul>
GP11	<ul style="list-style-type: none"> <li>• Workload</li> <li>• Came to "hate" the job</li> <li>• Patient demands</li> <li>• Patient expectations</li> <li>• Complaints</li> <li>• Lack of support from colleagues</li> <li>• Feeling isolated</li> <li>• Lack of resources/finances to meet patient demand</li> <li>• Feeling "helpless" and "powerless" in face of complex social problems/change in patient population</li> </ul>	<ul style="list-style-type: none"> <li>• Workload</li> <li>• Retraining (returner scheme)</li> <li>• Patient demand</li> <li>• current nature of the job</li> </ul>
GP12	<ul style="list-style-type: none"> <li>• Political and managerial interference and its impact on professional autonomy and job satisfaction</li> <li>• Felt "intellectual challenge" had gone out of job</li> <li>• Target culture and impact on doctor-patient consultation</li> <li>• Appraisals and revalidation</li> <li>• Recognised early symptoms of burnout and decided to make career changes pre-emptively</li> </ul>	<ul style="list-style-type: none"> <li>• Now enjoys professional autonomy in new job and feels loss of professional autonomy is the main barrier to returning to general practice</li> <li>• Political and organisational changes</li> </ul>
GP13	<ul style="list-style-type: none"> <li>• Acute illness onset</li> <li>• Workload</li> <li>• "Reduction in job satisfaction and being treated like an automaton and feeling helpless to do anything about it"</li> <li>• Remuneration "I always think pay peanuts, get monkeys, and if you are not rewarded for what you do, then again it devalues the position that you hold"</li> <li>• Political changes "this washing machine affair of being in constant change, goalposts moving every</li> </ul>	<p>Unable to return to practice due to health issues. However if she had been in good health, the following applied:</p> <p><b>What changes may have influenced decision to leave</b></p> <ul style="list-style-type: none"> <li>• returning the profession to a vocation: "to me my definition of my vocation was to look after the patient's to the best of my ability and to give them what they needed"</li> </ul>

	<p>year... this feeling of helplessness, this feeling of "we are powerless"</p> <ul style="list-style-type: none"> <li>• Not feeling valued</li> <li>• Isolation</li> <li>• A general "malaise" growing within the profession: "I saw the way the wind was blowing, I saw the juggernaut coming, I saw the devaluation of the NHS from the political classes, I saw the devaluation of the profession from the political parties and when we have political masters who take no notice essentially of mid Staffordshire and the crimes essentially against humanity that were undertaken in that hospital. When they are that blasé, what are they going to do to general practice?"</li> <li>• Changes to the appraisal system: "Appraises were not liking it at all. It went from being formative to far more summative"</li> <li>• Tick box culture</li> <li>• Negative media portrayal</li> </ul>	<ul style="list-style-type: none"> <li>• "total embargo on secondary care to primary care shift of workload"</li> <li>• "a recognition of the real job that truly great GPs do. The complexity of it, the responsibility of it"</li> <li>• "a positive media campaign saying let's say thanks to these guys instead of whipping them "</li> <li>• a "return to patient advocacy"</li> <li>• "abolition of referral management centres"</li> <li>• "out of hours taken back by GP collectives and cooperatives"</li> <li>• "much more interface and dialogue between primary care and secondary care"</li> <li>• "the confidence and the ability to question colleagues"</li> <li>• "more robust occupational health service for GPs"</li> <li>• "more support"</li> </ul> <p>Recommendations</p> <ul style="list-style-type: none"> <li>• "we cost hundreds of thousands to train, we are haemorrhaging in droves, there are a lot of women out there working part-time so again a lack of continuity of care"</li> <li>• listen to why GPs are leaving</li> <li>• asked them how things can be made better</li> <li>• enable those who have left to get back into practice through a process which is non-judgemental, facilitative and supportive so as to instil competency and confidence.</li> <li>• Those who have had to leave due to ill-health could be offered a more academic role which can draw upon "a lifetime of experience" (See GP2)... "at the end of the day one's brain is still working"</li> </ul> <p><b>Barrier to returning to practice</b></p> <ul style="list-style-type: none"> <li>• health</li> <li>• fear of having deskilled - impact on her confidence and patient safety due to fear of making mistakes</li> </ul>
GP14	<ul style="list-style-type: none"> <li>• Job became increasingly stressful/pressure/workload</li> <li>• No longer enjoyed work, came to "hate" job</li> <li>• No work/life balance</li> </ul>	<ul style="list-style-type: none"> <li>• Current job very interesting and very rewarding, more job satisfaction</li> <li>• Future for general practice looks bleak</li> <li>• Increasing patient demands</li> </ul>

