Navigating Burnout within the Changing Context of the NHS: An Exploration into the Experiences of General Practitioners

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Navigating Burnout within the Changing Context of the NHS: An Exploration into the Experiences of General Practitioners

PHILIPPA AMY SHAW

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Abstract

General practice currently faces major challenges, including a staffing crisis, unprecedented pressures, and a high prevalence of mental ill-health among general practitioners. In the context of the current turbulence in the NHS, however, there is a scarcity of qualitative research exploring general practitioners’ poor wellbeing, particularly regarding their experiences of burnout and recovery. Thus, the research presented in this thesis aimed to address this gap in the literature by answering the research question: what are the experiences of GPs with poor occupational wellbeing within the current healthcare context?

Study 1 explored the nature of general practitioner distress through a thematic synthesis of published qualitative research. The findings showed that general practitioners felt devalued, experienced voicelessness, and there was a need to further research burnout experiences qualitatively. Therefore, Study 2 investigated the lived experiences of general practitioners’ burnout using an interpretative phenomenological approach. This interview study found that general practitioners experiencing burnout felt trapped and conflicted in their role, which had implications for their identity and recovery. These burnout outcomes were perceived as enduring. Study 3 subsequently investigated the effectiveness of support received through an NHS service by general practitioners in distress. Statistically significant improvements in mental health over a year were found for participants who engaged with the assessments. To explore in more depth general practitioners’ recovery from burnout, a subset of these participants (those who self-identified as having overcome burnout) were recruited for Study 4. Narratives and participant-generated photographs provided insight into the importance of the social context, settings and being open to broader perspectives in the experience of recovery, plus indicating the potential for growth through adversity.

The understanding gained through this research sharpens the focus on the unheard and nuanced narratives of general practitioner burnout and recovery. This advancement in knowledge is particularly timely given the imminent challenges that general practice faces in light of the additional pressures of the COVID-19 pandemic.

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Author's Declaration

I declare that all the material contained in this thesis is my own work.

Signed: *Philippa Shaw* (17th March 2022)

List of Abbreviations

ANOVA	Analysis of variance
BJGP	British Journal of General Practice
CHIME	Connectedness, hope, identity, meaningfulness, and empowerment
COVID-19	Coronavirus disease 19
DSM	Diagnostic and Statistical Manual of Mental Disorders
GAD-7	Generalised anxiety scale – 7 item
GP	General Practitioner
IPA	Interpretative Phenomenological Analysis
IRAS	Integrated Research Application System
NHS	National Health Service
PHQ-9	Patient health questionnaire depression scale – 9 item
PHS	Practitioner Health Service
PSS-10	Perceived stress scale – 10 item
PSYCHLOPS	Psychological Outcome Profiles
SPSS	Statistical Package for the Social Sciences
T1	Timepoint 1 (initial assessment)
T2	Timepoint 2 (six-months or discharge at six-months assessment)
T3	Timepoint 3 (one-year or discharge at one-year assessment)
UK	United Kingdom
UREC	University of Westminster Research Ethics Committee
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
WHO	World Health Organization

Chapter 1.

Introduction

1.1. Background

Over half a century after it was created, the National Health Service (NHS) is still successfully providing care (Ingleby et al., 2012). However, despite extensive reform, the intensification of pressure on NHS services in recent years has left NHS staff increasingly feeling "like collateral damage in the battle between rising demand and squeezed budgets" (Royal College of Physicians, 2016, p. 3). Furthermore, Ogbonnaya et al. (2018) note that some problems have been consistent in the prevention of delivering effective patient care for over 25 years, such as staff shortages and financial issues. Some of these challenges raise questions about the commitment of the NHS to patient and staff safety; for example, increasing bureaucracy and level of workload have resulted in some healthcare professionals "firefighting daily" (Hignett et al., 2018, p. 8).

In general practice there is concern over the unprecedented work demands (Cheshire et al., 2017b). This has been compounded by increasing patient complexity, an ageing population, and rising demand of the public (Baird et al., 2016). This has negatively affected continuity of care and resulted in longer wait times for appointments with general practitioners (GPs) (Institute for Government, 2019). Majeed (2015) recommended that these challenges in primary care need to be managed to maintain readily accessible, high-quality care and to support the sustainability of working in general practice (Marshall et al., 2020).

Research exploring the impact of the increasing pressures in general practice has become progressively more important with the additional pressure on general practice caused by the coronavirus disease 2019 (COVID-19) pandemic. COVID-19, first reported in December 2019, is an infectious disease caused by coronavirus commonly associated with respiratory illness (World Health Organization, 2020a) that led to a global pandemic (Freedman, 2020). The pandemic is predicted to lead to continued pressures on the health and social care system (Khan et al., 2020). Appointments with GPs have increased by 15% from March 2020 to March 2021 alone, with little growth in numbers of full-time equivalent GPs to deal with the demand (British Medical Association, 2021b).

Traditionally, working in general practice has been associated with an occupation where an individual can thrive despite the challenges (Stevenson et al., 2011). For some GPs, this remains the case. However, the mental health and wellbeing of GPs have become a growing concern (Kinman & Teoh, 2018), especially over the last few years (House of Commons and Health and Social Care Committee, 2021). It is essential to understand the extent of GPs facing poor mental health and wellbeing as well as understanding the experiences related to the prevalence data. General practitioner burnout is a topic receiving increasing focus in research as well as the media.

The definition and theoretical model of burnout are still contested (Schaufeli, 2021). However, the most frequently cited definition of burnout describes it as a syndrome comprising of emotional exhaustion, depersonalisation, and reduced personal accomplishment, which results from the conditions of the workplace (Maslach et al., 2001). A systematic review of prevalence studies found that GPs and consultants have the highest levels of burnout among healthcare professionals (Imo, 2017), with reports of GPs from England suggesting 54% have high emotional exhaustion, 45% high depersonalisation, and 32% low personal accomplishment (Soler et al., 2008). Burnout has been associated with "job satisfaction, intention to change job, sick leave utilization, the (ab)use of alcohol, tobacco and psychotropic medication, younger age and male sex" (Soler et al., 2008, p. 245), with broader implications for a high prevalence of GP burnout too, such as worse perceptions of safety in patient care (Hall et al., 2019).

At this juncture, it is imperative to explore the accounts and perceptions of GPs who have experienced poor occupational wellbeing within the current organisation, political, and social context to guide future research and outline implications for practice. This thesis investigated this using four different approaches, mainly focussing on the experiences of GPs related to burnout. An overview of the current research and how this is presented in this thesis is described next.

1.2. Outline of the Thesis

After this introduction (Chapter 1), Chapter 2 will review the literature and theoretical background to the studies presented in this thesis. This chapter will first outline the research context for the thesis, including the NHS and general practice. Next, a review of the literature relating to wellbeing, burnout, and the implications of GP poor occupational wellbeing is provided, as well as an overview of the recovery literature. After presenting the background literature, the overarching aims of the thesis will be outlined. This contextualises the four research studies of the thesis, which span Chapters 3 to 8. The research studies aim to answer the question, what are the experiences of GPs with poor occupational wellbeing within the current healthcare context? More specifically, answering, what are the experiences of UK based GPs who self-identify as having or have had burnout within the context of additional NHS pressure and turbulence, and, what are GPs' experiences of accessing support and overcoming burnout?

Chapter 3 will present the first study of the thesis. As far as the researcher is aware, this is the first qualitative synthesis exploring the experiences and views of GPs relating to poor occupational wellbeing. The findings highlighted the increased focus of research on this topic over the last five years, and that GPs were experiencing voicelessness amongst the perceived poor execution of changes in primary care. Additionally, findings showed that GPs' work organisations and broader society exacerbate the increasing pressures. A scarcity of in-depth qualitative research investigating GPs' experiences of burnout during these times of unprecedented pressures and turbulence was emphasised in the meta-synthesis. Therefore, this was investigated in Study 2, and is presented across Chapter 4 and Chapter 5.

Chapter 4 presents the methods to Study 2. Study 2 aimed to give voice to those on the front line by investigating the lived experience of primary care GPs who self-identified as experiencing or having experienced burnout. This chapter also describes the dissemination methods for this study including the creation of an art-based summary booklet. The findings and a discussion for Study 2 are presented in Chapter 5. Four themes were identified, highlighting participants felt trapped and conflicted and were reluctant to seek help through burnout. The participants were each at a different point in their life related to an episode of burnout which allowed for an in-depth understanding at the idiographic level but a shallower understanding across participants. Importantly, GPs explored their experiences of still striving to navigate burnout, discussing the ongoing impact on their professional and personal lives. This prompted exploring the potential for improvement in GP wellbeing over time when they had sought and received support.

Study 3 is presented in Chapter 6. This study investigated the potential for improving the mental health and wellbeing of GPs through support from the Practitioner Health Service (PHS) by analysing quantitative scores collected routinely by the service. The results from the quantitative analysis suggested that GPs who had received support from the PHS and engaged with the assessment questionnaires showed an improvement in wellbeing and mental health over time. As GPs' mental health and wellbeing for those who engaged with the service improved, and there is limited research exploring what happens for GPs after burnout, this informed the last study in the thesis.

Study 4 explored GPs’ accounts of overcoming burnout. The methods for this study are outlined in Chapter 7. This study aimed to increase our understanding of the experiences of recovery from burnout through a deeper examination of GP recovery narratives. Therefore, a sub-sample of the participants from Study 3 were interviewed to explore their experiences of seeking support from the PHS and their recovery from burnout. Novel methods of photo-elicitation with participant generated photographs was employed in this study. Chapter 8 presents the findings from this study, which, as far as the researcher is aware, is the first study to look at how narratives of recovery from burnout are created by GPs, developing the understanding of how participant create their stories and chose to depict them visually with photographs. This study highlighted points in the recovery experience where support could be strengthened and showed how GPs framed their recovery from burnout as successful.

Finally, Chapter 9 presents the general discussion for the thesis. This chapter outlines the key findings across the four studies and compares these to the broader literature. This chapter also presents the reflexivity section, the strengths and weaknesses across the thesis, implications for practice and future research, and lastly, the overall conclusions.

Chapter 2.

Literature and Theoretical Review

This literature and theoretical review chapter frames the four studies in this thesis. The context of these studies will be presented, including an outline of the NHS and general practice, followed by overviews of key research areas related to wellbeing, burnout, and recovery from burnout.

2.1. Research Context

This section discusses the context of the thesis by outlining the NHS and general practice. These areas are important to introduce in this chapter as the studies that make up this thesis are embedded in this context and culture.

2.1.1. The National Health Service

In 1948, the NHS was established in the UK to provide free healthcare for everyone at the point of access (Welch, 2018). The NHS has three levels of care: primary covering healthcare delivered in the community, secondary which includes patient care provided in hospitals, and tertiary for providing care for patients requiring complex treatment (National Institute for Health and Care Excellence, n.d.). In 2012, Ingleby et al. integrated the findings from reports (Schoen et al., 2011; Thomson et al., 2011) to compare the performance of the NHS to health services in 11 other countries. Although there were criticisms, such as lower cancer survival rates and measles vaccination uptake, overall, there were more positives than negatives reported for the NHS, including lower financial barriers to care and higher patient satisfaction and confidence in providing effective treatment (Ingleby et al., 2012). The Royal College of Physicians (2016) later noted that the NHS provides some of the most efficient and most accessible healthcare in the world.

However, the Royal College of Physicians (2016) suggested that while there was much to be proud of within the NHS, there was also room for improvement, mainly related to the barriers between hospital care and the community. This report also acknowledged that the NHS is “underfunded, underdoctored, and overstretched” (p. 2). Schoen et al.

(2011) concluded that there were opportunities to learn from other healthcare systems to improve the NHS, including the potential benefits of redesigning primary care.

The scope of this thesis does not allow for in-depth reporting of the history, and the extensive changes that have taken place across the NHS and the broader political and social context since Ingleby et al. (2012) collated the evidence looking at the performance of the health services and concluded that primary care could be improved. However, some internal changes are particularly relevant to the studies in this thesis, such as the 2012 Health and Social Care Act (Powell, 2020), which are outlined in the following subsection, and the proposals set out in the NHS Long Term Plan (NHS, 2019a). Of note, the NHS Long Term Plan outlined a new service model to support patients to receive more joined-up care, suggesting a more integrated primary care to address the increased pressures currently being faced (NHS, 2019a). Simpkin & Mossialos (2017) highlighted some of the pressures across the NHS, including rising clinical demand, an ageing population, a reduction in social care funding, increasing cost of medicine and health technology, and a widening gap between clinical need and resources available. Such challenges have resulted in increased risk of occupational poor mental health and wellbeing in healthcare professionals (Kinman & Teoh, 2018).

The focus on the wellbeing of healthcare professionals in the wider literature has increased through the PhD (September 2017 to September 2021). All four studies in this thesis took place as the UK navigated Brexit, and parts of Study 3, Study 4, and the dissemination strategies occurred during the COVID-19 pandemic. At the start of this PhD project, there was still significant debate around the impact Brexit could have on the NHS (Mossialos et al., 2016), such as furthering the NHS workforce crisis as the NHS workforce was heavily reliant on European Union staff (Fahy et al., 2017). The UK formally left the European Union in January 2020, with the transition period lasting till the end of 2020 (Van Schalkwyk et al., 2020).

Additionally, workforce pressures have increased exponentially across health and social care due to COVID-19, and healthcare workers in contact with patients with COVID-19 were at a higher risk than the general population for COVID-19 (World Health Organization, 2020b). The discretionary effort harnessed that was fuelling the NHS during the pandemic is suggested to be unsustainable (House of Commons and Health and Social Care Committee, 2021). Consequently, in July 2020, there was an inquiry into NHS workforce burnout and resilience that found the mental health for some NHS and care staff was at significant risk (House of Commons and Health and Social Care Committee, 2020). This report stressed the need to detail how the wellbeing of the staff would be supported when continuing to navigate the sustained pressures and the backlog associated with COVID-19 (House of Commons and Health and Social Care Committee, 2020). Additional reports have been published with proposed changes to be integrated, some with a particular focus on supporting NHS healthcare professionals' wellbeing, such as the publication of 'Our NHS People Promise' (NHS England, 2020a) and 'We are the NHS: People Plan for 2020/21– action for us all' (NHS England, 2020b) in 2020.

The broader NHS, political, and social context briefly explored above will aid in interpreting the findings of the studies in this thesis and setting the context when considering the impact for practice and policy in the general discussion of this thesis. At this juncture of further change and increased pressure, it is essential to understand the current literature related to the NHS, which can best inform the opportunities to re-build in an evidence-based way that supports the health of both patients and healthcare professionals.

2.1.2. General Practice

Until now, there has been a greater amount of research conducted into stress and workplace wellbeing in secondary care than in primary care (West & Coia, 2019). Yet, primary care, specifically general practice, is an area of the healthcare system that is currently facing serious challenges. For this reason, it provides the focus of this thesis.

Therefore, this section will provide an overview of the research context focusing on general practice.

Primary care is the cornerstone of the NHS (Boerma et al., 1997). It provides care in the community mainly through GPs, but also through the important roles played by community pharmacists, opticians, and dentists (NHS England, n.d.). Having a regular doctor or place of care, with a relationship built over time between patient and GP, is seen as the critical foundation for primary care (Schoen et al., 2004). Moreover, it has been found that the strength of a country's primary care system is negatively associated with population health outcomes such as mortality and cause-specific premature mortality from major respiratory and cardiovascular diseases (Macinko et al., 2003).

For this thesis, primary care indicates primary medical care provided by GPs. General practitioners are the first point of contact for general medical care for people who live in a particular area (Boerma et al., 1997), managing care for acute and chronic conditions (Allen et al., 2005), while also promoting health based on patient advocacy and continuity of care in the community (Beaulieu et al., 2009). The key functions of a GP include providing an entry point for delivering core medical and preventive care, helping patients receive coordinated and integrated care (Schoen et al., 2004), and providing treatment that improves the overall quality of life and patient functioning (Starfield, 1998). Furthermore, some services traditionally provided by secondary care specialists are now the responsibility of primary care, which means making a definitive distinction between secondary and primary care specialists is sometimes difficult (Atun, 2004).

Over time, GPs have witnessed significant changes, such as changes in their education, the advent of quality assurance programmes, and the general restructuring of the health care system, all of which influence their current role (Bensing et al., 2006). Some of the recent significant organisational changes to general practice within the UK are worth outlining, including the following: the introduction of a new contract in 2004 (including the introduction of the Quality and Outcomes Framework– a voluntary annual reward and incentive programme designed to honour achievements in medical practice, and enhanced services payments); the Health and Social Care Act 2012 (including the creation of Clinical Commissioning Groups) and NHS England taking on statutory responsibility for commissioning health services; the introduction of local Healthwatch organisations; the abolishment of Primary Care Trusts and Strategic Health Authorities (Powell, 2020); and the establishment of a process of revalidation for GPs.

Moreover, the change in contracts in 2004 signalled a move away from the previous practitioner-based contract and towards a practice-based contract. This followed from the new contract of 1990, which placed greater emphasis on performance-related pay and shifted the management of chronic conditions into general practice and away from secondary care (Napier, 2017). Two of the most impactful consequences of the 2004 contract were that 90% of GPs opted out of out-of-hours care (Lind, 2017), and general practice moved towards clinical targets with the introduction of the Quality and Outcomes Framework (Checkland et al., 2008). This fundamentally changed the way general practice worked, especially in removing GPs' autonomy in deciding what they did and how they did it, as they were no longer recognised as independent contractors (Napier, 2017).

Alongside these changes, there has been a gradual shift in the demographic makeup of the GP workforce. The number of female GPs has increased by 16% from 2012 to 2017 (54% of GPs are now female), and there has been a slight increase in the number of younger GPs (+3%) and a reduction in the number of GPs aged 50 and older (-3%) with many more considering taking early retirement (General Medical Council, 2017). Importantly, both in the UK and internationally, general practice is facing a shortage of GPs (Baird et al., 2018), with a sustained fall in the number of GPs relative to the UK population (Palmer, 2019), leading to "serious staffing issues in general practice" (Beech et al., 2019, p. 1). Consequently, there has been an increasing tendency in policy to respond to GP shortages (General Medical Council, 2017). There have been efforts to retain as well as reengage GPs, such as through the NHS Improvement's retention programme and a refresher scheme for GPs. But a relatively small number of people have applied for the refresher scheme, and there are broader challenges such as pressure on staff and poor work-life balance impacting these attempts (Beech et al., 2019). These adverse factors may be contributing to a significant loss of skilled staff due to retirement (Royal College of Physicians, 2016).

There has also been an increase in demand in the clinical workload of GPs. Several reasons for this have been proposed, such as people living longer (resulting in an aging population) (Department of Health, 2006) and people contacting GPs about minor illnesses that could easily be addressed using self-care (O'Cathain et al., 2020). Indeed, Baird et al. (2016) reported that from 2010 to 2015 face-to-face consultations increased by 13.3% and telephone consultations by 62.6%. However, the workforce only grew by 4.75% during the same time period. Meanwhile, Hobbs et al. (2016) completed a retrospective analysis of consultations in primary care from 2007 to 2014. They reported that GP workload had increased by 16%, and the average duration of GP consultations had increased by 6.7%. Such high levels of demand exceed the capacity of primary care, making general practice a less attractive career choice (West of England Academic Health Science Network, 2015). International studies also report that GPs are working in high-demand and low-control environments (Sundquist & Johansson, 2000; Vanagas & Bihari-Axelsson, 2005b) and have experienced organisational changes (Arnetz, 2001).

2.2. Wellbeing

Given the current context of primary care, as discussed in the previous sections, it is unsurprising that recent studies have reported a decline in the mental health and wellbeing of GPs. To explore the findings related to poor mental health and wellbeing, the concept of wellbeing and its components must first be outlined. This is important to explore within this chapter, as defining wellbeing will provide context to all studies as well as to the subsequent sections in this chapter that explores poor wellbeing, specifically burnout.

Psychological perspectives of wellbeing propose that subjective wellbeing derives from Hedonia, an individual's search for pleasure (Kahneman et al., 1999), and Eudaimonia, reaching or fulfilling or developing the best in oneself (Ryff & Keyes, 1995). Hedonia and Eudaimonia are believed to create a holistic sense of wellbeing. In isolation, psychological theories can enable insight into health and wellbeing subjectively but have been criticised for ignoring broader systemic issues such as loneliness (Ehrenreich, 2010). Mead et al. (2019) instead use wellbeing to refer to a positive psychological experience, which can be influenced by positive health behaviours, and is promoted through a sense of connectedness to ourselves as individuals, as well as to the communities and environment in which we live. In the broadest sense, wellbeing can be defined as stable when individuals have the psychological, social and physical resources they need to meet a particular psychological, social or physical demand (Dodge et al., 2012).

Despite the challenges outlined above, a substantial number of GPs continue to thrive in their roles (Zwack & Schweitzer, 2013). Increased resilience is suggested to be a protective factor when maintaining mental health and wellbeing. Resilience is defined as an individual being able to withstand or recover quickly from difficult conditions, including adaption to both adverse and positive experiences (Fletcher & Sarkar, 2013). Resilience is associated with qualities such as optimism, humour, understanding of self-worth, and adaptability (Matheson et al., 2016).

In a qualitative study, GPs believed that resilience should be the responsibility of both the individual and organisation (Cheshire et al., 2017b). Organisations can play a protective role against poor mental health by empowering employees (Kumar, 2007). Likewise, support has been found for the positive relationship between employees' engagement in their roles and job resources such as knowledge, autonomy, and a supportive environment (Nahrgang et al., 2011). Resilience is perceived to be strengthened by GPs maintaining the ability to control their working hours (Stevenson et al., 2011) or detrimentally weakened when control is relinquished (Stodel & Stewart-Smith, 2011). In some cases, GPs are proactive in reclaiming control to improve wellbeing by decreasing hours worked per week and subsequently reducing their workload (Cheshire et al., 2017b). A few authors, including Stevenson, Phillips, and Anderson (2011), have advocated the move to support GPs' desire to work part-time as a means to reducing the likelihood of poor mental health.

Moreover, and particularly important to consider in this literature review to contextualise the research in this thesis are the social dimensions of wellbeing. Social factors influence perceptions, actions, and experience (Wade & Halligan, 2004), and social determinants, including level of social isolation, are recognised to influence health and wellbeing (Shim et al., 2014). More specifically, the role of social support has been well researched and is shown to be protective against illness and poor wellbeing (Huppert, 2009; McAlpine & Mechanic, 2010; Silva et al., 2016), and providing support to others has been reported as greatly beneficial in improving health and wellbeing (Brown et al., 2003). Additionally, Tew et al. (2012) reviewed the evidence to investigate the role of social factors in the recovery from mental health difficulties, finding key social factors related to "empowerment and negotiating positive social identities, supportive personal relationships and social inclusion" particularly important (p. 455). Some literature has specifically noted the value of the social element when supporting the health and wellbeing of GPs, as in the research of Kinman and Teoh (2018). They emphasise that a good work-life balance is important for GPs. That is to say, a GP should spend time with friends and family and engage in other social activities to help them replenish their mental resources before returning to work. However, as the previous sections outlined, with the increasing work pressures in primary care, achieving a good work-life balance is becoming increasingly difficult, and GPs are experiencing an increasingly reduced sense of control. Consequently, it is important to explore what has been published qualitatively in relation to poor GP wellbeing and mental health to establish the current findings and inform the direction of future research and practice.

2.2.1. Burnout

Due to the findings that there is increased pressured in primary care and reduced wellbeing among GPs, greater research attention has been focused on these issues in recent years, with a particular focus on burnout. As burnout is a central experience explored within this thesis, an overview of the theory underpinning burnout will be explored over the next few sections.

2.2.1.1. Definitions and Conceptualisation of Burnout. The term 'burnout' was applied by Freudenberger in the 1970s to volunteers in a health clinic to describe their progressive loss of idealism, purpose, and energy as a result of the conditions of their work (Freudenberger, 1974). Since Freudenberger's first use of burnout, vast amounts of research has been published using this term (Brenninkmeijer & VanYperen, 2003) with recent years being described as the golden age of stress in which the pressure to perform is relentless, resulting in an epidemic of exhaustion (Buys, 2016). The most commonly used definition of burnout in research is that described by Maslach; a syndrome comprising emotional exhaustion, depersonalisation, and reduced personal accomplishment, which results from the conditions of the workplace (Maslach et al., 2001). To further clarify these characteristics, emotional exhaustion can be defined as a chronic state of emotional, cognitive and physical depletion caused by job demands perceived as excessive and continuous (Wright & Cropanzano, 1998); depersonalisation as the psychological withdrawal from relationships and the development of a negative, cynical, or callous attitude (Hartney, 2008); and reduced personal accomplishment as low self-esteem that results from a perception of a loss of effectiveness and competence (Hartney, 2008).

However, despite the frequency with which Maslach et al.'s (2001) definition is cited, there are many critics of the three-dimensional characterisation of burnout. For instance, Guseva Canu et al. (2021), after reviewing the definitions and models of burnout in the literature, reported that although this is the most commonly used definition of burnout, it has "no unanimous acceptance" (p. 99). One such line of argument suggests that depersonalisation is not applicable across all situations, nor is it generalisable across all individuals (Garden, 1987; Shirom, 1989) and that emotional exhaustion is the only dimension that is consistent across all definitions and assessments of burnout, resulting in the argument that exhaustion is the only intrinsic dimension of burnout (Evans & Fischer, 1993). Nevertheless, Kristensen et al. (2005) emphasised that burnout is not simply exhaustion or fatigue, and definitions that extend the notion of exhaustion are numerous. For example, Gundersen (2001) proposed that loss of interest in work and personal life was vital, while Ekstedt and Fagerberg (2004) focused on ineffective coping strategies when faced with enduring stress and other impacting factors such as role ambiguity or role conflict.

Leiter (1993), meanwhile, argues that it may be more helpful to refer to the extreme point of the accumulation of work stress as burnout, whereas the other end of the burnout scale points to effective professional involvement. Therefore, it can be argued that points in between represent a sliding scale of professional efficacy, not just the absence of crisis (Leiter, 1993). Other researchers propose a contrast to the continuum of burnout experiences proposed by Maslach et al. (2001) and Leiter (1993). Demerouti et al. (2001) present burnout as a dichotomous state in which an individual experiences simultaneous exhaustion and disengagement, while Pines and Aronson (1981) equate burnout to tedium, but specify that the exhaustion is unique to people who work with people in situations that are emotionally demanding. Moreover, when considering the social dimensions of burnout, emotional fatigue may impact a person’s ability to relate to people in general (Pines & Maslach, 1980).

Highlighted above are some of the main definitions and contradictions between conceptualisations. However, there is also conflict over whether burnout is genuinely a unique syndrome. For example, whether burnout is distinct from depression. Depression and burnout are both regarded as stress-related disorders (Orosz et al., 2017), but it has been argued that the two pathologies can be differentiated (Maslach et al., 2001) and the overlap can be accounted for by the joint second-order factors of depression and burnout, which increase the correlation among their primary factors (Leiter & Durup, 1994). However, research reporting the separate nature of the two is inconsistent. It can be reasoned that the distinction between depression and burnout is conceptually fragile as it is unclear how the end stage of burnout differs from clinical depression (Bianchi et al., 2015a), with dysfunctional attitudes, ruminative responses, and pessimistic attributions found to be similarly associated between burnout and depression (Bianchi & Schonfeld, 2016). Furthermore, symptoms of burnout and depression have been found to cluster both at baseline and at follow-up measurements, with emotional exhaustion more strongly related to depression than to depersonalisation (Bianchi et al., 2015b). Therefore, some have proposed that it may be more rational to conceptualise emotional exhaustion and depersonalisation as depressive responses to occupational environments (Bianchi et al., 2015b) rather than characteristics of burnout given that there appears to be no difference in terms of stigma and help-seeking behaviour or attitudes when the two syndromes are compared (Bianchi et al., 2016)

Given that the conceptualisation of burnout in itself is problematic, there is much uncertainty over how best to define and measure it (Peckham, 2015). The Royal College of Psychiatrists referred to the International Classification of Diseases-10 when defining burnout for their report exploring workforce burnout and resilience in the NHS and social care, but added that it was necessary to develop a comprehensive definition of what workforce burnout is and to identify evidence-based interventions to address it (House of Commons and Health and Social Care Committee, 2020). Schaufeli (2021) writes that although there is extensive agreement that the key defining feature of burnout is exhaustion, “the burnout enigma has not yet been solved” (p. 170). Indeed, there are still several questions left unaddressed, which is hampering progress in knowledge related to the antecedents, epidemiology, consequences, and interventions associated with burnout. Therefore, Guseva Canu et al. (2021) conducted a systematic review and Delphi consensus in 29 countries to harmonise the definition of occupational burnout to enable it to be become a recognised outcome in health research. The systematic search identified 88 unique definitions of burnout. The analysis led to the formulation of the definition “in a worker, occupational burnout or occupational physical AND emotional exhaustion state is an exhaustion due to prolonged exposure to work-related problems” (Guseva Canu et al., 2021, p. 95), which 82% of experts agreed with.

The research in this thesis does not attempt to definitively conceptualise what burnout is, but rather looks to investigate the experiences and the meaning-making of GPs relating to self-identified burnout and recovery from burnout. As accounts of lived experience and narratives of recovery from burnout are investigated within this thesis, next some of the models of burnout will be outlined.

2.2.1.2. Models of Burnout. As with the definition of burnout, there are discrepancies between models of burnout, and thus there is no definitive model. A comprehensive examination of the literature related to definitions, populations studies, symptoms, and theoretical models or tools has been published by Guseva Canu et al. (2021). Key models referred to in this thesis, include those proposed by Freudenberger and North (2006), Maslach (1976), and Ekstedt and Fagerberg (2004), are outlined below.

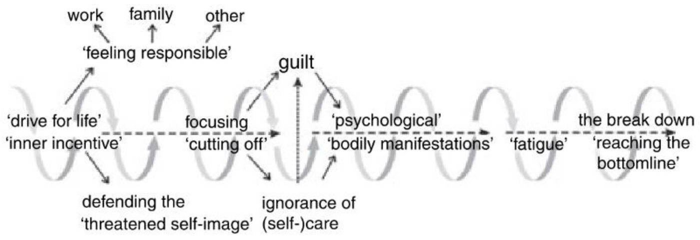
Freudenberger's (1974) model of burnout focused on feelings of exhaustion and other physical experiences such as sleepiness and shortness of breath and behaviours such as irritation. The 12 steps towards burnout as outlined by Freudenberger and North (2006) include stages such as ‘excessive ambition’ where an employee has a desire to prove themselves and therefore is eager to accept more responsibility at any time, and thus ‘[neglects] personal care and needs’, including spending time with loved ones and family.

Maslach (1976) proposed an alternative model in which emotional stress leads to burnout, which in turn leads to the deterioration of wellbeing. This model was further specified to suggest that working closely with people could lead to burnout, which could have a detrimental effect on individuals' job performance, physical and psychological health, and their ability to interact with people in general (Pines & Maslach, 1980). The elements of Maslach’s model of burnout have been used in additional models such as Leiter's process model (Leiter, 1993) and van Dierendonck, Schaufeli, and Buunk's (2001) model. Leiter (1993) theorises that emotional exhaustion surfaces first, preceding depersonalisation, which is followed by low personal accomplishment. This process begins in response to a demanding environment and the individual being overwhelmed by the personal demands of their job, which leads to emotional exhaustion. Alternatively, van Dierendonck, Schaufeli, and Buunk (2001) proposed that employees' resilience is compromised by feelings of reduced accomplishment. Employees start to then distance themselves from their role, seeing their job as less attractive, which leads to lower satisfaction with their role and consequently emotional exhaustion.

Alternatively, Ekstedt and Fagerberg (2004) explored the lived experiences of the time preceding burnout among eight participants. In this paper they proposed the model presented in Figure 1.

Figure 1

Ekstedt and Fagerberg's (2004) Model of the Lived Experience of the Time Proceeding Burnout (p. 62)



In the model individuals start with a drive for life that is threatened by attempting to balance responsibilities with self-nourishing behaviours. If this balance is challenged, such as through unpredicted events, this may lead to reduced participation in recovery activities and eventually to feeling overwhelming fatigue.

2.2.1.3. Factors Contributing to GP Burnout. Despite the lack of an agreed definition or model of burnout, the prevalence of burnout has been heavily researched, revealing considerable variability in prevalence across countries and specialities (Peckham, 2015). However, recent large-scale studies have reported similar and more stable figures of around 50% of GPs suffering from burnout at the time of cross-sectional surveys (Peckham, 2015; Shanafelt et al., 2015). The potential consequences of this syndrome are drug and alcohol misuse (Tolentino et al., 2017), severe depression, and suicide, all of which occur at a higher prevalence in GPs than in the general population (Trollope-Kumar, 2012).

As with the extensive literature exploring the prevalence of burnout, a considerable body of literature has also explored the antecedence of burnout. The literature on burnout comprises mainly research identifying correlations between quantitatively measured antecedent factors and burnout. Several occupational factors have been proposed as being associated with burnout, such as work overload, lack of control, insufficient reward, absence of community, lack of fairness, and conflict in values within the workplace (Maslach et al., 2001). Maslach’s definition of burnout suggests that the root of burnout is the work environment. However, other factors may play a role as not all who work in these environments develop burnout. Thus, it may be the case that individual risk factors and protective factors are involved. Associated risk factors include age, sex, family status, educational status and personality traits (Maslach et al., 2001). Furthermore, many other factors such as a lack of control over the hours worked (Carr et al., 2003), lack of autonomy (Linzer et al., 2016), impossibly long working hours, inadequate sleep, lower quality of life (Hutter et al., 2006) and a mismatch between the nature of the job and the nature of the person who does the job (Maslach et al., 2001) have been associated with the development of burnout.

Although single factors have been highlighted as making a significant contribution to the development of burnout, most studies refer to several factors when discussing contributions to the development of burnout and their impact over time, reinforcing the idea that burnout is multifactorial. Stressors are cumulatively building towards the endpoint, whether GP burnout or a GP leaving practice (Doran et al., 2016). Concerning the burnt-out GP, research has been growing since the early 2000s, exploring this phenomenon in GPs throughout their careers, from medical students through to retiring GPs, with increased focus in recent years. It has been proposed that the process of developing burnout may originate during the GP's time at medical school (Santen et al., 2010), with modern medical training being suggested as producing a specific brand of GP who is increasingly susceptible to low wellbeing (Drummond, 2015).

The GP workload, cited as intense and unrelenting, was the most commonly discussed amongst those factors contributing to the development of burnout (Chambers et al., 2016; Kavalieratos et al., 2017; Matheson et al., 2016; Stodel & Stewart-Smith, 2011). The workload in these studies is associated with a high volume of patients and the accompanying necessary but unwelcome administrative tasks. Workload has also been associated with several related dimensions of the role, such as information overload (Matheson et al., 2016), understaffing (Chambers et al., 2016), increased administration (Spinelli et al., 2016), time pressure (Matheson et al., 2016), reduced time for patient-centred care (Doran et al., 2016; Spinelli et al., 2016) and decreased work-life balance (Cheshire et al., 2017b; Gunasingam et al., 2015).

In addition, the workload is associated with the organisation's culture and prompts the recommendation for reduced hours and overall policy change. Burnout not only holds negative consequences for the GP but also for the GP's family, colleagues, the overall health organisation, and, notably, the GP's patients, as can be seen in the below quote:

> 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 [Quality and Outcomes Frameworks] and the money in, is the actual patient relationship. (Doran et al., 2016, p. e131)

In this respect, burnout is conceptualised as externally driven, including the reduced time associated with building individual resilience. The decreased work-life balance has been associated with decreased time occupied by recovery-focused activities. Conceptually, this links to one of the explanations for exhaustion, which is a key part of burnout – the depletion of human energy at a rate faster than it is replenished. Emotional exhaustion is mainly related to job demands such as workload and time pressure. In contrast, cynicism or disengagement from work is more strongly related to poor job resources such as lack of feedback, poor job control, lack of social support, and lack of participation in decision making (Demerouti et al., 2001).

Other organisational factors perceived to contribute to burnout are tension and frustration with management (Chambers et al., 2016; Kavalieratos et al., 2017), conflicts between departments (Kavalieratos et al., 2017), poor communication (Matheson et al., 2016), workplace changes (Cheshire et al., 2017b; Doran et al., 2016) and lack of support or acknowledgement (Doran et al., 2016; Gunasingam et al., 2015). Nevertheless, although organisational factors are commonly cited, this was not the case unanimously; for example, in Stevenson, Phillips, and Anderson, (2011), organisational factors were rarely cited as one of the main contributors to unsustainable practice. Less mentioned but still worthy of consideration is the impact of changing patient demand and expectations (Doran et al., 2016) on GP workload and wellbeing. The GPs in Fisher, Croxson, Ashdown, and Hobbs' (2017) study emphasised the growing issue of patients not taking responsibility for their self-management, which results in increased unnecessary work for the GP and a change in the GP’s role.

Furthermore, Matheson, Robertson, Elliott, Iversen, and Murchie (2016) argue that the education and recruitment process for GPs may attract those who have a predisposition to burnout vulnerability. When investigating how junior doctors verbally express experiences of stress, Thompson, Corbett, and Welfare (2013) found that participants typically normalise, deflect or trivialise their own experiences of stress. Consistent patterns of talking about stress – ‘business’, ‘patient responsibility’, and being the ‘good doctor’ – were identified. However, an adverse reaction to behaviours and experiences associated with burnout was found in the focus groups interviewed by Kavalieratos et al. (2017), with the most common emotions recalled after experiencing burnout being fear and remorse. Participants in Peisah et al.'s (2009) study seemed to reiterate this when exploring the theory that those who suffer burnout and do not recover are victims of a form of natural selection within the field. Nevertheless, some GPs perceive burnout as a natural (Kavalieratos et al., 2017) and even inevitable phenomenon, especially if the GP is working under conditions rife with monotony and a limited potential of progress (Selamu et al., 2017). Moreover, during the course of the pandemic, 60% of healthcare professionals across the NHS have reported experiencing higher than normal levels of exhaustion or fatigue (British Medical Association, 2021b), with 45% of GPs reported to be currently suffering from burnout, emotional distress, stress, depression, anxiety, or another mental health condition (British Medical Association, 2020).

Qualitative studies have identified another protective factor against burnout as having the opportunity for and experiencing personal and professional growth. In one study, older GPs with lower levels of burnout attributed their lower scores to the length of time spent in their profession (Peisah et al., 2009). Peisah, Latif, Wilhelm, and Williams (2009) discuss the length of time in the profession, allowing an accumulation of experience and development of professional confidence within their role, and increased knowledge and strategies to mitigate burnout, such as the importance of setting professional boundaries. These ideas are reiterated in several papers, such as allowing the doctors to allocate time to personal and professional growth (Beaune et al., 2018) and enabling a deeper understanding of the GP roles and responsibilities (Satterfield & Becerra, 2010). Furthermore, promoting personal strategies such as dedicating time for GPs to become self-aware (Beckman et al., 2012) and promoting the practice of self-reflection in order for GPs to understand their limits (Prayson et al., 2017) can help to develop GPs’ adaptive responses to stress (Satterfield & Becerra, 2010) and therefore reduce the likelihood of burnout. The inverse of developing burnout, those who can adapt to environmental stress, can experience positive mental growth in the face of challenge and adversity (Beaune et al., 2018).

In addition, many GPs have highlighted having the time for patient-centred care (Spinelli et al., 2016) and cultivating relationships with patients (Peisah et al., 2009) as desirable yet limited features of their work. There has been a fundamental change to primary care, with increased administrative tasks, time spent using new digital technology, and more extensive involvement of regulatory bodies. This has increased workload and reduced the time that GPs can allocate to each patient and reduced the frequency of energy-replenishing activities such as social interactions between colleagues. Patient-centred care and GPs celebrating making minor differences in patients’ lives can help GPs prosper in their field (Spinelli et al., 2016). Stevenson et al. (2011) directly investigated perceptions of GPs regarding factors that helped GPs thrive, despite working in particularly challenging environments. It was found that GPs with low burnout scores were motivated by the knowledge that they were helping a disadvantaged population, a population they respected.

2.3. Implications of Poor Occupational Wellbeing and Burnout

Despite the ongoing uncertainty surrounding the definition and models of burnout, many research studies and reports have nevertheless focused on burnout in healthcare professionals. Reports have been commissioned to identify issues of concern with current staff health and wellbeing services in the NHS; to bring together best practices in the NHS and other organisations; and to highlight the benefits, to staff, patients and NHS bodies, of investing in improving staff health and wellbeing (Boorman & Fellow, 2009). Recently the House of Commons and Health and Social Care Committee (2021) published a report titled “workforce burnout and resilience in the NHS and social care” (p. 1). Employee wellbeing is conducive to promoting GPs’ intentions to remain working within their role and their willingness to provide services that improve patient satisfaction (Ogbonnaya et al., 2018). The workplace, therefore, should be a place to improve wellbeing, not merely to prevent occupational injury (World Health Organisation, 2002), which is reflected in the values of the NHS: “respect, dignity, compassion, and care should be at the core of how patients and staff are treated – not only because that is the right thing to do, but because patient safety, experience, and outcomes are all improved when staff are valued, empowered and supported” (Department of Health and Social Care, 2021, Principles that guide the NHS, para. 3). It has therefore been suggested that it is important to research the conditions that can both foster and undermine the potentials of individuals as this can have practical as well as theoretical implications by helping to develop knowledge but also inform the future design of social environments or change existing ones to optimise performance and wellbeing (Ryan & Deci, 2000).

There has been increased interest in improving the wellbeing of healthcare professionals, including identifying NHS staff health and wellbeing as a priority in the five-year forward view that was published in 2014 (Black, 2008; NHS England, 2014). Taking this a step further and considering some of the continued and new challenges facing the NHS, Boorman (2009a) highlighted calls for the NHS to practise what it preaches, focusing on prevention related to healthcare professionals' health and wellbeing. It is suggested that this could be done by championing healthy lifestyle improvements for staff. Boorman (2009a) writes: “Our work highlights a culture in which highly motivated staff do not always recognise the impact of their own health needs, and where early access to care is erroneously considered to risk disadvantaging patients in the wider population” (p. 3). GPs have reported being poor at help-seeking, and there are high levels of sickness absence and presenteeism, as doctors working when sick has been associated with “short-staffing, feelings of responsibility to their patients, fear of letting colleagues down, the need to present a ‘healthy’ image at work and concerns for their future career prospects” (Kinman & Teoh, 2018; p. 2).

It is suggested that healthcare professionals have low perceived control with a high, intense and complex workload whilst working in an organisation undergoing rapid change, which is associated with inadequate opportunities to physically and mentally recover from the job (Kinman & Teoh, 2018), which may impact GP wellbeing. Boorman (2009a) reported that NHS “staff are not convinced that their health and wellbeing is seen as important to their employer” (p. 2). Kinman and Teoh (2018) suggest that GPs are more vulnerable to work-related stress, particularly emotional exhaustion and other mental health problems, than doctors in other specialities and the general population. This is in line with reports of a decline in GP wellbeing, mainly related to elevated occupational stress (Manocha et al., 2009; Riley, 2004; Vanagas & Bihari-Axelsson, 2005) and burnout (Bruce et al., 2005; Grassi & Magnani, 2000; Kjeldmand & Holmström, 2008; Linzer et al., 2001; Shanafelt et al., 2012; Soler et al., 2008; Twellaar et al., 2008).

2.3.1. Implications For General Practice and the NHS

This section will continue the discussion of the impacts of poor occupational wellbeing and burnout by outlining the impact on the organisation, such as presenteeism, high job turnover, recruitment issues, less appealing speciality, and the public’s trust in the profession.

The link between wellbeing and work performance can be considered through research in the field of organisational psychology. Krekel et al. (2019) conducted a meta-analysis exploring wellbeing in businesses that suggested there is a strong positive correlation between employee satisfaction, employee productivity, and customer loyalty, in addition to a robust negative correlation between employee satisfaction and staff turnover. This links to the human relation theory that suggests that higher job satisfaction leads to higher morale, in turn leading to higher productivity (Strauss, 1968) and less absenteeism and lower staff turnover. Job satisfaction has also been linked to increased job performance and lower absenteeism (Harrison & Newman, 2006) and citizenship behaviours such as helping colleagues (Fisher, 2002; Ilies et al., 2006). The emotional theory (Staw et al.,

1994) suggests that emotional states can drive and affect performance, such as positive mood heightening motivation and having favourable outcomes at work, including a more supportive social context and work achievement. Warr and Nielsen (2018) additionally have suggested that people and groups who have higher wellbeing perform better in their jobs than people with lower wellbeing; however, the authors do suggest that there is doubt among researchers about the direction of causation within this theory. Additionally, self-determination theory is an approach to human personality and motivation that highlights the importance of people's inner needs for behaviour self-regulation and personality development (Ryan et al., 1997). This theory suggested that there are three core human needs: autonomy (the need to experience behaviour as voluntary and to feel as though you are in control), competence (the need to feel like you have done a good job), and relatedness (the need to have meaningful relationships with other people and to have meaningful interactions).

This theoretical understanding maps onto the patterns being observed within general practice. Poor GP mental health and wellbeing are suggested to be linked to the poor retention and turnover rates in general practice, impacting the NHS's financial performance (Kinman & Teoh, 2018). Increased levels of exhaustion have been reported to impact the individual, organisations, and the economy, as it causes a reduced sense of wellbeing and increased absenteeism rates (Toppinen-Tanner et al., 2005). Poor working conditions can lead to the following problems: doctors feeling disengaged and undervalued, decreased morale among practitioners, falling recruitment, reduced productivity, and compromised patient safety and experience (Royal College of Physicians, 2016). Moreover, the increasing feelings of pressure and excessive strain being experienced in the medical community are linked to increasing numbers of staff leaving, which impacts the medical profession and the long-term viability of the NHS (Royal College of Physicians, 2016). More specifically, sub-optimal health behaviours of healthcare professionals have been linked to stress, illness, increased healthcare costs, obesity, high staff turnover, errors, and poor quality of care (AbuAlRub, 2004; Adams et al., 2004; Brand et al., 2017).

Careful consideration must be taken when looking at improving policy related to employee wellbeing as this can be resource-intensive (Krekel et al., 2019). Nevertheless, Boorman (2009a) suggests a business case for prioritising NHS staff health and wellbeing as improved health and wellbeing has been linked to better performance, improved patient satisfaction, stronger quality scores, lower levels of sick leave, and higher levels of staff retention. Moreover, Boorman (2009a) suggests that with this prioritisation of improving wellbeing, sickness rates are predicted to reduce by a third, creating 3.4 million additional working days and effectively saving the NHS £555 million per year.

2.3.2. Implications For Patient Care

Employee wellbeing is conducive to promoting GPs' intentions to remain working within their role and their willingness to provide services that improve patient satisfaction (Ogbonnaya et al., 2018). NHS England (2017) reported that treatment outcomes are far better across the NHS, and public satisfaction is higher than twenty years ago. Nevertheless, claims have been made suggesting that healthcare systems need to be redesigned to provide patient care that is safe, effective, efficient, and that meets the multiple needs of patients (Xie & Carayon, 2015).

Burnout has various adverse effects for the GP; however, Zenasni et al. (2012) suggest burnout might be as toxic for the patient as it is for the GP. General practitioner burnout has previously been associated with lower patient satisfaction and reduced health outcomes (Bodenheimer et al., 2014). Stressed, burnt-out, and dissatisfied GPs report a greater likelihood of making errors and more frequent instances of suboptimal patient care (Williams et al., 2007). Evidence suggests a significant correlation between poor wellbeing and worse patient safety, as identified in the systematic reviews completed by Hall, Johnson, Watt, Tsipa, and O'Connor (2016), and Dewa et al. (2017). The most concise description of patient safety is to not harm the patient (Morath & Turnbull, 2005).

However, while some research is investigating the impact of GP burnout on patient care, it is limited due to poor scope, low quantity, mixed quality, and a lack of consistency in the measures used.

Hall et al. (2018) found that GPs perceived their burnout as impacting their patient care. GPs believed that poor wellbeing and burnout affected the quality of care by reducing doctors' abilities to empathise, to display positive attitudes and listening skills, and to increase the number of inappropriate referrals made. Participants also noted that burnout and poor wellbeing can have negative consequences for patient safety through various mechanisms, including reduced cognitive functioning and decision-making abilities, a lack of headspace, and fatigue.

Nevertheless, Hall, Johnson, Watt, Tsipa, and O’Connor (2016), after reviewing research into the impact of GP burnout on patient care in a systematic review, reported that not all the evidence supports this negative relationship. There are contradictory findings; for example, Garrouste-Orgeas et al. (2015) concluded that burnout was not directly associated with medical errors, even when depression was controlled for in the analysis. Furthermore, when each domain of burnout (as measured by the Maslach Burnout Inventory) is evaluated separately, only a high score for depersonalisation has been associated with self-reported suboptimal patient care practices (Shanafelt et al., 2016).

Overall, greater levels of GP burnout have been associated with reduced patient safety, quality of care, patient satisfaction, reduced professional effort, self-reported suboptimal care at least monthly, and medical errors (Trollope-Kumar, 2012). Nevertheless, most of this evidence is presented only as a correlation in the literature. The overall evidence base to implicate burnout in suboptimal patient care is sparse, promoting unsupported conclusions (Kay, 2012). On the contrary, evidence suggests that the level of burnout does not limit GP awareness and diagnosis of mental health issues (Zantinge et al., 2009), nor affect a GP’s ability to make decisions (Pedersen et al., 2015). Consequently, a line of argument can also be drawn to suggest that the focus on the dramatic figures of the prevalence of GP burnout and the numerous correlations reported is restricting the progression of research into those GPs with good health and resilience (Kay, 2012) and into the true relationship between GP burnout and patient care.

2.4. Recovery

The previous section discussed the context of the thesis and described the evidence base related to GP poor wellbeing, specifically burnout. However, recovery is also important to introduce in this chapter, as defining this broad concept will provide context to Studies 3 and 4.

The language of recovery is used widely in health policy, service provision, and research, but it has various antecedents and is applied in numerous different ways (Ramon et al., 2007). Indeed, there are contrasting perspectives on the meaning of recovery (Campbell et al., 2008), and both service users and service providers find it hard to define (Aston & Coffey, 2012). Recovery in its narrowest and most mainstream conceptualisation is the change from ill health with symptom presentation to being healthy without symptoms (Price-Robertson et al., 2017).

However, the recovery model goes beyond this biomedical perspective and has a stronger focus on the personal. Rather than emphasising an individual being symptom-free, the recovery model focuses on a person being the object of recovery rather than the illness (Lukoff, 2007). The model suggests recovery is when a person has a satisfying life, even when they are subject to ongoing limitations (Anthony, 1993; Mental Health Commission of Canada, 2012). Davidson et al. (2006) add to this notion concerning mental health, arguing that recovery is a journey. Therefore, recovery is something that a person is described as ‘being in’ rather than as an endpoint or final destination (Davidson et al., 2006); in other words, it is a process (Liberman & Kopelowicz, 2005). The recovery model suggests that individuals can develop meaning and purpose in their lives, move beyond and grow from the event of illness (Anthony, 1993), and modify limited feelings, thoughts, or beliefs (Price-Robertson et al., 2017). Through this understanding, recovery is concerned with living a life beyond illness (Ramon et al., 2007; Shepherd et al., 2008). However, it is argued that the medical model of recovery cannot be discounted entirely due to the need to accept the illness in order to recover (Turner-Crowson & Wallcraft, 2002).

Moreover, while understandings of recovery have expanded to include key components such as agency and hope (Repper & Perkins, 2003), the recovery model is criticised when applied to mental health as it neglects to account for social determinants (Allen et al., 2014; Furlong, 2013). The burden of recovery falls with the individual, with other strong predictors of recovery such as social and familial factors being primarily ignored (Adeponle et al., 2012; Rose, 2014). Such prominent ideas have promoted the self-help approach where the individual is seen as isolated and enclosed in their recovery away from other interactions and social connections (Furlong, 2013; Stolorow, 2013).

Leamy et al. (2011) aimed to address this neglect of social determinants with their CHIME framework; CHIME is an acronym for connectedness, hope, identity, meaningfulness, and empowerment. This model moves to include the social through the process of connectedness – an idea that is further embraced by relational recovery, which has its core in the understanding that individuals are interdependent and inescapably part of their social contexts (Price-Robertson et al., 2017). Price-Robertson et al. (2017) wrote that interpersonal relationships are not only a part of recovery but that they are embedded with recovery, including through the processes of identity and empowerment.

2.4.1. Burnout Recovery

Successful recovery from burnout has previously been defined as an individual reaching a place where they are satisfied by their job, meaning that they consider it to be fulfilling, positive, and sustainable (Bakker & Costa, 2014). Recovery in this sense is the opposite of burnout, namely job engagement (Maslach, 2003). Maslach (2003) defines job engagement according to three key qualities: energy, involvement, and efficacy.

The high prevalence of GP burnout suggests the need to understand better the path to burnout recovery (Salminen et al., 2017). However, there is debate over the possibility and the extent to which an individual with burnout can recover. On the one hand, Cherniss (1992) reported that long-term recovery from burnout is possible and is not accompanied by significant long-term consequences. In line with this idea, Bernier (1998) explored stages of successful recovery from severe burnout in Canada in a range of professionals, identifying a typical process of acknowledging their experiences, establishing distance from work, restoring health, questioning values, exploring work possibilities, and making objective changes. Additionally, in a longitudinal study of treating job burnout in Finland through employee rehabilitation (care as usual compared to care with a workplace connection), Hätinen (2008) found that participants experienced reduced depression and improved job satisfaction. However, some of those with the most severe presentations of burnout did not benefit. This led the author to reflect that these individuals may have had burnout for longer and, therefore, had more treatment-resistant symptoms.

Therefore, Hallsten et al. (2011) suggest that job burnout may be a risk factor for long-term sick leave. Interestingly, Fältholm (2007) found that those doctors returning to the same work environment after burnout had not received adequate treatment, and therefore often did not return full-time. Such findings raise questions over whether a full recovery can be achieved when individuals with burnout stay in the same place of work. A further criticism of studies reporting successful recovery was presented by Schaufeli et al. (2007), who noted that although the initial conception of burnout was built on the presentation of severe cases, there has been a shift in the research in recent years to explore the success of support for milder presentations of burnout.

In a study exploring recovery in participants from a range of professions, it was reported that the most beneficial path to recovery from burnout was when the individual had a supportive work environment, as well as having high personal agency and favourable personal factors (Salminen et al., 2017). This being said, Maslach (2003) states that burnout is an issue of the social environment of a worker’s occupation, rather than that of the individual. Elsewhere it has been reported that more flexible work environments and improved communication strategies led to a shorter time on sick leave for those experiencing burnout in Sweden (Norlund et al., 2011). These notions pose a problem to the idea of recovery for GPs. As Fältholm (2007) has indicated, doctors returned to the same work environment after a period of sick leave. Restructuring working patterns and shift lengths is essential, however, organisations could do more to foster clinical teams, generate a sense of belonging, and balance the sometimes conflicting demands of evidence-based practice and clinician autonomy (Khan et al., 2018; Loas et al., 2018; West et al., 2016).

Strategies, such as mindfulness, Balint groups, coaching, and supervision groups have all been found to help reduce burnout and distress in doctors (Gardiner et al., 2013; Kjeldmand & Holmström, 2008; Nielsen & Tulinius, 2009; Schneider et al., 2014; Verweij et al., 2016). Interventions have also been shown to have positive outcomes when used more widely across professions (Hätinen et al., 2013; Norlund et al., 2011; Salminen et al., 2017; Stenlund et al., 2012). However, published intervention studies tend to be from countries where burnout is diagnosable, i.e., Finland and Sweden, and focus on populations that do not consist of GPs. Such recovery studies also tended to explore recovery quantitatively through correlational designs. One study which explored recovery qualitatively from an agency perspective found participants felt more in control the further along the path to recovery they were (Salminen et al., 2017). Other characteristics helped in the recovery process for non-healthcare professionals, such as the beneficial effects of affirmation from healthcare professionals and peer group members (Fjellman-Wiklund et al., 2010) and the fostering of responsibility for their wellbeing through cumulative support awareness and approval (Salminen et al., 2015).

The focus of research has shifted to preventative approaches, mainly relating to the individual and those still in work (Sonnenschein et al., 2007) and the need for individuals to develop adaptive coping skills (Kakiashvili et al., 2013). Nevertheless, resilience training to help protect doctors from the stressors created by their organisations has been questioned by clinicians, as resilience training can be perceived as shifting the responsibility of the struggling workforce onto the individuals (Balme et al., 2015; Oliver, 2017) and has led to a gap in knowledge in how to support GPs with severe burnout within the current context.

2.5. Research Questions

With the theoretical and empirical literature outlined, this brings the thesis to the research questions. One overarching question spans this PhD, asking what are the experiences of GPs with poor occupational wellbeing within the current healthcare context? The overarching research question has two sub-questions; the first is interested in what are the experiences of UK based GPs who self-identify as having or have had burnout, and the second is interested in what are GPs' experiences of accessing support and overcoming burnout?

2.5.1. Methods to Address the Research Questions

To explore these research questions, different approaches and methods have been used in this thesis. Each method will be explored in detail in the relevant chapter. For Study 1, a meta-synthesis was completed to collate the published qualitative research into GP poor occupational wellbeing, allowing gaps in qualitative research and implications for research and practice to be highlighted.

Based on the research gap identified in Study 1 of a lack of qualitative research exploring burnout experiences for GPs, an interpretive phenomenological approach was taken in Study 2, using in-depth semi-structured interviews with GPs to elicit accounts of their lived experiences. The findings were interpreted into art to be disseminated more widely than the traditional academic methods using an art-based booklet.

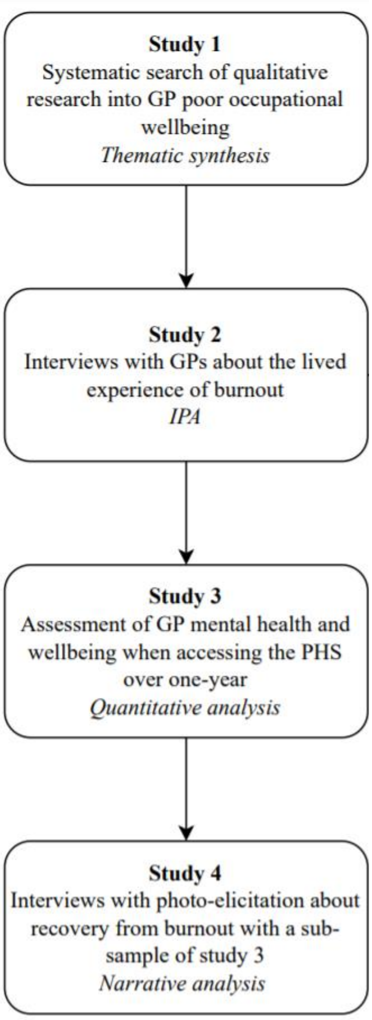
Study 3 moved away from qualitative research to explore the broader picture, the potential for improvement in wellbeing and mental health of GPs in distress through exploring the outcome data from the Practitioner Health Service (PHS). This service supports GPs to explore the potential for improving the wellbeing of GPs experiencing distress. This study measured participants' wellbeing and mental health at three timepoints, comparing psychometric scores across the year.

Finally, the stories of overcoming burnout were explored through a narrative approach, using unstructured interviews with photo-elicitation with participant-generated images analysed with narrative analysis. The word ‘overcoming’ is purposefully used over ‘recovery’ here and in the research sub-question due to the lack of consensus around the definition of recovery and the possibility of recovery from burnout, which is discussed in sections 2.4 and 5.4.3.

All studies address the question ‘what are the experiences of GPs with poor occupational wellbeing within the current healthcare context?’, captured most widely through the meta-synthesis exploring the perceptions and experiences of GPs internationally published in qualitative research. Addressing the more specific research questions within the overarching question, Study 2 specifically related to burnout, and the Study 3 and 4 combine to address the question ‘what are GPs’ experiences of accessing support and overcoming burnout?’. Each study informed the next, being brought together at the point of overall interpretation in the general discussion. The overview of the studies that make up the thesis has been presented in Figure 2.

Figure 2

Overview of the Studies in the Thesis



Chapter 3.

Study 1 – Voiceless and Conflicted: A Thematic Synthesis on GP Distress

Beaulieu et al. (2009) have described the universality of the challenges being faced in family medicine, and listed among those challenges the high mental strain and the increasingly heavy workloads (Le Floch et al., 2019). These widespread challenges have led to doctors' mental ill-health becoming “a global and growing concern” (Carrieri et al., 2020; p. 1). However, as explored in the previous chapter, research into poor GP occupational mental health and wellbeing has primarily focused on quantitative prevalence studies (Imo, 2017; Shanafelt et al., 2015; Soler et al., 2008) and, more recently, the impact of doctor burnout on patient care (Hall et al., 2019; Hall et al., 2016; Linzer et al., 2009; Panagioti et al., 2018).

Qualitative research enables the deeper meanings and dynamics of poor GP occupational wellbeing to be explored (Morse, 2003) while providing greater insights into the impact of organisational and societal changes. At this juncture of the healthcare crisis, it is essential to collate qualitative research on poor GP occupational wellbeing to better conceptualise and contextualise the prevalence data (Russell et al., 2016; Toye et al., 2016) and understand the direction for future research and policy. This is important as “a high-performing primary healthcare workforce is necessary for an effective health system” (Le Floch et al., 2019; p. 2), and, therefore, policy needs to adapt to sustain a readily accessible, high-quality service (Majeed, 2015; Mukhtar et al., 2018).

This chapter complements the broad exploration of the empirical and theoretical literature in the previous chapter by narrowing the scope to explore and synthesise qualitative published literature studying poor GP wellbeing. Meta-synthesis is a method that has the “potential of going beyond” (Bondas & Hall, 2007; p. 101) individual qualitative studies in order to create new understandings (Campbell et al., 2003) and identify new directions for research whilst making connections that already exist within the literature (Pope et al., 2007).

This chapter will first outline what a meta-synthesis is, justify the selected approach, detail the methods for conducting the qualitative synthesis, and finally present and discuss the findings. The meta-synthesis addressed the question of how do we best understand and conceptualise the experiences of GPs in relation to poor occupational wellbeing? It must be emphasised that this synthesis focuses on one group of publications, those that explore poor wellbeing, to understand these particular experiences better. However, this does not discount the whole spectrum of health and wellbeing that can be experienced by GPs, from GPs experiencing poor wellbeing to GPs thriving in their occupation.

3.1. Methodology

3.1.1. Meta-Synthesis

Meta-synthesis is a relatively new research ‘technique’ that is modelled on the traditional systematic review method, a parallel to the quantitative meta-analysis (Bennion et al., 2012; Jensen & Allen, 1996; Thorne et al., 2004). Meta-synthesis and its numerous contributing approaches have been defined many times in recent years; most broadly, meta-synthesis can be considered the systematic integration and interpretation of primary qualitative research (Ludvigsen et al., 2016). Crucial to add to this definition is the “potential of going beyond or behind the studies (‘meta’)” (Bondas & Hall, 2007a, p. 101), which Bondas and Hall (2007b) suggest is the primary value of the meta-synthesis. Campbell et al. (2003), therefore, argue that the synthesis aims to create a new understanding of the phenomenon under investigation that is “greater than the sum of parts” (p. 672). Furthermore, meta-synthesis can allow researchers to identify new questions to explore in the research area while making connections within the literature (Pope et al., 2007).

The popularity of the meta-synthesis approach has increased in recent years (Tong et al., 2012), with the number of meta-synthesis papers being published increasing from ten published in 1995 to 3250 published in 2015 (Thorne, 2017). Although this indicates an increased acceptance of the technique, concerns have been raised over the misuse of selected approaches. Poor reporting (Bondas & Hall, 2007b; Thorne, 2017) and inconsistencies in language around key synthesis stages contribute to confusion (Dixon-Woods, 2011) and potential tarnishing of the meta-synthesis (Thorne et al., 2004). Therefore, while conducting this meta-synthesis, the researcher aims to be transparent in their approach. However, this was difficult given the “chaos in the methodological terminology” (Bondas & Hall, 2007b, p. 115). To navigate the field, the researcher utilised critical reviews of qualitative synthesis methods, such as those completed by Barnett-Page and Thomas (2009) and Bondas and Hall (2007a), to select an appropriate approach. When identifying an approach for this meta-synthesis, the researcher considered the appropriacy for addressing the research aim and intended outcomes of the synthesis, epistemological position, the type of studies that would be synthesised – the need for homogeneity or heterogeneity, the stringency of guidelines, and allowance for the depth of synthesis.

Barnett-Page and Thomas (2009) conducted a critical review of the methods used in the literature for the synthesis of qualitative research and identified nine key approaches to meta-synthesis such as thematic synthesis (Thomas & Harden, 2008), grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1997), and meta-ethnography (Noblit & Hare, 1988). Thematic synthesis was selected to enable the aims of the study to be met. Thematic synthesis allows an inductive approach for deep analysis across the studies to generate higher-order themes (Nicholson et al., 2016), which would allow a better understanding of the experiences of GPs in relation to poor occupational wellbeing to be documented. Importantly, unlike meta-ethnography or synthesising using grounded theory, which necessitate homogeneity in the primary sources, especially regarding methods, the flexibility in the thematic synthesis approach allows for heterogeneity in the primary research. This was crucial to consider as a scoping exercise of the available literature highlighted research focused on a range of experiences of poor wellbeing (such as distress, depression, or burnout), used a range of data collection and data analysis methods, and investigated the topic from different epistemological standpoints. Finally, the researcher also had a preference for using well-defined guidelines (these will be described in section 3.1.3.4), and approached this synthesis from the epistemological position of critical realism, which is commonly aligned with thematic synthesis, framework synthesis and textual narrative synthesis (Barnett-Page & Thomas, 2009; Bondas & Hall, 2007b).

Therefore, thematic synthesis was selected as the dominant approach to inform this meta-synthesis. The researcher purposefully uses the word ‘dominant’ as searching for and identifying research was informed by the methods involved with Cochrane systematic reviews (Higgins & Green, 2006). The researcher has undertaken training with Cochrane and previously used these methods (Cardoso et al., 2017).

3.1.2. Theoretical Approach

Although the meta-synthesis is inductive, meaning the analysis was driven by the data, the researcher aligns with the belief that analysis is not completed within a vacuum and thus the researcher's biases and epistemological assumptions must be acknowledged (Braun & Clarke, 2006). The researcher’s epistemological position towards the meta-synthesis aligns with critical realism, for which hermeneutically based methodologies are the starting point (Price & Martin, 2018). It can be argued that language provides insight into the lifeworld of individuals (Bhaskar, 2016; Price & Martin, 2018), for which the researcher is an active agent in the interpretation of meaning; therefore, the approach embraces hermeneutics.

Archer et al. (2013) argue that critical realism, which states that “knowledge of reality is mediated by our perceptions and beliefs” (Barnett-Page & Thomas, 2009, p. 11), offers an alternative to positivism and postmodernism. Critical realism, when considering epistemological positioning as a continuum, falls in between idealism and positivism, with the two extremes being subjective idealism (reality is not shared and holds its place independently of multiple human constructions) and naïve realism (the existence of reality independent of human construction with knowledge able to be acquired directly) respectively.

When referring to thematic analysis in primary research, Braun and Clarke (2006, 2014) argue that it often assumes a realist approach, as it is aligned with exploring the meanings, experiences and realities of participants. Similarly, research employing thematic synthesis as the method for analysis is commonly associated with the epistemological position of critical realism (Bhaskar, 2013), as adopted here. Braun and Clarke (2006) advocate using this method through the lens of this epistemological position as it “works both to reflect reality and to unpick or unravel the surface of ‘reality’” (p. 81).

3.1.3. Procedure

3.1.3.1. Search Strategy and Screening Process. Shaw et al. (2004) and Barroso et al. (2003) articulate the difficulty in searching for and identifying qualitative literature. The current meta-synthesis employed a search strategy combining ‘free-text’ and ‘broad-based’ terms (Shaw et al., 2004). Therefore, various terms were used, ranging from the specific (narrative analysis) to the broad (interview). Terms were selected to include ‘who’ (primary care GPs), ‘what’ (poor occupational wellbeing), and ‘how’ (qualitative research), as informed by Bennion et al. (2012). The search strategy used can be found in Appendix A (Table A1). However, this broad strategy comes with a caveat, as strategies that aim to maximise the chances of identifying relevant papers are more likely to result in many false positives (Shaw et al., 2004). Therefore, the researcher ensured the allocation of sufficient time to screen a large volume of returns.

Although the search was systematic and therefore replicable, the author furthered the search by using a subsequent more iterative process more akin to the ‘berry-picking model’. This involved manually searching the reference lists of known relevant texts and the researcher communicating with experts in the field for known qualitative work. This allowed for some searching of the ‘grey literature’, which was an important consideration given the difficulty in retrieving qualitative literature and hopefully aided in avoiding the pitfall reported of many meta-syntheses that “merely represents the imprecision of electronic search” (Thorne, 2017, p. 5) and reducing the potential bias in the included papers (Conn et al., 2003).

For the literature search reported within this chapter, four databases were searched (PubMed, British Journal of General Practice (BJGP), Science Direct, and PsychInfo), and the references located extracted into Mendeley (Appendix A). For duplication removal, a combination of automatic (Mendeley automatically removed duplicates when RIS documents were uploaded) and manual (when Mendeley prompted a partial match had been located and when the researcher manually screened titles) duplication-checking was employed.

The researcher screened the title and abstracts of all references against the inclusion criteria. If the whole paper needed to be assessed, full texts were sought and reviewed for inclusion. The researcher established consistency and accuracy of screening titles and abstracts using a peer reviewer (10% titles and abstracts were assessed by a second researcher, and the independent ratings were compared). Furthermore, to check for the quality and consistency of the screening at the whole paper stage, 25% full papers were read by the researcher and a peer independently to screen for inclusion. When the reviewers disagreed on inclusion, this was discussed between the researchers and a third peer researcher.

3.1.3.2. Inclusion Criteria. Based on the aims of the study, the following inclusion and exclusion criteria were defined. Studies were included when more than 50% of their participants were fully trained GPs who worked in primary care, the authors had employed both qualitative research methods and qualitative analysis techniques, and the findings were orientated towards occupational wellbeing (e.g., stress, low mood, burnout, and experiences of distress related to work) or the perceived negative impact relating to changes in the GPs' context. Although there are differences in the healthcare provided by primary care GPs in different countries, there are enough similarities in the core elements to allow adequate qualitative synthesis (Strazdins et al., 2019). Therefore, no restrictions were imposed on the language of publications, and efforts were made to source translated copies of potentially relevant papers. A list of the inclusion criteria can be found in Table 1. The inclusion criteria allowed for a relatively narrow focus on the papers selected for inclusion, thus enabling manageability (Walsh & Downe, 2005).

Table 1

Inclusion Criteria for Study Screening

Criteria Type	Criteria
Types of studies	1) Studies must have a focus on: a) Impact of organisational, political, and societal changes for GPs related to negative attitudes towards work (e.g., distress/frustration oriented towards this). b) Alternatively, focus on negative mental wellbeing, either in experiences of illness or distress (e.g., stress, demoralisation, low morale). 2) Studies must be qualitative in their design, e.g., be theoretically informed by grounded theory, narrative, or discursive approaches. a) Studies must use a data collection method to generate qualitative data, e.g., interviews, focus groups, or qualitative responses to questionnaires. b) Studies must use qualitative analysis methods, e.g., thematic analysis or interpretive phenomenological analysis. c) Mixed methods studies will be included if sufficient qualitative data is analysed and reported to add to the qualitative synthesis. Only the relevant study will be reviewed if the research is part of a larger project, such as a PhD thesis comprising multiple studies/sections.
Participants	3) The majority of the participants must be GPs who work in traditional primary care – 51% and above (or have previously worked within primary care). Studies must focus on traditional in-hours primary care with a general focus rather than experience related to one patient group. a) Studies will be included if the participants have an adjunct role, such as academic GPs if most of the findings are related to illness or negative emotions related to clinical work or organisational, political, and societal changes related to general practice. 4) Samples will be included if most participants hold no clinical diagnosis or hold a clinical diagnosis centred around emotional distress, such as depression, anxiety, or burnout. a) Samples will be excluded if most participants hold a clinical diagnosis not centred around emotional distress, such as addiction (substance misuse) or attention deficit hyperactivity disorder.
Interventions	5) Studies will be excluded if they are an evaluation of an intervention as the qualitative analysis is likely to be focussed on the intervention rather than the wellbeing of the GP or organisational, political, and societal changes within general practice.
Outcomes	6) The outcomes from the analysis must be qualitative, and the findings from the study must be substantially supported with participant (GP) quotes. A minimum of 10 quotes was used to exclude papers (quotes made up of more than five words).

Like many aspects of synthesising qualitative data, the ideal number of studies is contested (Willig & Wirth, 2018). In practice, the number of primary studies included within a meta-synthesis has an extensive range. Bondas and Hall (2007a) report that meta-syntheses in the health sciences have been completed on a range of papers, from three (Russell et al., 1997) to 292 (Paterson et al., 2001). However, most reported on the inclusion of eight to 19 studies. Kearney (2001) argues that greater numbers of primary studies facilitate a more saturated and transferable analysis, whilst others caution that the inclusion of more than ten (Sandelowski et al., 1997) or 12 (Paterson et al., 2001) primary studies is likely to compromise the depth of the analysis.

3.1.3.3. Critical Appraisal of Included Studies. The creation of criteria for assessing the quality of qualitative studies and the transferability of such tools across qualitative methods is debated through the literature (Dixon-Woods et al., 2004). Nevertheless, within meta-synthesis, it is common to employ at least one type of critical appraisal to included studies; as Campbell et al. (2003) argue, this should take place first so that the results are presented transparently to the reader. This helps build a holistic picture of the synthesised studies for the reader and enables increased credibility of the method (Campbell et al., 2003). Therefore, the researcher has included the stage of a quality appraisal.

Before analysis, the quality of the included studies was assessed using the modified version of Spencer et al.'s (2004) quality framework. This modified framework was selected due to previous and frequent use in meta-synthesis exploring occupational health and wellbeing (such as Andersen et al., 2012; Gewurtz & Kirsh, 2009; MacEachen et al., 2006; MacEachen et al., 2010). The criteria includes 17 of the 18 questions published by Spencer et al. (2004) relating to “methodology (study design, sampling, and execution); analysis of data (theoretical approach, process, diversity in perspective, sensitivity to context); reporting (detail, depth, and complexity); reflexivity (careful attention to the context in which research occurs); neutrality; and ethics” (MacEachen et al., 2010, p. 183). This framework asks 17 questions of the published paper such as ‘How credible are the findings?' and 'How clear are the links between data, interpretation, and conclusions – i.e. how well can the route to any conclusions be seen?'.

For this meta-synthesis, the researcher adopted the approach of completing critical appraisals of included studies, but without using this as a criterion for exclusion, in line with recommendations from Sandelowski and Barroso (2006). A key element to this decision was the consideration that although papers may perform poorly against standard quality criteria, they may still hold considerable value. Therefore, all papers included within the synthesis were appraised for their quality by the researcher. The complete set of questions are provided under Appendix B (Table A3). A peer independently reviewed one-third of these, the results were cross-checked, and any disagreements were discussed (Appendix B, Table A4).

3.1.3.4. Synthesis of the Studies. This section will outline the synthesis methods informed by Thomas and Harden's (2008) approach. Before the synthesis, the researcher familiarised herself with the included papers, reading them in their entirety several times. While reading, the researcher 'free' coded the papers, making notes of interesting and salient points. To aid with initial familiarisation and understanding of the original context of the papers, the researcher explored the existing themes across papers, comparing conceptual terms and clustering ideas. Thomas and Harden's (2008) guidance to complete a thematic synthesis has been distilled into the four key stages followed for the current meta-synthesis. These are:

1) The extraction of data from the included studies. For this stage, the researcher extracted all text under 'results' or 'findings' and text which referred to the findings within the abstract. This text was copied verbatim into NVivo.
2) Coding the data. This included line-by-line coding according to its meaning and context. Studies were analysed in alphabetical order based on the first author's last name. It is argued that the process of translation of concepts between studies begins

at this stage as codes formed in the first paper are used to code the second paper. When new concepts were found, new codes were added to the bank of codes. Then codes from the first two papers are used to code the third, and so forth. This was completed with articles until coding saturation was reached.

3) Grouping of codes. For this, the researcher looked for similarities and differences between the codes to start grouping them into a hierarchical structure. New labels were created to capture the meaning of the groups and the translated ideas, which are descriptive themes. Thomas and Harden (2008) argue that the findings may be similar to the original findings of the included studies at this stage.
4) The final stage allows the deepening of synthesising across heterogeneous studies. The generation of analytical themes is completed by further exploring the hierarchical structures and initial coding at a greater depth, focussing on the meaning and interpretation of the structures related to chosen phenomena. This involves the mapping of key concepts across studies. A flow diagram depicting analysis related to the theme generation and an example of the hierarchical structure development is presented under Appendix C.

3.1.3.5. Rigour and Trustworthiness. As outlined within the theoretical approach to this study, the researcher aligns with critical realism. As the process of thematic synthesis is subject to and depends on the researcher's judgment and insights (Thomas & Harden, 2008), including when they assemble the coded data into a coherent and new whole (Sandelowski & Leeman, 2012), the synthesis will inevitably be just one of the multiple possible interpretations from the data (Toye et al., 2014). However, Finfgeld-Connett (2010) argues that the rigour of the methods and analysis can be strengthened in several ways, such as through well-documented audit trails, systematic sampling, and transparency in reporting. There is general guidance for meta-synthesis that can be followed, with knowledge learned from meta-ethnography as there are overlaps between approaches primarily related to the analytical theme stage.

To this end, the researcher actively sought to be transparent in decisions, approaches, procedures, and findings. The researcher documented the search and identification of articles in line with Cochrane guidelines. This included reporting search terms, the rationale for excluded studies at the point of full-text assessment, and using the PRISMA guidelines (Moher et al., 2009) to document the flow of information through the screening phase. As outlined in the data searching and screening, a peer researcher completed parts of the screening processes independently, and the accuracy and reliability across researchers were checked.

Furthermore, in line with recommendations by Thomas and Harden (2008), the researcher worked to preserve context by providing the reader with summaries of the included studies. This was done by presenting study characteristics in tables and presenting information regarding the quality of studies. The researcher also used systematic recording and reporting, and electronic software was used for reference storing and analysis to help create audit trails, thus bolstering transparency (Hadi & Closs, 2016). Peer debriefing was also employed through the analysis, with the researcher discussing themes and codes with peers and supervisors. Finally, in line with the epistemological position of the researcher, a reflexive journal was kept, which allowed the researcher to explore their perceptions, biases, and position towards the research through each stage (a section on reflexivity across the thesis can be found in the general discussion chapter). This was an important element due to the engagement in a triple hermeneutic. The researcher interprets and makes sense of the primary researchers' (authors of the included papers) interpretations of the primary data (Malpass et al., 2009).

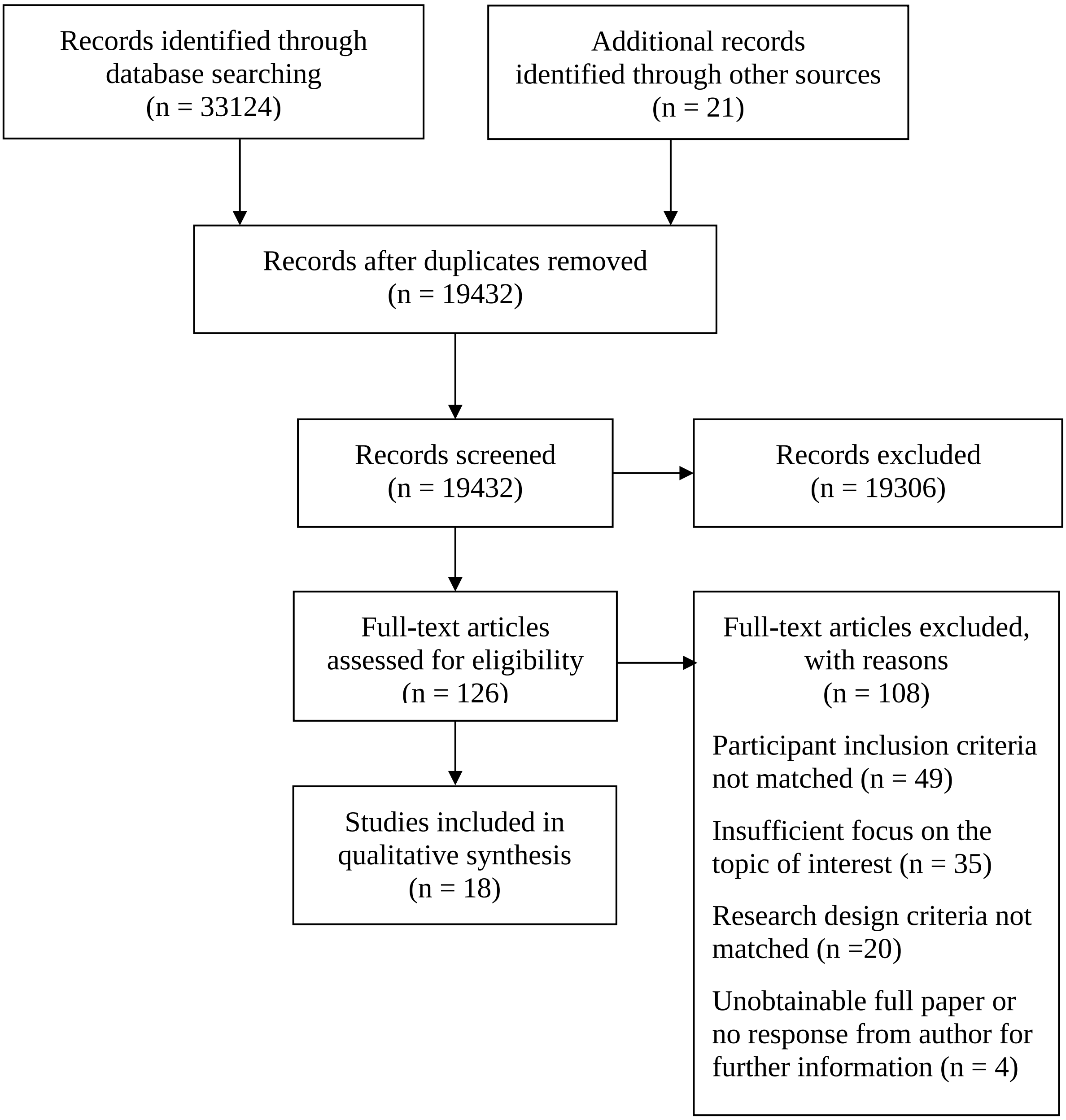
Where applicable, the PRISMA checklist (Moher et al., 2009) was used to ensure quality reporting of the systematic elements of the meta-synthesis and the enhancing transparency in reporting the synthesis of qualitative research statement (Tong et al., 2012) was used to inform the write-up of the qualitative synthesis elements. Following the approach Lachal et al. (2017) outlined, the findings presented in the following section consist of themes built from first- and second-order constructs. The organisation and interpretation helped develop the synthesis into a story; however, these were not considered third-order themes.

3.2. Meta-Synthesis Findings

The search returned over 1000 references from the four databases. After duplications were removed, a total of 19432 titles and abstracts were screened for suitability. A total of 126 full texts were deemed appropriate for review, of which 18 met the inclusion criteria based on their full text. The numerical breakdown of the search can be found within the flowchart presented Figure 3 and Appendix A. The table of excluded papers with allocated rationale code can be found in Appendix D (Table A5).

Figure 3

Flowchart Depicting the Records Processed from Identification to Inclusion



3.2.1. Thematic Saturation

Searching of the literature including grey literature was completed until thematic saturation was reached. Green and Thorogood (2004) suggest that saturation is reached when observing more data (in this case through the addition of more papers to the synthesis) would not provide significant development or discovery of more information related to the research aims. For this study, the new information was locating additional codes which informed the themes. To demonstrate how claims of saturation were established (Kerr et al., 2010), a breakdown of the generation of new codes per additional paper analysed is presented in Table 2. This table depicts the coding saturation by showing the total and additional codes (allocated to each paper in the analysis order).

Lowe et al. (2018) outline a critique of this method of demonstrating thematic saturation. Most importantly, they highlighted that it does not evidence the completeness of themes (or theoretical saturation) or that future observation would not provide new knowledge. However, this demonstration of thematic saturation is reasonable in framing the thematic saturation within the scope of this research study’s aim and the analytical framework adopted (Saunders et al., 2018). Furthermore, while no additional codes were found after the coding of Spiers et al. (2018), additional papers did support the analysis through the added richness of the themes, which is shown by the additional sub-codes identified in Agana et al. (2017) and Evans (2018).

Table 2

Table of Thematic Saturation

Reference (in order of coding)	Total nodes (including sub-codes)	Number of new codes (including sub-codes)
Cheshire et al. (2017b)	25	25
Croxson et al. (2017)	27	11
Dale et al. (2015)	32	7
Doran et al. (2016)	31	5
Fältholm (2007)	37	14
Huby et al. (2002)	24	0
Riley et al. (2018a)	27	4
Riley et al. (2018b)	18	2
Spiers et al. (2017)	38	3
Spiers et al. (2018)	46	1
Spinelli et al. (2016)	21	0
Agana et al. (2017)	20	2*
Agarwal et al. (2020)	29	0
Dillon et al. (2019)	32	0
Evans (2018)	49	2*
Petchey (1994)	26	0
Strazdins et al. (2019)	28	0
Svedahl et al. (2019)	29	0

*Additional sub-codes only

3.2.2. Characteristics of Included Studies

The meta-synthesis findings were based on 18 qualitative studies exploring GP’s experiences and perceptions of occupational well-being conducted between 1994 and 2020. Four of the 18 included papers report results from the same sample (Riley et al., 2018a; Riley et al., 2018b; Spiers et al., 2017; Spiers et al., 2018), however for this overview, they have been treated individually due to different themes presented within each and a subset of the participants being explored by Spiers et al., (2018). Except for three studies (Fältholm, 2007; Huby et al., 2002; Petchey, 1994), most were published after

2015. Ten out of the 18 reported on samples from the UK, with other studies based in America, Australia, Norway, and Sweden.

Most of their participants were primary care GPs, with 13 studies including solely GPs in their sample. There was an extensive range of participant numbers used in the samples, the smallest number of participants were found in Spiers et al. (2018), and Evans (2018) with ten participants and Dale et al. (2015) had the largest with 1192 GPs. The two extremities reflect the heterogeneity of the studies, with Dale et al. (2015) sampling a large number of participants with a mixed-method survey. In contrast, Spiers et al. (2018) took an interpretive phenomenological approach (IPA) which lends itself to small samples. The average number of participants based on the inclusion of all studies is 96.

The majority of the studies collected data via one-to-one interviews or interviews with focus groups with participants, whilst two employed the methods of only focus groups (Agana et al., 2017; Spinelli et al., 2016) and two used surveys (Dale et al., 2015; Petchey, 1994). Eight of the studies employed thematic analysis as their approach to analysis, and four studies (Dillon et al., 2019; Huby et al., 2002; Petchey, 1994; Spinelli et al., 2016) did not fully define their approach to data analysis. Summary characteristics of included studies are presented in Table 3 and Table 4.

Table 3

Characteristics of Included Studies (Country, Participants, and Quality)

Ref	Year	Country	Participants	N (GP)*	Quality**
Agana et al.	2017	America	Academic GPs	26	M
Agarwal et al.	2020	America	Primary Care Practitioners	21 (26)	H
Cheshire et al.	2017b	England	GPs	22	VH
Croxson et al.	2017	England	GPs	34	H
Dale et al.	2015	England	GPs	1192	H
Dillon et al.	2019	America	Front line physicians	15 (17)	H
Doran et al.	2016	England	GPs - Early Leavers	21	M
Evans	2018	Australia	GPs	10	VH
Fältholm	2007	Sweden	Physicians on sick leave	9 (15)	VH
Huby et al.	2002	England & Scotland	GP Principles	63	M
Petchey	1994	England	GP Principles	49	M
Riley et al.,	2018a	England	GPs	47	H
Riley et al.	2018b	England	GPs	47	VH
Spiers et al.	2017	England	GPs	47	VH
Spiers et al.	2018	England	GP Partners	10	VH
Spinelli et al.	2016	America	Healthcare Professionals	39 (44)	H
Strazdins et al.	2019	Australia	GPs	26	H
Svedahl et al.	2019	Norway	GPs & Co-Workers	23 (33)	VH

Note:

*N = The number in brackets is presented when the whole sample included participants other than GPs. N refers to the total number of participants in the study, including the GPs, whereas the figure outside the brackets refers to total GPs.

**Codes for the quality assessment: Very High (VH), High (H), Medium (M) and, Low (L)

Table 4

Characteristics of Included Studies (Aims, Methods, and Themes)

Ref	Aims (To Explore)	Data Collection	Analysis	Main Themes
Agana et al. (2017)	The factors that contribute to job satisfaction and burnout in faculty members in a family medicine department	Focus Groups	Constant Comparison	Time. Resources for clinicians. Undervalue of family medicine. Benefits of a family medicine career. Practice demands. Physician wellbeing.
Agarwal et al. (2020)	Factors contributing to burnout and low professional fulfilment, as well as personal solutions, by eliciting the views of primary care physicians	Focus Groups and Interviews	Grounded Theory	External contributors to burnout and low professional fulfilment. Internal manifestations. Potential solutions.
Cheshire et al. (2017b)	GPs' experiences of workplace challenges and stresses, and their coping strategies	Focus Groups and Telephone Interviews	Thematic Analysis	Work intensification and morality: 'It's becoming very Big Brother. Intensification and patient complexities. GP coping, work-life balance, and downsizing.
Croxson et al. (2017)	GPs' perceptions and attitudes towards workload	Interviews	Thematic Analysis	Patient needs and expectations. Relationship between primary and secondary care. Bureaucracy and resources. Balance of workload within a practice.