	<ul style="list-style-type: none"> <li>• Encountered restrictions on career progression due to being part-time</li> <li>• Felt isolated</li> <li>• No time, impact on job satisfaction, felt couldn't really "make a difference"</li> </ul>	<ul style="list-style-type: none"> <li>• Not valued or appreciated</li> <li>• Workload and targets</li> <li>• Paperwork/administration</li> </ul>
GP15	<ul style="list-style-type: none"> <li>• Government changes to public pension</li> <li>• Income (could no longer afford to practice in central London)</li> <li>• Loss of professional autonomy "the endless micromanagement of general practice"</li> <li>• Changes to job role "less empowered;" "less professionally responsible", "profound erosion in the basis of trust in the relationship between doctors and patients" no longer a "confidential relationship"</li> <li>• No time to practice good quality medicine to be the patient advocate and practice holistic care</li> <li>• "I was feeling undervalued by the NHS and the government"</li> <li>• Disillusioned used to believe in the "core values of the National Health Service"</li> <li>• Professional role reduced to "data clerk for public health and for management" ... "demoralising and frustrating" reduced to "QOF monkeys"</li> </ul>	<ul style="list-style-type: none"> <li>• Current post in Australia offers more professional autonomy, more career progression, more supportive and collegiate working environment, more money and work life balance</li> <li>• Feels there is an "aggressive, vicious, bullying culture that permeates management in the National Health Service" and doubts whether a shift can be made "to a non-overseeing, facilitative, hands off, trusting culture"</li> <li>• Views entry requirements, assessments and refresher work as "a ridiculous joke considering the level that I'm working at here ... It's kind of insulting"</li> <li>• feels "badly let down by the profession as a whole" ... "I've seen the role of a GP change and the professions leaders have been complicit in that"</li> </ul>
GP16	<ul style="list-style-type: none"> <li>• Family reasons relocated to Canada stayed longer than intended and felt "devastated to hand in my resignation" and regrets that she had to relinquish her licence.</li> </ul>	<ul style="list-style-type: none"> <li>• Intends to return to UK General practice</li> <li>• Now family reasons are the main reason for returning to the UK</li> <li>• Wishes there were "less hoops to jump through. " Regrets having to relinquish her licence. Feels the fact she has recently taken very similar exams in the last 12 months in Canada, could be taken into consideration and thinks that those on a returner scheme could be considered on an individual basis</li> </ul>
GP17	<ul style="list-style-type: none"> <li>• Did not intend to leave general practice but left primarily because another "unique opportunity" came up: "I've ended up doing something else, but it wasn't because I wanted to leave general practice"</li> <li>• Partnership stresses were main reason for leaving: "the thing I probably found most difficult was the partnership relationships and those sort of 'in-house politics' (p3)</li> </ul>	<ul style="list-style-type: none"> <li>• Now enjoys professional autonomy, flexible hours and being own boss: "I would find it very difficult to go back now in terms of having worked for myself [...] I work at home and if there's something going on at the kids school, I can go for it and I'm doing what I love and I'm my own boss" (p8)</li> </ul>