Ref	Aims (To Explore)	Data Collection	Analysis	Main Themes
Dale et al. (2015)	Underlying factors to increasing rates of early retirement and intentions to reduce hours of working	Mixed methods – survey	Thematic Framework Analysis	Growth in patient expectations and demand. Recruitment and retention difficulties. Burgeoning administration and bureaucracy. Growth in additional roles, responsibilities, and meetings. Transfer of work from secondary care. Increasing complexity and chronic ill health. Revalidation and regulatory assessment. The introduction of seven-day working in general practice. Emotional impact of working as a GP. Cumulative impact of work-related pressures on GPs. Improving working conditions to retain the GP workforce. Workplace influences. Individual motivators.
Dillon et al. (2020)	The perspectives of health system leaders and frontline physicians on the contributors to physician burnout and strategies to improve wellbeing.	Interviews	Unclear	Workplace and poor work-life balance: desktop medicine. Organisational structure and culture: the push for productivity. Support staff, physician autonomy, and leadership. Social support, feeling valued and meaning in work. Coping with burnout: fractional quitting and quitting.

Ref	Aims (To Explore)	Data Collection	Analysis	Main Themes
Doran et al. (2016)	Why GPs leave general practice early	Telephone Interview	Thematic Analysis	Organisational changes. Clash of values. Increased workload. Negative media portrayal. Workplace issues and lack of support. Impact on job satisfaction and wellbeing.
Evans (2018)	The influence of resilience on perceived job demands, burnout, and an intention to quit the profession, as well as the lived experiences of GPs	Interviews	Thematic Analysis	Job resources. Job demands. Work-family conflict. Resilience. Burnout. Intention to quit.
Fältholm (2007)	What happened before, during, and after sick leave	In-Person and Telephone Interviews	Grounded Theory	Dealing with changing working conditions. Resisting sick and patient roles. Resisting sick leave. Leave. Returning to work.
Huby et al. (2002)	GPs’ experiences of wellbeing and distress at work	Focus Groups and Interviews	No Defined Approach	Partnership arrangements and personal style. Workload, partnership arrangements, and personal style.

Ref	Aims (To Explore)	Data Collection	Analysis	Main Themes
Petchey (1994)	GPs' practice orientation and responses to change	Questionnaire	Unclear	Collectivism. Pragmatism. Traditionalism. Alienation.
Riley et al. (2018a)	The sources of stress and distress experienced by GPs	In-Person and Telephone Interviews	Thematic Analysis	Emotional work. Practice culture. Work role and demands.
Riley et al. (2018b)	GPs' experiences of living and working with mental illness and distress	In-Person and Telephone Interviews	Thematic Analysis	Symptoms of burnout. Symptoms of anxiety. Symptoms of depression. Suicidal Ideation. Shame and feelings of failure.
Spiers et al. (2017)	GPs experiences of considering seeking help for their mental distress	In-Person and Telephone Interviews	Thematic Analysis	Barriers and facilitators to help-seeking for distress. Survival strategies.
Spiers et al. (2018)	Experiences of GP partners in mental distress	In-Person and Telephone Interviews	IPA	Experience of extreme distress. Conflicted doctor identity. Toxic versus supportive partnerships.

Ref	Aims (To Explore)	Data Collection	Analysis	Main Themes
Spinelli et al. (2016)	Experiences of burnout and perceptions about its causes	Focus Groups	No Defined Approach	Perceived Impact of the Work Environment. Perceived Impact of Work Tasks. The Perceived Role of "E-Stress".
Strazdins et al. (2019)	How the demands of general practice, especially new time pressures, impact GPs' professional and personal lives and work hour choices	Interviews	Thematic Analysis	Time demands and work intensification of GPs. Time pressures linked with demographic change in the GP workforce. Part-time work: an imperfect coping strategy.
Svedahl et al. (2019)	How they perceive and tackle their workload, and their experiences and reflections regarding explanations for and consequences of increased workload in Norwegian general practice	Focus Groups and Interviews	Systematic Text Condensation	Heavy and increasing workload – more trend than fluctuation? Explanations for the high workload. Transfer of tasks. Increased work per patient. Changes in society. Consequences of high workload. Consequences for patients and the healthcare system. Personal consequences for GPs.

3.2.3. Quality Appraisal of the Included Studies

The quality ratings were based on the criteria (Table 5) for low, medium, high, and very high, as MacEachen et al. (2006) specified. Final ratings can be found in Table 3, and scores for each component are reported in Appendix B.

Table 5

Requirements for Study Quality Grading

Rating	Requirement
Low	An overall lack of detail is provided with an inadequate analysis or sampling strategy. The notion that the data does not ‘ring true’ and it appears that the authors have super-imposed their ideas onto the findings
Medium	The analysis and findings are vague or descriptive, with relatively few details provided for context and detail. The appearance of superficiality
High	Provides an adequate level of analysis but is still descriptive in places. Has presented considerations of the context as well as more nuanced information of study participants and their complex environment
Very High	A more detailed picture of the analysis and findings demonstrates nuance, context, and the author's theoretical focus. Inclusion of findings and discussion which hold an explanatory value that with a discussion of the potential for transferability

The overall quality of the included studies was high. Seven studies ranked very high, seven high, and four medium. Across the studies, high ratings were seen on questions one through four, all in relation to the credibility of findings, extending the existing knowledge in the field, addressing the study's aims, and explaining the broader inference. Through the rest of the criteria, there was considerable variation between studies. Of note were the poorer ratings for questions relating to explicit theoretical assumptions, declarations of values, consideration of ethical issues, and documentation of the research process.

Some of this variation in scoring can be related to the methods employed by the studies; for example, those that employed grounded theory or IPA tended to score higher on the question relating to the depth and complexity of the data analysis compared to those using thematic analysis. Variation in reporting and quality scores can also be understood through the journal that published the article and the allocated space. The difference in depth of reporting can be expected when, for example, Spinelli et al.'s (2016) paper spanned five pages compared with Fältholm's (2007) 13 pages. Those with shorter word allocations tended to prioritise the presentation of findings rather than documenting methodological rigour. All included studies contributed data to the synthesis; however, the quality of the studies tended to reflect their contribution to the findings. Those with lower quality scores usually had less depth in their findings or a shorter findings section, and therefore contributed less. This reinforces the decision not to exclude studies based on quality, as each findings section helped achieve a more nuanced synthesis.

3.2.4. Themes

The findings from the thematic synthesis are presented through three themes and nine sub-themes (Table 6). Quote tables that accompany this results section are in Appendix E.

Table 6

Themes of the Meta-Synthesis

Themes	Sub-Themes
Escalating professional demands	General practice The wider healthcare system Beyond the healthcare system
Feeling devalued and silenced	Questioning their value Doctors’ experiences of wellbeing Lost narratives
Surviving	Striving to cope with the role Personal limitations The unsustainable role

3.2.4.1. Escalating Professional Demands. This theme explored the perceived challenges that influence the GP role. Working on the front line in general practice holds inherent and new challenges. Most notable was the increased burden of work, including the advancement of technology and the bureaucracy of the job, both of which added substantially to the perception of time pressure. While there was an emphasis in the studies on everyday GP work, this was often presented within the inescapable context of the growing pressures in the wider healthcare system and a progressively more demanding society.

3.2.4.1.1. General Practice. Participants frequently compared their current working conditions to a time when their role was more tolerable: “There definitely used to be a slack in the day when you could sort of, you know, have a breather, just sit and chat to your colleagues, and that’s gone” (Croxson et al., 2017). The new challenges in their role overshadowed the “historical benefits of being a family physician” (Agana et al., 2017), which were discussed more frequently as being increasingly detrimental to their wellbeing. As one participant noted, “After 33+ years in GP I've never known morale to be so low” (Dale et al., 2015).

GPs described an exponentially “escalating” (Evans, 2018) workload resulting in unachievable demands, with GPs being “under intense and historically unprecedented pressures” (Cheshire et al., 2017b). This pressure can be seen in GPs feeling “increasingly time-stretched” (Doran et al., 2016) with additional work (mainly administrative tasks), which was viewed as “mind-boggling”, (Croxson et al., 2017), “overwhelming” (Agarwal et al., 2020), “unreasonable” (Cheshire et al., 2017b) and an “absolute nightmare” (Evans, 2018). The increased endurance and speed needed to complete this work is demonstrated in the language used: “the marathon Sunday” (Dale et al., 2015), and “everything had to be done at 90 miles an hour” (Spiers et al., 2018). However, simultaneously, GPs felt they were being held back – “swimming through treacle” (Riley et al., 2018b) – with work often bleeding into their personal time: “You’re in pajamas, and you’re finishing your work for the day” (Dillon et al., 2019).

A substantial number of participants related this additional workload to elevated levels of bureaucracy within general practice. Some GPs saw this as being due to the speed of implementation (Petchey, 1994) and the disjointed nature of the changes, referencing the Care Quality Commission, the Quality and Outcomes Framework, technological advancements, and the growing accessibility of GPs (Cheshire et al., 2017b; Croxson et al., 2017; Dale et al., 2015; Riley et al., 2018a). This was perceived to have increased workload and fundamentally changed the type of work into that of a “data clerk” (Doran et al., 2016). Most reported this in connection to feelings of resistance and frustration (Agana et al., 2017; Strazdins et al., 2019; Svedahl et al., 2019). However, in contrast, a few GPs saw positives in this evolution of general practice: “They were able to carry out more and more complicated medical interventions because of the medical and technological development” (Fältholm, 2007). However, quotes that showed support for these developments were commonly linked with reporting of the mismatch between demands and resources, or poor implementation: “Pressure to audit absolutely everything, which I agree is a good idea, but it is actually quite difficult to do it with no extra resources in terms of money to spend on staff to help” (Huby et al., 2002).

3.2.4.1.2. The Wider Healthcare System. The experiences of GPs were often framed within the wider context of their healthcare system. As Cheshire et al. (2017b) noted, system factors were “particularly important in understanding GP stress.” A poor medical culture was reported in healthcare systems across countries included in the synthesis. Dissatisfaction was typically related to organisational changes, such as the “continually escalating organizational demands for increased productivity and patient access” (Spinelli et al., 2016). Some connected this to the detachment of the decision-makers from the practicalities of working on the front line and scientific evidence: “I would like political interventions and policies to be based on scientific evidence, not whim" (Dale et al., 2015), and consequently their implementation of decisions without "long-term vision" (Doran et al., 2016) or considerations of the repercussions (Agarwal et al., 2020). As one participant summarised, "I think general practice is getting harder. We're getting expected to do more and more complex things and it's hard to, especially for The Powers to recognise the complexity of managing multiple health issues" (Strazdins et al., 2019).

This resulted in the perception among some GPs that they were holding together the "broken machine" (Spiers et al., 2018) of their healthcare system. General practitioners described escalating pressures despite reaching current capacity: "We can't cope with 5 days at the moment, how on earth are they going to get us doing 7 days!" (Cheshire et al., 2017b). The lack of resources to perform tasks adequately was a common theme across the studies (Dillon et al., 2019; Evans, 2018), as one participant described: "You're supposed to be God and to be able to handle this without getting the proper resources or support" (Fältholm, 2007). Moreover, relations between general practice and the wider healthcare system were perceived as "fragmented and depersonalised" (Doran et al., 2016) for both GPs and their patients (Svedahl et al., 2019). In some extracts, secondary and primary care seems to be on opposing sides when providing care, with general practice being buried in the transfer of workload (Agana et al., 2017; Dillon et al., 2019) – "We are a giant funnel, and we take everyone in" (Agarwal et al., 2020) – with no clear overflow system for primary care (Fältholm, 2007).

The frustration for doctors became more prominent when change and poor communication between services impacted their everyday provision of care: "Obviously patients can no longer get normal GP appointments as a large number of our appointments are now used up doing hospital outpatient duties" (Dale et al., 2015). Although the frustration with the transfer of work burden to primary care was expressed by participants, in the studies by Croxson et al. (2017), Svedahl et al. (2019), and Petchey (1994), some participants supported the changes: “There are whole disease areas which we’ve taken on, quite rightly actually” (Croxson et al., 2017).

The ways GPs attempted to cope when facing unmanageable workloads have foundations in the medical culture where “medical school deliberately stripped away the emotions of doctors” (Spiers et al., 2018) and being taught that “as a doctor you're supposed to handle being on emergency duty three days in a row without being tired. You played some kind of heroic role, almost like Superman” (Fältholm, 2007). This resulted in a “survival of the fittest” culture where participants adopt an individualistic approach, specifically “every man for himself” (Riley et al., 2018a). A minority of included papers reported that such a culture could foster a breeding ground for bullying and consequently vulnerability of healthcare professionals to mental illness (Doran et al. 2016; Huby et al., 2002; Riley et al., 2018b; Spinelli et al., 2016).

Conversely, a few doctors indicated that their attempts to continue working in an unsustainable way might perpetuate these issues. GPs reported that succumbing to the year-on-year demand of “come on, try a little harder” (Spinelli et al., 2016) had the effect of diminishing the problems within healthcare: “The longer we go on pretending we can, the longer that the system is going to limp along and no one is actually going to address the issues” (Spiers et al., 2018). Nevertheless, for some, there was no optimism that resistance would lead to the necessary change – “I don’t know if people are capable of that cultural shift” (Doran et al., 2016) – which is noted across countries as some participants’ mentioned that “commitment to the overall organization had vanished” (Fältholm, 2007).

3.2.4.1.3. Beyond the Healthcare System. GPs described the perception of growing public expectations and patients’ increased reliance on primary care across studies. Patients are reported as becoming more complex (Cheshire et al., 2017b) and often attending appointments with multiple issues (Evans, 2018), “leading to unmanageable pressure within the current model of 10 [minute] consultations” (Dale et al., 2015).

Participants also reported patients as having increased empowerment and entitlement in terms of their healthcare, increasingly adopting a consumer approach (Agarwal et al., 2020; Evans, 2018; Fältholm, 2007): “I often make the parallel of children demanding … as many sweets as they would like” (Petchey, 1994). Despite an expectation that patients need to self-manage, some participants thought that patients show a diminished ability to self-manage and emphasised their concerns that patients are increasingly “not educated in terms of seeking appropriate help, and […] do not attempt self-care” (Dale et al., 2015). Some GPs viewed part of the increasing demand to be a consequence of patients presenting with more minor illnesses and more frequently, which is increasing the demand on healthcare (Huby et al., 2002; Strazdins et al., 2019), specifically the front line of general practice: “Some patients act like you are their instant message buddy” (Agarwal et al., 2020). Some doctors saw this as an issue in a society where the GP is replacing the role of social support, which is now less available in the community, meaning that “minor issues that previously could be solved by ‘asking grandmother’” are now being referred to GPs (Svedahl et al., 2019). This led to GPs reporting a sense that they were “propping up society” (Croxson et al., 2017). As patient expectations and needs changed, some participants mentioned that they needed to “adapt to” (Dale et al., 2015) rather than reject them. Nevertheless, the possibility of adapting was challenged as patient expectations outstrip what can be provided within the NHS.

Some noted that the empowerment of patients has led to an entitlement to “complain and criticise the profession at every available opportunity” (Dale et al., 2015), which was reported to reduce the status and power held by doctors (Petchey, 1994). Some GPs highlighted the emotional vulnerability of the doctor when receiving complaints which saps an “immense amount of time and emotional energy” (Cheshire et al., 2017b), as “often they arrive at the times when you’re most vulnerable, so quite a few people are very badly affected by complaints” (Riley et al., 2018a). Others expressed concern over what they called ‘complaint culture’, which had contributed to changing the way they practised medicine:

> Now I, we, work in, I think, in [sic] increasingly, not only litigious, but complaining environment, and that really for me is the reason why I just visit everybody that asks me to. I don’t question any of it anymore, and again I think, I think that probably fear is probably pushing workload up. (Croxson et al., 2017)

This resulted in “not the sickest, but the angriest” (Fältholm, 2007) patients receiving more health information and additional care.

The precarious standing of general practice in the community was seen to be further eroded (Doran et al., 2016) by the harmful media and political campaigns against GPs as illustrated in a few papers: “A perceived negative portrayal of GPs by the UK media and politicians particularly concerned participants” (Cheshire et al., 2017b). The media was perceived to ‘batter’ GPs regularly, with the profession being portrayed in a negative light. Participants referred to this as acting as a ‘demotivator’, becoming “very wearing” (Doran et al., 2016) and being “demoralising” (Spiers et al., 2017). GPs commented that they were receiving the brunt of the blame for problems within society or the healthcare system, with a “change in attitude from politicians and press blaming all the NHS problems at the door of general practice” (Croxson et al., 2017), in which doctors “were regarded as part of the problem” (Fältholm, 2007).

3.2.4.2. Feeling Devalued and Silenced. The occupation context outlined above impacted how GPs experienced and perceived their role. Consequently, GPs described belonging to an increasingly devalued profession, being set up to fail, and their voices were being left unheard. This impacted their mental health and raised concerns for the provision of quality care.

3.2.4.2.1. Questioning their Value. The role of ‘doctor’ was commonly portrayed by participants as a substantial part of their identity, with a strong commitment to patient care and hard work. Those who were able to maintain this commitment strove to work hard “because they liked what they were doing” (Fältholm, 2007). The underlying motivation for their work was explained as follows: “We all love our job, we work for the patients” (Cheshire et al., 2017b), and that “Helping patients makes work meaningful” (Dillon et al., 2019).

The increases in workload not only further burdened GPs but also stripped away their autonomy, with the NHS being perceived as very “Big Brother” (Cheshire et al., 2017b). Increased micromanagement resulted in GPs describing reduced autonomy; as one of Fältholm's (2007) participants explains:

> Reduced us to wage-earners on the conveyor-belt in a fundamentally different way. When you describe what it was like fifty years ago, when you were master in your own house, that doesn’t exist today. (Fältholm, 2007)

There is also an additional impact of disrespect (Dillon et al., 2019; Evans, 2018) on GP status, as one GP reflects: “The lack of respect the powers that be and the public have for us. We have been de-professionalised, de-humanised and de-moralised” (Dale et al., 2015).

The increased pressures and responsibility, while also having reduced autonomy, were seen as particularly problematic for doctors. Their profession, which GPs described with passion, was perceived to now have elements that were devoid of real meaning (Svedahl et al., 2019). Doran et al. (2016) described it as “organisational changes resulting in a clash of values and diminishing professional autonomy as health care became more centralised, standardised, and depersonalised.” This standardisation of work paired with the earlier-mentioned medical training removing the emotion from doctors serves to strip the human element from the GP profession: “Our tools are our brains; but because that is so much more nebulous than a procedure, it is not as respected or preserved” (Agarwal et al., 2020). It was highlighted that the traditional view of the role is being challenged, with some doctors feeling the “creativity” (Petchey, 1994) and humanity of the occupation is being eroded, which has resulted in GPs reporting feeling deskilled and devalued.

Most GPs across the studies considered these changes mentioned above as having created barriers to their role's desirable and rewarding elements, such as providing care. One GP highlights the frustration: “I just want to get on with caring for the patients, I am fed up with the endless pointless paper exercises” (Dale et al., 2015). Some demonstrate an active distaste for such a shift away from their values and expectations of the role: “You want me to put them on a tablet just to get the money in? This is not what I signed myself up for” (Cheshire et al., 2017b).

One of the dominant narratives surrounding diminishing doctor wellbeing is the concern over the quality of care received by patients. This was mentioned in direct relation to the change in the type of work and the value of care (Agarwal et al., 2020): “I felt it affected my rapport with the patients” (Doran et al., 2016). This led to more significant worry: “You’re constantly worried and the more stressed you are the more worried that, ‘Oh my God, I’m definitely missing something now’” (Cheshire et al., 2017b). For some, the impact of the increasing workload was most concerning when they considered how they felt when practising medicine, with participants reporting feelings of reduced empathy and reduced connections to patients: “I was saying all the right things but […] I felt quite detached from it” (Riley et al., 2018b).

3.2.4.2.2. Doctors’ Experience of Wellbeing As would be expected across diverse samples, GPs’ depictions of their wellbeing varied. For example, Huby et al. (2002) reported that their participants “described a range of experiences of general practice, from deep distress to high levels of satisfaction.” As explored above, concerns that were dominantly reported were the perceptions of change and the sources of distress for GPs:

> Loss of control, top-down decisions. You may have heard these buzzwords. These are the examples of things that have come along that have stripped away at a physician's sense of autonomy, control, and then therefore leads to responses of feeling burned out. (Dillon et al., 2019)

A further key theme was the experiences related to poor wellbeing. There seemed to be a consensus across most papers that GP wellbeing, particularly morale, is decreasing over time. More specifically, across most studies, participants discussed various states, such as exhaustion, stress, anxiety, low morale, distress, burnout, disillusionment, feeling overwhelmed, and suicidal ideation.

The increase in work intensity has had a considerable impact on the day-to-day work of these GPs, as one participant states directly: "My current [work] conditions are destroying my health and psychological wellbeing" (Dale et al., 2015). In support of this notion, some GPs give examples of basic needs within their day that they neglected (Svedahl et al., 2019). As one GP highlighted:

> I have a flask in my room and a little fridge to ensure I keep hydrated, otherwise I wouldn't get a drink because it's just so, I can't pop out. I probably have one wee a day! You forget to wee unfortunately, 'cos you're so busy, and it's the non-stop, it's the non-stop sort of the job I think that's the hardest. (Croxson et al., 2017)

GPs discussed working harder and resorting to rushing through their "unlimited" (Dale et al., 2015) workload with little or no time to prioritise their personal needs. Elevated stress was a common theme across studies; Riley et al. (2018b) reported that even participants who self-reported having no mental health problems described feelings and symptoms which would be associated with high stress and anxiety. For some doctors, the distressing experiences of work were intense, "I thought I could be super human or super woman, and I just was crashing and burning most of the time" (Strazdins et al., 2019), whilst others spoke of having a sense of impending “dread” when thinking about work (Doran et al., 2016).

This constant negative occupational culture resulted in reduced energy for some “I was beginning to feel very tired as a result and that it was taking more out of me than it ought to really” (Riley et al., 2018b). One participant described a culture rife with bullying and lack of patient respect as being comparable to a bad relationship: “If you spend a considerable portion of your day defending yourself, being abused and treated in a disrespectful way, your life becomes a miserable thing” (Evans, 2018) not dissimilar to “an abusive relationship, where I’m unwell and I’m being shouted at at work. I hate coming into work” (Riley et al., 2018a). Moreover, the experiences of GPs within the current organisation and societal turbulence, when taken collectively, often sounds as though they are victims of abuse. “GPs are battered” (Dale et al., 2015), one participant noted, echoing the “media battering” described elsewhere (Doran et al., 2016), while another participant said of their working day: “I get home after a 10 [hour] day and feel as if I have been hit round the head with a brick” (Dale et al., 2015). The feelings of lack of support, media battering, and challenged resilience within the context of non-stop work for some became normalised: “You don’t really feel it happening; you’re just trying to get through” (Spiers et al., 2018). As Fältholm (2007) says of the normalisation of poor wellbeing: “It became clear that it had been characterized by stress and fatigue, but that this had become part of normal life.” In its most extreme form, a minority of participants mentioned reaching a crisis point of suicidal ideation: “I could not stop thinking that I wanted to kill myself” (Spiers et al., 2017), and “I started thinking, ‘I’m going to jump onto those train tracks’” (Riley et al., 2018b).

3.2.4.2.3. Lost Narratives. An additional way in which GPs felt “criticized and unappreciated” (Spinelli et al., 2016) was through the lack of acknowledgement of their positive achievements (Dale et al., 2015; Dillon et al., 2019; Doran et al., 2016; Evans, 2018;

Spinelli et al., 2016). For some, it was frustrating to see no voices of support or concern for GPs: “Nobody has stood up for GPs to say that it is too much, so I am retiring earlier than I had planned. Perhaps when there are no GPs left someone will ask why?” (Dale et al., 2015).

Doctors spoke about being silenced, having lost their voice in the wider healthcare system (Agarwal et al., 2020; Petchey, 1994; Svedahl et al., 2019), decision making, policy, and within their practices and partnerships. Some GPs highlighted that they felt they were “getting over-ruled by the senior partner”, like their “views weren’t taken into account” (Riley et al., 2018a), that they were being “undermined” (Dale et al., 2015; Doran et al., 2016) and that they were “beholden to the system” (Strazdins et al., 2019). Moreover, some GPs felt they were being “set up to fail” (Cheshire et al., 2017b), with “no way to put limits or say no and really demand that we get treated better” (Agarwal et al., 2020). A compelling account was quoted in Spiers et al. (2018) where a GP partner interpreted their physical voice loss as a consequence of being “silenced” in their practice. This was after taking time off for stress, with Spiers et al. (2018) interpreting it in the following way: “Her partners were symbolically drowning her voice out, or maybe it was an element of her own identity that wanted to speak out, but didn’t feel able to.” This lack of having a heard voice was epitomised in a reflection of Fältholm, who said:

> Many of the participants seemed desperately to need somebody to talk to and ‘gave’ me the role of therapist in some of the interview sessions, which was something that, in addition to what they actually said, made me think that I was the only one who had ever taken the time to sit down and listen to their stories. (Fältholm, 2007)

The medical culture itself was thought to prevent GPs from speaking about their mental health. This idea was evident when a participant described the aftermath of a peer suicide, where the emotions and experiences of those left behind were ignored:

> Well, we've just got to carry on. We've got this job to do,' and there was no time to (pause) even really acknowledge it, you know, beyond having the usual things like funerals and stuff. So it was almost swept under the carpet like, 'Well, you know, let's just carry on. Let's not address what perhaps might have contributed to it at work. (Riley et al., 2018b)

Nevertheless, some GPs spoke of occasions where communication was more open, such as in regard to discussing their ill-health (Huby et al., 2002). A minority of participants in Spiers et al. (2017) expressed the positives of being open within their workplace, which could facilitate help-seeking, and as one participant said, "I try and act as a bit of an advocate, really, within the practice, and within medical circles. I haven't – I haven't hidden any of it."

3.2.4.3. Surviving. The final theme related to how GPs navigated their changing context, either through efforts to survive in the role or acknowledging the incompatibility of a full-time GP role with good wellbeing.

3.2.4.3.1. Striving to Cope in the Role. Participants described the strategies they used to cope in their role: "My current strategy (in theory) is to concentrate on personal survival" (Petchey, 1994). This often involved self-distraction through focusing on their drives and values, "what they enjoyed about their job" (Cheshire et al., 2017b) or self-care, which could be as simple as ensuring they got a good night's sleep (Riley et al., 2018b). Being aware of one's psychological limits was mentioned by several participants and was often linked to "establishing boundaries, understanding what your limitations are" (Spiers et al., 2017). Participants referred to setting boundaries for a better work-life balance, as work "bleeds into the time you should be enjoying yourself" (Agarwal et al., 2020), and acknowledging that time spent away from work holds great value as a distraction or an escape or as a way to reclaim a sense of self, "separate from their professional role as a GP" (Spiers et al., 2018).

Some participants found that they could regain or rebalance their sense of control by reducing their hours, particularly moving to locum work, which was seen as a proactive way to prevent deterioration of wellbeing (Evans, 2018). However, for some, reducing their hours was not seen as a viable option (Strazdins et al., 2019; Svedahl et al., 2019): "I think if I were to drop a session or two it would make a farce of the whole inequitable system that is already in place" (Huby et al., 2002). Though those who were locums tended to report positive aspects of their work, particularly regarding control, their increased control was seen by one participant to be inefficient for the wider GP community: "I'm never a big fan of locums, because I think it does not decrease your workload. Yes, they see the patient in that minute, but the patient hasn't been sorted out" (Croxson et al., 2017).

Furthermore, many participants commented that strategies for coping and accessing good support were necessary but increasingly becoming a luxury to engage with. Some GPs across the studies indicated the impracticalities of socialising, debriefing and reflecting: "Never mind reflective practice and Balint groups and all of this, people are just, you know, nose to the grindstone absolutely all of the time" (Spiers et al., 2017). In line with this, some participants reported that their job has no space for rest and has become increasingly isolating (Agarwal et al., 2020; Dillon et al., 2019). As one participant exemplifies, "You don't really leave your room or talk to many other people" (Riley et al. 2018a). This was further emphasised as detrimental through the inadequacies of medical training in preparation for a role of a GP: "My training hadn't prepared me for […] feeling like a lone worker in many ways" (Doran et al., 2016).

Support was perceived to be the foundation for a functioning team within primary care which extended to the relationships with managers, nurses, and administrative staff (Agana et al., 2017; Evans, 2018; Huby et al., 2002). Some GPs spoke about their colleagues knowing them well enough to be able to approach them when they appeared to be struggling and support them to seek help (Spiers et al., 2017), and others the compassion shown from colleagues: “[during a period of stress] they were all really lovely and they would keep coming and bringing me cups of tea and chocolate and stuff and they were all really sweet” (Spiers et al., 2018).

Furthermore, one GP reflected upon the support they received from their peers on returning to work after a period of sick leave, feeling “protected” and supported to help maintain good habits (Fältholm, 2007). Such descriptions highlight the strength of an inclusive, welcoming culture of “genuine support” (Spiers et al., 2018) shown by team members through experiences of poor wellbeing. Such small acts of kindness within the daily grind seemed to have a significant impact on their day, potentially due to maintaining some element of the doctor being a human within such a dehumanised occupation.

3.2.4.3.2. Personal Limitations. A notion reported in multiple studies was that, despite efforts made to create a supportive team, maintaining adaptive coping strategies, and preserving work-life boundaries, this was not enough to sustain GPs in the face of increased demands, changing roles, and negative occupation context (Agarwal et al., 2020; Cheshire et al., 2017b; Dillon et al., 2019; Huby et al., 2002). Some GPs commented that sickness in the role was not a new phenomenon (Doran et al., 2016); however, illness and poor coping have become less avoidable due to increased pressures. As one participant noted, “It does not matter how resilient or positive you are, the work environment, especially in primary care will eventually be a problem” (Dillon et al., 2019); however, for some participants, this was perceived as a personal limitation.

Acknowledging illness was challenging for many doctors due to the “stigma attached to mental illness and the culture of invulnerability within medicine” (Riley, et al., 2018b). The organisational expectations of GPs to perform and manage the workload without an impact on their wellbeing are emphasised in the following quote: “You’re not groomed to be ill, are you? You’re not groomed to be a failure” (Spiers et al., 2017). The implications of this are shown in the use of the word “pathetic” in one participant’s statement: “While I know it sounds pathetic I really don't feel I can cope working 3 days anymore” (Dale et al., 2015). These feelings of shame and inadequacy led to several doctors denying their sickness (Fältholm, 2007) and feeling pressured to hide the extent of their poor wellbeing in fear of the ramifications: “I was afraid that I would be dumped” (Huby et al., 2002).

Consequently, some GPs spoke of the stigma of having a mental illness and the incompatibility of being mentally unwell with their ideas about their role, describing the associated feeling of being weak and vulnerable. Riley et al. (2018b) summarised this common theme: “Participants described how they felt ashamed, embarrassed, humiliated and a sense of having failed, due to their perceived lack of resilience and inability to cope.” Fältholm (2007), who explored doctors' experiences on sick leave, found participants to be conflicted: “patients, not doctors, get sick.” The notion of being ill conflicted with their understanding of themselves as GPs – an identity crisis that was also explored in Spiers et al. (2017), who found that participants expressed difficulty in switching between their patient and their doctor identities.

3.2.4.3.3. The Unsustainable Role. There were some differences across participants and studies when considering the characteristics of the individual contributing to the unsustainability of the role. Such characteristics included being a GP partner, being female, and working rurally. Female GPs were sometimes viewed as having additional challenges (Dillon et al., 2019; Huby et al., 2002; Strazdins et al., 2019; Svedahl et al., 2019) in achieving a work-life balance through trying to “combine work and family life” (Fältholm, 2007). Cheshire et al. (2017b) found that “childcare forced some GPs to ‘down tools’ earlier, but this then meant working overtime to catch up.” Additionally, partnership was increasingly seen as less aspirational for young GPs (Dale et al., 2015), with those currently in a partnership role describing additional burdens “relating to their financial responsibilities” (Riley et al., 2018a). Consequently, Croxson et al. (2017) observed that "full-time partnership was generally not considered to be possible, and many participants felt workload was unsustainable" (Croxson et al., 2017). For most participants, it was the wider healthcare changes, as opposed to the patients, that led to the unsustainability of the role: "I've always said I would gladly see twice as many people if I could see them, treat them, and then walk out of the room and have nothing else to do" (Spinelli et al., 2016).

Nevertheless, generally, a full-time GP role without these additional constraints was also considered incompatible with a work-life balance. Although only referred to by a few participants, some felt that happiness was potentially unobtainable as a doctor – "People who aren't doctors, they seem to enjoy life more" (Spiers et al., 2018) – and it was only when they took early retirement or resigned that they were able to access a life which they could finally enjoy:

> I'm just thoroughly enjoying myself. I've never had time to myself in my life. So I'm seeing friends, I'm going for runs, I'm walking the dog, I'm interested in cooking and, yeah, for the first time in my life I'm actually relaxed and happy. (Spiers et al., 2017)

Consequently, as one participant reflected, "I lost my confidence. I lost my faith in the system. I lost my faith in my profession" (Doran et al., 2016). Furthermore, for those who had taken a period of sick leave and returned to work as in Fältholm's (2007) study, all were working at reduced hours: "The physicians are in a sense back where they started, a bit more bitter and vulnerable, but also much more reflecting."

Nevertheless, whilst some spoke of feeling "like you're not strong enough" (Riley et al., 2018), others highlighted the limits of the GP in such situations: "What you've got to be careful to do is not ignore the fact that actually, maybe, for most of us, we are not coping with the stressors because there's too much stress, not because we're not resilient enough" (Cheshire et al., 2017). One participant related this to the recruitment of new GPs: "Now in primary care I realize why people encourage medical students to not go into primary care” (Agana et al., 2017), where the issues in recruitment are seen as a “symptom” (Svedahl et al., 2019) of the wider issues in general practice. This led some participants to consider leaving the profession as a last resort – “I really don’t want to go. But if things get worse, I would go” (Spiers et al., 2017) – whilst others indicated that the job had become so intolerable that they were ready to act on their impulse to leave: “Actually, I don’t think I want to do it anymore really. The kind of – the – I think it’s a mug’s game (laughs)” (Spiers et al., 2018). Doran et al. (2016) found that “all survey responders indicated that they had left English general practice for multiple reasons”; however, with an increasing rate of GPs leaving their profession or retiring early, this has led “to concerns about a diminishing workforce” (Croxson et al., 2017), which is echoed in multiple papers (Cheshire et al., 2017b; Dale et al., 2015; Doran et al., 2016; Evans, 2018; Petchey, 1994; Svedahl et al., 2019).

Some participants reflected on how costly it was to be losing so many GPs; their skills were not being put to use, their sacrifices were wasted, and they were “lost to the NHS” (Dale et al., 2015). Responding to the hopelessness of this situation, Agarwal et al. (2020) stressed the need for primary care practitioners to be viewed as “multidimensional human beings”, and Strazdins et al. (2019) reported that “it was explicitly stated by some GPs that a fundamental shift is necessary to change societal, medical and patient attitudes towards time spent working in order to resolve this dilemma.”

3.3. Discussion

As far as the researcher is aware, this is the first qualitative synthesis across this topic despite the growing interest in GP stress, distress, and burnout. This meta-synthesis of 18 studies specifically explored poor mental wellbeing, allowing for a deeper exploration and understanding of GPs’ perspectives. The analysis showed that the negative experiences for some of these GPs have roots in medical school, where mental health problems are stigmatised, and emotions are shut down. Thus, GPs are programmed to tolerate stresses on their own, an approach that is then culturally reinforced approach by the healthcare system, ultimately leaving them to face internal and external pressures largely unaided. In turn, doctors experience a kind of voicelessness, disempowerment, and moral conflict in their occupation. The intolerable occupational pressures, increasingly demanding patients, and the devaluing of primary care (including by the media) mean that the GP role is now seen as less attractive or sustainable. With the apparent lack of forthcoming systemic solutions, GPs are conflicted about working in organisational cultures that are disorientating and where they are fearful about the potential for damaging themselves and their patients. Not surprisingly, participants are increasingly looking to life beyond the profession as a means of restoring a work-life balance.

Rising awareness of the potential for poor GP wellbeing as one type of GP experience is highlighted by increasing rates of academic publications exploring the experience of GP distress; indeed, 17 out of 18 papers in this synthesis were published after 2000, and 14 were published within the last five years. The findings align with previous research related to increasing work volume, change in the type of work (Fisher et al., 2017), increasing work complexity (Cheshire et al., 2017a), and poor communication (Feeney et al., 2016; Matheson et al., 2016). The synthesis captured concern from some doctors related to greater standardisation of care and rewarding the measurable, distancing the doctor from the patient (Hockly & Caan, 2012). Oliver (2017) described this as part of a system on the edge from top-down target pressures and politicised reorganisations. The connection between the increased volume of administrative tasks and higher stress among GPs is not new (Makin et al., 1988), with previous research suggesting this leads to a conflict between GP values and their reality, as well as removing any kind of meaning from their work (Cain et al., 2017). This has been associated with a higher prevalence of mental health issues in doctors (Vijendren et al., 2015). The increased occupational challenges were also perceived as being compounded by the rising societal expectations imposed on doctors and the increased reliance of patients on their GP, which echoes Staten and Lawson (2018). Raised patient expectations and the resulting workload have previously been associated with GPs' intentions to leave the profession (Leese et al., 2002).

Doctors in the wider healthcare system were more susceptible to mental ill-health when they felt unable to do the job they were trained for (Carrieri et al., 2020). Employee engagement is the subject of much academic debate (Barker et al., 2018), and there is evidence for the value of investment in staff engagement (Boorman, 2009b) and positive associations between staff wellbeing and patient experience (Maben et al., 2012). This synthesis furthers these notions by exploring how bureaucracy and unachievable workload lead to loss of legitimacy and feelings of weakness or failure for GPs. Nevertheless, the analysis suggests that some GPs believed that organisational changes could have potential yet are limited by poor execution. In contrast, others experience an inner conflict in perpetuating the growing distance between GPs and the ‘art’ of medicine.

Consequently, GPs felt they had lost control over their work and felt increasingly alienated within their roles and wider healthcare, as was discussed by Napier (2017). The synthesis highlighted how the human aspects of GPs had been neglected through organisational change. Their psychological and emotional needs are ignored, resulting in feelings of devaluation and demoralisation. This has been associated with the removal of factors that restore emotional energy within the wider healthcare setting, such as connecting authentically with patients, working as part of a team, and creativity (Cain et al., 2017). Moreover, feedback for GPs is either non-existent or almost exclusively negative, with healthcare providers' work often taken for granted (Maslach, 2003) while their activities are scrutinised (Houghton, 2016). Despite the loss of authority and autonomy (Gerada, Chatfield, Rimmer & Godlee, 2018), doctors are increasingly working within a culture of litigation, blame, and shame (Oliver, 2017) where the average GP can expect to be sued twice in their career (Bower, 2015). The negative portrayal of doctors in the media additionally negatively impacts wellbeing – a connection that has been reported by GPs (Staten & Lawson, 2018) and doctors in the wider healthcare system (Clarke, 2017; Houghton, 2016).

Furthermore, many GPs acknowledged the unaccepting attitude towards mental illness within healthcare, resulting in delayed help-seeking behaviour and the concealment of illnesses, in turn leading to conflicts in identity. Similarly, within general practice, it is reported that "the 'stiff upper lip' is alive and well in the profession" (Staten & Lawson, 2018, p. xii), and that doctors are ashamed to admit to their vulnerabilities (Gerada, Warner, et al., 2018). Hall et al. (2017) noted closed-off communication within practices in their study exploring strategies to improve GP wellbeing, with reduced levels of openness among participants in focus groups with their practice doctors, when compared to focus groups with locums. Invulnerability, perfectionism, and stigma around mental ill-health were found within the wider healthcare system (Carrieri et al., 2020; Donaldson, 2006). The stigma attached to mental health, described as the "dark side of the profession" (George et al., 2014, p. 24), has been highlighted previously, with Myers (2017) writing "stigma kills" (p. 91). The difficulty accessing appropriate support for such problems (Kay, Mitchell, Clavarino & Doust, 2008) leads to the consistently reported poor help-seeking of doctors (Úallacháin, 2007). Thus, doctors are taught to work when they are sick, meaning that they have a tendency to trivialise their experiences of stress (Thompson & Corbett, 2013). Dew (2011) reported that presenteeism and being sick at work were concerns across the wider healthcare system. Working harder or longer as a strategy to compensate for illness has been shown to reduce wellbeing over a duration of time. The effort-recovery theory is extended to hypothesise that continuing work during off-time results in lower daily recovery and therefore increased risk of burnout (Fritz & Sonnentag, 2005; Oerlemans & Bakker, 2014). It could be argued that GPs have always been stressed in their role, but the new, more challenging context of their role means that it is harder to work through their sickness.

Having said this, the synthesis revealed a relatively nuanced picture of the situation, with some doctors speaking out about their mental health as well as recognising that the ‘invulnerable GP persona’ needs to be dismantled. Similarly, GPs commented on the power of peers to demonstrate compassion through small acts, helping them feel supported during times of need. This was echoed by other papers, such as in Hall et al. (2017), where participants discussed the positive value of making a cup of tea for a peer who has a full workload. This synthesis also showed that a minority of GPs talked about reclaiming the humanisation of GPs, the importance of admitting to their vulnerability, and the value of openly speaking to peers about their poor wellbeing. Positive responses to disclosure were similarly described in Staten and Lawson (2018), where it was found that the more a GP spoke about the challenges they faced and the burnout they suffered, the more support the GP received. The idea of the social influence within the experience of poor wellbeing supports wider research where interventions are most effective in promoting wellbeing when emphasising belonging and relationships (Carrieri et al., 2020).

A minority of the included studies explored the experiences of GPs solely in relation to their poor wellbeing rather than by focusing on the impact of organisational, political, and societal changes. Yet despite workload being explored in-depth concerning the causes of stress and distress for doctors within the synthesis and workload consistently identified as an important factor related to burnout (Dillon et al., 2019), there was little focus on the experience of GP burnout. Within this review, although Spinelli et al. (2016) aimed to understand the lived experience of burnout and perceptions of the contributing factors leading to burnout in American doctors, their results focused on perceived causes rather than lived experience (the themes presented were work environment, work tasks, and e-stress). Some insight was provided by Agarwal et al. (2020), Dillon et al. (2019), Evans (2018), Fältholm (2007), Riley et al. (2018b), and Spiers et al. (2017, 2018) regarding experience. However, each of these studies included participants with a range of illnesses rather than just burnout. Therefore, there is a need for a study that focuses solely on the lived experience of primary care GP burnout in England, where low levels of satisfaction and high pressure continue to be reported (Gibson et al., 2015, 2018) and satisfaction rates are found to be lower than in other Western countries (Martin et al., 2016).

This synthesis echoes the calls for doctors to be valued, supported, and cared for (George & Gerada, 2019; Hall et al., 2017; Patterson, 2016) and for the improved sustainability of healthcare roles (Baird et al., 2016). Publications in the wider healthcare system stress that looking after the workforce is a moral duty (Barker & Ford, 2018; Boorman, 2009b) and is intrinsically important rather than being a concern solely because of the potential negative impact on patients (Spiers et al., 2016).

3.3.1. Conclusion

In conclusion, this study demonstrated that there are doctors who are currently experiencing very low psychological wellbeing. The organisational changes within the last 20 years have had a detrimental impact on GPs, challenging the sustainability of their role and producing a workforce that is demoralised and vulnerable to mental illness. This meta-synthesis highlighted an increased focus within qualitative research on poor GP wellbeing over the previous five years, capturing the detrimental consequences of organisational and societal changes to general practice. Increasingly intolerable pressures – including the perceived devaluation of the profession, the dehumanisation of the GP role, and the sacrifices required for GPs to remain in their occupation – were identified as areas of concern. Further research is needed to investigate how to create a sustainable general practice and how the wellbeing of GPs can be prioritised. Moreover, research is needed to investigate the lived experience of GP burnout within the current NHS context.

Chapter 4.

Study 2 – The Lived Experience of GP Burnout: An Interpretative Phenomenological Analysis

There is presently a scarcity of in-depth qualitative research investigating GPs' burnout experiences during these times of unprecedented pressures and turbulence within the NHS, as indicated in the introduction and concluded in the meta-synthesis presented in the previous chapter. Some research has qualitatively investigated aspects of the phenomena, such as GPs' perceptions and beliefs regarding recommendations for interventions (Cheshire et al., 2017a; Hall et al., 2017). However, to date, the literature around GP burnout is saturated with quantitative prevalence studies (Imo, 2017; Peckham, 2015; Shanafelt et al., 2015; Tolentino et al., 2017) and a new trend toward exploring the impact of doctor burnout on patient care (Hall et al., 2017; Hall et al., 2016; Panagioti et al., 2018). Although important, this contributes to the dominant narrative shaped by research and the media, suggesting that doctors' wellbeing is of concern because of the potential negative impact on patients (Spiers et al., 2016).

Therefore, this study aims to deepen our understanding of GP burnout, giving voice to those on the front line by investigating the lived experience of primary care GPs who self-identify as experiencing or having experienced burnout. This study strives to better understand the complexity of the phenomena by undertaking in-depth semi-structured interviews with GPs to elicit narratives of their lived experiences. Furthermore, to give voice to GPs, this study aims to disseminate the study findings widely to the general public and those in the medical field. This will be achieved by using an art-based summary of findings distributed online and physically in exhibits.

This chapter will first discuss the theoretical underpinnings of the current study and discuss the methods, including the interview schedule, quantitative measures (used to collect participant characteristics), the approach to dissemination and how this will be evaluated, and considerations of trustworthiness. The subsequent chapter, Chapter 5, will report on the study's findings.

4.1. Methodology

This study takes a phenomenological approach, allowing the researcher to focus on the experiential narrative and meaning-making of the participants (Langdridge, 2007). Specifically, the shared personal experiences of these GPs will be analysed using interpretive phenomenological analysis (IPA) as this will allow for a better understanding of the nature and quality of GP burnout (Willig, 2013). Interpretive phenomenological analysis was deemed more appropriate than its qualitative counterparts, namely discourse analysis, narrative analysis, thematic analysis, and grounded theory, as IPA allows each participant's voice to be heard. Interpretive phenomenological analysis can help researchers understand complex experiences of a relatively homogenous group of people within their socio-cultural context (Larkin & Thompson, 2012); in this study, this applied to the experience of burnout in primary care GPs. More specifically, this is an approach committed to examining how people make sense of their significant life experiences (Charlick et al., 2016) and that aims to gain an insider perspective (Noon, 2018) to explore the meaning individuals assign to experiences. This is completed through rigorous analysis; the findings fulfil the criteria of being interpretive, transparent, and plausible (Larkin & Thompson, 2012). Interpretive phenomenology analysis has been used widely and effectively within health psychology to explore lived experiences (e.g., Blank et al., 2016; Brooks et al., 2015; Chan et al., 2017; Levy & Cartwright, 2015).

Wagstaff et al. (2014) reported that one of the major strengths of the approach is that "IPA is the creation of a richly interpreted, phenomenological account of participant data, arising from the meticulous engagement between the researcher and a small number of participants" (p. 10). However, some considerations must be given to the potential difficulties in the completion of IPA. As Larkin et al. (2006) write, IPA is "easy to do badly and difficult to do well" (p. 53), which Wagstaff et al. (2014) relate to a misinterpretation or misunderstanding of the phenomenological approach, mistakenly categorising IPA as a descriptive methodology due to the derivation of themes from in-depth personal accounts of experience. Holloway and Todres (2003) advocate for transparency in the methodology within qualitative research, yet Joseph et al. (2009) argue that although the qualitative 'method' (techniques of investigation) is being employed more widely in research, the qualitative 'approach' (philosophical orientation of the research) is less frequently employed, leading to a divorce between these two practices. Therefore, before the methods of IPA are outlined, it is first important to detail the approach or methodology.

4.1.1. Theoretical Approach

Interpretive phenomenological analysis was developed in the mid-1990s by Smith (1996). However, the theory underlying the practice dates back further. Smith et al. (2009) suggest that a researcher conducting IPA should be familiar with the underlying philosophy to conduct exploration and analysis that is consistent, sophisticated, and nuanced. The researcher aligns with hermeneutic phenomenological epistemology (Laverty, 2003; Smith et al.,1999; Smith & Osborn, 2004). This epistemology gives experience primacy (Holloway & Todres, 2003). It allows the understanding of phenomena through understanding an individual's everyday experience of reality in great detail (McLeod, 2011). Within this philosophical approach, the roots of IPA are in phenomenology, hermeneutics, and ideography (Smith, 2015).

4.1.1.1. Phenomenology. The phenomenology movement originated with Husserl, who questioned what we take for granted in our experience (Davidsen, 2013) and moved to focus on what people perceive rather than how people perceive it (Brooks, 2015). Husserl provided the foundation for IPA, informing the use of reflection and thorough examination of experience (Wagstaff et al., 2014). Nevertheless, Wagstaff et al. (2014) suggest that the search for the ‘essence’ of experiences which is key within Husserl’s phenomenology, is too abstract to be helpful when researching actual experiences. Therefore, these notions were later developed by Heidegger, Merleau-Ponty, Gadamer, and Schleiermacher (Smith et al., 2009), leading to more tangible philosophies in informing research approaches in psychology.

Most pertinent to the current research is Heidegger’s divergence from Husserl’s phenomenological philosophy. Though remaining informed by Husserl, Heidegger moved from transcendental phenomenology to the epistemology of hermeneutics to reduce the elements of the abstract and question ‘knowing’ without interpretation (Smith et al., 2009). As Shaw (2010) explains, IPA conducted through the lens of phenomenology looks to understand the world from intersubjectivity and the participant's context. Therefore, data generated from an interview is a product of the researcher, the participant, and the context – that is to say, it is a co-construction (Medico & Santiago-Delefosse, 2014).

Phenomenology, therefore, has progressed from a discipline focusing on thorough descriptions (Husserl) to placing a greater emphasis on interpretation being inherent in experiences (Davidsen, 2013). When completing IPA, the process is informed by the phenomenology philosophy relating to establishing our world and experiences through consciousness (Smith, 2015) and adopting an approach that concentrates on the meaning that people find in their experiences (Smith et al., 2009).

4.1.1.2. Hermeneutics. Hermeneutics, a central pillar of IPA, is concerned with interpretation and meaning-making (Smith & Eatough, 2007) in a critical but empathetic process to bring to light what is typically hidden (Wagstaff et al., 2014). Expressly, within hermeneutic phenomenology, the idea of bracketing the researcher's biases and assumptions is rejected, acknowledging that these perspectives are inseparable from the research process (Laverty, 2003). The researcher, like the participant, employs the same mental and personal skills to understand experiences. Yet, the researcher uses them more systematically and consciously. Within IPA, the researcher's sense-making is second-order; in other words, the researcher is making sense of the participant making sense of their experiences – a double hermeneutic.

Alignment to hermeneutic phenomenology informs the methods of the current study, specifically in terms of trustworthiness in the use of reflexivity. Laverty (2003) describes the need of the researcher to be transparent about their biases and assumptions in an ongoing and explicit way.

4.1.1.3. Idiography. Idiography is the focus on the particular. The idiographic approach that underpins IPA focuses on the individual's subjective interpretations concerning their lived experience. Therefore, analysis within IPA explores unique experiences and highlights shared experiences by exploring both the parts and the whole (Smith, Flowers, & Larkin, 2009). An idiographic focus pairs with the assumption that individuals are active interpreters of their subjective world (Wagstaff et al., 2014), with no objective reality or objective truth (Lyons & Coyle, 2007).

The ideographic nature of IPA lends itself to use with a small homogenous sample and rich individual data (Smith, 2011), which allows unique experiences in the group to be represented. Smith et al. (2009) argued that this enables a greater reflection of the complexity inherent to human experience and thus leads to a superior and more holistic understanding of the experience under investigation. The researcher remains mindful that within the generation of experiences, which are both subjective and context-reliant, the researcher plays a fundamental part in generating and interpreting data (Smith & Eatough, 2007).

Due to these factors, the current study has adopted a small sample in the study design to help explore each individual's sense-making of burnout.

4.1.2. Participants

Advertisements were placed on social media and distributed through professional networks, relevant newsletters, and services that support doctors with their mental health to recruit participants. Participants were included if they were currently a GP, received their medical training in the UK, and self-identified as having experienced or were currently experiencing burnout. No restrictions were placed on age or gender, and participants could either be practising or currently on leave. For in-person interviews, participants had to be available to meet in London.

Participant selection was completed purposively to select those who all shared the same experience, burnout, and were willing and open to sharing their story and experience to encourage a full detailed answer (Turner, 2010); therefore, the sample was relatively homogenous. Six participants took part in the interviews, five in person and one via Skype.

The sample size was theoretically consistent with IPA's orientation, meaning the sample was selected purposefully to identify GPs who had lived experience of burnout and could thus provide deep, detailed, and insightful accounts of it. In a critical review of the use of IPA in health psychology, Brocki and Wearden (2006) found that IPA samples ranged from one (Robson, 2002) to 30 (Collins & Nicolson, 2002), but noted that small samples were the norm for IPA (Smith, 2004). The larger the sample, the more likely that the idiographic nature of IPA and the potential for more subtle meaning-making could become lost (Collins & Nicolson, 2002). One of the strengths of the interpretive phenomenological approach is the drive to acquire rich and deep data that is more manageable in smaller numbers (Wagstaff et al., 2014). A sample size of six was consistent with several previously published IPA studies (Blank et al, 2016; Holt & Slade, 2003; Hunt & Smith, 2004; Johnson et al., 2004; Levy & Cartwright, 2015; Smith et al., 2002; Swift et al., 2002).

4.1.2.1. Demographic characteristics. Demographic information such as age and gender were requested from participants, and the completion of one validated questionnaire relating to wellbeing (see Appendix F). This information was collected to frame the qualitative findings (Bailey, 2008).

4.1.2.1.1. Wellbeing. Wellbeing was measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007), validated with adult populations aged 16 and above in student and general populations. Analysis for the validation for the WEMWBS within the general population found Cronbach’s alpha = 0.91 (n = 1749), indicating good levels of internal consistency (Stewart-Brown & Janmohamed, 2008).

The WEMWBS is a 14-item scale that measures key dimensions of an individual’s state of mental wellbeing, including positive affect, agency, and optimism, over the previous two weeks. Questions such as “I’ve had energy to spare” and “I’ve been interested in new things” are measured using a five-item Likert scale (from *none of the time* to *all the time*). There is no cut-off for the WEMWBS as this scale is not designed to measure exceptionally high or low positive mental health; however, scores are approximate to a normal distribution with no floor or ceiling effects (Stewart-Brown & Janmohamed, 2008). The WEMWBS results in a range of 14 to 70, with higher scores representing higher general wellbeing. Stewart-Brown and Janmohamed (2008) reported the normal distributions of the WEMWBS from Braunholtz et al. (2007) and Gosling et al. (2008) surveys of the general population reporting normally distributed data with a slight left-skew, mean 50.7 (Std Dev 8.79, N= 1749). Table 7 presents demographic characteristics for the participant.

Table 7

Characteristics of GPs who Participated in the Lived Experience of GP Burnout

Characteristics	Kate	Lucy	Saima	John	Beth	Rachel
Gender	-	F	F	M	F	F
Age (Years)	-	41-50	31-40	61-70	41-50	41-50
Years in Practice	-	11-20	≤10	31-40	11-20	≤10
WEMWBS (Wellbeing)	64	60	46	45	45	61

Note: One of the GPs elected not to provide demographic characteristics but did complete the scale. Scores for the WEMWBS can be from 14 to 70, with higher scores depicting higher general wellbeing (average for the general population is 50.7).

As shown in Table 7, the ages of the participants ranged from 39-64 (average 49.8). There was a bias towards female participants in the sample (four females, one male, one prefer not to say). A bias towards female participants was also seen in Riley et al. (2018). This does not reflect the overall GP population, 56% women and 44% male in England (NHS Digital, 2019). However, being a female GP has been correlated with an increased prevalence of burnout compared to being a male GP (Amoafo et al., 2014; Kumar, 2016). Three GPs scored better than average wellbeing while three scored lower than average wellbeing, range 45-64 (average 54).

4.1.3. Procedure

Semi-structured in-depth interviews were carried out with GPs from November 2018 to June 2019. Interviews were organised with participants at a mutually convenient time and place, either at the University of Westminster, at the participant’s home, or at their GP surgery.

Before the interview, the researcher provided the participant with the information sheet (Appendix G) and allowed the participant to clarify any points and ask any questions. On the interview day, the researcher revisited salient points within the information sheet with the participant (such as safeguarding concerns), checking for a complete understanding before gaining informed consent (see Appendix H). Following this, the researcher provided the questionnaire for the participant to complete (see Appendix F for the questionnaire). After completing the questionnaire, the researcher introduced the interview, reiterating key points such as their right not to answer questions that they were uncomfortable with.

4.1.3.1. Semi-structured interviews. One-to-one semi-structured interviews are widely viewed as the optimal method of data collection for IPA (Eatough & Smith, 2008); they facilitate and build in-depth discussions that are of a personal and sensitive nature (Smith et al., 1999). These then enable the researcher to form a narrative of the lived experiences whilst being mindful of the topic's sensitive nature.

An interview schedule was developed to explore GPs' experience of burnout. Smith et al. (2009) recommend an interview schedule consisting of six to ten open-ended questions (with prompts) which account for 45 to 90 minutes of conversation. Creswell (2017) argues that the construction of effective research questions is one of the most crucial components of the interview design, specifically because each question enables the maximum amount of data to be collected on each respective topic. The topics of the questions were chosen according to an extensive reading of the literature. Their format was based on the recommendations proposed by McNamara (2009), such as being open-ended and neutrally phrased. These initial questions were developed through guidance in an IPA training event in Glasgow and then reviewed by the supervisory team of this project. The semi-structured interview schedule included both broad questions such as “Can you tell me about your experiences of burnout?” and narrower prompts such as “Can you tell me about any thoughts or associations with the experiences of burnout?” (see Appendix I).

With this type of guide, the researcher has the adaptability to follow new lines of enquiry and uncover further information (McNamara, 2009; Turner, 2010). This allows the participant to explore what is important to them, whilst being guided by the researcher in a personalised way. Therefore, active listening was employed to facilitate appropriate probing (Wagstaff et al., 2014), ensuring that the interview process was led by the participant rather than by the researcher's agenda by allowing the researcher to remain in the moment.

4.1.4. Analysis

4.1.4.1. Transcription. All interviews were recorded using an encrypted dictaphone and transcribed verbatim by the researcher (interviews lasted from 60 to 90 minutes). Transcription of the audio data from the interview, which is an interpretive process, forms the first step of the data analysis in qualitative studies (Bailey, 2008). The transcription represented speech turns, with a new line for each speaker; in addition, false starts, repetitions, interruptions, overlaps, laughs, encouraging noises, and pauses were all recorded when transcribing. Audio files were revisited for clarification of tone when needed during the analysis. While transcribing and analysing, the researcher created short potted summaries of the interviews, which helped form an insight into the participant as an individual and helped highlight unique and defining features of their narrative.

After transcription, the researcher carefully checked for and removed information that may lead to the participant being identified. Such details were replaced with an anonymising label, e.g., “University of Westminster” was replaced with “[University].”

4.1.4.2. IPA. The methods for IPA have mainly been informed by Larkin and Thompson (2012), Smith et al. (2009), and Smith and Osborn (2004). First, a decision was made to use traditional pen-and-paper methods over computer software for analysis to allow creativity and flexibility. Considerations of the use of software were reflected upon by Wagstaff et al. (2014), with some arguing that IPA cannot be satisfactorily implemented with computer software. Therefore, all transcripts were printed in a table on A3 sheets (column one containing the transcript with line numbers, column two left blank for description, column three left with space for language analysis, and column four allocated to emergent codes). Four stages of analysis were completed for each of the transcripts:

1) Familiarisation with the transcript (Smith, 2015). This began with the transcription of the interviews. The researcher made notes on salient points such as interesting language use or changes in tone. The researcher then read a printed copy of the transcript several times, making notes that could be considered ‘free’ coding relating to the participants sense-making (Larkin & Thompson, 2012).
2) Line by line coding (Larkin & Thompson, 2012). The researcher commented first on the descriptive and then the language present in the transcript.
3) Transformation of initial notes into codes (Larkin & Thompson, 2012). This was completed using the final column on the analysis sheets by reading across transcript data and insights gained from descriptive and linguistic understanding.
4) Identification of patterns - cluster codes together to inform themes (Larkin & Thompson, 2012). The researcher worked to make sense of connections between codes within this process, reworking the patterns to explore themes. This was completed by the creation of mind-maps, each of which explored different patterns within the codes. An example of stages one through three has been included in Appendix J, including an initial mind-map for the third participant.

This process was repeated with each of the transcripts with an additional stage of integration or conversion across the participants. The researcher created mind-maps to note overlaps and unique elements or offered a new perspective at this stage. This led to themes evolving as additional participants were analysed. The initial understanding of themes across the first four participants and the clustering of participant quotes with these themes can be found in Appendix J.

Themes were further developed through discussion with the supervisory team and an iterative approach of returning to the themes by rearranging printed quotes over large sheets of paper. Development of the themes from the codes and attempts to understand potential overlap can be found in the diagram under Appendix J.

Finally, the researcher wrote the findings whilst mindful of the hermeneutic circle – that is, to understand the whole, we must consider the parts, and to understand the parts, we must consider the whole. The researcher continued to interpret and increase sense-making even through the writing up of results. During the write-up, the researcher commonly referred to the original analysis documents to ensure the original context had been preserved.

4.1.5. Dissemination

Dissemination was particularly important for this project – it was vital to give voice to GPs and their experiences. Researchers have a duty to share their knowledge with a broad audience, including the general public (Langat et al., 2011), which has led to increased efforts to promote knowledge mobilisation (Kukkonen & Cooper, 2017). An active and creative dissemination approach, which goes beyond the traditional route to communicate research in a meaningful way to a wider audience, has been adopted in line with recommendations for qualitative research (Keen & Todres, 2007; Walter et al., 2003).

Selected for this research is an art-based approach to reflect the richness of experiential data within this project. Art-based dissemination strategies can create interest among a wider and more diverse audience (Gergen & Gergen, 2011) than may be achieved through traditional dissemination strategies alone (Colantonio et al., 2008) and have been employed in the dissemination of results for numerous health conditions (Boydell et al., 2012). Art-based knowledge translation is the creation of art based on research findings, interpretation, and representation (Kukkonen & Cooper, 2017). Visual art can challenge dominant ideologies, provide new insight (Leavy, 2015), promote dialogue and empathy (Boydell et al., 2012; Jones, 2006), as well as further our understanding of illness (Pauwels, 2010). Painting and sculpture have been specifically chosen as art forms for the arts-based knowledge translation. These are cost- and time-effective methods compared to alternatives such as drama or dance, and they enabled a dissemination strategy that could be two-pronged – in physical form through a gallery display and online through a summary booklet using photographs of the art.

4.1.5.1. Creation of the Art. The art, one piece per theme, was created by two artists. The artists were provided with a detailed summary of the study themes to inform their work and open communication with the researcher to ask any questions or clarify details. The style and the materials used were the choices of the artists. The four pieces of art are shown within the next chapter, with each piece presented after the corresponding theme (Figure 4, Figure 5, Figure 6, and Figure 7), alongside an artist statement describing in their own words what their art depicts and how this relates to the art materials selected.

4.1.5.2. Art-Based Summary Booklet To disseminate the findings, a booklet was created using the online platform Canva (Appendix K). Within the booklet, the study was introduced, and the methods were briefly outlined. In the centre pages, the artwork was presented in parallel to a summary of the theme (including participant quotes) and artist statements. This booklet presents the themes alongside illustrative artwork, which Michielutte et al. (1992) found can increase accessibility to high-risk populations whilst maintaining appeal to those of all reading abilities. This aligns with the understanding that for health education materials to be effective, it is important that they can be read, understood, and remembered (Hoffmann & Worrall, 2004). Therefore, considerations were made for the content and design of the booklet, including using documented evidence-based communication techniques such as using plain language, avoiding medical jargon, and considering accessible design criteria (Coleman et al., 2017; Gupta et al., 2019; Health Service Executive, 2009; Horner et al., 2010; Niace, 2009).

The Health Service Executive (2009) checklist was used to determine whether the booklet used plain language and was easy to follow. The checklist advises using “you” and "we" where possible, keeping paragraphs relatively short, and avoiding groups of italics. Furthermore, the Simple Measure of Gobbledygook (SMOG) readability formula (Hedman, 2008) was used to assess the text, which resulted in an average score for the booklet of 13. According to the NHS (2019), 52% of UK adults can comprehend text at this level. The SMOG readability formula was selected to measure readability as Wang et al. (2013) found this scale to be the most consistent performer in their literature search. However, a readability score of under 14 signifies only that complex words were used less frequently, not that the content was useful to readers (NHS, 2019b). Therefore, to assess the accessibility of the booklet, it was read by three members of the general public who had no prior specialist knowledge, with each of them providing feedback to help improve the booklet.

Moreover, understandability and actionability were assessed using the Patient Education Materials Assessment Tool (Shoemaker et al., 2014). This was completed independently by the researcher, a peer (outside of the research team), and an individual not involved in academia to reduce bias. The independent assessments agreed with high scores for understandability (94%) and actionability (80%) on the Patient Education Materials Assessment Tool scale.

The booklet aimed to disseminate findings so as to increase knowledge of the experience of GP burnout among both healthcare professionals and the general public. Thus, the target audience for this evaluation was twofold. First, the summary of findings reaches GPs who may experience burnout in the future or individuals who may encounter GPs experiencing burnout (for example, other GPs, colleagues of GPs, other NHS workers, those who support GPs with mental illness, and researchers interested in the area). Secondly, members of the public who engage with the disseminated findings to increase awareness and knowledge of the experience of GP burnout.

The online distribution of the booklet took place through newsletters (such as the monthly newsletter distributed to the National Association of Sessional GPs, Health Watch, and the Practitioner Health Service; PHS), social media (such as Twitter), research platforms (such as Research Gate) and posting on relevant forums (such as GP Survival). Further dissemination is planned in the near future by presenting the artwork and summaries in exhibitions and talks, including at an exhibit at the University of Westminster. A questionnaire has been created to explore this dissemination strategy's impact (see Appendix L).

4.1.6. Rigour and Trustworthiness

4.1.6.1. The Lived Experience of GP Burnout. Qualitative research has a high degree of subjectivity (Hadi & Closs, 2016). This is an especially relevant consideration for a PhD project, the purpose of which is to demonstrate independent research. Therefore, a plan to establish the rigour and trustworthiness of this research was embedded within the research design.

Traditionally, Cho and Trent (2006) write, the ‘validity’ of qualitative research relates to the degree to which claims about knowledge and reality made by the researcher match with the reality of the participants in the study. However, the judgment of quality in qualitative research has been debated heavily (Rolfe, 2006). Qualitative research often falls foul of criticisms to do with lack of rigour, particularly in terms of poor justifications for method choice and lack of transparency (Noble & Smith, 2015). Only recently has some consensus been formed relating to the judgement of quality in qualitative research (Cohen & Crabtree, 2008), yet due to the different methodologies within qualitative research, Rolfe (2006) argues a standard set of ‘validity’ criteria may be futile. Nevertheless, researchers can aim for robust procedures to strengthen readers’ confidence in quality (Porter, 2007).

Five of the strategies to ensure trustworthiness, as specified by Hadi and Closs (2016), were employed to improve the credibility of the findings. These were audit trails, member checking, peer debriefing, thick description, and reflexivity. A brief description of each and how they were applied to the current study is presented below. This section was also informed by the criteria for rigour as outlined by Lincoln and Guba (1986).

These strategies were deemed the most appropriate to the research approach and methods; for example, triangulation would not have been appropriate due to the idiographic nature of IPA and focus on personal experience and meaning-making. In some cases, triangulation relies on using multiple methods or data sources to verify data and overcome research deficiencies based on one investigation or method (Reid et al., 2005). In line with the current study's epistemological position, which views the experience as the reality for these participants within their unique context, this data cannot be verified as true or false by alternative data sources.

4.1.6.1.1. Audit Trails. Establishing a clear audit trail allows readers to understand how the researcher came to both their findings and their conclusions, thus demonstrating transparency (Sandelowski, 1986). Usually, an audit trail is achieved by systematically documenting each aspect within the research study (Hadi & Closs, 2016). The use of audit trails links with Lincoln and Guba's (1986) key consistency criteria, which arguably works in parallel with trustworthiness. The presentation of such audit trails would provide enough detail to allow an independent researcher to reach comparable findings when followed.

For the current study, this has been achieved by transparently documenting each stage of the project within the write-up and providing supplementary materials in the appendix. The audit trail is strengthened by using photos of hand-written elements, such as the coding and creation of mind-maps during the analysis.

4.1.6.1.2. Thick Description. Within published papers, qualitative research methods are often brief and vague due to the limitations imposed on word count. However, the actual process of qualitative research is complex and necessitates documentation in its entirety to promote transparency and integrity. The strategy of audit trails links hand in hand with ‘thick description’, whereby the researcher provides rich detail regarding the methods and approaches behind the study (Hadi & Closs, 2016). Within the findings, transparency has been bolstered by developing the narrative based on substantial verbatim quotes (Reid et al., 2005). This strategy increases transparency and gives value to participants' voice, and is consistent with Lincoln and Guba's (1986) criteria of ‘truth value’.

4.1.6.1.3. Member Checking. Hadi and Closs (2016) refer to member checking as the informal validation provided by research participants of elements including analysis, interpretations, and conclusions. To implement member checking within this study, during the debrief the researcher asked the participant if they would like to review their transcript and subsequently the findings from the study. It was made clear to participants that this was an optional element of the study. All GPs requested participation in both elements; however, only one read their transcript in practice. Peer Debriefing. A vital element built into the analysis process was peer debriefing. Hadi and Closs (2016) conceptualise this approach to trustworthiness as creating a dialogue with a peer who has an element of separation from the data to clarify interpretation and highlight potential elements of bias.

This was approached both informally and formally. Informally, the researcher discussed data interpretations and themes with peers within the psychology department at the University of Westminster who were completing separate projects. Additionally, the researcher attended an IPA workshop in which participants provided constructive dialogues regarding the interpretation of transcripts. Informal discussion of interpretations with members of the group were maintained after the workshop. Finally, the researcher and director of studies formally discussed interpretations at each stage of the analysis. For example, TC reviewed extracts of each participant’s transcripts independently before the researcher and TC met to discuss coding and interpretation.

4.1.6.1.4. Reflexivity. Qualitative researchers make a distinction between reflection and reflexivity (Shaw, 2010; Woolgar, 1988). Reflection is often associated with the positivist’s desire for accuracy in reporting qualitative findings, generally constructed of documentation of thoughts regarding process and verification. In contrast, reflexivity refers to the internal reflection of the researcher and the influence they have on the co-construction of data and meaning-making (Shaw, 2010). This requires the researcher to turn inward to question and recognise how they construct knowledge (Finlay, 2002).

The use of reflexivity is viewed as an essential component for research informed by an interpretive phenomenological approach (Laverty, 2003; Rolfe, 2006; Shenton, 2004). As Finlay (2002) writes, “Phenomenologists argue that researchers need to look within to attempt to disentangle perceptions and interpretations from the phenomenon being studied” (p. 534). Qualitative research, especially IPA, positions the researcher more centrally within the research process. In part, reflexivity aligns with both Lincoln and Guba's (1986) ‘neutrality’ and ‘truth value’ criteria to establish qualitative research with defensible rigour. Regarding neutrality, reflexivity enables the active acknowledgement of the complexity of engagement with participants through data collection and member checking while enabling the researcher to be transparent with their understanding of their personal experience and perspectives and the implications within the study. This leads to the highlighting of ‘truth value’ and the advocation for the researcher presenting experience and viewpoints which may influence or bias the findings.

To practise reflexivity, the researcher maintained a reflexive journal and recorded reflexive notes at each research stage. The process of reflexivity within the literature appears somewhat ambiguous; therefore, the researcher elected to follow the guidance provided by Finlay (2002), practising reflexivity across three stages, pre-research, data collection, and data analysis. Within reflexivity, the researcher also looked inward to self-assess how their training and education may influence the findings, according to Hammersley and Atkinson (2007) and Long and Johnson (2000).

4.1.7. Ethical Considerations

4.1.7.1. The Lived Experience of GP Burnout. Ethical approval was granted by the University of Westminster Research Ethics Committee (UREC; ETH1718-2343) and received a favourable opinion from the Health Research Authority (Integrated Research Application System (IRAS) ID 249046); approval documents can be found in Appendix M and Appendix N, respectively.

Important considerations for this population are noted here, specifically the potential for distress and safeguarding issues. Provisions for such occurrences were carefully considered, and, therefore, a sensitivity protocol and a safeguarding protocol were developed (see Appendix O and Appendix P, respectively). Safeguarding concerns did not arise in the interviews; however, due to the sensitive nature of burnout, distress was evident in some participants. As such, the researcher followed the distress protocol and re-established consent before continuing with the interview.

After the interview, the researcher allowed time to talk to the participants, discuss their experience of being involved in the research, and monitor any unforeseen adverse effects of the interview. Each participant was then given a paper copy of the debrief sheet

(Appendix Q), which included contact information for the researchers should participants have further questions or wish to withdraw before analysis. Each debrief sheet also displayed contact details of a support organisation.

4.1.7.2. Dissemination. Ethical approval was granted by the University of Westminster Psychology Ethics Committee (ETH1819/0121); the approval document can be found in Appendix R.

The themes generated from ‘the lived experience of GP burnout’ were potentially distressing. The artists viewed a complete summary, and short summaries were provided within the booklet to be viewed by the general public and healthcare professionals. Therefore, when the artists were creating the art, care was taken to ensure they were fully aware of their role and could talk to the researcher team if they found the study’s findings distressing. The information presented to participants was brief, and select quotes were limited due to the nature of a summary. The summary is equivalent to the information that will be publicly available through research papers. Therefore, reading the summary and completing the evaluation questionnaire were deemed to be of low risk. Nevertheless, at the end of the summary and the online questionnaire, researcher details and signposting for support were provided.

Consideration was also given to those medical professionals who may read the leaflet and interpret the presented material according to their experience. It is hoped that in this case GPs seek help. Therefore, signposting was provided within the online leaflet to the PHS for GPs or other healthcare professionals if they needed support, and also at the end of the online questionnaire.

Chapter 5.

The Lived Experience of GP Burnout: Findings

The themes and sub-themes from the interpretative phenomenological analysis (IPA) of the six interviews can be found in Table 8.

Table 8

Themes and Sub-Themes in the Lived Experience of GP Burnout

Theme	Sub-theme
Broken doctors in a broken system	The broken system The breaking of doctors Being broken
Trapped and conflicted	Conflicted, to stay or go Isolated, neglected and misunderstood
The meaning of self	Professional identity Maintaining care
Navigating burnout	First steps Shifting perspectives Ongoing impact

5.1. Broken Doctors in a Broken System

This theme relates to brokenness – that is, GPs' feelings of personally reaching rock bottom while their organisation is crumbling. The health system is an organisation that GPs have been moulded by and dedicated years of their lives to, and yet, on reflection, it is also an organisation that is perceived as cold and uncaring. This theme will first provide the context of how participants view the system they work within, exploring how participants view the system's influence on the onset of burnout and finally capturing the defining experiences of burnout, over and above the individual symptoms.

5.1.1. The Broken System

Although accounts of burnout were deeply personal, all participants traced the cause of their burnout experiences to the wider healthcare system. Most participants spoke of initially viewing the NHS in an idealistic way and of holding it in the highest regard:

> We all don’t trust who we know want to break the NHS, so I think I’ve always believed that the NHS is a really great institute … I like the teamwork, the ethos and the spirit, and I think that is what makes us strong, those NHS values are essential … I think that is really why I have been working and I have got to a point now where the NHS isn’t what it used to be. (Saima)

Here Saima says she strongly believes in the NHS and that she views its reputation and principles as being key to her resolutely staying in her role, despite experiencing burnout. Across all participants is the feeling of belonging to the NHS and sharing a connection with fellow medics, as highlighted by the use of “we” and “us” in Saima’s quote, which indicates shared beliefs and experiences.

However, the sentiment portrayed in the latter section of Saima’s quote above represents feelings across these participants while they experienced burnout. Whilst experiencing burnout, participants’ views of the NHS shifted from idealistic to negative. They started to notice cracks in the organisation: “It wasn’t what I was told to expect … combination of being extremely overwhelmed beyond what your shoulders can carry and also feeling impotent about doing anything about it” (John).

On the surface, participants relate the brokenness of the NHS to current policy with the unmanageable increasing pressures plus the fragility of the future of general practice. Their experiences led to the perception that within this new era of healthcare provision, a full-time role as a GP was both damaging and unsustainable. All GPs described the increased workload and their powerlessness to combat this within their role, with relentless and increasing pressures. The sense of now feeling defeated, which comes through in the final statement of Saima’s quote, was also felt strongly by Kate, Rachel, Beth, and Lucy.

However, for some participants, the extent to which the NHS was ‘broken’ was also related to feelings of powerlessness and insignificance in their ability to fix it, which came across strongly for Saima, John, and Rachel. Participants feel they have the responsibility to personally work to improve the system's running yet feel unequipped to do so. Among some participants, the language used to describe their experience was more typical of soldiers at war than what one might expect from GPs. John describes seeing conflict within a practice with GPs and community practitioners “warring with each other”, whilst Rachel and Saima personally feel like they are constantly “firefighting” (Rachel) with the goal of “holding the fort” (Saima) within their organisations. Such accounts of reactive doctoring are deemed a necessary resort when entering “survival mode” to “soldier on” (Lucy). The language used paints a picture of working in general practice that is bleak: doctors are “surviving” (Beth) rather than thriving. This idea of having to fight to save the NHS whilst also trying to personally survive as a GP is brought to the fore in the following quote:

> I am a pawn in this big game, I am a worker, I think ‘I am a worker’ I think ‘I am the leader and I am good at systems change and I am going to make things happen,’ and then I think ‘no I am not it’s a game.’ (Saima)

The repeated use of “I” when Saima refers to being a pawn contrasts with her use of “we” when describing the NHS at the beginning of this thematic section. Her words epitomise the detachment of doctors from the system and the view of GPs as dispensable foot soldiers, the “pawns” of the NHS. Through this, we get a sense of sacrifice for limited rewards, resulting in feelings of being devalued, which in turn lead to a loss of faith in the organisation, which had once been the source of motivation to work hard:

> There is just multiple examples to show you the healthcare doesn't care about you and I think that really crushed me more than anything and added to my stress and this burnout and it is just the fact something you have dedicated your life, tears, sweat to. (Rachel)

5.1.2. The Breaking of Doctors

The dysfunctional state of the NHS is often characterised as an antagonist in the participants' narratives, being cast in an active role in the breaking of the GPs. This is directly antithetical to the beliefs and expectations held about the NHS, an organisation built on the purported values of providing care and healing. On the contrary, the relentlessness of increased workload and the pressure upon its employees is perceived as causing their ill-health:

> If only the practice had, if only the, if only general practice was structured differently and had the funding and the manpower, I actually don't think this would have happened. (Beth)

All GPs spoke of continuing to work while starting to feel burnout. Initially, some participants said there was an element of them being in denial, as was exemplified in Lucy's account: "I sort of feel, well you know, I am just overdue a holiday, when I get back it will feel better" (Lucy). She goes on to say, "the new normal, the new normal had become this extra busy, extra crazy, it had just become the new normal" (Lucy). Their inability to control their situations was a determinant in how GPs initially reacted to noticing the emerging symptoms of burnout; rather than acknowledging and solving the problem, they tried to take the struggles in their stride, which only served to worsen their burnout experiences. Above we can see Lucy's attempts to normalise the escalating intensity of the workload, labelling it the "new normal", thus minimising the significance of the change and making it harder to rationalise why she could no longer cope. Beth also refers to the normalisation of the culture of overwork when saying that colleagues staying late at work was considered typical:

> You didn’t really notice the days just got later and later really, and everyone else was there also working late, so it just became the norm so it normalised it really, the receptionists had gone but it normalised it. (Beth)

Within Beth’s practice, GPs were perceived as all applying the same coping strategies to deal with the extra work, creating the illusion that this was normal and acceptable. All participants gave examples of the intense exhaustion they felt as a consequence of the continued perceived necessity to work in this manner. The increasing occupational pressures were felt to weaken their resilience. Kate conveys a sense of her reserves of resilience becoming depleted, which increased her vulnerability to burnout, “I think over those four months it just gradually wore me down and my resilience was just zilch” (Kate). In these descriptions, there is a strong sense of resilience being diminished by the escalating workload and challenging occupational conditions alongside a minimising or denial of emotional needs that are simultaneously not being met. The sense of these factors cumulatively leading to burnout came across strongly:

> Because burnout is insidious … it slowly starts off, a bit of challenge, a bit of stress more stress, irreversible stress slowly getting burnt out … so if I so if you were completely unaware it seems obvious to you looking in but when you are in it you are completely [pause] it is so insidious. (Rachel)

These words highlight she was blinkered in her approach to burnout. This is echoed below by Beth, who describes the process as one that “creeps” up on you in a way that is “dangerous.” Though all participants discussed a gradual accumulation of factors leading to burnout and a gradual realisation of the severity of their experience, the GPs also describe relinquishing, at least in part, their responsibility as they began to break. John describes one thing going wrong after another, where he ‘could see it all going backwards’, with nothing he could do to solve the problem, whilst both Kate and Lucy describe such experiences as a “spiral”, “it’s kind of like a spiral yeah then it goes out of control and then you’re just like I can’t do it anymore” (Kate). The analogy of a spiral conveys the sense of the individual being powerless to stop an uncontrollable force of destruction. Spiralling also captures images of spinning out, thus creating the impression of GPs running headlong through days that all blur together.

The notion of control was described differently across the participants’ different narratives. However, common to all descriptions was the idea that feeling broken undermined the individual’s usual position of control. Lucy expresses her confusion over her experience:

> It just didn’t make sense to me … because there hasn’t been any time where, I mean I have always had exam stresses and pressures, but you just get through it and you just do it, and it has never done this to me before. (Lucy)

She struggles to understand the differences in herself; her experience of burnout is seen as a dramatic change from the strong internally driven medical student (and subsequently doctor) that she once was. Note here that the “it” to which she attributes the blame for her illness is her work, or, in the other words, the organisation. She casts herself in a passive role and the NHS in an active role: it has done this *to* her. Her sense of control is no longer internally oriented; she is unable to “get through” as she perceives the opposition, work, to be stronger than her. Rachel echoes this:

> It is just latent in its attack, it is very hidden so you keep on getting assaulted and assaulted and assaulted, and you think I can cope, assault, I can cope, the more you say it the more you believe it. (Rachel)

This indicated that she was trying to hold on for as long as possible and resist what was happening.

5.1.3. Being Broken

Two key elements that epitomise being in the pit of burnout, over and above the individual symptoms, are the internal breaking often paired with external presentation and efforts to create barriers and protect or salvage the remnants of their vulnerable self. This came through in how GPs used language to describe the outer presentation of maintained professionalism and composure, a façade that sharply contrasted with how they actually felt. The narratives point to an experience which is more than a combination of symptoms; the meaning of the experience and the more profound feeling of a depleting sense of wholeness, which at times was referred to as seeing themselves as being broken: “I thought that a break was going to fix it [burnout] … I hadn’t really noticed that [I] was broken before” (Lucy).

The word “broken” demonstrates how the participants see themselves as damaged and vulnerable. It also conjures images of falling apart, shattering, and no longer being able to function as well as before, which most of the participants linked to experiencing great exhaustion:

> Sense of hopelessness with the whole thing was a mistake and that who I was and what I had been doing were either mistaken or an accident that was not actually totally meaningful or helpful but that sort of sense of feeling very disempowered. (John)

In contrast to the above quote, where burnout is attributed to the individual’s organisation, Kate retrospectively blames herself for capitulating to burnout:

> I went in [to see her GP] and just to say this is it [burnout] and he could tell I was a complete kind of wreck to be honest that I, I you know I look back and think ‘God how did I even get to that stage?’ It is quite scary thinking that I let myself get to that stage. (Kate)

Within this extract, Kate shows a strong notion of self-blame using the phrase “I let myself.” Again, being a “complete wreck” embodies the sense of being broken; a wreck is synonymous with destruction, implying that the person feels like little more than debris after their battle with burnout.

All GPs spoke of experiencing complete exhaustion, which was extreme in contrast to their usual experiences, to the point that it was considered alarming. John describes his reaction to increasing problems with sleep and frequency of migraines – “alarm bells that I was thinking of that I was in trouble” – whilst Kate and Lucy express their concern over their irrepressible outpouring of emotions: “I was just crying all the time, even when I was sitting in the GP practice I was just uncontrollably crying” (Kate). For Beth and Lucy, strong feelings were still present while recounting their experiences within the interview; their accounts were emotional and raw. An interesting point of divergence between participants can be seen in Rachel; in the storm of burnout, she sees her core, the emotional self, as calm:

> People keep on saying how do you manage, I don’t know [laugh], because of deep down I was calm, it was just very peaceful you know, now it didn’t hit my core that is what I am trying to say, my core was the emotional part. (Rachel)

The language used here, “calm” and “peaceful” contrasts with the use of “uncontrollably crying”, “alarm bells”, and “a wreck” in other accounts. However, Rachel was not able to fully explore how she could maintain the strength and peace within her core; some of this success she attributes to her strong religious faith and ongoing validation from still being able to provide help for those around her. Similarly, Beth notes that although she self-identified as a highly sensitive person, she was nevertheless always able to manage this while at work. Differently but still internally driven, Kate speaks of creating distance between her broken self and the outer world of unceasing work:

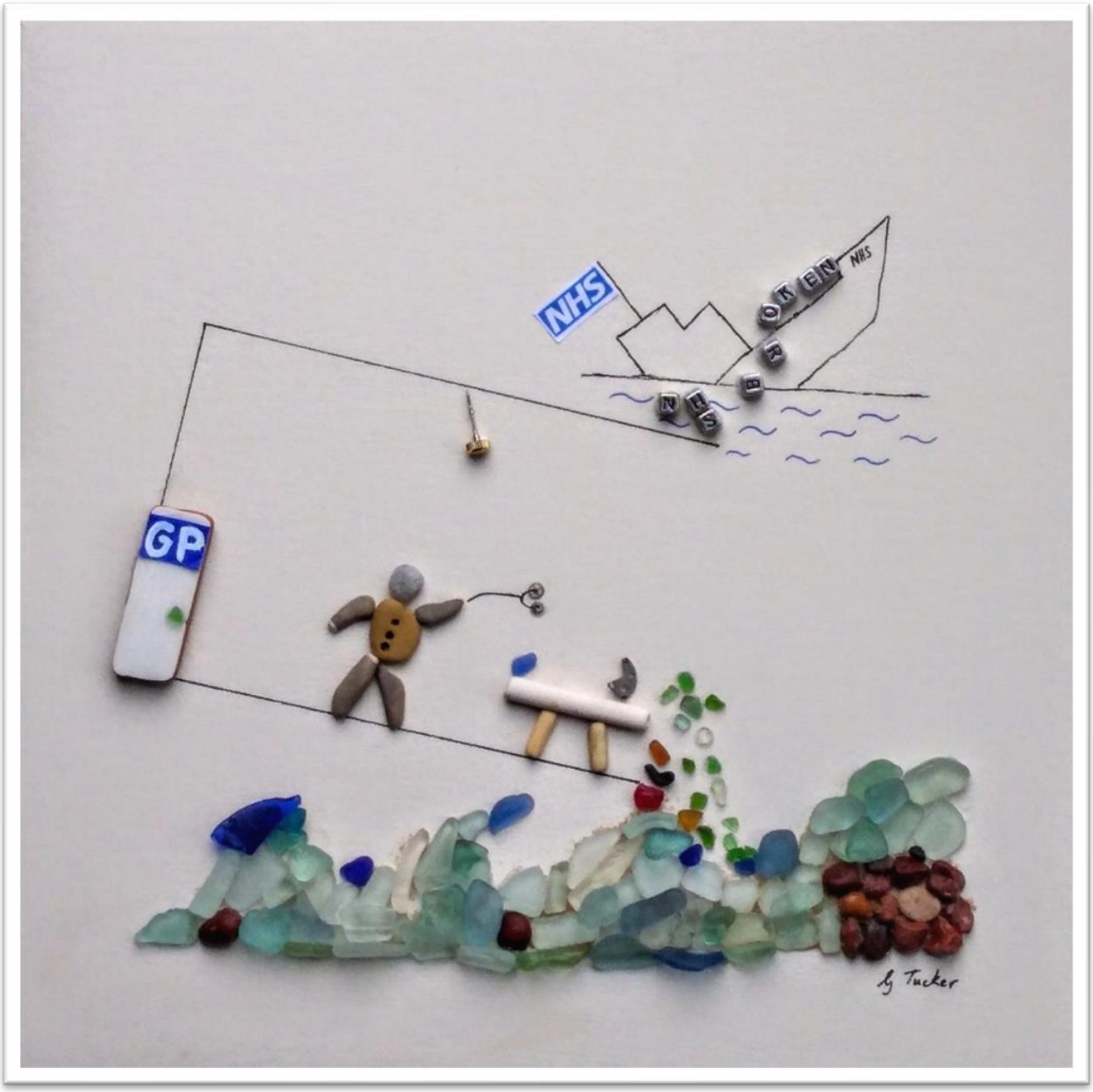
> I remember just walking around, walking around and just feeling like I was in a cloud like in a bubble just kind of where nothing affected me, I was just numb, I think numb is a good word, I just felt very numb, I didn’t know how to feel like happiness, I didn’t feel anything. I was just walking around and just existing. (Kate)

In their attempts to make sense of burnout, participants used many different analogies. Note how here we can see Kate exploring how it felt mid ‘episode’. Images of a “bubble” and a “cloud” are inherently pleasant, perhaps used to signify a place of mental safety where her perceptions were dulled and thus less sensitive to the external impact of the job. However, Kate’s coping strategy of attempting to mute her feelings has the consequence of dampening all emotions, not just unpleasant ones. These images indicate a blurring of her connection with the world, a detachment leading to her floating above life, existing rather than living. This detachment is seen more literally, highlighting the escapism from overwhelming feelings and interactions with the world, in the following quote by John: “I used to wander round at night with dark glasses … a sense of keeping the world away.” He also distanced himself from experiences over time, sealing memories away: “I now have little floods of memories and bits coming back erm I think I was just getting an increasing sense of helplessness and hopelessness.” This distancing is a coping mechanism, armouring them against, as Rachel described, the continuous “assault.”

5.1.4. Art for ‘Being Broken in a Broken System’

Figure 4

Art for 'Being Broken in a Broken System' – Created by Gillian Tucker



5.1.4.1. Artist Statement for 'Being Broken in a Broken System'.

For me, this piece embodies the worn-down broken GP, a wreck of a human, inside another shell - that of the ill-functioning NHS. I wanted to capture the destructive, cold, and uncaring nature of the healthcare system as seen through the eyes of the disengaging GPs. I decided to use my found beachcombing treasure and drawn lines to portray the real-life of an organisation – one which is gradually sinking and taking with it everything that is inside its shell including it's overworked, demoralised and exhausted workforce.

The broken GP along with their consultation room and equipment slipping slowly, further away, deeper and deeper into the ocean, hitting rock bottom. The sketched GPs consultation room tilting towards the ocean shows an opening up of conscious, it's very direct with everything in the room slipping towards the ocean. I use the smooth ocean-tumbled sea glass, with the green and blue colours for the ocean showing the effect of fragility in life. The textures of the rocks on the ocean floor adding depth to the vision of a GP hitting rock bottom and complete darkness. (Gillian Tucker)

5.2. Trapped and Conflicted

This theme captures the feelings of being pushed away from work, desperately wanting to escape, needing to take time off, or wanting to leave the profession whilst dutifully remaining in work, held there by internal and external pressures. We see the GPs trying to make sense of their situation by continually weighing up their potential options while feeling the burden of responsibility. There is a key divide between participants: Saima remains ‘trapped’, while Kate, Beth, and Lucy were able to seek help and take time off yet feel guilt and worry as a consequence, whereas John and Rachel’s circumstances allowed them the freedom to escape. Though these circumstances seem relatively heterogeneous, the experience of feeling caged within the role is a strong current through each narrative.

5.2.1. Conflicted, to Stay or Go

Most of the participants gave examples of conflicted thinking when evaluating their working circumstances, which for some was especially prevalent when considering leaving the profession or taking time off. This was often described as an internal battle or as a continual weighing up of their options, commonly being split between escaping from their “horrible” (Lucy) daily experiences yet still loving the fundamentals of their job, particularly the patient care aspect of it. In addition, being trapped was often described in relation to unavoidable responsibilities, such as financial constraints or commitments to peers and family: “I was only really working for fun up until a point … now I am kind of stuck because I am now paying private school fees” (Saima).

Though reported in all the transcripts, the feeling of being trapped was described slightly differently by each participant. Some describe it in a practical way, as Saima does above, relating it to the burden of financial commitments. Others describe being stuck in narratives based on potential success and wishful thinking. Kate speaks to the growing sensation of wanting to physically escape but being unable to, the restraint for her being more ambiguous:

> I remember just thinking ‘I wish I could just get on a plane and fly away somewhere where no one knows me and I don’t have to just go into work, where I don’t have to you know deal with this life anymore’ … I was never suicidal thoughts or not wanting to be here, but I was always wanted to escape to get away from it and I remember thinking you know in the mornings ‘actually no one is making me go into work, I don’t have to go into work, I don’t have to go into work’. (Kate)

In this extract, Kate reflects on her internal conflict over attending work each day, with the betrayal of these conscious reassurances to herself evident in the repeated mantra “I don’t have to go into work.” For most of the participants, this level of escapism seemed unreachable. Note from this quote the qualification of not experiencing suicidal thoughts, unprompted by the interviewer. This shows Kate assessing just how dire her situation was, considering suicide to be a more extreme option that was not warranted. Such a stipulation was also seen in Lucy’s narrative: “I never felt personally helpless and I never felt, I think I just felt trapped that I couldn’t change it and yet I also felt like I couldn’t leave” (Lucy). Later, she clarifies her definition of helpless as, “I never felt suicidal, I never had any of those sorts of feelings, I just felt that I’m not sure if I could keep doing this anymore” (Lucy).

These notions of wanting to escape, of wanting to leave the role, and of hopelessness were also conveyed by John, who, in contrast, was able to act on his escapist instincts. When John was confronted with his declining mental health as he slipped into burnout, he described approaching a natural crossroads in his life. He described how his declining commitment to his role within primary care coincided with the end of a long-term relationship; consequently, specific pressures and feelings of being trapped were considerably eased. John was able to prioritise some time for himself by taking a sabbatical to travel across the world and consider new roles outside of England:

> They [a potential new employer outside of England] said can you start next week [loud laugh] and I said absolutely not next week, I desperately need this three-month sabbatical, but yes, yes I will because I think there is nothing left for me in England. (John)

Similarly, Rachel felt she was able to prioritise her drive to leave more readily. Rachel stated numerous times that she was lucky to have the means to leave when she needed to, though she does speak of being trapped much longer than desirable after consideration. As opposed to Saima’s family responsibility (financial), which led to her being trapped within the role, Rachel saw her parents’ health needs as a rationale to leave. Rachel saw this is as a morally correct action, yet acted without full consideration of the processes that she needed to follow to take leave:

> I think during that time I wasn’t as lucid as I am now in the sense, not with managing patients, but I should have gone through the right steps with the [General Medical Council] that is, they have a specific form you have to fill out if you want to take a career break, I just dropped everything, literally. (Rachel)

This is in stark contrast to the lack of conceivable freedom currently being experienced by Saima:

> That’s how I feel, I want to leave every day, can I say that on there [dictaphone] … [whispers] I want to leave every day, every day I think this is just not right [pause] … I burnt out a long time ago but I am still working, um, I can’t leave. (Saima)

Except for John and Rachel, participants struggled with the potential consequences of disengagement from their roles as doctors. Again, we see John is distinct about considering perceived options: “I remember thinking maybe I will just end up selling ice cream on Bondi beach because I don’t mind, I will follow any likely path” (John). Here we see the consideration of an unrelated career, an escape, moving to a different country with a willingness to engage with a role free from the bonds of responsibility and pressure. This almost drastic consideration was mirrored in Rachel's actions. Rachel chose to disconnect entirely from medicine, seeking a role outside of general practice.

This sense of ease in seeking a new direction in John and Rachel's accounts was not evident in the narratives of the other GPs, whose accounts were epitomised by the following quote from Lucy: "I've got to work out how to manage this differently, it must be something about what I am doing that I need to change so I can still do this job." This hints at a sense of being trapped by their dedication to keep working as a GP. The onus of allowing that to happen within this extract is personal. Participants also took personal responsibility for seeking help, feeling isolated within this and wanting guidance:

> Trying to find someone to just help me or guide me, which they obviously couldn't do, and I could see it like a disaster was going to happen, but like I said, yeah I just didn't know how to stop it. (Kate)

Beth examines the wider ramifications of being trapped in the role with burnout, looking at how such negative feelings affected her life outside of work:

> It is global because it affects everything, it effects how I am with my work, it effects how I am with my family and friends, and then it affects me and how I feel about life and whether I am enjoying life and enjoy things that I would normally enjoy. (Beth)

This extract emphasises the reach of burnout and the effects that participants consider to be important. Although most participants specifically relate the feeling of being trapped to their GP role, they also suggest that burnout impacts all areas of life.

5.2.2. Isolated, Neglected, and Misunderstood

This sub-theme captures the participants' reflections on their experiences within a context where they feel misunderstood and increasingly isolated. Interestingly, all participants reported the feeling that others did not understand their situation. However, Rachel, Saima, and Kate emphasised that their peers were most likely to understand yet least likely to engage in conversations about burnout. Kate describes being frustrated after receiving guidance from non-medical friends and family due to a perceived lack of empathy with her situation:

> My husband who at the time didn’t understand… even kind of friends and family who weren’t just wouldn’t really understand so I felt like they weren’t listening to me … so I think it was frustration because I would sit there and try and explain it to them and they would be like yeah yeah we get it, but they wouldn’t get it. (Kate)

Kate’s words reflect an urgent need to be understood and to receive help; instead, she is left feeling ignored and alone. In their attempt to make sense of burnout, GPs describe searching for but not receiving validation of their experiences. This mismatch leaves GPs feeling alone and isolated through this challenging time: “I feel trapped and then I feel I have no one who understands because I feel no one can understand apart from other GPs who are in the same situation” (Saima).

Nevertheless, as explored by all participants, communication between GPs about their experiences is uncommon, as they fear judgement and, more specifically, being regarded as failures. Lucy described not confiding in others due to a desire for privacy, uncertainty about what to say, and inability to control her emotional reaction when recounting her story. Thus, GPs are unable to tap into the support they need, instead being left to self-isolate and suffer alone. John, meanwhile, uses a supernatural metaphor to describe a different but similar phenomenon – the mismatch between his perceptions and that of other GPs and policymakers in the industry – which likewise resulted in feelings of isolation:

> I think that this [method seen to improve general practice] was important and that aware that somehow other people couldn’t see it …. this is as clear as saying can

> you see that ghost there that is standing behind you and apparently nobody else could see it … as solid as anything you can imagine and I don’t know why other people can’t see it but I can’t not see it. (John)

Additionally, Rachel, Kate, and Beth talked about feeling physical isolation in their role behind the consultation door, whilst Saima, Rachel, and Beth described how interacting with patients provided an insufficient social reward, leaving the “social beast” within the GPs feeling neglected,

> Alone from a social point of view because I am very sociable a social beast and just to be stuck you know in that room, you are doing good you are seeing patients, but patients are completely different to your social life, there is a barrier. (Rachel)

The energy fulfilling-element of “doing good” was not counteracted by the negative drain of the isolation for Rachel. The physical isolation for these doctors added further complications in not allowing the chance to debrief, talk through problems, and connect with peers. To make matters worse, burnout led participants to isolate themselves outside of work as they felt exhausted and needed to preserve the last remnants of their energy for their next workday. This heightens the doctors’ feelings of existing in an isolated bubble, as their social needs cannot even be satisfied outside of work as their trials in the workplace have already sapped too much of their energy. Thus, most participants speak about closing themselves off to opportunities to form social connections. For instance, Lucy describes no longer being able to attend to her hobbies, Kate laments the effort needed to visit her partner’s family, and Beth reflects on changing her interaction style in such a way as to discourage deeper conversation:

> I remember giving out these quite busy signals … I was really clear that they were aware that I was really busy and I think I would say ‘oh work is awful’ or ‘oh it is so busy’ and in a sense that puts people off communicating with you. (Beth)

5.2.3. Art for 'Trapped and Conflicted'

Figure 5

Art for 'Trapped and Conflicted' – Created by Eddie Tucker

5.2.3.1. Artist Statement for ‘Trapped and Conflicted’.

The doctor huddles to self-protect and shut the world out. The body shape in the art has been constructed in handwriting using the words of the participants. The quoted text is taken from doctor’s statements, the words of those caught up in the turmoil of their situation – trapped and conflicted in what they want to do, what they need to do, and what they can do! Yet, the shape of the mouth is made solely by shading, as no words were used here to express and speak about their problems enough.

The shadows from the broken glass act as bars to a cage. Bars keep people out. Bars that keep people from helping, and bars that act as a defence mechanism. The bar lines are also metaphorically like a net, trapping the victim in place. The broken mirror is symbolic of the system, the burnt-out doctor, not being whole or complete, “losing a bit of myself.”

The use of black ink on white print was influenced by the subject matter. Black symbolises darkness, gloom, as well as other negative connotations. The gathering gloom and darkness in the work as well as the surrounding mount is symbolic of the inner turmoil and building pressure within the doctor and the system. (Eddie Tucker)

5.3. The Meaning of Self

Identity and the meaning given to their sense of self for participants was a theme running throughout each of the participant's narratives, thus highlighting the complexity of the experience of burnout among doctors. For all the participants, their connection to their professional identity is strong and intrinsically linked to their experiences and perceptions of burnout. The nature of their professional identity leads to the neglect of their life outside the role, adding to the accumulating challenges of the role. Simultaneously, attachment to their perception and expectations of the role prevents GPs from taking sick leave in a timely way, leading to exacerbation of symptoms. The participants' identities are challenged, the experience of burnout being incompatible with their expectations and perceptions of themselves, leading to the feeling of their identity being lost. Finally, this theme captures the participants' discussions of navigating these experiences related to their identity, especially pertinent to the doctor's acknowledgement of working towards preserving their self-image.

5.3.1. Professional Identity

The professional identity of being a doctor was deeply ingrained for all the participants. They all recognised the value in helping people, describing it as their calling: "There's no better role in a way than helping someone physically or mentally" (Kate). A sense of caring for their patients came across in both Kate and Saima's responses. The reverence for the role remains strong in most of the GPs, as epitomised in Rachel's account of working during a break away from medicine:

> This was a hobby, I didn't look at it as a profession but I still had that work drive you know, but it was a hobby so I was approaching it from a different perspective passionately, if it was work I wouldn't have recovered. (Rachel)

However, as noted in the latter part of the quote, this redefinition of work allowed her to recover. Additionally, participants describe that the ability to manage the academic demands of medical school to become a doctor was a sign of strength, and, by extension, an indication of their superior resilience to those not in the medical profession:

> I feel like you probably hear about it [mental illness] less because you are taking a group who I feel are probably more resilient than the average person so actually you can give them a lot more to deal with until they turn around and say ‘actually enough is enough.’ (Kate)

Yet, during the onset of burnout, their role appears all-consuming to the detriment of other aspects of self. For instance, Lucy reflects on the experience of her broader identity gradually being depleted: “[it was like] things dropping off at each level until it was just phurrf … losing other little bits of yourself along the way” (Lucy). Similarly, Saima describes the neglect of ‘other’ identities:

> I am also a woman and I have to think about being a mother, so we have other roles outside and those roles are so important and I don’t want to neglect those roles, erm I think when my son didn’t get into a good school it really hit me. (Saima)

She uses the word “hit” to convey a sudden realisation; that is, she became starkly aware of the things she may have been missing outside of her career. Through these extracts, we can see that these ‘other’ identities have been displaced; for example, the language used when Saima is speaking about her job, peers, projects, and patients is often redolent of familial responsibilities: “They [staff] become like your family, and you neglect your own family,” “walked away from my big roles … it is like a bereavement reaction, you know this is like my baby”, and “the patients have almost been weaned off.” Note the displacement between her staff and her family and the way in which she likens her project to her own child.

In terms of having a strong and primary connection to their job, participants comment on the young age at which they decided to pursue medicine, leading to sacrifice and dedication over the years wedding them to the role: “You make these decisions when you are so young … that’s the thing with medicine and it’s very hard to then know your personality or what you're going to be like at 23, 24, 25" (Kate). In this extract, we see Kate outlining the expectations of identity dictated at a young age, which dominates the space for development and nurturing, leaving the personal side of GPs' lives neglected. Rachel expands on this notion, arguing that the creation of a doctor starts much earlier:

> That is how we are reared, not just from university but from school, that is how we are reared, that work hard, read hard, work work work, automaton robotic programming you know that's how we are programmed. (Rachel)

All participants described a contrast between the self 'pre-burnout' and during burnout. Although all participants discussed preserving their 'doctor' identity through their belief in their ability to maintain quality patient care, distress was caused by the disruption to the elements of a 'worker' or 'carer' when needing to seek help or take time off. Participants were concerned that their identities as doctors could potentially be compromised by accepting that they were struggling. This led to a process of internal questioning and self-doubt: "I was just thinking 'is it me, is it me that's just not strong enough, why can't I deal with this? What the hell is wrong with me? Why? Why can't I deal with this?'" (Kate).

Consequently, John alludes to the conflict at a fundamental level, saying that the profession is ill paired, as "a GP is a sense-maker", a role that is misaligned with the increasing administration and withdrawal from direct patient care that is now typical of the job. The secondary threat when burnout surfaces is of no longer being able to fit within the perceptions of being a 'worker', a characteristic which some participants note as an innate core value or, as with Rachel above, one which is cultivated from an early age. Lucy notes the inner conflict that this causes: "I was not even being able to work out my notice. So, it really went against the grain."

5.3.2. Maintaining Care

GPs navigated this turbulence in their careers in various ways. They either worked harder to maintain care, switched into their professional persona when interacting with patients, took steps to reduce their workload, or took time off.

Beth discussed the balancing act of feeling more strongly connected to patients whilst remaining sufficiently distant to allow herself the space and freedom to enjoy her own experiences outside of consultations. She talked about the cost to herself when trying to maintain care:

> I was trying to make sure that I you know, I cared for patients how I was to care for patients, but it was much harder to do that because it came at much more cost to me, a lot more cost to me because I hadn't got the energy and the concentration that I needed to have. (Beth)

Alternatively, Lucy acknowledged symptoms of burnout and was surprised at her ability to continue functioning:

> Bizarrely no I really felt, I could still be doing I was still concentrating on things I was still able to erm I erm do still think I was being efficient, I don't even think I was slowing … actually I think I was still juggling things amazingly well in lots of ways. (Lucy)

Lucy's surprise that she was still performing well is shown through her use of the words "bizarrely" and "amazingly." The notion of providing competent patient care even whilst being burnt out was an important thread through all the participants' accounts. The GPs were acutely aware of the proposed connection between burnout and patient care and would work to provide quality care to the detriment of their own mental health: "I was at work, I knew that I wasn't doing anything unsafe." (Kate) and "I was saying all the right things" (Lucy). For some, this association was contested: "Well I don't know about underperforming, I am not happy with this link between underperforming and burnout" (John).

Some participants rationalised this by describing their innate professionalism, which remained even whilst they were experiencing burnout. In the consultation room, this professionalism entailed the execution of appropriate doctor-patient communication, likened to bedside manners. Saima spoke about maintaining a professional mask to distinguish the personal and professional selves, an ability that she argued was strengthened through medical training. Here she speaks of concealing her feelings during a consultation: "that's not professional … that is not part of the therapeutic relationship, it's their problem, you can't bring your problem into the consultation" (Saima). In other words, instead of being a natural ability, this is a consciously and effortfully applied mask designed to cover the broken person inside. Saima goes on to say that a large part of the role is "pretending" and that she must "cover up" her inner stresses.

Nevertheless, some participants spoke about a disconnect between a passion for helping patients and their actual consultations. Kate, Lucy, and Saima noticed an internal change behind their professional performance, which led to inner questioning and often action: "I remember just thinking 'I just don't care, I don't care, I don't want to be here, I don't care and that's it,' I remember thinking 'no this isn't right'" (Kate). Therefore, whilst participants described still performing adequately during consultations, they also highlighted the turbulence hidden below the surface. Arguably it was when this turbulence became impossible to ignore that GPs started to accept being broken. All GPs spoke about concealing certain negative feelings, but Saima and John said that their exhaustion and stress were so extreme at times that they rose to the surface and could no longer be concealed in spite of their best efforts to conceal them:

> My friend [name] looked at my face and brought me straight in and almost put me to bed straight away and looked after me for a couple of weeks, it was obvious I was wearing it on my face how stressed I was. (John)

The notion of having a mask to conceals negative feelings was interpreted as an essential thread through all the participants’ accounts. Both these doctors seem at this point to have lost control of their masks.

5.3.3. Art for 'The Meaning of Self'

Figure 6

Art for 'The Meaning of Self' – Created by Eddie Tucker

Note: The artist titled this work 'Identitatis - De Sensu Scilicet Sui Ipsius'.

5.3.3.1. Artist Statement for 'The Meaning of Self'.

For centuries, in literature and painting, the mirror has been symbolic of seeing into oneself or discerning the true nature of something by its reflection. Not recognising one-self in the mirror, not being able to identify who you are or what you have become, I depicted as the ultimate horror. The broken mirror symbolises the splitting between the person and their reflection. There are now two separate manifestations of the person – their public face and their inner identity. The split between the two figures in the work symbolise the public face and the inner identity of a suffering doctor. They may look the same on the outside but inside they are changed or changing, so much so they are unable to recognise who they are or whom they are becoming.

The cracked and broken mirror throws shadows across the image keeping the inner and outer personas apart, trapping them both in their separate places and breaking the connect between the inner and outer self, losing the identity of who they are. Horrified by what is happening and their inability to deal with it. The use of dark pigments and tones was influenced by the subject matter to symbolise darkness, gloom, and horror. The gloom and darkness in the work is symbolic of the inner turmoil and building pressure within the doctor and the system much like the gloom and darkness before a storm breaks. (Eddie Tucker)

5.4. Navigating Burnout

This theme explores three strands of how participants navigated their lives once they had accepted their experience of burnout, incorporating the complexity of their perceptions of their experiences, including the following: the conflict which resurfaces when some participants decide to take the next step by leaving or seeking help, how their perceptions change at different points of their stories, and finally, the reality for some that burnout seems to remain with them indefinitely after an ‘episode’.

5.4.1. First Steps

Although in the depth of enduring burnout with no reprieve, Saima often hopes to be free from burnout where she can personally regain control of her life, though she is struggling to find a way to achieve this – the epitome of the trapped and conflicted theme. However, in her interview, she spoke about how she was trying to reduce her burdens and re-establish control: “I have cut down my clinical sessions because if I can’t do it, I won’t do it, I would rather not see the patients” (Saima). In contrast, the other five participants give a sense of containing their burnout within a clear time period, with three detailing start and end dates – an ‘episode’. However, we also see that what is confined within those periods are the most extreme presentations or consequences of burnout.

Kate, Rachel, Beth, and Lucy are at similar stages of having had time off and then returning to their work, yet were distinct in that Beth and Lucy are still trying to understand their experience. In contrast, Kate has integrated her ‘burnout self’ with her identity. This acceptance occurred at the lowest point of burnout, described as a “full-blown breakdown”: “I was internalising it all and I was just getting more and more unhappy and more and more stressed and it was only when I had my full-blown breakdown that I accepted it for what it was” (Kate).

Woven into the doctor's identity is their expectation of what a doctor is, and therefore what they expect of themselves – which is to be invulnerable. This led Beth, Kate, and Lucy to experience difficulties in justifying the necessity of both seeking help and taking time off from their roles. We see these participants minimising their experiences through their narratives, creating distance from the experience to prevent the need to accept the severity of the situation as something their hard work could not fix. When the severity was unavoidable, this justified being allowed to speak out and seek help. Reassurance was felt when this was validated by external support: “Recognition of also, ok this must be really big if someone is telling me to take time off work” (Lucy). However, this new perspective conflicted with Lucy’s sense of self: “Her suggesting I needed time off was just terrible … all those kinds of sensations of failing, of not being able to do this, I should be able to do this, why am I not doing my job?” (Lucy). On the other hand, Beth arrived at her own conclusion that she needed time off:

> Ultimately, I am an adult and I actually have to end up deciding what I am going to do in a sense and it is actually up to me, so if someone had said ‘oh you are burnt out’ I would have probably gone no [laugh]. (Beth)

As explored within the theme ‘trapped’, John is distinct from the other GPs. His circumstances allowed him more freedom to prioritise himself and more readily accept the notion of taking time away from work. This enabled John to assertively and proactively take control of his situation: “So I went, I decided because I felt I was quite unwell, so I put myself on a three-month sabbatical” (John). The repeated phrase “I put myself” indicates his decisiveness and his willingness to take personal action. This decisiveness is reflected in Saima’s small victories, such as her reducing her hours to maintain her caring capacity and Rachel’s sudden departure from her role. Although the participants departed their roles in different ways, they were all similar in that they each needed time out from their role in medicine. By completely removing themselves from these situations, these doctors were able to enter a new period after their ‘episodes’. The start of a new period for each of the GPs is signalled by the removal of themselves from work, which for most led to a great sense of relief. As Kate describes, “It felt like I had a bit of a weight lifted off my chest.”

5.4.2. Shifting Perspectives

All GPs spoke of changing perspectives towards themselves and their work during their experiences of burnout. Shifts in perceptions were mainly prompted during time away from work when participants had the space and time for reflection, which is a idea that started to emerge in the previous sub-theme. The GPs regained a perception of control and of being able to re-navigate their workplace with the new perspective of prioritising their mental health. The regaining of control for Lucy came through moving to a new workplace, an action that together with differences in working, helped change her view of working as a GP:

> I think if anything the practice is busier than the one I have just left, but it feels more manageable, possibly for a few reasons, possibly because I am in a better place but I think equally just because it’s a better structure and a better format, and better individuals and how they all work. (Lucy)

The intense workload previously branded the “new normal” was now perceived as “manageable” due to the changes Lucy made after, as John described, “feeling the fear and doing it anyway.” For Rachel, her perception of being a GP and embracing change was defined by her moments of facing the fear and reflecting on the outcome. She re-evaluates how much career progression and the necessity of the role defined her life: “I gave that up and the world did not collapse around me and I still survived” (Rachel). This re-evaluation was a pivotal reflection in her narrative, which allowed her to foster more freedom away from her role and consider alternative career paths, such as returning to work as a doctor in secondary care and considering work outside of England.

This sense of rediscovery, of both freedom and the self, separate from the identity of ‘doctor’, is echoed with varying emphasis through most narratives. The notion came through most strongly in John and Rachel’s narrations, epitomised by John saying, “It was [whilst travelling] where I just fell back in love with life” and “I was rediscovering my youthful days of backpacking and going around and just enjoying.” Overall, there was a strong sense that years of medical school and then being a young GP had limited their personal development. For Rachel, she felt that she was able to take a step back from her work. She was able to explore a passion from her childhood, tapping into unexplored promise. This positive rediscovery of life embraces a more holistic perspective, enabling the GPs to regain some balance in their lives.

In another way, Rachel discussed fully embracing and rediscovering how to connect with patients more profoundly and differently. The realisation of her vulnerability allowed her to humanise the patients, to take a step back from the professional barrier that she had formed, and thus allow herself to dedicate more time and care to the patient, which represents a dramatic departure from how she referred to herself before burnout, as “grumpy” and “impatient.” This change in approach allowed for some revitalisation and connection with the role. When asked how this made her feel, she replied, “Oh very happy, very happy and it is amazing what you learn about them when you spend a bit more time, some have lived really colourful lives I had one who owned a cabaret bar [laugh]” (Rachel). More subtly, Kate described how through her experience and understanding, she feels she has become more empathetic and can more deeply connect with her patients:

> I am now a lot more understanding when it comes to patients when it comes to mental health, and I think they know that, and I get a lot of patients who come back because I can now understand. I think before I understood and would speak to them, but now I really get it. (Kate)

Here we can see that her experience has been used positively. Perhaps sadly, we see here she is providing the support, time, and understanding she craved when she was experiencing burnout. Discussed by all the participants was the notion that, although burnout was undesirable, it was hoped that by giving voice to their experiences they this could help other doctors and make a difference. Lucy and Saima reflect on their experiences of the NHS and medical training; for example, Lucy highlights a gap in her education and the need for a change in medical culture:

> We are losing doctors, there needs to be something put in place which starts at medical school that teaches that this is the challenges you are going to face, and actually it is fine to admit you are suffering, this is where you get help, this is how we can help. (Lucy)

She focuses on help, repeating this for a second time, echoing her feelings of isolation and of not knowing where to go for help, feeling unsupported, and having to find her own way out when she was at her lowest in terms of both mood and motivation. Rachel also reflects on the NHS and her medical career, viewing her anger at the NHS from a time after burnout through what she calls a pragmatic view of life speaking to the “nature of the beast”:

> I understand it is the nature of the beast, that is what we signed up for, and I am pragmatic about it now but in the heat of it I really just couldn’t fathom it. (Rachel)

Through this, Rachel could prioritise herself: “I think it is now time to think about myself.” This was a sentiment that Saima also related to: “I want my own life, I don’t want my life to be so much of this NHS world.” Yet, changing roles in order to prioritise their own mental health was not always freeing or desirable, as seen in Beth’s sadness over taking on a locum role and her acknowledgement that she may never amount to more than that: “I suspect I will be a locum for the rest of my working life which I am sort of coming to terms with” (Beth). Beth said she made this decision partly because she realised the NHS would not provide the necessary guidance and support, and so she had to take matters into her own hands by reducing her workload. Such acceptance is key for these GPs. Now they can take charge of their own health and prioritise this as they understand that the organisation is not going to do that for them. This critical change in perspective leads to the next sub-theme, ongoing impact.

5.4.3. Ongoing Impact

Saima is still fighting as a burnt-out full-time GP, searching for a solution to help her leave. Therefore, in the broadest interpretation of ongoing impact, for Saima, burnout has endured for years. Yet, Kate, Beth, Rachel and Lucy also acknowledged that burnout had had an ongoing impact on their lives. Through this theme, we see disparities between participants' responses, especially in those of John and Rachel who, unlike Lucy and Kate, seem to have mostly bridged the gap between personal identity and the experience of burnout, helped greatly by a journey of self-discovery. The other four GPs, however, spoke about burnout and its ongoing impact. Beth and Lucy even became tearful when revisiting their experiences in the interviews; the impact of burnout was still fresh and the associated emotions very much just under the surface:

> I can't believe how strong it [the emotional reaction] is when you think about it again … yeah it just amazes me you know that it still hits me every now and again … it just really amazes me because the rest of the time I am doing so well erm and I still don't quite understand why that happens. (Lucy)

Although she referred to making progress in returning to work, which was "mostly going absolutely fine," Lucy found herself unexpectedly upset, especially when recounting her experiences. This has led her to confide only in close friends and colleagues because she is a private person and because of the emotional turmoil that continues to resurface. This highlights that Lucy is still working to connect with her experience but is being hindered by her almost traumatic recollections. Kate, meanwhile, spoke more bluntly about the long-term impact of burnout:

> I do feel personally once you have had that burnout it does affect you forever. It still stays with you and I feel now that I am less of a resilient person, I still am, but less of a resilient person. (Kate)

In this extract, we see the stark realities for the participants in terms of the permanence of the damage caused by burnout, with them saying that returning to their ‘pre-burnout’ selves is unachievable. The ongoing nature of burnout was echoed through participants detailing plans of continual reassessment of role suitability and prioritisation of their mental health.

Rachel discussed changes she would make in terms of exercise, diet, her faith, and keeping note of warning signs. Yet, in her interview, there was an undercurrent of sadness that went with the need for this constant vigilance. Kate used the phrase “purposefully to try and protect my mental health,” which represents a shift in her priorities, while Lucy said, “It could very easily happen again, but I am pretty sure I won’t let it.” This protection of their now salvaged mental health is a priority for Beth too. For Beth this was shown in her advocation for herself and her awareness that a salaried role would likely result in the diminishing of her health through the NHS’s inability to ensure set hours:

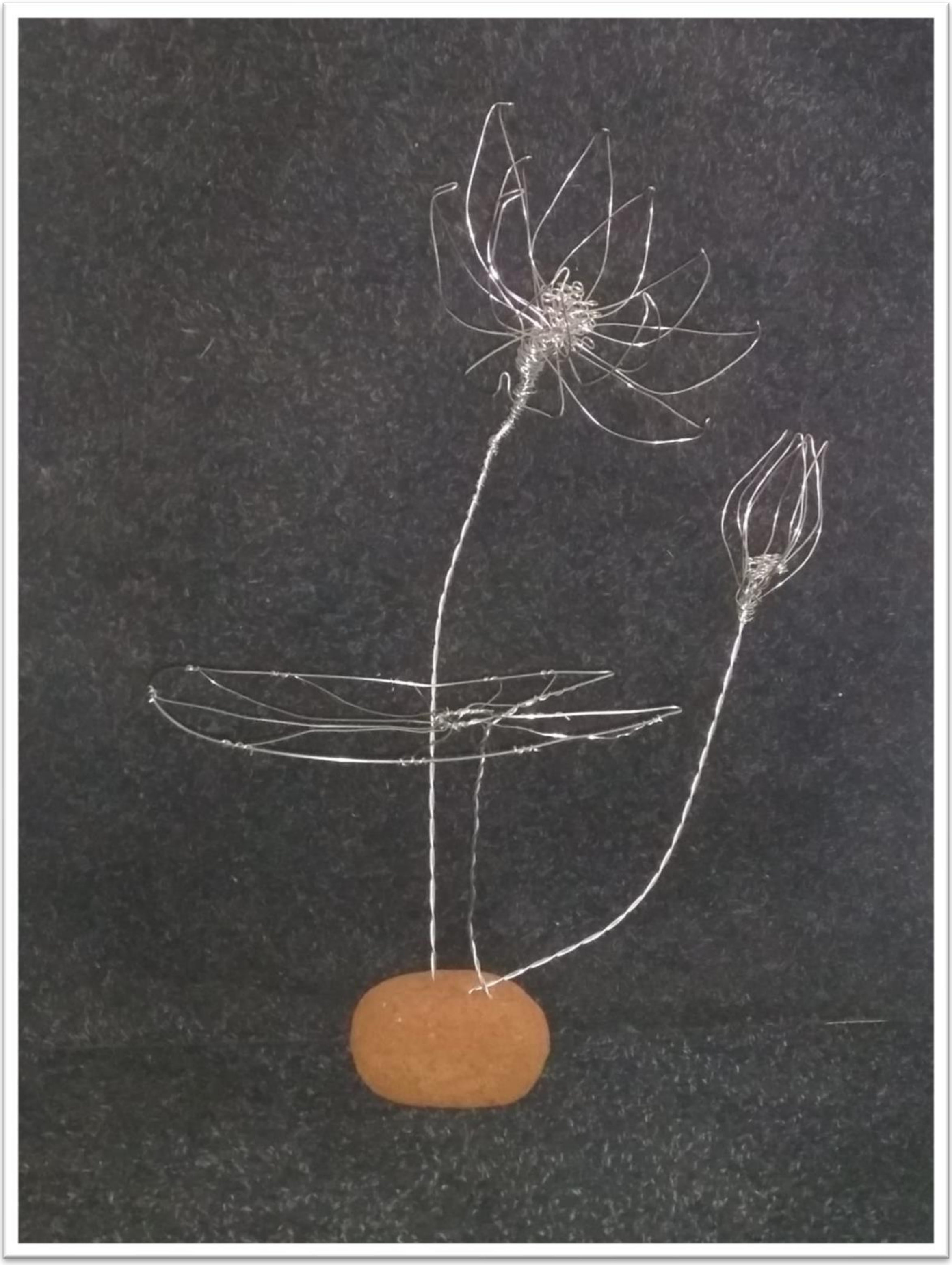
> I have practices saying ‘oh come and be salaried,’ ‘come on we need a salaried GP,’ ‘we really want you,’ ‘come on it will be great’ and I am thinking ‘but what is going to stop you pulling me back in and me doing long hours and that is not ok.’ (Beth)

Kate, Lucy, and John discussed the perceived control they have over maintaining their mental health, often referring to habits and good practices. The necessity of maintaining mental health highlights their perceived vulnerability resulting from burnout. This vulnerability is akin to acceptance of their experience: “I guess it is just that reminder to not get overly confident from a recovery point of view, it’s that reminder not to get overly confident and not to get back into all the old habits” (Lucy). Participants described themselves as having reduced resilience. Through these shifting perspectives, we see that the participants acknowledged feeling more vulnerable. However, this did not necessarily indicate a diminished resilience but rather an increased awareness of their emotional and physical needs, which is now driving their self-prioritisation.

5.4.4. Art for 'Navigating Burnout'

Figure 7

Art for 'Navigating Burnout' – Created by Gillian Tucker



5.4.4.1. Artist Statement for 'Navigating Burnout'.

This piece brings out the hope from the theme life after burnout - although the consequences of burnout seem to continue on, the doctors seem to have a greater concern for prioritising their-self to prevent future relapse. Therefore, I chose to represent this in sculpture form, constructing a lotus flower using stainless steel wire. The lotus for this piece representing self-regeneration, the petals signifying the path to self-awakening, together with the leaf they are raised well above the water surface.

The grade of wire used shows good resistance to wear and tear and, in this piece, displays the strength and remaining resilience of the GPs to return to work. The wire is soft and malleable and is easy to mould into place using human hands showing the GPs increased awareness and acceptance of their vulnerabilities. The sea worn brick represents the shallow and murky waters, the GPs still with their roots firmly in the mud. (Gillian Tucker)

5.5. Discussion

These findings were based on interviews with six primary care GPs who self-identified as having experienced burnout. Participants spoke about their experiences at different stages of their burnout journey: one still deep within burnout, four working to navigate their lives after an episode of burnout, and one reflecting on their experience from a period of time later. However, all the accounts showed that burnout was a complex experience that resulted from a cumulation of work, lifestyle, personality traits, and socio-political dimensions (Staten & Lawson, 2018). Participants' experiences seemed to relate most closely to the frenetic type of burnout identified by Farber (1990), becoming exhausted by their efforts from pushing themselves too hard for too long. Consequently, burnout was a global experience for the participants, characterised by fatigue, increased irritability, depersonalisation, and many other common symptoms previously associated with burnout (Kakiashvili et al., 2013). Participants used words that captured their feelings of incompleteness when summarising their experience of burnout, which highlighted the negative ways in which they viewed themselves and echoed Myers' (2017) description of burnout as "an erosion of the soul" (p. 70).

The cynicism sparked by experiencing burnout (adverse reactions to other people or to their occupation) has been reported to manifest in a variety of ways (Maslach, 2003). Participants blamed themselves and questioned their value (Maslach, 2003), feelings that were compounded by their own and others' expectations of their ability. However, for this group of GP participants, cynicism and animosity were directed primarily towards their organisation despite extensive contact with people in emotionally charged environments. Participants described all six occupational risk factors for developing burnout related to the mismatch between the person and the nature of the job: work overload, insufficient reward, breakdown of workplace community, lack of control, absence of fairness, and value conflict (Maslach, 2003). These findings were consistent with Ekstedt and Fagerberg (2004).

The current healthcare culture prolongs the experience of occupational stress. However, participants also emphasised the impact of burnout on their personal lives and the potential influence of their personal lives on the development of burnout. This relationship between personal factors and burnout has previously been reported (Maslach et al., 2001), such as an increased risk of burnout when there are additional caring responsibilities outside of the occupation (Maslach, 2003). Participants' experiences were similar to the exhaustion funnel model proposed by Åsberg (2018). Within this model, individuals focus on the elements they perceive to be the most important as their lives get busier, losing sight of other aspects of their lives. As seen within the interviews, the first aspects of life to be lost were nourishing activities, such as hobbies, which are perceived as optional yet play an essential role in replenishing energy to prevent the onset of mental exhaustion (Williams & Penman, 2011). When exploring the time proceeding burnout, Ekstedt and Fagerberg (2004) labelled this process "cutting off" (p. 62), theorising that it serves as a mechanism to defend one's self-image.

Those who continue down the exhaustion funnel tend to be the most conscientious (Williams & Penman, 2011), which captures a fundamental personality trait described by the GPs. Participants also spoke of strongly identifying with the role of being a doctor, which is a trend that has been reported previously (Cascón-Pereira et al., 2016; Henderson et al., 2012) and which results in the loss of their other selves, as also found within Spiers et al. (2018) in GP partners, and more widely by Dumelow et al. (2000) in hospital doctors. Wessely and Gerada (2013) report that this merging of the professional and personal selves, with an individual becoming defined by their role, has its foundations in medical training. In parallel, the organisation was felt to be "losing sight of the person behind the professional" (Mahajan & Johnstone, 2017, p.13). A further consequence of this is the amplification of the participants' isolation within the role, reducing social activities, and compromising relationships outside of work. Participants felt misunderstood and alone in their experience, which is a key risk factor for medical students and doctors to experience mental illness (Carrieri et al., 2020).

Within the accounts, participants described symptoms common to earlier stages of burnout (Kumar, 2016) which seemed to be of great concern, such as symptoms associated with anxiety disorders (Staten & Lawson, 2018). Depersonalisation towards patient care was presented more prominently than inefficacy and avoidant maladaptive behaviours (such as procrastination). These later manifestations of burnout, inefficacy and avoidant maladaptive behaviours, are often paired with the potential for impaired performance (Everall & Paulson, 2004). The foregrounding of depersonalisation when participants described the impact on patient care could relate to the important impact on consultation satisfaction. Doctors' sense of themselves has previously been linked to consultation satisfaction, with consultations where the doctors can maintain a coherent sense of themselves as more satisfactory (Fairhurst & May, 2006). Research exploring healthcare workers more widely also showed that being prevented from doing the job they were trained for leads to emotional exhaustion and increased mental distress (Carrieri et al., 2020; Lacy & Chan, 2018). Nevertheless, this type of depersonalisation can also be a product of the medical culture, such as medics creating an emotional buffer that still allows genuine caring (Maslach, 2003). This was evident in the narratives when the participants described using a professional mask.

After a period of feeling trapped, most participants acknowledged the disconnect they felt. They seemed actively aware that their practice at this point could be impaired, as reported in the literature (Wise, 2018), or reached the point of no longer being able to continue working in the same way. Participants described needing to be at rock bottom before they could seek help, which is consistent with reports of healthcare professionals taking a long time to reach out to support services (Gerada, Chatfield, Rimmer, & Godlee, 2018). These findings add to the growing body of literature demonstrating the conflict of illness, particularly mental illness, with a doctor's professional identity within a culture of non-acceptance in primary care (Brooks et al., 2017). This is problematic for help-seeking and enabling doctors to change their work proactively before getting to crisis point.

The avoidance of the patient role was also explored by Fältholm (2007) as described in Study 1 and elsewhere for doctors more generally (George et al., 2014). The participants in the current study explored their experiences of help-seeking in a similar way to other healthcare professionals (Putnik et al., 2011). However, this analysis adds that GPs felt the need to have their sick leave validated or needed to be incredibly sick to justify help-seeking behaviours. One GP remains in work whilst being burnt out, and the other five have returned to work after periods of time away. The experience for the five who had sick leave or sought help was similar to the experiences outlined by Ekstedt and Fagerberg (2004), which in their study was defined as “the turning of the tide” (p. 62). However, these findings add to the literature by indicating GPs’ potential for growth after experiencing burnout.

Through traumatic adversity, some GPs develop negative symptoms characteristic of PTSD, others are relatively unaffected, and others experience growth. Growth through adversity (Joseph & Linley, 2005) which has previously held different labels such as a positive change in outlook (Joseph et al., 1993) and stress-related growth (Park et al., 1996), is a positive psychological theory. Growth has been documented in people who have experienced a range of stressful or traumatic events, such as women who now live without partner abuse (Giles, 2004) and medics after making errors (Plews-Ogan et al., 2013). Growth through adversity is reported to have three main components: relationships are enhanced (e.g., increased altruism towards others), people change their views of themselves (e.g., they develop a greater sense of resilience), and individuals feel a new appreciation for life (Joseph & Linley, 2006). In the current study, after an episode of burnout, there was evidence of increased altruism towards patients, greater acceptance of vulnerability and renegotiation of what matters to the participants, including prioritising their health. Similar to previous findings of growth through adversity, benefits were more likely to be seen after a long time elapsed (Linley & Joseph, 2004). Participants were starting to re-establish who they were as their own person (Giles, 2004).

Despite this, some of the findings mirror those from Fältholm (2007) who explored returning to work after sick leave for a wide range of illnesses, not just burnout (depression, chronic fatigue syndrome, heart disease, high blood pressure), and found that healthcare professionals undergo poor recovery when returning to the same damaging environment. In the current study, participants had all changed their work in some way, whether through reducing their hours, changing their working schedules, or moving to a new practice. However, participants also drew attention to the enduring nature of burnout with the continual re-evaluation of their roles and capacities. One participant described feeling that their resilience was permanently weakened because of burnout. In line with the theory of growth through adversity, this would relate to increased awareness of their vulnerability to ill-health and improved awareness of their limits. However, for these participants, concerns about the enduring nature of burnout were viewed negatively. Some participants also asked if what they had experienced was normal or had been similarly reported by other participants, which linked with the notion of voicelessness brought to the fore in the meta-synthesis. The concept of pluralistic ignorance is relevant to these experiences, contributing to their sense of isolation within and after burnout – when others do not share what they truly feel, others erroneously think they are alone in their distress (Maslach, 2003). However, in line with the theory of growth through adversity, passing on the knowledge of lessons learned to others was the motive for some participants for taking part in this study.

5.5.1. Conclusion

The findings indicate that the emotional distress of burnout has deeper complexity, with challenges to GPs’ sense of identity, how they view the NHS, and how they navigate their work. The long-lasting detriment to the mental health of GPs is of great concern, indicative of the need to better understand the nuances of GPs’ experiences post burnout. However, there were also indicators that burnout could trigger growth through adversity for participants, which requires further exploration. Action should be taken to work towards organisational change within primary care as a preventative measure and in medical school to support the development of more holistically supported individuals. Furthermore, the insights taken from GPs’ front-line reports should be used to improve interventions and communication between GPs about their experiences to help destigmatise burnout and help-seeking behaviour.

Chapter 6.

Study 3 – Assessment of the Support Provided for GPs in Distress

Previous studies in this thesis have highlighted GP wellbeing as an increasing concern but found GPs remain hesitant when seeking help during periods of poor wellbeing in the context of the medical culture with the stigmatisation of mental ill-health and encouraged hard work and stoicism. Moreover, when exploring the experiences of GP burnout, the potential for overcoming distress and burnout was debated. Thus, it is important to understand if support available for GPs is effective and the perceptions and experiences of individuals receiving the support. Therefore, Study 3 investigated the potential for improving the mental health and wellbeing of GPs through support from an NHS Practitioner Health Service in the UK (referred to within this thesis as the PHS) by analysing mental health and wellbeing scores collected routinely by the service. This study reports on mental health more broadly than burnout, analysing scores from five outcome scales that focus on different dimensions of mental health and wellbeing.

Study 3 has its foundations in pilot studies completed by Gerada et al. (2019) and Simpson, Ashworth, and Ayis (2021). These pilot studies explored the outcomes from the PHS over six-months and reported promising findings for improving doctor and dentists' wellbeing. As most medical professionals accessing support from the PHS continued to receive support beyond six-months, these initial pilots may not capture additional improvement for doctors over time, or whether improvements are maintained to participants remaining in the service a further six months (to the assessment at the one-year point or discharge at one-year). The chapter goes beyond the pilot research by focusing on the speciality of GPs and exploring the effectiveness of treatment interventions for participant wellbeing over a year. The current study had the aim of establishing whether there were changes in scores of wellbeing across timepoints, from initial assessment (T1) to the six-months assessment or discharge at six-months (T2), and from T1 to T2 to the one-year assessment or discharge from the service at one-year (T3).

In this chapter, first, the PHS will be briefly described to frame the study. Next, the participant demographics will be outlined with the study's procedures, followed by the reporting of the quantitative findings. Finally, a discussion will be presented, including a comparison to the wider literature and a summary of the potential reasons for the low match rate in this dataset. This chapter will contextualise Study 4, where a sub-set of this sample were recruited to take part in an interview study that explored their experiences of support and recovery, specifically related to their narratives of recovery from burnout.

6.1. Context – the NHS Practitioner Health Service

The PHS is a free confidential NHS service for medical professionals (doctors and dentists) across England. The service was commissioned in 2008 and specialises in meeting the specific mental health needs of doctors (such as increasing the accessibility of care and understanding additional concerns surrounding confidentiality; Brooks et al., 2017; Brooks, Chalder, et al., 2011; Brooks, Gerada, et al., 2011), to improve the wellbeing of the medical workforce (Gerada, Warner, et al., 2018b). As explored in the introduction, medical professionals have an increased prevalence of mental health problems compared to the general population. Donaldson (2006) reported that excessively stressful work environments could significantly impact their health and wellbeing, yet medics are reluctant to seek help. Consequently, Gerada et al. (2018) writes that medical professionals self-referring to the PHS often have:

> Reached the end of their ability to self-sacrifice and to care, and their professional, personal and social lives are often in tatters. They have waited too long to seek help and when adversity strikes, they work harder in the belief that their problems will magically disappear. (p. 3)

Through the service, support is provided for a range of mental health issues, including addiction problems. A range of treatment options are provided through the PHS, including case management, prescribing for mental health and addiction issues, cognitive behavioural therapy, brief intervention psychotherapy, inpatient and community detoxification, and several specialist support services concerned with workplace and regulator issues. For further details relating to the context of the PHS, please refer to Gerada et al. (2018).

6.2. Design

This study measured wellbeing and mental health of participants at three timepoints (T1, T2, and T3). Data (demographic characteristics and assessment outcomes) was extracted for analysis from all participants who had accessed the service at any of the assessment points and consented to have their data anonymised and used in the investigation of the outcomes from the service between May 2019 to May 2020[1]. From the 824 GPs who completed one or more of the assessments within the year, 9% declined consent for their data to be used within research exploring the service outcome data and 2% did not engage with the consent question (provided no answer). This chapter reports on the 89% of participants who consented to have their data used.

6.3. Participants

This chapter presents the analysis and results from a subset of participants included in the service outcome data (Shaw et al., n.d.), as it reports on only the speciality of GPs. This is due to the over-representation of GPs presenting to the service over the year (71%) and the focus on the medical speciality within this thesis. There were 734 GPs who completed T1 and consented to participate in service research exploring the service outcome data, 134 GPs who completed T1 and T2 (T1-T2), and 26 GPs who completed all three assessments (T1-T3). Demographic characteristics are presented in Table 9.

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[1] If participants had completed either the T2 or T3 within the period, the earlier records were located and used to allow a more complete evaluation

Table 9

Participant Demographics

	T1 (N = 734)	T1-T2 (N = 134)	T1-T3 (N = 26)
Age (years)	*M* = 39.42, *SD* = 9.04, Range = 24 to 71	*M* = 40.98, *SD* = 9.54, Range = 26 to 64	*M*= 43.88, *SD* = 9.02, Range = 29 to 64
Gender	Female = 69.5%, Male = 30.2%, Missing = 0.3%	Female = 69.4%, Male = 29.9%, Missing = 0.7%	Female = 69.2%, Male = 30.8%
Relationship status	In a relationship = 17.9%, Married = 61.1%, Single = 20.1%, Other = 0.5, Missing = 0.3%	In a relationship = 16.3%, Married = 59.0%, Single = 23.9%, Missing = 0.7%	In a relationship = 3.8%, Married = 73.1%, Single = 19.2%, Missing = 3.8%
Ethnicity	Asian or Asian British = 20.3%, White British = 64.3%, White Other = 5.3%, Prefer Not to Say = 1.9%, Other = 8.1%	Asian or Asian British = 10.4%, White British = 77.6%, White Other = 4.5%, Prefer Not to Say = 0.7%, Other = 6.6%	Asian or Asian British: Indian = 7.7%, White British = 92.3%,
Work status	Maternity/paternity leave = 2.9%, Retired = 1.0%, Sick leave = 19.9 %, Suspended = 1.6%, Sabbatical = 0.5%, Unemployed =1.5%, Working = 70.8%, Missing = 1.8%	Maternity/paternity leave = 0.7%, Retired = 1.5%, Sick leave = 18.7%, Suspended = 2.2%, Unemployed =1.5%, Working = 69.4%, Missing = 6.0%	Short-term sick leave = 19.2% Working = 53.8%, Missing = 26.9%
Years working	*M* = 12.22, *SD* = 8.62, Range = 0 to 46	*M* = 12.81, *SD* = 8.90, Range = 0 to 36	*M* = 13.21, *SD* = 8.90, Range = 1 to 29
Hours per week (hours)	*M* = 33.41, *SD* = 12.20, Range = 0 to 80	*M* = 33.63, *SD* = 12.01, Range = 0 to 55	*M* = 35.95, *SD* = 11.82, Range = 12 to 52

6.4. Procedure

At T1 participants routinely completed two forms. The first form recorded consent to use their data within research exploring outcome data from the PHS, and demographic data including name, address, email, phone number, date of birth, gender, emergency contact details, marital status, carer status, dependents status, smoking status, alcohol consumed, medical conditions, height, weight, personal GP details, work status, training status, GMC number, education details, ethnicity, sexuality, religion, disability status, and work concerns (collected through the statement “Please describe any work concerns below”). The second form (see Appendix S) recorded participants to complete a battery of questionnaires related to wellbeing including the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), the perceived stress scale (PSS-10), the patient health questionnaire depression scale (PHQ-9), the generalised anxiety scale (GAD-7), and the Psychological Outcome Profiles (PSYCHLOPS). This battery of questionnaires (referred to collectively as ‘mental health and wellbeing questionnaires’ within this chapter) were also completed at T2 and T3. Each questionnaire is described below except the WEMWBS, which is briefly recapped as this was previously described in section 4.1.2.1.1 of the thesis.

Data was extracted and anonymised by a PHS administrator (removing identifiable information such as personal contact details and medical registration details) prior to the data transfer to the researcher at the University of Westminster for matching, coding, and analysis.

6.4.1. Psychological Outcome Profiles

The PSYCHLOPS is a psychometric instrument that measures individual’s perspective on their psychological distress (Ashworth et al., 2004). The PSYCHLOPS has three versions; ‘pre-therapy’ (completed at T1), ‘during therapy’ (completed at T2), and ‘post-therapy’ (completed at T3). The pre-therapy questionnaire first asks the participant to “Choose a problem that troubles you most” and score how much this has affected them over the previous week on a six-point Likert scale from *not at all affected* to *severely* *affected*. Following this, the participant scores when they were first concerned with the problem on a five-point Likert scale from *under one month* to *over five years*. These questions are repeated for the participant's second problem. Following this, participants are asked to name one thing they find difficult because of the stated problem(s) and rate how hard this has been over the last week on a six-point Likert scale from *not at all hard* to *very hard*. The last question asks, "How have you felt in yourself this last week?" which is rated on a six-point Likert scale from *very good* to *very bad*.

The 'during therapy' PSYCHLOPS repeats all the 'pre-therapy' questions, with a further question asking for any additional problems discovered during therapy, and for the participant to score this on a six-point Likert scale from *not at all affected* to *severely affected*.

Finally, the 'post-therapy' questionnaire repeats all questions of the 'during therapy' questionnaire with the addition of the question of "Compared to when you started therapy, how do you feel now?" which participants rate on a six-point Likert scale from *much better* to *much worse*. Scores for each questionnaire result in a range from 5 to 20, with higher scores indicating that the person is affected more severely.

For all wellbeing questionnaires, internal consistency was explored (Table 10). A reliability coefficient of Cronbach α .70 or higher is usually considered acceptable in research (Santos, 1999). All Cronbach α scores for the PSYCHLOPS are higher than Cronbach α .70 and those reported elsewhere (.79; Ashworth et al., 2005).

Table 10

Cronbach α for the Mental Health and Wellbeing Questionnaires

	Cronbach α				
	T1-T2 (N=134)		T1-T3 (N=26)		
Questionnaire	T1	T2	T1	T2	T3
PSYCHLOPS	.79	.83	.87	.81	.86
PSS-10	.77	.94	.80	.92	.80
GAD-7	.82*	.91	.84	.94	.92
WEMWBS	.89	.96	.89	.95	.95
PHQ-9	.81	.90	.78	.86	.88

*(N=133)

6.4.2. Perceived Stress Scale

Perception of stress was measured using the Perceived Stress Scale (PSS; Cohen et al., 1983). The PSS-10 measures how stressful participants appraise situations in their life, tapping into overload, unpredictability and uncontrollability, and directly looking at experienced stress over the previous month (Cohen, 1994). Questions such as “In the last month, how often have you felt nervous and ‘stressed’?” and “In the last month, how often have you found that you could not cope with all the things that you had to do?” are measured using a five-item Likert scale (from *never* to *very often*). Scoring of the PSS-10 results in a range 0 to 40, with higher scores representing higher perception of stress (as this is not a diagnostic tool there are no cut-off points).

The 10 item PSS (Cohen, 1994) has been reported to have superior psychometric properties when compared with the 14 item scale (Lee, 2012). Lee (2012) examined the literature reporting tests of reliability and found PSS-10 had a Cronbach α of >.70 in all 12 studies reviewed. The current study is consistent with this and found a high Cronbach α across timepoints.

6.4.3. Generalised Anxiety Scale

Generalised anxiety disorder was measured by the GAD-7, a seven item scale developed by Spitzer et al. (2006) to reflect the symptom criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The questionnaire asks participants to indicate how often they had been bothered by the stated symptoms over the last four weeks on a four-point Likert scale (from *not at all* to *nearly every day*). Examples of symptoms include “Worrying too much about different things” and “Becoming easily annoyed or irritable.” Scoring of the GAD-7 results in a range 0 to 21 with higher scores representing more severe generalised anxiety. Spitzer et al. (2006) suggests results of 4 or below indicates minimal, 5 to 9 indicates mild, 10 to 14 indicates moderate, and 15 and above indicates severe generalised anxiety. A subsequent systematic review recommends a lower cut off score of 8 to 9 for the GAD-7 (Plummer et al., 2016). The GAD-7 is reported to have excellent internal consistency with a Cronbach α of .92 (Spitzer et al., 2006). The Cronbach α found in the current study for the GAD-7 were also high.

6.4.4. Warwick-Edinburgh Mental Wellbeing Scale

In brief, the WEMWBS questionnaire measures key dimensions of an individual’s state of mental wellbeing including positive affect, agency, and optimism, over the previous two weeks, with higher score indicating higher wellbeing. All Cronbach α were similar or higher than have been reported elsewhere (.89; Stewart-Brown et al., 2011) and would be considered an acceptable level. For full details of the WEMWBS, please see page 89.

6.4.5. Patient Health Questionnaire Depression Scale

Depression was measured with the patient health questionnaire depression scale which is referred to as the PHQ-9 (Kroenke & Spitzer, 2002). The PHQ-9 questions relate to the criteria of depression in the DSM-IV and has been found to be equal or superior to other depression measures (Williams Jr et al., 2002). The PHQ-9 questions explore depression severity over the previous two weeks by asking participants to respond to statement such as “Little interest or pleasure in doing things” and “Feeling tired or having little energy” on a four-point Likert scale (from *not at all* to *nearly every day*).

The PHQ-9 has scores from 0 to 27 which relate to depression severity and proposed treatment action. These are as follows: scores of 1 to 4 show no severity of depression and requires no treatment, scores of 5 to 9 indicates mild depression and suggests watchful waiting, scores of 10 to 14 indicate moderate depression with a need to consider a treatment plan such as counselling and/or pharmacotherapy, scores of 15 to 19 indicates moderate severity with suggested immediate treatment needed, and finally scores of 20 to 27 indicates severe depression and immediate treatment needed (Spitzer et al., 1999).

The internal reliability of the scale has previously been reported as excellent with a Cronbach α of .89 in primary care patients, and excellent test-retest reliability (Kroenke et al., 2001; Kroenke et al., 2010). The Cronbach α found in the current study for the PHQ-9 were high.

6.5. Analysis

The data was extracted into several excel files by an administrator who works for the PHS, de-identified and transferred securely to the researcher. The data was then checked by the researcher who looked for human error and missing data (see Appendix T). The researcher then matched the data across the three timepoints using anonymous patient numbers and dates of birth. When matching the data, the following audit trails were created: 26 excel spreadsheets that document the stages of matching were saved for transparency of the matching process, an SPSS syntax was created to allow replication of statistical analysis whilst also providing a log of data processing and analysis completed, and all statistical output was saved as PDFs for review. The analysis was completed independently by PS at the University of Westminster, but PHS practitioners were supported with the initial understanding of the raw data and checking the accuracy of the matching. To assess data extraction and matching accuracy, PS compared 150 randomly selected entries of matched data points with the raw files. A further 185 matched data points were reviewed by PHS practitioners against their system (see Appendix T).

Age for the participants was calculated using dates of birth and the date participants completed T1. Therefore, age within this chapter refers to age of the participant when they first accessed the service. The following questions produced qualitative responses: ‘work concerns’, PSYCHLOPS at T1 “Choose the problem that troubles you most”, “Choose another problem that troubles you”, and “Choose one thing that is hard to do because of your problem (or problems). These responses were coded into quantitative categorical values following the coding process within conventional content analysis, where the categories “flow from the data” (Hsieh & Shannon, 2005, p. 1279).

Once data was transferred to Statistical Package for the Social Sciences (SPSS), total scores were calculated for the three timepoints for each of the mental health and wellbeing questionnaires for each participant (see Appendix T. Demographic characteristics and frequency of categorised responses to qualitative questions were explored using relevant descriptive statistics.

Three sets of statistical tests were completed. Firstly, to determine whether the mean difference between the mental health and wellbeing questionnaires at T1 and T2 was statistically significantly different from zero, paired-samples t-tests were completed. Where assumptions were violated, appropriate transformations were performed. If transformations still violated the assumption, an appropriate non-parametric test (Wilcoxon signed-rank test) was used.

Secondly, to establish whether there were differences between the mental health and wellbeing questionnaires scores across timepoints when participants had remained in the service an additional six-months (T3), data from the three timepoints were analysed using one-way repeated measure analysis of variance (ANOVA) and post-hoc analysis with Bonferroni adjustment. Where assumptions were violated, appropriate transformations were performed. Although the one-way repeated measure ANOVA is fairly robust to non-normality (Blanca et al., 2017), if transformed data still violated normality an appropriate non-parametric test (Friedman test) was used with Bonferroni correction for multiple comparisons.

Thirdly, analysis was completed to explore if there were differences in wellbeing questionnaire scores between participants who completed T1-T2 and participants who completed T1-T3, at baseline (T1) and six-months (T2). Due to the unequal participant numbers in the groups being compared, Mann-Whitney U tests were completed.

All given values of *p* are two-tailed, and all analysis and generation of graphs presented were performed using SPSS for Windows, version 25. Assumptions for each statistical test and how these were checked are detailed within the appendix (Appendix T).

6.6. Ethical Considerations

Ethical approval for this study was granted by the UREC (ETH1819-1912) and received a favourable opinion from the NHS Health Authority (IRAS ID 265031). This approval was for exploring recovery of medical professionals through two methods, a quantitative investigation into the service's outcome data which is detailed in this chapter, and a qualitative study exploring a sub-set of these participants and their experience of recovery, which is presented in the next chapter (Chapter 7). Approval documents can be found in Appendix U and Appendix V, respectively. Key ethical considerations for this study were ensuring consent from participants, the confidentiality of the participants within the data set, and the safe transfer of anonymised data between the organisation and researcher.

First, before the commencement of the data collection period (May 2019), the PHS added a statement to their T1 form asking participants to indicate whether they consented to their anonymised data to be used within research. The current study was completed with data from those who gave consent.

Second, identifiable participant details collected at T1 were omitted, such as name, contact details, next of kin details, GP details, place of work, and General Medical Council number. These were removed from the data set by the PHS administrator prior to data transfer to the University of Westminster. Similarly, qualitative data which was provided in responses to the statement of “Please describe any work concerns below” and the three PSYCHLOPS questions, were checked by the PHS administrator and identifiable information removed.

Finally, for the secure transfer of data between the PHS and research team, ethical approval was granted for the transfer of the data in person – the researcher would attend the PHS site and directly upload the data to the University of Westminster secure server. However, subsequent significant amendments were made to this ethics application to account for the changing context of the COVID-19 pandemic, which involved seeking approval for the secure transfer of the outcome data via password protected files over email (with the password texted to the researcher). The procedural change occurred due to the restricted movement of people during lockdown in the UK and considerations of increased risk to the researcher and staff at the PHS through in person meetings. Approval of the amendment from UREC (ETH1920-2296) and the NHS Health Authority (IRAS ID 265031) can be found in Appendix W and Appendix X, respectively.

6.7. Results

This section of the chapter presents the results of the investigation into the outcome data of participants who had accessed support from the PHS. First frequencies of work concerns and PSYCHLOPS problems are provided, followed by the results from the analysis exploring wellbeing scores.

6.7.1. Work Concerns and PSYCHLOPS Problems

Participants appeared to approach the question asking about work concerns in different ways. Some answered whether concerns had been raised about them by others, whilst others reported if they had problems with their work themselves. The summarised responses are shown in Table 11.

Table 11

Participants' Work Concerns. Number of Participants (Percentage in Brackets)

Activity	T1 N (%)	T1-T2 N (%)	T1-T3 N (%)
No concerns	381 (51.9)	54 (40.3)	7 (26.9)
Work stress / not coping with work	124 (16.9)	24 (17.9)	9 (34.6)
Workload	69 (9.4)	14 (10.4)	2 (7.7)
Concerns with clinical ability / received complaint	43 (5.9)	10 (7.5)	-
Other	39 (5.5)	7 (5.2)	-
Negative work environment e.g. bullied / isolated	29 (4.0)	10 (7.5)	1 (3.8)
Burnout	11 (1.5)	4 (3.0)	-
Missing	38 (5.2)	11 (8.2)	7 (26.9)
Total	734	134	26

These responses can be paired with questions from PSYCHLOPS, which relate to perceived main problems and how these impact participants' lives. These questions are useful for understanding the concerns of participants entering the service and contextualising the analysis. The breakdown can be found in Table 12. The most common problems selected across the two questions (a problem that troubles you the most and another problem that troubles you) were anxiety, low mood, and other mental health concerns. Because of the selected problems, participants found it challenging to work, function cognitively (such as being able to focus and make decisions), and sleep (Table 13).

Table 12

Problems Reported on the PSYCHLOPS, Number of Participants (Percentage in Brackets)

	Choose a problem that troubles you N (%)					
Problem	The most T1	Another T1	The most T1-T2	Another T1-T2	The most T1-T3	Another T1-T3
Anxiety	192 (26.2)	103 (14.0)	33 (24.6)	16 (11.9)	7 (26.9)	4 (15.4)
Work anxiety/stress	92 (12.5)	34 (4.6)	13 (9.7)	5 (3.7)	1 (3.8)	1 (3.8)
Low Mood	91 (12.4)	95 (12.9)	20 (14.9)	20 (14.9)	5 (19.2)	2 (7.7)
Stress	50 (6.8)	46 (6.3)	6 (4.5)	8 (6.0)	3 (11.5)	3 (11.5)
Relationships	46 (6.3)	69 (9.4)	10 (7.5)	13 (9.7)	1 (3.8)	2 (7.7)
Work	46 (6.3)	44 (6.0)	12 (9.7)	13 (9.7)	2 (7.7)	1 (3.8)
Mental Health (Other)	35 (4.8)	55 (7.5)	6 (4.5)	11 (8.2)	2 (7.7)	4 (15.4)
Other	40 (5.5)	61 (8.2)	7 (5.2)	9 (6.5)	1 (3.8)	2 (7.7)
Anxiety & Depression	35 (4.8)	7 (1.0)	8 (6.0)	1 (0.7)	1 (3.8)	1 (3.8)
Depression	33 (4.5)	30 (4.1)	4 (3.0)	3 (2.2)	1 (3.8)	-
Burnout	21 (2.9)	12 (1.6)	3 (2.2)	1 (0.7)	1 (3.8)	-
Sleep Difficulties	15 (2.0)	40 (5.4)	5 (3.7)	10 (7.5)	-	2 (7.7)
Low self-esteem	15 (2.0)	27 (3.7)	3 (2.2)	8 (6.0)	1 (3.8)	1 (3.8)
Physical health	14 (1.9)	33 (4.5)	3 (2.2)	4 (3.0)	-	1 (3.8)
Exhaustion	5 (0.7)	18 (2.5)	1 (0.7)	4 (3.0)	-	1 (3.8)
None	-	59 (8.0)	-	7 (5.2)	-	-
Missing	4 (0.5)	2 (0.3)	-	1 (0.7)	-	1 (3.8)
Total	734	734	134	134	26	26

Table 13

PSYCHLOPS Question: Choose one thing that is hard to do because of your problem (or problems)? Number of Participants (Percentage in Brackets)

Activity	T1 N (%)	T1 & T2 N (%)	T1 -T3 N (%)
Work	127 (17.3)	26 (19.4)	6 (23.1)
Cognitive functioning	124 (16.9)	20 (14.9)	5 (19.2)
Control emotions	87 (11.9)	15 (11.2)	-
Sleep	70 (9.5)	19 (14.2)	6 (23.1)
Day to day activities	58 (7.9)	6 (4.5)	-
Relax	50 (6.8)	7 (5.2)	2 (7.7)
Motivation & energy	39 (5.3)	6 (4.5)	1 (3.8)
Relationships	35 (4.7)	7 (5.2)	1 (3.8)
Socialise	33 (4.5)	7 (5.2)	2 (7.7)
Steps to progress recovery	32 (4.4)	5 (3.7)	1 (3.8)
Self-care	25 (3.4)	7 (5.2)	1 (3.8)
Create balance	25 (3.4)	5 (3.7)	1 (3.8)
Most things	14 (1.9)	4 (3.0)	-
NA	9 (1.2)	-	-
Other	4 (0.5)	-	-
Missing	2 (0.3)	-	-
Total	734	134	26

6.7.2. Mental Health and Wellbeing from T1 to T2

Total scores were explored for those who had completed the assessments at T1 and T2. The mean, standard deviation, and range scores for each questionnaire at the timepoints are shown in Table 14.

Table 14

Overview of the Questionnaire Scores at the T1 and T2 (N = 134)

Questionnaire	Assessment	Mean (SD)	Range
PSYCHLOPS (↓** = improvement)	T1	15.15 (3.45)	4-20
	T2	7.07 (4.53)	0-19
PSS-10 (↓** = improvement)	T1	26.11 (4.99)	11-40
	T2	17.50 (7.74)	0-37
GAD-7 (↓** = improvement)	T1*	12.08 (4.68)	1-21
	T2	5.89 (4.59)	0-21
WEMWBS (↑** = improvement)	T1	36.92 (7.71)	14-64
	T2	49.28 (10.32)	23-70
PHQ-9 (↓** = improvement)	T1	12.54 (5.59)	1-25
	T2	5.99 (5.40)	0-24

* (N=133)
** Statistically significant results

The results from the *t*-tests showed statistically significantly decreased scores from T1 to T2 for the PSYCHLOPS (*M* decreased of 8.08, 95% CI [-9.05, -7.12]; *t*(133) = -16.558, ***p* < .001**, *d* = 1.43), the PSS-10 (*M* reduction of 8.61, 95% CI [-9.99, -7.23]; *t*(133) = -12.366, ***p* < .001**, *d* = 1.07), and the GAD-7 (*M* decreased of 6.29, 95% CI [-7.23, -5.34]; *t*(132) = -13.163, ***p* < .001**, *d* = 1.14), which indicates an improvement in perceived psychological distress, perceived stress, and generalised anxiety respectively.

The *t*-test's assumption of normality was violated when explored for the WEMWBS and the PHQ-9, therefore the Wilcoxon signed-rank test was used. Of the 134 participants who completed the WEMWBS at T1 and T2, 116 showed an increase in their scores, 3 showed no improvement, and 15 participants showed a decrease in their scores of wellbeing. Overall, there was a statistically significant median increase in WEMWBS scores (*Mdn* = 12.00) from T1 (*Mdn* = 36.50) compared to T2 (*Mdn* = 50.00), *z* = 9.35, ***p* <**

.001, indicating increased participant wellbeing over the six-months. For the PHQ-9, 134 participants completed T1 and T2, of which 115 showed a decrease in their scores, 5 showed no improvement, and 15 participants showed an increase in their scores of depression. Overall, there was a statistically significant median decrease in PHQ-9 scores (*Mdn* = -6.50) from T1 (*Mdn* = 12.00) compared to T2 (*Mdn* = 5.00), *z* = -8.63, ***p* < .001**, which indicated an improvement in depression scores over time.

6.7.3. Mental Health and Wellbeing from T1 to T3

The next section presents the results from the one-way repeated measures ANOVAs across T1 to T3. As an overview of the data, mean scores, standard deviation, and range scores for each questionnaire for participants who completed T1-T3 are shown in Table 15.

Table 15

Overview of the Questionnaire Scores at the T1, T2, and T3 (N = 26)

Questionnaire	Assessment	Mean (SD)	Range
PSYCHLOPS (↓** = improvement)	T1	15.85 (3.56)	5-20
	T2	5.81 (4.03)	0-17
	T3	3.58 (4.10)	0-17
PSS-10 (↓** = improvement)	T1	27.77 (5.11)	16-38
	T2	15.15 (7.19)	1-30
	T3	12.62 (6.14)	1-30
GAD-7 (↓* = improvement)	T1	13.19 (4.92)	4-20
	T2	3.92 (4.63)	0-21
	T3	2.85 (4.13)	0-21
WEMWBS (↑** = improvement)	T1	35.46 (7.74)	18-53
	T2	52.27 (9.07)	36-67
	T3	56.85 (8.47)	32-70
PHQ-9 (↓* = improvement)	T1	13.19 (5.55)	1-22
	T2	4.92 (4.41)	0-15
	T3	3.12 (3.78)	0-18

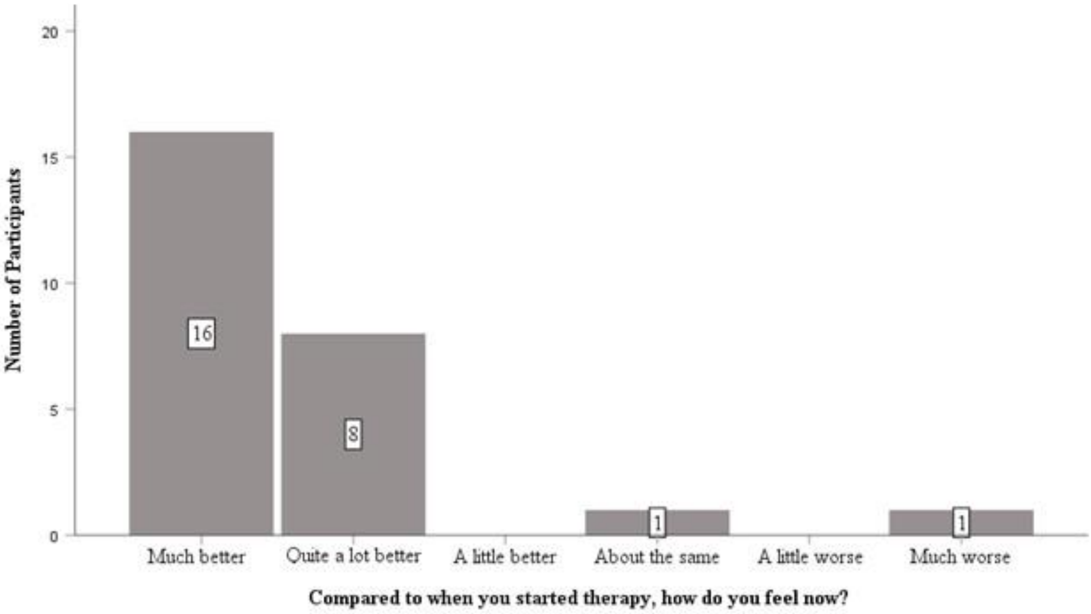
* Statistically significant results T1-T2, T1-T3, but not T2-T3

** Statistically significant results T1-T2, T1-T3, and T2-T3

6.7.3.1. PSYCHLOPS. As shown in Figure 8, most participants who completed the ‘post-therapy’ PSYCHLOPS questionnaire (T3) reported feeling quite a lot better (31%) or much better (62%).

Figure 8

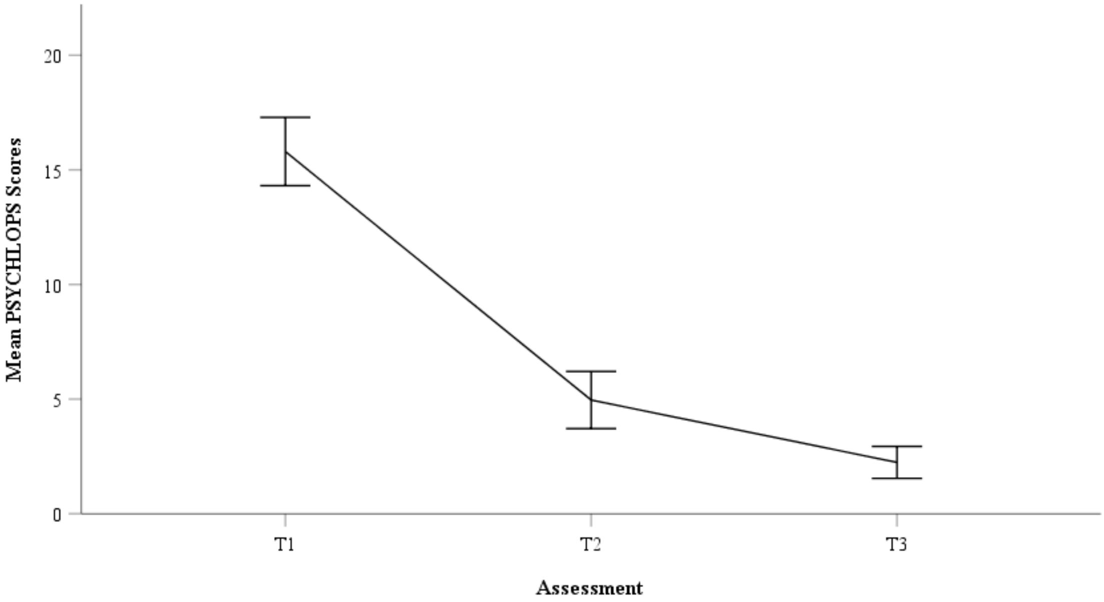
Responses to the PSYCHLOPS Post-Therapy Questionnaire



The non-parametric test, Friedman test, was completed due to the violation of the assumption of normality. PSYCHLOPS scores were statistically significantly different at the different assessment points, $\chi^2(2) = 45.083$, ***p* < .001**. PSYCHLOPS scores decreased across time as shown Figure 9, indicating a reduction in the levels of perceived impact of participants’ problems. Pairwise comparisons showed PSYCHLOPS scores were statistically significantly different between T1 (*Mdn* = 16.00) and T2 (*Mdn* = 6.00; ***p* < .001**), T1 to T3 (*Mdn* = 3.00; ***p* < .001**), and for T2 to T3 **(*p* = .049)**.

Figure 9

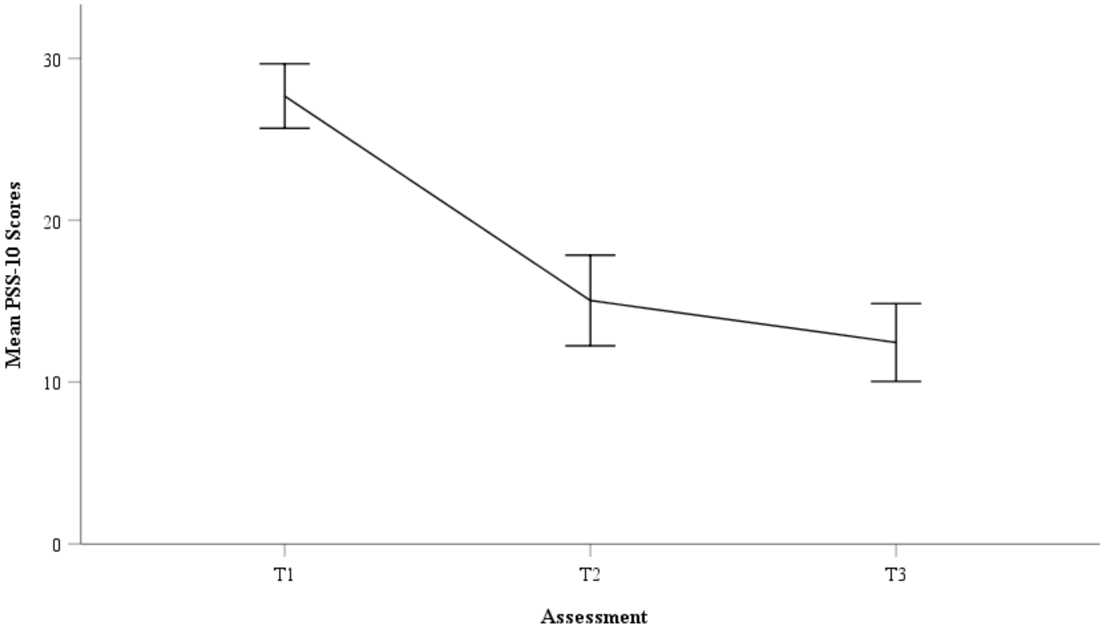
Mean PSYCHLOPS Scores from T1 to T3 (Error Bars set to 95% Confidence Intervals)



6.7.3.2. PSS-10. Total PSS-10 scores were statistically significantly different at the three timepoints, *F*(2, 50) = 90.713, ***p* < .001**, partial η^2 = .78, with PSS-10 scores decreasing over time as shown in Figure 10. Post-hoc analysis showed that PSS-10 scores statistically significantly decreased from T1 to T2 (*M* = -12.62, 95% CI [-16.04, -9.17], ***p* < .001**), from T2 to T3 (*M* = -2.54, 95% CI [-4.88, -0.14], ***p* = .020**), and from T1 to T3 (*M* = -15.15, 95% CI [-18.55, -11.76], ***p* < .001**).

Figure 10

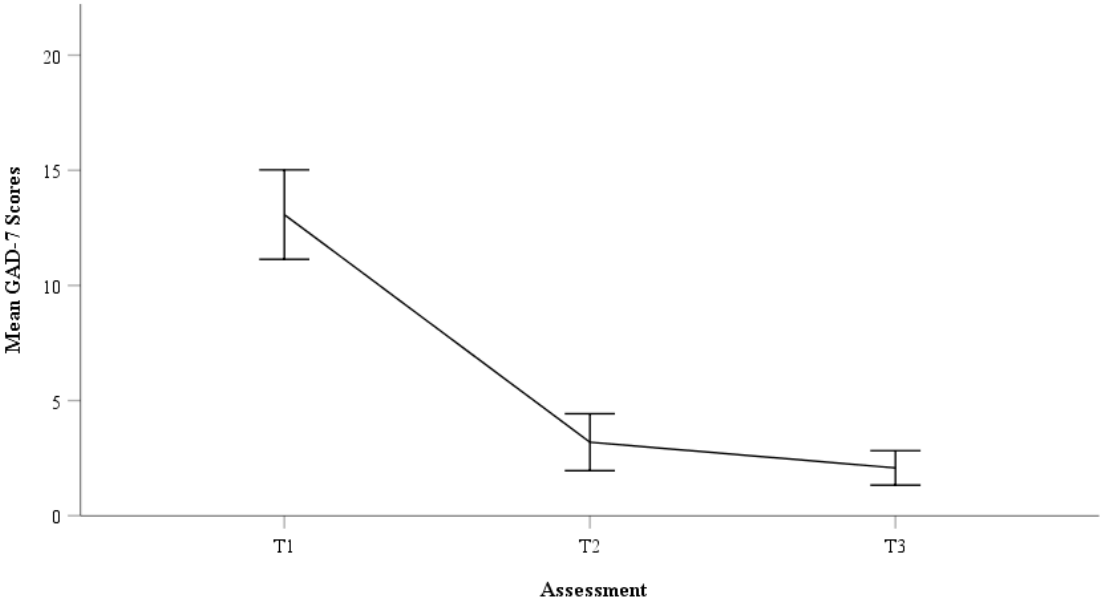
Mean PSS-10 Scores from T1 to T3 (Error Bars set to 95% Confidence Intervals)



6.7.3.3. GAD-7. Friedman test was completed due to the violation of the assumption of normality. GAD-7 scores were statistically significantly different at the different timepoints, $\chi^2(2) = 41.579$, p **< .001**, with scores decreasing across time as shown in Figure 11, indicating a reduction in generalised anxiety. Pairwise comparisons showed GAD-7 scores were statistically significantly different between T1 (*Mdn* = 14.00) and T2 (*Mdn* = 3.00; ***p*** **< .001**), and T1 to T3 (*Mdn* = 2.00; ***p*** **< .001**), but not T2 to T3 ($p = .472$).

Figure 11

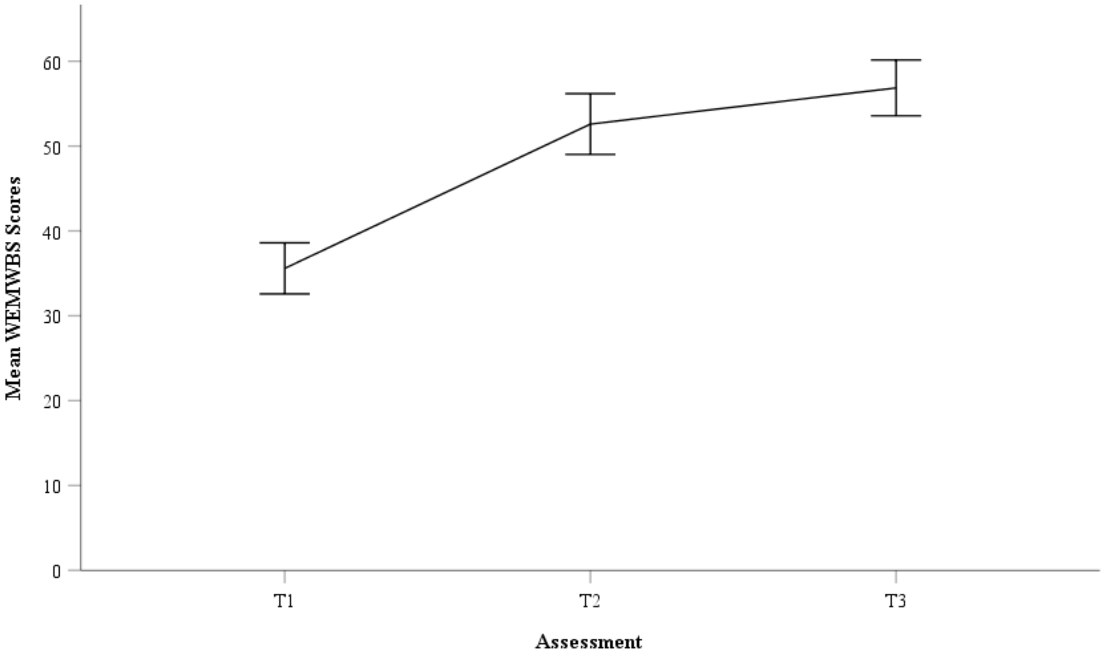
Mean GAD-7 Scores from T1 to T3 (Error Bars set to 95% Confidence Intervals)



6.7.3.1. WEMWBS. Total WEMWBS scores were statistically significantly different at the different assessment points, *F*(2, 50) = 110.117, ***p* < .001**, partial η^2 = .82, with WEMWBS scores increasing from across time, as shown in Figure 12, indicating improved levels of wellbeing. Post-hoc analysis showed that WEMWBS scores were statistically significantly increased from T1 to T2 (*M difference* = 16.81, 95% CI [12.38, 21.24], ***p* < .001**), from T2 to T3 (*M difference* = 4.58, 95% CI [1.73, 7.43], ***p* = .001**), and from T1 to T3 (*M difference* = 21.39, 95% CI [17.17, 25.60], ***p* < .001**).

Figure 12

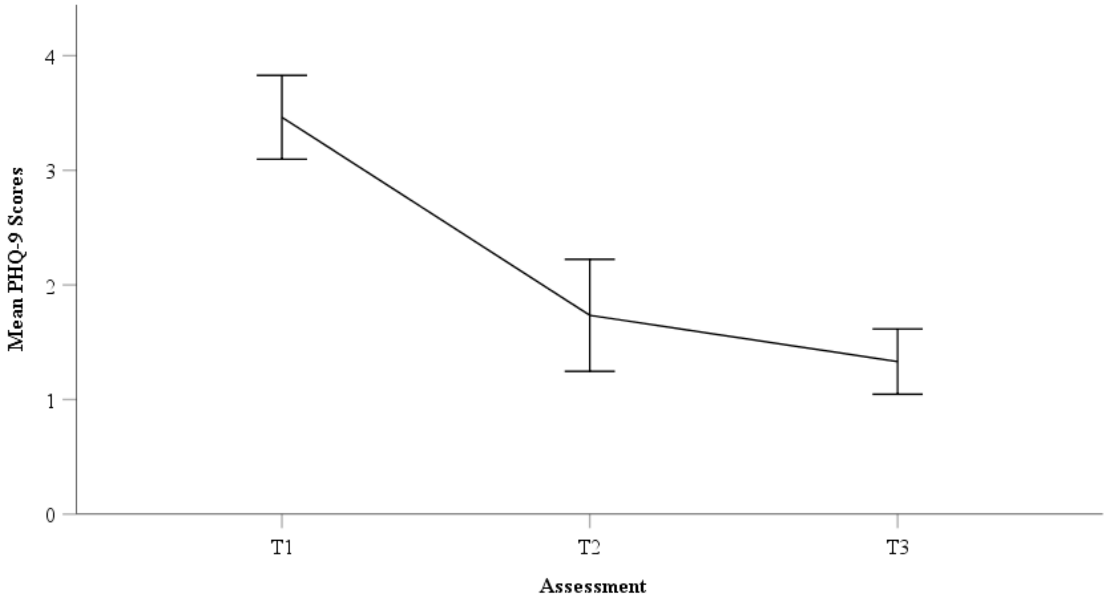
Mean WEMWBS Scores from T1 to T3 (Error Bars set to 95% Confidence Intervals)



6.7.3.1. PHQ-9. For the ANOVA exploring the change in scores over time, PHQ-9 scores were transformed due to a violation of normality. Scores were statistically significantly different at the assessment timepoints, $F(2, 46) = 53.303$, $\boldsymbol{p < .001}$, partial $\eta^2 = .70$, with PHQ-9 scores decreasing from as shown in Figure 13, indicating reduced depression. Post-hoc analysis revealed that PHQ-9 scores statistically significantly decreased from T1 to T2 ($M = -1.73$, 95% CI [-2.34, -1.11], $\boldsymbol{p < .001}$), and from T1 to T3 ($M = -2.13$, 95% CI [-2.64, -1.62], $\boldsymbol{p < .001}$), but not from T2 to T3 ($M = -0.40$, 95% CI [-0.98, -0.18], $p = .246$).

Figure 13

Mean Transformed PHQ-9 Scores from T1 to T3 (Error Bars set to 95% Confidence Intervals)



6.7.4. Comparison of T1-T2 and T1-T3 Completers Scores at T1 and T2

Mann-Whitney U tests were used to determine if there were statistically significant differences in wellbeing questionnaire scores at T1 and T2 depending on assessment completion, either T1-T2 or T1-T3. Similar distributions of data for T1-T2 and T1-T3 completers were found for each wellbeing questionnaire, examined through visual examination of plotted scores at T1 and T2.