	<ul style="list-style-type: none"> <li>• Blame culture/media portrayal</li> <li>• Unable to switch off from job role</li> <li>• Feeling isolated</li> </ul>	<ul style="list-style-type: none"> <li>• Perceived increase in patient demand/draining: "I think the thing that scares me the most is going and listening to patients now, I would find quite difficult I think, so patients offloading. It's a very draining part of the job [...] It's rewarding in some ways and frustrating in others"</li> <li>• Low morale among fellow professionals</li> </ul>
GP18	<ul style="list-style-type: none"> <li>• Relocated because partner got a job in New Zealand</li> <li>• "If I thought about things that didn't hold me back in the UK, then it would be the move towards the target-based reward system, the QOF and that loss of the sense of ongoing commitment which is both 24-hour care and personal lists" (p11)</li> <li>• "Having said that, if my partner hadn't got a job [in NZ] than those things wouldn't have been enough to make me leave on their own"</li> </ul>	<ul style="list-style-type: none"> <li>• Initially relocating to New Zealand was a temporary measure, but his work has since taken off, so now has no intention to return to UK</li> <li>• More career progression in current post</li> <li>• NZ does not have the same negative media portrayal</li> <li>• Better interaction between primary and secondary care</li> <li>• More patient continuity of care</li> <li>• More enjoyable, less isolated, more flexibility, shorter working days, more work life balance</li> <li>• More job satisfaction</li> </ul>
GP19	<ul style="list-style-type: none"> <li>• Revalidation/reaccreditation</li> <li>• Poor job satisfaction: The misery/drudgery/low morale</li> <li>• Erosion of professional autonomy "you're not a professional in the UK anymore, that's gone"</li> <li>• Partnership stresses</li> <li>• Isolation in practice and changes in communication channels between primary and secondary care</li> <li>• Patient demands/misuse of service reduced to "pizza delivery service"</li> <li>• Shifting goalposts constant change</li> <li>• Took good job posts abroad</li> </ul>	<ul style="list-style-type: none"> <li>• The overall climate in general practice: "The misery and I didn't want to become part of that misery; the drudgery; the lack of direction as a profession. The political problems with the NHS as a whole, but with general practice as part of that specifically. The 'directionlessness' of it [...] It doesn't seem to have any structure anymore."</li> </ul>
GP20	<ul style="list-style-type: none"> <li>• Fear of being sued (developed anxiety disorder and depression)</li> <li>• Job did not meet prior expectations "I thought it [culture of litigation/practising defensively] wouldn't be like that"... "I was shocked at how little people respected their doctors" (p6)</li> <li>• "long hours, it was the thought that actually if I had young children I wouldn't see them if I'm working 14 hour days"</li> <li>• Partnership stresses</li> </ul>	<p><b>What factors would influence decision to return</b></p> <ul style="list-style-type: none"> <li>• More supportive collegiate environment: "I think if I'd had a salaried job in a really nice, supportive practice where they would have held my hand through nasty patients and always had an open door to me asking questions, I would still be in general practice" (p9) ... "I would consider if it was the right time, the right offer, the</li> </ul>

	<ul style="list-style-type: none"> <li>• Pay "I don't think it was well paid enough for what you had to do"</li> </ul>	<p>right place. Because there are aspects of it [working as GP] I really did enjoy"... "I would want to be paid to retrain and then I would want to be able to work four sessions a week in a supportive practice" (p12)</p> <ul style="list-style-type: none"> <li>• Reduced workload</li> <li>• Better pay</li> <li>• Less stressed</li> <li>• More respected</li> <li>• doesn't pay enough</li> </ul> <p><b>Main barrier to returning at present</b></p> <ul style="list-style-type: none"> <li>• Currently enjoys better wage, less stress and more reasonable hours with her current job where she feels she can "make a difference to people with what I am doing and I can't in general practice"</li> <li>• Has young child and plans to have a second child</li> </ul>
GP21	<ul style="list-style-type: none"> <li>• Health</li> <li>• Family</li> <li>• Appraisals</li> <li>• Lack of flexibility in working hours: difficulties working part time</li> </ul>	<p>Does not intend to return to practice at the moment unless her husband became unable to work</p> <ul style="list-style-type: none"> <li>• Family</li> <li>• De-skilled, not up-to-date</li> <li>• Lack of knowledge being out of profession three years – impact on confidence to practice</li> <li>• Not familiar with I &amp; R scheme and the overall processes of getting back into practice.</li> </ul>