Median scores (shown in Table 16) at T1 were statistically significantly different between participants who had completed T1-T2 and participants who had completed T1-T3 for the PSS-10 (*U* = 1762.00, *z* = 2.019, ***p* = .043**). This result suggests at T1 participants who completed T1-T3 had significantly higher perceived stress than participants who completed T1-T2 . However, median scores were not statistically significantly different for the PSYCHLOPS (*U* = 1649.00, *z* = 1.387, *p* = .166), the GAD-7 (*U* = 1620.00 *z* = 1.302, *p* = .193), the PHQ-9 (*U* = 1553.00, *z* = 0.840, *p* = .401), and the WEMWBS (*U* = 1207.50, *z* = -1.108, *p* = .268).

For scores at T2, median scores were statistically significantly different between participants who had completed T1-T2 and participants who had completed T1-T3 for the GAD-7, (*U* = 860.50, *z* = -3.068, ***p* = .002**). This suggests at T2 participants who completed T1-T2 had significantly higher generalised anxiety than participants who completed T1-T3 However, median scores were not statistically significantly different between for the PSYCHLOPS (*U* = 1118.50, *z* = -1.611, *p* = .107), the PSS-10 (*U* = 1090.50, *z* = -1.823, *p* = .068), the PHQ-9 (*U* = 1239.00, *z* = -0.932, *p* = .351), and the WEMWBS (*U* = 1700.00, *z* = 1.666, *p* = .096).

Table 16

Overview of the Medians for the Wellbeing Questionnaire Grouped by Participants Completion of T1-T2 (N=134) or T1- T3 (26)

Questionnaire	Completion	T1 Median	T2 Median
PSYCHLOPS	T1-T2	15.00	7.00
(↓ = improvement)	T1-T3	16.00	6.00
PSS-10	T1-T2	26.00**	18.00
(↓ = improvement)	T1-T3	29.00**	15.00
GAD-7*	T1-T2	12.00	6.00**
(↓ = improvement)	T1-T3	14.00	3.00**
WEMWBS	T1-T2	37.00	49.00
(↑ = improvement)	T1-T3	34.50	54.00
PHQ-9	T1-T2	12.00	5.00
(↓ = improvement)	T1-T3	14.00	3.00

*(N=133)

** Statistically significant results for T1-T2 completers compared to T1-T3 completers

6.8. Discussion

This section discusses the findings from the quantitative investigation into the changes in scores on five mental health and wellbeing questionnaires across three timepoints, for a group of GPs who had accessed support from the PHS over six-months or a year. This discussion section is presented in three parts. The first summarises the overall results of this study, the second makes comparisons to the wider literature, and the third presents the study conclusions. Conclusions made here frame the final study of the thesis (Study 4) and subsequently are integrated into the main discussion chapter (Chapter 9).

6.8.1. Summary of Results

The results from this small sample suggest that after receiving support from the PHS, such as cognitive behavioural therapy, brief intervention psychotherapy, community-based detoxification, group work and support groups, GP mental health and wellbeing improved over time: WEMWBS scores increased, and scores for the PSS-10, PHQ-9, GAD-7, and PSYCHLOPS decreased. This study replicated the promising findings of the pilot studies by showing statistically significant improvement in all mental health and wellbeing scores across six-months, extending the pilot study findings by analysing the mental health and wellbeing scores over an additional six-months, to one year with the service.

However, although participants who completed assessments at all three time points were found to have improved significantly during the first six-months within the service on all measures of mental health and wellbeing; however there was a statistically significant improvement in PSYCHOPS, PHQ-9, or GAD-7 scores was not found for participants from the six-month assessment point to one year with the service. Moreover, differences between participants who had completed the registration assessment and six-month assessment or all three assessments at baseline showed participants who has completed all three assessments were experiencing poorer mental health and wellbeing than those who completed only completed the registration assessment and six-month assessment.

However, this was only statistically significant for the PSS-10, where the group who completed all three assessments was found to have statistically significantly higher perceived stress. Interestingly, the pattern of data at six-months showed the group who completed all three assessments had overall better scores across the mental health and wellbeing questionnaires than those who completed only assessments up to six-months with the service, however, scores of those who had completed all three assessments were only statistically significantly better than scores of those who has completed initial registration assessment and six-month assessment on the GAD-7 questionnaire.

Therefore, the pattern in data suggests that participants show statistically significant improvements from initial assessment to six-months, which is maintained to one year with the service, rather than showing continued improvement across all timepoints. However, through exploring the group differences between participants who had completed up to six-months with the service or completed all three assessment, those who are completing all three assessments may be participants who have had greater success with the support provided by the PHS and therefore have improved more within the first six-months. Research is needed with a larger sample of responders who complete assessments at the one year point with the service to explore this further.

There was both strength and limitations to this study being a naturalistic study using data collected for clinical purposes. The study had access to an unrivalled database of distressed NHS doctors seeking help but lacked a control group. Without a control group, caution is needed in attributing GP improvement to the support provided by PHS, with further research needed to explore if there would have been an improvement in GP mental health and wellbeing over time with no intervention. However, due to the large numbers of doctor-patients accessing the service and the comprehensive battery of psychometric tests used, new insight was gained, including their reasons for the presenting. Moreover, steps were added to the procedure to increase the rigour of the research, including reviews of the coding frames for face value and usefulness, documentation of audit trails, and steps to assess matching accuracy. This rigorous process of data checking helped improve understanding of the raw data and the systems this was extracted from, and therefore, understand potential reasons behind the poor match rate (the percentage of data connected across time points for each participant).

Possible participant level explanations for the low match rate include the recognised challenges with engaging medical professionals with questionnaires and research, those participants who were not improving may have disconnected from the service at either T2 or T3, and participants who improved without the support from the PHS after registering for the service may have also disengaged. Possible explanations at the service level for the poor match rate includes the absence of processes to distribute follow-up questionnaires to non-completers; the PHS changing their data recording systems five-months into the study (on 1st October 2019) that led to complications with data extraction due to inconsistent data transfer and new data saving practices; recording of T2 data by external organisations (for example when participants are receiving support from a provider of CBT in their local area as recommended by PHS); inconsistencies in distributing and returning of T2 and T3 assessments in a timely way; additional delays in distribution and completion of T2 and T3 assessments due to the pressures faced by the medical workforce through COVID-19 over the last few months of the study time period; and consideration that the timeframe of the research was too short as after a further review of the system it was found a large percentage of participants remain with the service for longer than a year. Although these are presented as individual explanations, it is likely that these simultaneously impacted the possibility of good data matching.

6.8.2. Comparison to the Literature

There are few research studies investigations into the effectiveness of support services for medical professionals published. When they are, comparisons that can be made are limited, due to the services providing different treatments, using different measures of improvement, not providing outcomes, or focussing on different participant groups (Bosch, 2000; Casas et al., 2001; DuPont et al., 2009; Garelick et al., 2007). The current study adds to previous pilots (Gerada et al., 2019; Simpson, Ashworth, & Ayis, 2021) by exploring scores over an additional six-months, focussing on the medical specialism of general practice, and demonstrating that the substantial improvement in GPs mental health and wellbeing experienced over six-months may be maintained to T3 rather than participants showing continued improvement. However, additional consideration to this finding is that demographic characteristics were not collected again at T3 and therefore, it is unknown how many of these participants were still on sick leave, had returned to work, or had left general practice while showing a maintained improvement in scores of wellbeing and mental health.

Nevertheless, in considering the study at the participant level, GPs were selected as the sample for this study due to their overrepresentation in the wider cohort, as 71% of the 1304 medical professionals who accessed the service at any of the timepoints, and 93% of the participants who completed T1-T3 were GPs (Shaw et al., n.d.). Therefore, this sub-sample was large enough to be the participants in this chapter and enabled a more focussed insight into one speciality. A survey by the British Medical Association (2019) also found an overrepresentation of the GP speciality related to help-seeking, with half of the GPs surveyed having sought support for a condition that was affecting their work or training. Findings from a systematic review of the literature on stress-related disorders, including burnout, in UK doctors helps to provide some rationale for this overrepresentation, with GPs and consultants having the highest levels of burnout among healthcare professionals (Imo, 2017). The review found that hours worked, overload, low job satisfaction, and neuroticism was associated with higher presentations of stress-related disorders (Imo, 2017), which aligns with the findings from the synthesised qualitative research in Study 1 of this thesis. Taken together this helps create an understanding of GPs’ current context and their experiences and perceptions related to poor wellbeing, and therefore why GPs may seek help. However, it provides little insight into why their help seeking may be disproportionate to other specialities. Potential explanations for the overrepresentation of GPs accessing support from the PHS specifically are that the service is led and predominantly run by GPs and the increased needs of GPs due to unprecedented pressures and low overall wellbeing (Cheshire et al., 2017b; Dale et al., 2015; Riley et al., 2018; Spiers et al., 2017), as was explored in the synthesis presented in Chapter 2. However, the work in this thesis does not compare GPs with other specialities, therefore further research is needed to explore the greater prevalence of help seeking in this speciality, and more specifically why there is an overrepresentation of GPs seeking help from the PHS.

In line with this, baseline scores of WEMWBS, PSS-10, PHQ-9, GAD-7, and PSYCHLOPS for GPs accessing the PHS were poor. PSYCHLOPS ranges from 0 to 20, with a higher score indicating individuals are more affected by their problems. For this sample, the T1 mean score was 16. There is no normative population data for the PSYCHLOPS as scores are related to unique participant problems, and Ashworth (2009) cautions against comparison with other participant data. However, for other questionnaires, the wellbeing of the sample (group T1-T3) at T1 was considerably worse than has been found in population studies using these scales. Compared to normative general population data, at T1, scores were twice higher for the PSS-10 scores (Cohen, 1994), four times higher for PHQ-9 scores (Kocalevent et al., 2013) and GAD-7 scores (Löwe et al., 2008), and WEMWBS scores were 15 points lower than norm data (Gosling et al., 2008) which signifies lower levels of wellbeing in this sample. At T3, mean scores for all wellbeing questionnaires were similar or better than population means.

The demographic characteristics of the GPs can also be compared to the wider literature, specifically considering age and gender. The PHS has reported a decrease in the age of medical professionals accessing the service, with the average age reducing from 52 years old in 2008/9 to 39 years old in 2017/8. This may reflect the finding from a British Medical Association (2019) survey that suggested younger doctors were more aware of mental health diagnoses and how to seek help. The mean age of GPs in this sample (40-43 years depending on timepoint) was slightly higher than the across speciality average. When considering gender, most participants in this study were female (69-70%), which is consistent with the pilot studies (Gerada et al., 2019; Simpson, Ashworth, & Ayis, 2021). This is in line with the overall figures of gender across speciality accessing the service, where the percentage of females accessing the service has risen from 47% to 67% (Gerada et al., 2018). Slightly higher numbers of female GPs would be expected as there are more female GPs (54% females in 2017; General Medical Council, 2017), however, the overrepresentation may connect to research suggesting female GPs are at an increased risk to poorer wellbeing and poorer coping mechanisms due to having a more stressful burden of their family roles (Cheshire et al., 2017b; Robertson et al., 2016; Unrath et al., 2012).

Moreover, the most common work concerns of GPs in this study (work stress, workload, or more generally feeling they were unable to cope) are in line with previous research (Croxson et al., 2017; Doran et al., 2016; Fisher et al., 2017). When participants specified their main problems on the PSYCHLOPS at T1, they mostly referenced anxiety, low mood, and other mental health concerns which previously have all been associated with reported work concerns (Baird et al., 2016; Gibson et al., 2015), and the elevated prevalence of these mental health concerns in GPs have also been found elsewhere (O’Connor et al., 2000; Soler et al., 2008). Interestingly, while increased workload and work stress has also commonly been associated with burnout (Chambers et al., 2016; Kavalieratos et al., 2017; Matheson et al., 2016; Stodel & Stewart-Smith, 2011), however, only five participants used the word burnout to describe their presenting problems in the current study. Hall et al. (2018) reported that GPs in their focus group study often used the words wellbeing and burnout interchangeably, with no clear distinction, and stigmatisation of mental health diagnosis has previously been reported in doctors (Brooks, Chalder, et al., 2011). However, in this study, participants commonly reported anxiety, depression, and other health concerns. Therefore, although stigmatisation may contribute to hesitancy in help-seeking, the uncommon use of the word burnout could potentially be interpreted as lack of familiarity with the characteristics of burnout, and/or awareness that burnout is not a mental health diagnosis thus with limited support available. Nevertheless, common consequences of these problems, such as participants feeling unable to work and reduced ability to function cognitively, have also been found in the wider literature (Hall et al., 2018).

6.8.3. Conclusion

When GPs seek help through self-referral to the PHS and engage with the support (interpreted through the completion of assessments), there is the suggestion that improvement in their scores on measures of mental health and wellbeing could be related to the PHS. As found in the pilot studies, the first six-months show statistically significant improvement. However, this study adds to previous research by showing that these improvements are maintained at the point of discharge from the service. However, due to the substantial amount of missing data, and the lack of a comparison group, these conclusions are not fully representative of the experiences of GPs using the PHS, and improvements in wellbeing and mental health cannot be firmly attributed to the PHS.

Nevertheless, these findings do suggest that there is potential for GPs who are experiencing distress to improve, an idea discussed within Study 2 by GP participants. They were interviewed about their lived experience specifically related to burnout. Therefore, the subsequent study in the thesis will explore narratives of GPs who had engaged with the support offered by the PHS and considered themselves to have made progress in their recovery, specifically in overcoming burnout. Although only small numbers labelled their presenting problem as burnout, informal discussion with the PHS indicated that a larger number of GPs might identify with the term further through their journey of recovery.

Chapter 7.

Study 4 – Recovery from Burnout: A Narrative Interview Study with Photo-Elicitation

Help-seeking behaviour in doctors is not encouraged and this negative attitude towards seeking help has been linked to the overarching culture of medicine (Spiers et al., 2016). This leads to GPs only seeking help when their condition is severe, as found in Study 2, where GPs only sought help for burnout after they had reached rock bottom. Additionally, in Study 2, while deeper insight was gained into the experiences of GP burnout within the current NHS context, there was heterogeneity in the perspectives relating to the possibility of, and nuance within, recovery. Recovery has come to the forefront of policy agendas (Bonney & Stickley, 2008), and new developments are important to guide practice (Davidson et al., 2006; Ramon et al., 2007). Only a small number of GPs accessing the support from the Practitioner Health Service (PHS) initially self-identified their main presenting problem with the word ‘burnout’ (Study 3), and where burnout was investigated in the meta-synthesis (e.g., in Fältholm's (2007) study based in Finland) concerns were raised about the sustainability of improved wellbeing after a period of sick leave when doctors returned to the same workplace.

Therefore, this informed the current study, prompting questions about the nuance of recovery from burnout, factors that may promote recovery, and what recovery from burnout means to UK-based GPs. Exploring stories of GP recovery from burnout and interpreting these using narrative analysis may be beneficial to practice and theory, such as informing interventions to support GPs experiencing burnout. Consequently, this study aimed to improve our understanding of GPs’ recovery from burnout by exploring the stories of GPs who self-identified as having overcome burnout after receiving support from the PHS. Thus, a sub-sample of participants from Study 3 was recruited. Their experiences were investigated through an interview study guided by the narrative approach, and transcripts were analysed through line-by-line narrative analysis.

Additionally, this study continued to give voice to GPs' experiences by incorporating photo-elicitation (using participant-generated images) in the interviews to give more control to the participants. The methods for the current study will be outlined in this chapter. The findings from the narrative analysis will be presented in the subsequent chapter (Chapter 8).

7.1. Methodology

Before describing the participants, this methodology section will introduce the reader to the concepts of narrative inquiry and visual narrative inquiry. These sections will build the foundation for the procedure, followed by an outline of the approach to analysis and dissemination. Finally, the last two sections in this chapter will look at the trustworthiness of the study and key ethical considerations.

7.1.1. Narrative Inquiry

The impulse to tell stories is viewed as being a fundamental part of what it means to be human (Plummer, 1995), with De Fina and Georgakopoulou (2015) arguing that exploring the past through personal narratives is a deeply human practice. The structuring of experience into a story allows experiences to become meaningful (Polkinghorne, 1988). It helps individuals organise experiences into episodes (Berger, 1997) constructed through their assumptions and interpretations (Joyce, 2017). When applied to interviews, the narrative approach allows the researcher to tap into interpretation, sequence, and structure (Riessman, 1993). Consequently, the narrative approach lends itself to participant-led data collection, enabling the interviewee to create their world within their narrative, with characters, context, and meaning applied through the sequential unfolding of events (Ross, 2011).

Within this, the connection between the narrator, the stories, and the self is key. Through storytelling, people can define themselves within the context of experience and bring a sense of temporal continuity (Ross, 2011). Bamberg's model of positioning provides a way to think about how people may meaningfully construct a sense of self and a sense of others (Bamberg & Georgakopoulou, 2008; Bamberg, 1997), and brings attention to how selves are located in storylines (Davis & Harré, 1990), whilst Ross (2011) writes that the narrative story can also help individuals explore and deal with exceptional circumstances and provide insight into their ongoing personal development. For the current study, the narrative approach informed the exploration of participants' experiences of recovery from burnout. The onset of a health condition – in this case, burnout – may be considered a landmark life event that evokes a life story (Riessman, 1993). Exploring the events of burnout recovery through hindsight within their life as a whole could prompt significant reflection in participants (Frank, 2018) and help provide deeper insight into the topic.

7.1.2. Visual Narrative Inquiry

An additional approach employed to give control to the participants was the use of participant-generated photographs. The definitions used within this thesis follow those outlined by Oliffe and Bottorff (2007). Photovoice relates to participants capturing their experience through photographs, and photo-elicitation is the discussion of participant-generated photographs within the interview setting. Photovoice, developed by Wang and Burris (1997), puts the participant in charge of how they depict their unique situation (Tajuria, 2018) and provides participants with the opportunity to tell their story from their point of view (Vaughan, 2011). Radley (2002) suggested that through photovoice, participants become more active in the research, allowing the meaning-making and the story generation to be more collaborative with the researcher, enabling the researcher to gain a deeper understanding of the participant's world. This is especially important when participants' experiences or issues have previously been documented mainly through professionals' viewpoints (Harrison, 2002; Ramella & Olmos, 2005), and photovoice is suggested to be an appropriate tool to use when participants have previously experienced a lack of control regarding their situation (Foster-Fishman et al., 2005).

Photo-elicitation within the interviews enabled participants to use their photographs to tell a story, thus allowing them to share their private experiences of illness (Radley, 2002). Riessman (2008) writes that “a photograph stabilizes a moment in time, preserving a fragment of experience that otherwise would be lost” (p. 179). In contrast, an oral account fixes the moment within a stream of conversation. Moreover, photo-elicitation not only gives the researcher access to each participant’s world by facilitating deeper communication and emotional expression (Drew et al., 2010; Guillemin & Drew, 2010; Harrison, 2002; Humphreys & Brézillon, 2002; Lykes et al., 2003), but also allows the opportunity to make these worlds more accessible to people outside of the research (Booth & Booth, 2003).

7.1.3. Theoretical Approach

Narratives of illness “indicate the onset of problems and the temporally situated facts as subjectively remembered and interpreted” (Hall, 2011; p. 4) and often include changes and recovery transitions (Kirkpatrick, 2008; Mattingly, 1998; McAdams et al., 2001). A narrative approach suggests that there is no absolute truth or single interpretation of a text (Riessman, 2008), or in the case of this study, of a participant’s account of recovery from burnout. However, narratives tend to reveal personality, identity, and development (Hall, 2011). The recovery paradigm considers each individual as unique and therefore fits with the narrative approach, which values individual experience and voice and “puts a human face on the experience” (Kirkpatrick, 2008; p. 62).

With the focus on the social construction of the institution of the NHS and the effect of social norms, as well as the impact of society on GPs highlighted in Study 1 and 2, social constructivism is an appropriate theory to frame the current study. The social constructivist perspective is a difficult epistemological standpoint to provide a concise summary for, as there is no one definition of it. However, the commonalities between perspectives highlight the meaning and understanding as being central to human activities and are inherently embedded in social interaction (Lock & Strong, 2010).

Constructivism assumes that narratives are co-constructed by the teller and the audience (Hall, 2011) during all stages of the research: the interview, the analysis, and the writing of the findings. Exploring accounts of overcoming burnout through a social constructivist lens encourages us to consider how people develop their stories and make sense of them or apply meaning about the events as embedded in their socio-cultural contexts (Sharma, 2019). Individuals' worldviews can therefore be understood to be established due to their interaction with their environment and socio-cultural norms (Bandura, 2002; Echterling et al., 2005). Therefore, social constructivism emphasises that how individuals think, feel, act, and define moments of crisis is ingrained in the surrounding social and cultural networks (Weiss & Berger, 2010).

7.1.4. Participants

Potential participants were primary care GPs who self-identified as having overcome burnout, had been working in primary care at the time of burnout, and in line with previous research (Bernier, 1998), needed to self-identify as having overcome burnout in the last five years to prevent distortion or recall problems. Participants were recruited through the PHS, and no restrictions were placed on age, gender, or UK location. The PHS distributed an email invitation to all potential participants (Appendix Y) with the study information sheet (Appendix Z) attached. If interested, GPs were asked to contact the researcher directly to register their interest. Due to line-by-line narrative analysis being labour intensive, a small number of participants is recommended (Fraser, 2004) to enable the researcher to get close to the data (Eisikovits et al., 1998). Previous studies using qualitative methods combined with photo-elicitation have had small final sample sizes ranging from 5 to 15 (Aubeeluck & Buchanan, 2006; Frith & Harcourt, 2007). The current study recruited in line with this guidance: seven female GPs and one male GP took part in the study.

Before the interview, participants were asked to provide informed consent (Appendix AA) and complete the same questionnaire used in 'Study 2' (Appendix F). to collect demographic data to frame the interview findings. Demographic characteristics can be found in Table 17. The average age of these participants was 49 (range of 37 to 59) years, and the average years in practice was 21 (range of 7 to 32) years. When exploring the wellbeing scores, five out of the eight participants scored better on the WEMWBS than the average for the general population.

Table 17

Characteristics of GPs who Participated in the Study Recovery

Characteristics	Marie	Holly	Julie	Heather	Laura	Anthony	Meghan	Abigail
Gender	F	F	F	F	F	M	F	F
Age (Years)	41-50	51-60	41-50	51-60	51-60	51-60	41-50	30-40
Years in Practice	11-20	31-40	11-20	21-30	11-20	21-30	21-30	0-10
WEMWBS (Wellbeing)	57	51	58	44	56	41	47	58

Notes: Scores for the WEMWBS can be from 14 to 70 with higher scores depicting higher general wellbeing (average for the general population is 51).

7.1.5. Procedure

After registering their interest in the study, participants were sent an email that summarised the study. A date and time for the interview were mutually agreed between the research and the participant (participants could choose to have their interview in a quiet location in London, e.g., the interview rooms at the university or via Skype).

Before the interview, participants were asked to complete the demographic questionnaire and securely send the images they would like to discuss to the researcher. The methods employed for photovoice follow those outlined by Oliffe and Bottorff (2007); therefore participants were asked to imagine they were contributing two to four digital photographs to an exhibit titled ‘recovery from GP burnout’, which portrays their experience from their unique perspective. Participants were not restricted in choosing the subject matter of their photographs (when taking photographs themselves or finding existing images), although they were informed that photographs of people could not be used within the write-up or dissemination of the study. When images were not photographed by the participant (such as selecting an image from a website), the researcher sought permission to include this image in dissemination materials from the owner of the photograph and a note accompanies the image. In preparation for the interviews, if the interviews were to take place in person, the researcher printed the submitted photographs onto card. If the interview took place via Skype, these photographs were downloaded to be accessed on the day of the interview and explored with the participant using the share-screen function on Skype. For the current study, one of the participants elected to conduct the interview face to face, whereas the other seven took part in their interviews using Skype.

On the day of the interview, the researcher explained the interview process and again sought informed consent. The participants were asked where they would like to start in their recovery story and how they would like to explore their story throughout the interview. As a narrative approach was adopted, the interview aimed to elicit stories of burnout recovery from the participants. Facilitating a participant-led approach to data collection that enabled participants to speak about what was important from their expert perspective informed the creation of the interview schedule due to the researcher being an outsider (Vaughan, 2011). Therefore, an unstructured interview style was selected as this would encourage an interviewee-led style where the researcher was not governed by set questions and could actively listen and respond (Reinharz & Davidman, 1992). However, broad questions phrased to encourage a narrative were noted, such as starting with “When did you first” and “Thinking back over the last few months”, as suggested by Gilbert (2008), and appropriate prompts were prepared which align with narrative inquiry such as “How did it begin?” or “Then what happened?” as encouraged by Hydèn (1994). To facilitate detailed storytelling, a conversational style of interviewing was employed, whereby participants were engaged in a friendly, informal way (Fraser, 2004). The interview protocol can be found in Appendix BB.

The interview structure commonly explored the participants' lives before, during, and after burnout, providing the life-span context (Giles, 2004). The researcher also explained that if a participant’s photographs became relevant to their story or it felt natural to explore an image at any point of the interview, then they must let the researcher know, and the image would be introduced into the conversation. If photographs had not been explored by the end of the participant’s story, these were discussed once the story was complete. Three steps of visual narrative inquiry were employed (Rose, 2001). The first two steps occurred in the interview with the researcher first asking questions to understand how and where the image was produced, and secondly exploring the story behind the photograph, its components and composition. When exploring the photographs, the researcher used broad prompts such as “Tell me about the photograph” and “Tell me what led you to select this photograph.” In the process of analysis, the third step of visual narrative inquiry was employed, for which written texts were generated to help guide the audience when viewing the photograph.

The length of the interviews ranged from 1 hour 18 minutes to 2 hours, and the average time for the interviews was 1 hour 37 minutes. After the interviews, participants reviewed their photographs with the researcher and completed the photograph consent form (see Appendix CC). On this form, each participant indicated which photographs they consented to be used in the study write-up and noted if any of these photographs required de-identification first. Participants were provided with £50 Amazon vouchers offered as an inconvenience allowance.

7.1.6. Analysis

The analysis of the photovoice occurred within the interview when the interviewee interpreted and explored the images through photo-elicitation. Within the research findings chapter, photographs consented to be used in the write-up will be paired with the relevant commentary. The verbatim transcribed interview data was analysed using the six-phase guide for narrative analysis as outlined by Fraser (2004), and summarised in Table 18 with additional guidance taken from Davis (1998, 2008) and Riessman (2008). This approach to data collection and analysis allows the experience to be analysed and the flow of the narrative in relation to sequence and consequence (Riessman & Quinney, 2005). In considering the unit and focus of the analysis, the ‘categorical-content’ combination (Lieblich et al., 1998) was selected. This means that references to experiences of recovery from burnout were compared across accounts to understand the process shared between participants (‘categorical’) whilst focussing on the surface content, such as exploring what happened and who was present, and the latent content, such as the meaning of the story to the participant, their motives, and intentions (‘content’) (Earthy & Cronin, 2008). These were selected above the unit of analysis of ‘holistic’ that explores the narrative as a whole and the significance and change in the context of the participants' lives, and the focus of ‘form’ that explores how the accounts are structured, as this study was exploring in depth what happens for GPs after burnout.

Additional internal elements of narratives were explored when looking at the content in the line-by-line coding on the participants’ transcripts at phase four. This included narrative elements outlined by Davis (1998, 2008). These elements include: 1) ‘characters’ which captures people discussed in the accounts and how they are depicted; 2) ‘settings’ which draws the attention of the analysis to where the story is taking place which could be a physical location, such as the GP surgery, or more abstract such as the participant’s body; 3) ‘events’ which highlights what is happening in the story and the level of emphasis the participant is giving to these events, including different plotlines; 4) ‘audience’ which is the consideration of who the participant is directing their story to, which could be immediate or predicted audiences; 5) ‘causal relationships’ which explores indirect or direct connections made by the participant between elements of their story, such as between characters and events; 6) ‘themes’ of the accounts, which can be explored for prominence and consistency; 7) what ‘language’ is being used and choices made about language by the participant; and 8) ‘time’ including how the story unfolds, whether the story is chronologically presented, and how time moves through the account. Furthermore, the components of expressed or implied values (Fisher, 1989), morals or the ethics of right and wrong (Farrell, 1985), coherence related to the goals of the participant (Riessman, 1993) were also explored when analysing the transcripts. Examples of the initial noting of domains and elements can be seen in the Appendices (See Appendix DD).

Table 18

The Six Phases of Narrative Analysis as Proposed by (Fraser, 2004)

Phase	Components
1. Hearing the stories and emotions	The audio recordings were listened to as if they were radio shows to prompt lateral thinking, and notes were made about how the interviews began, unfolded, and ended. Notes were made of any emotions that emerged.
2. Transcribing the material	The recordings were transcribed, and the researcher read these multiple times to help with familiarisation. When participants had agreed, the transcripts were password protected and sent to the participant to be reviewed.
3. Interpreting individual transcripts	Each transcript was reviewed individually to identify types, directions, and contradictions within stories. Within this phase, long chunks of text were segmented into smaller parts of the narrative.
4. Scanning across different domains of experience	The stories were scanned to explore domains of experience from different perspectives: intrapersonal (stories involving mind-body experiences), interpersonal (stories involving other people), cultural (stories involving larger groups of people and cultural convention), and structural (stories involving public policies or social systems).
5. Linking the personal with the political	The transcripts were re-read, paying attention to popular discourse and metaphors.
6. Looking across participants	The data was explored across participants, looking for commonalities and differences.

7.1.7. Dissemination

As explored previously (section 4.1.5), dissemination was felt as particularly important for the studies in this thesis. Alongside academic dissemination, findings for this study will also occur in parallel to the physical presentation of the art-based findings from Study 2. It is planned that the photographs participants had provided and consented to be used in the write-up and dissemination from this study will be printed and displayed with corresponding narrative descriptions to be viewed by the exhibit visitors after the COVID-19 restrictions in the UK have been lifted.

7.1.8. Rigour and Trustworthiness

This study's approach to rigour and trustworthiness followed many of the same steps outlined in the previous qualitative method chapters in this thesis, including audit trails, member checking, peer debriefing, thick description, and reflexivity. Participants were given the option to review their transcripts to see if they would like to change, elaborate on, or remove anything. Seven out of the eight participants opted to be included in this stage. For peer debriefing within this study, the researcher informally discussed interpretations of data and the creation of themes with peers within the Psychology department at the University of Westminster, who were completing separate projects. The researcher and TC discussed interpretations at each stage of the narrative analysis, and the findings were also discussed with a clinician at the PHS to ensure interpretations were reasonable.

Additionally, audit trails combined with thick description were used to document how the researcher arrived at the narrative findings and conclusions. Detailed outlines of the data collection process and analysis have been provided. Finally, as with each qualitative study in this thesis, reflexivity was followed by the researcher. The section documenting reflexivity across this PhD project can be found in the general discussion in section 9.3.

7.1.9. Ethical Considerations

Ethical approval for this study was granted by the UREC (ETH1819-1912) and received a favourable opinion from the NHS Health Authority (IRAS ID 265031). Approval documents can be found in Appendix U and Appendix V respectively. Subsequent significant amendments were made to this ethics application to account for the pandemic's changing context, which involved seeking approval to remove in-person interviews as an option. The procedural change occurred due to the restricted movement of people during the lockdowns in the UK as it increased physical health risk to the researcher and participant if they were to meet in person. Approval of the amendment from UREC (ETH1920-2296) and the NHS Health Authority (IRAS ID 265031) can be found in Appendix W and Appendix X respectively.

Key ethical considerations for this study were the confidentiality of the participants during recruitment, the potential for distress in the interview, and thorough protocols for the use of photographs. Firstly, as the researcher was working with the PHS to recruit GPs who had been discharged from their services, it was essential to create a recruitment plan which maintained the anonymity of those who wanted to participate. The PHS mailed out the recruitment emails (Appendix Y) to those GPs who matched the inclusion criteria. These emails invited interested GPs to email the researcher directly to register their interest. Therefore, at no point did the researcher have access to the list of potential participants, nor did the staff at the PHS know which GPs registered interest in the research or elected to participate.

Secondly, this study involved GPs revisiting their stories of recovery from burnout, a process that had the potential to cause distress in the participants. Therefore, a sensitivity protocol and a safeguarding protocol were created (see Appendix EE and Appendix FF, respectively). Safeguarding concerns did not arise in the interviews, although distress was sometimes evident in participants. On such occasions, the researcher followed the sensitivity protocol and re-established consent before continuing with the interview. After each interview, the researcher allowed time to talk to the participant, to discuss their experience of involvement in the research, and monitor any unforeseen adverse effects of the interview. Participants were given a copy of the debrief sheet (Appendix GG), which included contact information for the researchers should participants have further questions or wish to withdraw before transcript analysis, and a contact number of a support organisation to contact if they needed to.

Finally, consideration was given to the use of photographs within this study, including ensuring there were options for the participants to send their photographs to the researcher securely, a separate consent form for the use of photographs, and a plan for the de-identification of photographs. For the photograph consent form, participants were asked to indicate which photographs could be used in the write-up and dissemination of the work and asked to indicate any elements in these photographs which would be identifiable to them. Any images which included people were omitted automatically.

Chapter 8.

Recovery from Burnout: Findings

The elements explored in phase four of the line by line coding in the analysis, such as settings, characters, and culture create the building blocks of this findings section. Key elements and descriptions related to the narrative accounts have been summarised in tables in Appendix HH. These elements are weaved throughout this finding section within the overarching themes. Overall, there were three overarching themes: ‘reframing the experience’, ‘people shaping the narrative’, and ‘finding strength through adversity’. These themes and their sub-themes are presented in Table 19.

Table 19

Themes

Themes	Sub-themes
Reframing the experience	Just getting on with it
	Taking control
	Integrating wider perspectives
People shaping the narrative	People of negative impact
	Letting in the light
	Belonging
Finding strength through adversity	From achievement to burnout
	Strength through vulnerability
	Recovery optimism

‘Reframing the experience’ explored how participants gained control within their lives after experiencing burnout. They integrated new knowledge and perceptions of greater options into their understanding of their experiences and potential futures, which allowed them to progress from the mindset of ‘just getting on with it’. ‘People shaping the narrative’ brings the importance of people to the forefront of the accounts and demonstrates the integral function of characters through the phases of ‘finding strength through adversity’ and ‘reframing the experience’. Often people coded as ‘antagonists’ were the catalyst for burnout, whereas people who were categorised as ‘sources of light’, ‘sources of safety’, and ‘sounding boards’ were positive influences through recovery. Finally, ‘finding strength through adversity’ captures the narrative built around the participants' growth. Participants viewed themselves as resilient individuals in medical school and when embarking on their journey as a GP. After facing adversity, participants were able to return to strength in their recovery, but in a new way related to increasing their self-awareness and establishing a firmer connection with their values. They were then able to move forward and face new challenges more successfully.

As chronology is a crucial element in how people naturally tell stories (Earthy & Cronin, 2008), the sub-themes related to recovery need to be framed within the context of how the participants perceived their experiences of burnout to understand the process of recovery, therefore the sub-themes have been presented in chronological order and grouped into two sections: ‘setting the scene’ and ‘overcoming burnout’ (Table 20). The purpose of this chapter is to document the accounts of overcoming and recovering from burnout; therefore sub-themes that focus on experiences after burnout have purposefully been given more focus in the write-up.

Table 20

Structure of the Findings

Sections (Plots)	Sub-themes
Setting the scene	From achievement to burnout
	Just getting on with it
	People of negative impact
Overcoming burnout	Taking control
	Letting in the light
	Finding a place of belonging
	Strength through vulnerability
	Integrating wider perspectives
	Recovery optimism

8.1. Setting the Scene

This first section of the findings focuses on the time leading up to and during burnout. Within this section, the participants' understanding of who they were coming into medicine and general practice is explored in the sub-theme 'from achievement to burnout', how the participants approached this period of their lives is discussed in the sub-theme 'just getting on with it', and influential people in shaping the narrative during the experiences of facing adversity are presented in 'people of negative impact'.

8.1.1. From Achievement to Burnout

Some participants perceived themselves as entering medicine as strong individuals who had never failed; they had succeeded academically and were ambitious: "I've always been someone who's had ideas and wants to make change" (Abigail). Participants recounted stories of medical school and medical culture where they managed to complete their training, having "struggled our way through" (Heather). Moreover, participants commonly described a period of positivity when working in general practice, finding "a healthy balance" (Anthony) within their roles at work and home.

However, participants faced unrealistic expectations of patients, which participants countered by building up "protective layers" (Heather). General practice had become more problematic over time, which Holly described as everything going "pear-shaped." Interpersonally there was a noticeable lack of communication and support, and participants, although identifying as people who were "not usually one who shies away" (Julie) from voicing concerns, felt they were now less likely to voice their concerns than previously. Participants reflected on their potentially erroneous thinking: "Sometimes you cling onto the things that used to be good" (Holly).

Participants faced adversity when trying to navigate their experiences in a problematic workplace while they were increasingly burnt out. Their experiences of burnout became so challenging that they began viewing their lives through a dark filter, with the physical settings in their accounts commonly referred to as heavy and isolating. Participants reported needing increasing amounts of effort to "turn up" to their commitments, including work (Abigail), and burnout was described as an "entombing" experience (Holly) that "overshadowed" life (Meghan). Heather captures the feeling of being stuck by describing how she saw no "light at the end of the tunnel." Holly utilised a photograph at this point in her interview to show a "grubby" and "hollow shell" of a GP when in burnout, as presented in Figure 14

"The Black Hole":

> Well you're looking at a big pile of crap [laugh] it's a complex mess isn't it … There's a lot of stuff there and some of it is just trivial rubbish, but some of it has probably been quite an important part of somebody's life at some point … But this is just a complete and utter disaster isn't it, a collection of everything, every aspect of life all mushed together in a big ruin, and I think that is a pretty good summary of burnout. (Holly)

Figure 14

“The Black Hole”

Intrapersonally, this was a complicated and confusing time for participants: “I was a bit worried that I might have broken my brain” (Marie). Narratives centred on concerns about morality, with participants being concerned with wanting to do “the right thing” (Holly) often for the “sake of the patient’s wellbeing” (Anthony). Therefore, when experiencing burnout, participants might describe the conflict involved, e.g., as “a position of academic and physical torture” (Holly) when considering the moral implication of needing to work through burnout.

8.1.2. Just Getting on With It

As the GPs started to experience burnout, they were still able to maintain their drive to care for patients, committing themselves to the value of hard work, and, as one participant described, embracing the motto of “just get on with it” (Heather). This sentiment was repeated using similar language across the accounts. For example, Meghan emphasised the importance of “just getting through it [work]”, while Laura underscored how vital it was to “just do it [work].” This reflected the necessity to keep working in the face of potential burnout: “I’ve got to go to work” (Holly). At the time of burnout, Julie recognised she was on automatic pilot, and was aware that this was not an effective way to work. During this period, Anthony described a lack of awareness: “I had no idea what was going on.”

Consequently, participants found that they needed more time away from work to start feeling “human” (Meghan) again. They felt overwhelmed and could not see alternative options: “These days are just going to keep coming” (Heather). There came a time for each participant where doggedly persisting with their work was no longer achievable. Marie, for instance, spoke about experiencing a fight-or-flight response to the increasing number of patients waiting for their consultations. She highlighted the importance of this by featuring a computer screen as one of her photographs (Figure 15):

> This reminds me of when I was frozen, I would just stare at the screen and watch that number climbing and just go ‘oh my God I can’t, I just can’t face it, I can’t face anybody like this’ [pause] and there is just this sense of being completely stuck [pause]. (Marie)

Figure 15

“Being Completely Stuck”

8.1.3. People of Negative Impact

Participants spoke about the potential for long-term implications related to antagonists' behaviours. This ranged from a "really nasty episode" (Laura) of bullying by peers in workplaces outside of medicine to people in medical school who helped instil a "stupid sort of self-invincibility" (Abigail). Some participants acknowledged the consequences of this for their approach to work and not coping, framing themselves (protagonists) as antagonists by being their "own worst enemies" (Holly). However, in the lead-up to burnout, antagonists were particularly prominent, and they were often integral to the relationship between events and participants' decreasing self-esteem. The main antagonists acted as important catalysts for the development of burnout within the broader context of a problematic organisation, commonly being presented within the setting of a problematic workplace.

Nevertheless, some characters who negatively impacted the participants were presented with less coherence, including when people were expected to take a more positive role in supporting the participant but demonstrated negative personal traits. In some cases, this affected recovery from burnout, such as in Abigail's account when friends failed to provide the expected support after she told them about her struggles with her mental health. Megan perceived a similar dismissal of her experiences, but by a cognitive behavioural therapist who placed undue emphasis on psychometric scores: "two little scores", that did not represent her actual experiences, to which she responded, "Excuse me but I can't do my job" (Meghan). Thwarted help-seeking could have implications for future help-seeking, creating reluctance to seek help – "I don't have faith in the process, I told the medical director" (Anthony) – and discouraging sufferers from disclosing everything they felt in subsequent interactions: "I didn't tell her the whole truth" (Abigail).

8.2. Overcoming Burnout

This section focuses on the participants' descriptions of overcoming or recovering from burnout, exploring the sub-themes 'taking control', 'strength through vulnerability', ‘letting in the light’, ‘integrating wider perspectives’, ‘finding a place of belonging’, and finally ‘recovery optimism’.

8.2.1. Taking Control

The narratives showed how each participant experienced a ‘turning point’ in their burnout. Marie had to act after becoming paralysed with indecision in the face of work demands, Heather decided to work part-time as she “decided that I had had enough of it”, and Anthony reflected that he was “going to harm somebody if I don’t get help.” For some participants, there was a need for someone to be firm when giving advice, even if it was unexpected, such as when an appraiser advised, “I think you should resign … refer yourself to GP Health” (Meghan). The reasons for seeking help differed between participants; however, each participant accepted that they could no longer support themselves to get better. After reaching this conclusion, participants were more open to support. Participants at this stage were also likely to change from just powering through work to understanding that taking time away and seeking help was the right thing to do: “This is not skiving, this is not petty stress” (Abigail). Having their experience validated by healthcare professionals helped participants take better control in their approach to recovery: “What am I going to do about it?” (Meghan).

Consequently, each participant made a firm decision to not “go through [burnout] again” (Laura). Participants began setting clearer boundaries and recognising that approaches that have “served me well for donkey’s years” (Heather) needed to change. Holly began to take control of the way she was doctoring and made sure she could have breaks to see peers – “I have to make it happen” – while Meghan took control of her work through reflecting on and learning how to improve her consultation style. Meghan was proactive in this learning and viewed it as important to her recovery, as discussed in relation to a chair, as seen in Figure 16:

> [The chair] made me think of the consultation that it, I tried to think of me sat there, I am the one in the chair, thinking about the process of being a GP and what it involves, what it is doing to me, how I can make it work better. (Meghan)

Figure 16

“The Process of Thinking About Work”

During this stage of the accounts, when participants were recounting experiencing a turning point, some participants started to use language related to and focusing on what they could do, rather than what they could not do. Key in participants’ definitions of recovery was having the “ability to continue” (Julie), starting to take control, seeing a future, and being more in the moment.

A critical part of the recovery journey was starting to look forward in their lives. When they were in burnout, the future looked bleak and empty. Here, participants felt they could focus on more than just putting one foot in front of the other, as life was “more looking around me than looking down” (Holly). This led to participants prioritising what was important to them, focusing on their values and needs, and who they were: “I am more than just this person who sorts out everyone else's problems … that is not my only function" (Laura). Abigail, meanwhile, captured becoming better aligned with her values and priorities in Figure 17. Being completely broken down gave her the chance to reset. She chooses to say "actually yes you can" to her family to have those valuable interactions, such as when asked by her children if they could draw on a wall:

> It is enjoying the little things and I think that is just having children generally, but I think the fortunate thing for us as a family is that, because we have had to hold a mirror up to ourselves as a family, I think we are now doing it better than we would have been doing it otherwise, because we had to pause and reset. (Abigail)

Figure 17

"We Have Had to Hold a Mirror up to Ourselves"

With an increasing awareness of options (e.g., they could seek help or take time off), the participants started to feel more independent and increasingly took more responsibility for their decisions.

8.2.2. Letting in the Light

Characters who were categorised as ‘sounding boards’ were consistently presented as providing an important mental space for the participants to talk about their feelings and experiences: “He just listened” (Laura). However, whilst these characters were valued, they did not fully enable participants to feel less alone during burnout, e.g., “not quite sure he [her husband] understood” (Heather). However, some characters did have an impact by helping participants feel less alone during burnout: “I wasn’t in that black pit by myself anymore” (Heather), and were coded as ‘sources of light’. Crucially, others could offer hope and share the load. Practitioners from the PHS were viewed as approachable – “could be helpful, it doesn’t sound very threatening” (Abigail) – and often played this role. For Anthony, an initial conversation with the service resulted in him becoming “overwhelmingly emotional because I felt like somebody cared.” Sources of light were less passive in helping participants overcome burnout and achieved this when disclosure occurred positively, with an emphasis on collaborative work: “We’d done all the work” (Heather). For Laura, communicating her decision to stop drinking to a PHS practitioner helped her put her decision into practice: she found that “Now I actually have to do my bit and not open a bottle of wine” as she did not want to say, “Well I have gone back.”

Other characters who provided some light during the darkness of burnout were superiors, peers, or patients. Talking to peers was “the most important bit of the day” for Holly, while Meghan experienced peer support as therapeutic “[colleagues] dropped everything if you raised your head up and said help.” Laura, meanwhile, spoke about patients who replenished some of her depleted energy, as “they would react to me almost like a human being”, whereas Abigail felt bolstered by a supervisor who stood by her: “I’ll support you.” Notably, participants commonly talked about the positive impact of interpersonal validation and reassurance. This could be words of reassurance from an outside party – “You are not responsible” (Marie) – or hearing and accepting the values of the participant: “You are right this shouldn’t happen” (Anthony).

Some sources of light were unexpected; for example, people who were expected to act as antagonists, such as parents of a patient lost to suicide, were “warm”, “jolly”, and “lovely” (Marie). Or, equally unexpectedly, they came in the form of animals, as was the case for Heather and Laura. A newly adopted cat (Figure 18), for instance, helped Heather with burnout but also helped her to slow the plot: “This little being absorbs the focus and attention” and allowed a “shifting gear on life” (Heather):

> I think I can now appreciate why people are so into pets because she is very timid and just being able to stroke her, chat to her, and talk to her, I didn’t appreciate how calming it was … because you have to move and speak so gently, gently and quietly like you would with a very young child, you kind of had to slow down. (Heather)

Figure 18

“Shifting Gear”

However, there were missed opportunities for those acting as sounding boards to be sources of light. For example, Anthony described how people supported him privately yet were noticeably “very quiet and unsupportive” in meetings when he needed their voice. Moreover, although Holly discussed the importance of talking to people, she also described the process of accepting burnout as something she needed to do alone. In her interview, Holly reflected that it would have been helpful to talk to others at the time. However, the value of being alone was mentioned by others, as it actively created a boundary between antagonists and the problematic workplace; for example, when Abigail walked out of the practice, it physically created space, but also mentally too: “I turned my phone off.” For Meghan, distancing herself from the workplace was similarly positive: “I started to recover almost as soon as I left.” Changes in environment were seen by participants as being helpful for letting in the light. This sentiment was commonly connected to a holiday or trip; participants emphasised how a change in their environment helped them: “It doesn’t have to be hot and sunny just enjoying being in different environments” (Laura). The settings presented were commonly shown through photographs of nature. Julie talked about starting to reset on holiday in relation to Figure 19:

> At that point I didn’t know how it was all going to pan out or was I going to go to back to work two weeks later or what … and so it was just that, to get and just walk, to blow the cobwebs away. (Julie)

Figure 19

“Blow the Cobwebs Away”

Note: Image used with the kind permission of visitswanseabay.com (Swansea Council)

Within these settings, participants started to value the space away from others, spending time alone, and becoming their own sounding boards and sources of light. Consequently, they could prioritise open spaces and check in with themselves – "Is this ok, do I want to do it?" (Holly) – as the separation from work and colleagues helped them to open their minds to reflection.

8.2.3. Strength Through Vulnerability

For Holly and others, the foundations for potential recovery and personal growth exist in burnout itself, but it was easy for participants to overlook this. Participants could overlook progress or feelings of residual strength due to the overwhelming nature of the darkness in burnout. Looking back to Figure 14, the rubbish heap which depicted a burnt-out GP, Holly commented that the scene was "not all cloud" and reflected that "there is growth elsewhere and not too far away." Holly selected Figure 20 to discuss the idea further in the interview, as the candle represents the participant in the first stages of starting to overcome burnout, the participant fighting and managing to keep a flame going, supported by an increase in reflection:

> There is a tiny glow, it is alight, and it is aflame … it's just doing its best to do, to be, relighting itself, it is just very plain, a simple issue and concentrating on very few things. I think the simplicity of the flame, the reflective surface [pause] that's a mirror, you can't really tell it's a mirror but that's a mirror, so I think that out of a hollow shell comes a bit more light. (Holly)

Figure 20

"Out of a Hollow Shell Comes a Bit More Light"

Overall, participants talked about how moving forward was possible, reaching a time where they thought, "Wow, I can actually do this" (Meghan), or reflecting that "I came out the other side" (Marie). Participants talked about "rebuilding" themselves and seeing an opportunity: "You have got a new page; you can start again" (Holly). Meghan was able to start "working out" the direction she wanted to go in by asking herself "who I am", "what is my calling", and "where are my priorities". Through recovery, the participants showed they valued the opportunity to learn more about themselves and felt a greater connection to their values and identity. For some participants, this was transformative: "I behave differently, I am a different person" (Anthony). They found strength in their vulnerability, which prompted personal and professional growth.

Another aspect of strength through vulnerability was the participants gaining independence in their decision making. For example, Meghan re-evaluated a decision to stay at work and concluded, "Why don't I just make my own decisions here?" Anthony described moving away from external influences in Figure 21, where although his friends were complimentary of the painting he created during rehabilitation – “Wow, you did that” – he “didn’t care if everyone thought it wasn’t very good” as he was doing it for himself:

> How I felt after I had completed this or after those sessions of art therapy was just incredible, a real sense of achievement … I am going to, in fact I am going to focus on that tomorrow I am going to go buy some art materials and do something creative in my free time, because I have free time. (Anthony)

Figure 21

“A Period of Reflection”

Participants described progressing to a point in their journey of recovery at which they no longer needed as much support and could continue without a “safety blanket” (Heather). This contrasted with how participants referred to themselves and their experiences before and during burnout, using the language of early development, for example, feeling that they were “brought up” (Heather) within the medical culture, or feeling “about two years old” (Marie) when faced with an angry patient or when moving to a new practice.

8.2.4. Integration of Wider Perspectives

On occasion, wider perspectives were integrated during burnout, such as when someone external provided an alternative perspective on the participants’ experiences; however, this was more common post burnout. Wider perspectives could come from multiple sources; for example, Julie was able to reassess her view of general practice when working as an appraiser of GPs, as this allowed her to appreciate the potential for doctors to be valued by their community. Alternatively, Meghan was able to reconsider how she viewed her job after hearing the opinion, “Life is more important than a job you don’t love.”

However, some perspectives were considered to be more difficult to dismantle, such as those related to problematic workplaces once participants had become “settled” (Julie) as the “longer you’re doing the same thing, the more difficult it is to change” (Holly). Anthony was able to move to a new workplace with the support of his partner and eventually integrated new perspectives of what a functional workplace was like. However, he reflected that it took time to unlearn his expectations of receiving poor treatment in a different work environment. When participants had changed practice, they had access to different people and work cultures, which allowed them to see the bigger picture and allowed new experiences to form: “It is extraordinary how different things can be just a short distance away” (Holly). However, not all new workplaces were as successful. Laura’s move to a new workplace appeared ideal in theory, but the move turned out to be “the biggest disaster” because of challenging workplace dynamics. Yet, even when workplaces were not as successful, this still presented opportunities to integrate new perspectives such as what an effective team looked like, and a better appreciation of options: “I realised that the job market is good enough that you can leave a job … there is enough work out there” (Meghan).

Moreover, in recovery, participants felt more open to new ideas. They reframed their understanding, as emphasised by Marie, who referred to her experiences as “a tremendous gift.” She had been able to embrace mindfulness practices and represented this in Figure 22:

> It is quite a wide expanse and there’s sort of a, one of the things that I have found from doing the mindfulness is that … it kind of opened my mind up a lot more … I

> became a lot more open to you know perhaps [patients'] mood and what they wanted. (Marie)

Figure 22

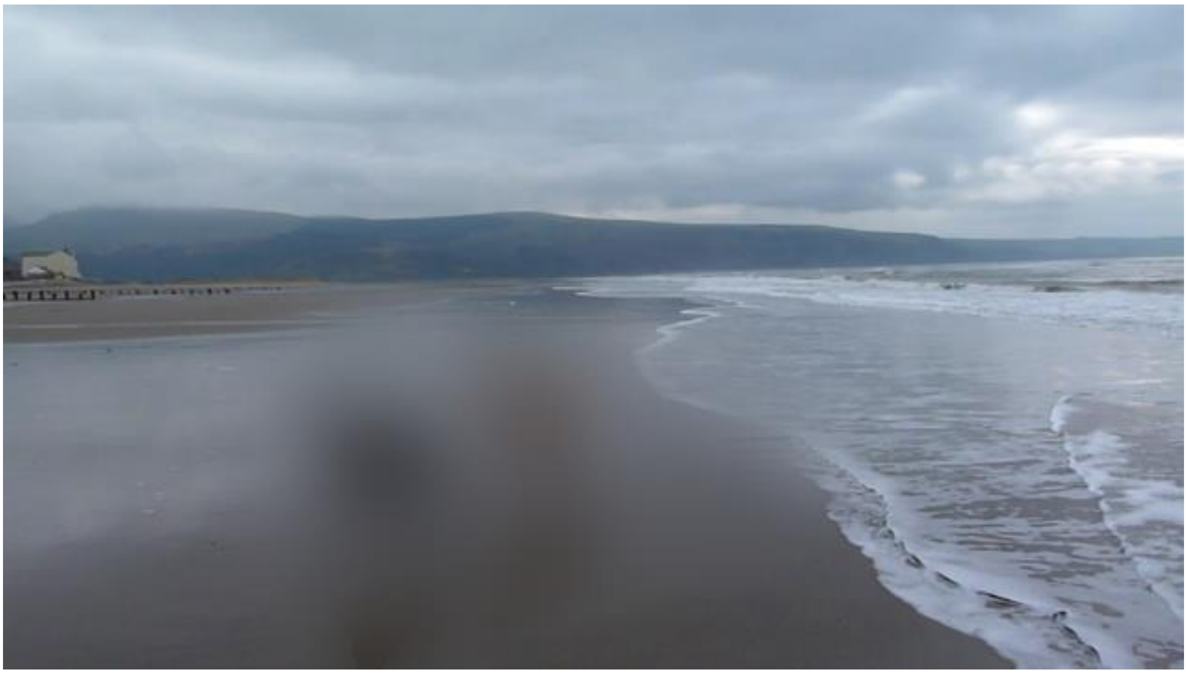
"A Wide Expanse"

This photograph represents the opportunity for reflection and evaluation when mental and physical space is created through mindfulness. Open spaces were significant in the narratives when participants needed to reflect on their experiences. Often these were described when they were coming to terms with burnout and were at the start of their recovery journey. As Heather noted, "there are places to go and be peaceful", such as walking on the beach to recharge one's batteries. In connection to this photograph, Laura also acknowledges the integration of new behaviours, permitting herself to go on holiday in Figure 23:

> I find it really useful to get outside with the dogs and I found this particular photo because it is on the beach at [place] because now I quite regularly go for a weekend on the coast just to get away … just being more in the moment I guess but also giving myself permission to go away for the weekend. (Laura)

Figure 23

"Not Being Somewhere Else"



Opportunities to connect with others in a non-judgmental way were also valued. Through receiving support, in this case from the PHS, Heather recognised the value of reflecting with someone new, a PHS practitioner, to better understand her experiences by "making connections" between different elements of her account. New positive experiences related to support led to participants needing to update their "mental model of the world" (Marie), such as by reconfiguring the bias in their expectations of others. Space for reflection was created over time. In the interviews, participants were able to view their whole narrative from a place of overcoming burnout. Marie commonly made explicit evaluations – "the learning point from that is" – while Holly commonly used questions to test the response of the research interviewer as a sounding board. Anthony, Laura, and Heather, meanwhile, discussed the integration of new understanding or connections from the research interview. For Anthony, exploring his experiences with the interviewer after the events "helped me to create in my mind a definition of burnout", as he had previously not fully considered the language associated with burnout and instead relied on a "sense of what it was". Laura's interview prompted her to reflect on how difficult the isolation had been. Heather, on a similar note, was able to see how far she had come as “You’re so busy going forward you forget to look back sometimes.”

8.2.5. Finding a Place of Belonging

Participants emphasised the importance of “a real team feel” (Julie) aligning with the values of respect, professionality, and hard work when looking for better workplaces. Having similar values to peers made it easier to share responsibilities, receive support, and feel able to voice views and opinions. Holly explained that before her practice merged, she was part of a small team that felt “very much like a family”. Similar feelings were expressed by Anthony when he first started in general practice, “it felt like a family.” However, there were potential limitations in a strongly connected team. Heather spoke about feeling a commitment to her team – “We’re a good team, we’ll manage” – which made it harder for her to seek help in a timely way.

Finding deep connections and a sense of belonging outside of the workplace were also emphasised as important in their journey of overcoming burnout. Participants found it valuable to find connections with communities (e.g., at church) and groups that could be a safe space to support them. Particularly valuable was engaging with people “who had been through similar things” (Meghan). Hearing other people’s stories was a way to learn about experiences, feel connected, and re-frame their experiences. For Anthony, this search for belonging was the key theme in his account, and one of the places essential to his continued recovery was a support group that he discussed in relation to Figure 24:

> [The support group] was a huge support because it was people who, not only people who have addiction but also people who are from my community, the LGBT community, people who I feel I could talk to openly, I feel could understand me and who could relate to a lot of the experiences I had. (Anthony)

Figure 24

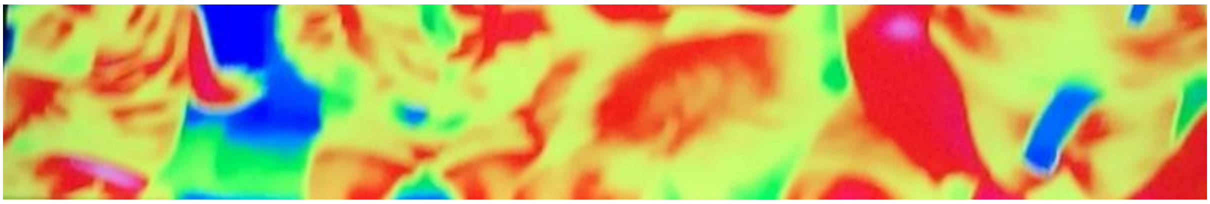
"You Feel Supported, You Feel Safe"

A space that induced feelings of safety and belonging was also commonly associated with families and close friends. Meghan felt the need to connect to her immediate family: "I just need to be with those four people … it doesn't really matter where or the weather" (Meghan). Similarly, this idea was described by Abigail in relation to Figure 25; she felt she had been able to reconnect with her family and create a feeling of normality:

> It was probably the first time in two months that I had been with my children and husband because, prior to that, if he was around to look after them, I'd be somewhere else. So, that was, I was not better at all, I was completely not … But it was a brief moment of me, not forgetting about things but being me, being normal for a moment. (Abigail)

Figure 25

"It Was a Brief Moment of … Being Reasonably Normal"



There was a warmth and comfort attributed to these characters, with many participants discussing photographs of those close to them. When starting to recover, participants actively sought out more of these connections through planning activities such as trips with "old friends" from medical school (Laura). Anthony spoke about reconnecting with friends from medical school with great fondness: "Everyone was so lovely," and "It was like we had never been apart." Moreover, finding more time for those who were valued was seen as progress: "[My family] still drive me crackers, but at least I'm here" (Julie). Participants mentioned these characters when talking about their future, which Meghan represented in a photograph of her family on a bridge that symbolised their future path together.

8.2.6. Recovery Optimism

Two photographs from Meghan show the stark difference between the perception of burnout and recovery. Figure 26 shows burnout and grief overshadowing a holiday:

> It *was* a lovely break, but it was at a tricky time in my life so the sort of darkness of the photo fits really with a lot of parts that I was dealing with, which is really why I chose it. (Meghan)

Whereas Figure 27 shows a clear, bright day where Meghan felt able to reflect and contemplate on the future and felt like she was overcoming burnout:

> I got up very early one morning because the light was just amazing and drove just before breakfast to this place and just took some photos … it is all about the memory, the time, and the fact that it is important to grasp what I really wanted to

> do with my life not just be ground down by keeping a job that I didn't love all the time. (Meghan)

Figure 26

"It Was a Dark Time in my Life"

Figure 27

"A Very Special Time and Such a Good Thing"

Through their accounts, participants described overcoming burnout to reach recovery, as depicted in Figure 26. This was reinforced through most of the narrative elements, from the interpersonal such as the external perspective on Holly's appearance and behaviour post burnout: “You look different” and someone noting a “spring in your step”, to a greater connection with their values and morals. When considering the intrapersonal, participants demonstrated that they held different views in the final sections of their narratives, having come to terms with burnout – “You can genuinely process it” (Abigail) – and considering other viewpoints such as patients who made the job harder as they came into the consultations with “their backs up” because they “weren’t getting a good deal” from the practice (Julie). Marie reflected on some of her previous challenges by saying, “I can laugh about it now”, whereas Julie commented on being sued during burnout, saying she was “quite philosophical about it now.” In these reflections, participants use language that distances them from the burnout: a then and “now”.

Related to this was the theme of self-awareness and self-prioritisation as all participants were still working in general practice where they continued to face challenges: “There are just days where you are swimming or sinking in it” (Meghan). Marie described being able to accept and therefore better manage her emotions, while Holly talked about recognising the value of putting her “gas mask on first.” Laura applied this new knowledge to a criterion for vetting a new practice, asking “What is your turnover like?” and “How do you resolve conflict?” Valuing this new awareness often translated into attempting to break the pattern of engaging with and passing on the culture of medicine, with those working in mentoring roles actively seeking to encourage more positive mentalities, with one participant even putting themselves forward to train students in the art of resilience.

The ongoing positive implications of having recovered were also evidenced when participants reported their success in facing new challenges, categorised as secondary events. These were labelled under the code of the ‘changing goalposts’ of recovery during analysis. An example of this was Holly, who described facing the challenge of navigating the warning signs for another episode of burnout and was able to avoid this through recognising the risks. An instance of changing the goalposts for Heather was when she received a new diagnosis (separate from burnout), as can be seen in Figure 28. This photograph was of the holiday when she first stared to think there might be something additional stalling her recovery:

> I chose [the photograph] because that is the holiday where the embryo of am I [diagnosis] started, and it was just so peaceful [pause] … I am a bit of an introvert and it is ok but sometimes you just need a bit of time and space to myself. (Heather)

Figure 28

"The Embryo of Am I [Diagnosis]?"

In the face of these new challenges, participants evaluated what they were experiencing, and, in some cases, when injustice was seen, participants were able to stand up for what they believed in. Holly fought for herself when setting boundaries to prevent burnout, feeling the need to be “quite brutal to say it loud enough for anyone to listen” when breaking the mould of the medical culture and going against the stereotypes of being “lazy” and “not pulling your weight” (Holly). Similarly, Meghan wrote to complain after not receiving the support she needed, while Heather, in her search for support for her new diagnosis, was ready “to do battle with the practice”, finding herself “quite fiery about it at the moment.” For others, from the perspective of having overcome burnout, they could assess situations more objectively. For Abigail, when faced with two job rejections, she chose to view this as an indication that they were not the practices for her rather than taking it personally. In contrast, however, although Laura identifies as having overcome burnout, an additional challenge with feeling financially secure was acknowledged as creating a bleaker outlook on her work, feeling she was now “treading water till I retire.” Yet, as illustrated by Abigail, facing additional challenges did not necessarily have to undermine any attempts to maintain the connection to recovery: “I’m not stressed out and I am not burnt out, I’m still recovered” (Abigail). However, the identification with the word ‘recovered’ was not definitive for all. For Heather, although able to look back and recognise how far she had come, she still felt that her recovery was a work in progress: “I didn’t feel like I was better … I still feel like I am not.” Laura, meanwhile, described recovery as an ongoing process: “I didn’t think of it as recovered and that’s it, I see it as an ongoing process.” From this perspective, there is an acceptance that new challenges will arise and that the goalposts will constantly change, but also the sense that such obstacles can be overcome through continued self-awareness and self-prioritisation.

8.3. Discussion

This section is presented in three parts covering 1) the key findings, 2) comparing the findings to the wider literature, and 3) conclusions.

8.3.1. Summary of Findings

This study explored the accounts of eight UK-based GPs who had received support from the PHS and self-identified as having overcome burnout. Data collection methods of narrative interviews with photo-elicitation using participant-generated images were novel in their application to this topic and enabled a nuanced insight into participant experiences. Through narrative analysis, the significant experience of recovery was investigated within the broader context of the participants' lives, focusing on how different narrative elements aided in the understanding of burnout recovery. A summary of the main settings, characters, and other key elements (events, interpersonal, intrapersonal, culture, values, and morals) are presented in Appendix HH.

Importantly, characters had integral but differing functions in the accounts, from being impactful in causing burnout to being pivotal in providing hope and guidance to help participants navigate away from the darkness of burnout. Notably, after accepting burnout, participants became open to new perspectives and became more engaged with alternative recovery spaces, such as spending more time in nature and seeking out spaces which had a sense of community. Within this, captured through photovoice and photo-elicitation, participants emphasised that forming greater connections with people was associated with feelings of warmth and safety, and aligned with their values and moral codes. There were benefits in sharing their stories with those who had similar experiences or characteristics to them. Key too was having access to recovery spaces away from the workplace. Moreover, the passage of time and being among nature both aided reflection.

Looking at the stories in their entirety, a further key finding was the type of narratives created, with participants presenting their accounts as stories of self-development and strength through adversity or post-traumatic growth. As chronology is a crucial element in how people naturally tell stories (Earthy & Cronin, 2008), the narrative elements can be mapped against time (see Appendix II) which captures the findings of this study in diagram form.

8.3.2. Comparison to the Literature

Within this section, the findings will be compared to existing recovery research and burnout recovery research, before being connected to narrative theory.

Although the participants in this study were medical professionals, their accounts of overcoming burnout were more complex than describing recovery using the medical model (Price-Robertson et al., 2017). All participants had accepted their experiences during the turning points of their accounts and had integrated burnout into their narratives in line with Turner-Crowson and Wallcraft's (2002) suggestion that people need to accept the illness in order to recover from it. In achieving this, participants could live a life beyond illness (Ramon et al., 2007; Shepherd et al., 2008). The accounts were more akin to the participants experiencing a journey of recovery (Davidson et al., 2006) or going through a recovery process (Liberman & Kopelowicz, 2005) where participants had managed to reach a point in their lives where they felt more satisfied despite potentially still facing some limitations (Anthony, 1993).

Moreover, elements of recovery that are commonly absent from early definitions appeared to be essential for these participants. Particularly valuable were the components of hope, agency, and the social context as explored previously (Allen et al., 2014; Furlong, 2013; Repper & Perkins, 2003). Hope was influential in the initial stages of overcoming burnout, especially when seeking help. It was often created when others accepted and validated their experiences and could signpost to recovery. Agency, which is strongly connected to a participant’s sense of meaning and purpose (Adler, 2012), was also an important influence in each participant's journey, as they moved from ‘just getting on with it’ to ‘taking control’. Within the accounts, the participants were then able to perceive themselves as having an ability to influence the course of their lives, both within general practice and outside of work.

Moreover, the social context of recovery was prominent in these accounts, standing firmly opposed to the self-help approach in which the individual is seen as isolated and enclosed in their recovery away from other interactions and relationships (Furlong, 2013; Stolorow, 2013). In line with the arguments from Rose (2014), the participants were not overcoming burnout in isolation; they were embedded in their social contexts. For the participants in the current study, initial attempts to overcome burnout in isolation were seen as futile, leading to the need to seek help from others. Through recovery, characters were central, from helping the participants feel less alone in the dark pit of burnout by acting as sources of light, by being close allies who serve as sounding boards, or by helping them to plan a future with warmth and kindness. Importantly, when feeling recovered, participants felt like they belonged and were connected to others. This relates to the idea of replenishing moral agency within recovery stories, as Myers (2016) discussed concerning stories of recovery from psychosis. Moral agency here relates to having the intentions and aspirations to reach and the resources available to facilitate a meaningful and “good life” (Myers, 2016; p. 436), which leads to a stronger connection to others. This was especially apparent within the sub-theme of belonging: participants felt like they belonged when they were able to find their niche, as their values and ethical perspectives were being matched and respected. In this way, their sense of self was nourished.

Overall, participants’ stories fit well within the CHIME framework, which captures the five interrelated recovery processes: Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment, as proposed by Leamy et al. (2011). The element of ‘connectedness’ came through powerfully. The participants felt the need to belong in a work team and to find their place in wider society. As mentioned above, ‘hope’ was a crucial element of each of the participant’s turning points. The participants struggled with their ‘identity’, seeing their sense of self-being eroded by burnout but then rebuilding themselves into stronger individuals by being more self-aware, accepting their vulnerabilities, and finding a deeper connection and respect for their values and morals. ‘Meaningfulness’ was found in these accounts of overcoming burnout through engaging with opportunities to grow and learn and focusing on what had been gained from the experience. Finally, participants were ‘empowered’ to stay recovered, prioritise themselves, fight for what was right and, if they were able to, pass on what they had learned to others.

The latter concept of empowerment links to the theme of strength through adversity, which was noted as a potential outcome of burnout in Study 2. In the current study, participants focused on enhanced relationships, changed views of themselves, and a new appreciation for life, which are core components of post-traumatic growth (Joseph & Linley, 2006). Post-traumatic growth was potentially more prominent in this study due to more time elapsing between burnout and the interviews, as suggested by Linley and Joseph (2004) and Semeijn et al. (2019), and also due to the emphasis on supporting characters. Joseph (2011) suggests that talking through significant experiences with supportive people can enhance a person’s ability to process events, which can lead to gaining new insights and perspectives and ultimately lead to post-traumatic growth. Participants used post-traumatic growth to make sense of their experience and used self-enhancing appraisals when telling their stories (Malhotra & Chebiyyam, 2016), demonstrating credibility with supportive actions (Hobfoll et al., 2007).

Moreover, this study added to the literature by showing that participants redeveloped coherence and self-esteem in their accounts. The previously reported redevelopment of optimism, resilience, and self-efficacy were found to occur after recovery from burnout in Dutch workers (Semeijn et al., 2019). The growth of these protective characteristics may be usefully considered in light of research that suggested that higher levels of perceived growth in medical professionals contributed to lower risk of burnout (Taku, 2013), and in light of research showing that post-traumatic growth was a coping resource that reduced nurses' burnout (Hamama-Raz et al., 2020). Recently, higher levels of post-traumatic growth in nurses during the COVID-19 pandemic may have played some part in lower burnout rates (Chen et al., 2021), although further research is recommended.

However, there are some differences related to burnout recovery specifically. While most participants did explore the concept of job engagement as characterised by energy, involvement, and efficacy, which Maslach (2003) argues is the opposite of burnout, this was not the focus in their narratives. This is potentially due to the strict focus of this definition on the occupation. In the current study, the narratives went beyond occupational burnout to cover the participants’ lives outside of the workplace. Therefore, this definition from Maslach may be limited in communicating the whole experience of what it means to overcome burnout for GPs. However, the journey of overcoming burnout for the GPs in the current study did follow the pattern of recovery as proposed by Bernier (1998), who suggested that the typical steps for recovering from burnout were to admit to the problem, establish distance from work, restore health, question values, explore work possibilities, and make objective changes. However, in the current study, participants gave limited attention to the process of restoring health, with some commenting that distancing themselves from their problematic workplace or the antagonists when taking sick leave made them feel instantly and dramatically better.

Additionally, making objective changes was seen as challenging within medicine. The occupational flexibility proposed to aid faster recovery (Norlund et al., 2011) was not always available within general practice. As previously noted by Fältholm (2007), there is an issue of medical professionals experiencing burnout in a workplace, only to return to the same workplace even though no organisational or systematic changes have been made. Faced with inflexibility and a lack of control in their workplace, participants in the current study often made the objective change to move to a new practice and continued to explore work possibilities.

This can also be considered in relation to Hallsten et al.’s (2011) ideas, which suggest that those with job burnout are at risk of long-term sick leave. Similarly, the possibility of burnout recovery was proposed by Cherniss (1992) but with the caveat that individuals could suffer long-term consequences. While this was not explored directly within this study, participants reinforced the idea of being stronger through increased self-awareness, having built protection for themselves, and were alert to the potential risks. Added to this are the integrated wider perspectives that it is acceptable to move on from a place of work, that help could be sought earlier, and that there is an increased awareness and acceptance of the support available to help them if needed. Therefore, it could be proposed that there may be a reduction in risk for long-term sick leave, and the perspectives of GPs who have overcome burnout are framed as positive consequences.

Furthermore, the accounts can be interpreted through the lens of narrative frameworks and theory. Earthy and Cronin (2008) suggest that the purposes behind chronic illness narratives can be applied to other interview topics, particularly when the subject being discussed is seen as problematic or associated with stigma. Participants' accounts could be interpreted as both a moral narrative, as participants addressed the changed self, and contingent narratives, as participants tried to make sense of the burnout experience (Bury, 2001). The use of photographs enhanced participants’ use of metaphors and literal depictions when describing their realities (Kantrowitz-Gordon & Vandermause, 2016), whilst also giving participants the time and space to consider how they wanted to present their perspectives and experiences within the interview (Woodgate et al., 2014). Analysing the accounts with narrative analysis allowed insight into different elements, such as notable settings.

Settings have previously been explored in relation to recovery; for example, Taylor and Radley (2003) explored the role the hospital ward setting plays in recovery, but the role of settings is yet to be explored in relation to GP recovery from burnout. Through the analysis, it became apparent that some settings, such as the home, open natural spaces, and other recovery spaces, may play a considerable role in overcoming burnout. In the accounts, settings had become more than just a place. As reported elsewhere, the settings were infused with feelings and memories during the reflection (Taylor & Radley, 2003). In the current study, therapeutic settings were often set in nature with open spaces. Maclean (2020) reported that nature-related environments were perceived by a general population sample with a range of mental health conditions as helpful in improving wellbeing and could be the foundation for fostering a safe space, community, and peer support. Moreover, a systematic review found greenspace exposure to be beneficial for health (Twohig-Bennett & Jones, 2018), and integrating natural environments or green space exercise into interventions has been identified as important (Marselle et al., 2019; Rogerson et al., 2020), as natural environments or green spaces are viewed as restorative (Bowler et al., 2010; Christie & Cole, 2017; Mackay & Neill, 2010). Indeed, Summers and Vivian (2018) write of how the interaction with nature can enhance healing and growth, which has been explored elsewhere, such as resilience training combined with woodland immersion for medical professionals as described by Heeks (2019), and implemented for GPs (Rimmer, 2019) with such interventions finding preliminarily positive outcomes (Sebah, 2019).

Additionally, as Oliffe and Bottorff (2007) explored, using photovoice and photo-elicitation as alternative research methods provides a new lens through which to view individuals' experiences. Integrating this method into the narrative approach allowed different perspectives related to the experience and re-exploration of essentialist ideas, such as the dominant ideas related to stigmatisation towards mental ill-health and help-seeking in the medical community. The culture of stoicism, delayed help-seeking, and the stigma around mental ill-health in medicine were discussed in the interviews; however, participants also created a new narrative around burnout. Although the narrative analysis was approached through the combined dimensions of categorical-content (Lieblich et al., 1998), it became clear that there were interpretations that could be made through the holistic unit of analysis by understanding the significance of the experience for the participant, mainly how they created their identities and described post-traumatic growth. This could link with the political process of the accounts, moving the stories away from shame and guilt, as was seen in the findings of the lived experience of burnout in Chapter 6. It has been suggested that causal connections can be made through life which can be interpreted to inform the narrative; in the current study, this occurs through 'self-change' (how impressions of past events have shaped the self in dramatic ways) rather than 'self-stability' (maintain a continued sense of self) (Lilgendahl & Mcadams, 2011). Lilgendahl and Mcadams (2011) report that self-change connections are particularly important in midlife. They capture how the person had perceived themselves to develop over time, related to the perception of self-growth.

Bell (2002) argues that humans make sense of their experiences by matching them to story structures that they are already aware of. When experiencing adversity (such as burnout in the current study), Adler et al. (2015) drew on general narratives and strategies used by participants to make sense of hardship, such as overcoming physical ill-health. It was suggested that stories about agency, communion, redemption and contamination have strong links to facing adversity and are associated with mental health. The accounts in the current study represent stories of 'the fighter', a typical protagonist within illness narratives, who takes on their illness in a bid to restore their health.

Consequently, the stories follow a redemption arc, starting with the adverse experience of burnout but ending with the participant reaching a positive conclusion. The participant can demonstrate their growth by tapping into their priorities and their connections with others. The narrative theme of communion, whereby participants focus on social connectedness to regain vitality, occurred in parallel in the current study. Belongingness is a fundamental human need (Deci & Ryan, 2000) and is emphasised through overcoming burnout. Previous research suggests that self-redemption narratives may stimulate prolonged behavioural change (as studied in recovering alcoholics) and might therefore be a modifiable psychological process (Dunlop & Tracy, 2013) that may be influential in overcoming burnout. Lilgendahl and Mcadams (2011) have reported that creating an account connected to self-growth is associated with psychological wellbeing. It has also been suggested that when people create and tell new stories about their experiences, they move towards living this narrative (Adler, 2012).

8.3.3. Conclusion

Overall, this study presented coherent accounts of GPs overcoming burnout, which involved them integrating their burnout experiences into their narrative identities and reframing their accounts to present a story with post-traumatic growth. The purpose of the accounts could be interpreted as demonstrating a new narrative within the burnout experience, focusing on strength through adversity and the integration of wider perspectives. Participants were able to engage in reflective thinking whilst being exposed to new ideas and environments once they had started to move away from the experiences of burnout and become more self-aware. The experiences of recovery were embedded in the social context of each participant, and the impact of key characters varied depending on the stage of burnout. Furthermore, key settings were important during recovery, particularly those in nature and those connected to people the participants valued as supportive. Future research should investigate the usefulness of these narratives for other GPs in reframing their experiences of burnout as well as their usefulness in implementing interventions at stages where GPs may be most responsive.

Chapter 9.

General Discussion

The overarching aim of this thesis was to study the experiences and perceptions of GPs with poor occupational wellbeing within the current healthcare context. Two other specific aims were as follows: 1) to explore the experiences of UK-based GPs who self-identified as having faced burnout, and 2) to investigate GPs' experiences of accessing support and overcoming burnout. Four complementary studies that employed different methods and approaches were completed to achieve these aims. Two studies, Studies 1 and 3, were broad in their investigations. Study 1 was a thematic synthesis of the existing qualitative literature exploring GPs' poor occupational wellbeing and mental health. Study 3 investigated the outcome data for GPs seeking support over the course of a year from the Practitioner Health Service (PHS). Two qualitative studies, Studies 2 and 4, explored the experiences of GPs more deeply; the former investigated the lived experiences of GPs who self-identified as experiencing burnout, whereas the latter explored GPs' accounts of burnout recovery.

This general discussion chapter first summarises the key findings of the four studies in the thesis, highlighting that GPs' experiences of distress, poor wellbeing, and burnout were inseparable from the contexts in which they occurred, and, furthermore, were inherently relational (as explained below). These findings are important given unprecedented pressures in general practice (Cheshire et al., 2017b) and the need to establish a more sustainable and effective primary care system (Majeed, 2015; Marshall et al., 2020). Additionally, these findings are timely in the context of worsening GP wellbeing due to the additional challenges of the COVID-19 pandemic (British Medical Association, 2021b), which is predicted to impact the NHS for several years (Khan et al., 2020).

These findings will then be contextualised within the theoretical and empirical literature. Following the discussion of the findings, sections will be presented on the researcher’s reflexivity, the strengths and limitations of the research in the thesis, the overall implications of the research, future directions, and general conclusions.

9.1. Summary of the PhD and Key Findings

9.1.1. Study 1

In line with the overarching aim to study the experiences and perceptions of GPs with poor occupational wellbeing, and to better understand the existing evidence base contextualising the reported decline in GP mental health and wellbeing (Kinman & Teoh, 2018), Study 1 synthesised published qualitative research related to GP mental health and wellbeing. As far as the researcher is aware, this is the first qualitative synthesis on this topic, despite the growing interest in GP distress, the prevalence of GP low wellbeing, and the impact of burnout on patient care (Hall et al., 2016, 2019; Imo, 2017; Linzer et al., 2009; Panagioti et al., 2018; Shanafelt et al., 2015; Soler et al., 2008). The publication years of the included qualitative studies reflected the increased attention on the topic, with 14 out of 18 studies being published within the last five years.

This synthesis of original qualitative research allowed for a deeper exploration and understanding of GPs’ perspectives. The findings contribute to the literature by consolidating a clearer outline of the issues. The need to dismantle the invulnerable GP persona and the detrimental impact of GPs feeling dehumanised and morally conflicted whilst facing an intolerable workload was highlighted. The findings also suggested that GP distress had its roots in medical school, where mental health problems are stigmatised. GPs were socialised to tolerate such stresses in isolation, leading to delayed help-seeking. Moreover, GPs experienced a kind of voicelessness and felt devalued in their occupational roles.

The study identified research gaps in the published qualitative literature, including a limited focus on the experience of GP burnout. This study’s implications and future directions also suggested a need to focus on recognising the importance of supporting positive disclosures of poor coping and on dismantling the damaging medical culture.

9.1.2. Study 2

Study 2 was an interpretive phenomenological analysis (IPA) of the lived experience of GP burnout, addressing the scarcity of qualitative research investigating GPs' burnout experiences in the contemporary NHS context. This study also addresses the research gap in line with the thesis aim of exploring the experiences of UK-based GPs who self-identified as having faced burnout by exploring the deeper complexity and meaning-making behind GP burnout, as well as providing a detailed exploration of cumulative risk factors and how GPs framed their experiences.

Key findings highlighted burnout as a complex, global, gradual, and spiralling experience resulting from a mix of work, lifestyle, personality traits, and socio-political dimensions. Burnout had significant implications for the participants' sense of self, and participants described feeling broken, trapped, and reaching 'rock bottom' before deciding to seek help. This study added to the literature and the current understanding of GP burnout experiences, as it showed that the negative impacts of burnout could be perceived as persistent. However, there were indications that life after burnout could also include recovery and personal growth.

Markedly, participants' accounts were usually first-time disclosures of burnout, with uncertainty around whether their experiences were typical. This uncertainty suggested that burnout narratives were not commonly shared, contributing to a sense of isolation among GPs who had experienced burnout. This acquired understanding, paired with findings from Study 1 that suggested that GPs felt silenced, informed the need for an active dissemination strategy to communicate the findings in a meaningful way to a wide audience. As art can reflect the richness of experiential data, and provide a way to create interest, promote dialogue, and facilitate deeper understanding of illness (Boydell et al., 2012; Colantonio et al., 2008; Gergen & Gergen, 2011; Pauwels, 2010), the findings from the current study were interpreted via artwork and presented as an art-based booklet for dissemination.

Recommendations for future research included the need to explore how to better recognise GPs who may be struggling with burnout, investigate the effectiveness of interventions for GPs at ‘rock bottom’, and explore accounts of GPs who self-identify as having overcome burnout.

9.1.3. Study 3

To explore the effectiveness of interventions for GPs at ‘rock bottom’ and address the thesis aim of investigating GPs’ experiences of accessing support, Study 3 used quantitative methods to investigate the support (and outcomes) provided for GPs in distress through a free, confidential NHS support service for medical professionals – the Practitioner Health Service (PHS). Over a year, this study explored demographic characteristics and changes in wellbeing and mental health scores of GPs at three timepoints (initial assessment, six-month assessment, and one-year assessment).

The findings of this study provided some evidence that GPs who engaged with assessments over the course of a year showed improvements in mental health and wellbeing. The pattern of scores suggested statistically significant improvement in the first six months with the service, which was maintained for an additional six months. However, there was a poor data match rate; therefore, care should be taken when interpreting the findings. Nevertheless, findings aligned with previous research and found that GPs could access adequate support for mental health and cognitive problems. This study added to the literature by highlighting the low number of GPs in this cohort who self-labelled their struggles with the word ‘burnout’ at the point of help-seeking.

As a result of this study, practical implications were considered and integrated into the PHS, particularly in tackling modifiable issues with routine data collection. Due to the quantitative nature of this study, little insight was gained about GPs who had labelled themselves as experiencing burnout. Therefore, this study informed the need for qualitative research exploring accounts of GPs who had accessed the PHS and perceived themselves to have recovered from burnout.

9.1.4. Study 4

Study 4 used the narrative approach with photo-elicitation to explore gaps in the literature related to the nuances of recovery from burnout, factors that may promote recovery, and what recovery from burnout means to UK-based GPs. A sub-set of the sample from Study 3 were recruited to take part in this interview study which addressed the thesis aim of investigating GPs' experiences of accessing support and overcoming burnout.

Findings revealed that the social context was pivotal in experiences of burnout and recovery and that following acceptance of burnout experiences, participants became more open to helpful new perspectives. Participants found there were benefits to sharing stories with those who had similar experiences. There was value in the passage of time and being in natural settings for reflection and self-awareness. The methods used in this study were novel for the field and allowed for an improved understanding of the nuances of GP recovery from burnout, particularly in understanding post-traumatic growth. Personal growth was particularly evident when participants explored how to integrate their difficult experiences into their narrative identity and reported better approaches to tackling future challenges.

This study demonstrated the value of promoting a recovery approach for GPs to prevent future experiences of burnout. Further research should explore the value of GPs sharing and reshaping their stories of burnout recovery, creating support groups to foster the feeling of belonging and social connection, and integrating nature into interventions to support GPs experiencing burnout.

9.2. Comparison to the Literature

Overall, the methods used within the thesis allowed for a more global and contextualised understanding of the extensively reported upward trend of GP burnout. The studies presented in this thesis have allowed for a deeper understanding of the context, experiences, perceptions, and meaning-making around GP burnout. Greater insight has been gained into the impact of personal, organisational, political, and social issues impacting general practice. In going beyond the findings of the primary research in the synthesis and exploring the experience of burnout and burnout recovery, new directions for research and implications for practice and policy have been highlighted.

This section situates the findings from Studies 1 to 4 within theoretical and empirical literature, further highlighting the original contributions made to knowledge on the subject. First, the overarching context for these studies will be considered with a particular focus on change, followed by discussing the psychological dimensions across the studies, such as participants' identity and psychological navigation of burnout and recovery. Finally, the experiences presented as a fundamentally social phenomenon will be explored.

9.2.1. Experiences of GPs' Poor Occupational Wellbeing Within a Changing Occupational Context

There are documented positives associated with the NHS (e.g., Royal College of Physicians, 2016; Schoen et al., 2011; Thomson et al., 2011) and with being a GP, such as being able to provide one-to-one care whilst working in a challenging medically diverse discipline (Watson et al., 2011), and the potential for the provision of good continuity of care (Davison et al., 2019). However, due to the focus of the current studies on burnout and distress, this discussion section focuses on GPs' experiences of adversity when navigating their changing contexts (Bensing et al., 2006).

These current studies reflected the perceptions of unprecedented pressures reported in general practice (Baird et al., 2016; Beech et al., 2019; Palmer, 2019) and the wider NHS (NHS, 2019a; Royal College of Physicians, 2016; Simpkin & Mossialos, 2017). These findings contrast with some previous findings that general practice offers an opportunity for work-life balance, associated with good wellbeing (Davison et al., 2019;

Kinman & Teoh, 2018). Across the studies, there was an acknowledgement that there were increased pressures, reduced autonomy, increased stress, and frequent blurring of the boundaries between work and home. Such experiences have been connected to an increased likelihood of burnout when individuals perceive themselves as voiceless in influencing decisions, feel a loss of control (Linzer et al., 2016), and perceive work to be unfair and unjust (Maslach et al., 2001; Carr et al., 2003). The participants' accounts of poor wellbeing and burnout in the qualitative studies connect to broader theories, notably theories that emphasise exhaustion narratives set within a critique of organisations (Schaffner, 2016). Moreover, the findings should be interpreted alongside other research showing that doctors may present accounts about experiences of stress framed as a wider professional issue, potentially to sidestep a personal inability to cope with stress, and what this means for their own identity and performance as doctors (Thompson, Corbett, & Welfare, 2013).

Nevertheless, participants reported attempting to adapt to and normalise the organisational change (Studies 1, 2, and 4) but that these changes accumulated to become unmanageable (Studies 2 and 4). A similar emphasis on experiencing gradual changes with feelings of normalisation was seen in Thompson, Corbett, and Welfare's (2013) study, where doctors typically normalised, deflected, or trivialised their own experiences of stress. Related to this, the consequence of individuals feeling they were going through the motions, as Gundersen (2001) described, was apparent for the participants in the current studies, prominently in Studies 2 and 4. In the current studies, participants often reported disconnection from primary care and the wider NHS changes.

Study 2, for example, highlighted how participants felt cynical towards the inflexible healthcare system. For the participants in the studies in this thesis, despite the perception that their workload was intensifying, the resources available to them did not seem to be changing in line with this, nor did the culture and support within general practice seem to be shifting. In the wider literature there are elements of optimism related to adapting primary care, such as examples of best practices where functional changes have been implemented successfully (West & Coia, 2019). However, where there are initiatives implemented to enact positive change, such as investment in practice nursing and technology, closer working with specialities, and expansion of the GP workforce, the results of these may be being felt first and most by targeted areas (Owen et al., 2019).

However, organisational research suggests that when people cannot cope with the stress of the work, the result is depersonalisation (Golembiewski et al., 1986), and resistance to change can be associated with burnout and turnover intention (Srivastava & Agrawal, 2020). Moreover, research exploring healthcare workers more widely shows how being prevented from doing the job they were trained for leads to emotional exhaustion and increased mental distress (Carrieri et al., 2020; Lacy & Chan, 2018). Therefore, West and Coia (2019) suggest that many healthcare environments are not designed to ensure best use of medical professionals’ skills, and Owen et al. (2019) suggest that this is one factor influencing healthcare professionals’ intention to leave. The finding that full-time work as a GP is unsustainable (Studies 1, 2, and 4) supports previous findings in the literature (General Medical Council, 2017). For example, almost 40% of GPs based in south-west England described career intentions that would have negative consequences for the workforce, such as taking a break, reducing hours, or leaving the profession (Fletcher et al., 2017), and 49% of GPs based in Wessex reported they had brought forward their plans of retirement to leave their role in the next two years (Owen et al., 2019). This compounds concerns over existing reports of staffing issues within general practice (Baird et al., 2018; Palmer, 2019; Royal College of Physicians, 2016).

In line with this, Study 1 highlighted that poor GP wellbeing was increasingly being researched using qualitative methods. The synthesis emphasised the potentially severe consequences of GPs experiencing diminished wellbeing. High numbers of GPs sought support for distress in Study 3, particularly for anxiety and stress, commonly related to their work. Moreover, between May 2019 and May 2020, 71% of doctor patients accessing support from the PHS were GPs (Shaw et al., n.d.), suggesting an overrepresentation of GPs seeking support, as only 27% of UK-registered doctors are listed as GPs by the General Medical Council (General Medical Council, 2021). These findings indicate there may be merit in concerns such as those outlined by Kavalieratos et al. (2017) that poor wellbeing and burnout may be becoming inevitable for GPs.

Understanding the experiences of GPs, especially with increasing pressures due to the COVID-19 pandemic, is important following reports of increasing levels of exhaustion and mental health problems (British Medical Association, 2020, 2021b; House of Commons and Health and Social Care Committee, 2020, 2021). Additionally, worsening GP wellbeing could have significant implications for general practice related to lower productivity (Harrison & Newman, 2006; Warr & Nielsen, 2018), lower motivation (Ryan et al., 1997), and higher absenteeism (Toppinen-Tanner et al., 2005).

9.2.2. GPs' Experiences of Burnout and Overcoming Burnout

Although it has been consistently reported that some GPs are experiencing poor wellbeing, including a high prevalence of burnout (Hayter et al., 1996; Imo, 2017; Kinman & Teoh, 2018; Manocha et al., 2009; Riley, 2004; Vanagas & Bihari-Axelsson, 2005), there was limited use of the term burnout by participants in Studies 1 and 3. GPs' identification with the term was explored in Studies 2 and 4, with the participants typically identifying with burnout only after they had sought help. Consistent between Studies 2 and 4, participants talked about burnout as an end state, where their wellbeing had deteriorated past a certain level. Previous research such as that of Leiter (1993) suggested that considering burnout as an endpoint may be one of the more valuable ways to conceptualise burnout. This also indicates that GPs may make sense of their experiences by viewing burnout dichotomously, as Demerouti et al. (2001) described.

While this thesis did not set out to further define burnout, it needs to be acknowledged that there may still be a question over the legitimacy of – and awareness of – burnout, especially in this professional group. In relation to mental ill-health, Ridge et al.

(2017) note that gaining support requires disclosure, legitimisation and visibility. Schaufeli et al. (2019) proposed that burnout occurs in people who have worked productively and satisfactorily for an extended period, potentially leading to a lack of recognition of burnout symptoms when they arise. This may be compounded by the gradual nature of burnout onset, which participants in Study 2 emphasised, and which is documented elsewhere (Pines & Maslach, 1980; Schaufeli & Enzmann, 1998). Additionally, there was a reference to a prevailing culture of stigma towards mental ill-health and sick leave across the qualitative studies. This may contribute to the lack of communication around GP burnout experiences, to GPs' lack of clarity about what burnout is, when to seek help, how to seek help, and recovery trajectories.

Although Guseva Canu et al. (2021) made progress to clarify what burnout is in their attempt to systematically reach a consensus around a core definition, the findings in this thesis align with the comments of Schaufeli (2021), that the burnout enigma has not been solved with Guseva Canu et al's (2021) definition. As Schaufeli (2021) writes there is agreement that exhaustion is a core symptom, but there is a lack of clarity around the kind of exhaustion (mental, physical, emotional, or cognitive) or whether this is sufficient as a criterion to capture burnout alone. Additionally, this new definition limits burnout to being connected to formal work. The studies in this thesis found informal caring was also a contributing factor, and to understand burnout more comprehensively, the individuals' wider context should be considered. These findings of this thesis together with conclusions of Schaufeli's (2021) critique, taken with the findings from this thesis, prompt the suggestion that there may be value in defining or presenting GP burnout in a more holistic way, such as drawing on a lived experience definition of burnout. Rather than focusing on symptoms for diagnosis and prevalence, this thesis explored how burnout and poor wellbeing were perceived in the contemporary NHS context and the GPs' meaning-making of their experiences. The presentation of burnout, seen as a cumulation of factors in Study 2 and Study 4, was categorised by darkness and was impactfully captured by the artwork in this thesis, such as with the artist’s stark interpretation of the broken GP in Study 2, and the participants-generated photographs capturing bleakness in Study 4. The processes described (related to burnout in Studies 2 and 4) appeared to follow a narrative of gradual decline, which often led to the neglect of personal needs, as was particularly apparent in the participants’ home lives and in connection to their social needs. Such experiences have been described in burnout models, including that of Freudenberger and North (2006), and reduced social interactions documented by Pines and Maslach (1980). Schaufeli et al. (2019) described how burnout captures the experiences of extreme fatigue and the disruption of emotional and cognitive processes and the creation of mental distance, which was a significant challenge to GPs’ sense-making of their experience, particularly in relation to GP identity.

Participants in the qualitative studies strongly identified with the role of being a doctor, which has been reported on previously (Cascón-Pereira et al., 2016; Henderson et al., 2012). Wessely and Gerada (2013) suggest that a merging of the professional and personal identities where doctors become defined by their role has its foundations in medical training. The current studies highlighted that participants reported similar characteristics to those connected to burnout by Freudenberger and North's (2006), particularly excessive ambition. Modern medical training is argued to focus on those who fit the category of the workaholic, independent, perfectionist with dampened emotions, who therefore may be more susceptible or are predisposed to low wellbeing and burnout (Drummond, 2015; Matheson et al., 2016). Thus, it has been proposed that the process of developing burnout may originate during each GP’s time at medical school (Santen et al., 2010). This was similarly highlighted in Studies 1, 2, and 4, and raises questions about the recruitment of medics who have traditionally been selected for their personality traits, their conscientiousness, their hardworking nature, and for being academic overachievers (O’Dowd, 1987). This is exacerbated through burnout. In line with Åsberg’s (2018) exhaustion funnel, through exhaustion, the participants prioritised their professional life over their personal life. This also supports Ekstedt and Fagerberg's (2004) model of burnout, particularly the stage that they label as “cutting off” (p. 62), which is theorised to be a mechanism to defend an individual’s self-image or as Schaufeli et al. (2019) suggests, a dysfunctional attempt to prevent further exhaustion.

Although the experiences explored in this thesis are specifically related to burnout and set within the context of the NHS, there can be parallels drawn between these experiences and those described in the broader literature of people experiencing mental illness in the workplace. For example, Ridge et al. (2017) wrote about similar experiences when exploring depression, finding that experiences were shaped by normative and neoliberal policies that demand healthy and productive employees. Not surprisingly, there was concern from the participants about the impact of burnout on patient care in the current qualitative studies. However, similar to experiences previously reported (Bhugra et al., 2019), GPs described continuing to work hard in the face of poor mental health, including stress and burnout, and appeared acutely aware of the association between burnout and reduced patient care. Bhugra et al. (2019) wrote that medical professionals working through poor mental health have advantages and disadvantages, captured in the current studies (mainly seen in Study 2 and Study 4). Doctors continued to provide care as they felt trapped due to the patients’ needs, and there was no overflow system for primary care. Participants, therefore, faced ethical dilemmas about their fitness to work and the continued impact of this on their wellbeing. Some participants acknowledged the connection between burnout and lower quality of patient care. Some described how poor encounters with patients served as the turning point for them to seek help or make changes. However, others rejected the negative impact on patient care, suggesting that they could maintain good care through learned professional skills, putting on the doctor’s mask to get through. Turning points for participants in the current qualitative studies related to when participants felt they could no longer work as they had done. These experiences were similar to those outlined by Ekstedt and Fagerberg (2004) in their study exploring burnout, where this experience was given the label of “turning of the tide” (p. 62).

The studies in this thesis connect to how Clouston (2015) discussed general psychological wellbeing in relation to self-identity, which includes having personal congruence and coherence. A personal sense of autonomy and coherence was first challenged by the organisational changes highlighted in Study 1. However, the nuance in this experience was explored more deeply in Studies 2 and 4 in relation to their impacted work identity. A further understanding was gained in overcoming burnout, making sense of the experience by integrating this into a new narrative account in Study 4. These findings resonate with experiences of meaning-making, particularly for those who are making sense of depression. Examples include women attempting to understand and rework their sense of self in Schrieber (1996) and the Westernised reworking of self when people who have experienced depression attempt to lead a more authentic life in Ridge (2008). On their own or with some support, the participants in Study 4 were able to integrate strategies that have been associated with an adaptive response to stress (Satterfield & Becerra, 2010), such as dedicating time to become self-aware (Beckman et al., 2012) and practising self-reflection in order for GPs to better understand themselves and their limits (Prayson et al., 2017).

Moreover, Ryan and Deci (2000) wrote about the theoretical and practical importance of understanding conditions fostering or undermining human potential. The current thesis has provided a deeper understanding of the conditions that undermine GPs’ potential in Studies 1 and 2. Participants described that their spirit had become diminished by their experiences of burnout, with this being particularly applied to their social and organisational context. However, in participants’ stories of overcoming burnout in Study 4, the fostering of human potential was emphasised. The recovery narratives were associated with self-motivation, agency, inspiration, and the desire to learn, with the onus placed on the individual to facilitate recovery and foster their own potential. Maslow's (1943) self-actualisation and motivational framework suggests that human needs such as belonging, connection, safety, and self-esteem are structured within an integrated hierarchy, and meeting these allows a person to reach self-actualisation, which is associated with improved wellbeing, which includes greater self-acceptance, life satisfaction, positive relations, a defined purpose in life, environmental mastery, and self-transcendent experiences (Kaufman, 2018). Participants in Study 4 were able to start focussing on growth, health, and integration, describing a renewed sense of curiosity and embracing the unknown such as through trying out new workplaces, which has been suggested to be connected with personal growth (Kashdan et al., 2018).

The research in this thesis advanced understanding related to post-traumatic growth (Joseph & Linley, 2006). Participants overcame burnout by re-establishing who they were as people (Giles, 2004), by practising increased altruism towards patients, by being more accepting of their own vulnerability, and by renegotiating what matters in life, including prioritising their health (Joseph & Linley, 2005). As was explored in Study 4, it appears that participants had re-invented themselves as resilient, and participants presented versions of themselves associated with qualities such as optimism, understanding of own self-worth, and being adaptable (Matheson et al., 2016). It has been previously reported that GPs want resilience to be the responsibility of both the individual and organisation (Cheshire et al., 2017b). However, in the current research, most participants had reluctantly shifted to understand that they needed to prioritise their wellbeing without significant support from the organisation. It was commonly noted that participants perceived themselves as better doctors when in recovery, often by understanding their patients better, which helped develop deeper connections and greater satisfaction with their work. Harrison and Newman (2006) suggest that job satisfaction provides powerful predictors of performance, absence, and turnover. Therefore, the additions to the literature regarding burnout recovery from this thesis may have substantial implications for improving practice.

9.2.3. The Experiences of GPs – Relationality Across the Studies

Findings related to social factors connect to poor wellbeing (Clouston, 2015), and were apparent in each study. For example, medical cultural influences on the stigmatisation of mental ill-health in the qualitative studies; the concern over relationships being impacted by distress in Study 3; and the positive influence of interactions with people to the recovery journey in Study 4. The importance of relationships and their interactions came through strongly in this thesis, and has been highlighted elsewhere in relation to medical professionals, such as in the importance of a supportive team (Matheson et al., 2016; Satterfield & Becerra, 2010); the value of being able to share personal experiences (Beckman et al., 2012); or the importance of experiencing human contact throughout the working day (Cheshire et al., 2017b).

Maslach et al. (2001) suggested an association between the absence of community and burnout. The current work has advanced the literature by recognising the potential importance of relational issues like ‘belonging’ within the experiences of burnout and recovery from burnout, showing that this kind of positive relationality is particularly important within the current organisational and social context for GPs. Clouston (2015) has also noted the importance of belonging to achieving wellbeing, not to mention the value of having somewhere to feel safe and secure. Concerns about the lack of availability of such relational resources is an issue across the wider NHS. For example, 40% of doctors working in the COVID-19 pandemic reported that they lack access to a shared space for relaxing or communicating with peers (British Medical Association, 2021a). These unmet needs have been recognised and consequently emphasised in reports such as that carried out by NHS England (2020b) which recommended a focus “on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care” (p. 5).

Moreover, it has been argued that in the study of recovery from mental illness, distress needs to be considered from a relational perspective, with deeper consideration given to the network of relationships that allow people to grow and heal (Wyder et al., 2021). Relationality opposes the individualistic underpinnings of much mental health and recovery research and theorising to-date, suggesting the problem is more complex than the individual being shaped by, influenced, and interpreting experiences within their context. Instead, individuals themselves need to be considered as inseparable – and emergent – from their social interactions and contexts (Price-Robertson et al., 2017). The networks in which the participants were experiencing burnout and healing were highlighted in the current studies in terms of their peer, familial, educational, political, and organisational dimensions. Participants and burnout only became intelligible via their descriptions of interpersonal relationships, including the construction of their identities in Studies 1 and 2, or hope and sense of empowerment in Study 4 (Rose 2014).

Importantly, relationality does not discount that the individual is a main actor, but rather says that they exist within a complex social relationship and system context (Mudry et al., 2018). However, it was via social relationships that personal experiences were able to be redefined (Price-Robertson et al., 2017). The findings suggest that recovery from burnout was occurring via participants' social networks, which contributed to "healing interpersonal patterns" (Mudry et al., 2018, p. 2). Thus, 'the other' seems critical to engage if participants are to better cope with burnout. Yet, there is evidence of an individualistic culture (Orange 2010) experienced by participants through the results of the thesis. For example, participants prioritised value based on independence and personal achievement in Studies 2 and 4. Additionally, the narratives in Study 4 involving post-traumatic growth described modifying personal limited thoughts, feelings, and beliefs, only in part suggesting these were shaped through social interactions. It could also be argued that there is an overemphasis on the subjective inner experience in the framing of qualitative Studies 2 and 4 by the researcher, which has previously been suggested to obscure the interpersonal context (Price-Robertson et al., 2017). Moreover, the CHIME framework, used to interpret the findings of Study 4, has been criticised due to relationships playing a secondary role (Price-Robertson et al., 2017).

Research looking at the experiences of recovery from burnout through the relational perspective is in its infancy. Thus there remains an emphasis on the individual, especially in prevention, such as those focusing on resilience discourses (Balme et al., 2015; Oliver, 2017). There has been criticism of recovery research, focusing on individual rather than collective responsibility (Harper & Speed, 2014; Howell & Voronka, 2012). Additionally, a growing body of literature demonstrates the conflict of mental illness with a doctor's professional identity within a culture of denial in primary care (Brooks et al., 2017; Spiers et al., 2018). The culture of the NHS was mainly portrayed negatively across the studies. Within Studies 1 and 2 the culture was predominantly depicted as unfavourable, with references to bullying, the perpetuation of superhuman psychology, and the need to keep working through distress, including burnout and its connection to poor help-seeking.

Highlighting burnout recovery as inherently social and encouraging discussions of relational perspectives is the first step towards change. However, the current research itself is limited in the extent to which it foregrounds the relational paradigm. In Study 4, the analysis was bounded in nature, with the coding of the interpersonal and the intrapersonal separately. However, the current burnout research does turn the focus away from the individual, towards the assemblage of people, animals, spaces, things and events that may mediate the social, affective, and material aspects of recovery (Duff, 2014). Especially with the photo-elicitation, the current study captures the deeper encounters, events, processes, and relations that are part of recovery experiences (Duff et al., 2017). However, more work is needed to explore burnout specifically from a relational perspective, of which, the current thesis suggests fruitful research lies ahead.

9.3. Reflexivity

Reflexivity requires an awareness of my contribution to the construction of meaning through research, acknowledging the impossibility of remaining separate from the subject matter (Nightingale & Cromby, 1999). This section is situated in the general discussion to enable the presentation of reflexivity across the timeframe of the PhD and its contributing qualitative studies. Within this section, I will discuss 1) the key information related to domain one of the consolidated criteria for reporting qualitative research (COREQ), ‘research team and reflexivity’, 2) my personal reflexivity, and finally 3) methodological reflexivity. This reflexivity section cannot detail all the reflexivity notes taken during the PhD; therefore, the most relevant has been prioritised.

9.3.1. Personal Characteristics

I will first outline my characteristics in line with the COREQ. It provides the reader with the opportunity to assess how this might have influenced my interpretations and therefore improve the credibility of the research (Tong et al., 2007). My personal experiences during the PhD, including my interest in the research topic, will be discussed within the next section, titled ‘personal reflexivity’.

I (White British cisgender female) grew up in a village in the Northeast of England, completed my undergraduate and master’s education in the Midlands (my credentials are a BSc degree in Psychology and an MSc in Mental Health Research). I moved to London at age 24 to take up a doctoral researcher position, and I am finalising my thesis at aged 27. During this PhD I have also held several work roles in parallel including working as a Visiting Lecturer, a Research Associate, and a Listener at the Samaritans. I have completed several training courses of relevance during my doctoral studies, including courses on qualitative research methods and extensive active listening training through the Samaritans (further details of work and training courses are provided in Appendix JJ).

To further provide context I will briefly describe my supervisory team. My director of studies was Dr Cartwright, an academic health psychologist and an experienced qualitative researcher (specialised in the methods of IPA). My second supervisor was Professor Ridge, who initially studied medicine before moving to the social sciences and becoming a qualitative research expert (particularly in narrative research) and psychotherapist. My third supervisor was Professor Peters, who trained as a family doctor, in osteopathic medicine, and as a musculoskeletal physician, and is additionally specialised in holistic healthcare and resilience.

9.3.2. Personal Reflexivity

My interest in this research topic originated when I evaluated mindfulness-based cognitive therapy for healthcare professionals for my MSc research project. My growing interest in the topic was rooted in my beliefs that individuals' wellbeing and mental health are of great importance and need to be supported, as well as a curiosity to understand more about those who appeared to outsiders as infallible. As a result, I applied for this PhD position to research 'the impact of GP burnout on patient care', proposing a mainly quantitative project. Looking back at my first attempt to engage with reflexivity from November 2017 – I was an eager researcher with overambitious ideas that hinged on confidence in the certainty around definitions of key concepts (such as burnout) and methods to be used (quantitative), with a surface-level understanding of who I was in relation to this work.

My mainly quantitative project proposal (focussed on the collection and analysis of quantitatively measured GP burnout and measures of patient outcomes) evolved through my reading, patient and public involvement (questionnaires, a focus group, and conversations), discussing ideas with peers and my supervisory team, attending conferences, and was further directed by the findings of my research studies. This led me into unfamiliar territory, qualitative research, which necessitated addressing my development needs. This was a challenge because of my knowledge gaps relating to qualitative research when starting the PhD and bias against uncertainty, but on reflection, it allowed me to better align the research with my underlying interest in research topic and methods – although I feel comfort in the certainty (provided for me in the structure of statistics), I identify as ‘a listener’ and see great value in hearing other people’s experiences and perspectives.

As this PhD mainly focuses on GP experiences, it is pertinent to present my own experiences with GPs. Before this PhD I had limited awareness of GPs beyond my own experience as a patient in the consultation room, experiences I reflect on with neutrality. Although medical care is something I have always been grateful to access, it was associated with necessity and little thought beyond fixing the presenting problem. In the Yorkshire village where I grew up, my immediate family shared the same local GP – he was my GP from birth to when I left for university. We held great respect for him and the wider healthcare system and how they had supported us, but within my family, there were underlying stoical views towards our health, needing to be very ill before we could book an appointment.

My experiences of GPs when I moved away for my undergraduate degree were considerably different – whilst I have mainly had positive interactions with GPs, I found my healthcare to be disjointed without a consistent GP, and at times I felt unheard and unconnected to my medical provider. Yet, perhaps the distance from my ‘family GP’ helped me feel more open in my appointments and feel less guilty when booking an appointment. Other than thinking my GP might be having a bad day on the occasions when I had felt frustrated with a consultation, I had not considered GPs outside of their role. I reflected that I saw GPs much like how I saw teachers when I was growing up, only existing in that one teacher's identity without considering they have a different existence beyond the school walls.

This brings me to my relationship with participants. None of the participants in this thesis were known to me before the research, however, my assumptions and perceptions still influenced these studies. From the start of this work, I was conscious that I was an outsider to the participant group and the topic being explored within this thesis – the value or hinderance of this seems to be split in the literature. However, I believe I had a curiosity and openness to the experience of burnout and the experiences of GPs, which was valuable in the research, as well as being able to be separate from the topic. I attempted to bolster my efforts despite my outsider status through hearing from a diverse network of people when discussing how to approach my research and in my interpretations of findings.

However, key to mention here is how I perceived the power dynamics in the interview. In all previous interactions with GPs, I have looked to the GP in the room for answers and for their support. In some ways, within the interviews, this was no different as I was still relying on the GP for the answers – they were the expert by experience. However, I still had to maintain control in the interview despite being an outsider to medicine (I found this most challenging when the interviews took place in the participant's own space), and when discussing sensitive topics where I needed to take the role of the supporter. However, after initial apprehension, I felt able to settle into the interviews, connect more with my role as the researcher, and reassess how I was approaching my perception of power – my participants were not in their role of GP in the interview, and I was not in the role of patient.

As I finalise this PhD and look back at my interactions with my participants and recent interactions with healthcare providers, I feel the illusion of infallibility has been mostly dismantled in a positive way. I still respect medical professionals (whilst also acknowledging the range of experiences patients can have with GPs and vice versa), the work they do, and the NHS. But I also see the GP as more like me, humans who are more expansive than their occupation.

9.3.3. Methodological Reflexivity

This section explores principal elements of my methodological reflexivity, the first being the conceptualisation of burnout. I had no experience with working closely with a debated concept, which frustrated my preference for certainty. This came through strongly in my reflexivity considering critical language awareness (Fairclough, 2013). I acknowledged my belief that language plays a role in constructing meaning and shapes a person’s experience. At the start of the PhD, I felt a need to define fully, model, and measure burnout. A turning point in my work was when my second supervisor questioned my need to have certainty around the term burnout, prompting me that there was interest and value in exploring experiences and perceptions, which led to a restructuring and different focus in my theoretical and empirical literature review and opened up my perspectives for the direction of the PhD studies. This allowed me to embrace exploring the experiences of people who self-identified as connecting with the word, rather than focussing on the diagnostic label itself, drawing from the ideas of Smith et al. (2009) and Bentall (2004) by focussing on the meaning given to, nature of the symptoms, and the experience.

My previous education and experiences informed my bias towards quantitative research methods and how I approached and framed specific topics. In addition to how I approached the concept of burnout, in its most apparent form, I felt inexperienced in the qualitative research methods and at first clung to some understanding more aligned to quantitative work. My language betrayed me as I referred to Study 1 through the proposal stage as a systematic review, later a qualitative systematic review, and finally a meta-synthesis. I reflected on my use of language through the project, and when reviewing my transcripts and observing myself as a researcher, I saw patterns in my use of language. Whilst I stayed within the confines of my topic and followed guidance on framing questions, I often found myself asking questions with a focus aligned with my training in active listening in my volunteer work. I had a bias towards asking about feelings, thoughts and clarifying meaning rather than asking for practical or background detail. In noticing this in Study 2, I was able to alter my approach within Study 4. However, although I felt confident conducting interviews, prominent in my reflective logs was my initial overwhelm at the data analysis stage, where I felt deeply connected to the phrase "drowning in a deep bowl of spaghetti" (Wagstaff et al., 2014, p. 52) when describing my experience.

Finally, through the PhD I have been exposed to different perspectives which have challenged my understanding and bias, including my connection to the biomedical model when approaching the topic of mental health and recovery (educated under the School of Medicine for my MSc), and through teaching health psychology, I gained an appreciation for positive psychology. My awareness of different perspectives is highlighted in my epistemological positioning, starting by aligning with critical realism in Study 1. I finally aligned with the epistemological perspective of social constructivism by Study 4. Whilst it may be unusual to present different epistemological perspectives of one person within one body of work; this reflects the journey of my development through the PhD. Although I have explored my development within this section, I reflect that this work has been completed with rigour, and the support of experts in the topic under investigation and qualitative research methods has supported the credibility of the work.

9.4. Strengths and Limitations

This section will discuss some of the main strengths and limitations of the studies included in this thesis. Key strengths include 1) the wide range of perspectives collected and integrated to inform the research proposals for, and the continued steering of, the research in this thesis, 2) the methodological integrity of the research and the use of novel methods to address the aims of the thesis, and 3) the robust dissemination strategies for this research. However, there are also limitations to this work that must be considered, such as 1) the small sample sizes which are not representative of the target population and therefore challenges the transferability of the research findings, and 2) the procedural challenges across the studies, including the identification of primary qualitative research for inclusion in Study 1 and the poor match rate of data in Study 3.

The first strength to be considered is the wide range of perspectives collected to inform the direction of the research included in this thesis. The literature informed PhD research proposals, and these created research proposals were honed through discussion with a range of people, including the public. Public involvement has been suggested to be an essential part of health-related research as it improves the quality and relevance of the research (Holmes et al., 2019). For public involvement, the researcher first distributed short questionnaires related to the research proposals to a range of people to explore what the public considered important. Next, the researcher hosted a small focus group to refine the research direction, including discussing ethical and practical considerations of the work. After seeking general feedback, the researcher had individual conversations with several GPs and external researchers to shape the project further. This integration of broader public perspectives to inform the research direction supplemented the guidance from the multi-disciplinary team supervising this project. The collaborative team that supervised this project had different backgrounds and specialities (health psychology, social psychology, psychotherapy, and medicine, including general practice). Collating perspectives from people with a range of backgrounds improves the quality and rigour of research (Barry et al., 1999) and helps develop a more complex and rich understanding through analysis (Lee et al., 2015). Moreover, the researcher employed strategies to improve the trustworthiness of the research, including seeking feedback on the research findings from peers, experts in the field, and participants.

Integration of broad perspectives from research proposal creation to reviewing the findings set the foundation for the second main strength of this work. This overall thesis has strong methodological integrity, in both the fidelity to the subject matter and utility in achieving the research goals (Levitt et al., 2018). When considering the fidelity to the subject matter, procedures were selected that maintained allegiance to the phenomenon under study. Novel methods were used to explore the topic, this thesis presented the first studies on this topic to use meta-synthesis methods and narrative interviews with photo-elicitation. The use of multiple approaches in parallel studies enabled an exploration of the breadth and depth of the experiences of GP poor occupational wellbeing and mental health.

Methods were selected to address the specific research aims, including when this necessitated the researcher to address their gaps in research method knowledge, which allowed for new and nuanced insight into the phenomenon. Study 4 particularly highlights how the research methods selected enabled new insights, as using a narrative approach provided the opportunity to access storytellers' assumptions and interpretations (Joyce, 2017), including allowing insight into how the participant constructed themselves and others (Bamberg & Georgakopoulou, 2008; Bamberg, 1997).

The third key strength of this work is the robust dissemination strategies employed in addition to traditional academic dissemination strategies (papers for all studies in this thesis are in preparation). Researchers are responsible for distributing their findings widely (Langat et al., 2011), yet this is often neglected in research. Dissemination was highlighted as an essential consideration as the findings from Study 1 indicated some GPs felt silenced. Therefore, Studies 2, 3, and 4 had additional dissemination strategies integrated into their research proposals. For Studies 2 and 4, the art supported the plans for dissemination. Artist interpretations of the findings enabled the creation of an art-based booklet for Study 2. The use of photographs in Study 4 allowed further insight into the participants' lifeworld in an unobtrusive way, enabling the private experiences to become a shared comprehension (Radley, 2002). Art has been suggested to help research findings be more accessible to those outside the research (Kantrowitz-Gordon & Vandermause, 2016). The art-based booklet has been disseminated widely online, including through NHS organisation newsletters and social media, and on ResearchGate alone, the art-based booklet has been viewed 260 times. The booklet has been well received by GPs and members of the public, and the dissemination is planned to continue with a physical exhibition of the art from Study 2 and the photographs from Study 4 at the University of Westminster. Studies 2, 3, and 4 have also been presented outside academic conferences to wider audiences, such as at a PHS monthly national multi-disciplinary meeting in August 2021 which was recorded and disseminated widely.

Although the research in this thesis has been completed with rigour and used novel methods which enabled original contribution to knowledge, there are limitations to this research that should be considered. Firstly, Studies 2, 3, and 4 had small sample sizes, reducing the transferability of the research findings and the value of inferences and recommendations for future research and practice (Murad et al., 2018). Recruitment of GPs for Studies 2 and 4 was challenging. Challenges recruiting medical professionals has been documented in previous studies (McKay-Brown et al., 2007; Williamson et al., 2007), with Brodaty et al. (2013) finding the burden of time was the main barrier for participation. Furthermore, Henderson et al. (2012) report on the reluctance of healthcare professionals to participate in research due to concern over confidentiality and anonymity and, Spiers et al. (2017) that many GPs, although interested in their qualitative research, did not choose to engage with the project after receiving the information sheet.

The challenge of the burden of time was apparent for the GPs in the current studies, particularly in Study 2. For Studies 2 and 4, there were numerous interested potential participants. However, it was typical for potential participants to disengage when arranging interview appointments, repeatedly reschedule interview appointments, and cancel on the interview day. Nevertheless, the methods selected in Study 2 and 4 lent themselves to smaller samples. Study 2 aimed to explore experiences in-depth with IPA involving meticulous engagement with rich data from a small number of participants (Wagstaff et al., 2014). Additionally, the labour-intensive nature of line by line narrative analysis used in Study 4 necessitated a limited number of participants to enable the researcher to get close to the data (Eisikovits et al., 1998; Fraser, 2004). Moreover, generalisation was not the aim of these studies but rather the presentation of detailed accounts where experiences were given primacy (Holloway & Todres, 2003) and allowed the opportunity for new narratives to be captured.

The small sample in Study 3 links to the second limitation, the procedural challenges across the studies. The poor match rate was the main limitation of this study.

Only 18% of participants who completed the initial assessment also completed the six-month assessment, and only 4% of those who completed the initial assessment completed all three assessments. The low participant numbers created an unrepresentative sample which challenged generalising the results and drawing conclusions. As outlined in section 6.8, there were multiple possible explanations for the low match rate in this study. However, this research still allowed for practical recommendations for the PHS, discussed in the next section.

Procedural challenges were also experienced for Study 1. For meta-synthesis, difficulties in identifying qualitative literature have been previously detailed (Barroso et al., 2003; Shaw et al., 2004; Thorne, 2017), which informed the use of the broad-based search strategy (Shaw et al., 2004) and additional searches in grey literature to maximise the chances of identifying relevant papers. However, the broadness of the search terms led to excessive returns in the database searches, with the majority being irrelevant. Specifically, due to the combination of terms, searches captured qualitative research related to patient wellbeing, where GPs had been mentioned in the paper. Furthermore, the search terms were limited related to experience and country of study. The searches focussed on locating research reporting mental wellbeing broadly rather than focussing on specific experiences (except burnout) and included terms that were more likely to return research related to GPs in certain parts of the world (mainly the UK) rather than being fully representative of the terminology around family doctors working internationally. Therefore, this synthesis may not include all available qualitative papers exploring GP poor occupational wellbeing. However, thematic saturation was reached, and the suggested maximum number of studies to enable adequate depth of thematic saturation was included.

9.5. Implications for Practice and Directions for Future Research

There are five main implications for practice and directions for future research from the four studies completed in this thesis: 1) future research is needed to investigate how to improve timely help-seeking; 2) practical recommendations have been made to improve the collection of outcomes data in the PHS; 3) further research is needed to explore the usefulness of disseminating GPs narratives of burnout and overcoming burnout and the value of using these stories in interventions; 4) further research is needed to investigate how best to meet the social needs of GPs as well as recommendations for the creation of social spaces for GPs with protected time for socialisation; and 5) recommendations for prioritisation of time and space away from work in burnout and recovery, with further research needed to explore the value of open and natural spaces in the recovery journey.

First, Study 1 highlighted a stigma towards mental health problems within primary care internationally and indicated experiences of insufficient support for GPs when they returned to work after a period of sick leave. It appears that the social, cultural, and psychological factors undermined GP help-seeking in a timely way. Studies 2, 3, and 4 showed examples of GPs reaching rock bottom before asking for help, experiencing poor wellbeing and mental health at the point of accessing support. It was also suggested that there is insufficient awareness of the support available and a lack of knowledge and communication around experiences of mental health problems (particularly burnout) and positive experiences of help-seeking. This suggests a need for open conversations about the realities and vulnerabilities of being a GP within the NHS and wider context. Future research is needed to explore how to improve communication around burnout experiences, take steps to dismantle the stigma of mental ill-health, and improve awareness of the benefits of timely help-seeking. There is opportunity for this throughout a GPs' career but incorporating a greater focus on wellbeing in medical school could be a supportive point of intervention as a start to dismantling stigma. Moreover, it is important to combine the findings from the current studies with the broader spectrum of GP experiences reported on. Integrating research that explores GP poor well-being with research into how GPs thrive (Murray et al., 2017; Stevenson et al., 2011; Zwack & Schweitzer, 2013) will lead to a holistic picture of GP experiences and highlight how to support the development of primary care that will better meet GPs needs and contribute to a more sustainable occupation. Further research is needed into how best to achieve this without taking a one size fits all approach and how to shift the responsibility of supporting employee wellbeing away from only the shoulders of the GP.

Second, further research is needed to explore the usefulness of the PHS to support GPs experiencing burnout, considering the modifiable factors to improve the match rate in evaluative studies, such as increasing the length of the research period. Additional practical recommendations for the PHS include using a single non-personal identifier across systems for patients and implementing a process for following-up participants who have not completed an assessment. Furthermore, it is recommended that longitudinal data be collected from those discharged before a year with the service to explore if these statistically significant improvements persist over time. The researcher had the opportunity to communicate these practical recommendations to the service, which has led to changes already being implemented.

Third, further research is needed to explore the value of disseminating the range of burnout accounts and exploring the usefulness of interventions based on sharing stories that could help GPs better identify with potential experiences of burnout but also reframe their narratives. The first steps towards this were investigated within this thesis. The value of GPs sharing their stories became apparent in Studies 1, 2, and 4, with participants discussing the usefulness of having their experiences validated and normalised. Moreover, participants in Studies 2 and 4 commented on the value of sharing their stories within the interview but also questioned whether their accounts were typical. The dissemination of stories may be supportive in GPs recognising, naming, and seeking help for their experiences before they reach crisis point. The lived experiences of burnout and the narratives of burnout recovery highlighted it may be useful for GPs to identify and seek help when beginning to feel stressed and overwhelmed, feel like they are functioning increasingly in autopilot or survival mode, and when feeling isolated within that experience. Therefore, the dissemination strategies of research exploring GP burnout should be evaluated for impact and usefulness. Moreover, related to this, Nurser et al. (2018) suggest that there may be value in people telling their stories in the process of recovery, and there could be promising benefits with integrating storytelling into interventions, as making sense and self-authoring a narrative can help people move forward in recovery (Scottish Recovery Network, 2012). Potential interventions could also be informed by this research and the highlighted value of sharing stories. It may be helpful to explore the use of narrative tools to help GPs shape their experiences. By framing the experience through a redemption narrative and focussing on growth, this may be protective when an individual faces new challenges (Adler et al., 2015).

Fourth, further investigating the usefulness of focussing on the social needs of individuals in the medical profession, such as encouraging time for social interactions with colleagues in general practices and creating support groups for medical professionals who self-identify as starting to overcome or having overcome burnout. The importance of belonging and social interaction was highlighted particularly strongly within Study 4. Future research should explore if continued conversations can help participants integrate new perspectives, explore and deal with, or have greater insight into their experiences, as Ross (2011) suggested. This links to the foundation of understanding of burnout as outlined by Maslach (2003), who states that burnout is an issue of the social environment within their occupation, rather than that of the individual, which is often related to the neglect of the human side of work and the disparity between the nature of the persona and the nature of the job, increasing the risk of burnout. Through using support groups to aid with continued learning and to keep GPs well, this may also help GPs access more of the human and social side of their work. Moreover, this thesis took the first steps to identify burnout and burnout recovery as inherently social and argued the value of exploring burnout experiences from the relational perspective. Future research is needed to continue this work to better understand burnout and burnout recovery through the relational perspective.

Fifth, there were also encouraging findings in Study 2 and 4 relating to the value of spending time away from work when experiencing burnout. The narratives and photovoice in Study 4 emphasised the potential value of open and green spaces to support recovery from burnout. Promising early findings for interventions that use open green spaces for GPs has been found (Sebah, 2019). This current research in this thesis recommends further research into the effectiveness of such activities as preventions and intervention. As an intervention, the research in this thesis suggests there may be optimal points in the recovery journey to implement such interventions. Accessing open space may have immediate benefits, but incorporating open spaces with group activities or recovery activities such as mindfulness may be best implemented when GPs have begun to integrate wider perspectives during the recovery process. However, further research is needed in studies with larger samples.

9.6. Conclusion

This thesis sought to explore the experiences of GPs suffering from poor occupational mental health and wellbeing within the current healthcare context of increasing pressures and turbulence within the NHS. Despite the increasing frequency with which GP burnout is reported, the definitions, models, and even the uniqueness of ‘burnout’ is contested, with the concept of burnout recently being described as an enigma because of the lack of a consensus regarding its definition within the literature. Therefore, in the current work, attention was focused on gaining a deeper understanding of the experiences of UK-based GPs who self-identified as having faced burnout and GPs who had accessed support and self-identified as having overcome burnout. To advance understanding of burnout, the current research focused on the meaning-making of GPs, using a combination of methods including those novel in their application to burnout which contributed to the originality of this work. Consequently, this allowed a greater understanding of the context, experiences, and perceptions around GP burnout, and provided insight into the impact of organisational, political, and societal changes within general practice.

Overall, the research in this thesis suggests that GPs’ experiences are complex and nuanced, and that experiences of burnout are relational. This thesis provides a first step in understanding accounts of those GPs who identified with having overcome burnout, adding to the literature the potential of strength through adversity and the importance of the social factors in the workplace, in burnout, and through recovery. Nevertheless, future research is needed to focus on the social dimensions of general practice and how this could be useful in preventing burnout and be implemented to support GP recovery from burnout. This focus could be beneficial for the organisation, with the potential of increased role sustainability by supporting GPs to continue to work whilst remaining mentally well.

The understanding gained through this research has practical implications and creates the foundations for a greater focus on the unheard narratives of GP burnout and recovery. This work is particularly timely and vital given the additional challenges that the COVID-19 pandemic has posed to GPs. However, the literature suggests that this also provides the opportunity to build on the good that the NHS is already doing, by tackling the prevailing problems in primary care emphasised in this thesis, such as the negative medical culture and the lack of a support structure offering channels of open communication. A key practical implication of this research is the need to focus more on prioritising the wellbeing of GPs, which will necessitate dismantling the stigma around mental ill-health among medical professionals and providing for GPs’ basic human needs by improving feelings of belonging and value.

Appendix A:

Meta-Synthesis Search Strategy

Table A1

Search Term Combinations

No.	Search
1	General Practitioner* OR GP* OR Doctor* OR Physician* AND Burnout AND Qualitat*
2	General Practitioner* OR GP* OR Doctor* OR Physician* AND Burnout AND Interview* OR Focus Group*
3	General Practitioner* OR GP* OR Doctor* OR Physician* AND Burnout AND Grounded Theory OR Thematic Analysis OR Content Analysis OR IPA OR Interpretive Phenomenological Analysis OR Observation OR Ethnography OR Narrative Approach OR Discursive Approach
4	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Exhaustion OR Depersonalisation OR Personal Accomplishment AND Qualitat*
5	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Exhaustion OR Depersonalisation OR Personal Accomplishment AND Interview* OR Focus Group*
6	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Exhaustion OR Depersonalisation OR Personal Accomplishment AND Grounded Theory OR Thematic Analysis OR Content Analysis OR IPA OR Interpretive Phenomenological Analysis OR Observation OR Ethnography OR Narrative Approach OR Discursive Approach
7	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Fatigue OR Professional Efficacy AND Qualitat*
8	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Fatigue OR Professional Efficacy AND Interview* OR Focus Group*
9	General Practitioner* OR GP* OR Doctor* OR Physician* AND Emotional Fatigue OR Professional Efficacy AND Grounded Theory OR Thematic Analysis OR Content Analysis OR IPA OR Interpretive Phenomenological Analysis OR Observation OR Ethnography OR Narrative Approach OR Discursive Approach
10	General Practitioner* OR GP* OR Doctor* OR Physician* AND Wellbeing OR Well-being OR Distress OR Mental illness OR Mental Health AND Qualitat*
11	General Practitioner* OR GP* OR Doctor* OR Physician* AND Wellbeing OR Well-being OR Distress OR Mental illness OR Mental Health AND Interview* OR Focus Group*
12	General Practitioner* OR GP* OR Doctor* OR Physician* AND Wellbeing OR Well-being OR Distress OR Mental illness OR Mental Health AND Grounded Theory OR Thematic Analysis OR Content Analysis OR IPA OR Interpretive Phenomenological Analysis OR Observation OR Ethnography OR Narrative Approach OR Discursive Approach

Table A2

Search Results

No.	PsychInfo	BJGP	Pubmed	Science Direct
1	71	14	206	90
2	104	89	238	102
3	42	61	107	103
4	10	10	21	15
5	26	50	27	31
6	15	40	6	34
7	7	17	0	1
8	22	96	3	3
9	6	90	0	5
10	780	62	1510	4858
11	2119	393	777	9606
12	584	251	3160	7262
Total	**3786**	**1173**	**6055**	**22110**

The PsychInfo search was completed on 22nd June 2020, the BJGP search was completed on 19th and 20th June 2020, the Pubmed search was completed on 17th and 19th June 2020, and the Science Direct search completed on 23rd and 24th June 2020.

Appendix B:

Meta-Synthesis Quality Appraisal

A modified version of the Quality Framework (Spencer et al., 2004) was used in the appraisal of quality of studies included in the meta-synthesis. The 17 questions as outlined in (MacEachen et al., 2006) were used, shown in Table A3.

Table A3

Quality Framework Questions

No.	Criteria question
1	How credible are the findings?
2	How has knowledge/understanding been extended by the research?
3	How well does the study address its original aims and purpose?
4	Scope for drawing wider inference – how well is this explained?
5	How defensible is the research design?
6	How well defended is the sample design/target selection of cases/documents?
7	Sample composition/case inclusion – how well is the eventual coverage described?
8	How well was the data collection carried out?
9	How well has the approach to, and formulation of, the analysis been conveyed?
10	Contexts of data sources– how well are they retained and portrayed?
11	How well has diversity of perspective and content been explored?
12	How well has detail, depth, and complexity (i.e., richness) of the data been conveyed?
13	How clear are the links between data, interpretation, and conclusions – i.e., how well can the route to any conclusions be seen?
14	How clear and coherent is the reporting?
15	How clear are the assumptions/theoretical perspectives/values that have shaped the form and output of the study?
16	What evidence is there of attention to ethical issues?
17	How adequately has the research process been documented?

Table A4

Quality Appraisal Scores - Per Question, Per Study

	Question number																
Paper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Agana et al. (2017)	VH	M	VH	M	L	L	L	M	H	L	L	M	M	VH	L	L	L
Agarwal et al. (2020)	VH	VH	VH	VH	H	VH	H	VH	VH	M	M	H	H	VH	M	M	H
Cheshire et al. (2017b)	VH	VH	VH	H	VH	VH	VH	H	VH	H	H	H	VH	VH	H	M	VH
Croxson et al. (2017)	VH	VH	VH	VH	M	M	VH	VH	L	VH	VH	H	H	VH	L	M	M
Dale et al. (2015)	VH	VH	VH	VH	M	M	VH	L	H	H	M	M	H	M	H	L	L
Dillon et al. (2019)	VH	VH	VH	VH	H	M	H	VH	VH	H	M	H	M	VH	L	M	H
Doran et al. (2016)	VH	VH	VH	M	M	M	L	L	VH	H	M	M	VH	VH	L	M	M
Evans (2018)	VH	VH	VH	VH	VH	VH	VH	VH	H	H	H	VH	VH	VH	VH	VH	VH
Fältholm (2007)	VH	VH	VH	VH	VH	VH	VH	VH	VH	L	VH	VH	VH	VH	VH	H	H
Huby et al. (2002)	VH	VH	VH	VH	L	L	M	L	L	L	M	H	H	H	L	L	L
Petchey (1994)	H	VH	H	VH	M	M	L	M	M	L	VH	VH	VH	VH	M	L	L
Riley et al. (2018a)	VH	H	H	H	M	VH	VH	VH	VH	H	M	H	H	H	VH	M	H

	Question number																
Paper	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Riley et al. (2018b)	VH	VH	VH	VH	M	H	VH	VH	VH	H	M	M	VH	VH	VH	M	VH
Spiers et al. (2017)	VH	VH	VH	VH	VH	H	VH	M	VH	M	VH	H	VH	VH	M	L	H
Spiers et al. (2018)	VH	VH	VH	VH	VH	VH	H	L	VH	H	VH	VH	VH	VH	VH	M	M
Spinelli et al. (2016)	VH	VH	VH	VH	VH	H	H	H	VH	H	M	H	H	VH	H	M	H
Strazdins et al. (2019)	VH	VH	VH	VH	VH	VH	H	H	M	H	VH	H	VH	VH	M	M	H
Svedahl et al. (2019)	VH	VH	VH	VH	M	VH	VH	VH	VH	VH	H	VH	VH	VH	VH	H	VH

The quality of included papers was peer reviewed by AE. Reviewers (AE and PS) were in agreement with 98% of scores (overall total quality allocation matched 100% without discussion). Where there was disagreement on the individual items, these were discussed and agreement reached.

Appendix C:

Meta-Synthesis Theme Development

Figure A1

Flow Diagram Showing the Theme Development Mapped onto Analysis Steps

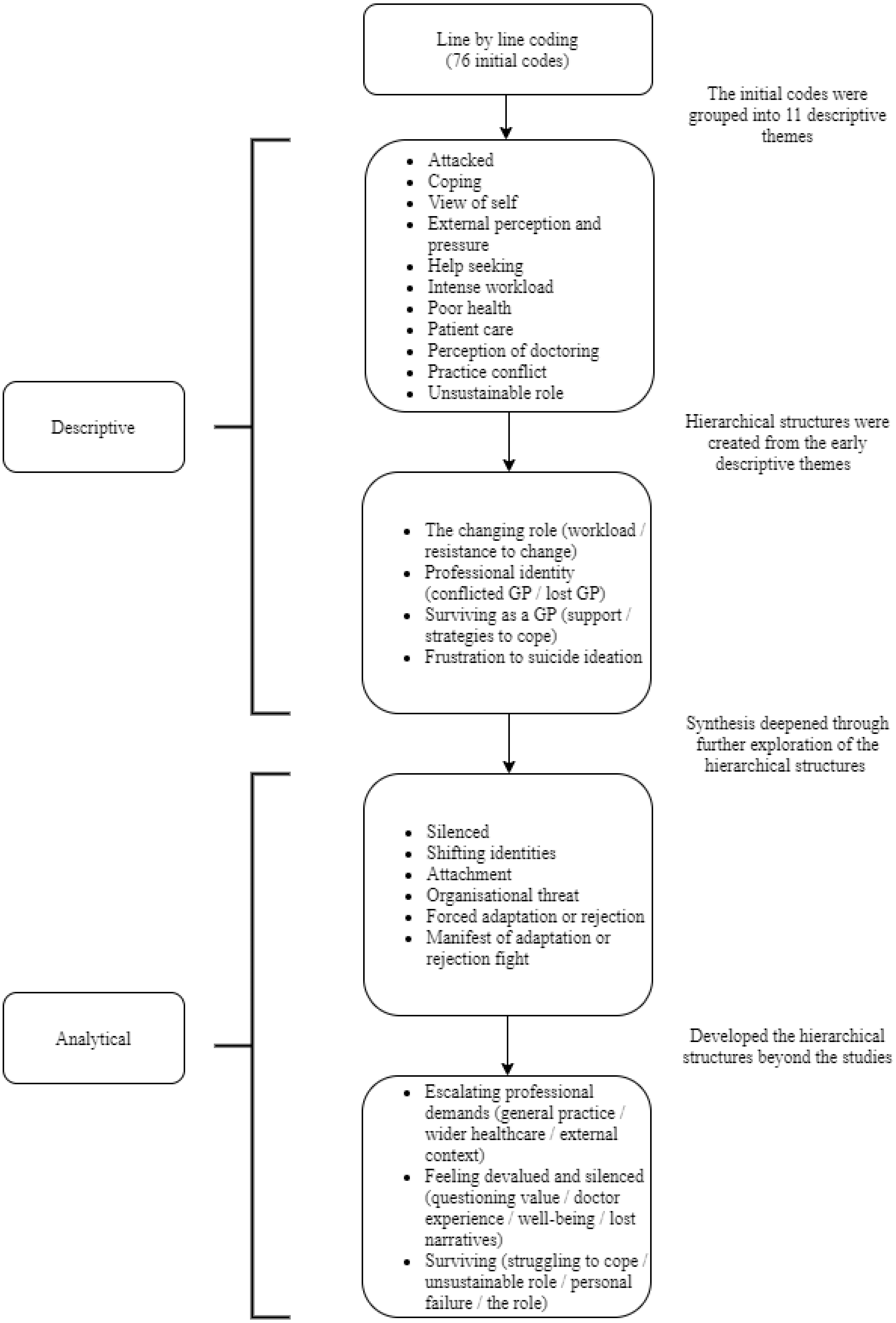
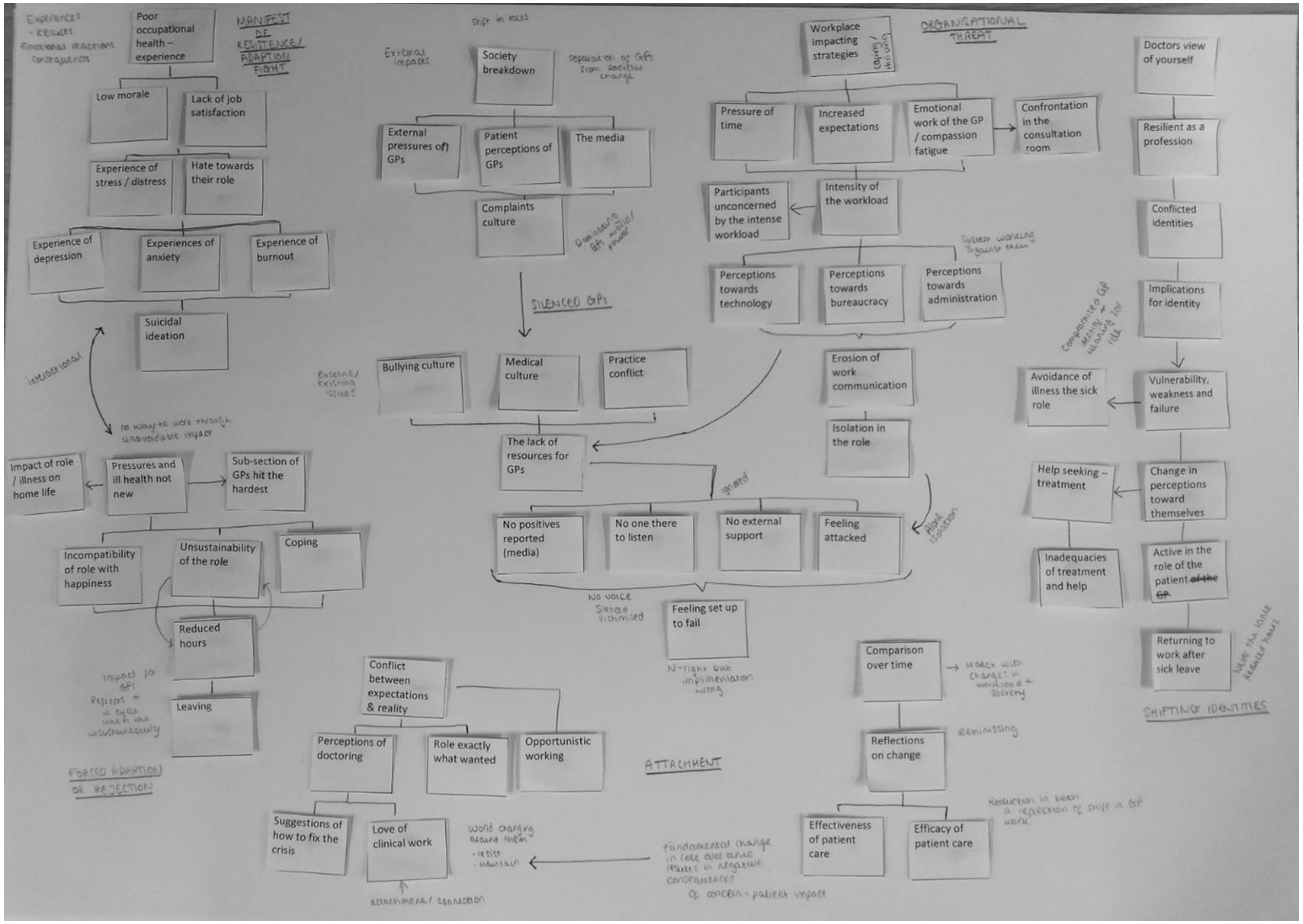


Figure A2

Example of the Hierarchical Structures Development Stage



Appendix D:

Meta-Synthesis Excluded Studies with Rationale

Table A5

Excluded Studies with Rationale

Ref	Exclude	Ref	Exclude	Ref	Exclude
Adám (2009)	2	Branson & Armstrong (2004)	1	Czachowski & Pawlikowska (2011)	1
Ahmad et al. (2006)	1	Brooks et al. (2017)	4	Derksen et al. (2018)	1
Ahmed et al. (2020)	7	Cain et al. (2017)	3	Dowell et al. (2000)	6
Anandarajah & Roseman (2014)	1	Cameron et al. (2010)	3	Eley et al. (2018)	1
Arman et al. (2011)	3	Carr et al. (2003)	2	Feliciano et al. (2011)	3
Austin (2018)	1	Cebrià et al. (2001)	6	Fairhurst & May (2006)	1
Ayalon et al. (2016)	1	Cervero-Liceras et al. (2015)	3	Firth-Cozens & Greenhalgh (1997)	3
Berlanda et al. (2018)	6	Cezar-Vaz et al. (2009)	3	Fisher et al. (2017)	1
Bianchi et al. (2016)	3	Chipp et al. (2011)	3	George et al. (2014)	3
Bouza et al. (2020)	1	Clemen et al. (2018)	3	Giebner (2016)	3
Foggin et al. (2016)	1	Bower et al. (2011)	1	Glasberg et al. (2007)	2
Forsythe et al. (1999)	2	Clough et al. (2019)	3	Götze et al. (2013)	6

Ref	Exclude	Ref	Exclude	Ref	Exclude
Gregory et al. (2017)	6	Khandaker et al. (2009)	3	Miedema et al. (2012)	1
Gronseth et al. (2020)	1	Krakowski (1984)	3	Napier (2017)	6
Hall et al. (2017)	1	Lacy & Chan (2018)	3	Norz (2018)	3
Halley et al. (2018)	3	Lemaire & Wallace (2010)	3	O’Dowd et al. (2018)	3
Harris et al. (2020)	1	Linde et al. (2020)	3	Otte et al. (2017)	1
Henderson et al. (2012)	7	Lindås et al. (1991)	7	Parker et al. (2019)	E
Henke et al. (2008)	1	Loeb et al. (2012)	1	Pedrazza et al. (2016)	2
Heras-Mosteiro et al. (2016)	1	Loeb et al. (2016)	1	Peisah et al. (2009)	6
Hockly & Caan (2012)	6	Lovell et al. (2009)	3	Pink et al. (2007)	2
Høifødt & Talseth (2006)	3	MacLeod (2001)	3	Putnik et al. (2011)	3
Hunter et al. (2013)	3	Makin et al. (1988)	3	Rees et al. (2019)	3
Iacovides et al. (2003)	6	Matheson et al. (2016)	3	Rinaldi et al. (2016)	3
Ingstad & Christie (2001)	1	May & Plews-Ogan (2012)	3	Romera et al. (2010)	3
Jaffe et al. (n.d.)	7	Mckevitt & Morgan (1997)	1	Rout (1996)	3
Jego et al. (2018)	1	Meldrum (2010)	3	Saini et al. (2016)	1
Jensen et al. (2013)	1	Miedema et al. (2009)	1	Schenk & Bui (2018)	3

Ref	Exclude	Ref	Exclude	Ref	Exclude
Schultz et al. (2012)	3	Stevenson et al. (2011)	1	Wallace & Lemaire (2007)	3
Schrijver et al. (2016)	3	Stewart (2019)	3	Whitehead (2014)	3
Selamu et al. (2017)	3	Stewart et al. (2000)	6	Wallace & Lemaire (2009)	3
Short et al. (2004)	1	Stone et al. (2019)	3	Weiner et al. (2001)	1
Simpson & Grant (1991)	6	Taubert & Nelson (2011)	3	Wojtyna & Stawiarska (2009)	2
Smith et al. (2016)	7	Tavazza (2007)	5	Wynn et al. (2018)	3
Sowińska & Sokół (2019)	1	Tavella & Parker (2020)	3	Zwack & Schweitzer (2013)	3
Spiers & Riley (2019)	1	Uygur (2012)	1		
Stanton & Randal (2016)	3	Uygur et al. (2019)	1		

Key

1. Not match topic
2. Not primary qualitative research
3. Not primary care GPs
4. Disorder
5. Is an evaluation of an intervention
6. Insufficient primary data presented
7. Requested info / paper not found

Appendix E:

Quote Table for the Meta-Synthesis

Table A6

Escalating Professional Demands

Sub-theme	Quotes
General practice	"I think the main thing on time is the technology; advances that have been made…EMR has been an absolute time killer." (Agana et al., 2017) "A few participants felt burdened by seemingly punitive rules, including time requirements for finishing notes, and by linkage between salaries and population health metrics. One remarked, 'You are being punished for something that is completely out of your control'." (Agarwal et al., 2020) 'It's not just that you're working long hours. The thing which *[sic]* massively changed is the intensity of when I'm here." (Croxson et al., 2017) "More and more now though I feel as if getting the information onto the computer is more important to listening to the patient." (Dale et al., 2015) "You're losing the revenue we can make for the organization by derailing us doing these [in-basket] messages. There are not enough hours in the day." (Dillon et al., 2019) "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." (Doran et al., 2016) "Over the years, during my time at the practice, as a GP supervisor, you do see how stressful it can certainly be to some GPs. Especially to young GPs who come in and are not kind of used to it." (Evans, 2018) "General practice was always the place for characters and individuals. The spirit is being squeezed out of us by bureaucrats." (Petchey, 1994) "Everything was running around in my mind at 200 miles an hour. I was in sort of hyper drive." (Riley et al., 2018b) "I can't keep up. I can't keep up with all the things I need to know to be efficient on the computer." (Spinelli et al., 2016)

Sub-theme	Quotes
The wider healthcare system	“Negative comments surrounding resources included needing more resources, like staff, to help with increasing work demands. Additionally, physicians felt they were not compensated enough for their work.” (Agana et al., 2017) “Others described how patients who were unable to contact other departments would “turn to [the PCP] for their last chance to get things done.” (Agarwal et al., 2020) “The pendulum has swung so far on patient satisfaction and patient expectation that no one has thought about the repercussions on [PCPs] and their ability to handle what is expected of them.” (Agarwal et al., 2020) “Participants’ comments emphasised the importance of the NHS, government and representative professional bodies adopting a more ‘realistic’ approach.” (Dale et al., 2015) “I loved leadership, but it was a second or third job. And the support for leaders is not what it could be in terms of just resourcing support and stipends.” (Dillon et al., 2019) “There is a really aggressive, vicious, bullying culture that permeates management in the NHS. That then flows all the way down to whoever your locality middle managers are.’" (Doran et al., 2016) “If you just look at it on the surface a GP sees all these multitudes of different services, all vying for amounts of government and non-government money, how do they know where to go? How do they choose between these different services?” (Evans, 2018) “Neither politicians nor management was familiar with the conditions “in the field”, which created a distance between those that take decisions and those that implement the decisions taken.” (Fältholm, 2007) “They [participants] referred frequently to the inadequacy of medical education or vocational training.” (Petchey, 1994) “Perceived impact of the work environment reflecting the organizational environment in which providers work.” (Spinelli et al., 2016) “While GPs supported this approach [comprehensive, holistic and preventative], they also explained that it could not be realistically achieved in one consultation.” (Strazdins et al., 2019) “A consequence of a more fragmented and subspecialised secondary care, focusing on shortening hospital stays, and it contributed to a feeling of impaired autonomy. Some GPs stated that they sometimes felt like they were working in ‘both primary and tertiary care’.” (Svedahl et al., 2019)

Sub-theme	Quotes
External context	"I am more concerned about patient satisfaction when people get on the internet because I personally am more inclined to voice a complaint than if I am completely satisfied with a product to get on and rave about it." (Agana et al., 2017) "Because of the breakdown in society, I think because, you know, people don't know their neighbours or their family and there's no wise person down the road that they can go to if their baby vomits, I feel like GPs are in a sense propping up society. We are just, we're taking that role of the wise old granny down the road." (Croxson et al., 2017) "Significant technological and social developments have resulted in a fast-paced information driven society where individuals expect instant service with little regard for how this need might be inconvenient others. General practice is not immune to this development." (Evans, 2018) "According to the interviewees patients often had unrealistic expectations about appointment scheduling and the ability for GPs to address multiple issues within short appointment times." (Evans, 2018) "Demands were felt to be limitless: 'We are often abused by patients as a free, open-all-hours service'." (Petchey, 1994) "I would like patients to be more responsible (less selfish) in the way they use me … I don't want gratitude: I want respect." (Petchey, 1994) "A serious complaint is a failure, isn't it? You've done something badly wrong probably, or someone thinks you've done something badly wrong." (Riley et al., 2018a) "[Participant] was threatened in her room by a patient, resulting in the police being called." (Spiers et al., 2018) "They come back and complain, and it really burns me out. I'm doing the right thing. If I did the wrong thing they would be happy and life would go on and be beautiful, but I am actually choosing the right care, and they are not appreciating it." (Spinelli et al., 2016) "That's a huge pressure, always keeping things moving and just the pressure. People so rarely come in with one problem and some days I just find that absolutely exhausting. Everybody has at least three problems and want you to get it all done in 15 minutes." (Strazdins et al., 2019) "People see their GP much more often nowadays. (…) Now you see the doctor at once – if you've been feeling ill for a few days (…) If a child gets a rash, then the parents go straight to the doctor to check it out. They didn't do that before. Now they demand an answer – 'What is this?" (Svedahl et al., 2019)

Table A7

Feeling Devalues and Silenced

Sub-theme	Quotes
Questioning their value	“Voiced a desire to be ‘allowed to judge what is important to [the patient]’ rather than ‘checking boxes and making sure I’m ordering every test that is required even though it may not be clinically correct for the patient’.” (Agarwal et al., 2020)
	"I felt unsafe in my practice because my head was too full and there was too much going on and I didn’t feel I was able to think clearly, rationally." (Cheshire et al., 2017b)
	“Organizational centralization and standardization efforts reduced physician autonomy and contributed to feelings of disempowerment and burnout.” (Dillon et al., 2019)
	“The interviewee experienced a growing disrespect for medical professionals illustrated through poor patient-doctor relations: ‘… I have had people walk out of consultations. I have had people throw the prescription back at the receptionist to show their contempt to what I had in all honesty given them’.” (Evans, 2018)
	“Doing tasks we see as useless, like, one we all wish we could be rid of is the over 75 annual health checks.” (Huby et al., 2002)
	“I would like patients to be more responsible (less selfish) in the way they use me… I don't want gratitude: I want respect.” (Petchey, 1994)
	“Oh bloody hell, I’m doing the job. Can’t you see I’m doing it alright? Why do I have to prove I’m doing it alright?” (Riley et al., 2018a)
	“I’d lost my empathy with my patients. You know, and er I’m just—I was just—you’re just like a ketchup bottle in a production line […]”(Riley et al., 2018b)
	“I started getting this general feeling of shame as I was speaking to patients or I was trying to sort things out that, ‘What I’m saying has no value’.” (Spiers et al., 2018)
	“Part of it is that our professionalism ought to help us do things above and beyond what we get directly paid for. Yet when we start feeling pressured by this rule and that rule, this task and that task, it starts to feel overwhelming and then the professionalism loses some of its impetus.” (Spinelli et al., 2016)

Sub-theme	Quotes
Doctors' experiences of wellbeing	"I have seen there is a lack of training for physicians to actually handle some of the things [psychological burdens] that have been discussed." (Agana et al., 2017) "It's demoralizing when you never have a sensation that your job is actually completed for the day." (Agarwal et al., 2020) "Then there's the stress, we're talking about stressors, the stress of not knowing that you're not going to get home for bed time with the kids or to have a bit of a row with the other half because you've been late leaving yet again." (Cheshire et al., 2017b) "We need to have time when we get home that we don't feel completely shattered and too tired to go and do some exercise, and stuff like that, and keep ourselves fit." (Croxson et al., 2017) "There are several Drs I know that are burning out, including a colleague who is on long-term sick leave now for this. This is a wonderful experienced GP who we are now likely to lose forever because they feel they cannot take the pressure anymore" (Dale et al., 2015) "Might lead to my burnout because who wants to be spreading bad news to people all the time? I mean, I know there's good news, but a lot of things unfortunately are 'Do more, do more on the hamster wheel." (Dillon et al., 2019) "It's just not much fun to be a doctor anymore. It is simple … if you don't get satisfaction from your work you will become resentful and depressed… All human beings enjoy being treated respectfully and lovingly and hate being stood over and oppressed." (Evans, 2018) "Over the years as a GP I have felt increasingly threatened and potentially overwhelmed." (Petchey, 1994) "I basically felt like I was treading water but drowning slowly." (Riley et al., 2018b) "I mean there were times certainly when I arrived at work and just sat outside and cried before I even went in the building. And I often cried on the way home. I'd often cry when I came in from work, um just collapse in a heap, and get to bed actually crying." (Riley et al., 2018b) "Several GPs explained that high levels of exhaustion resulted in poorer care for patients, and this was therefore unacceptable." (Strazdins et al., 2019) "The GPs described that the workload had consequences for their own health and well-being. At work, they often skipped coffee breaks, shortened their lunch break, and postponed toilet visits. At home, some said that they felt exhausted, easily irritated and stressed, and did not find time to exercise. Two of the younger female GPs worried about being burned out, and not being able to continue working as a GP in the future." (Svedahl et al., 2019) "You get so tired, because you're half an hour late all the time. It's like a 'rat race' really." (Svedahl et al., 2019)

Sub-theme	Quotes
Lost narratives	“Everyone else is defining us.” (Agarwal et al., 2020) “PCPs emphasized solutions based on their particular relevance to primary care; for example, promoting PCPs’ voice and recalibrating expectations to address the responsibility authority mismatch.” (Agarwal et al., 2020) "Negative portrayal of the profession in the press I think, is a strong demotivator. It actually impacts quite significantly on the doctor–patient relationship as well … When they walk into the consulting room, that wariness is very, very difficult to overcome, to gain a rapport.” (Cheshire et al., 2017b) “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.” (Croxson et al., 2017) “Physicians described an absence of recognition of the positive aspects of their work that led them to feel de-valued, and that being valued required more than a pat on the back.” (Dillon et al., 2019) “Felt frustrated that the more positive aspects of their hard work and professionalism went largely unreported: "‘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.” (Doran et al., 2016) “People fail to tell doctors that what they are doing is of value.” (Evans, 2018) “You will be surprised to hear that things have changed dramatically for the better. We are all much happier. We did our own facilitation and practised some very transparent, honest and truthful communication and changed things. It was well worth doing and we have achieved a win-win solution.” (Huby et al., 2002) “Somehow the successful adaptors to the new system are unheard” (Petchey, 1994) “Colleagues’ willingness to talk about vulnerability and illness and having open channels of communication within the practice.” (Riley et al., 2018a) “There is a sort of an unwritten rule that you don’t admit to mental illness in any way in general practice, I think. Even though everybody knows that everybody has it, it’s just not talked about.” (Spiers et al., 2017)

Table A8

Surviving

Sub-theme	Quotes
Striving to cope in the role	“We’re friends… I think we vent if we are frustrated about things.” (Agana et al., 2017) "Sometimes you just stay late or you come in another day and you do your extra work. I find actually I’d rather do that than cope with that feeling of being overwhelmed really.” (Cheshire et al., 2017b) “The importance of a good team was frequently cited as a positive influence on workload and job satisfaction.” (Croxson et al., 2017) “Collegial support is vital … you might be just down the corridor and say, ‘Oh my God, I need a debrief. I just had the most terrible consultation’. You can debrief with a lot of colleagues … collegial support is very important.” (Evans, 2018) “I am very good on boundaries, so I pretty much only have my professional hat on when I’m professionally working and try to keep the friends’ stuff separate.” (Evans, 2018) “I can't sit here and say that I'm sick ….We've got to help each other. If not, somebody else will get sick.” (Fältholm, 2007) “I think the forum we have for the meeting on a Tuesday lunchtime, everybody does meet together and every so often we have all the staff in as well, which does allow people to air their gripes and glooms.” (Huby et al., 2002) “The ones that are left of us at the moment are being very supportive of each other and making sure that we’re not getting too bogged down with work each and that we are OK.” (Riley et al., 2018a) “But if for one or two of those days you’re not doing just GP-ing, it’s a break.” (Spiers et al., 2017) “I suppose with work shortages, number shortages, that’s where the issue gets hard because then we always have the pressure to do more if there’re a few more hours to do it in… I wish there was more of us because I feel pressured to take people on when I really don’t have time.” (Strazdins et al., 2019)

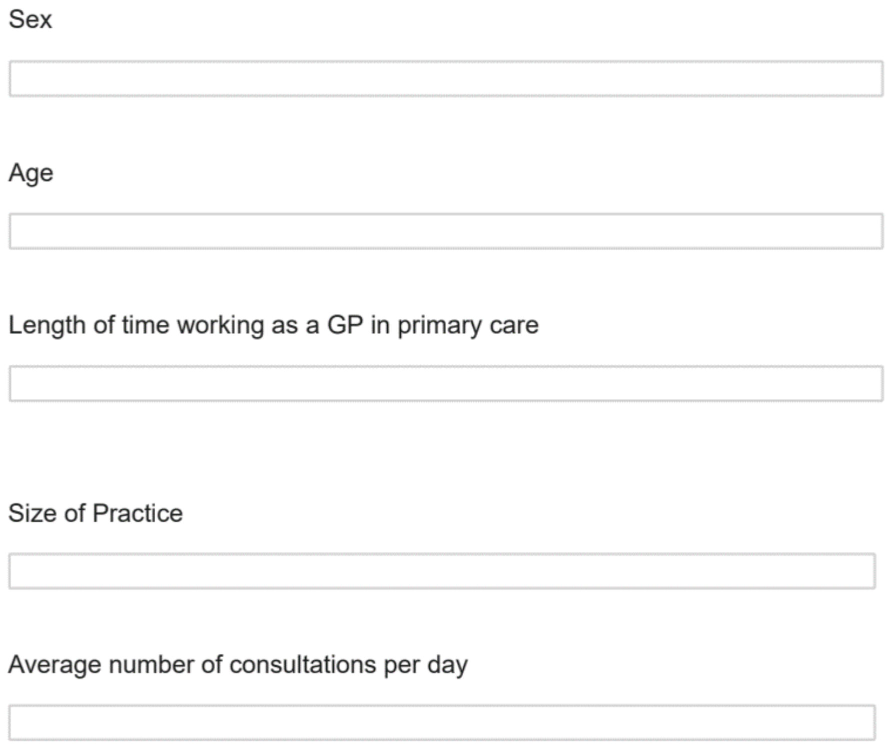
Sub-theme	Quotes
Personal limitations	"Then there's the stress, we're talking about stressors, the stress of not knowing that you're not going to get home for bed time with the kids or to have a bit of a row with the other half because you've been late leaving yet again." (Cheshire et al., 2017b) "The workload in the last sort of 5 years is just sort of seeming to go up year on year, and I know that I'm rushing a) patients, and b) decisions, so I don't feel I'm as safe as I was 5 years ago. I'm working harder and rushing, so I don't have time to think about things quite so much." (Croxson et al., 2017) "When you start eating away at your ability to enjoy your family, and you start feeling guilt, it just all falls apart. As women, we have to really support and advocate for one another that your family is really important." (Dillon et al., 2019) "The need for more support, particularly in the form of a more 'robust' occupational health service for doctors." (Doran et al., 2016) "Since doctors are only human beings they will not cope much of this domineering and disrespectful behaviour without having feelings towards that [e.g. leaving the profession]." (Evans, 2018) "I went back to work about a year ago, but it took me about nine months to get back up to the nine sessions a week and my practice were pressurising me to get back up to nine sessions …" (Huby et al., 2002) "This feeling of wanting to be everything to all men and being stretched in every direction at once." (Petchey, 1994) "Many talked about their shame, humiliation and embarrassment at their perceived inability to cope with the stresses of their job and/or their symptoms of mental illness." (Riley et al., 2018b) "I think I just had to be ill enough. I didn't realise how ill I was until I was off work, and then it became quite clear to me I was seriously quite unwell and needed, you know, I needed to do something fairly serious." (Spiers et al., 2017) "Doctors perceive themselves as immortal and immune to illness." (Spiers et al., 2018) "Felt like failure as a person, as a mother, as a GP." (Spiers et al., 2018) "Male GPs also experienced time conflicts with family care and reflected on the detrimental impact on their ability to be the fathers they wanted to be. Their options to address them were particularly constrained." (Strazdins et al., 2019) "It's how it impacts on family. I never saw my kids… And my second son said to me one day 'I can never remember dad being home'." (Strazdins et al., 2019)

Sub-theme	Quotes
The unsustainable role	“So when do you do your charting, when do you do your in-basket stuff, how do you not bring a ton of work home? I would say in primary care, that is the inherent challenge.” (Agana et al., 2017) “Participants thought that their institution, given its size and clout, could play a leading role in advocating for broader changes in the realm of primary care.” (Agarwal et al., 2020) “However, most GPs were adamant that being a full-time GP was now ‘too stressful’. For some, their current role was perceived as undermining their ability to function effectively, or even safely.” (Cheshire et al., 2017b) “Full-time partnership was generally not considered to be possible, and many participants felt workload was unsustainable, particularly given the diminishing workforce.” (Croxson et al., 2017) “I worry about the future of General Practice with a workforce crisis due to experienced GP’s leaving the profession or retiring early and newly qualified GP's choosing to work abroad or only wanting to work part time.” (Dale et al., 2015) “Before getting to the point where I really thought I was going to burn out 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 while I still have the wherewithal to go and do it.” (Doran et al., 2016) “According to this interview, as GPs are no longer satisfied with the levels of personal accomplishment derived from general practice they will begin to look for opportunities to minimise their exposure to the excessive demands.” (Evans, 2018) “Some warned against mistaking subjective perception for objective reality: ‘I would say that there is a reduction in the numbers entering general practice because their perception of morale in general practice is that it is poor.'” (Petchey, 1994) “I feel I won't be able to keep going indefinitely under the current pressures.” (Petchey, 1994) “Of note, female GPs seldom mentioned having time for personal needs, including maintaining their own health. ‘Looking after a family and being a GP are equally exhausting. Very demanding and time pressured. I find it’s exhausting always trying to keep on time. So it’s a constant pressure here’.” (Strazdins et al., 2019) “The GPs expressed worries that they will not be able to provide the population with the expected care and services in the future.” (Svedahl et al., 2019)

Appendix F:

Questionnaire for the Collection of Demographic and Wellbeing Data

The online version of the demographic questionnaire used in Chapter 4 and Study 4 – Recovery from Burnout: A Narrative Interview Study with Photo-Elicitation.



Sex

Age

Length of time working as a GP in primary care

Size of Practice

Average number of consultations per day

Please select the answer that best describes your experience of each <u>over the last 2 weeks</u> for each of the statements

	None of the time	Rarely	Some of the time	Often	All the time
I've been feeling optimistic about the future	○	○	○	○	○
I've been feeling useful	○	○	○	○	○
I've been feeling relaxed	○	○	○	○	○
I've been feeling interested in other people	○	○	○	○	○
I've had energy to spare	○	○	○	○	○
I've been dealing with problems well	○	○	○	○	○
I've been thinking clearly	○	○	○	○	○
I've been feeling good about myself	○	○	○	○	○
I've been feeling close to other people	○	○	○	○	○
I've been feeling confident	○	○	○	○	○
I've been able to make up my own mind about things	○	○	○	○	○
I've been feeling loved	○	○	○	○	○
I've been interested in new things	○	○	○	○	○
I've been feeling cheerful	○	○	○	○	○

Appendix G:

Information Sheet for the Lived Experience of GP Burnout

Information Sheet

General Practitioner Burnout

Primary Researcher: Philippa Shaw (MSc; PhD candidate).

Supervisors: Dr. Tina Cartwright, Prof. Damien Ridge and Prof. David Peters.

We would like to invite you to take part in an interview whose aim is to explore the experience of burnout from the perspective of practicing GP. There is a scarcity of qualitative research into the experience of burnout among those on the NHS front line, therefore, we aim to give voice to GPs by exploring personal accounts of GP burnout.

The Study:

If you decide to take part in this study, you will be asked to:

- Provide basic demographic information (such as age, sex and length of employment as a GP) and complete 2 validated questionnaires taking no more than 10 minutes in total
- Participate in an audio recorded interview with the researcher which will last 60 to 90 minutes.
    - The location and time of this interview will be arranged to be agreeable for both you and the researcher
    - Exampled of topics for the interview: experiences of burnout, personal wellbeing, coping mechanisms, and techniques employed to maintain work quality

Ethical Approval:

This study has been approved by the University of Westminster's Research Ethics Committee (ETH1718-2343) and has received a favourable opinion from the NHS Health Research Authority (IRAS ID 249046).

Participant's Rights:

You have the right to:

- have your questions about the procedures answered
- decide to stop being a part of the research study at any time, without explanation to omit or refuse to answer any question that is asked of you

Benefits and Risks:

- Participation in this study involves completion of some standardised tests, investigating burnout and wellbeing, which are not used for diagnostic purposes
- There are no anticipated disadvantages involved with this study. If you feel any discomfort or distress in answering any of the questions on during the study, please let the researcher know

Data Privacy:

When your interview is transcribed, your data will be anonymised meaning your interview transcripts will be censored, with identifiable information removed and your name will be coded to ensure pseudo-anonymisation on all documents. Personal data from which you could be identified (e.g., your name and email) will be held in an encrypted spreadsheet. All data will be stored in compliance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) 2018.

Results of the study:

The results of this study are likely to be disseminated at national and/or international conferences and published in scientific peer-reviewed journals. These results will also be written up for the purposes of Philippa Shaw's PhD thesis.

If you wish to obtain a copy of any published results, please inform a member of the research team.

For further information:

Philippa Shaw (P.Shaw@my.westminster.ac.uk) and supervisor Tina Cartwright (T.Cartwright@westminster.ac.uk) will be glad to answer your questions about this study at any time.

If you have questions, concerns or suggestions about this research that you do not feel can be addressed by the researcher, please contact the University of Westminster's Psychology Research Ethics committee convenor Coral Dando (C.Dando@westminster.ac.uk).

Appendix H:

Consent Form for the Lived Experience of GP Burnout

Consent Form

General Practitioner Burnout

By signing below, you are agreeing that:

(1) You have read and understood the information sheet for the above study and have had the opportunity to ask questions which have been answered satisfactorily.

(2) You are taking part in this research study voluntarily and have been made aware of your rights to withdraw at any time without providing an explanation and can decline to answer any question.

(3) You understand once you have taken part in the study, you are still able to withdraw **your data** at any point until the research has been published/submitted as part of the research project.

(4) You are aware your identity, contact details and the information provided will be treated confidentially and in accordance with the University of Westminster ethical guidelines and British Psychological Society code of human research ethics. Your personal information may be shared with members of the research team.

(5) Your interview will be digitally audio recorded for later transcription and analysis. Your data will be securely stored in compliance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) 2018. Once transcribed and the research is complete, the digital recording will be securely destroyed.

(6) Your data will be anonymised, and all identifying features/information will be removed so that my contribution will not be identifiable when reporting this research. Pseudo-anonymous direct quotes from the interview may be used in the study reports.

Participant’s signature*	Date
______________________________	______________________________
Name of person obtaining consent (Printed)	Signature of person obtaining consent
______________________________	____________________________

**Participants wishing to preserve some degree of anonymity may use their initials (from the British Psychological Society Guidelines for Minimal Standards of Ethical Approval in Psychological Research)*

Appendix I:

Interview Schedule for the Lived Experience of GP Burnout

Interview Schedule

General Practitioner Burnout

Introduction pointers: not recorded.

- Talk through the information sheet and consent form with the participant
- Talk through the interview introduction (below) – this was bullet pointed on a prompt card for the interviewer
- Ask the participant if they have any questions?
- Check if the participant is comfortable to begin, remind the participant to take their time and they need only answer questions they are happy to.

Interview introduction

"I asked you here today to take part in a semi-structured interview. This means that although I have a list of topics about things which I am interested in, I hope the interview will be more like a chat, with you doing most of the talking. If I ask a question which doesn't make sense, please ask me! Sometimes in these interviews people have felt like they have been talking too much, don't worry about that, if you go off track, I will ask you some questions which will set you right again. Because I want to find out about your own personal opinions and experiences, there are no right or wrong answers. Sometimes questions I ask may sound a bit obvious or strange – this is because I am trying not to take anything for granted and to find out your own opinions. I hope you will be able to be as open and honest with me as possible and I will try to be completely non-judgmental about the things we talk about. I am happy to answer any questions you have about me, but I would rather leave that to the end of the interview."

Interview

The below questions will be used as a guide only, allow the participant to guide the interview and express what is important to them. After each interview these questions will be reflected upon, feedback sought and in necessary questions changed and improved.

General prompts to keep in mind:

- How did that make you feel?
- Can you give me another example?
- Why do you think that was?
- What does that mean to you?
- Can you tell me a bit more about that?

Semi-Structured Schedule

Begin recording. [Date. Interview between Philippa Shaw and GPx.]

1. *Can you tell me about your experiences of burnout?*

(potential prompts: tell me about a typical day for you at the time. What kind of health problems did you experience? How did they feel in your body? How did you interpret the symptoms? Why do you think the symptoms of burnout surfaces at that point in your career? What was going through your mind during this? Can you tell me about any thoughts or associations with the experience of burnout? How does it feel to talk about these experiences?)

2. *What were your reactions to the symptoms of burnout?*

(potential prompts: how did you decide to go about dealing with these problems? Can you tell me a bit about seeking help in relation to burnout? How do you feel about asking for help as a GP experiencing burnout? Can you talk to me a bit about these experiences and the role of other people such as peers or family?)

3. *Can you tell me about your experiences working with patients as GP whilst experiencing burnout?*

(potential prompts: what went through your mind before a work day? How do you progress form a challenging patient consultation to the next consultation? Do you think your behaviour is perceived differently by patients when experiencing burnout? Is there anything which sticks out in your memory about patient interactions during this time? What feelings do you associate with these experiences? Could you tell me about personal wellbeing coping mechanisms you employ? How does your experience with burnout connect with ideas surrounding GP quality?)

4. *What did you expect working as a GP to be like?*

(potential prompts: are there aspects which have lived up to your expectations? In what ways has it deviated from expectations?)

5. *We have talked a lot about the challenges of burnout, is there anything positive surrounding this topic you would like to add?*

(prompts: support from family? Peer communication?)

6. *Is there anything you would like to add to this interview?*

(prompt: what kind of treatment or help for burnout do you think would be most appropriate? How do you feel your experience compares to others in your field?)

Thank the participant for taking part in the interview. Stop the recording.

Ask the participant if they have any questions or would like to provide any feedback.

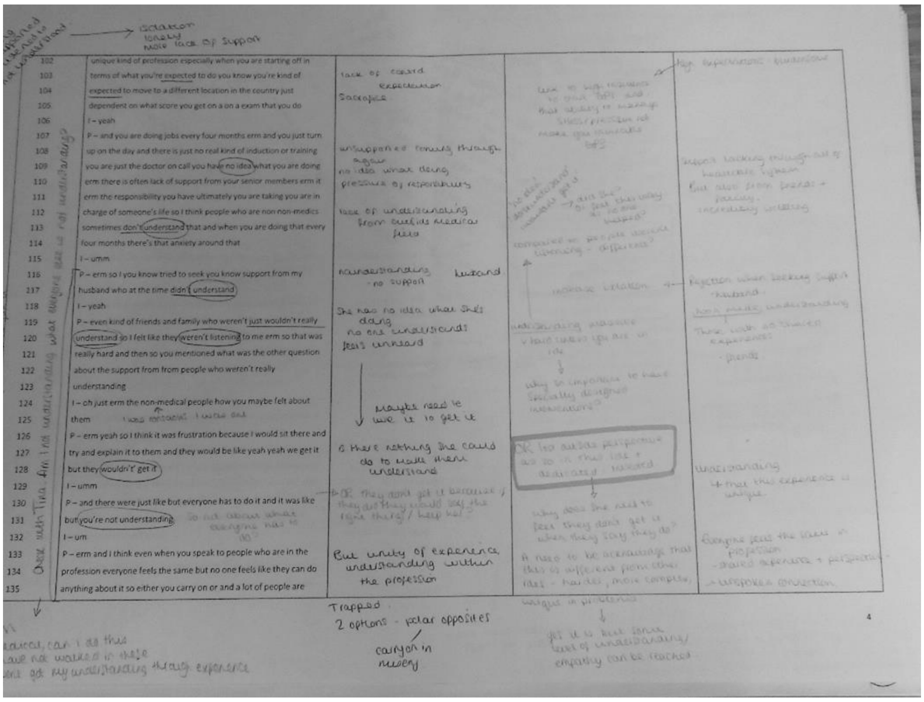
Follow this with explanation of the debrief sheet, noting the signpost for help if distressed and researcher contact details. Inform the participant of what will happen next.