## Appendix 4 Main themes and Sub themes

	Main Theme	Sub Themes
1	Changing role of GP and its impact	<ul style="list-style-type: none"> <li>● <b>1) Political/organisational changes</b> <ul style="list-style-type: none"> <li>- Shift to evidence based care</li> <li>- Hospitals becoming more specialised</li> <li>- Changes to methods of referral /more complex communication channels across services</li> <li>- Funding cuts/cost cutting at expense of patient care</li> <li>- Bureaucracy - management targets, regulations and guidelines</li> <li>- More of a "machine" - centralised, standardised, depersonalised, fragmented patient care</li> </ul> </li> <li>● <b>2) Clash of values GP's versus system</b> <ul style="list-style-type: none"> <li>- Reduced to "service provision role"/"government clerks"</li> <li>- Impossible targets</li> <li>- Unrealistic appointment times</li> <li>- "Tick box" culture numbers game versus quality patient care</li> <li>- Changing doctor-patient relationship/less patient centred</li> </ul> </li> <li>● <b>3) Increased workload</b> <ul style="list-style-type: none"> <li>- More work shifting from hospital to primary care</li> <li>- Negative impact on continuity of care/maintaining patient quality care and ability to practice holistic patient care</li> <li>- Change in patient population and demand</li> <li>- Time pressures</li> <li>- Medical legal issues (Fear of litigation: practising defensively)</li> </ul> </li> <li>● <b>4) Negative media portrayal</b> <ul style="list-style-type: none"> <li>- Fear of "political spin"</li> <li>- Portrayed as "overpaid and underworked"</li> <li>- Undermining/demoralising/unsupportive</li> </ul> </li> <li>● <b>5) Lack of support</b> <ul style="list-style-type: none"> <li>- Government: more expected of GP's with less financial resources and support in place</li> <li>- NHS/other professional bodies - no "true advocacy" for GP's</li> <li>- Colleagues: less time for informal support or "catch up"</li> <li>- Need for a more "robust" occupational health service</li> </ul> </li> <li>● <b>6) Workplace issues</b> <ul style="list-style-type: none"> <li>- Partnership conflicts over workload/flexible hours/funding/ill-health/career progression</li> <li>- Bullying/unfair constructive dismissal</li> <li>- NHS appraisals and revalidation</li> </ul> </li> <li>● <b>Impact on:</b> <ul style="list-style-type: none"> <li>- Job satisfaction</li> <li>- Work/life balance</li> <li>- Personal health and wellbeing                             <ul style="list-style-type: none"> <li>- Loss of confidence</li> <li>- Ill-health, including: stress/anxiety /depression /burnout</li> </ul> </li> </ul> </li> </ul>
2	Erosion of professional autonomy and values	<ul style="list-style-type: none"> <li>- Professional autonomy and values feel under threat</li> <li>- Feeling powerless and helpless</li> <li>- Feeling undervalued and under appreciated</li> <li>- Lack of control/flexibility</li> <li>- No time for reflection</li> <li>- Loss of intellectual challenge</li> <li>- Having to cut corners</li> <li>- Burdened by conflicting priorities</li> </ul>

		<ul style="list-style-type: none"> <li>- Ability to act as patient advocate feels compromised</li> <li>- Feeling no longer giving a good service (impact on quality and continuity of patient care)</li> <li>- Losing confidence with regards competency</li> <li>- Fearing litigation/practising defensively</li> <li>- Feeling demoralised</li> </ul>
3	Job satisfaction	<ul style="list-style-type: none"> <li>- Feel no longer giving good service/impact on job satisfaction</li> <li>- Less patient centered/lack of continuity of care impacting doctor/patient relationship and job satisfaction</li> <li>- No control over workload</li> <li>- External controls/impact on job satisfaction</li> <li>- Clash of values GP versus system</li> <li>- Bullying culture</li> <li>- No flexibility</li> <li>- Loss of intellectual challenge/impact on job satisfaction</li> <li>- Less time (long hours and poor quality patient interaction)</li> <li>- Feeling ill prepared for business side of being a GP</li> <li>- Feeling undervalued/impact on job satisfaction</li> <li>- Feeling isolated</li> <li>- Negative media portrayal/impact on morale/job satisfaction</li> <li>- Increasing patient demands /stress/impact on work/life balance</li> <li>- Changing patient population/impact on work/life balance/job satisfaction</li> <li>- Low job satisfaction leading to increased anxiety /feeling overwhelmed/dread/stress/burnout/coming to "hate job"</li> </ul> <p>Expectations:</p> <ul style="list-style-type: none"> <li>● <b>Job not meeting expectations</b></li> <li>- More time pressure, stress and administrative tasks</li> <li>- Continuity of patient care not as expected</li> <li>- Less intellectual challenge</li> <li>- Less opportunity for innovation and career progression</li> <li>- More isolated, controlled and constrained</li> <li>- Erosion of professional autonomy and values</li> <li>- Current job unrecognisable from the professional role they took on</li> </ul>
4	Measures taken to cope	<ul style="list-style-type: none"> <li>- Going part time</li> <li>- Taking on other roles (either inside or outside medicine)</li> <li>- Relocating abroad</li> <li>- Early retirement on medical grounds</li> <li>- Part time hours</li> </ul> <p style="padding-left: 40px;">Stresses inherent in going part time:</p> <ul style="list-style-type: none"> <li>- Feeling rusty</li> <li>- Patient safety/fear of making mistakes</li> <li>- Professional anxiety</li> <li>- Administration/ constantly "playing catch up"</li> </ul>



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