Appendix J:

Analysis and Development of Themes for the Lived Experience of GP Burnout

Figure A3

Example IPA Analysis



isolation
lonely
more lack of support

unique kind of profession especially when you are starting off in terms of what you're expected to do you know you're kind of expected to move to a different location in the country just dependent on what score you get on a on a exam that you do

I – yeah

P – and you are doing jobs every four months erm and you just turn up on the day and there is just no real kind of induction or training you are just the doctor on call you have no idea what you are doing erm there is often lack of support from your senior members erm it erm the responsibility you have ultimately you are taking you are in charge of someone's life so I think people who are non non-medics sometimes don't understand that and when you are doing that every four months there's that anxiety around that

I – umm

P – erm so I you know tried to seek you know support from my husband who at the time didn't understand

I – yeah

P – even kind of friends and family who weren't just wouldn't really understand so I felt like they weren't listening to me erm so that was really hard and then so you mentioned what was the other question about the support from from people who weren't really understanding

I – oh just erm the non-medical people how you maybe felt about them

P – erm yeah so I think it was frustration because I would sit there and try and explain it to them and they would be like yeah yeah we get it but they wouldn't get it

I – umm

P – and there were just like but everyone has to do it and it was like but you're not understanding

I – um

P – erm and I think even when you speak to people who are in the profession everyone feels the same but no one feels like they can do anything about it so either you carry on or and a lot of people are

lack of control
expectation
Sacrifice

unsupported coming through again
no idea what doing
pressure of responsibility

lack of understanding from outside medical field

misunderstanding husband
- no support

She has no idea what she's doing
no one understands
feels unheard

Maybe need to live it to get it

Is there nothing she could do to make them understand

But unity of experience understanding within the profession

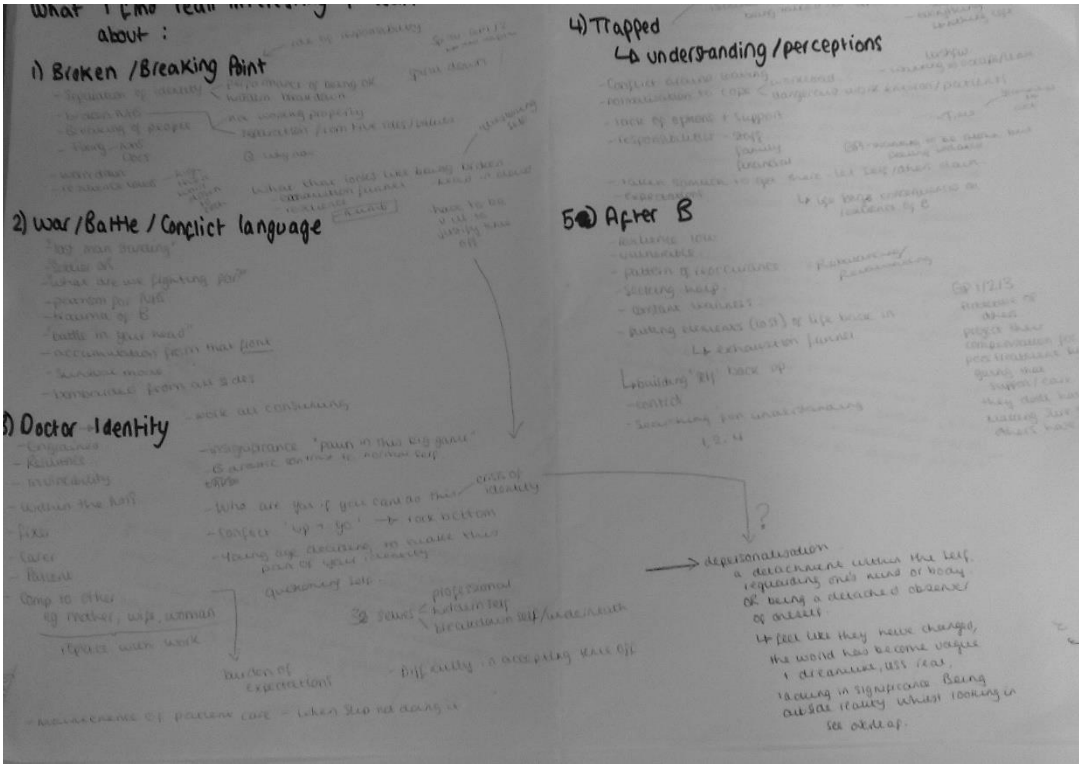
Trapped
2 options - polar opposites
carry on in misery

Figure A4

Mind-Map of Codes Exploring the Relationships

Figure A5

Early Super-Ordinate Themes



What I find really interesting about :

1) Broken /Breaking Point

- Separation of identity < performance of being OK / hidden breakdown
- broken NHS — not working properly
- Breaking of people — separation from true roles/values
- worn down

2) War/Battle / Conflict language

- "last man standing"
- "what are we fighting for"
- trauma of B
- "battle in your head"
- accumulation from that front
- survival mode
- bombarded from all sides

3) Doctor Identity

- Engrained
- Resilience
- invincibility
- within the NHS
- fixer
- carer
- Parent
- Comp to other eg mother, wife, woman
- replace with work

burden of expectations

- work all consuming
- insignificance "pawn in this big game"
- Who are you if you can't do this — crisis of identity
- conflict 'up + go' → rock bottom
- Young age deciding to make this part of your identity

questioning self

3 selves < professional / hidden self / breakdown self/weakness

- Difficulty in accepting time off
- maintenance of patient care – when stop not doing it

4) Trapped
↳ understanding / perceptions

- Conflict around working
- normalisation to cope < workload / dangerous work
- lack of options + support
- responsibilities - staff / family / financial
- expectations

5) After B

- resilience low
- vulnerable
- pattern of recurrence — Remaining/Recovering
- seeking help
- putting elements (lost) of life back in
  - ↳ exhaustion funnel
- ↳ building 'self' back up
- control
- searching for understanding

1, 2, 4

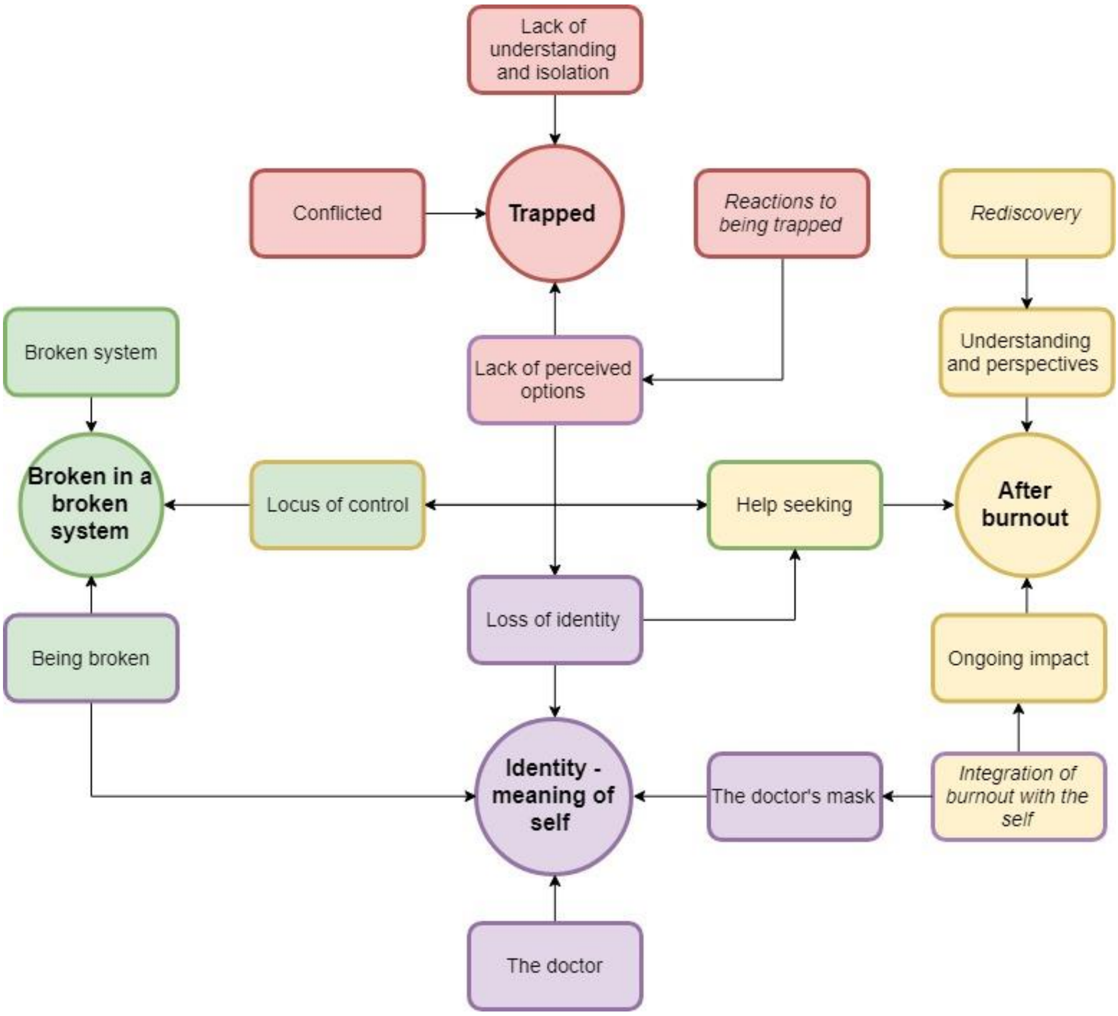
GP 1/2/13

?

→ depersonalisation
a detachment within the self, regarding one's mind or body or being a detached observer of oneself.
↳ feel like they have changed, the world has become vague + dreamlike, less real, lacking in significance. Being outside reality whilst looking in see oneself.

Figure A6

Diagram of Theme Development



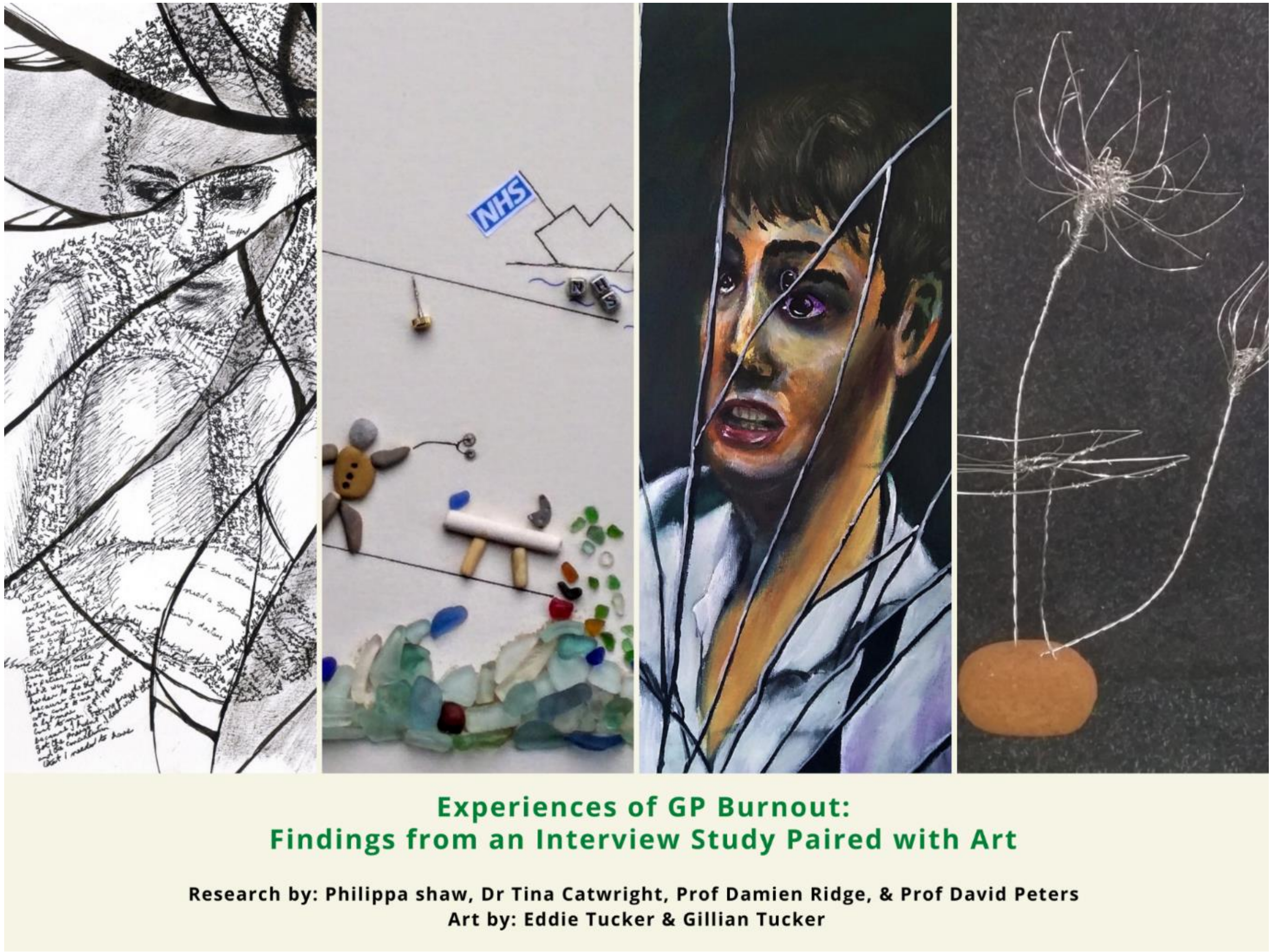
A diagram to show how the developing themes might relate to one another is shown in Table A6. The main themes are indicated by circular boxes whereas the sub-themes are indicated in by the boxes. The direction of support is shown by the direction of arrows, i.e., ‘the doctor’ is a sub-theme within ‘identity’. Note the bidirectional arrows between ‘help seeking’ and ‘locus of control’ and each feed into each other. Where there is overlap the subtheme is indicated by shading to the theme it belongs with the outline colour indicating the theme of partial overlap.

Appendix K:

Art Based Summary Booklet for Dissemination of Findings from the Lived Experience of GP Burnout

Figure A7

Dissemination Booklet – Front Cover



Experiences of GP Burnout:
Findings from an Interview Study Paired with Art

Research by: Philippa shaw, Dr Tina Catwright, Prof Damien Ridge, & Prof David Peters
Art by: Eddie Tucker & Gillian Tucker

Figure A8

Dissemination Booklet – Introduction and Methods

The Research Behind 'Experiences of GP Burnout'

Background

Growing work pressures in the NHS are negatively affecting GPs' wellbeing. Research has found half of GPs are experiencing burnout - a state of exhaustion caused by excessive and continuous stress. In this study we aimed to understand what it is like to experience burnout as a GP.

Methods

We conducted interviews with six GPs who had experienced burnout. These were analysed using interpretative phenomenological analysis - an analysis method which enables us to explore shared and unique experiences while understanding how GPs made sense of burnout.

Findings

From the analysis, we identified four main themes:

1. The gradual onset of burnout and the feeling of being broken.
2. Being trapped within an ill-functioning organisation, and feeling torn between their responsibilities and their wellbeing.
3. The resulting vulnerability which distorted how they saw themselves as a doctor.
4. Navigating burnout by trying to understand their experience and the ongoing impact of burnout.

Turning Interview Findings into Pieces of Art

A Wider Audience for the Research Findings

We hope that many people read this summary of findings as research has found GP experiences of burnout are infrequently reported in media and research, and that there is poor identification and support of burnout in GPs.

Art from the Findings

One way to increase engagement with research is pairing findings with art. Research suggests art can help communicate research whilst creating dialogue and raising awareness.

Therefore, two artists worked with summaries of themes to produce pieces of art. One piece of art was created for each theme.

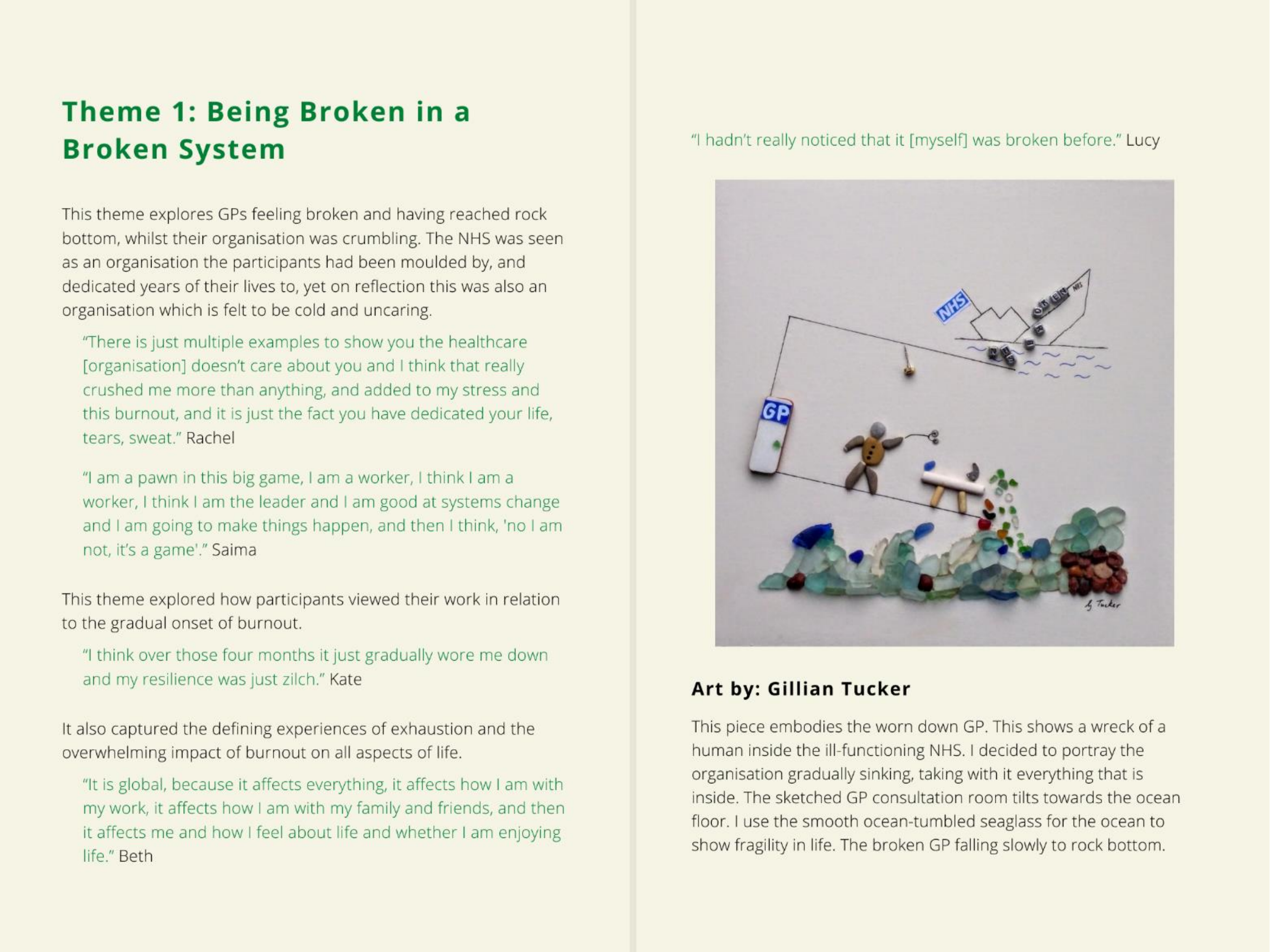
This Booklet

Over the next few pages you can read a summary of each theme written by the researchers, with quotes from the GPs interviewed. Pseudonyms have been used instead of participant names.

These summaries are presented with a photograph of the art and comments made by the artist about their artwork.

Figure A9

Dissemination Booklet – Being Broken in a Broken System



Theme 1: Being Broken in a Broken System

This theme explores GPs feeling broken and having reached rock bottom, whilst their organisation was crumbling. The NHS was seen as an organisation the participants had been moulded by, and dedicated years of their lives to, yet on reflection this was also an organisation which is felt to be cold and uncaring.

> "There is just multiple examples to show you the healthcare [organisation] doesn't care about you and I think that really crushed me more than anything, and added to my stress and this burnout, and it is just the fact you have dedicated your life, tears, sweat." Rachel

> "I am a pawn in this big game, I am a worker, I think I am a worker, I think I am the leader and I am good at systems change and I am going to make things happen, and then I think, 'no I am not, it's a game'." Saima

This theme explored how participants viewed their work in relation to the gradual onset of burnout.

> "I think over those four months it just gradually wore me down and my resilience was just zilch." Kate

It also captured the defining experiences of exhaustion and the overwhelming impact of burnout on all aspects of life.

> "It is global, because it affects everything, it affects how I am with my work, it affects how I am with my family and friends, and then it affects me and how I feel about life and whether I am enjoying life." Beth

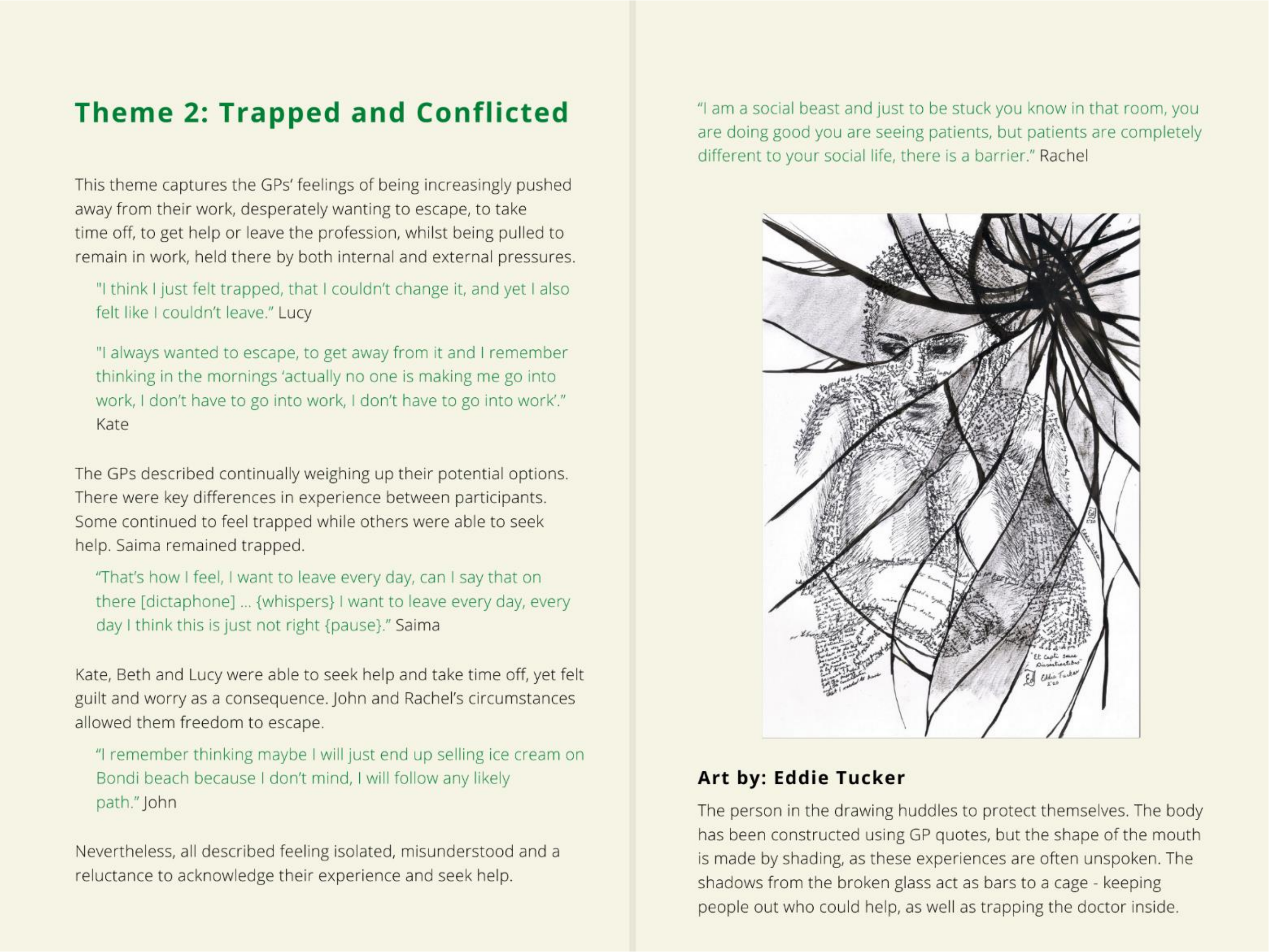
> "I hadn't really noticed that it [myself] was broken before." Lucy

Art by: Gillian Tucker

This piece embodies the worn down GP. This shows a wreck of a human inside the ill-functioning NHS. I decided to portray the organisation gradually sinking, taking with it everything that is inside. The sketched GP consultation room tilts towards the ocean floor. I use the smooth ocean-tumbled seaglass for the ocean to show fragility in life. The broken GP falling slowly to rock bottom.

Figure A10

Dissemination Booklet – Trapped and Conflicted



Theme 2: Trapped and Conflicted

This theme captures the GPs' feelings of being increasingly pushed away from their work, desperately wanting to escape, to take time off, to get help or leave the profession, whilst being pulled to remain in work, held there by both internal and external pressures.

> "I think I just felt trapped, that I couldn't change it, and yet I also felt like I couldn't leave." Lucy

> "I always wanted to escape, to get away from it and I remember thinking in the mornings 'actually no one is making me go into work, I don't have to go into work, I don't have to go into work'." Kate

The GPs described continually weighing up their potential options. There were key differences in experience between participants. Some continued to feel trapped while others were able to seek help. Saima remained trapped.

> "That's how I feel, I want to leave every day, can I say that on there [dictaphone] … {whispers} I want to leave every day, every day I think this is just not right {pause}." Saima

Kate, Beth and Lucy were able to seek help and take time off, yet felt guilt and worry as a consequence. John and Rachel's circumstances allowed them freedom to escape.

> "I remember thinking maybe I will just end up selling ice cream on Bondi beach because I don't mind, I will follow any likely path." John

Nevertheless, all described feeling isolated, misunderstood and a reluctance to acknowledge their experience and seek help.

> "I am a social beast and just to be stuck you know in that room, you are doing good you are seeing patients, but patients are completely different to your social life, there is a barrier." Rachel

Art by: Eddie Tucker

The person in the drawing huddles to protect themselves. The body has been constructed using GP quotes, but the shape of the mouth is made by shading, as these experiences are often unspoken. The shadows from the broken glass act as bars to a cage - keeping people out who could help, as well as trapping the doctor inside.

Figure A11

Dissemination Booklet – Identity the Meaning of Self

Theme 3: The Meaning of Self

How GPs viewed themselves highlighted the complexity in experiences of burnout. All participants felt strongly connected to their professional identity, part of which was a strong work ethic.

> "That is how we are reared, not just from university but from school, that is how we are reared … automaton robotic programming, that's how we are programmed." Rachel

The nature of their professional identity led to the prioritisation of work over their life outside the role, adding to the challenges of the role.

> "[It was like] things dropping off at each level until it was just phurrf … losing other little bits of yourself along the way." Lucy

All gave their last reserves of energy to maintain the quality of care.

> "I was trying to make sure that I cared for patients… but it was much harder to do that because it came at much more cost to me, a lot more cost to me because I hadn't got the energy and the concentration that I needed to have." Beth

But perceptions of their key role as a GP acted to prevent them from taking sick leave in a timely way, leading to exacerbation of symptoms.

> "It is that belief in that superhuman doctor that actually makes the system run… you have almost got to keep that game up."
> Saima

The experience of burnout was incompatible with their expectations of themselves, leading to the feeling that they had lost their identity.

> "What the hell is wrong with me? Why? Why can't I deal with this?"
> Kate

> "There's no better role in a way than helping someone physically or mentally …. I think that yeah that's ultimately that's why I locum."
> Kate

Art by: Eddie Tucker

The broken mirror symbolises the splitting between the GP and their reflection. There are two separate manifestations of the person – their public face and their inner identity. The gloom and darkness in the work is symbolic of the inner turmoil and building pressure within the doctor before a storm breaks.

Figure A12

Dissemination Booklet – Navigating Burnout

Theme 4: Navigating Life After Burnout

This theme explores the period after participants accepted their experience of burnout. Some participants decide to take time away or seek help.

> "I thought 'oh I can justify it now because I can't function, and I am literally hitting rock bottom'." Kate

Participants described how their perceptions changed through different points of their recovery journey, and the reality for some that the consequences of burnout will remain with them indefinitely. With this acknowledgement of vulnerability came the need to prioritise their own health.

> "I think it is now time to think about myself." Rachel

> "I suspect I will be a locum for the rest of my working life which I am sort of coming to terms with." Beth

While also wanting to reclaim who they are.

> "I want my own life, I don't want my life to be so much of this NHS world." Saima

However, for some GPs their understanding of their experience had some positive outcomes.

> "I am now a lot more understanding when it comes to patients when it comes to mental health, and I think they know that, and I get a lot of patients who come back because I can now understand." Kate

> "it was [whilst travelling] where I just fell back in love with life." John

> "There's need to be something put in place ... that teaches that this is the challenges you are going to face and actually it is fine to admit you are suffering, this is where you get help." Lucy

Art by: Gillian Tucker

The lotus for this piece represents self-regeneration, whilst the sea brick represents the murky waters the GPs have their roots in. The steel used has good resistance showing the GPs' strength to return to work. However the wire is also malleable showing the GPs' changing perspectives - their increased awareness and acceptance of their vulnerabilities, now prioritising themselves.

Figure A13

Dissemination Booklet – Study Conclusions and Questionnaire

Study Conclusions

Overall, this study gave insight into the complexity and long-lasting nature of burnout, highlighting the challenges burnout poses to resilience and identity.

Participants tied their experience to the organisation they work for, and most linked their experience of burnout to the medical culture and the growing pressures around their role. We also found GPs had inner conflicts, related to their work-life balance and the need to prioritise their own health when faced with needing to take time off or seek help.

We are currently working on the second study of this project - exploring GPs' stories of recovery from burnout through interviews and photographs.

Thank-you

Thank you for taking the time to read the summarised research findings. We would also like to thank the GPs who generously shared their time and experiences for the purposes of this study.

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eddie tucker art

We Want to Hear Your Views

With this booklet we are trying to distribute research findings widely and improve awareness of the experiences of GP burnout.

Questionnaire

We would love to hear from you about how you found reading these research finding summaries paired with art.

To complete the short feedback questionnaire follow the below link:

https://westminsterpsych.az1.qualtrics.com/jfe/form/SV_23uuVTS7QOrPFEF

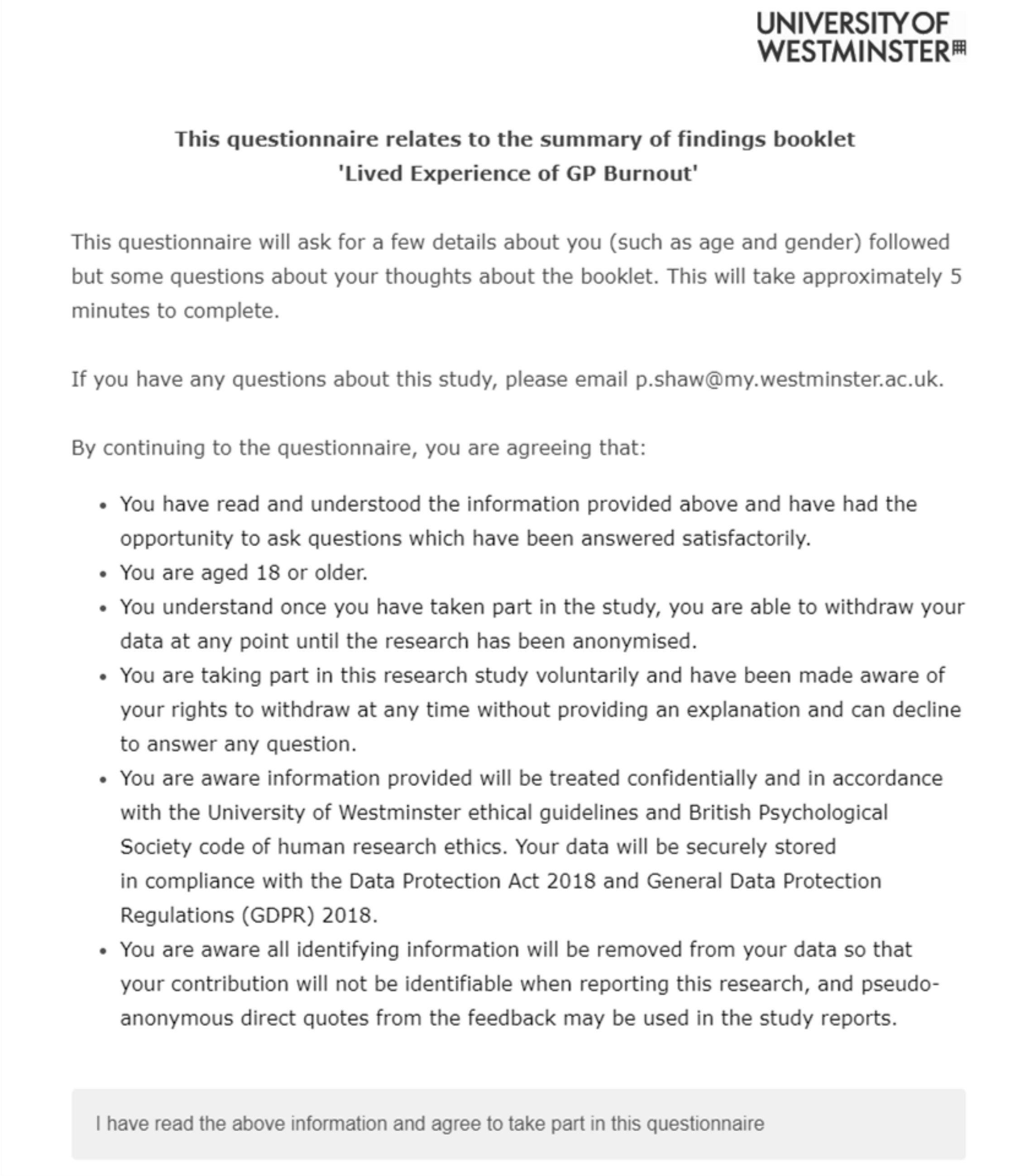
Contact

To contact the research team, please email Pippa using P.Shaw@my.westminster.ac.uk

If you are a GP and would like support with burnout, please contact the Practitioner Health Service. Details can be found via practitionerhealth.nhs.uk or by calling 0300 0303 300

Appendix L:

Questionnaire for the Investigation into the Effectiveness of the Art Based Summary Booklet



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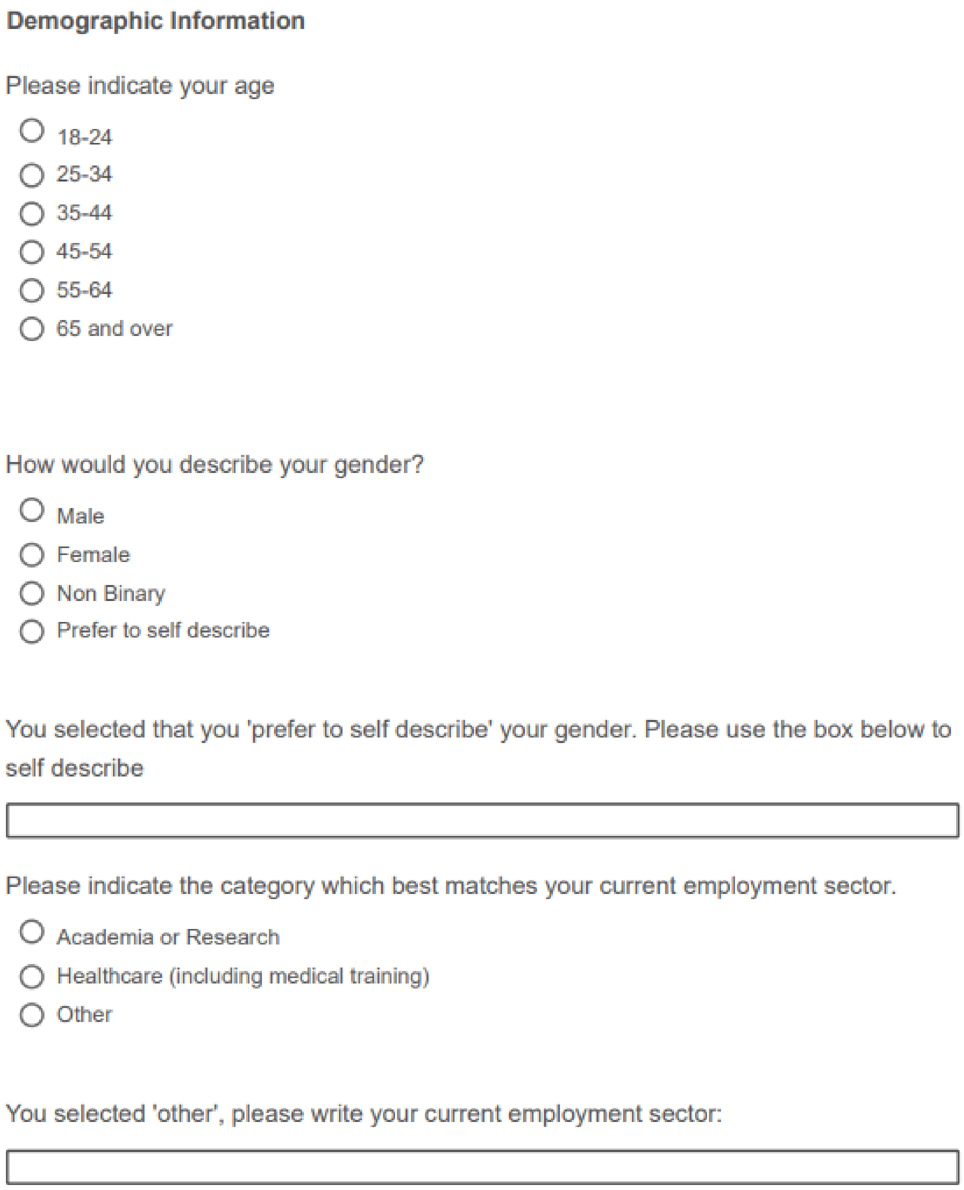
This questionnaire relates to the summary of findings booklet
'Lived Experience of GP Burnout'

This questionnaire will ask for a few details about you (such as age and gender) followed but some questions about your thoughts about the booklet. This will take approximately 5 minutes to complete.

If you have any questions about this study, please email p.shaw@my.westminster.ac.uk.

By continuing to the questionnaire, you are agreeing that:

- You have read and understood the information provided above and have had the opportunity to ask questions which have been answered satisfactorily.
- You are aged 18 or older.
- You understand once you have taken part in the study, you are able to withdraw your data at any point until the research has been anonymised.
- You are taking part in this research study voluntarily and have been made aware of your rights to withdraw at any time without providing an explanation and can decline to answer any question.
- You are aware information provided will be treated confidentially and in accordance with the University of Westminster ethical guidelines and British Psychological Society code of human research ethics. Your data will be securely stored in compliance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) 2018.
- You are aware all identifying information will be removed from your data so that your contribution will not be identifiable when reporting this research, and pseudo-anonymous direct quotes from the feedback may be used in the study reports.



Demographic Information

Please indicate your age

- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65 and over

How would you describe your gender?

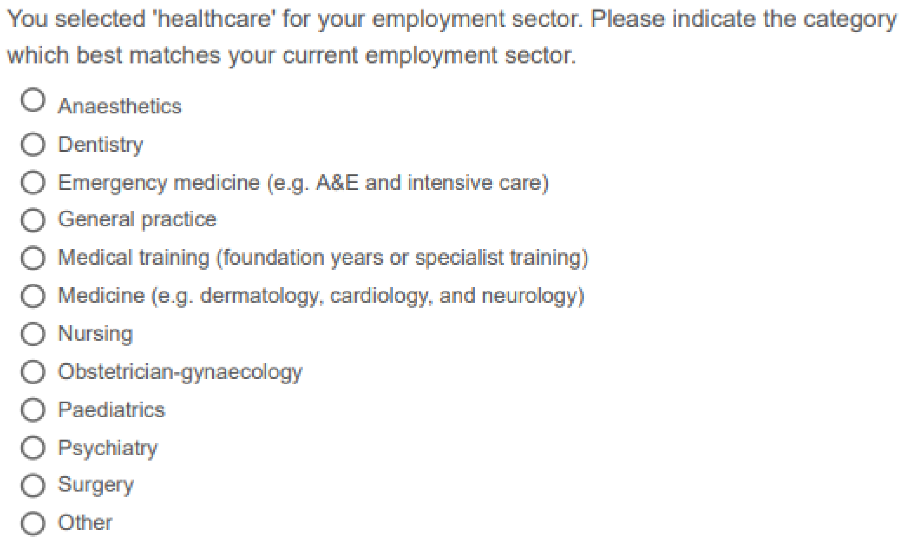
- ○ Male
- ○ Female
- ○ Non Binary
- ○ Prefer to self describe

You selected that you 'prefer to self describe' your gender. Please use the box below to self describe

Please indicate the category which best matches your current employment sector.

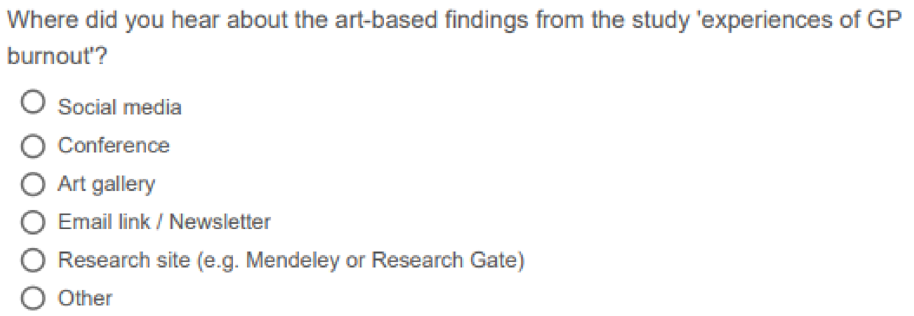
- ○ Academia or Research
- ○ Healthcare (including medical training)
- ○ Other

You selected 'other', please write your current employment sector:



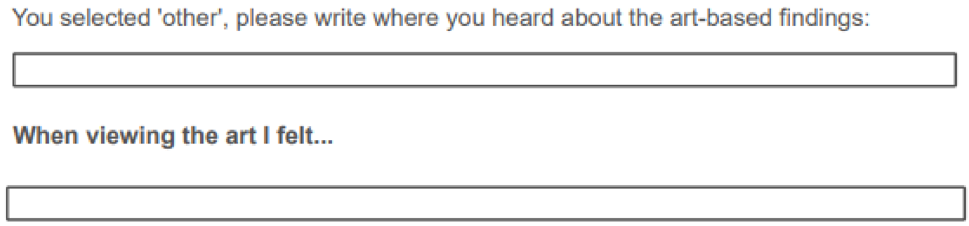
You selected 'healthcare' for your employment sector. Please indicate the category which best matches your current employment sector.

○ Anaesthetics
○ Dentistry
○ Emergency medicine (e.g. A&E and intensive care)
○ General practice
○ Medical training (foundation years or specialist training)
○ Medicine (e.g. dermatology, cardiology, and neurology)
○ Nursing
○ Obstetrician-gynaecology
○ Paediatrics
○ Psychiatry
○ Surgery
○ Other



Where did you hear about the art-based findings from the study 'experiences of GP burnout'?

○ Social media
○ Conference
○ Art gallery
○ Email link / Newsletter
○ Research site (e.g. Mendeley or Research Gate)
○ Other



You selected 'other', please write where you heard about the art-based findings:

When viewing the art I felt...

Please complete this statement:

When viewing the art-based findings for 'experiences of GP burnout' I felt...

For the following questions please indicate how much you agree or disagree with the provided statements relating to the art-based findings. There is space to provide comments below each.

I learned something new about the experience of burnout

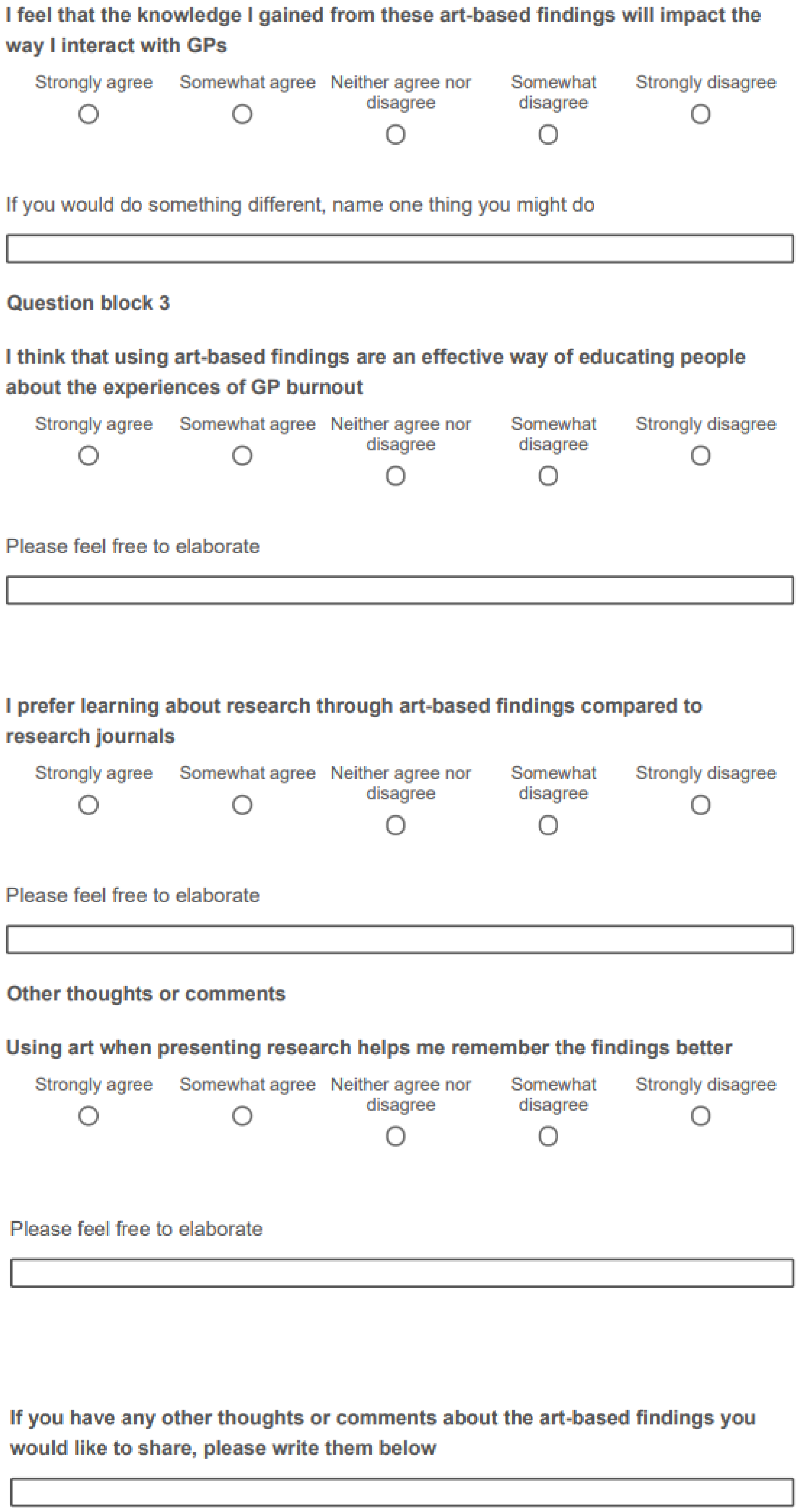
Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

If you learned something new, name one thing you learnt about burnout that you didn't know before

I have more of an understanding of what it means to experience burnout from the perspective of GPs

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

If you have more of an understanding, name one thing you learnt about the GP perspective you didn't know before



I feel that the knowledge I gained from these art-based findings will impact the way I interact with GPs

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

If you would do something different, name one thing you might do

Question block 3

I think that using art-based findings are an effective way of educating people about the experiences of GP burnout

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

Please feel free to elaborate

I prefer learning about research through art-based findings compared to research journals

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

Please feel free to elaborate

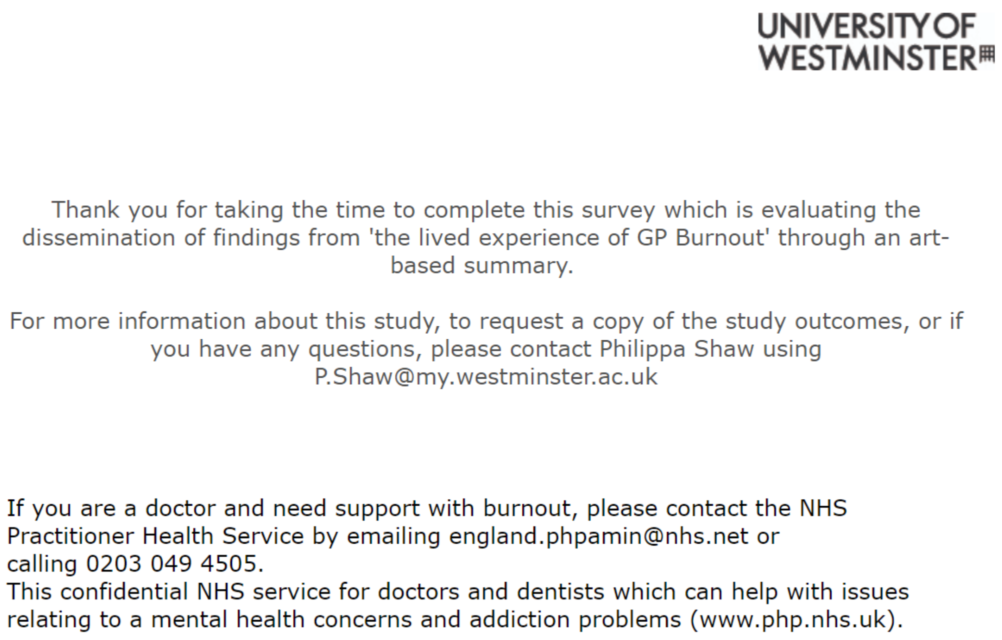
Other thoughts or comments

Using art when presenting research helps me remember the findings better

Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree
○	○	○	○	○

Please feel free to elaborate

If you have any other thoughts or comments about the art-based findings you would like to share, please write them below



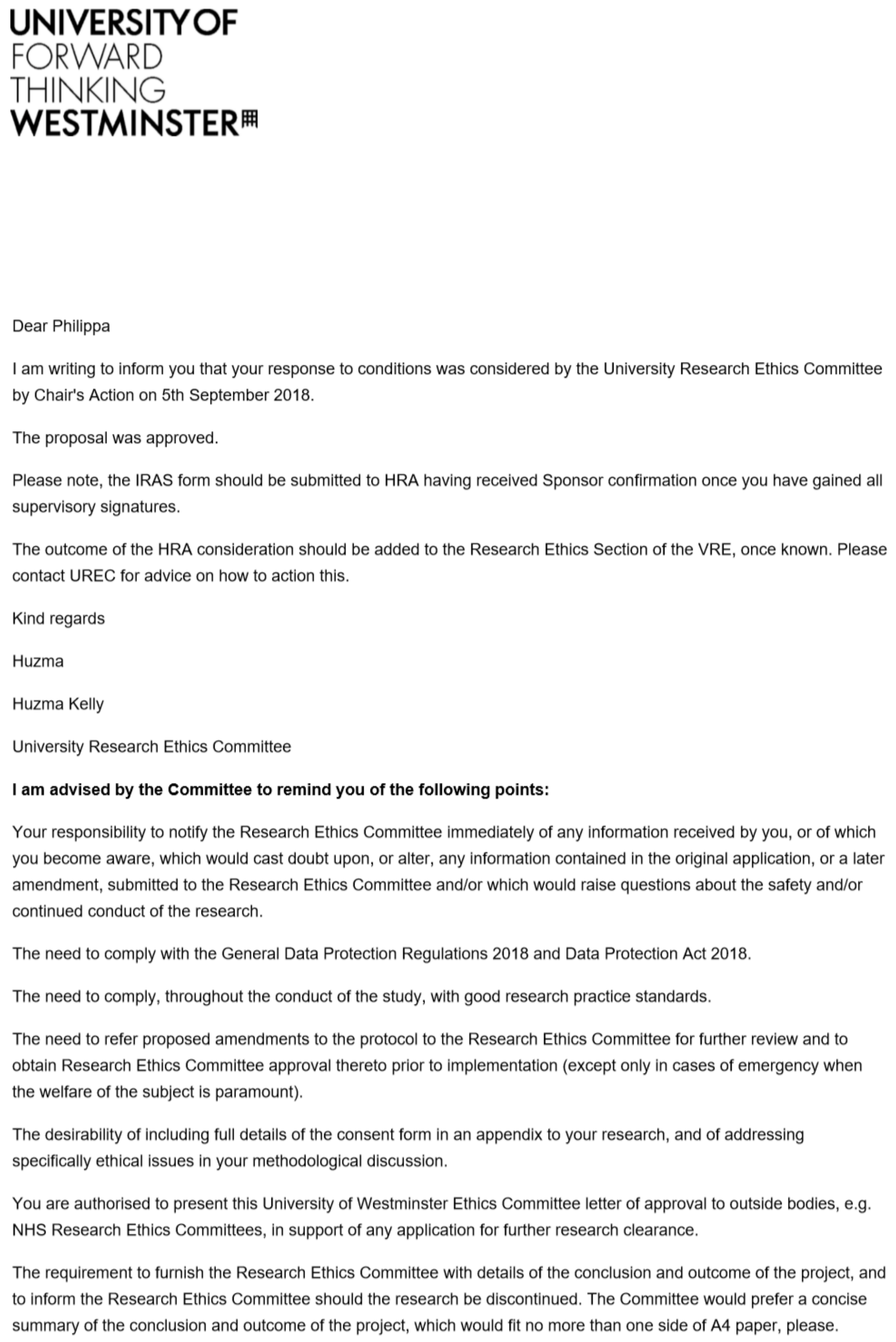
Thank you for taking the time to complete this survey which is evaluating the dissemination of findings from 'the lived experience of GP Burnout' through an art-based summary.

For more information about this study, to request a copy of the study outcomes, or if you have any questions, please contact Philippa Shaw using P.Shaw@my.westminster.ac.uk

If you are a doctor and need support with burnout, please contact the NHS Practitioner Health Service by emailing england.phpamin@nhs.net or calling 0203 049 4505.
This confidential NHS service for doctors and dentists which can help with issues relating to a mental health concerns and addiction problems (www.php.nhs.uk).

Appendix M:

UREC Ethics Approval for The Lived Experience of GP Burnout



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Dear Philippa

I am writing to inform you that your response to conditions was considered by the University Research Ethics Committee by Chair's Action on 5th September 2018.

The proposal was approved.

Please note, the IRAS form should be submitted to HRA having received Sponsor confirmation once you have gained all supervisory signatures.

The outcome of the HRA consideration should be added to the Research Ethics Section of the VRE, once known. Please contact UREC for advice on how to action this.

Kind regards

Huzma

Huzma Kelly

University Research Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the General Data Protection Regulations 2018 and Data Protection Act 2018.

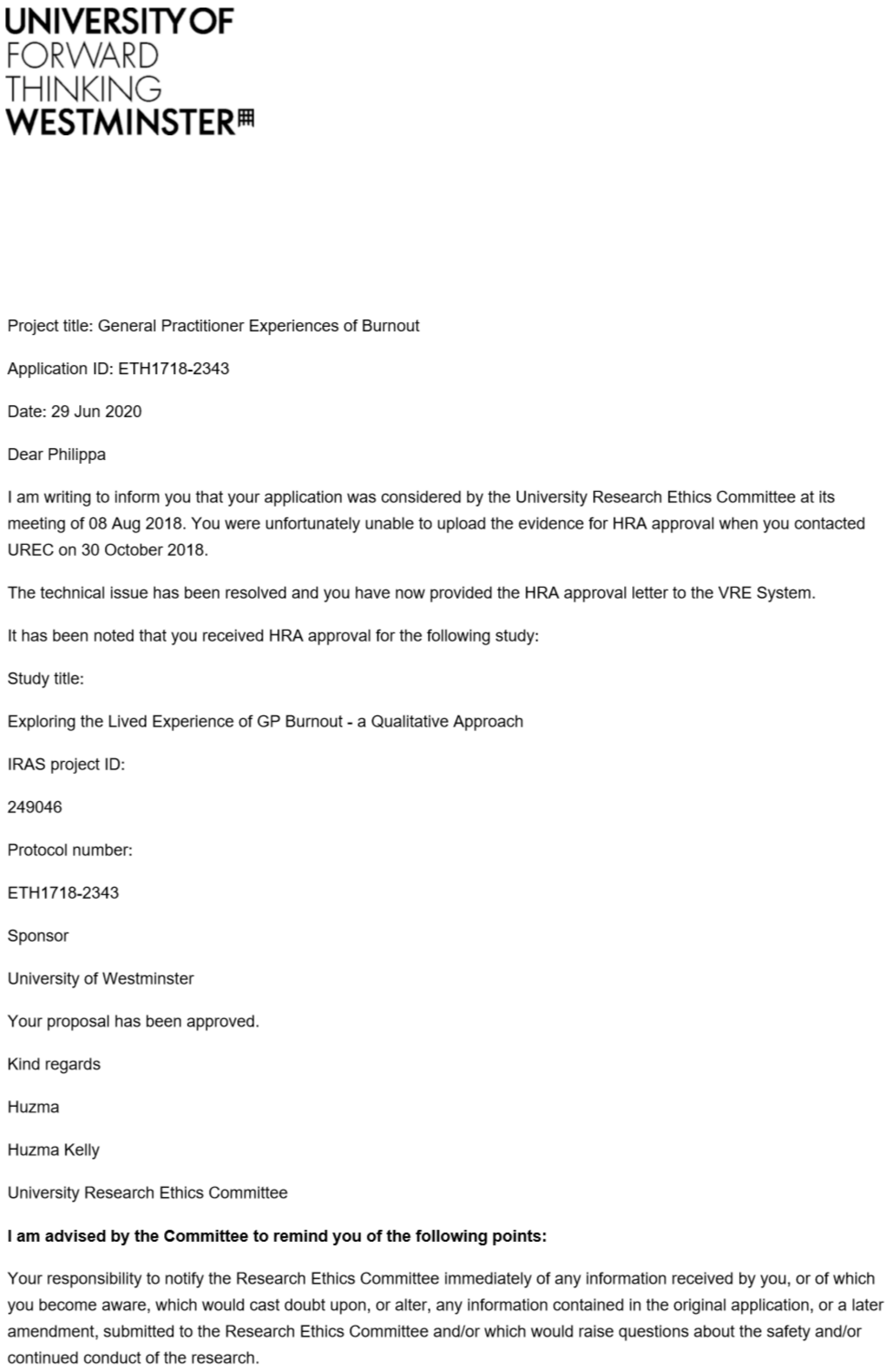
The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

You are authorised to present this University of Westminster Ethics Committee letter of approval to outside bodies, e.g. NHS Research Ethics Committees, in support of any application for further research clearance.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.



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Project title: General Practitioner Experiences of Burnout

Application ID: ETH1718-2343

Date: 29 Jun 2020

Dear Philippa

I am writing to inform you that your application was considered by the University Research Ethics Committee at its meeting of 08 Aug 2018. You were unfortunately unable to upload the evidence for HRA approval when you contacted UREC on 30 October 2018.

The technical issue has been resolved and you have now provided the HRA approval letter to the VRE System.

It has been noted that you received HRA approval for the following study:

Study title:

Exploring the Lived Experience of GP Burnout - a Qualitative Approach

IRAS project ID:

249046

Protocol number:

ETH1718-2343

Sponsor

University of Westminster

Your proposal has been approved.

Kind regards

Huzma

Huzma Kelly

University Research Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

Appendix N:

NHS HRA Ethics Approval for The Lived Experience of GP Burnout

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Dr Tina Cartwright
115 New Cavendish Street
Clipstone, Psychology, Floor 6
London
W1W 6UW

18 October 2018

Dear Dr Cartwright

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring the Lived Experience of GP Burnout - a Qualitative Approach**
IRAS project ID:	**249046**
Protocol number:	**ETH1718-2343**
Sponsor	**University of Westminster**

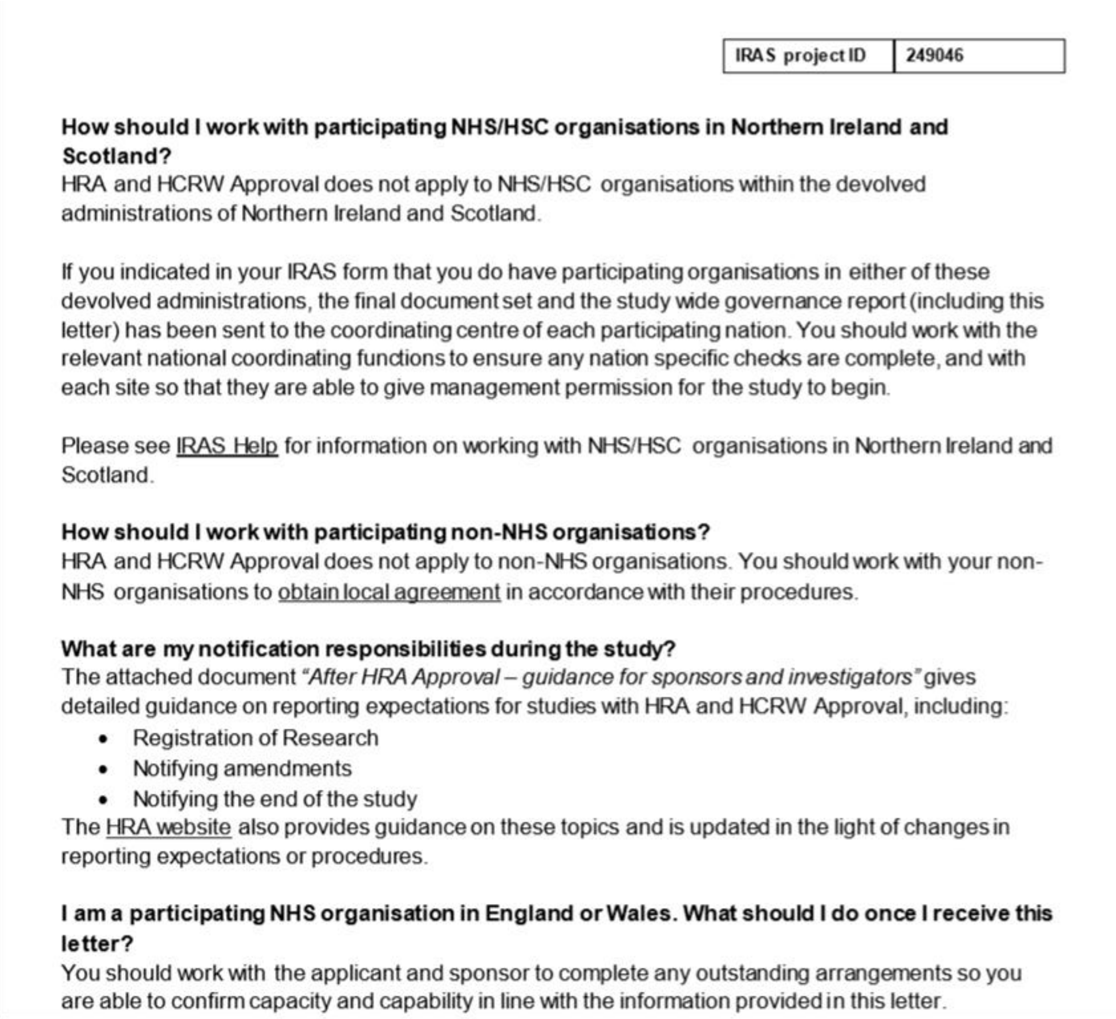
I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.



IRAS project ID	249046

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

Appendix O:

Sensitivity Protocol for the Lived Experience of GP Burnout

Sensitivity Protocol

General Practitioner Burnout

As participants in this study are volunteering to discuss their experiences of burnout, it may lead to the interviewee talking about personal information that they may find distressing. In preparation for such an occurrence within the interview several approaches have been considered to minimise potential distress to the participants. These include use of a participant information sheet (which the participants will be provided with in advance to allow time for consideration and to ask questions to the researcher) and a consent form along with the implementation of a research sensitive protocol, to be used in cases of participant distress.

Participant Information Sheet and Consent form

The following will be made clear to participants, in all written information sheets and conversation (e.g. during recruitment and prior to the interview):

a) What the interview topic will be
b) That they may stop or delay the interview at any time, or withdraw from the study without having to give a reason
c) that all data they provide is confidential and will be reported in a way that preserves their anonymity

Research sensitive protocol

The researcher will implement a ‘sensitive research protocol’, which will involve:

- Monitoring participants for distress (including monitoring for change in the participant during interviews which might signal being uncomfortable with the question)
- Actively re-establishing consent with the participant during the interview is a sensitive or unforeseen topic arises
- Stopping the interview if a participant becomes upset and only recommencing when (and if) the interviewee is ready to do so
- Any interview will be ceased completely if the interviewee is too distressed to continue, without any blame from the researcher or pressure to reschedule
- If the participant is willing to continue the interview the researcher will provide the chance to talk about the distressing topic (if the participant wishes), to explore these emotions with the hope of containing the distress to the interview and maintaining the participant’s wellbeing
- Asking specifically if there are any issues raised during the interview at the end of the interview and providing the opportunity for the interviewee to give feedback and ask questions
- Offering to sit with, and listen to, any participant who has become upset during interview
- Encouraging participants to contact the researcher by email or direct phone line if they have any concerns post interview

- Providing all participants with a support and information sheet that includes free and low-cost counselling options (see below) as well as a debrief sheet with the GP NHS helpline included on this
- Following up any participants that become upset by email in the following days

Researcher experience and expertise

The researcher is a Psychology PhD student and has had some experience with conducting qualitative interviews as well as in-depth training related to this type of research. For extra support the supervisors of this project, Professor Damien Ridge and Dr Tina Cartwright, are experts in sensitive qualitative research, having researched difficult topics (e.g. suicide, depression) for over 20 years. This study is also being guided by Professor David Peters who used to work as a GP and is an expert in the field of GP research. Therefore, if any issues arises the participants will be given proper assistance.

Support and information sheet

Please find below a list of organisations who can provide support including information and low cost counselling options

Organisation	**Support**	**Contacts**
Samaritans	Low cost counselling	Helpline 08457 90 90 90 Website www.samaritans.org
The depression Alliance	Online information	Website http://www.depressionalliance.org/
Mind	Charity about mental health and related topics.	Website www.mind.org.uk
University of Westminster	Counselling sessions offered at the university of Westminster.	Website counselling@westminster.ac.uk

Useful Point of Contact:

NHS GP Health Service-

- A confidential NHS service for GPs and GP trainees across various location in England.
- The service can help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work.
- This service is provided by health professionals who have additional expertise in addressing the issues concerning doctors

Access the service by emailing gp.health@nhs.net or by calling 0300 0303 300.
The service is available Monday – Friday (8am – 8pm) and Saturday (8am – 2pm).

Appendix P:

Safeguarding Protocol for the Lived Experience of GP Burnout

Safeguarding Guidance

General Practitioner Burnout

As participants in this study are volunteering to discuss their experiences of burnout whilst working as a GP, it may lead to the interviewee talking about situations which may raise safeguarding issues for the researcher's consideration.

The British Psychological Society defines safeguarding as protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment.

In preparation for such disclosures within the interview this document collates the key concerns which could arise during the interview alongside guidance on the protocol to be followed by the researcher if disclosures of potential safeguarding issues arise.

Role of the Psychology Researcher

Trust is an essential part of the researcher-participant relationship and confidentiality is central to this. The participant may choose to not fully engage with the research if they think their personal information will be disclosed by researchers without consent, or without the chance to have some control over the timing or amount of information shared.

As a researcher there is a duty of confidentiality to their participants, but there is also a wider duty to protect and promote the health of the participants and the public. Therefore, confidentiality / anonymity will be maintained unless serious safeguarding concerns are raised.

Potential areas for concern

Safeguarding issues relating to children or adults, specifically GP disclosure of harm to others i.e. malpractice and GP disclosure of harm to themselves.

Institutional abuse

In relation to GPs, institutional abuse would be defined as the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk are using the services. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.

Under circumstances of disclosure of serious malpractice, the researcher will acknowledge this within the interview and re-establish consent from the participant to whether they would like to continue with the discussion of the malpractice - on the basis that advice from the research team will need to be sought regarding issues of safeguarding.

Disclosure of harm to oneself

Under circumstances where the participant disclosed intended or potential harm against oneself the researcher will refer to the sensitivity protocol where appropriate, specifically signposting services which can be accessed by the GP.

In case serious risks to self are disclosed during the interview one of the more experienced researchers will be available to be reached by phone for advice. Furthermore, the phone line for the NHS GP health services (0300 0303 300) who can help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work concerning doctors, will be at hand.

Responding to safeguarding issues

In any case where safeguarding issues arise advice will be sought from the more experienced researchers in the research team and guidance from the British Psychology Society will be adhered to.

The supervisors of this project, Professor Damien Ridge and Dr Tina Cartwright, are experts in sensitive qualitative research, having researched difficult topics (e.g. suicide, depression) for over 20 years. This study is also being guided by Professor David Peters who is an expert in the field of GP research. Therefore, if any issues arise the participants will be given proper assistance.

As above advice from the NHS GP health service may be sought by the researchers, whilst seeking this guidance, anonymity of the participant will be maintained.

Appendix Q:

Debrief Sheet

Debrief Sheet

We would like to thank personally for your participation in this study exploring the lived experience of general practitioner burnout.

What's next?

The researcher will contact you following this interview by email to ask if you would like to review the transcript of your interview. Following this, the researcher will also contact you to give you the chance to provide feedback regarding the interpreted findings from the study.

Results of the study:

The results of this study are likely to be disseminated at national and/or international conferences and published in scientific peer-reviewed journals. These results will also be written up for the purposes of in the PhD thesis of Philippa Shaw. If you wish to obtain a copy of any published results, please contact a member of the research team and we will forward to you copies of any published papers.

For further information:

You are welcome to contact one of the research team at the University of Westminster:

Philippa Shaw: P.Shaw@my.westminster.ac.uk

Tina Cartwright: T.Cartwright@westminster.ac.uk

Useful Point of Contact:

NHS GP Health Service-

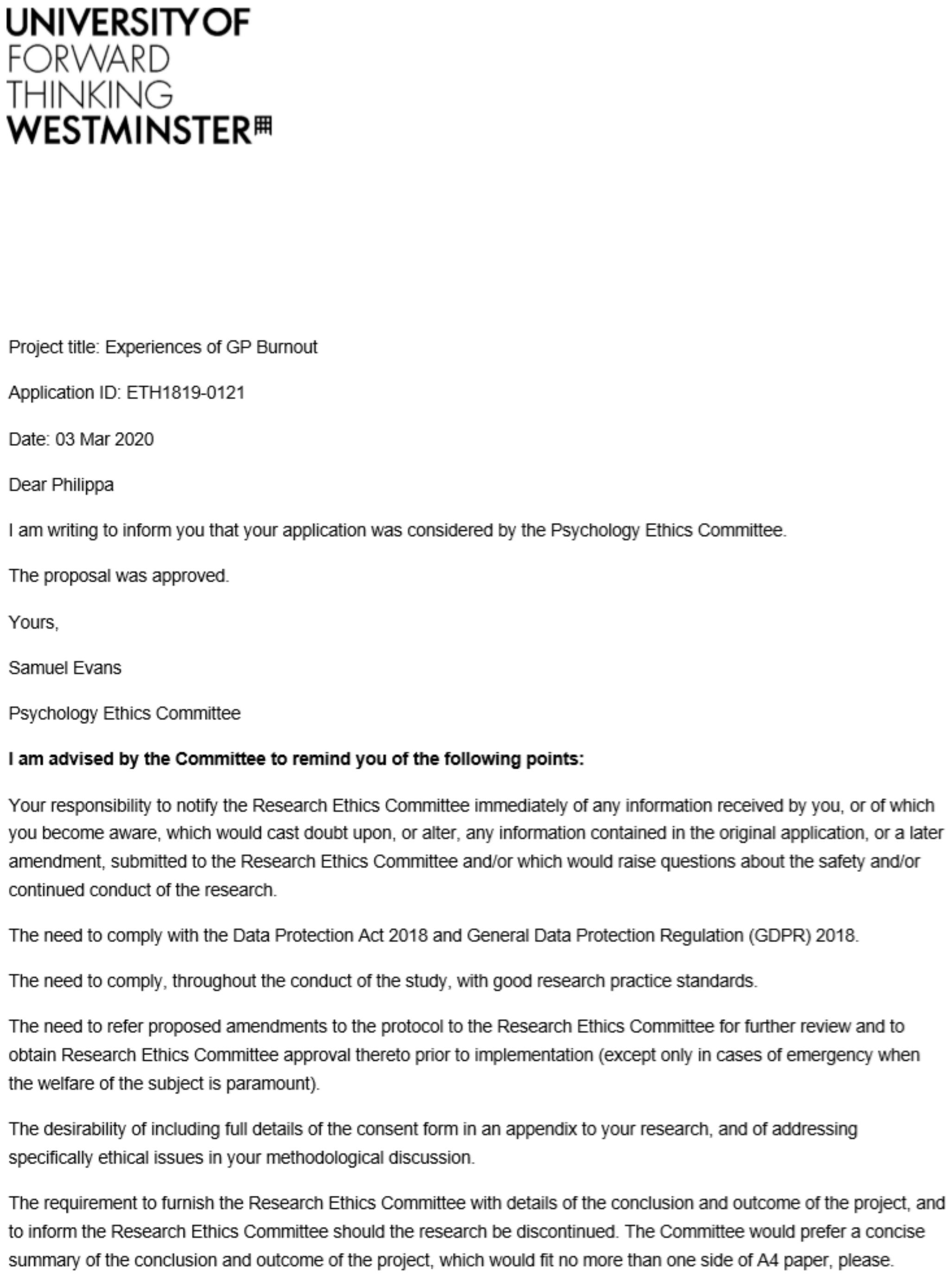
- A confidential NHS service for GPs and GP trainees across various location in England.
- The service can help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work.
- This service is provided by health professionals who have additional expertise in addressing the issues concerning doctors

Access the service by emailing gp.health@nhs.net or by calling 0300 0303 300.

The service is available Monday – Friday (8am – 8pm) and Saturday (8am – 2pm).

Appendix R:

Psychology Ethics Approval for the Investigation into the Effectiveness of the Art Based Summary Booklet



UNIVERSITY OF
FORWARD
THINKING
WESTMINSTER

Project title: Experiences of GP Burnout

Application ID: ETH1819-0121

Date: 03 Mar 2020

Dear Philippa

I am writing to inform you that your application was considered by the Psychology Ethics Committee.

The proposal was approved.

Yours,

Samuel Evans

Psychology Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

Appendix S:

Practitioner Health Service Questionnaire

NHS
GP Health Service

NHS General Practitioner Health Service Initial Assessment

Basic Information
Please note that any information you provide will be kept in the strictest confidence.

GP Health Service requests your response to the questions below. The responses will be kept anonymous and help the service improve on key parameters. Please base your answers only on your experience with GP Health Service.

1. Please complete the following information so that we can identify your response. *

First name:

Last name:

2. What is your date of birth? DD/MM/YYYY

PSYCHLOPS Pre-Therapy Questionnaire
A questionnaire about you and how you are feeling - now that you are starting therapy

3. Choose the problem that troubles you most. (Please write it in the box below.) *

4. How much has it affected you over the last week?
(Please tick one box below where 0 = Not at all Affected and 5 = Severely Affected)

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

5. How long ago were you first concerned about this problem? (Please tick one box below.)

☐ Under one month
☐ Between one month and three months
☐ Over three months but under one year
☐ One to five years
☐ Over five years

6. Choose another problem that troubles you. (Please write it in the box below.)

☐

7. How much has it affected you over the last week?
(Please tick one box below where 0 = Not at all Affected and 5 = Severely Affected) *

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

8. How long ago were you first concerned about this problem? (Please tick one box below.)

☐ Under one month
☐ Between one month and three months
☐ Over three months but under one year
☐ One to five years
☐ Over five years

9. Choose one thing that is hard to do because of your problem (or problems).
(Please write it in the box below.)

10. How hard has it been to do this thing over the last week?
(Please tick one box below where 0 = not at all hard and 5 = very hard)

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

11. How have you felt in yourself this last week?

(Please tick one box below where 0 = very good and 5 = very bad.)

☐ 0
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5

The Warwick-Edinburgh Mental Well-Being Scale

Below are some statements about your feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.

12. Please tick the box that best describes your experience of each over the last 2 weeks

	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	☐	☐	☐	☐	☐
I've been feeling useful	☐	☐	☐	☐	☐
I've been feeling relaxed	☐	☐	☐	☐	☐
I've been feeling interested in other people	☐	☐	☐	☐	☐
I've had energy to spare	☐	☐	☐	☐	☐
I've been dealing with problems well	☐	☐	☐	☐	☐
I've been thinking clearly	☐	☐	☐	☐	☐
I've been feeling good about myself	☐	☐	☐	☐	☐
I've been feeling close to other people	☐	☐	☐	☐	☐
I've been feeling confident	☐	☐	☐	☐	☐
I've been able to make up my own mind about things	☐	☐	☐	☐	☐
I've been feeling loved	☐	☐	☐	☐	☐
I've been interested in new things	☐	☐	☐	☐	☐
I've been feeling cheerful	☐	☐	☐	☐	☐

Perceived Stress Scale
Measures the degree to which situations in one's life are appraised as stressful.

13. The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

	Never	Almost never	Sometimes	Fairly often	Very often
1. In the last month, how often have you been upset because of something that happened unexpectedly?	☐	☐	☐	☐	☐
2. In the last month, how often have you felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
3. In the last month, how often have you felt nervous and "stressed"?	☐	☐	☐	☐	☐
4. In the last month, how often have you felt confident about your ability to handle your personal problems? *	☐	☐	☐	☐	☐
5. In the last month, how often have you felt that things were going your way? *	☐	☐	☐	☐	☐
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	☐	☐	☐	☐	☐
7. In the last month, how often have you been able to control irritations in your life? *	☐	☐	☐	☐	☐
8. In the last month, how often have you felt that you were on top of things? *	☐	☐	☐	☐	☐
9. In the last month, how often have you been angered because of things that were outside of your control?	☐	☐	☐	☐	☐
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	☐	☐	☐	☐	☐

PHQ 9 and GAD 7 Scales

14. PHQ-9: Over the last 2 weeks, how often have you been bothered by any of the following problems?
Scoring: 0 - Not at all, 1 - Several days, 2 - More than half the days, 3 - Nearly every day

	0	1	2	3
1. Little Interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, depressed or hopeless.	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things such as reading a newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

15. GAD-7: Over the last 2 weeks, how often have you been bothered by any of the following problems?
Scoring: 0 - Not at all, 1 - Several days, 2 - More than half the days, 3 - Nearly every day

	0	1	2	3
1. Feeling Nervous, anxious or on edge.	☐	☐	☐	☐
2. Not being able to stop or control worrying.	☐	☐	☐	☐
3. Worrying too much about different things.	☐	☐	☐	☐
4. Trouble relaxing.	☐	☐	☐	☐
5. Being so restless it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen.	☐	☐	☐	☐

Appendix T:

Notes on the Statistical Analysis

AT.1. Data Checking

The matching of data was completed across 26 Excel files. This is the matched data for the wider cohort study, a sub-set of this is presented in the write up of this thesis. The overall matched data (file 26) was checked for matching and coding errors.

First PS checked for errors of manually merging matched data, checking the correct transfer of raw data into the master document by randomly reviewing 20 sections of data for each timepoint. This is documented in Excel files 27 to 30 and show 60/60 EMIS numbers checked were correct. Secondly PS explored matching across the timepoints where additional data had been included to create a more complete data set (T1 data from prior to May 2019 included when a T2 or T3 data was within the timeframe). This was completed by checking the entire row of data, across all timepoints and referring to all raw files. Initially 30 whole matched row checks were completed which revealed one error (one participant had two rows of data which meant the T2 and T3 data were not aligned). Therefore, to investigate if additional errors had been made, 60 whole matched row checks were completed. One additional error was found of a missing T2 assessment for a participant. This is shown across files 31 to 37. Overall, from these 150 checks two matching errors had been made and corrected.

Additional checks were subsequently completed by the PHS after PS had input the matched data into SPSS and generated output showing how many participants had completed each assessment. JK from the PHS manually reviewed 35 matched data points with the system to check the extraction process, and LD from the PHS checked the discharge dates for 150 participants which enabled checking of data extraction and matching.

AT.2. Calculating Scores

Total scores were calculated by adding item scores across questions for the WEMWBS (all 14 items), the PHQ-9 (all nine items), and the GAD-7 (all seven items). Total PSS-10 scores were obtained by adding scores across the questionnaire after reversing responses (0=4, 1=3, 2=2, 3=1, and 4=0) for the four positively stated items (questions 4, 5, 7, and 8). The PSYCHLOPS questionnaires were scored by summing the four six-point Likert scores present in the 'pre-therapy', 'during therapy', and 'post-therapy' questionnaires.

AT.3. Wellbeing from T1 to T2

When exploring the differences between scores at T1 and T2, the data met the assumptions of the paired-sample *t*-test by having continuous dependent variables (total scores from the wellbeing questionnaires) and independent categorical variables with two related groups (T1 and T2). Before the analysis, the differences between the two related groups was checked for significant outliers (data points more than 1.5 box-lengths from the edge of the box in a boxplot) and the distribution of the differences in the dependent variable between the two related groups were checked for approximate normal distribution.

The non-parametric alternative to the paired-sample t-test, the Wilcoxon signed-rank test, was used when assumptions of the paired-sample *t*-tests were violated and failed to be corrected through appropriate transformation. The data met the assumptions of the Wilcoxon signed-rank test by having continuous dependent variables and matched independent categorical variables. Before completing the test, distribution of the differences between the two related groups were checked to see if they were symmetrical in shape.

Next the assumption checks are reported for each wellbeing score, as well as the documenting when the alternative non-parametric was used.

AT.3.1. WEMWBS

Six outliers were detected through the boxplot however inspection of the values did not reveal them to be extreme and therefore they were kept in the analysis. The difference scores for the WEMWBS at T1 and T2 were not normally distributed, as assessed by Shapiro-Wilk's test (p = .004). After transformation, the normality was still violated (p = .008). The paired-sample t-test has been suggested to be robust to violations of normality with respect to Type I error (Wiedermann & von Eye, 2013), therefore the findings from the test are reported here with the acknowledgement of the violated assumption; participants showed a significant increase of 12.36 (95% CI [10.54, 14.17]) in wellbeing scores from T1 to T2, *t*(133) = 13.473, ***p* < .001**, *d* = 1.16. However, due to the violation of normal distribution, and the assumption of symmetry in the data being met, the Wilcoxon signed-rank test was used and reported in the main section of the thesis.

AT.3.2. PSS-10

No outliers were detected and the difference in scores for PSS-10 T1 and T2 were normally distributed, as assessed by Shapiro-Wilk's test (*p* = .399). Therefore, a paired-sample *t*-test was used and reported in the main text.

AT.3.3 PHQ-9

Six outliers were detected, but inspection of the values did not reveal them to be extreme and therefore they were kept in the analysis. The difference scores for the WEMWBS T1 and T2 violated the assumption of normal distribution, as assessed by Shapiro-Wilk's test (*p* = .043) and remained violated after transformation (*p* = .007). PHQ-9 scores reduced by 6.55, 95% CI [-7.63, -5.48] from T1 to T2, *t*(133) = 12.073, ***p* < .001**, *d* = 1.04. However, due to the violation or normal distribution and the assumption of symmetry in the data being met, Wilcoxon signed-rank test was used and reported in the main section of the thesis.

AT.3.4. GAD-7

One outlier was detected; however inspection of the value did not reveal it to be extreme and therefore it was kept in the analysis. The difference scores for the GAD-7 T1 and T2 were normally distributed, as assessed by Shapiro-Wilk's test (*p* = .256). Therefore, a paired-sample *t*-test was used and reported in the main text.

AT.3.5. PSYCHLOPS

One outlier was detected; however inspection of the value did not reveal it to be extreme and therefore it was kept in the analysis. The difference scores for the PSYCHLOPS T1 and T2 were normally distributed, as assessed by Shapiro-Wilk's test (p = .084). Therefore, a paired-sample *t*-test was used and reported in the main text.

AT.4. Wellbeing from T1 to T3

One-way repeated measure ANOVAs and post-hoc analysis with Bonferroni adjustments were used to analyse the change in mean scores over time, from T1, to T2, to T3. The data met the assumptions of a one-way repeated measure ANOVA by having the continuous dependent variable of wellbeing questionnaire scores and having a within-subjects factor that is categorical with three levels (time; T1, T2 and T3). Before analysis three additional assumptions were checked: that there were no significant outliers in any level of time, that dependent variable were approximately normally distributed for each level of time, and the variances of the differences between all combinations of levels of time were equal.

Although the one-way repeated measure ANOVA is fairly robust to non-normality (Blanca et al., 2017), if transformed data still violated normality an appropriate non-parametric test was used with Bonferroni correction for multiple comparisons. The non-parametric alternative to the one-way repeated measure ANOVA is Friedman test. Assumptions for this test were met with the data having one continuous dependent variable (wellbeing questionnaire scores), and one independent variable with three or more categorical related groups (time; T1, T2, and T3).

The additional assumptions were checked and the results for each wellbeing questionnaire are reported below, as well as the documenting when the additional non-parametric test was used.

AT.4.1. WEMWBS

One outlier was detected through boxplot, however, inspection of the value did not reveal it to be extreme and therefore it was kept in the analysis. Total WEMWBS scores were normally distributed at T1, T2 and T3 as assessed by Shapiro-Wilk's test ($p > .05$). Mauchly's test of sphericity indicated that the assumption of sphericity met, $\chi^2(2) = 5.300$, $p = .071$.

AT.4.2. PSS-10

One outlier was detected more than 1.5 box-lengths from the edge of the box in a boxplot, however inspection of the value did not reveal it to be extreme and consequently these were kept in the analysis. Total PSS-10 scores were normally distributed at each time point, as assessed by Shapiro-Wilk's test ($p > .05$), and Mauchly's test of sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 4.79$, $p > .05$.

AT.4.3. PHQ-9

Three outliers were detected. One was determined to not be extreme through further inspection and therefore kept in the analysis, whereas two were identified as extreme outliers and therefore removed from the analysis. Total PHQ-9 scores were normally distributed at T1, as assessed by Shapiro-Wilk's test ($p > .05$), however violated the assumption of normality at the T2 and T3 ($p = .022$ and $p = .018$, respectively). By exploring histograms and Q-Q Plots it was determined that there was a moderate positive skew for each, therefore a square root transformation was applied. After the transformation, scores were normally distributed at each timepoint, as assessed by Shapiro-Wilk's test ($p > .05$). The ANOVA was therefore conducted using the transformed data. Mauchly's test of sphericity indicated that the assumption of sphericity had not been violated, $\chi^2(2) = 1.047$, $p > .05$.

AT.4.4. GAD-7

Three outliers were detected that were more than 1.5 box-lengths from the edge of the box in a boxplot. Inspection of the values revealed one outlier was not extreme (these were kept in the analysis) and two were extreme and therefore removed from the analysis. Total GAD-7 scores were normally distributed at the T1, as assessed by Shapiro-Wilk's test ($p > .05$), however violated the assumption of normality at T2 and T3 ($p = .004$ and $p = .007$, respectively). By looking at histograms and Q-Q Plots it was determined that there was a moderate positive skew for each, therefore a square root transformation was applied. After the transformation the normality as assessed by Shapiro-Wilk's test was still violated for T3 ($p = .001$) but not T2 ($p = .096$).

AT.4.5. PSYCHLOPS

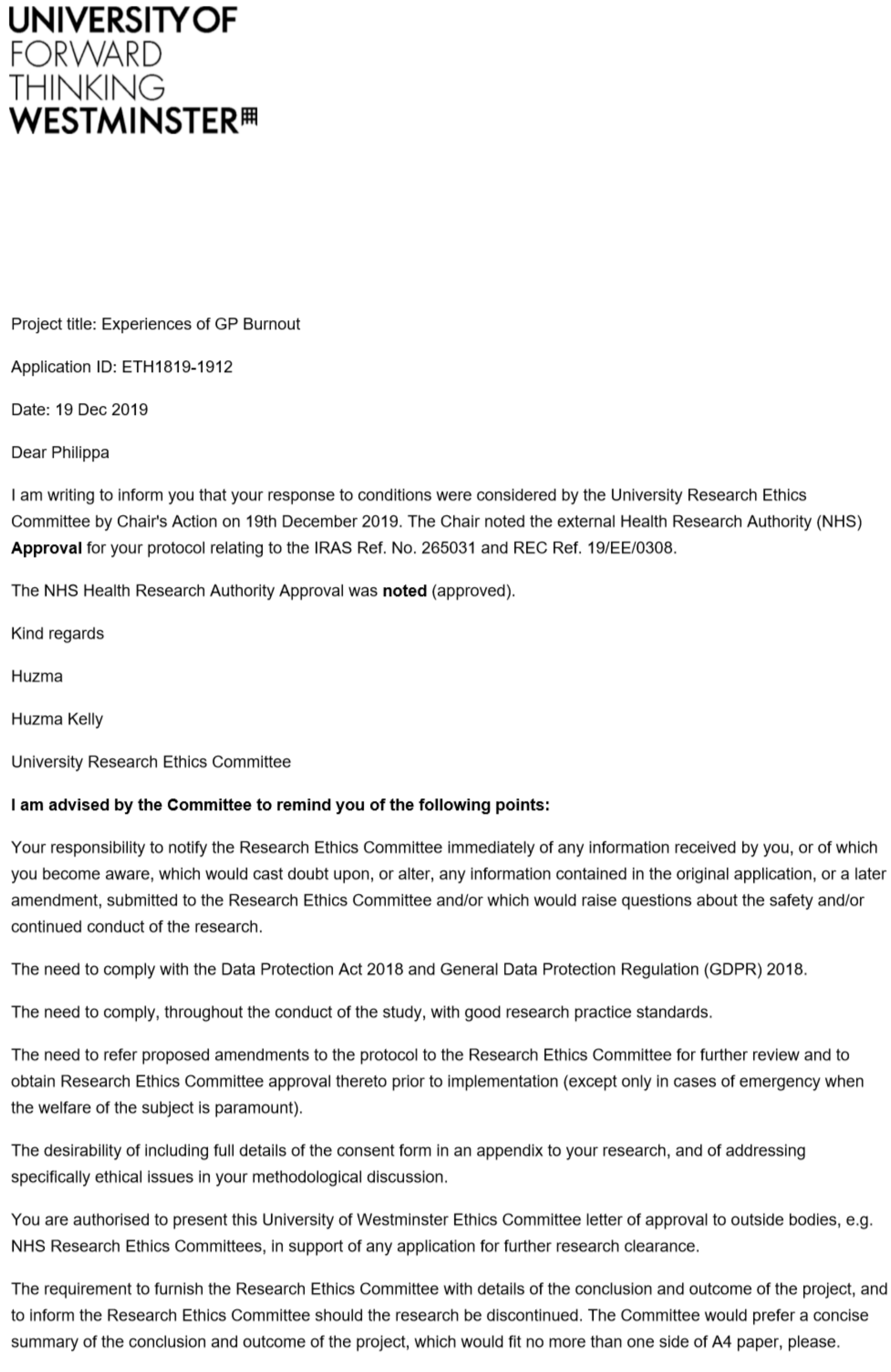
Four outliers were detected using boxplot. On further inspection of the values, three were not extreme and therefore were kept in the analysis, but one was considered extreme and therefore removed from the analysis. Total PYCHLOPS scores were normally distributed at T2 as assessed by Shapiro-Wilk's test (p > .05), however violated the assumption of normality at the T1 and T3 ($p = .017$ and $p = .004$ respectively). By looking at histograms and Q-Q Plots it was determined that there was a moderate positive skew for this data set, therefore a square root transformation was applied. After the transformation the normality was still violated for T1 and T3 ($p = .001$ and $p = .028$ respectively).

AT.5. Comparison of T1-T2 and T1-T3 Completers Scores at T1 and T2

The non-parametric version of the independent samples *t*-test was completed due to the unequal samples of grouped data T1-T2 compared to T1-T3. The data met the requirement for the Mann-Whitney U by having continuous dependent variables of wellbeing questionnaire total scores, independent variable categorised into two groups (completed T1-T2 or T1-T3), and independence of observations (participants could only qualify for one of these groups). The distribution of scores for groups for each wellbeing questionnaire had the same shape, as checked through graphs.

Appendix U:

UREC Ethics Approval for Recovery Studies



UNIVERSITY OF
FORWARD
THINKING
WESTMINSTER

Project title: Experiences of GP Burnout

Application ID: ETH1819-1912

Date: 19 Dec 2019

Dear Philippa

I am writing to inform you that your response to conditions were considered by the University Research Ethics Committee by Chair's Action on 19th December 2019. The Chair noted the external Health Research Authority (NHS) **Approval** for your protocol relating to the IRAS Ref. No. 265031 and REC Ref. 19/EE/0308.

The NHS Health Research Authority Approval was **noted** (approved).

Kind regards

Huzma

Huzma Kelly

University Research Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

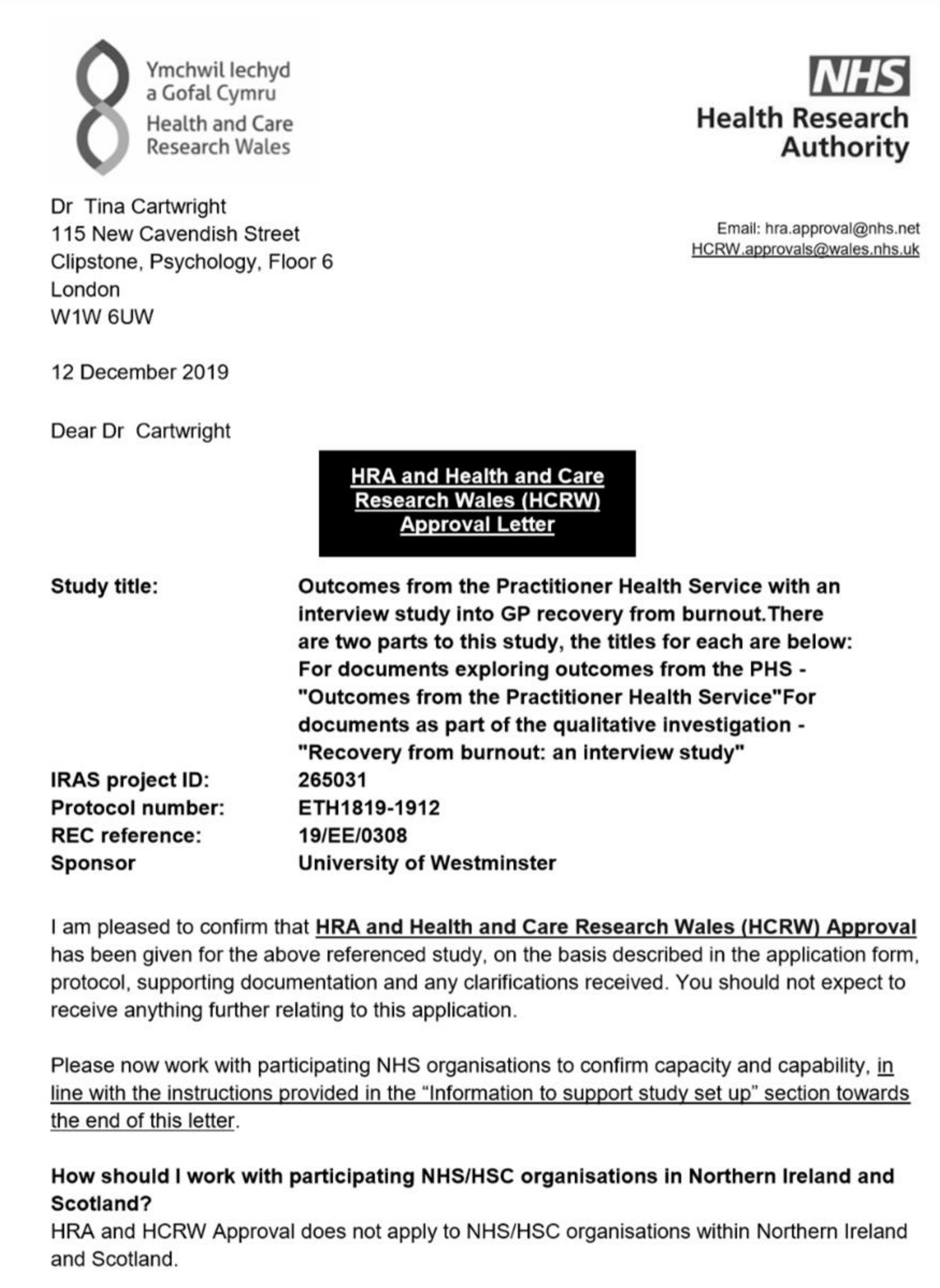
The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

You are authorised to present this University of Westminster Ethics Committee letter of approval to outside bodies, e.g. NHS Research Ethics Committees, in support of any application for further research clearance.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

Appendix V:

NHS HRA Favourable Opinion for Recovery Studies Ethics



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Dr Tina Cartwright
115 New Cavendish Street
Clipstone, Psychology, Floor 6
London
W1W 6UW

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

12 December 2019

Dear Dr Cartwright

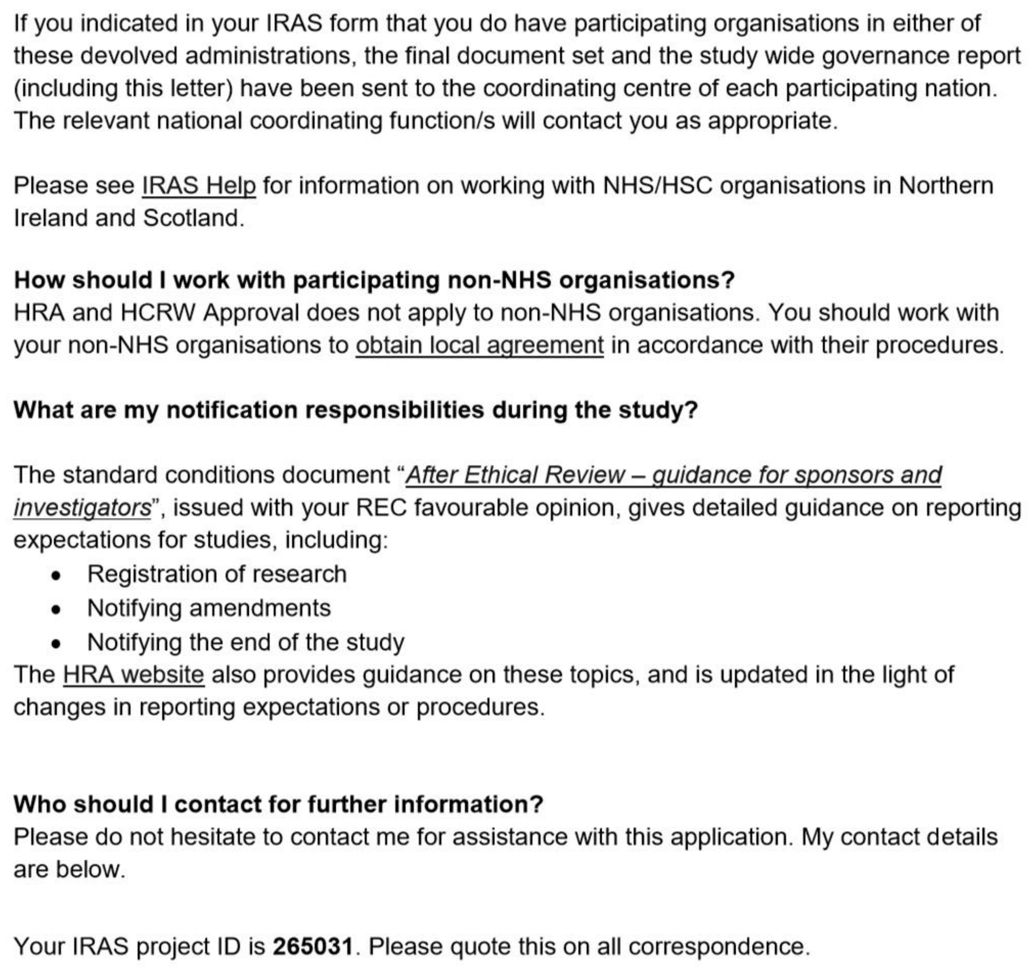
HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Outcomes from the Practitioner Health Service with an interview study into GP recovery from burnout.There are two parts to this study, the titles for each are below: For documents exploring outcomes from the PHS - "Outcomes from the Practitioner Health Service"For documents as part of the qualitative investigation - "Recovery from burnout: an interview study"**
IRAS project ID:	**265031**
Protocol number:	**ETH1819-1912**
REC reference:	**19/EE/0308**
Sponsor	**University of Westminster**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.



If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

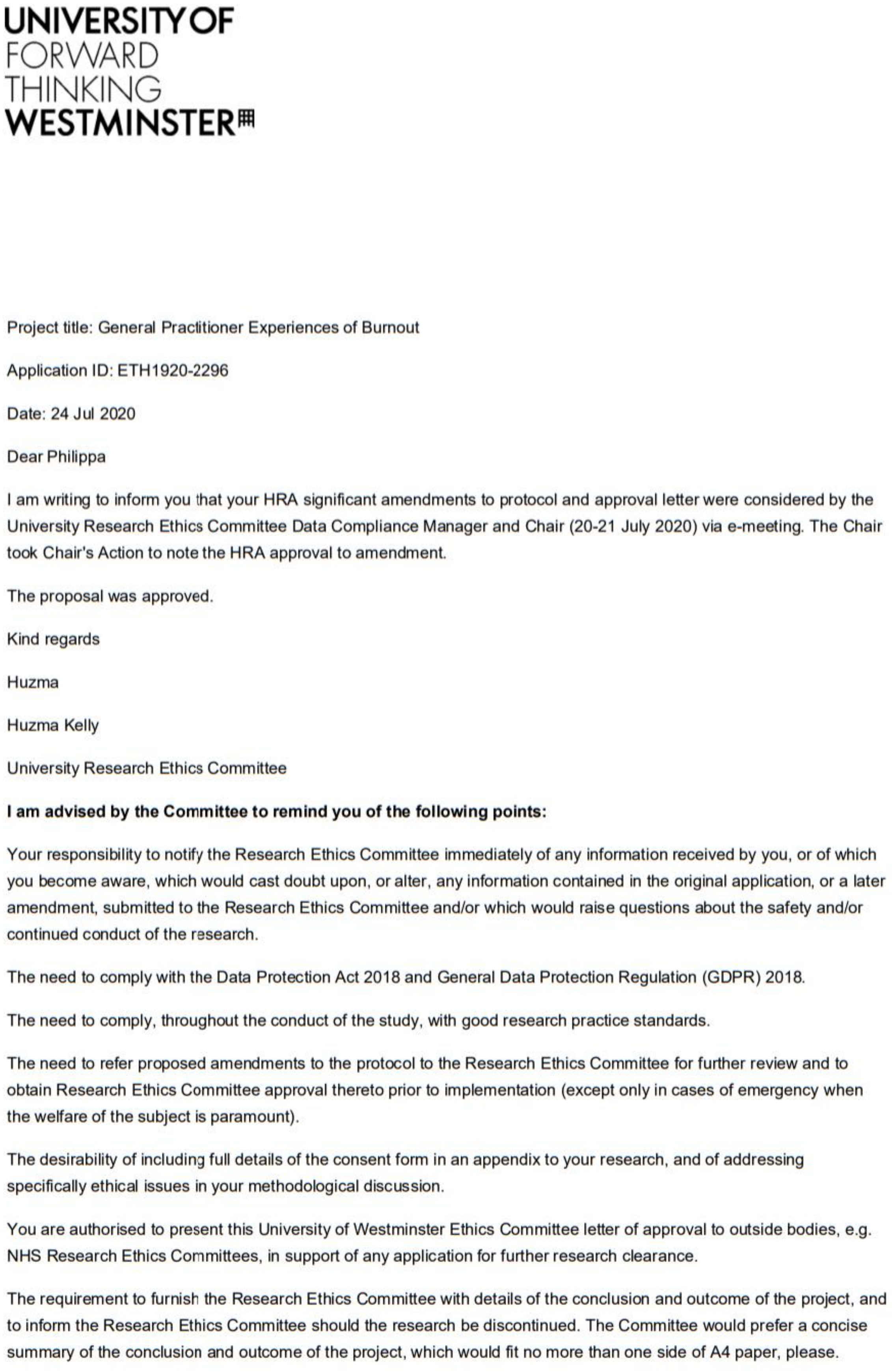
The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **265031**. Please quote this on all correspondence.

Appendix W:

UREC Ethics Approval for Recovery Studies – Significant Amendments



UNIVERSITY OF
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WESTMINSTER

Project title: General Practitioner Experiences of Burnout

Application ID: ETH1920-2296

Date: 24 Jul 2020

Dear Philippa

I am writing to inform you that your HRA significant amendments to protocol and approval letter were considered by the University Research Ethics Committee Data Compliance Manager and Chair (20-21 July 2020) via e-meeting. The Chair took Chair's Action to note the HRA approval to amendment.

The proposal was approved.

Kind regards

Huzma

Huzma Kelly

University Research Ethics Committee

I am advised by the Committee to remind you of the following points:

Your responsibility to notify the Research Ethics Committee immediately of any information received by you, or of which you become aware, which would cast doubt upon, or alter, any information contained in the original application, or a later amendment, submitted to the Research Ethics Committee and/or which would raise questions about the safety and/or continued conduct of the research.

The need to comply with the Data Protection Act 2018 and General Data Protection Regulation (GDPR) 2018.

The need to comply, throughout the conduct of the study, with good research practice standards.

The need to refer proposed amendments to the protocol to the Research Ethics Committee for further review and to obtain Research Ethics Committee approval thereto prior to implementation (except only in cases of emergency when the welfare of the subject is paramount).

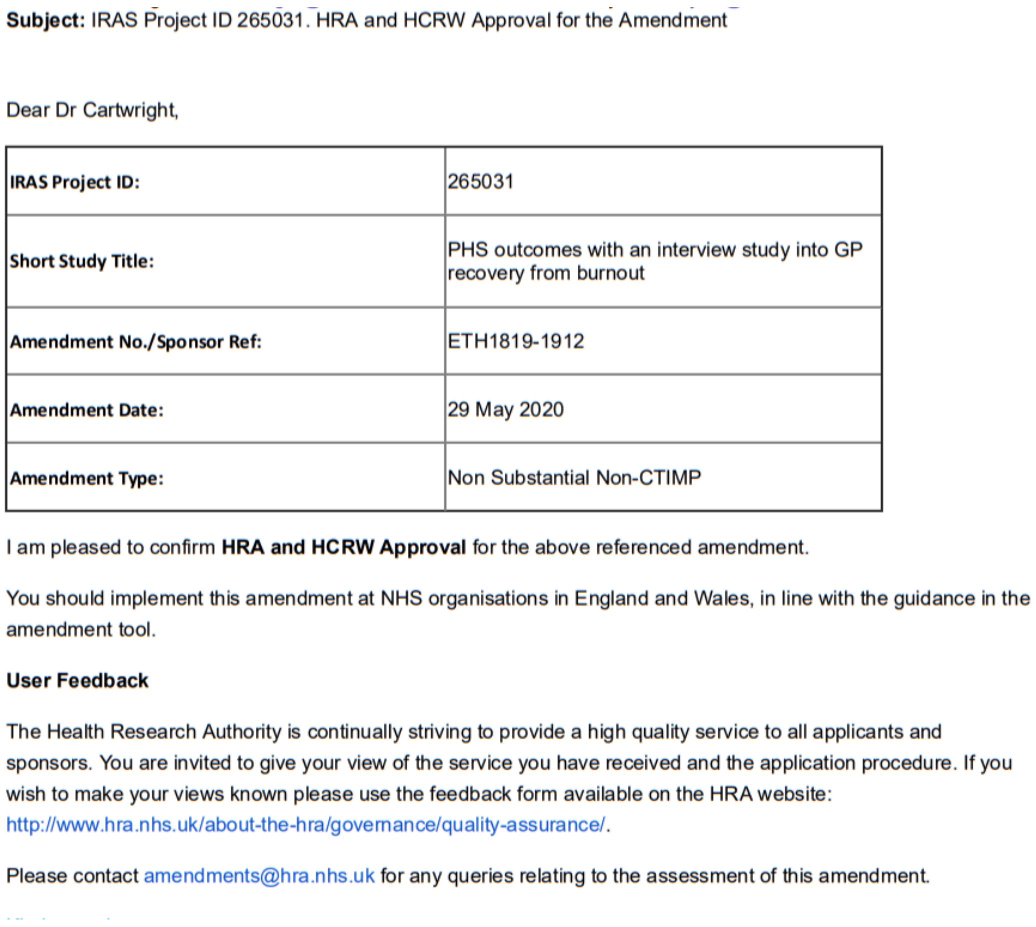
The desirability of including full details of the consent form in an appendix to your research, and of addressing specifically ethical issues in your methodological discussion.

You are authorised to present this University of Westminster Ethics Committee letter of approval to outside bodies, e.g. NHS Research Ethics Committees, in support of any application for further research clearance.

The requirement to furnish the Research Ethics Committee with details of the conclusion and outcome of the project, and to inform the Research Ethics Committee should the research be discontinued. The Committee would prefer a concise summary of the conclusion and outcome of the project, which would fit no more than one side of A4 paper, please.

Appendix X:

NHS HRA Favourable Opinion for Recovery Studies Ethics – Significant Amendments



Subject: IRAS Project ID 265031. HRA and HCRW Approval for the Amendment

Dear Dr Cartwright,

IRAS Project ID:	265031
Short Study Title:	PHS outcomes with an interview study into GP recovery from burnout
Amendment No./Sponsor Ref:	ETH1819-1912
Amendment Date:	29 May 2020
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Appendix Y:

Email Invitation for the Recruitment of Participants in Recovery from Burnout

This letter of invitation will be emailed to general practitioners (GPs) who were selected as matching the inclusion criteria during the screening of the Practitioner Health Service (PHS) database. This email will be distributed by PHS administrative staff. From this email it is the choice of the GP whether they reach out to the researcher, or not, for involvement.

Subject line: Invitation to participate in an interview exploring recovery from burnout

Dear xxx

This email is being sent from the Practitioner Health Service on behalf of a research team, as we feel you may be interested in their project.

We are a research team from the University of Westminster made up of Psychology researchers and an academic GP. We are interested in the experiences of primary care GPs who have overcome burnout, and are contacting you to invite you to take part in a research study called “recovery from burnout: an interview study.”

This study aims to explore the stories of GPs to gain insight into what happens for GPs after they have experienced burnout, perceptions of the possibilities of successfully overcoming burnout and how individuals are making sense of these experiences. We hope to use these narratives to improve our knowledge of burnout experiences, specific to GPs, which will help inform and improve the support GPs receive for burnout.

Therefore, we are looking to interview primary care GPs who self-identify as having experienced burnout and subsequently consider their mental wellbeing to have improved significantly during the last 5 years (some may consider this to be a process of “recovery”).

The interview will be in person in London at a venue convenient to you, or via Skype, and will last approximately 60 to 90 minutes. We are also exploring burnout recovery visually through participant created photographs. Therefore, prior to the interview we ask you to imagine you are contributing to an exhibition titled “GP’s recovery from burnout”, which would represent your individual experience. The contribution is in the form of two to four photographs which you feel are related to your experience of burnout recovery. These will be discussed during the interview.

We understand that confidentiality is important in relation to this sensitive topic and have worked with the PHS to create our process of recruitment and subsequent anonymisation of information (photographs and transcribed interviews). The information sheet for this study is attached to this email invitation which provides a more detailed outline. An inconvenience allowance of £50 Amazon vouchers will be provided for participation.

If you would like to take part in the research or have any questions please email the research team using P.Shaw@my.westminster.ac.uk.

Thank you.
Yours sincerely,
Philippa Shaw

Appendix Z:

Information Sheet for Recovery from Burnout

Information Sheet

Recovery from burnout: an interview study

Primary Researcher: Philippa Shaw (MSc; PhD candidate).
Supervisors: Dr. Tina Cartwright, Prof. Damien Ridge and Prof. David Peters.

We would like to invite you to take part in an interview whose aim is to explore the experience of GPs who self-identify as having overcome burnout within the past 5 years. This study aims to explore the stories of GPs to gain insight into what happens for GPs after they have experienced burnout, perceptions of the possibilities of successfully overcoming burnout, and how individuals are making sense of their experiences. We hope to use these narratives to improve our knowledge of burnout experiences, specific for GPs, which will help inform and improve the support GPs receive for burnout.

The Study:

Below is a detailed outline of your role within the study if you decide to take part.

Organising the when and where of the interview:

Contact Philippa via **P.Shaw@my.westminster.ac.uk** (or call 020 7911 5000 ext 69030) to register your interest and to work with the researcher to organise a convenient time and location (or Skype) for an interview. In person interviews are available for those in London (a room can be booked in the University of Westminster, or you can select a quiet location where you would be comfortable, for example your home or a quiet meeting room at work). For interested participants who are outside of London the interview will be conducted via Skype (or if you live in London but would feel more comfortable with a Skype interview). Times for the interview can be flexible including outside of working hours if you prefer.

Photo collection / generation:

During the period of time prior to your interview (one or two weeks would be preferable), you will be asked to think about the photo-elicitation element of the interview. This is the use of photographs during the interview (provided by the participant) which allows the exploration of the story behind the photograph and what it means to you.

A potentially useful way to think about this is to imagine you are contributing to an exhibition titled “GP’s recovery from burnout”, which would show your individual experience. The contribution is in the form of two to four photographs which you feel are related to your experience of burnout recovery which will be given to the researcher prior to the interview. You can be as creative as you like with this. The photographs could be anything which resonate with your experience of burnout to overcoming burnout, from photographs taken during the time to new photographs of scenes, items or artwork. If you select items or artwork, you are more than welcome to bring the original item or artwork to the interview to talk about.

These photographs should be taken digitally (using a phone camera or digital camera). There are several secure ways which the photographs can be given to the researcher prior to the interview, the researcher is more than happy to discuss the way which best suits you. Options could be the researcher arranging a visit to collect the photographs on an encrypted memory stick, emailing a password protected word document with the photographs inserted in the file or use of Dropbox.

The Interview

Before the interview, you will have the opportunity to ask questions to the researcher and go through this information sheet before providing consent.

You will be asked to complete an optional questionnaire regarding your demographic information (such as age and length of employment as a GP) which will help prove context to the findings of the study. There will also be two short validated questionnaires taking no more than 10 minutes in total. These questionnaires can either be completed online prior to the interview (if you prefer or if the interview is to be held on Skype) or hard copy (on the day of the interview if you have organised a face to face interview).

The interview will be between you and the researcher and will last approximately 60 to 90 minutes where we will discuss your experiences of overcoming burnout. Examples of topics for the interview: experiences of recovery, what recovery means to you, navigating work after burnout, and current experience of quality of life. We will also talk though the photographs or items you have selected and what they mean to you and your experience with burnout.

The interview will be audio recorded using an encrypted dictaphone.

The researchers have a duty of confidentiality to their participants, but also have a wider duty to protect and promote the health of the participants and the public. Therefore, confidentiality / anonymity will be maintained unless serious safeguarding concerns are raised. In any case where safeguarding issues arise, this will be discussed within the research team and guidance from the British Psychology Society will be adhered to. Advice from the NHS GP Health Service may be sought by the researchers (whilst seeking this guidance, anonymity of the participant will be maintained).

After the interview

When the interview is complete the researcher will provide you with an inconvenience allowance of £50 Amazon Vouchers. This can be physically if the interview is in person, or arrangements can be made to email you the allocated codes to use on Amazon or post the vouchers to a provided address.

When your interview is transcribed your data will be anonymised, with identifiable information removed, and your name will be coded to ensure pseudo-anonymisation on all documents. Therefore, after the interview the researcher will explain the process of anonymisation (for the interview transcript and photographs) and check with you for consent to use the photographs after anonymisation in the study write up and dissemination.

There will be a separate consent form where you will be able to indicate which photographs you are happy to be used in publication and dissemination, and indicate specific elements you wish to be anonymised (for example this may be blurring / covering faces, house numbers, street names or cropping elements out of the picture).

We will provide you with the opportunity to review the anonymised transcripts and photographs to make sure you are happy all potentially identifiable information has been removed. The reviewing of anonymised transcripts and photographs is optional.

Ethical Approval:

This study has been approved by the University of Westminster's Research Ethics Committee (*ETH1819-1912*) and has received NHS REC Approval (*IRAS ID: 265031*).

What are your choices within this research?

- You can decide not to answer any question that is asked of you
- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have

Benefits and Risks:

- Participation in this study involves completion of some standardised questionnaires, investigating burnout and wellbeing, which are not used for diagnostic purposes
- There are no anticipated disadvantages involved with this study. If you feel any discomfort or distress in answering any of the questions on during the study, please let the researcher know

How will we use information about you?

We will need to use information from your participation for this research project.

This information will include data collected from the questionnaire, the interview and photographs. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Data Privacy:

The research team at the University of Westminster will collect information from you for this research study in accordance with HRA guidelines. The team will keep your name and contact details confidential. The research team will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study.

The University of Westminster is the sponsor for this study (based in the United Kingdom). We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Westminster will keep identifiable information about you for 2 years after peer review publication or submission of Philippa Shaw's thesis (whichever is later).

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained if this has been anonymised. To safeguard your rights, we will use the minimum personally-identifiable information possible. All data will be stored in compliance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) 2018.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- by sending an email to P.Shaw@my.westminster.ac.uk
- by ringing us on 020 7911 5000 ext 69030

Findings of the study:

The results of this study are likely to be disseminated at national and/or international conferences and published in scientific peer-reviewed journals as well as shorter reports creatively disseminated though other avenues such as social media and relevant newsletters.

For further information:

Philippa Shaw (P.Shaw@my.westminster.ac.uk) and supervisor Tina Cartwright (T.Cartwright@westminster.ac.uk) will be glad to answer your questions about this study at any time.

If you have questions, concerns or suggestions about this research that you do not feel can be addressed by the researcher, please contact the University of Westminster's Psychology Research Ethics committee convenor Coral Dando (C.Dando@westminster.ac.uk).

Appendix AA:

Consent Form for Recovery from Burnout

Consent Form

Recovery from burnout: an interview study

By signing below, you are agreeing that:

(1) You have read and understood the information sheet for the above study and have had the opportunity to ask questions which have been answered satisfactorily.

(2) You are taking part in this research study voluntarily and have been made aware of your rights to withdraw at any time without providing an explanation and can decline to answer any question.

(3) You understand once you have taken part in the study, you are still able to withdraw your data (demographic information, interview transcripts and provided photographs) at any point until the data has been anonymised.

(4) You are aware your identity, contact details and the information provided will be treated confidentially and in accordance with the University of Westminster ethical guidelines and British Psychological Society code of human research ethics. Your personal information may be shared with members of the research team.

(5) You are aware that what you discuss within the interview will be confidential. The only exception to this is where there may be a risk of harm to myself or others (safeguarding concerns).

(6) Your interview will be digitally audio recorded for later transcription and analysis. Your data will be securely stored in compliance with the Data Protection Act 2018 and General Data Protection Regulations (GDPR) 2018. Once transcribed and the research is complete, the digital recording will be securely destroyed.

(7) Your data (interview transcripts and provided photographs) will be anonymised, and all identifying features/information will be removed so that my contribution will not be identifiable when reporting this research. Pseudo-anonymous direct quotes from the interview will be used in the study reports and dissemination of findings.

Participant’s signature Date

________________________________ ________________________________

Appendix BB:

Interview Schedule for Recovery from Burnout

Interview Schedule

Recovery from burnout: an interview study

The interview:

- I hope the interview will be more like a chat, with you doing most of the talking. We will explore your story of recovery from burnout.
- Sometimes in these interviews people have felt like they have been talking too much, don't worry about that, if you go off track, I will ask you some questions which will set you right again.
- If I ask a question which doesn't make sense, please ask me.
- Because I want to find out about your own personal opinions and experiences, there are no right or wrong answers. Sometimes questions I ask may sound a bit obvious or strange – this is because I am trying not to take anything for granted and to find out your own opinions.

The photographs:

- When we are talking through your story, if you feel like a photograph fits with what you are saying please do mention it and we can talk about that photograph at that point.
- If all the photographs have not been brought into the conversation by the end of your story, I will ask you to explore any remaining pictures in the order you choose.

Finally, at the end I will check if there is anything else you would like to add and then I will talk you through what happens next. In that debrief you can ask anything you would like about me or the work that I am doing.

I would also like to remind you that you don't have to answer any questions you don't feel comfortable with and remind you that I will be recording the interview. If you need a drink or to take a call or anything like that, just let me know and we can pause the interview. c

Any questions?

Due to this study being informed by the narrative approach and employing photo-elicitation, an unstructured interview has been deemed most appropriate. Therefore, the interview will be interviewee led with use of the following interviewer questions and prompts where appropriate.

Examples of the questions the interviewer may ask:

- Starting at the beginning, tell me about the time leading up to burnout
- When did you first experience burnout?
- Tell me about recovery
- Where do these photographs fit within your story? – What would be the best order to talk through these?
- Tell me about photograph [*1 / 2 / 3 / 4*]
- Thinking back over the last few months, how are things for you now?

The interviewer will be using questions like those provided above to elicit narrative from the interviewee and will have minimal input to reduce the interruption of narrative flow.

Prompt questions will be used where appropriate. Examples of such questions are provided below:

- What do you mean when you said [*quote*]?
- How did that make you feel?
- Where does this fit into your story?
- How do you relate this to your recovery from burnout?
- How does this relate to earlier in your life, for example in medical school?

Appendix CC:

Photograph Consent Form in Recovery from Burnout

Consent Form – Photo Publication

Recovery from burnout: an interview study

The researcher will provide you with a copy of each photo with the allocated photograph numbers.

Please indicate which photographs you are happy for the research team to use in the dissemination of findings and study reports, by ticking the box to the left of the picture number. If you would like the photograph to be used but feel the image may have identifiable elements, please indicate these elements under "Identifiable Elements" so the researcher can adapt the image appropriately.

Photograph	Identifiable Elements
☐ 1	
☐ 2	
☐ 3	
☐ 4	

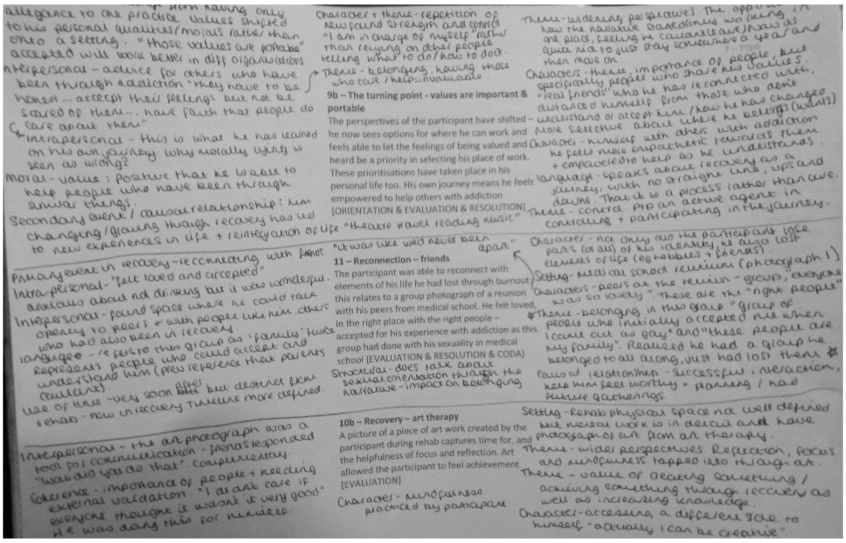
By signing below, you are agreeing to the photographs you ticked to be anonymised and potentially used in the write up and dissemination of study findings. You will be given the opportunity to review the selected photographs once the researcher has completed the anonymisation. If you elect to not review the photographs at the next stage (this is optional), continued consent for ticked photographs will be assumed.

Participant's signature Date

________________________________ ________________________________

Appendix DD:

Examples of the Narrative Analysis – Domains and Elements



from having only allegiance to the practice values shifted to his personal qualities/morals rather than onto a setting. "those values are portable" accepted will work better in diff organisations

Interpersonal – advice for others who have been through addiction "they have to be honest … accept their feelings but not be scared of them…. have faith that people do care about them"

Intrapersonal – this is what he has learned on his own journey why morally lying is seen as wrong?

Moral – value: positive that he is able to help people who have been through similar things.

Secondary event / causal relationship: him changing/growing through recovery has led to new experiences in life + reintegration of life "theatre travel reading music"

Character + theme – repetition of new found strength and control "I am in charge of myself" rather than relying on other people telling what to do/how to do it.

→ Theme – belonging, having those who care / help = invaluable

9b – The turning point - values are important & portable

The perspectives of the participant have shifted – he now sees options for where he can work and feels able to let the feelings of being valued and heard be a priority in selecting his place of work. These prioritisations have taken place in his personal life too. His own journey means he feels empowered to help others with addiction [ORIENTATION & EVALUATION & RESOLUTION]

Theme – widening perspectives. The opposite in how the narrative started (only working in one place, feeling he couldn't leave) now as quite nice to just stay somewhere a year and then move on

7 – Ptp6

Characters – theme, importance of people, but specifically people who share his values. "real friends" who he has reconnected with, distanced himself from those who don't understand or accept him / how he has changed

More selective about where he belongs (wants)

Character – himself with others with addiction he feels more empathetic towards them + empowered to help as he understands

Language – speaks about recovery as a journey, with no straight line, ups and downs. That it is a process rather than cure.

Theme – control Ptp an active agent in controlling + participating in the journey.

Primary event in recovery – reconnecting with friends.

Intrapersonal – "felt loved and accepted" anxious about not drinking but it was wonderful.

Interpersonal – found space where he could talk openly to peers + with people like him. others who had also been in recovery

Language – refers to this group as 'family' twice represents people who could accept and understand him (prev reference their parents couldn't).

Use of time – very soon ~~bef~~ after but distinct from rehab – now in recovery Timeline more defined.

"it was like we'd never been apart"

11 – Reconnection – friends

The participant was able to reconnect with elements of his life he had lost through burnout; this relates to a group photograph of a reunion with his peers from medical school. He felt loved, in the right place with the right people – accepted for his experience with addiction as this group had done with his sexuality in medical school [EVALUATION & RESOLUTION & CODA]

Structural – does talk about sexual orientation through the narrative – impact on belonging

Character – not only did the participant lose parts (or all) of his identity, he also lost elements of life (eg hobbies + friends)

Setting – medical school reunion (photograph 1)

Characters – peers at the reunion – group, "everyone was so lovely". These are the "right people"

☆ Theme – belonging in this group "group of people who initially accepted me when I came out as gay" and "these people are my family". Realised he had a group he belonged to all along, just had lost them ☆

Causal relationship – successful interaction, help him feel worthy = planning / had future gatherings.

Interpersonal – the art photograph was a tool for communication – friends responded "wow did you do that" complimentary

Coherence – importance of people + needing external validation. "I didn't care if everyone thought it wasn't very good" He was doing this for himself.

10b – Recovery – art therapy

A picture of a piece of art work created by the participant during rehab captures time for, and the helpfulness of focus and reflection. Art allowed the participant to feel achievement [EVALUATION]

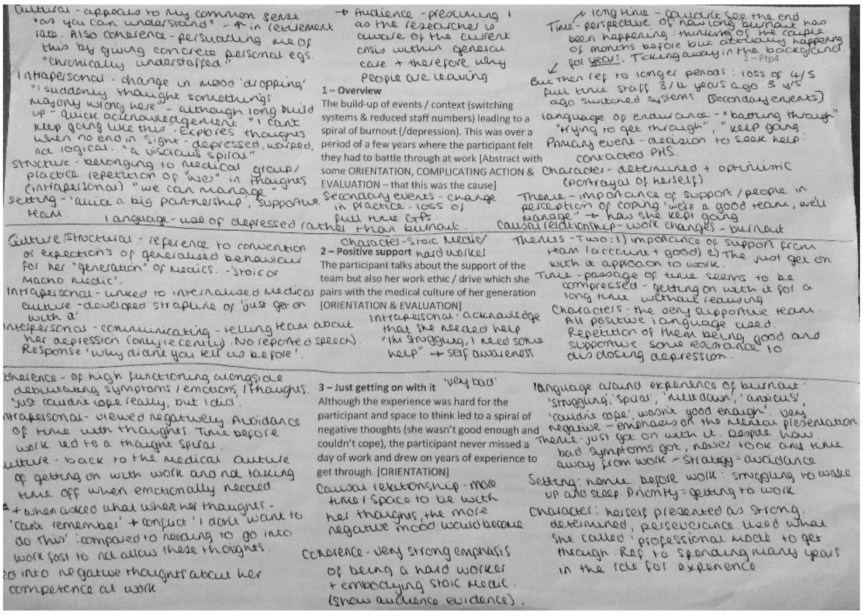
Character – mindfulness practiced by participant

Setting – Rehab physical space not well defined but mental work is in detail and have photograph of art from art therapy.

Theme – wider perspectives. Reflection, focus and mindfulness tapped into through art.

Theme – value of creating something / achieving something through recovery as well as increasing knowledge.

Character – accessing a different side to himself "actually I can be creative"



Cultural – appeals to my common sense "as you can understand" – ↑ in retirement rate. Also coherence – persuading me of this by giving concrete personal egs. "chronically understaffed"

Intrapersonal – change in mood 'dropping' "I suddenly thought something's majorly wrong here" – although long build up – quick acknowledgement. "I can't keep going like this". Explores thoughts when no end in sight – depressed, warped, not logical. "a viscious spiral"

Structure – belonging to medical group/practice repetition of "we" in thoughts (intrapersonal) "we can manage"

Setting – 'quite a big partnership', supportive team.

Language – use of depressed rather than burnout.

→ Audience – presuming I as the researcher is aware of the current crisis within general care + therefore why people are leaving

1 – Overview

The build-up of events / context (switching systems & reduced staff numbers) leading to a spiral of burnout (/depression). This was over a period of a few years where the participant felt they had to battle through at work [Abstract with some ORIENTATION, COMPLICATING ACTION & EVALUATION – that this was the cause]

Secondary events – change in practice – loss of full time GPs.

↗ long time – couldn't see the end

Time – perspective of how long burnout has been happening: thinking of the couple of months before but actually happening for years. Ticking away in the background.

1 – Ptp4

↙ But then ref to longer periods: loss of 4/5 full time staff 3/4 years ago. 3 y/s ago switched systems (Secondary events)

Language of endurance – "battling through" "trying to get through", "keep going"

Primary event – decision to seek help. contacted PHS.

Character – determined + optimistic (portrayal of herself)

Theme – importance of support / people in perception of coping "we're a good team, we'll manage" → how she kept going

Causal relationship – work changes – burnout

Culture/Structural – reference to convention or expections of generalised behaviour for her "generation" of medics. – 'stoic or macho medic'.

Intrapersonal – linked to internalised medical culture – developed strapline of 'just get on with it'

Interpersonal – communicating – telling team about her depression (only recently). No reported speech). Response 'why didn't you tell us before'.

Character – Stoic Medic/hard worker

2 – Positive support

The participant talks about the support of the team but also her work ethic / drive which she pairs with the medical culture of her generation [ORIENTATION & EVALUATION]

Intrapersonal – acknowledge that she needed help "I'm struggling, I need some help" → self awareness

Themes – Two: 1) importance of support from team (account + good) 2) The just get on with it approach to work.

Time – passage of time seems to be compressed – getting on with it for a long time without realising

Characters – the very supportive team. All positive language used. Repetition of them being good and supportive. Some reassurance to disclosing depression.

oherence – of high functioning alongside debilitating symptoms / emotions / thoughts. 'just couldn't cope really, but I did'.

ntrapersonal – viewed negatively. Avoidance of time with thoughts. Time before work led to a thought spiral.

ulture – back to the medical culture of getting on with work and not taking time off when emotionally needed.

* + when asked what where her thoughts – 'can't remember' + conflict 'I don't want to do this'. compared to needing to go into work fast to not allow these thoughts.

ed into negative thoughts about her competence at work

'very bad'

3 – Just getting on with it

Although the experience was hard for the participant and space to think led to a spiral of negative thoughts (she wasn't good enough and couldn't cope), the participant never missed a day of work and drew on years of experience to get through. [ORIENTATION]

Causal relationship – more time / space to be with her thoughts, the more negative mood would become

Coherence – very strong emphasis of being a hard worker + embodying stoic medic. (shows audience evidence).

Language around experience of burnout: 'struggling', 'spiral', 'melt down', 'anxious', 'couldn't cope', 'wasn't good enough'. Very negative – emphasis on the mental presentation

Theme – just get on with it. Despite how bad symptoms got, never took any time away from work – Strategy = avoidance

Setting: home before work: struggling to wake up and sleep. Priority = getting to work

Character: herself presented as strong, determined, perseverance. Used what she called 'professional mode' to get through. Ref to spending many years in the role for experience

Appendix EE:

Sensitivity Protocol for Recovery from Burnout

Sensitivity Protocol

Recovery from burnout: an interview study

As participants in this study are volunteering to discuss their experiences of recovery from burnout, it may lead to the interviewee talking about personal experiences which they may find distressing. In preparation for such an occurrence within the interview several approaches have been considered to minimise potential distress to the participants. These include use of a participant information sheet (which the participants will be provided with in advance to allow time for consideration and to ask questions to the researcher) and a consent form along with the implementation of a research sensitive protocol, to be used in cases of participant distress.

Participant Information Sheet and Consent form

The following will be made clear to participants, in all written information sheets and conversation (e.g. during recruitment and prior to the interview):

d) What the interview topic will be
e) That they may stop or delay the interview at any time, or withdraw from the study without having to give a reason
f) that all data they provide (both interview transcripts and photographs) will be reported in a way that preserves the participants anonymity

Research sensitive protocol

The researcher will implement a ‘sensitive research protocol’, which will involve:

- Monitoring participants for distress (including monitoring for change in the participant during interviews which might signal being uncomfortable with the question)
- Actively re-establishing consent with the participant during the interview if a sensitive or unforeseen topic arises
- Stopping the interview if a participant becomes upset and only recommencing when (and if) the interviewee is ready to do so
- Any interview will be ceased completely if the interviewee is too distressed to continue, without any blame from the researcher or pressure to reschedule
- If the participant is willing to continue the interview the researcher will provide the chance to talk about the distressing topic (if the participant wishes), to explore these emotions with the hope of containing the distress to the interview and maintaining the participant’s well-being
- Asking specifically if there are any issues raised during the interview at the end of the interview and providing the opportunity for the interviewee to give feedback and ask questions
- Offering to sit with, and listen to, any participant who has become upset during interview
- Encouraging participants to contact the researcher by email or direct phone line if they have any concerns post interview
- Providing all participants with a support and information sheet that includes free and low-cost counselling options (see below) as well as a debrief sheet with the GP NHS helpline included on this
- Following up any participants that become upset by email in the following days

Researcher experience and expertise

The researcher is a Psychology PhD student and has had some experience with conducting qualitative interviews as well as in-depth training related to this type of research. For extra support the supervisors of this project, Professor Damien Ridge and Dr Tina Cartwright, are experts in sensitive qualitative research, having researched difficult topics (e.g. suicide, depression) for over 20 years. This study is also being guided by Professor David Peters who used to work as a GP and is an expert in the field of GP research. Therefore, if any issues arises the participants will be given proper assistance.

Useful Point of Contact:

In addition to the NHS GP Health Service which will be provided to all on their debrief sheets, the following services will be signposted by the researcher (where appropriate) if participants ask for signposting.

NHS GP Health Service-
gp.health@nhs.net or 0300 0303 300.

The Doctors Support Network (www.dsn.org.uk)

Provides a confidential peer support network for doctors and medical students with concerns about their mental health.

The Cameron Fund (www.cameronfund.org.uk)

A charity who supports GPs who are in financial need through ill health, disability or death.

The Royal Medical Benevolent Fund (www.rmbf.org)

A medical charity which supports doctors, medical students and their families, helping them through the stages of their career, including offering financial advice when in difficulty.

Samaritans (www.samaritans.org)

Samaritans are there to listen if you are going through a difficult time and would like to talk. You can do this in person at your local Samaritan branch, via email or by calling.

Helpline: 116 123

Email: jo@samaritans.org

Appendix FF:

Safeguarding Protocol for Recovery from Burnout

Safeguarding Guidance

Recovery from burnout: an interview study

As participants in this study are volunteering to discuss their experiences of burnout and recovery from burnout, this may lead to the interviewee talking about situations which may raise safeguarding issues for the researcher’s consideration.

The British Psychological Society defines safeguarding as protecting people’s health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect.

The fundamental standard on safeguarding is that children and adults using services must be protected from abuse and improper treatment.

In preparation for such disclosures within the interview this document collates the key concerns which could arise during the interview alongside guidance on the protocol to be followed by the researcher if disclosures of potential safeguarding issues arise.

Role of the Psychology Researcher

Trust is an essential part of the researcher-participant relationship and confidentiality is central to this. The participant may choose to not fully engage with the research if they think their personal information will be disclosed by researchers without consent, or without the chance to have some control over the timing or amount of information shared.

As a researcher there is a duty of confidentiality to their participants, but there is also a wider duty to protect and promote the health of the participants and the public. Therefore, confidentiality / anonymity will be maintained unless serious safeguarding concerns are raised.

Potential areas for concern

Safeguarding issues relating to children or adults, specifically GP disclosure of harm to others i.e. malpractice and GP disclosure of harm to themselves.

Institutional abuse

In relation to GPs, institutional abuse would be defined as the mistreatment or neglect by a regime or individuals, in settings which people who may be at risk are using the services. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services and includes a failure to ensure the necessary preventative and/or protective measures are in place.

Under circumstances of disclosure of serious malpractice, the researcher will acknowledge this within the interview and re-establish consent from the participant to whether they would like to continue with the discussion of the malpractice - on the basis that advice from the research team will need to be sought regarding issues of safeguarding.

Disclosure of harm to oneself

Under circumstances where the participant disclosed intended or potential harm against oneself the researcher will refer to the sensitivity protocol where appropriate, specifically signposting services which can be accessed by the GP.

In case serious risks to self are disclosed during the interview one of the more experienced researchers and Dr Jenny Keen from the Practitioner Health Service will be available to be reached by phone for advice.

Responding to safeguarding issues

In any case where safeguarding issues arise advice will be sought from the more experienced researchers in the research team and guidance from the British Psychology Society will be adhered to.

The supervisors of this project, Professor Damien Ridge and Dr Tina Cartwright, are experts in sensitive qualitative research, having researched difficult topics (e.g. suicide, depression) for over 20 years. This study is also being guided by Professor David Peters who is an expert in the field of GP research. Therefore, if any issues arise the participants will be given proper assistance.

As above advice from the NHS GP health service may be sought by the researchers, whilst seeking this guidance, anonymity of the participant will be maintained.

The majority of participants who take part in this study (if not all) will have been recruited from the Practitioner Health Service. If concerns are raised and consent for disclosure of their name to the Practitioner Health Service is provided, this service holds multi-disciplinary team meetings daily to discuss safeguarding, and any issues raised relating to practitioners who use their service.

Appendix GG:

Debrief Sheet for Recovery from Burnout

Debrief Sheet

We would like to thank you personally for your participation in “recovery from burnout: an interview study.”

What’s next?

If you have agreed, the researcher will contact you following this interview by email to ask if you would like to review the anonymised transcript of your interview and provided photographs. This is an optional element to the study where you are able to check that you are happy with the anonymisation process or whether you would like further amendments made.

Findings of the study:

The results of this study are likely to be disseminated at national and/or international conferences and published in scientific peer-reviewed journals as well as shorter reports creatively disseminated though other avenues such as social media and relevant newsletters.

These findings will also be written up for the purposes of the PhD thesis of Philippa Shaw. If you wish to obtain a copy of any published results, please contact a member of the research team and we will forward to you copies of any published papers.

For further information:

You are welcome to contact one of the research team at the University of Westminster if you have any questions or concerns regarding this research:

Philippa Shaw: P.Shaw@my.westminster.ac.uk

Tina Cartwright: T.Cartwright@westminster.ac.uk

Useful Point of Contact:

NHS GP Health Service-

- A confidential NHS service for GPs and GP trainees across various location in England.
- The service can help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work.
- This service is provided by health professionals who have additional expertise in addressing the issues concerning doctors

Access the service by emailing gp.health@nhs.net or by calling 0300 0303 300.

The service is available Monday – Friday (8am – 8pm) and Saturday (8am – 2pm).

The Doctors Support Network (www.dsn.org.uk)

Provides a confidential peer support network for doctors and medical students with concerns about their mental health.

The Cameron Fund (www.cameronfund.org.uk)

A charity who supports GPs who are in financial need through ill health, disability or death.

The Royal Medical Benevolent Fund (www.rmbf.org)

A medical charity which supports doctors, medical students and their families, helping them through the stages of their career, including offering financial advice when in difficulty.

Samaritans (www.samaritans.org)

Samaritans are there to listen if you are going through a difficult time and would like to talk. You can do this in person at your local Samaritan branch, via email or by calling.

Helpline: 116 123

Email: jo@samaritans.org

Appendix HH:

Descriptions of Key Elements in the Recovery from Burnout

Table A9

Settings

Title	Description
Problematic workplaces	The setting of a challenging workplace was a feature of all accounts through burnout, often related to primary events and causal relationships. Moving away from 'problematic workplaces' through accessing a greater understanding of their options or learning to self-prioritise and re-connect to their values were central to the recovery process.
The burnt out self	The setting of the participant experiencing burnout in themselves. This was characterised by darkness and heaviness and affected how they could interact with their world, with activities requiring more effort and participants feeling increasingly isolated. This mode provides a stark contrast to the open spaces which characterise the recovery journey.
The home	The home was present through burnout and the process of recovery but had distinct characteristics for each. The importance of the home, particularly ensuring there was a clear boundary from work, became apparent in post-burnout. Through recovery, this space became a place for self-prioritisation.
Open spaces	This setting has two sub-settings, both characterised by accessing a place of reflection, calmness, and tapping into wider perspectives. <u>Physical open spaces</u> Physical open spaces were commonly captured in photographs as important parts of the turning point into recovery. These were the opposite of 'problematic workplaces', and embodied light, positive character interactions, and prioritisation of values. <u>The open mind</u> Through recovery, the mind became more open, less jumbled, and new knowledge was integrated. Meaningful within this was the connection or re-connection with people participants felt safe to be around.
Additional recovery spaces	These were additional settings seen as valuable through recovery. These were spaces where the participant received support, where the participant could spend time alone away from work, and spaces that made the participants feel welcome, such as support groups, visiting the PHS, or a holiday location.

Table A10

Characters

Title	Description
Protagonists (participants)	The protagonists were commonly characterised by ambition, being understanding, and trying to do the right thing. The participant was not exclusively the protagonist; at different points, they presented themselves as the sounding board, sources of light, and occasionally the antagonist, e.g., when recognising their role in burnout. The participants shaped their accounts to demonstrate they had become stronger due to their experiences.
Antagonists	The way antagonists were framed depending on the context (burnout or recovery). These characters often impacted the relationship between burnout and participants' decisions to leave the role, take sick leave, or seek help. However, they also held a function to add meaning to participants' recovery (such as participants no longer reacting strongly to antagonists).
Sources of light	Each account involved characters (including pets) that held the function of providing support, hope, and validation to the protagonist. Often these characters would enter the narrative when the story was at its darkest. These characters were impactful in allowing the participant to pause and reflect and also moving recovery forward. These characters were not usually reoccurring through all scenes of the story. However, when they were present, they had a strong influence.
Sounding boards	Sounding boards were consistently presented throughout the accounts, but some important and valuable sounding boards effectively enter participants' lives during recovery. Sounding boards were less prominently presented than antagonists and sources of light. However, they held the important function of being a reliable non-judgemental ear that helped participants navigate and understand their experience, intrapersonally and interpersonally.
Sources of safety	These characters were distinct from the sources of light as they primarily provided warmth and safety and were described as akin to 'family' (but were not exclusively family members). Sources of safety helped the participant to grow and gain control, re-aligning with what they valued.

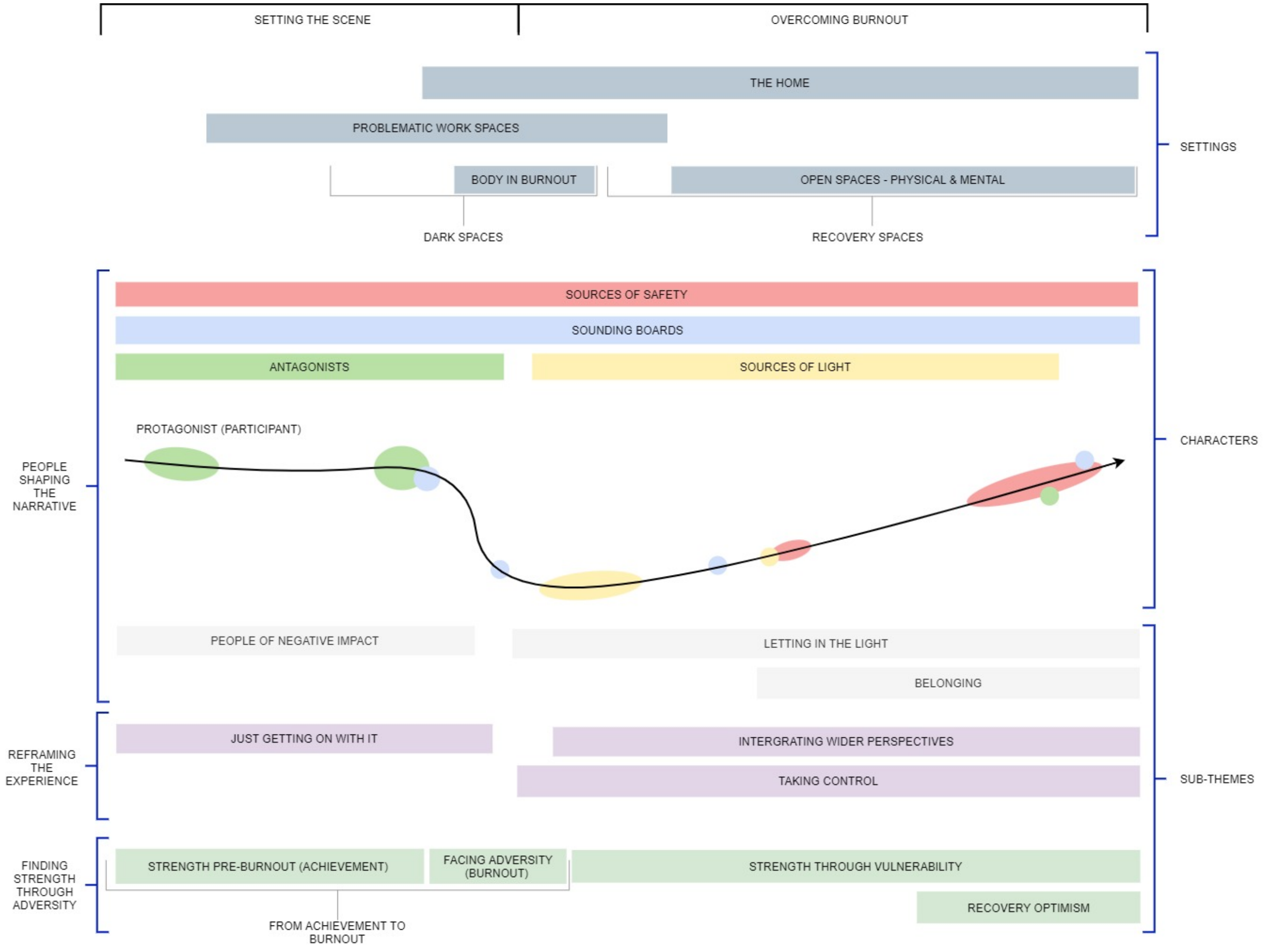
Table A11

Additional prominent narrative elements

Title	Description
Events	In addition to burnout, for all participants, there were significant events in their accounts. Events included moving workplaces, help-seeking, receiving patient complaints, changes made in their general practice, receiving ineffective support, dealing with ‘entitled patients’, and family bereavements.
Interpersonal	Reported communication was used to show the participants testing out their ideas, but commonly held the function of aiding plausibility, for example, demonstrating the extreme nature of their experiences, dissatisfaction with inappropriate support, or illustrating taking control and creating boundaries.
Intrapersonal	Evaluation and reflections were used throughout the accounts. Prominent uses related to the mental turning point from denial to reluctant acceptance or forced acceptance of not coping, consideration of the strength in who they were and their values/morals, reflections on the meaning of recovery, discussion their emotions and perceptions of work, and permitting themselves to do what they needed, and looking to the future.
Culture	Medical culture came through strongly, related to interactions in medical school, the culture of sacrifice, and the non-acceptance of mental ill-health. Each participant was (at least initially) steeped in this culture. External culture played a role too, with societies views of doctors and exploration of how participants navigated cultures in their personal life, such as their sexuality or growing up in a low-income family.
Values	Through the narratives, participants developed their values via interpersonal, intrapersonal, and cultural elements. Typical values include professionalism, respect and valuing staff in general practice, community and belonging, working hard, the opportunity to learn about themselves and grow, and valuing patient care over administration.
Ethics/Moral	Participants discussed morals within their stories, such as the differing morals between characters and the moral messages learnt from their experiences. Key was the improper treatment of GPs by the organisation and patients, conflicted accounts when working with patients through burnout, and by extension, trying to do the right thing and meet their responsibilities as a GP.

Appendix II:

Overview Diagram of the Themes, Characters, and Settings



This diagram depicts the elements from the narrative findings, illustrating how some of the core elements of the findings fit together within the structure of the findings, with the main overarching themes presented on the left and the core narrative elements shown to the right. The sub-themes and how the characters and settings are presented across the narrative are displayed in the centre column. The characters have corresponding coloured markers on the arrowed curved line that represent the ups and downs of the participants' ongoing journey, demonstrating when characters had a noticeable impact, with the size of the marker representing the strength of their impact.

Appendix JJ:

Reflexivity – Personal Characteristics

Relevant work in parallel to doctoral studies:

- Part-Time Visiting Lecturer, modules include:
    - Health Psychology
    - Mind-Body Therapies
    - Individual Differences
    - Psychology Project Supervision (projects focussed on experiences of health conditions and caring)
- Research Associate, projects include:
    - Evaluating a resilience training programme for hospital staff (Sebah et al., 2019a, 2019b; Shaw & Cheshire, 2018)
    - Researching how listening to the podcast series 'Menopause: Unmuted' changed knowledge and health activation around menopause for women living in the US (Edwards et al., 2021)
    - Supporting with a project to gain insights from carers of people living with dementia into the impact of COVID-19
- Volunteering:
    - Listener at the Samaritans
    - Dignity Champion at Healthwatch

Relevant training courses undertaken:

- A qualitative psychology research methods module (Master's conversion module) at the University of Westminster
- 'Interpretive phenomenological analysis workshop' at the University of Glasgow
- 'Getting great data: Supporting analysis in IPA' at the University of Derby
- Training for the 'Certificate of Special Study in Supporting Learning' at the University of Westminster which had an emphasis on reflection and discussion facilitation
- The University of Westminster preparation course for the three-minute thesis competition which emphasised language use and dissemination
- Extensive active listening training through the Samaritans
- The Cochrane systematic review training course - part of my MSc at the University of Nottingham. This influenced how I approach literature searches and the meta-synthesis (Study 1).

References

AbuAlRub, R. F. (2004). Job stress, job performance, and social support among hospital nurses. *Journal of Nursing Scholarship*, *36*(1), 73–78. https://doi.org/10.1111/j.1547-5069.2004.04016.x

Adám, S. (2009). Magas a munkahelyi és a családi szerepek közötti konfliktus prevalenciája az orvosnok körében: A társas támogatás hiánya mint lehetséges rizikótényezo. *Orvosi Hetilap*, *150*(50), 2274–2281. https://doi.org/10.1556/OH.2009.28583

Adams, K., Greiner, C., & Corrigan, J. (2004). A focus on communities: Next steps toward a new health care system. In *The 1st annual crossing the quality chasm summit*. National Academies Press. https://doi.org/10.17226/11085

Adeponle, A., Whitley, R., & Kirmayer, L. (2012). Cultural contexts and constructions of recovery. In A. Rudnick (Ed.), *Recovery of people with mental illness: Philosophical and related perspectives* (pp. 109–132). Oxford University Press.

Adler, J. M. (2012). Living into the story: Agency and coherence in a longitudinal study of narrative identity development and mental health over the course of psychotherapy. *Journal of Personality and Social Psychology*, *102*(2), 368. https://doi.org/10.1037/a0025289

Adler, J. M., Turner, A. F., Brookshier, K. M., Monahan, C., Walder-Biesanz, I., Harmeling, L. H., Albaugh, M., McAdams, D. P., & Oltmanns, T. F. (2015). Variation in narrative identity is associated with trajectories of mental health over several years. *Journal of Personality and Social Psychology*, *108*(3), 476–496. https://doi.org/10.1037/a0038601

Agana, D. F., Porter, M., Hatch, R., Rubin, D., & Carek, P. (2017). Job satisfaction among academic family physicians. *Family Medicine*, *49*(8), 622–625.

https://europepmc.org/article/med/28953294

Agarwal, S. D., Pabo, E., Rozenblum, R., & Sherritt, K. M. (2020). Professional dissonance and burnout in primary care: A qualitative study. *Journal of the American Medical Association Internal Medicine*, *180*(3), 395–401. https://doi.org/10.1001/jamainternmed.2019.6326

Ahmad, F., Hudak, P. L., Bercovitz, K., Hollenberg, E., & Levinson, W. (2006). Are physicians ready for patients with internet-based health information? *Journal of Medical Internet Research*, *8*(3). https://doi.org/10.2196/jmir.8.3.e22

Ahmed, K., Hashim, S., Khankhara, M., Said, I., Shandakumar, A., Zaman, S., & Veiga, A. (2020). Achieving better quality care in general practice: are incentives the answer? *British Journal of General Practice*, *70*(suppl 1). https://doi.org/10.3399/bjgp20X711461

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Allen, J., Gay, B., Crebolder, H., Heyrman, J., Svab, I., Ram, P., & Evans, P. (2005). The European definitions of general practice / family medicine. In *European Academy of Teachers in General Practice (Network within WONCA Europe) Report*.

Amoafo, E., Hanbali, N., Patel, A., & Singh, P. (2014). What are the significant factors associated with burnout in doctors? *Occupational Medicine*, *65*(2), 117–121. https://doi.org/10.1093/occmed/kqu144

Anandarajah, G., & Roseman, J. (2014). A qualitative study of physicians' views on compassionate patient care and spirituality: Medicine as a spiritual practice. *Spirituality & Medicine*, *97*(3), 17–22. https://pubmed.ncbi.nlm.nih.gov/24596925/

Andersen, M. F., Nielsen, K. M., & Brinkmann, S. (2012). Meta-synthesis of qualitative research on return to work among employees with common mental disorders. *Scandinavian Journal of Work, Environment & Health*, *38*(2), 93–104. https://doi.org/10.5271/sjweh.3257

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11–23. https://doi.org/10.1037/h0095655

Archer, M., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (2013). *Critical realism: Essential readings*. Routledge.

Arman, M., Hammarqvist, A. S., & Rehnsfeldt, A. (2011). Burnout as an existential deficiency - lived experiences of burnout sufferers. *Scandinavian Journal of Caring Sciences*, *25*(2), 294–302. https://doi.org/10.1111/j.1471-6712.2010.00825.x

Arnetz, B. B. (2001). Psychosocial challenges facing physicians of today. *Social Science & Medicine*, *52*(2), 203–213. https://doi.org/10.1016/S0277-9536(00)00220-3

Åsberg, A. (2018). *Burnout: The exhaustion funnel*. http://www.mindfulnext.org/burnout-the-exhaustion-funnel/

Ashworth, M. (2009). *Scoring PSYCHLOPS*.

Ashworth, M., Robinson, S., Godfrey, E., Shepherd, M., Evans, C., Seed, P., Parmentier, H., & Tylee, A. (2005). Measuring mental health outcomes in primary care: the psychometric properties of a new patient-generated outcome measure, “PSYCHLOPS” ('psychological outcome profiles’). *Primary Care Mental Health*, *3*, 1–10. https://kclpure.kcl.ac.uk/portal/en/publications/measuring-mental-health-outcomes-in-primary-care(8bd26b45-5480-428d-9067-f35c20eb756d).html

Ashworth, M., Shepherd, M., Christey, J., Matthews, V., Wright, K., Parmentier, H., Robinson, S., & Godfrey, E. (2004). A client-generated psychometric instrument: The development of 'PSYCHLOPS.' *Counselling and Psychotherapy Research*, *4*(2), 27–31. https://doi.org/10.1080/14733140412331383913

Aston, V., & Coffey, M. (2012). Recovery: What mental health nurses and service users say about the concept of recovery. *Journal of Psychiatric and Mental Health Nursing*, *19*(3), 257–263. https://doi.org/10.1111/j.1365-2850.2011.01776.x

Atun, R. (2004). What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services. *Copenhagen: World Health Organization Publisher.*

Aubeeluck, A., & Buchanan, H. (2006). Capturing the Huntington's disease spousal carer experience:A preliminary investigation using the 'Photovoice' method. *Dementia*, *5*(1), 95–116. https://doi.org/10.1177/1471301206059757

Austin, J. B. (2018). *A phenomenological investigation of physician job satisfaction in rural integrated primary care* [Antioch University New England].

Ayalon, L., Karkabi, K., Bleichman, I., Fleischmann, S., & Goldfracht, M. (2016). Barriers to the treatment of mental illness in primary care clinics in Israel. *Administration and Policy in Mental Health and Mental Health Services Research*, *43*(2), 231–240. https://doi.org/10.1007/s10488-015-0634-0

Bailey, K. (2008). *Methods of social research* (4th ed). Simon & Schuster.

Baird, B., Charles, A., Honeyman, M., Maguire, D., & Das, P. (2016). *Understanding pressures in general practice*. King's Fund.

Baird, B., Reeve, H., Ross, S., Honeyman, M., Nosa-Ehima, M., Sahib, B., & Omojomolo, D. (2018). *Innovative models of general practice*. King's Fund.

Bakker, A. B., & Costa, P. L. (2014). Chronic job burnout and daily functioning: A theoretical analysis. *Burnout Research*, *1*(3), 112–119. https://doi.org/10.1016/j.burn.2014.04.003

Balme, E., Gerada, C., & Page, L. (2015). Doctors need to be supported, not trained in resilience. *British Medical Journal, 315*, h4709. https://doi.org/10.1136/bmj.h4709

Bamberg, M. (1997). Positioning between structure and performance. *Journal of Narrative and Life History, 7*(1–4), 335–342. https://doi.org/10.1075/jnlh.7.42pos

Bamberg, M., & Georgakopoulou, A. (2008). Small stories as a new perspective in narrative and identity analysis. *Text & Talk*, *28*(3), 377–396. https://doi.org/10.1515/TEXT.2008.018

Bandura, A. (2002). Social cognitive theory in cultural context. *Applied Psychology, 51*(2), 269–290. https://doi.org/10.1111/1464-0597.00092

Barker, R., & Ford, K. (2018). *The case for employee engagement in the NHS: Three case studies*. https://www.pointofcarefoundation.org.uk/resource/the-case-for-employee-engagement-in-the-nhs-three-case-studies/

Barker, R., Ford, K., & Cornwell, J. (2018). *What does staff engagement mean in the NHS and why is it important?* The British Medical Journal Opinion. https://blogs.bmj.com/bmj/2018/05/16/what-does-staff-engagement-mean-in-the-nhs-and-why-is-it-important/

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *Biomed Central Medical Research Methodology*, *9*(1), 59. https://doi.org/10.1186/1471-2288-9-59

Barroso, J., Gollop, C. J., Sandelowski, M., Meynell, J., Pearce, P. F., & Collins, L. J. (2003). The challenges of searching for and retrieving qualitative studies. *Western Journal of Nursing Research*, *25*(2), 153–178.

https://doi.org/10.1177/0193945902250034

Barry, C. A., Britten, N., Barber, N., Bradley, C., & Stevenson, F. (1999). Using reflexivity to optimize teamwork in qualitative research. *Qualitative Health Research*, *9*(1), 26–44. https://doi.org/10.1177/104973299129121677

Beaulieu, M., Dory, V., Pestiaux, D., Pouchain, D., Rioux, M., Rocher, G., Gay, B., & Boucher, L. (2009). What does it mean to be a family physician? Exploratory study with family medicine residents from 3 countries. *Canadian Family Physician - Le Médecin de Famille Canadien*, *55*(8), e14-20. https://pubmed.ncbi.nlm.nih.gov/19675252/

Beaune, L., Muskat, B., & Anthony, S. J. (2018). The emergence of personal growth amongst healthcare professionals who care for dying children. *Palliative and Supportive Care*, *16*(3), 298–307. https://doi.org/10.1017/S1478951517000396

Beckman, H. B., Wendland, M., Mooney, C., Krasner M S, Quill, T. E., Suchman A L, & Epstein, R. M. (2012). The impact of a program in mindful communication on primary care physicians. *Academic Medicine*, *87*(6), 1–5. https://doi.org/10.1097/ACM.0b013e318253d3b2

Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., Mckenna, H., Murray, R., & Palmer, B. (2019). *Closing the gap: Key areas for action on the health and care workforce*. King’s Fund.

Bell, J. S. (2002). Narrative inquiry: More than just telling stories. *TESOL Quarterly*, *36*(2), 207–213. https://doi.org/10.2307/3588331

Bennion, A. E., Shaw, R. L., & Gibso, J. M. (2012). What do we know about the experience of age related macular degeneration? A systematic review and meta-synthesis of qualitative research. *Social Science & Medicine*, *75*(6), 976–985. https://doi.org/10.1016/j.socscimed.2012.04.023

Bensing, J. M., Tromp, F., Van Dulmen, S., Van Den Brink-Muinen, A., Verheul, W., & Schellevis, F. G. (2006). Shifts in doctor-patient communication between 1986 and 2002: A study of videotaped General Practice consultations with hypertension patients. *Biomed Central Family Practice*, *7*. https://doi.org/10.1186/1471-2296-7-62

Bentall, R. (2004). *Madness explained: Psychosis and human nature*. Penguin.

Berger, A. (1997). *Narratives in popular culture, media, and everyday life*. Sage Publications.

Berlanda, S., Pedrazza, M., Trifiletti, E., & Fraizzoli, M. (2018). Sources of physicians' well-being: An explorative qualitative study. *TPM-Testing, Psychometrics, Methodology in Applied Psychology*, *25*(1), 121–137. https://psycnet.apa.org/record/2018-11967-007

Bernier, D. (1998). A study of coping: Successful recovery from severe burnout and other reactions to severe work-related stress. *Work & Stress*, *12*(1), 5–5. https://doi.org/10.1080/02678379808256848

Bhaskar, R. (2013). *A realist theory of science*. Routledge.

Bhaskar, R. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge.

Bhugra, D., Sauerteig, S.-O., Bland, D., Lloyd-Kendall, A., Wijesuriya, J., Singh, G., Kochhar, A., Molodynski, A., & Ventriglio, A. (2019). A descriptive study of mental health and wellbeing of doctors and medical students in the UK. *International Review of Psychiatry*, *31*(7–8), 563–568. https://doi.org/10.1080/09540261.2019.1648621

Bianchi, E. F., Bhattacharyya, M. R., & Meakin, R. (2016). Exploring senior doctors' beliefs and attitudes regarding mental illness within the medical profession: A qualitative study. *British Medical Journal Open*, *6*(9).

https://doi.org/10.1136/bmjopen-2016-012598

Bianchi, R., & Schonfeld, I. S. (2016). Burnout is associated with a depressive cognitive style. *Personality and Individual Differences*, *100*, 1–5. https://doi.org/10.1016/j.paid.2016.01.008

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015a). Burnout–depression overlap: A review. *Clinical Psychology Review*, *36*, 28–41. https://doi.org/10.1016/j.cpr.2015.01.004

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015b). Is burnout separable from depression in cluster analysis? A longitudinal study. *Social Psychiatry and Psychiatric Epidemiology*, *50*(6), 1005–1011. https://doi.org/10.1007/s00127-014-0996-8

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015c). Is it time to consider the “burnout syndrome” a distinct illness? *Frontiers in Public Health*, *3*(108), 1–3. https://doi.org/10.3389/fpubh.2015.00158

Bianchi, R., Verkuilen, J., Brisson, R., Schonfeld I S, & Laurent, E. (2016). Burnout and depression: Label-related stigma, help-seeking, and syndrome overlap. *Psychiatry Research*, *245*, 91–98. https://doi.org/0.1016/j.psychres.2016.08.025

Black, C. (2008). *Working for a Healthier Tomorrow*. Department for Work and Pensions.

Blanca, M. J., Alarcón, R., Arnau, J., & Bendayan, R. (2017). Non-normal data: Is ANOVA still a valid option? *Psicothema*, *29*(4), 552–557. https://doi.org/10.7334/psicothema2016.383

Blank, A., Finlay, L., & Prior, S. (2016). The lived experience of people with mental health and substance misuse problems: Dimensions of belonging. *British Journal of Occupational Therapy*, *79*(7), 434–441. https://doi.org/10.1177/0308022615627175

Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. (2014). The 10 building blocks of high-performing primary care. *The Annals Family Medicine*, *12*(2), 166–171. https://doi.org/10.1370/afm.1616

Boerma, W. G., Van der Zee, J., & Fleming, D. M. (1997). Service profiles of general practitioners in Europe: European GP task profile study. *British Journal of General Practice*, *47*(421), 481–486. https://doi.org/PMC1313076

Bondas, T., & Hall, E. O. (2007a). Challenges in approaching metasynthesis research. *Qualitative Health Research*, *17*(1), 113–121. https://doi.org/10.1177/1049732306295879

Bondas, T., & Hall, E. O. (2007b). A decade of metasynthesis research in health sciences: A meta-method study. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(2), 101–113. https://doi.org/10.1080/17482620701251684

Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing*, *15*(2), 140–153. https://doi.org/10.1111/j.1365-2850.2007.01185.x

Boorman, S. (2009a). *NHS Health and Well-being: Full Report*. https://webarchive.nationalarchives.gov.uk/ukgwa/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799

Boorman, S. (2009b). *NHS Health and Well-being: Full Report*. https://webarchive.nationalarchives.gov.uk/20130103004910/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799

Boorman, S., & Fellow, R. C. N. (2009). *NHS health and well-being review*. NHS Health and Wellbeing Review.

Booth, T., & Booth, W. (2003). In the frame: Photovoice and mothers with learning difficulties. *Disability & Society, 18*(4), 431–442. https://doi.org/10.1080/0968759032000080986

Bosch, X. (2000). First impaired physicians therapy program appears to be successful in Spain. *JAMA*, *283*, 3186–3187. https://doi.org/https://doi:10.1001/jama.283.24.3186-JMN0628-2-1

Bouza, E., Gil-Monte, P. R., Palomo, E., Cortell-Alcocer, M., Del Rosario, G., González, J., Gracia, D., Martínez Moreno, A., Melero Moreno, C., Molero García, J. M., Montilla, P., Peñacoba, E., Rodríguez Créixems, M., Rodríguez de la Pinta, M. L., Romero Agüit, S., Sartorius, N., & Soriano, J. B. (2020). Work-related burnout syndrome in physicians in Spain. *Revista Clinica Espanola*. https://doi.org/10.1016/j.rce.2020.02.002

Bower, E. (2015). Why are medical indeminity fees rising? *GP Online*. https://www.gponline.com/why-medical-indemnity-fees-rising/article/1358134

Bower, P., Macdonald, W., Harkness, E., Gask, L., Kendrick, T., Valderas, J. M., Dickens, C., Blakeman, T., & Sibbald, B. (2011). Multimorbidity, service organization and clinical decision making in primary care: a qualitative study. *Family Practice*, *28*, 579–587. https://doi.org/10.1093/fampra/cmr018

Bowler, D. E., Buyung-Ali, L. M., Knight, T. M., & Pullin, A. S. (2010). A systematic review of evidence for the added benefits to health of exposure to natural environments. *Biomed Central Public Health*, *10*(1), 1–10. https://doi.org/10.1186/1471-2458-10-456

Boydell, K., Gladstone, B., Volpe, T., Allemang, B., & Stasius, E. (2012). The production and dissemination of knowledge: A scoping review of arts-based health research. *Participatory Qualitative Research*, *13*(1). https://doi.org/10.17169/fqs-13.1.1711

Brand, S. L., Coon, J. T., Fleming, L. E., Carroll, L., Bethel, A., & Wyatt, K. (2017).

Whole-system approaches to improving the health and wellbeing of healthcare workers: A systematic review. *PLoSONE, 12*(12), e0188418. https://doi.org/10.1371/journal.pone.0188418

Branson, R., & Armstrong, D. (2004). General practitioners' perceptions of sharing workload in group practices: Qualitative study. *British Medical Journal, 329*(7462), 1–4. https://doi.org/10.1136/bmj.38173.532465.7C

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being, 9*, 1–2. https://doi.org/10.3402/qhw.v9.26152.

Braunholtz, S., Davidson, S., Myant, K., & O'Connor, R. (2007). *Well? What do you think?(2006): The third national Scottish survey of public attitudes to mental health, mental wellbeing and mental health problems*. Scottish Executive.

Brenninkmeijer, V., & VanYperen, N. (2003). How to conduct research on burnout: advantages and disadvantages of a unidimensional approach in burnout research. *Occupational and Environmental Medicine, 60*(1), 16–20. https://doi.org/10.1136/oem.60.suppl_1.i16

British Medical Association. (2019). *Caring for the mental health of the medical workforce British Medical Association*. https://php.nhs.uk/wp-content/uploads/sites/26/2013/11/Brooks-2011-review-of-Drs-mental-

British Medical Association. (2020). *COVID-19 tracker survey: GPs only*. https://www.bma.org.uk/media/2847/bma-covid-19-survey-results-for-gps-july-2020.pdf

British Medical Association. (2021a, May). *Thousands of overworked doctors plan to leave the NHS, BMA finds*. BMA Media Centre. https://www.bma.org.uk/bma-media-centre/thousands-of-overworked-doctors-plan-to-leave-the-nhs-bma-finds

British Medical Association. (2021b, June 6). *Pressures in general practice*. NHS Delivery and Workforce. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, *21*(1), 87–108. https://doi.org/10.1080/14768320500230185

Brodaty, H., Gibson, L., Waine, M., Shell, A., Lilian, R., & Pond CD. (2013). Research in general practice: A survey of incentives and disincentives for research participation. *Mental Health in Family Medicine*, *10*(3), 163–173. https://www.ncbi.nlm.nih.gov/pmc/articles/pmc3822664/

Brooks, A. J., Rowse, G., Ryder, A., Narula, P., Corfe, B. M., Norman, P., & Lobo, A. J. (2015). “I can cope right now, because I know where I have come from”: A qualitative exploration of the lived experience of young adults with inflammatory bowel. *Gut*, *64*(1), 85. https://doi.org/10.1136/gutjnl-2015-309861.174

Brooks, J. (2015). Learning from the lifeworld: Introducing alternative approaches to phenomenology in psychology. *The Psychologist*, *28*(8), 642–643. http://eprints.hud.ac.uk/25556

Brooks, S. K., Chalder, T., & Gerada, C. (2011). Doctors vulnerable to psychological distress and addictions: Treatment from the Practitioner Health Programme. *Journal of Mental Health*, *20*(2), 157–164. https://doi.org/10.3109/09638237.2011.556168

Brooks, S. K., Gerada, C., & Chalder, T. (2011). Review of literature on the mental health of doctors: Are specialist services needed? *Taylor & Francis*, *20*(2), 146–156.

https://doi.org/10.3109/09638237.2010.541300

Brooks, S. K., Gerada, C., & Chalder, T. (2017). The specific needs of doctors with mental health problems: qualitative analysis of doctor-patients’ experiences with the Practitioner Health Programme. *Journal of Mental Health*, *26*(2), 161–166. https://doi.org/10.1080/09638237.2016.1244712

Brown, S. L., Nesse, R. M., Vinokur, A. D., & Smith, D. M. (2003). Providing social support may be more beneficial than receiving it: Results from a prospective study of mortality. *Psychological Science*, *14*(4), 320–327. https://doi.org/10.1111/1467-9280.14461

Bruce, S. M., Conaglen, H. M., & Conaglen, J. V. (2005). Burnout in physicians: A case for peer-support. *Internal Medicine Journal*, *35*(5), 272–278. https://doi.org/10.1111/j.1445-5994.2005.00782.x

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health & Illness*, *23*(3), 263–285. https://doi.org/10.1111/1467-9566.00252

Buys, A. E. (2016). *Moderating role of stressful life events on the relationship between emotional exhaustion and depersonalisation*. University of Pretoria.

Cain, C. L., Taborda-Whitt, C., Frazer, M., Schellinger, S., White, K. M., Kaasovic, J., Nelson, B., & Chant, A. (2017). A mixed methods study of emotional exhaustion: Energizing and depleting work within an innovative healthcare team. *Journal of Interprofessional Care*, *31*(6), 714–724. https://doi.org/10.1080/13561820.2017.1356809

Cameron, P. J., Este, D. C., & Worthington, C. A. (2010). Physician retention in rural Alberta: Key community factors. *Canadian Journal of Public Health*, *101*(1), 79–82. https://doi.org/10.1007/bf03405568

Campbell, J., Stickley, T., Bonney, S., & Wright, N. (2008). Recovery as a framework for care planning. In A. Hall, M. Wren, & S. Kirby (Eds.), *Care planning in mental health: Promoting recovery* (2nd ed., pp. 111–135). https://www.wiley.com/en-gb/Care+Planning+in+Mental+Health%3A+Promoting+Recovery%2C+2nd+Edition-p-9780470671863

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, *56*(4), 671–684. https://doi.org/10.1016/S0277-9536(02)00064-3

Cardoso, D., Wakeham, J., Shaw, P. A., Dutton, B., & Wildman, L. (2017). Chlorpromazine versus thiothixene for people with schizophrenia. *Cochrane Database of Systematic Reviews*, *9*. https://doi.org/10.1002/14651858.CD012790

Carr, P. L., Gareis, K. C., & Barnett, R. C. (2003). Characteristics and outcomes for women physicians who work reduced hours. *Journal of Women's Health*, *12*(4), 399–405. https://doi.org/10.1089/154099903765448916

Carrieri, D., Mattick, K., Pearson, M., Papoutsi, C., Briscoe, S., Wong, G., & Jackson, M. (2020). Optimising strategies to address mental ill-health in doctors and medical students: "Care under Pressure" realist review and implementation guidance. *Biomed Central Medicine*, *18*(76). https://doi.org/10.1186/s12916-020-01532-x

Casas, M., Gual, A., Bruguera, E., Arteman, A., & Padrós, J. (2001). El programa de atención integral al Integral, médico enfermo (PAIME) del Colegio de Médicos de Barcelona [Program for the (Barc). Care of the Physician (PAIME) of the Official Medical College of Barcelona]. *Med Clin*, *117*, 785–789. https://doi.org/https://doi.org/10.1016/s0025-7753(01)72259-2

Cascón-Pereira, R., Chillas, S., & Hallier, J. (2016). Role-meanings as a critical factor in understanding doctor managers' identity work and different role identities. *Social Science & Medicine*, *170*, 18–25. https://doi.org/10.1016/j.socscimed.2016.09.043

Cebrià, J., Segura, J., Corbella, S., Sos, P., Comas, O., García, M., Rodríguez, C., Pardo, M. J., & Pérez, J. (2001). Rasgos de personalidad y burnout en médicos de familia. *Atencion Primaria / Sociedad Española de Medicina de Familia y Comunitaria*, *27*(7), 459–468. https://doi.org/10.1016/S0212-6567(01)78836-1

Cervero-Liceras, F., McKee, M., & Legido-Quigley, H. (2015). The effects of the financial crisis and austerity measures on the Spanish health care system: A qualitative analysis of health professionals' perceptions in the region of Valencia. *Health Policy*, *119*(1), 100–106. https://doi.org/10.1016/j.healthpol.2014.11.003

Cezar-Vaz, M. R., Soares, J. F. de S., de Figueiredo, P. P., de Azambuja, E. P., Sant'Anna, C. F., & da Costa, V. Z. (2009). Percepción del riesgo en el trabajo en salud de la familia: Un estudio con trabajadores en el sur de Brasil. *Revista Latino-Americana de Enfermagem*, *17*(6), 961–967. https://doi.org/10.1590/S0104-11692009000600006

Chambers, C. N., Frampton, C. M., Barclay, M., & McKee, M. (2016). Burnout prevalence in New Zealand's public hospital senior medical workforce: a cross-sectional mixed methods study. *British Medical Journal Open*, *6*(11), 1–10. https://doi.org/10.1136/bmjopen-2016-013947

Chan, C. H. Y., YAO, H., Fung, Y. L., Ji, X., & Chan, C. L. W. (2017). Dynamic balancing in illness coping: An interpretative phenomenological analysis on the lived experience of Chinese patients with psoriasis. *Health Science Journal*, *11*(4), 515. https://doi.org/10.21767/1791-809X.1000515

Charlick, S., Pincombe, J., McKellar, L., & Fielder, A. (2016). Making sense of participant experiences: Interpretative phenomenological analysis in midwifery research. *International Journal of Doctoral Studies*, *11*, 205–216. https://doi.org/10.28945/3486

Checkland, K., Harrison, S., McDonald, R., Grant, S., Campbell, S., & Guthrie, B. (2008). Biomedicine, holism and general medical practice: Responses to the 2004 general practitioner contract. *Sociology of Health & Illness, 30*(5), 788–803. https://doi.org/10.1111/j.1467-9566.2008.01081.x

Chen, R., Sun, C., Chen, J.-J., Jen, H.-J., Linda Kang, X., Kao, C.-C., Chou, K.-R., Chao Sun, R., Jian-Jun Chen, R., Hsiu-Ju Jen, R., Xiao Linda Kang, R., Ching-Chiu Kao, R., & Kuei-Ru Chou, R. (2021). A large-scale survey on trauma, burnout, and posttraumatic growth among nurses during the COVID-19 pandemic. *International Journal of Mental Health Nursing, 30*, 102–116. https://doi.org/10.1111/inm.12796

Cherniss, C. (1992). Long-term consequences of burnout: An exploratory study. *Journal of Organizational Behavior, 13*(1), 1–11. https://doi.org/10.1002/job.4030130102

Cheshire, A., Hughes, J., Lewith, G., Panagioti, M., Peters, D., Simon, C., & Ridge, D, (2017a). GPs' perceptions of resilience training: A qualitative study. *British Journal of General Practice*, *67*(663), e709–e715. https://doi.org/10.3399/bjgp17X692561

Cheshire, A., Ridge, D., Hughes, J., Peters, D., Panagioti, M., Simon, C., & Lewith, G. (2017b). Influences on GP coping and resilience: A qualitative study in primary care. *British Journal of General Practice, 67*(659), e428–e436. https://doi.org/10.3399/bjgp17X690893

Chipp, C., Dewane, S., Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). "If Only Someone Had Told Me…": Lessons From Rural Providers. *The Journal of Rural Health*, *27*(1), 122–130. https://doi.org/10.1111/j.1748-0361.2010.00314.x

Cho, J., & Trent, A. (2006). Validity in qualitative research revisited. *Qualitative Research*, *6*(3), 319–340. https://doi.org/10.1177/1468794106065006

Christie, M. A., & Cole, F. (2017). The impact of green exercise on volunteers' mental health and wellbeing-findings from a community project in a woodland setting. *Journal of Therapeutic Horticulture*, *27*(1), 33. https://www.jstor.org/stable/26111989

Clarke, R. (2017). *Your Life In My Hands-a Junior Doctor's Story: A Junior Doctor's Story*. Metro Publishing.

Clemen, N., Blacker, B., Floen, M., Schweinle, W., & Huber, J. (2018). Work-life balance in women physicians in South Dakota: results of a state-wide assessment survey. *South Dakota Medicine*, *71*(12). https://pubmed.ncbi.nlm.nih.gov/30835988/

Clough, B. A., March, S., Leane, S., & Ireland, M. J. (2019). What prevents doctors from seeking help for stress and burnout? A mixed-methods investigation among metropolitan and regional-based australian doctors. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.22707

Clouston, T. J. (2015). *Challenging stress, burnout and rust-out: Finding balance in busy lives*. Jessica Kingsley Publishers.

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*, *6*(4), 331–339. https://doi.org/10.1370/afm.818

Cohen, S. (1994). *Perceived Stress Scale*. www.mindgarden.com

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal Storage*, 385–396.

Colantonio, A., Kontos, P. C., Gilbert, J. E., Rossiter, K., Gray, J., & Keightley, M. L. (2008). After the crash: Research-based theater for knowledge transfer. *Journal of Continuing Education in the Health Professions*, *28*(3), 180–185. https://doi.org/10.1002/chp.177

Coleman, C., Hudson, S., & Pederson, B. (2017). Prioritized health literacy and clear communication practices for health care professionals. *Health Literacy Research and Practice, 1*(3), e91–e99. https://doi.org/10.3928/24748307-20170503-01

Collins, K., & Nicolson, P. (2002). The meaning of ‘satisfaction’ for people with dermatological problems: Reassessing approaches to qualitative health psychology research. *Journal of Health Psychology, 7*(5), 615–629. https://doi.org/10.1177/1359105302007005681

Conn, V. S., Isaramalai, S., Rath, S., Jantarakupt, P., Wadhawan, R., & Dash, Y. (2003). Beyond MEDLINE for Literature Searches. *Journal of Nursing Scholarship, 35*(2), 177–182. https://doi.org/10.1111/j.1547-5069.2003.00177.x

Creswell, J. W. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Croxson, C. H. D., Ashdown, H. F., & Hobbs, F. D. (2017). GPs’ perceptions of workload in England: a qualitative interview study. *British Journal of General Practice, 67*(655), e138–e147. https://doi.org/10.3399/bjgp17X688849

Czachowski, S., & Pawlikowska, T. (2011). “These reforms killed me”: doctors’ perceptions of family medicine during the transition from communism to capitalism. *Family Practice*, *28*(4), 437–443. https://doi.org/10.1093/fampra/cmr003

Dale, J., Potter, R., Owen, K., Parsons, N., Realpe, A., & Leach, J. (2015). Retaining the general practitioner workforce in England: What matters to GPs? A cross-sectional study. *Biomed Central Family Practice, 16*(1), 140. https://doi.org/10.1186/s12875-015-0363-1

Davidsen, A. S. (2013). Phenomenological approaches in psychology and health sciences. *Qualitative Research in Psychology, 10*(3), 318–339. https://doi.org/10.1080/14780887.2011.608466

Davidson, L., O’Connel, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, *57*(5), 640–645. https://doi.org/10.1176/ps.2006.57.5.640

Davis, B., & Harré, R. (1990). *Positioning: The social construction of selves*. https://philpapers.org/rec/DAVPTS

Davis, E. M. (1998). *From pre-symptomatic to post-recovery and back again: A narrative analysis of medical discourse on breast cancer*. https://etd.ohiolink.edu/!etd.send_file?accession=osu1487949836206427&disposition=inline

Davis, E. M. (2008). Risky business: Medical discourse, breast cancer, and narrative. *Qualitative Health Research*, *18*(1), 65–76. https://doi.org/10.1177/1049732307309002

Davison, I., McManus, C., & Brown, C. (2019). Factors affecting recruitment into general practice: A double binary choice approach. *Advances in Health Sciences Education 2019 25:3*, *25*(3), 563–579. https://doi.org/10.1007/S10459-019-09938-W

Deci, E. L., & Ryan, R. M. (2000). The “what” and “why” of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, *11*(4), 227–268. https://doi.org/10.1207/S15327965PLI1104_01

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. *Journal of Applied Psychology, 86*(3), 499–512. https://psycnet.apa.org/journals/apl/86/3/499.html?uid=2001-06715-012

Department of Health. (2006). *Our health, our care, our say: A new direction for community services*. https://www.gov.uk/government/publications/our-health-our-care-our-say-a-new-direction-for-community-services

Department of Health and Social Care. (2021). *The NHS constitution for England* . https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Derksen, F. A. W. M., Olde Hartman, T., Bensing, J., & Lagro-Janssen, A. (2018). Empathy in general practice-the gap between wishes and reality: Comparing the views of patients and physicians. *Family Practice*, *35*(2), 203–208. https://doi.org/10.1093/fampra/cmx080

Dew, K. (2011). Pressure to work through periods of short term sickness: Can have long term negative effects on health and productivity. *British Medical Journal (Online) 343*(7817). https://doi.org/10.1136/bmj.d3446

Dewa, C. S., Loong, D., Bonato, S., Trojanowski, L., & Rea, M. (2017). The relationship between resident burnout and safety-related and acceptability-related quality of healthcare: A systematic literature review. *Biomed Central Medical Education. 17*(1). https://doi.org/10.1186/s12909-017-1040-y

Dillon, E. C., Tai-Seale, M., Meehan, A., Martin, V., Nordgren, R., Lee, T., Nauenberg, T., & Frosch, D. L. (2019). Frontline perspectives on physician burnout and strategies to improve well-being: Interviews with physicians and health system leaders. *Journal of General Internal Medicine*, *35*(1), 261–267. https://doi.org/10.1007/s11606-019-05381-0

Dixon-Woods, M. (2011). Using framework-based synthesis for conducting reviews of qualitative studies. *Biomed Central Medicine*, *9*(1), 39. https://doi.org/10.1186/1741-7015-9-39

Dixon-Woods, M., Shaw, R. L., Agarwal, S., & Smith, J. A. (2004). The problem of appraising qualitative research. *British Medical Journal Quality & Safety*, *13*(3), 223–225. https://doi.org/10.1136/qshc.2003.008714

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing*, *2*(3), 222–235. https://doi.org/10.5502/ijw.v2i3.4

Donaldson, L. (2006). *Good doctors, safer patients*. Department of Health.

Doran, N., Fox, F., Rodham, K., Taylor, G., & Harris, M. (2016). Lost to the NHS: A mixed methods study of why GPS leave practice early in England. *British Journal of General Practice*, *66*(643), e128–e134. https://doi.org/10.3399/bjgp16X683425

Dowell, A., Hamilton, S., & McLeod, D. (2000). Job satisfaction, psychological morbidity and job stress among New Zealand general practitioners. *New Zealand Medical Journal*, *113*(1113), 269.

Drew, S. E., Duncan, R. E., & Sawyer, S. M. (2010). Visual storytelling: A beneficial but challenging method for health research with young people. *Qualitative Health Research*, *20*(12), 1677–1688. https://doi.org/10.1177/1049732310377455

Drummond, D. (2015). Physician burnout: its origin, symptoms, and five main causes. *Family Practice Management*, *22*(5), 42–47. https://pubmed.ncbi.nlm.nih.gov/26554564/

Dumelow, C., Littlejohns, P., & Griffiths, S. (2000). Relation between a career and family life for English hospital consultants: Qualitative, semistructured interview study. *British Medical Journal*, *320*, 1437–1440. https://doi.org/10.1136/bmj.320.7247.1437

Dunlop, W. L., & Tracy, J. L. (2013). Sobering stories: Narratives of self-redemption predict behavioral change and improved health among recovering alcoholics. *Journal of Personality and Social Psychology*, *104*(3), 576–590. https://doi.org/10.1037/a0031185

DuPont, R., McLellan, A., Carr, G., Gendel, M., & Skipper, G. (2009). How are addicted physicians treated? A national survey of Physician Health Programs. *J Subst Abuse Treat.*, *37*, 1–7. https://doi.org/https://doi.org/10.1016/j.jsat.2009.03.010

Earthy, S., & Cronin, A. (2008). Narrative analysis. In N. Gilbert (Ed.), *Researching Social Life* (3rd ed.). Sage Publications.

Eatough, V., & Smith, J. A. (2008). Interpretative phenomenological analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology*. Sage Publications.

Echterling, L. G., Presbury, J., & McKee, J. E. (2005). *Crisis intervention: Promoting resilience and resolution in troubled times*. Pearson.

Edwards, A., Shaw, P., Halton, C., Bailey SC, Wolf MS, Andrews, E., & Cartwright T. (2021). “It just makes me feel a little less alone”: A qualitative exploration of the podcast “menopause: unmuted” on women’s perceptions of menopause. *Menopause, 28*(12). https://doi.org/10.1097/GME.0000000000001855

Ehrenreich, B. (2010). *Smile or die: How positive thinking fooled America and the world*. Granta books.

Eisikovits, Z., Buchbinder, E., & Mor, M. (1998). “What it was won’t be anymore”: Reaching the turning point in coping with intimate violence. *Affilia*, *13*(4), 411–434. https://doi.org/10.1177/088610999801300403

Ekstedt, M., & Fagerberg, I. (2004). Lived experiences of the time preceding burnout. *Journal of Advanced Nursing*, *49*(1), 59–67. https://doi.org/10.1111/j.1365-2648.2004.03264.x

Eley, E., Jackson, B., Burton, C., & Walton, E. (2018). Professional resilience in GPs working in areas of socioeconomic deprivation: A qualitative study in primary care. *British Journal of General Practice*, *68*(677), e819–e825.

https://doi.org/10.3399/bjgp18X699401

Evans, B. K., & Fischer, D. G. (1993). The nature of burnout: A study of the three-factor model of burnout in human service and non-human service samples. *Journal of Occupational and Organizational Psychology*, *66*(1), 29–38. https://doi.org/10.1111/j.2044-8325.1993.tb00514.x

Evans, H. J. (2018). *A model of resilience, burnout and intention to quit among general practitioners*. University of Western Sydney.

Everall, R. D., & Paulson, B. L. (2004). Burnout and secondary traumatic stress: Impact on ethical behaviour. *Canadian Journal of Counselling*, *38*(1), 25–35. https://eric.ed.gov/?id=EJ719898

Fahy, N., Hervey, T., Greer, S., Jarman, H., Stuckler, D., Galsworthy, M., & McKee, M. (2017). How will Brexit affect health and health services in the UK? Evaluating three possible scenarios. *The Lancet*, *390*(10107), 2110–2118. https://doi.org/10.1016/S0140-6736(17)31926-8

Fairclough, N. (2013). *Critical discourse analysis: The critical study of language*. Routledge.

Fairhurst, K., & May, C. (2006). What general practitioners find satisfying in their work: implications for health care system reform. *The Annals of Family Medicine*, *4*(6), 500–505. https://doi.org/10.1370/afm.565

Fältholm, Y. (2007). “Patients, not doctors, get sick”: A study of fifteen Swedish physicians on long-term sick leave. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 19–32. https://doi.org/10.1080/17482620601088277

Farber, B. A. (1990). Burnout in psychotherapists: Incidence, types, and trends. *Psychotherapy in Private Practice*, *8*(1), 35–44.

https://doi.org/10.1300/J294v08n01_07

Farrell, T. B. (1985). Narrative in Natural Discourse: On Conversation and Rhetoric. *Journal of Communication*, *35*(4), 109–127. https://doi.org/10.1111/j.1460-2466.1985.tb02976.x

Feeney, S., O'Brien, K., O'Keeffe, N., Iomaire, A., Kelly, M., McCormack, J., McGuire, G., & Evans, D. (2016). Practise what you preach: Health behaviours and stress among non-consultant hospital doctors. *Clinical Medicine, Journal of the Royal College of Physicians of London*, *16*(1), 12–18. https://doi.org/10.7861/clinmedicine.16-1-12

Feliciano, K. V. de O., Kovacs, M. H., & Sarinho, S. W. (2011). Burnout entre médicos da Saúde da Família: Os desafios da transformação do trabalho. *Ciencia e Saude Coletiva*, *16*(8), 3373–3382. https://doi.org/10.1590/S1413-81232011000900004

Fina, A. De, & Georgakopoulou, A. (2015). *The handbook of narrative analysis*. Wiley Blackwell.

Finfgeld-Connett, D. (2010). Generalizability and transferability of meta-synthesis research findings. *Journal of Advanced Nursing*, *66*(2), 246–254. https://doi.org/10.1111/j.1365-2648.2009.05250.x

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531–545. https://doi.org/10.1177/104973202129120052

Firth-Cozens, J., & Greenhalgh, J. (1997). Doctors' perceptions of the links between stress and lowered clinical care. *Social Science and Medicine*, *44*(7), 1017–1022. https://doi.org/10.1016/S0277-9536(96)00227-4

Fisher, C. D. (2002). Antecedents and consequences of real-time affective reactions at work. *Motivation and Emotion*, *26*(1), 3–30. https://doi.org/10.1023/A:1015190007468

Fisher, R. F. R., Croxson, C. H. D., Ashdown, H. F., & Hobbs, F. D. R. (2017). GP views on strategies to cope with increasing workload: A qualitative interview study. *British Journal of General Practice*, *67*(655), e148–e156. https://doi.org/10.3399/bjgp17X688861

Fisher, W. R. (1989). Human communication as narration: Toward a philosophy of reason, value, and action. *Philosophy and Rhetoric*, *22*(1). https://philpapers.org/rec/FISHCA

Fjellman-Wiklund, A., Stenlund, T., Steinholtz, K., & Ahlgren, C. (2010). Take charge: Patients' experiences during participation in a rehabilitation programme for burnout. *Journal of Rehabilitation Medicine, 42*, 475–481. https://doi.org/10.2340/16501977-0534

Fletcher, D., & Sarkar, M. (2013). Psychological resilience: A review and critique of definitions, concepts, and theory. *European Psychologist*, *18*(1), 12–23. https://doi.org/10.1027/1016-9040/a000124

Fletcher, E., Abel, G. A., Anderson, R., Richards, S. H., Salisbury, C., Dean, S. G., Sansom, A., Warren, F. C., & Campbell, J. L. (2017). Quitting patient care and career break intentions among general practitioners in South West England: Findings of a census survey of general practitioners. *British Medical Journal Open*, *7*(4), e015853. https://doi.org/10.1136/BMJOPEN-2017-015853

Foggin, E., McDonnell, S., Cordingley, L., Kapur, N., Shaw, J., & Chew-Graham, C. A. (2016). GPs' experiences of dealing with parents bereaved by suicide: A qualitative study. *British Journal of General Practice*, *66*(651), e737–e746. https://doi.org/10.3399/bjgp16X686605

Forsythe, M., Calnan, M., & Wall, B. (1999). Doctors as patients: postal survey examining consultants and general practitioners adherence to guidelines. *British Medical Journal*, *319*(7210), 605–608. https://doi.org/10.1136/bmj.319.7210.605

Foster-Fishman, P., Nowell, B., Deacon, Z., Angela Nievar, M., & Mccann, P. (2005). Using methods that matter: The impact of reflection, dialogue, and voice. *American Journal of Community Psychology*, *36*(3–4), 275–291. https://doi.org/10.1007/s10464-005-8626-y

Frank, A. W. (2018). What is narrative therapy and how can it help health humanities? *Journal of Medical Humanities*, *39*(4), 553–563. https://doi.org/10.1007/s10912-018-9507-3

Fraser, H. (2004). Qualitative social work doing narrative research analysing personal stories line by line. *Qualitative Social Work*, *3*(2), 179–201. https://doi.org/10.1177/1473325004043383

Freedman, L. (2020). Survival Global Politics and Strategy Strategy for a Pandemic: The UK and COVID-19. *Survival*, *62*(3), 25–76. https://doi.org/10.1080/00396338.2020.1763610

Freudenberger, H. J. (1974). Staff Burnout. *Journal of Social Issues, 30*(1), 159–165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. J., & North, G. (2006). Burned out. In U. Kraft (Ed.), *Burned out* (pp. 28–33). Scientific American Mind. https://www.jstor.org/stable/24939487

Frith, H., & Harcourt, D. (2007). Using photographs to capture women's experiences of chemotherapy: Reflecting on the method. *Qualitative Health Research*, *17*(10), 1340–1350. https://doi.org/10.1177/1049732307308949

Furlong, M. (2013). *Building the client's relational base: A multidisciplinary handbook.* Bristol University Press, Policy Press.

García Romera, I., Danet Danet, A., & March Cerdá, J. C. (2010). [Emotional climate in Primary Health Care teams. A qualitative approach]. *Revista de Calidad Asistencial : Organo de La Sociedad Espanola de Calidad Asistencial*, *25*(4), 200–206. https://doi.org/10.1016/j.cali.2010.02.004

Garden, A. M. (1987). Depersonalization: A valid dimension of burnout? *Human Relations, 40*(9), 545–559. https://doi.org/10.1177/001872678704000901

Gardiner, M., Kearns, H., & Tiggemann, M. (2013). Effectiveness of cognitive behavioural coaching in improving the well-being and retention of rural general practitioners. *Australian Journal of Rural Health*, *21*(3), 183–189. https://doi.org/10.1111/ajr.12033

Garelick, A., Gross, S., Richardson, I., von der Tann, M., Bland, J., & Hale, R. (2007). Which doctors and with what problems contact a specialist service for doctors? A cross sectional investigation. *Biomed Central Med*, *5*(26). https://doi.org/https://doi.org/10.1186/1741-7015-5-26

Garrouste-Orgeas, M., Perrin, M., Soufir, L., Vesin, A., Blot, F., Maxime, V., Beuret, P., Troché, G., Klouche, K., Argaud, L., Azoulay, E., & Timsit, J.-F. (2015). The Iatroref study: Medical errors are associated with symptoms of depression in ICU staff but not burnout or safety culture. *Intensive Care Medicine*, *41*(2), 273–284. https://doi.org/10.1007/s00134-014-3601-4

General Medical Council. (2017). Chapter 1. In *Our data on doctors working in the UK* (pp. 35–56). https://www.gmc-uk.org/static/documents/content/SoMEP_2017_chapter_1.pdf

General Medical Council. (2021). *Working with doctors working for patients*. https://data.gmc-uk.org/gmcdata/home/#/reports/The Register/Stats/report

George, S., Hanson, J., & Jackson, J. L. (2014). Physician, heal thyself: A qualitative study of physician health behaviors. *Academic Psychiatry, 38*(1), 19–25.

https://doi.org/10.1007/s40596-013-0014-6

Gerada, C., Ashworth, M., Warner, L., & Keen, J. (2019). Mental health outcomes for doctors treated at UK Practitioner Health Service: a pilot study. *Research and Advances in Psychiatry*, *6*(1), 7–14. https://www.practitionerhealth.nhs.uk/media/content/files/RAP%20paper%20CG%20et%20al%20PDF%20from%20journal.pdf

Gerada, C., Chatfield, C., Rimmer, A., & Godlee, F. (2018). Making doctors better. *British Medical Journal (Online)*, *363*. https://doi.org/10.1136/bmj.k4147

Gerada, C., Warner, L., Jones, R., & Al-Najjar, Z. (2018). *The wounded healer: Report on the first 10 years of Practitioner Health Service*. https://www.practitionerhealth.nhs.uk/media/content/files/PHP-report-web version final(1).pdf

Gergen, M. M., & Gergen, K. J. (2011). Performative social science and psychology. *Historical Social Research*, 291–299. http://www.qualitative-research.net/index.php/fqs/article/view/1595

Gewurtz, R., & Kirsh, B. (2009). Disruption, disbelief and resistance: A meta-synthesis of disability in the workplace. *Work*, *34*(1), 33–44. https://doi.org/10.3233/WOR-2009-0900

Gibson, J., Checkland, K., Coleman, A., Hann, M., McCall, R., Spooner, R., & Sutton, S. (2015). *Eighth National GP Worklife Survey*. http://man.ac.uk/04Y6Bo]

Gibson, J., Sutton, M., Spooner, S., & Checkland, K. (2018). Ninth National GP Worklife Survey 2017. In *Policy Research Unit in Commissioning and the Healthcare System*.

Giebner, B. (2016). Gedeelde ruimte: De ontvankelijkheid van zorgverleners in patëntencontacten [Shared space: The personal receptivity of medical professionals in their patient contact]. *Psyche En Geloof, 27*(1), 2–10.

Gilbert, N. (2008). *Researching social life* (3rd ed.). SAGE Publications.

Giles, J. R. (2004). *Growing through adversity, becoming women who live without partner abuse: A grounded theory study* [Auckland University of Technology]. http://hdl.handle.net/10292/245

Glasberg, A. L., Eriksson, S., & Norberg, A. (2007). Burnout and "stress of conscience" among healthcare personnel. *Journal of Advanced Nursing*, *57*(4), 392–403. https://doi.org/10.1111/j.1365-2648.2007.04111.x

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldire.

Golembiewski, R. T., Munzenrider, R. F., & Stevenson, J. (1986). *Stress in organizations: Toward a phase model of burnout*. Praeger Publishers.

Gosling, R., Bassett, C., Gilby, N., Angle, H., & Catto, S. (2008). *Health education population survey: Update from 2006 survey*. NHS Health Scotland.

Götze, H., Perner, A., Gansera, L., & Brähler, E. (2013). "da kann man nicht auf die Uhr gucken": Interviews mit Hausärzten zur ambulanten Palliativversorgung von Tumorpatienten. *Gesundheitswesen*, *75*(6), 351–355. https://doi.org/10.1055/s-0032-1321753

Grassi, L., & Magnani, K. (2000). Psychiatric morbidity and burnout in the medical profession: an Italian study of general practitioners and hospital physicians. *Psychotherapy and Psychosomatics*, *69*(6), 329–334. https://doi.org/10.1159/000012416

Gregory, M. E., Russo, E., & Singh, H. (2017). Electronic health record alert-related workload as a predictor of burnout in primary care providers. *Applied Clinical*

Informatics, *8*(3), 686–697. https://doi.org/10.4338/ACI-2017-01-RA-0003

Gronseth, I. M., Malterud, K., & Nilsen, S. (2020). Why do doctors in Norway choose general practice and remain there? A qualitative study about motivational experiences. *Scandinavian Journal of Primary Health Care*. https://doi.org/10.1080/02813432.2020.1753348

Guillemin, M., & Drew, S. (2010). Questions of process in participant-generated visual methodologies. *Visual Studies*, *25*(2), 175–188. https://doi.org/10.1080/1472586X.2010.502676

Gunasingam, N., Burns, K., Edwards, J., Dinh, M., & Walton, M. (2015). Reducing stress and burnout in junior doctors: The impact of debriefing sessions. *Postgrad Med J*, *91*(1074), 182–187. https://doi.org/10.1136/postgradmedj-2014-132847

Gundersen, L. (2001). Physician burnout. *Ann Intern Med*, *135*(2), 145–148. https://doi.org/10.7326/0003-4819-135- 2-200107170-00023

Gupta, T., Sisodia, M., Fazulbhoy, S., & Raju, M. (2019). Improving accessibility for dyslexic impairments using augmented reality. *International Conference on Computer Communication and Informatics*.

Guseva Canu, I., Marca, S. C., Dell’Oro, F., Balázs, Á., Bergamaschi, E., Besse, C., Bianchi, R., Bislimovska, J., Bjelajac, A. K., Bugge, M., Busneag, C. I., Çağlayan, Ç., Cernitanu, M., Pereira, C. C., Hafner, N. D., Droz, N., Eglite, M., Godderis, L., Gündel, H., … Wahlen, A. (2021). Harmonized definition of occupational burnout: A systematic review, semantic analysis, and Delphi consensus in 29 countries. *Scandinavian Journal of Work, Environment and Health*, *47*(2), 95–107. https://doi.org/10.5271/sjweh.3935

Hadi, M. A., & Closs, S. J. (2016). Ensuring rigour and trustworthiness of qualitative research in clinical pharmacy. *International Journal of Clinical Pharmacy*, *38*(3), 641–646. https://doi.org/10.1007/s11096-015-0237-6

Hall, J. M. (2011). Narrative methods in a study of trauma recovery. *Qualitative Health Research*, *21*(1), 3–13. https://doi.org/10.1177/1049732310377181

Hall, L. H., Johnson, J., Heyhoe, J., Watt, I., Anderson, K., & O'connor, D. B. (2017). Strategies to improve general practitioner well-being: Findings from a focus group study. *Family Practice, 35*(4), 511–516. https://doi.org/10.1093/fampra/cmx130

Hall, L. H., Johnson, J., Heyhoe, J., Watt, I., Anderson, K., & O'Connor, D. B. (2017). Exploring the impact of primary care physician burnout and well-being on patient care: A focus group study. *Journal of Patient Safety*, *16*(4), e278–e283. https://doi.org/10.1097/pts.0000000000000438

Hall, L. H., Johnson, J., Watt, I., & O'Connor, D. B. (2019). Association of GP wellbeing and burnout with patient safety in UK primary care: A cross-sectional survey. *British Journal of General Practice*, *69*(684), e507–e514. https://doi.org/10.3399/bjgp19X702713

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. *PLoS One*, *11*(7), e0159015. https://doi.org/10.1371/journal.pone.0159015

Halley, M. C., Rustagi, A. S., Torres, J. S., Linos, E., Plaut, V., Mangurian, C., Choo, E., & Linos, E. (2018). Physician mothers' experience of workplace discrimination: A qualitative analysis. *British Medical Journal (Online)*, *363,* k4926. https://doi.org/10.1136/bmj.k4926

Hallsten, L., Voss, M., Josephson, M., Stark, S., & Vingård, E. (2011). Job burnout and job wornout as risk factors for long-term sickness absence. *Work*, *38,* 181–192. https://doi.org/10.3233/WOR-2011-1120

Hamama-Raz, Y., Hamama, L., Pat-Horenczyk, R., Stokar, Y. N., Zilberstein, T., & Bron-Harlev, E. (2020). Posttraumatic growth and burnout in pediatric nurses: The mediating role of secondary traumatization and the moderating role of meaning in work. *Stress and Health*. https://doi.org/10.1002/smi.3007

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. Routledge.

Harper, D., & Speed, E. (2014). Uncovering Recovery: The Resistible Rise of Recovery and Resilience. *Studies in Social Justice*, *6*(1), 9–26. https://doi.org/10.1057/9781137304667_3

Harris, S. M., Binder, P. E., & Sandal, G. M. (2020). General practitioners' experiences of clinical consultations with refugees suffering from mental health problems. *Frontiers in Psychology*, *11*(412). https://doi.org/10.3389/fpsyg.2020.00412

Harrison, B. (2002). Photographic visions and narrative inquiry. *Narrative Inquiry*, *12*(1), 87–111. https://doi.org/10.1075/ni.12.1.14har

Harrison, D. A., & Newman, D. A. (2006). How important are job attitudes? Meta-analytic comparisons of integrative behavioral outcomes and time sequences diversity shrinkage: Cross-validating pareto-optimal weights to enhance diversity via hiring practices view project. *Article in The Academy of Management Journal*, *49*(2), 305–325. https://doi.org/10.5465/AMJ.2006.20786077

Hartney, E. (2008). *Stress management for teachers*. Bloomsbury Publishing.

Hätinen, M. (2008). Treating job burnout in employee rehabilitation: Changes in symptoms, antecedents, and consequences. In *Jyväskylä Studies in Education, Psychology and Social Research*. University of Jyväskylä.

Hätinen, M., Mäkikangas, A., & Kinnunen, U. (2013). Recovery from burnout during a one-year rehabilitation intervention with six-month follow-up: Associations with coping strategies. *Article in International Journal of Stress Management*. https://doi.org/10.1037/a0034286

Hayter, P., Peckham, S., & Robinson, R. (1996). *Morale in General Practice* .

Health Service Executive. (2009). *Plain language style guide for documents* .

Hedman, A. S. (2008). Using the SMOG formula to revise a health-related document. *American Journal of Health Education*, *39*(1), 61–64. https://doi.org/10.1080/19325037.2008.10599016

Heeks, A. (2019). Learning super-resilience from nature: Systemic responses to systemic overload. *Journal of Holistic Healthcare*, *16*(1), 20–20. www.karenhobden.com

Henderson, M., Brooks, S. K., Del Busso, L., Chalder, T., Harvey, S. B., Hotopf, M., Madan, I., & Hatch, S. (2012). Shame! Self-stigmatisation as an obstacle to sick doctors returning to work: A qualitative study. *British Medical Journal Open*, *2*(5). https://doi.org/10.1136/bmjopen-2012-001776

Henke, R. M., Chou, A. F., Chanin, J. C., Zides, A. B., & Scholle, S. H. (2008). Physician attitude toward depression care interventions: implications for implementation of quality improvement initiatives. *Implementation Science : IS*, *3*(1), 40. https://doi.org/10.1186/1748-5908-3-40

Heras-Mosteiro, J., Sanz-Barbero, B., & Otero-Garcia, L. (2016). Health care austerity measures in times of crisis: The perspectives of primary health care physicians in Madrid, Spain. *International Journal of Health Services*, *46*(2), 283–299. https://doi.org/10.1177/0020731415625251

Higgins, J. P. T., & Green, S. (2006). *Cochrane handbook for systematic reviews of interventions*. The Cochrane Library.

Hignett, S., Lang, A., Pickup, L., Ives, C., Fray, M., McKeown, C., Tapley, S., Woodward, M., & Bowie, P. (2018). More holes than cheese. What prevents the delivery of effective, high quality and safe health care in England? *Ergonomics*, *61*(1), 5–14. https://doi.org/10.1080/00140139.2016.1245446

Hobbs, F. D. R., Bankhead, C., Mukhtar, T., Stevens, S., Perera-Salazar, R., Holt, T., & Salisbury, C. (2016). Clinical workload in UK primary care: A retrospective analysis of 100 million consultations in England, 2007–14. *The Lancet*, *387*(10035). https://doi.org/10.1016/S0140-6736(16)00620-6

Hobfoll, S. E., Hall, B. J., Canetti-Nisim, D., Galea, S., Johnson, R. J., & Palmieri, P. A. (2007). Refining our understanding of traumatic growth in the face of terrorism: Moving from meaning cognitions to doing what is meaningful. *Applied Psychology*, *56*(3), 345–366. https://doi.org/10.1111/j.1464-0597.2007.00292.x

Hockly, A., & Caan, W. (2012). Could health service reforms make general practitioners ill? *Journal of Public Mental Health*, *11*(2), 50–53. https://doi.org/10.1108/17465721211236354

Hoffmann, T., & Worrall, L. (2004). Designing effective written health education materials: Considerations for health professionals. *Disability and Rehabilitation*, *26*(19), 1166–1173. https://doi.org/10.1080/09638280410001724816

Høifødt, T. S., & Talseth, A. G. (2006). Dealing with suicidal patients - A challenging task: A qualitative study of young physicians’ experiences. *Biomed Central Medical Education*, *6*. https://doi.org/10.1186/1472-6920-6-44

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, *3*(3), 345–357. https://doi.org/10.1177/1468794103033004

Holt, R. E., & Slade, P. (2003). Living with an incomplete vagina and womb: An interpretative phenomenological analysis of the experience of vaginal agenesis.

Psychology, Health & Medicine, *8*(1), 19–33. https://doi.org/10.1080/1354850021000059232

Horner, S. D., Surratt, D., & Juliusson, S. (2010). Improving readability of patient education materials. *Journal of Community Health Nursing*, *17*, 15–23. https://doi.org/10.2307/3427736

Houghton, M. (2016). Why is general practice no longer a coveted career choice? *British Medical Journal*, i5939. https://doi.org/10.1136/bmj.i5939

House of Commons and Health and Social Care Committee. (2020). *Delivering core NHS and care services during the pandemic and beyond Second Report of Session 2019-21*. www.parliament.uk/hsccom

House of Commons and Health and Social Care Committee. (2021). *Workforce burnout and resilience in the NHS and social care Second Report of Session 2021-22 Report, together with formal minutes relating to the report*. www.parliament.uk/hsccom

Howell, A., & Voronka, J. (2012). Introduction: The politics of resilience and recovery in mental health care. *Studies in Social Justice*, *6*(1), 1–7. https://doi.org/10.7282/T3QN68S2

Hsieh, H-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Huby, G., Gerry, M., McKinstry, B., Porter, M., Shaw, J., & Wrate, R. (2002). Morale among general practitioners: Qualitative study exploring relations between partnership arrangements, personal style, and workload. *British Medical Journal, 325*(7356), 140. https://doi.org/10.1136/bmj.325.7356.140

Humphreys, P., & Brézillon, P. (2002). *Combining rich and restricted languages in* *multimedia: Enrichment of context for innovative decisions*. https://doi.org/10.1.1.19.7853

Hunt, D., & Smith, J. A. (2004). The personal experience of carers of stroke survivors: An interpretative phenomenological analysis. *Disability and Rehabilitation*, *26*(16), 1000–1011. https://doi.org/10.1080/09638280410001702423

Hunter, J., Marshall, J., Corcoran, K., Leeder, S., & Phelps, K. (2013). A positive concept of health - Interviews with patients and practitioners in an integrative medicine clinic. *Complementary Therapies in Clinical Practice*, *19*(4), 197–203. https://doi.org/10.1016/j.ctcp.2013.07.001

Huppert, F. A. (2009). Psychological well-being: Evidence regarding its causes and consequences†. *Applied Psychology: Health and Well-Being*, *1*(2), 137–164. https://doi.org/10.1111/J.1758-0854.2009.01008.X

Hutter, M. M., Kellogg, K. C., Ferguson, C. M., Abbott, W. M., & Warshaw, A. L. (2006). The impact of the 80-hour resident workweek on surgical residents and attending surgeons. *Annals of Surgery*, *243*(6), 864–875. https://doi.org/10.1097/01.sla.0000220042.48310.66

Hydèn, M. (1994). Woman battering as a marital act: Interviewing and analysis in context. In *Qualitative studies in social work* (pp. 95–112). Sage Publications.

Iacovides, A., Fountoulakis, K. N., Kaprinis, S., & Kaprinis, G. (2003). The relationship between job stress, burnout and clinical depression. *Journal of Affective Disorders*, *75*(3), 209–221. https://doi.org/10.1016/S0165-0327(02)00101-5

Ilies, R., Scott, B. A., & Judge, T. A. (2006). The interactive effects of personal traits and experienced states on intraindividual patterns of citizenship behavior. *Academy of Management Journal*, *49*(3), 561–575. https://doi.org/10.5465/AMJ.2006.21794672

Imo, U. O. (2017). Burnout and psychiatric morbidity among doctors in the UK: A systematic literature review of prevalence and associated factors. *British Journal of Psychiatry Bulletin*, *41*(4), 197–204. https://doi.org/10.1192/pb.bp.116.054247

Ingleby, D., Mckee, M., Mladovsky, P., & Rechel, B. (2012). How the NHS measures up to other health systems. *British Medical Journal*, *344,* e1079. https://doi.org/10.1136/bmj.e1079

Ingstad, B., & Christie, V. M. (2001). Encounters with illness: the perspective of the sick doctor. *Anthropology & Medicine*, *8*(2–3), 201–210. https://doi.org/10.1080/13648470120101372

Institute for Government. (2019). *Performance Tracker 2019: General practice*. https://www.instituteforgovernment.org.uk/publication/performance-tracker-2019/general-practice

Jacquet, A., Grolleau, A., Jove, J., Lassalle, R., & Moore, N. (2015). Burnout: Evaluation of the efficacy and tolerability of TARGET 1 for professional fatigue syndrome (burnout). *Journal of International Medical Research*, *43*(1), 54–66. https://doi.org/10.1177/0300060514558324

Jaffe, D., Goldstein, M., & Wilson, J. (1985). Physicians in transition: From burnout to balance. *Saybrook Review*, *5*(1), 57–71.

Jego, M., Debaty, E., Ouirini, L., Carrier, H., & Beetlestone, E. (2018). *Caring for patients with mental disorders in primary care: A qualitative study on French GPs' views, atittudes and needs*. Family Practice. https://doi.org/10.1093/fampra/cmy107

Jensen, L. A., & Allen, M. N. (1996). Meta-synthesis of qualitative findings. *Qualitative Health Research*, *6*(4), 553–560. https://doi.org/10.1177/104973239600600407

Jensen, N. K., Norredam, M., Priebe, S., & Krasnik, A. (2013). How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. *Biomed Central Family Practice, 14*. https://doi.org/10.1186/1471-2296-14-17

Johnson, S., Burrows, A., & Williamson, I. (2004). ‘Does my bump look big in this?’: The meaning of bodily changes for first-time mothers-to-be. *Journal of Health Psychology*, *9*(3), 361–374. https://doi.org/10.1177/1359105304042346

Jones, K. (2006). A biographic researcher in pursuit of an aesthetic: The use of arts-based (re) presentations in “performative” dissemination of life stories. *Qualitative Sociology Review*, *2*(1), 66–85. http://eprints.bournemouth.ac.uk/1178/

Joseph, S. (2011). *What doesn’t kill us: The new psychology of posttraumatic growth*. Basic Books.

Joseph, S., Beer, C., Clarke, D., Forman, A., Pickersgill, M., Swift, J., Taylor, J., & Tischler, V. (2009). Qualitative research into mental health: Reflections on epistemology. *Mental Health Review Journal*, *14*(1), 36–42. https://doi.org/10.1108/13619322200900006

Joseph, S., & Linley, P. A. (2005). *Positive adjustment to threatening events: An organismic valuing theory of growth through adversity*. https://doi.org/10.1037/1089-2680.9.3.262

Joseph, S., & Linley, P. A. (2006). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review*, *26*(8), 1041–1053. https://doi.org/10.1016/j.cpr.2005.12.006

Joseph, S., Williams, R., & Yule, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to assess positive and negative responses. *Journal of Traumatic Stress*, *6*(2), 271–279. https://doi.org/10.1002/jts.2490060209

Joyce, C. (2017). *Lived long-term experience of eating disorders: A narrative exploration*. Lancaster University.

Kahneman, D., Diener, E., & Schwarz, N. (1999). *Well-being: Foundations of hedonic psychology*. Russell Sage Foundation.

Kakiashvili, T., Leszek, J., & Rutkowski, K. (2013). The medical perspective on burnout. *International Journal of Occupational Medicine and Environmental Health*. https://doi.org/10.2478/s13382-013-0093-3

Kantrowitz-Gordon, I., & Vandermause, R. (2016). Metaphors of distress: Photo-elicitation enhances a discourse analysis of parents' accounts. *Qualitative Health Research*, *26*(8), 1031–1043. https://doi.org/10.1177/1049732315575729

Kashdan, T., Stiksma, M., Disabato, D., McKnight, P., Bekier, J., Kaji, J., & Lazarus, R. (2018). The five-dimensional curiosity scale: Capturing the bandwidth of curiosity and identifying four unique subgroups of curious people. *Journal of Research in Personality*, *73*, 130–149.

Kaufman, S. B. (2018). Self-Actualizing People in the 21st Century: Integration With Contemporary Theory and Research on Personality and Well-Being. *Journal of Humanistic Psychology*. https://doi.org/10.1177/0022167818809187

Kavalieratos, D., Siconolfi, D. E., Steinhauser, K. E., Bull, J., Arnold, R. M., Swetz, K. M., & Kamal, A. H. (2017). "It is like heart failure. It is chronic and it will kill you": A qualitative analysis of burnout among hospice and palliative care clinicians. *Journal of Pain Symptom Management*, *53*(5), e901–e910. https://doi.org/10.1016/j.jpainsymman.2016.12.337

Kay, M. (2012). Do we overdramatize family physician burnout?: YES. *Canadian Family Physician*, *58*(7), 730–732. http://www.cfp.ca/content/58/7/730.short

Kearney, M. H. (2001). New directions in grounded formal theory. In R. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing*. Springer.

Keen, S., & Todres, L. (2007). Strategies for disseminating qualitative research findings: Three exemplars. *In Forum: Qualitative Social Research* , *8*(3), 17. http://eprints.bournemouth.ac.uk/5691/

Kerr, C., Nixon, A., & Wild, D. (2010). Assessing and demonstrating data saturation in qualitative inquiry supporting patientreported outcomes research. *Expert Review of Pharmacoeconomics and Outcomes Research*, *10*(3), 269–281. https://doi.org/10.1586/erp.10.30

Khan, A., Teoh, K. R., Islam, S., & Hassard, J. (2018). Psychosocial work characteristics, burnout, psychological morbidity symptoms and early retirement intentions: A cross-sectional study of NHS consultants in the UK. *British Medical Journal Open*, *8*(7), e018720. https://doi.org/10.1136/bmjopen-2017-018720

Khan, N., Jones, D., Grice, A., Alderson, S., Bradley, S., Carder, P., Drinkwater, J., Edwards, H., Essang, B., Richards, S., & Neal, R. (2020). A brave new world: The new normal for general practice after the COVID-19 pandemic. *British Journal of General Practice Open*, *4*(3). https://doi.org/10.3399/bjgpopen20X101103

Khandaker, G., Cherukuru, S., Dibben, C., & Ray, M. K. (2009). From a sector-based service model to a functional one: Qualitative study of staff perceptions. *Psychiatric Bulletin*, *33*(9), 329–332. https://doi.org/10.1192/pb.bp.108.022897

Kinman, G., & Teoh, K. (2018). *What could make a difference to the mental health of UK doctors? A review of the research evidence*. https://eprints.bbk.ac.uk/policies.html

Kirkpatrick, H. (2008). A narrative framework for understanding experiences of people with severe mental illnesses. *Archives of Psychiatric Nursing*, *22*(2), 61–68. https://doi.org/10.1016/J.APNU.2007.12.002

Kjeldmand, D., & Holmström, I. (2008). Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *The Annals of Family Medicine*, *6*(2), 138–145. https://doi.org/10.1370/afm.813

Kocalevent, R. D., Hinz, A., & Brähler, E. (2013). Standardization of the depression screener Patient Health Questionnaire (PHQ-9) in the general population. *General Hospital Psychiatry*, *35*(5), 551–555. https://doi.org/10.1016/j.genhosppsych.2013.04.006

Krakowski, A. J. (1984). Stress and the practice of medicine. III. Physicians compared with lawyers. *Psychotherapy and Psychosomatics*, *42*(1–4), 143–151. https://doi.org/10.1159/000287838

Krekel, C., Ward, G., & De Neve, J. E. (2019). *Employee Wellbeing, Productivity, and Firm Performance*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3356581

Kristensen, T., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen burnout inventory: A new tool for the assessment of burnout. *Work Stress*, *19*, 192–207. https://doi.org/10.1080/02678370500297720

Kroenke, K., & Spitzer, L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Depression in Primary Care*, *32*(9), 1–7. https://doi.org/10.3928/0048-5713-20020901-06

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R., Williams, J., & Löwe, B. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: A systematic review. *General Hospital Psychiatry*, *32*(4), 345–359. https://doi.org/10.1016/j.genhosppsych.2010.03.006

Kukkonen, T., & Cooper, A. (2017). An arts-based knowledge translation (ABKT) planning framework for researchers. *Evidence & Policy: A Journal of Research, Debate and Practice*, *15*(2), 293–311. https://doi.org/10.1332/174426417x15006249072134

Kumar, S. (2007). Burnout in psychiatrists. *World Psychiatry*, *6*(3), 186–189. https://www.ncbi.nlm.nih.gov/pmc/articles/pmc2175073/

Kumar, S. (2016). Burnout and doctors: prevalence, prevention and intervention. *Healthcare*, *4*(3), 37. https://doi.org/10.3390/healthcare4030037

Lacy, B., & Chan, J. (2018). Physician burnout: the hidden health care crisis. *Clinical Gastroenterology and Hepatology*, *16*(3), 311–317. https://doi.org/10.1016/j.cgh.2017.06.043

Langat, P., Pisartchik, D., Silva, D., Bernard, C., Olsen, K., Smith, M., Sahni, S., & Upshur, R. (2011). Is there a duty to share? Ethics of sharing research data in the context of public health emergencies. *Public Health Ethics*, *4*(1), 4–11. https://doi.org/10.1093/phe/phr005

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 101–116). John Wiley & Sons. https://doi.org/10.1002/9781119973249

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. https://doi.org/10.1191/1478088706qp062oa

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21–35. https://doi.org/10.1177/160940690300200303

Le Floch, B., Bastiaens, H., Le Reste, J. Y., Lingner, H., Hoffman, R., Czachowski, S., Assenova, R., Koskela, T. H., Klemenc-Ketis, Z., Nabbe, P., Sowinska, A., Montier, T., & Peremans, L. (2019). Which positive factors give general practitioners job satisfaction and make general practice a rewarding career? A European multicentric qualitative research by the European general practice research network. *Biomed Central Family Practice*, *20*(1), 96. https://doi.org/10.1186/s12875-019-0985-9

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*, 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Leavy, P. (2015). *Method meets art: Art-based research practice* (Second). Guilford Publications.

Lee, E. H. (2012). Review of the psychometric evidence of the perceived stress scale. *Asian Nursing Research*, *6*(4), 121–127. https://doi.org/10.1016/j.anr.2012.08.004

Lee, R. P., Hart, R. I., Watson, R. M., Rapley, T., & Lee, R. (2015). Qualitative synthesis in practice: Some pragmatics of meta-ethnography. *Qualitative Research*, *15*(3), 334–350. https://doi.org/10.1177/1468794114524221

Leese, B., Young, R., & Sibbald, B. (2002). GP principals leaving practice in the UK: Similarities and differences between men and women at different career stages. *The European Journal of General Practice*, *8*(2), 62–68. https://doi.org/10.3109/13814780209160835

Leiter, M P. (1993). Burnout as a developmental process: Consideration of models. In W.

B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 237–250). Taylor & Francis.

Leiter, Michael P., & Durup, J. (1994). The discriminant validity of burnout and depression: A confirmatory factor analytic study. *Anxiety, Stress, & Coping*, *7*(4), 357–373. https://doi.org/10.1080/10615809408249357

Lemaire, J. B., & Wallace, J. E. (2010). Not all coping strategies are created equal: A mixed methods study exploring physicians' self reported. *Biomed Central Health Services Research*, *10*. https://doi.org/10.1186/1472-6963-10-208

Levitt, H., Bamberg, M., Creswell, J., Frost, D., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist*, *71*(1), 26–46. https://doi.org/10.1037/amp0000151

Levy, A., & Cartwright, T. (2015). Men's strategies for preserving emotional well-being in advanced prostate cancer: An interpretative phenomenological analysis. *Psychology & Health*, *30*(10), 1164–1182. https://doi.org/10.1080/08870446.2015.1040016

Liberman, R. P., & Kopelowicz, A. (2005). Recovery from schizophrenia: A concept in search of research. *Psychiatric Services*, *56*(6), 735–742. https://doi.org/10.1176/appi.ps.56.6.735

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998). *Narrative research: Reading, analysis, and interpretation*. Sage Publications.

Lilgendahl, J. P., & Mcadams, D. P. (2011). Constructing stories of self-growth: How individual differences in patterns of autobiographical reasoning relate to well-being in midlife. *The Authors Journal of Personality*, *79*(2), 391–428. https://doi.org/10.1111/j.1467-6494.2010.00688.x

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation*, *1986*(30), 73–84. https://doi.org/10.1002/ev.1427

Lind, S. (2017). Government “making progress” with correcting 2004 GP contract, says Hunt. *Pulse*.

Lindås, R., Holst-Larsen, T., Johansen, P. O., Taraldsøy, E., Pedersen, B. B., Sårheim, H., & Moen, B. E. (1991). [Physicians’ work load. A comparison between company physicians and general practitioners in private practice]. *Tidsskrift for Den Norske Laegeforening : Tidsskrift for Praktisk Medicin, Ny Raekke*, *111*(18), 2283–2286. http://www.ncbi.nlm.nih.gov/pubmed/1896990

Linde, K., Maria Huber, C., Barth, N., & Schneider, A. (2020). How do young general practitioners experience the transition to general practice? A qualitative study. *Zeitschrift Fur Evidenz, Fortbildung Und Qualitat Im Gesundheitswesen*. https://doi.org/10.1016/j.zefq.2020.02.001

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress*, *17*(1), 11–21. https://doi.org/10.1023/B:JOTS.0000014671.27856.7e

Linzer, M., Baier Manwell, L., Williams, E. S., Bobula, J. A., Brown, R. L., Varkey, A. B., Man, B., McMurray, J. E., Maguire, A., Horner-Ibler, B., & Schwartz, M. D. (2009). Working conditions in primary care: Physician reactions and care quality. *Annals of Internal Medicine*, *151*(1), 28–36. 10.7326/0003-4819-151-1-200907070-00006

Linzer, M., Poplau, S., Babbott, S., Collins, T., Guzman-Corrales, L., Menk, J., Murphy, M. Lou, & Ovington, K. (2016). Worklife and wellness in academic general internal medicine: Results from a national survey. *Journal of General Internal Medicine*, *31*(9), 1004–1010. https://doi.org/10.1007/s11606-016-3720-4

Linzer, M., Visser, M. R. M., Oort, F. J., Smets, E. M. A., McMurray, J. E., & de Haes, H. C. J. M. (2001). Predicting and preventing physician burnout: results from the United States and the Netherlands. *The American Journal of Medicine, 111*(2), 170–175. https://doi.org/10.1016/S0002-9343(01)00814-2

Loas, G., Lefebvre, G., Rotsaert, M., & Englert, Y. (2018). Relationships between anhedonia, suicidal ideation and suicide attempts in a large sample of physicians. *PLoS ONE*, *13*(3). https://doi.org/10.1371/journal.pone.0193619

Lock, A., & Strong, T. (Eds.). (2010). *Social constructionism: Sources and stirrings in theory and practice*. Cambridge University Press.

Loeb, D. F., Bayliss, E. A., Binswanger, I. A., Candrian, C., & deGruy, F. V. (2012). Primary care physician perceptions on caring for complex patients with medical and mental illness. *Journal of General Internal Medicine*, *27*(8), 945–952. https://doi.org/10.1007/s11606-012-2005-9

Loeb, D. F., Bayliss, E. A., Candrian, C., DeGruy, F. V., & Binswanger, I. A. (2016). Primary care providers’ experiences caring for complex patients in primary care: A qualitative study. *Biomed Central Family Practice*, *17*(1). https://doi.org/10.1186/s12875-016-0433-z

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, *4*(1), 30–37. https://doi.org/10.1054/cein.2000.0106

Lovell, B. L., Lee, R. T., & Frank, E. (2009). May I long experience the joy of healing: Professional and personal wellbeing among physicians from a Canadian province. *Biomed Central Family Practice, 10*. https://doi.org/10.1186/1471-2296-10-18

Lowe, A., Norris, A. C., Farris, A. J., & Babbage, D. R. (2018). Quantifying thematic saturation in qualitative data analysis. *Field Methods*, *30*(3), 191–207. https://doi.org/10.1177/1525822X17749386

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the generalized anxiety disorder screener (GAD-7) in the general population. *Medical Care, 46*(3), 266–274. https://doi.org/10.1097/MLR.0b013e318160d093

Ludvigsen, M. S., Hall, E. O. C., Meyer, G., Fegran, L., Aagaard, H., & Uhrenfeldt, L. (2016). Using Sandelowski and Barroso’s meta-synthesis method in advancing qualitative evidence. *Qualitative Health Research*, *26*(3), 320–329. https://doi.org/10.1177/1049732315576493

Lukoff, D. (2007). Spirituality in the recovery from persistent mental disorders. *Southern Medical Journal*, *100*(6), 642–646. https://doi.org/10.1097/SMJ.0b013e3180600ce2

Lykes, M. B., Blanche, M. T., & Hamber, B. (2003). Narrating survival and change in Guatemala and South Africa: The politics of representation and a liberatory community psychology. *American Journal of Community Psychology*, *31*(1–2), 79–90. https://doi.org/10.1023/A:1023074620506

Lyons, E., & Coyle, A. (2007). *Analysing qualitative data in psychology*. Sage Publications.

Maben, J., Adams, M., Peccei, R., Murrells, T., & Robert, G. (2012). “Poppets and parcels”: The links between staff experience of work and acutely ill older peoples’ experience of hospital care. *International Journal of Older People Nursing*, *7*(2), 83–94. https://doi.org/10.1111/j.1748-3743.2012.00326.x

MacEachen, E., Clarke, J., Franche, R. L., & Irvin, E. (2006). Systematic review of the qualitative literature on return to work after injury. *Scandinavian Journal of Work Environment and Health*, *32*(4), 257–269. https://doi.org/10.5271/sjweh.1009

MacEachen, E., Kosny, A., Scott-Dixon, K., Facey, M., Chambers, L., Breslin, C., Kyle, N., Irvin, E., & Mahood, Q. (2010). Workplace health understandings and processes in small businesses: A systematic review of the qualitative literature. *Journal of Occupational Rehabilitation*, *20*(2), 180–198. https://doi.org/10.1007/s10926-009-9227-7

Macinko, J., Starfield, B., & Shi, L. (2003). The contribution of primary care systems to health outcomes within organization for economic cooperation and development (OECD) countries, 1970-1998. *Health Services Research*, *38*(3), 831–865. https://doi.org/10.1111/1475-6773.00149

Mackay, G., & Neill, J. (2010). The effect of “green exercise” on state anxiety and the role of exercise duration, intensity, and greenness: A quasi-experimental study. *Psychology of Sport and Exercise*, *11*(3), 238–245. https://doi.org/https://doi.org/10.1016/j.psychsport.2010.01.002

Maclean, A. (2020). *Mental health healing in the woods: An evaluation of the impact of the 2019 woodland wellbeing project in Deepdale Nature Reserve, Teesdale, County Durham*. https://www.brightwoodsforestschool.co.uk/app/uploads/Final-report-BWFSCIC_Woodland_Wellbeing_Project-2019.pdf

MacLeod, R. D. (2001). On reflection: Doctors learning to care for people who are dying. *Social Science and Medicine*, *52*(11), 1719–1727. https://doi.org/10.1016/S0277-9536(00)00289-6

Mahajan, S., & Johnstone, C. (2017). Human factors in suicide prevention. *InnovAiT: Education and Inspiration for General Practice.*, *10*(11), 379–686. https://doi.org/10.1177/1755738017724183

Majeed, A. (2015). Primary care: a fading jewel in the NHS crown. *London Journal of Primary Care*, *7*(5), 89–91. https://doi.org/10.1080/17571472.2015.1082343

Makin, P. J., Rout, U., & Cooper, C. L. (1988). Job satisfaction and occupational stress among general practitioners—A pilot study. *British Journal of General Practice*, *38*(312), 303–306. https://bjgp.org/content/38/312/303.short

Malhotra, M., & Chebiyyam, S. (2016). Posttraumatic growth: Positive changes following adversity-An overview. *Journal of Psychology and Behavioral Sciences*, *6*(3), 109–118. https://doi.org/10.5923/j.ijpbs.20160603.03

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009). “Medication career” or “moral career”? The two sides of managing antidepressants: A meta-ethnography of patients’ experience of antidepressants. *Social Science and Medicine*, *68*(1), 154–168. https://doi.org/10.1016/j.socscimed.2008.09.068

Manocha, R., Gordon, A., Black, D., Malhi, G., & Seidler, R. (2009). Using meditation for less stress and better wellbeing: A seminar for GPs. *Australian Family Physician*, *38*(6), 454.

Marselle, M. R., Warber, S. L., & Irvine, K. N. (2019). Growing resilience through interaction with nature: Can group walks in nature buffer the effects of stressful life events on mental health? *International Journal of Environmental Research and Public Health*, *16*(6), 986. https://doi.org/10.3390/ijerph16060986

Marshall, M., Howe, A., Howsam, G., Mulholland, M., & Leach, J. (2020). COVID-19: A danger and an opportunity for the future of general practice. *British Journal of General Practice*, *70*(695), 270–271. https://doi.org/10.3399/bjgp20X709937

Martin, S., Davies, E., & Gershlick, B. (2016). *Under pressure: What the Commonwealth Fund’s 2015 international survey of general practitioners means for the UK*. https://www.patientlibrary.net/tempgen/90361.pdf

Maslach, C. (1976). Burn-out. *Human Behaviour*, *9*, 16–22.

Maslach, C. (2003). *Burnout: The cost of caring*. Malor Books.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of*

Psychology, *52*(1), 397–422. https://doi.org/10.1146/annurev.psych.52.1.397

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. https://psycnet.apa.org/journals/rev/50/4/370/

Matheson, C., Robertson, H. D., Elliott, A. M., Iversen, L., & Murchie, P. (2016). Resilience of primary healthcare professionals working in challenging environments: A focus group study. *British Journal of General Practice*, *66*(648), e507-515. https://doi.org/10.3399/bjgp16X685285

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge University Press.

May, N., & Plews-Ogan, M. (2012). The role of talking (and keeping silent) in physician coping with medical error: A qualitative study. *Patient Education and Counseling*, *88*(3), 449–454. https://doi.org/10.1016/j.pec.2012.06.024

McAdams, D., Josselson, R., & Lieblich, A. (2001). *Turns in the road: Narrative studies of lives in transition.* American Psychological Association. https://psycnet.apa.org/record/2001-01078-000

McAlpine, D. D., & Mechanic, D. (2010). The influence of social factors on mental health. In M. Abou-Saleh, C. Katona, & A. Kumar (Eds.), *Principles and Practice of Geriatric Psychiatry: Third Edition* (pp. 97–101). John Wiley & Sons. https://doi.org/10.1002/9780470669600.CH18

McKay-Brown, L., Borland, R., Balmford, J., Segan, C. J., Andrews, C., Tasker, C., & Piterman, L. (2007). The challenges of recruiting and retaining GPs in research: Findings from a smoking cessation project. *Australian Journal of Primary Health*, *13*(1), 61–67. https://doi.org/10.1071/PY07008

Mckevitt, C., & Morgan, M. (1997). Illness doesn't belong to us. *Article in Journal of the*

Royal Society of Medicine, *90*(9), 491–495. https://doi.org/10.1177/014107689709000907

McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. Sage Publications.

McNamara, C. (2009). *General guidelines for conducting interviews*. https://managementhelp.org/businessresearch/interviews.htm

Mead, J., Fisher, Z., Wilkie, L., Gibbs, K., Pridmore, J., Tree, J., & Kemp, A. (2019). Rethinking wellbeing: toward a more ethical science of wellbeing that considers current and future generations. *Authorea Preprints*. https://www.authorea.com/doi/full/10.22541/au.156649190.08734276

Medico, D., & Santiago-Delefosse, M. (2014). From reflexivity to resonances: Accounting for interpretation phenomena in qualitative research. *Qualitative Research in Psychology*, *11*(4), 350–364. https://doi.org/10.1080/14780887.2014.915367

Meldrum, H. (2010). Exemplary physicians' strategies for avoiding burnout. *The Health Care Manager*, *29*(4), 324–331. https://doi.org/10.1097/HCM.0b013e3181fa037a

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. https://www.mentalhealthcommission.ca/sites/default/files/MHStrategy_Strategy_ENG.pdf

Michielutte, R., Bahnson, J., Dignan, M. B., & Schroeder, E. M. (1992). The use of illustrations and narrative text style to improve readability of a health education brochure. *Journal of Cancer Education*, *7*(3), 251–260. https://doi.org/10.1080/08858199209528176

Miedema, B., Ma, J. E., Fortin, P., Mses, R. H., & Tatemichi, S. (2009). Crossing boundaries: Family physicians' struggles to protect their private lives. *Canadian Family Physician - Le Médecin de Famille Canadien*, *55*, 286–287. https://pubmed.ncbi.nlm.nih.gov/19282540/

Miedema, B., MacIntyre, L., Tatemichi, S., Lambert-Lanning, A., Lemire, F., Manca, D., & Ramsden, V. (2012). How the medical culture contributes to coworker-perpetrated harassment and abuse of family physicians. *Annals of Family Medicine*, *10*(2), 111–117. https://doi.org/10.1370/afm.1341

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. J., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *British Medical Journal*, *339*(b2535). https://doi.org/10.1136/bmj.b2535

Morath, J. M., & Turnbull, J. E. (2005). *To do no harm: Ensuring patient safety in health care organizations*. John Wiley & Sons.

Morse, J. M. (2003). A review committee's guide for evaluating qualitative proposals. *Qualitative Health Research*, *13*(6), 833–851. https://doi.org/10.1177/1049732303013006005

Mossialos, E., Simpkin, V., Keown, O., & Darzi, A. (2016). Will the NHS be affected by leaving or remaining in the EU. In *lse.ac.uk*. https://www.lse.ac.uk/lse-health/assets/documents/press-briefings/NHS-and-EU-Referendum-briefing.pdf

Mukhtar, T. K., Bankhead, C., Stevens, S., Perera, R., Holt, T. A., Salisbury, C., & Hobbs, F. D. R. (2018). Factors associated with consultation rates in general practice in England, 2013–2014: a cross-sectional study. *British Journal of General Practice*, *68*(670), e370–e377. https://doi.org/10.3399/bjgp18X695981

Murad, M. H., Katabi, A., Benkhadra, R., & Monroti, V. M. (2018). External validity, generalisability, applicability and directness: A brief primer. *British Medical Journal Evidence-Based Medicine*, *23*(1), 17. https://doi.org/10.1136/ebmed-2017-110800

Murray, M. A., Cardwell, C., & Donnelly, M. (2017). GPs’ mental wellbeing and psychological resources: A cross-sectional survey. *British Journal of General Practice*, *67*(661), e547–e554. https://doi.org/10.3399/bjgp17X691709

Myers, M. F. (2017). *Why physicians die by suicide: lessons learned from their families and others who cared for them.* Myers.

Myers, N. (2016). Recovery stories: An anthropological exploration of moral agency in stories of mental health recovery. *Transcultural Psychiatry*, *53*(4), 427–444. https://journals.sagepub.com/doi/abs/10.1177/1363461516663124

Nahrgang, J., Morgeson, F. P., & Hofmann, D. A. (2011). Safety at work: A meta-analytic investigation of the link between job demands, job resources, burnout, engagement, and safety outcomes. *Journal of Applied Psychology*, *96*(1), 71–94. https://doi.org/10.1037/a0021484

Napier, J. (2017). Changing social defence systems: Narratives of UK general practice. *Organisational and Social Dynamics*, *17*(1), 1–18. https://firingthemind.com/product/osd-17-1-article/

National Institute for Health and Care Excellence. (n.d.). *Glossary* . Retrieved April 30, 2021, from https://www.nice.org.uk/Glossary?letter=P

NHS. (2019a). *The NHS Long Term Plan*. www.longtermplan.nhs.uk

NHS. (2019b). *Use a readability tool to prioritise content*. Digital Service Manual. https://service-manual.nhs.uk/content/health-literacy/use-a-readability-tool-to-prioritise-content

NHS Digital. (2019). *General and Personal Medical Services, England*. https://digital.nhs.uk/data-and-information/publications/statistical/general-practice-workforce-archive/final-30-june-and-provisional-30-september-2018-experimental-statistics

NHS England. (n.d.). *Primary care*. https://www.england.nhs.uk/primary-care/

NHS England. (2014). *Five year forward view*. https://www.england.nhs.uk/five-year-forward-view/

NHS England. (2017). *Next steps on the NHS five year forward view*. https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

NHS England. (2020a). *Our NHS people promise*. https://www.england.nhs.uk/wp-content/uploads/2020/07/Our_NHS_People_Promise.pdf

NHS England. (2020b). *We are the NHS: People plan for 2020/2021 - action for us all*. www.england.nhs.uk/ournhspeople

Niace. (2009). *Readability - how to produce clear written materials for a range of readers*. https://learningandwork.org.uk/resources/research-and-reports/readability-how-to-produce-clear-written-materials-for-a-range-of-readers/

Nicholson, E., Murphy, T., Larkin, P., Normand, C., & Guerin, S. (2016). Protocol for a thematic synthesis to identify key themes and messages from a palliative care research network. *Biomed Central Research Notes*, *9*(1), 478. https://doi.org/10.1186/s13104-016-2282-1

Nielsen, H. G., & Tulinius, C. (2009). Preventing burnout among general practitioners: is there a possible route? *Ducation for Primary Care*, *20*(5), 353–359. https://doi.org/10.1080/14739879.2009.11493817

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Open University Press.

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research.

Evidence-Based Nursing, 18(2), 34–35. https://doi.org/10.1136/eb-2015-102054

Noblit, G., & Hare, R. (1988). *Meta-ethnography: Synthesizing qualitative studies*. Sage Publications.

Noon, E. J. (2018). Interpretive phenomenological analysis: An appropriate methodology for educational research? *Journal of Perspectives in Applied Academic Practice, 6*(1), 75–83. https://doi.org/10.14297/jpaap.v6i1.304

Norlund, S., Reuterwall, C., Höög, J., Nordin, M., Edlund, C., & Birgander, S. L. (2011). Work related factors and sick leave after rehabilitation in burnout patients: Experiences from the REST-project. *Journal of Occupational Rehabilitation*, *21*(1), 23–30. https://doi.org/10.1007/s10926-010-9250-8

Norz, B. (2018). *Employed Physicians and Work Engagement in Health Care Organizations (HCOs)* [Fielding Graduate University].

Nurser, K. P., Rushworth, I., Shakespeare, T., & Williams, D. (2018). Personal storytelling in mental health recovery. *Mental Health Review Journal*, *23*(1), 25–36. https://doi.org/10.1108/MHRJ-08-2017-0034

O’Cathain, A., Simpson, R., Phillips, M., & Dickson, J. M. (2020). Tendency to contact general practice instead of self-care: A population vignette study. *British Journal of General Practice Open*, *4*(2), 1–15. https://doi.org/10.3399/bjgpopen20X101024

O’Connor, D. B., O’Connor, R. C., White, B. L., & Bundred, P. E. (2000). The effect of job strain on British general practitioners’ mental health. *Journal of Mental Health*, *9*(6), 637–654. https://doi.org/10.1080/jmh.9.6.637.654

O’Dowd, E., O’Connor, P., Lydon, S., Mongan, O., Connolly, F., Diskin, C., McLoughlin, A., Rabbitt, L., McVicker, L., Reid-McDermott, B., Byrne, D., O’Dowd, E., O’Connor, P., Lydon, S., Mongan, O., Connolly, F., Diskin, C., McLoughlin, A., Rabbitt, L., … Byrne, D. (2018). Stress, coping, and psychological resilience among physicians. *Biomed Central Health Services Research*, *18*(730). https://doi.org/10.1186/s12913-018-3541-8

O'Dowd, T. C. (1987). To burn out or to rust out in general practice. *British Journal of General Practice, 37*(300), 290–291. https://bjgp.org/content/37/300/290

Oerlemans, W. G. M., & Bakker, A. B. (2014). Burnout and daily recovery: A day reconstruction study. *Journal of Occupational Health Psychology*, *19*(3), 303–314. https://doi.org/10.1037/a0036904

Ogbonnaya, C., Tillman, C. J., & Gonzalez, K. (2018). Perceived organizational support in health care: The importance of teamwork and training for employee well-being and patient satisfaction. *Group & Organization Management*, *43*(3), 475–503. https://doi.org/10.1177/1059601118767244

Oliffe, J., & Bottorff, J. (2007). Further than the eye can see? Photo elicitation and research with men. *Qualitative Health Research, 17*(6), 850–858. https://doi.org/10.1177/1049732306298756

Oliver, D. (2017). When "resilience" becomes a dirty word. *British Medical Journal, 358*, j3604. https://doi.org/10.1136/bmj.j3604

Orosz, A., Federspiel, A., Haisch, S., Seeher, C., Dierks, T., & Cattapan, K. (2017). A biological perspective on differences and similarities between burnout and depression. *Neuroscience & Biobehavioral Reviews*, *73,* 112–122. https://doi.org/10.1016/j.neubiorev.2016.12.005

Otte, I. C., Jung, C., Elger, B., & Bally, K. (2017). "We need to talk!" Barriers to GPs' communication about the option of physician-assisted suicide and their ethical implications: results from a qualitative study. *Medicine, Health Care and Philosophy, 20*(2), 249–256. https://doi.org/10.1007/s11019-016-9744-z

Owen, K., Hopkins, T., Shortland, T., & Dale, J. (2019). GP retention in the UK: A worsening crisis. Findings from a cross-sectional survey. *British Medical Journal Open*, *9*, e026048. https://doi.org/10.1136/bmjopen-2018-026048

Palmer, B. (2019). *Is the number of GPs falling across the UK?* Nuffield Trust. https://www.nuffieldtrust.org.uk/news-item/is-the-number-of-gps-falling-across-the-uk

Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., Peters, D., Hodkinson, A., Riley, R., & Esmail, A. (2018). Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *Journal of the American Medical Association Internal Medicine*, *178*(10). https://doi.org/10.1001/jamainternmed.2018.3713

Park, C. L., Cohen, L. H., & Murch, R. L. (1996). Assessment and prediction of stress-related growth. *Journal of Personality, 64*(1), 71–105. https://doi.org/10.1111/j.1467-6494.1996.tb00815.x

Parker, D., Byng, R., Dickens, C., & McCabe, R. (2019). “Every structure we’re taught goes out the window”: General practitioners’ experiences of providing help for patients with emotional concerns’. *Health & Social Care in the Community*, *28*(1), 260–269. https://doi.org/10.1111/hsc.12860

Paterson, B., Thorne, S., Canam, C., & Jillings, C. (2001). *Meta-study of qualitative health research: A practical guide to meta-analysis and meta-synthesis* (3rd ed.). Sage Publications.

Pauwels, L. (2010). Visual sociology reframed: An analytical synthesis and discussion of visual methods in social and cultural research. *Sociological Methods & Research, 38*(4), 545–581. https://doi.org/10.1177/0049124110366233

Peckham, C. (2015). Physician burnout: It just keeps getting worse. *Medscape Family*

Medicine. https://www.medscape.com/viewarticle/838437

Pedersen, A., Carlsen, A., & Vedsted, P. (2015). Association of GPs' risk attitudes, level of empathy, and burnout status with PSA testing in primary care. *British Journal of General Practice*, *65*(641), e845–e851. https://doi.org/10.3399/bjgp15X687649

Pedrazza, M., Berlanda, S., Trifiletti, E., & Bressan, F. (2016). Exploring Physicians' Dissatisfaction and Work-Related Stress: Development of the PhyDis Scale. *Frontiers in Psychology*, *7*, 1238. https://doi.org/10.3389/fpsyg.2016.01238

Peisah, C., Latif, E., Wilhelm, K., & Williams, B. (2009). Secrets to psychological success: Why older doctors might have lower psychological distress and burnout than younger doctors. *Aging & Mental Health*, *13*(2), 300–307. https://doi.org/10.1080/13607860802459831

Petchey, R. (1994). Exploratory study of general practitioners' orientations to general practice and responses to change. *British Journal of General Practice*, *44*(389), 551–555. https://bjgp.org/content/44/389/551

Pines, A., & Aronson, E. (1981). *Burnout: From Tedium to Personal Growth*. Freedom Press.

Pines, A., & Maslach, C. (1980). Combatting staff burn-out in a day care center: A case study. *Child Care*, *9*(1), 5–16. https://doi.org/10.1007/BF01555032

Pink, J., Jacobson, L., & Pritchard, M. (2007). The 21st century GP: Physician and priest? *British Journal of General Practice*, *57*(543), 840–842. https://bjgp.org/content/57/543/840

Plews-Ogan, M., Owens, J. E., & May, N. B. (2013). Wisdom through adversity: Learning and growing in the wake of an error. *Patient Education and Counseling*, *91*(2), 236–242. https://doi.org/10.1016/j.pec.2012.12.006

Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: A systematic review and diagnostic metaanalysis. *General Hospital Psychiatry*, *39*, 24–31. https://doi.org/10.1016/j.genhosppsych.2015.11.005

Plummer, K. (2002). *Telling sexual stories: Power, change and social worlds*. Routledge.

Polkinghorne, D. (1988). *Narrative knowing and the human sciences*. Suny Press.

Pope, C., Mays, N., & Popay, J. (2007). *Synthesising qualitative and quantitative health evidence: A guide to methods*. Open University Press.

Porter, S. (2007). Validity, trustworthiness and rigour: Reasserting realism in qualitative research. *Journal of Advanced Nursing*, *60*(1), 79–86. https://doi.org/10.1111/j.1365-2648.2007.04360.x

Powell, T. (2020). *The structure of the NHS in England: Briefing paper Number CBP 07206*. https://commonslibrary.parliament.uk/research-briefings/cbp-7206/

Prayson, R. A., Bierer, S. B., & Dannefer, E. F. (2017). Medical student resilience strategies: A content analysis of medical students’ portfolios. *Perspectives on Medical Education*, *6*(1), 29–35. https://doi.org/10.1007/s40037-016-0313-1

Price-Robertson, R., Obradovic, A., & Morgan, B. (2017). Relational recovery: Beyond individualism in the recovery approach. *Advances in Mental Health*, *15*(2), 108–120. https://doi.org/10.1080/18387357.2016.1243014

Price, L., & Martin, L. (2018). Introduction to the special issue: Applied critical realism in the social sciences. *Journal of Critical Realism*, *17*(2), 89–96. https://doi.org/10.1080/14767430.2018.1468148

Putnik, K., de Jong, A., & Verdonk, P. (2011). Road to help-seeking among (dedicated) human service professionals with burnout. *Patient Education and Counseling*, *83*(1), 49–54. https://doi.org/10.1016/j.pec.2010.01.004

Radley, A. (2002). Portrayals of suffering: On looking away, looking at, and the comprehension of illness experience. *Body & Society, 8*(3), 1–23. https://doi.org/10.1177/1357034X02008003001

Ramella, M., & Olmos, G. (2005). Participant authored audio-visual stories: Giving the camera away or giving the camera a way? *Papers in Social Research Methods: Qualitative Series, 10*, 1–24. https://www.academia.edu/31256951/Participant_Authored_Audiovisual_Stories_PAAS_Giving_the_camera_away_or_giving_the_camera_a_way

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, *53*(2), 108–122. https://doi.org/10.1177/0020764006075018

Rees, S., Cohen, D., Marfell, N., Medicine, M. R.-O., & 2019, U. (2019). Doctors' decisions when disclosing their mental ill-health. *Occupational Medicine, 69*(4), 258–265. https://doi.org/10.1093/occmed/kqz062

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18*(1), 20–23. https://psycnet.apa.org/record/2005-02203-005

Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research.* Oxford University Press.

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. Bailliere Tindall.

Ridge, D. (2008). *Recovery from depression using the narrative approach: A guide for doctors, complementary therapists, and mental health professionals*. Jessica Kingsley Publishers.

Ridge, D., Broom, A., Kokanović, R., Ziebland, S., & Hill, N. (2017). Depression at work, authenticity in question: Experiencing, concealing and revealing: *Health*, *23*(3), 344–361. https://doi.org/10.1177/1363459317739437

Riessman, C. K. (1993). *Narrative Analysis*. Sage Publications.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage Publications.

Riessman, C. K., & Quinney, L. (2005). Narrative in social work: A critical review. *Qualitative Social Work*, *4*(4), 391–412. https://doi.org/10.1177/1473325005058643

Riley, G. J. (2004). Understanding the stresses and strains of being a doctor. *Medical Journal of Australia*, *181*(7), 350–353. https://doi.org/10.5694/j.1326-5377.2004.tb06322.x

Riley, R., Spiers, J., Buszewicz, M., Taylor, A. K., Thornton, G., & Chew-Graham, C. A. (2018). What are the sources of stress and distress for general practitioners working in England? A qualitative study. *British Medical Journal Open*. https://doi.org/10.1136/bmjopen-2017-017361

Riley, R., Spiers, J., Chew-Graham, C. A., Open, A., Taylor, A. K., Thronton, G. A., & Buszewicz, M. (2018). “Treading water but drowning slowly”: What are GPs’ experiences of living and working with mental illness and distress in England? A qualitative study. *British Medical Journal Open*, *8*(5), e018620. https://doi.org/10.1136/bmjopen-2017-018620

Rimmer, A. (2019). Sixty seconds on . . . nature immersion. *British Medical Journal*, *367*, l6801. https://doi.org/10.1136/BMJ.L6801

Rinaldi, C., Leigheb, F., Vanhaecht, K., Donnarumma, C., & Panella, M. (2016). Convertirse en «segunda víctima» en asistencia sanitaria: la vía de la recuperación después de un episodio adverso. *Revista de Calidad Asistencial*, *31*, 11–19.

https://doi.org/10.1016/j.cali.2016.05.001

Robertson, H. D., Elliott, A. M., Burton, C., Iversen, L., Murchie, P., Porteous, T., & Matheson, C. (2016). Resilience of primary healthcare professionals: A systematic review. *British Journal of General Practice*, *66*(647), e423–e433. https://doi.org/10.3399/bjgp16X685261

Robson, F. M. (2002). ‘Yes!—A chance to tell my side of the story’: A case study of a male partner of a woman undergoing termination of pregnancy for foetal abnormality. *Journal of Health Psychology*, *7*(2), 183–193. https://doi.org/10.1177/1359105302007002457

Rogerson, M., Wood, C., Pretty, J., Schoenmakers, P., Bloomfield, D., & Barton, J. (2020). Regular doses of nature: The efficacy of green exercise interventions for mental wellbeing. *International Journal of Environmental Research and Public Health*, *17*(5), 1526. https://www.mdpi.com/651450

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*(3), 304–310. https://doi.org/10.1111/j.1365-2648.2006.03727.x

Rose, D. (2014). The mainstreaming of recovery. *Journal of Mental Health*, *23*(5), 217–218. https://doi.org/10.3109/09638237.2014.928406

Rose, G. (2001). *Visual methodologies: An introduction to the interpretation of visual methods* (4th ed.). Sage Publications.

Ross, S. C. (2011). *Finding meaning after stroke: An analysis of Older People’s stroke narratives*. University of Edinburgh.

Rout, U. (1996). Stress among general practitioners and their spouses: A qualitative study. *British Journal of General Practice*, *46*(404), 157–160.

https://bjgp.org/content/bjgp/46/404/157.full.pdf

Royal College of Physicians. (2016). *Underfunded. Underdoctored. Overstretched. The NHS in 2016*. https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016

Russell, C. K., Bunting, S. M., & Gregory, D. M. (1997). Protective care-receiving: The active role of care-recipients. *Journal of Advanced Nursing*, *25*(3), 532–540. https://doi.org/10.1046/j.1365-2648.1997.1997025532.x

Russell, J., Berney, L., Stansfeld, S., Lanz, D., Kerry, S., Chandola, T., & Bhui, K. (2016). The role of qualitative research in adding value to a randomised controlled trial: Lessons from a pilot study of a guided e-learning intervention for managers to improve employee wellbeing and reduce sickness absence. *Trials*, *17*(1). https://doi.org/10.1186/S13063-016-1497-8

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68. https://doi.org/10.1037110003-066X.55.1.68

Ryan, R. M., Kuhl, J., & Deci, E. L. (1997). Nature and autonomy: An organizational view of social and neurobiological aspects of self-regulation in behavior and development. *Development and Psychopathology*, *9*(4), 701–728. https://doi.org/10.1017/s0954579497001405

Ryff, C., & Keyes, C. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*(4), 719–727. https://doi.org/10.1037/0022-3514.69.4.719

Saini, P., Chantler, K., & Kapur, N. (2016). General practitioners' perspectives on primary care consultations for suicidal patients. *Health and Social Care in the Community, 24*(3), 260–269. https://doi.org/10.1111/hsc.12198

Salminen, S., Andreou, E., Holma, J., Pekkonen, M., & Mäkikangas, A. (2017). Narratives of burnout and recovery from an agency perspective: A two-year longitudinal study. *Burnout Research*. https://doi.org/10.1016/j.burn.2017.08.001

Salminen, S., Mäkikangas, A., Hätinen, M., Kinnunen, U., & Pekkonen, M. (2015). My well-being in my own hands: Experiences of beneficial recovery during burnout rehabilitation. *Journal of Occupational Rehabilitation*, *25*(4), 733–741. https://doi.org/10.1007/s10926-015-9581-6

Sandelowski, M. (1986). The problem of rigor in feminist research. *ANS Adv Nurs Sci*, *8*(3), 27–37. https://doi.org/10.1097/00012272-198604000-00005

Sandelowski, M., Docherty, S., & Emden, C. (1997). Qualitative metasynthesis: Issues and techniques. *Research in Nursing & Health*, *20*(4), 365–371. https://doi.org/10.1002/(SICI)1098-240X(199708)20:4<365::AID-NUR9>3.0.CO;2-E

Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research*, *22*(10), 1404–1413. https://doi.org/10.1177/1049732312450368

Santen, S. A., Holt, D. B., Kemp, J. D., & Hemphill, R. R. (2010). Burnout in medical students: Examining the prevalence and associated factors. *Southern Medical Journal*, *103*(8), 758–763. https://doi.org/0.1097/SMJ.0b013e3181e6d6d4

Santos, J. (1999). Cronbach’s alpha: A tool for assessing the reliability of scales. *Journal of Extension, 37*(2), 1–5. https://www.joe.org/joe/1999april/tt3.php/journal-current-issue.php

Satterfield, J. M., & Becerra, C. (2010). Developmental challenges, stressors and coping strategies in medical residents: A qualitative analysis of support groups. *Medical Education, 44*(9), 908–916. https://doi.org/10.1111/j.1365-2923.2010.03736.x

Schaffner, A. K. (2016). *Exhaustion: a history*. Columbia University Press.

Schaufeli, W. (2021). The burnout enigma solved? *Scandinavian Journal of Work, Environment and Health*, *47*(3), 169–170. https://doi.org/10.5271/sjweh.3950

Schaufeli, W. B., Bakker, A. B., Hoogduin, K., Schaap, C., & Kladler, A. (2007). On the clinical validity of the maslach burnout inventory and the burnout measure. *Psychology & Health*, *16*, 565–582. https://doi.org/10.1080/08870440108405527

Schaufeli, W., De Witte, H., & Desart, S. (2019). *Handleiding. Burnout assessment tool. Version 1.1. Internal report.*

Schaufeli, W., & Enzmann, D. (1998). *The burnout companion to study & practice: A critical analysis*. Taylor & Francis.

Schenk, W. C., & Bui, T. (2018). Sri Lanka's post-tsunami health system recovery: A qualitative analysis of physician perspectives. *International Health*, *10*(1), 20–26. https://doi.org/10.1093/inthealth/ihx064

Schneider, S., Kingsolver, K., & Rosdahl, J. (2014). Physician Coaching to Enhance Well-being: A Qualitative Analysis of a Pilot Intervention. *Explore*, *10*(6), 372–379. https://doi.org/10.1016/j.explore.2014.08.007

Schoen, C., Osborn, R., Huynh, P., & Doty, M. (2004). Primary care and health system performance: Adults' experiences in five countries. *Health Affairs*, *23*(6). https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.W4.487

Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011). New 2011 survey Of patients with complex care needs in eleven countries finds that care is often poorly coordinated. *Health Affairs*, *30*(12), 1–12. https://doi.org/10.1377/hlthaff.2011.0923

Schrijver, I., Brady, K. J. S., & Trockel, M. (2016). An exploration of key issues and potential solutions that impact physician wellbeing and professional fulfillment at an academic center. *PeerJ*, *2016*(3). https://doi.org/10.7717/peerj.1783

Schultz, K., Delva, D., & Kerr, J. (2012). Emotional effects of continuity of care on family physicians and the therapeutic relationship. *Canadian Family Physician*, *58*(2), 178–185. https://pubmed.ncbi.nlm.nih.gov/22337743/

Sebah, I, Shaw, P., & Cheshire, A. (2019a). *Evaluation of the Westminster REFRAME Workshop for Guy's and St Thomas' Hospital Staff and Junior Doctors: 2018/19*. https://doi.org/https://doi.org/10.34737/v45x8

Sebah, I, Shaw, P., & Cheshire, A. (2019b). *Evaluation of the Westminster REFRAME Workshop for North Kensington General Practitioners: 2019* . https://westminsterresearch.westminster.ac.uk/item/v45x7/evaluation-of-the-westminster-reframe-workshop-for-north-kensington-general-practitioners-2019

Sebah, Ilham. (2019). *GPs in the Woods*. University of Westminster.

Selamu, M., Thornicroft, G., Fekadu, A., & Hanlon, C. (2017). Conceptualisation of job-related wellbeing, stress and burnout among healthcare workers in rural Ethiopia: A qualitative study. *Biomed Central Health Services Research*, *17*(1), 412. https://doi.org/10.1186/s12913-017-2370-5

Semeijn, J., Ruysseveldt, J. Van, Vonk, G., & Van Vuuren, T. (2019). In flight again with wings that were once broken; effects of post-traumatic growth and personal resources on burnout recovery. *International Journal of Workplace Health Management*, *12*(5), 1753–8351. https://doi.org/10.1108/IJWHM-01-2019-0006

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., West, C. P., Sloan, J., & Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, *172*(18), 1377–1385.

https://doi.org/10.1001/archinternmed.2012.3199

Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, *90*(12), 1600–1613. https://doi.org/10.1016/j.mayocp.2015.08.023

Shanafelt, T. D., Mungo, M., Schmitgen, J., Storz, K. A., Reeves, D., Hayes, S. N., Sloan, J. A., Swensen, S. J., & Buskirk, S. J. (2016). Longitudinal study evaluating the association between physician burnout and changes in professional work effort. *Mayo Clinic Proceedings*, *91*(4). https://doi.org/10.1016/j.mayocp.2016.02.001

Sharma, J. (2019). *Socio-cultural contexts in trauma recovery and post trauma growth in women who experienced intimate partner violence: A social constructivist lens*. Virginia Polytechnic Institute and State University. https://vtechworks.lib.vt.edu/handle/10919/91891

Shaw, P., Cartwright, T., Ridge, D., Peters, D., & Keen, J. (n.d.). *Evaluating the NHS Practitioner Health Service: A longitudinal cohort study*.

Shaw, P., & Cheshire, A. (2018). *Evaluation report of the Westminster REFRAME workshop for Guy's and St Thomas' hospital staff 2017/18*.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, *7*(3), 233–243. https://doi.org/10.1080/14780880802699092

Shaw, R. L., Booth, A., Sutton, A. J., Miller, T., Smith, J. A., Young, B., Jones, D. R., & Dixon-Woods, M. (2004). Finding qualitative research: an evaluation of search strategies. *Biomed Central Medical Research Methodology*, *4*(1), 5. https://doi.org/10.1186/1471-2288-4-5

Shenton A K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75. https://doi.org/10.3233/EFI-2004-22201

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality*. https://www.centreformentalhealth.org.uk/publications/making-recovery-reality

Shim, R., Koplan, C., Langheim, F., Manseau, M., Powers, R., & Compton, M. (2014). The social determinants of mental health: An overview and call to action. *Psychiatric Annals*, *44*(1), 22–26. https://doi.org/10.3928/00485713-20140108-04

Shirom, A. (1989). Burnout in work organizations. In C. L. Cooper & I. Robertson (Eds.), *International Review of Industrial and Organizational Psychology* (pp. 25–48). John Wiley & Sons.

Shoemaker, S., Wolf, M., & Brach, C. (2014). Development of the Patient Education Materials Assessment Tool (PEMAT): A new measure of understandability and actionability for print and audiovisual patient information. *Patient Education and Counseling*, *96*(3), 395–403. https://doi.org/10.1016/j.pec.2014.05.027

Short, D., Frischer, M., & Bashford, J. (2004). Barriers to the adoption of computerised decision support systems in general practice consultations: A qualitative study of GPs' perspectives. *International Journal of Medical Informatics*, *73*(4), 357–362. https://doi.org/10.1016/j.ijmedinf.2004.02.001

Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), 259–292. https://psycnet.apa.org/record/2017-05809-003

Simpkin, V. L., & Mossialos, E. (2017). *Brexit and the NHS: challenges, uncertainties and opportunities*. https://doi.org/10.1016/j.healthpol.2017.02.018

Simpson, K Ashworth, Ayis, S. (2021). An evaluation of NHS Practitioner Health: capturing mental health outcomes using five instruments. *British Journal of Psychiatry Open*, *7*(4). https://doi.org/10.1192/bjo.2021.926

Simpson, L. A., & Grant, L. (1991). Sources and magnitude of job stress among physicians. *Journal of Behavioral Medicine*, *14*(1), 27–42. https://doi.org/10.1007/BF00844766

Smith, F., Goldacre, M. J., & Lambert, T. W. (2016). Working as a doctor when chronically ill or disabled: Comments made by doctors responding to UK surveys. *Journal Of The Royal Society Of Medicine Open*, *7*(7), 205427041664928. https://doi.org/10.1177/2054270416649282

Smith, J. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, *11*(2), 261–271. https://doi.org/10.1080/08870449608400256

Smith, J. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, *1*(1), 39–54. https://doi.org/10.1191/1478088704qp004oa

Smith, J. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9–27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. (2015). *Qualitative psychology: A practical guide to research methods*. Sage Publications.

Smith, J., & Eatough, V. (2007). Interpretative phenomenological analysis. In *Analysing qualitative data in psychology* (pp. 35–50). Sage Publications.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis:*

Theory, method and research. Sage Publications.

Smith, J., Jarman, M., & Osborn, M. (1999). *Doing interpretative phenomenological analysis*. Sage Publications.

Smith, J., Michie, S., Stephenson, M., & Quarrell, O. (2002). Risk perception and decision-making processes in candidates for genetic testing for Huntington’s Disease: An interpretative phenomenological analysis. *Journal of Health Psychology, 7*(2), 131–144. https://doi.org/10.1177/1359105302007002398

Smith, J., & Osborn, M. (2004). Interpretative phenomenological analysis. In G. M. Breakwell (Ed.), *Doing social psychology research* (pp. 229–254). https://doi.org/10.1002/9780470776278.ch10

Soler, J. K., Yaman, H., Esteva, M., Dobbs, F., Asenova, R. S., Katić, M., Ožvačić, Z., Desgranges, J. P., Moreau, A., Lionis, C., Kotányi, P., Carelli, F., Nowak, P. R., de Aguiar Sá Azeredo, Z., Marklund, E., Churchill, D., & Ungan, M. (2008). Burnout in European family doctors: the EGPRN study. *Family Practice* , *25*(4), 245–265. https://doi.org/10.1093/fampra/cmn038

Sonnenschein, M., Sorbi, M. J., van Doornen, L. J. P., Schaufeli, W. B., & Maas, C. J. M. (2007). Evidence that impaired sleep recovery may complicate burnout improvement independently of depressive mood. *Journal of Psychosomatic Research*. https://doi.org/10.1016/j.jpsychores.2006.11.011

Sowińska, A., & Sokół, M. (2019). “Luckily, she’s alive”: Narratives of vicarious experience told by Polish doctors. *Journal of Pragmatics, 152*, 76–88. https://doi.org/10.1016/j.pragma.2018.01.007

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2004). *Quality in qualitative evaluation: a framework for assessing research evidence*. http://www.cebma.org/wp-content/uploads/Spencer-Quality-in-qualitative-evaluation.pdf

Spiers, J., Buszewicz, M., Chew-Graham, C. A., & Riley, R. (2018). The experiences of general practitioner partners living with distress: An interpretative phenomenological analysis. *Journal of Health Psychology*. https://doi.org/10.1177/1359105318758860

Spiers, J., Buszewicz, M., Chew-Graham, C., Gerada, C., Kesslerm D, Leggett, N., Manning, C., Taylor, A., Thornton G, & Riley, R. (2016). Who cares for the clinicians? The mental health crisis in the GP workforce. *British Journal of General Practice*, *66*(648), 344–345. https://doi.org/10.3399/bjgp16X685765

Spiers, J., Kessler, D., Leggett, N., Taylor, A. K., Thornton, G., Buszewicz, M., Chew-Graham, C. A., Gerada, C., Manning, C., & Riley, R. (2017). Barriers, facilitators, and survival strategies for GPs seeking treatment for distress: A qualitative study. *British Journal of General Practice*, *67*(663), e700–e708. https://doi.org/10.3399/bjgp17X692573

Spiers, J., & Riley, R. (2019). Analysing one dataset with two qualitative methods: The distress of general practitioners, a thematic and interpretative phenomenological analysis. *Qualitative Research in Psychology*, *16*(2), 276–290. https://doi.org/10.1080/14780887.2018.1543099

Spinelli, W. M., Fernstrom, K. M., Britt, H., & Pratt, R. (2016). “Seeing the patient is the joy:” A focus group analysis of burnout in outpatient providers. *Family Medicine*, *48*(4), 273–278. https://pubmed.ncbi.nlm.nih.gov/27057605/

Spitzer, R., Kroenke, K., & Williams, J. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ prrimary care study. *JAMA: Journal of the American Medical Association*, *282*(18), 1737–1744. https://doi.org/10.1001/jama.282.18.1737

Spitzer R, Kroenke K, Williams J B, & Löwe B A. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Srivastava, S., & Agrawal, S. (2020). Resistance to change and turnover intention: a moderated mediation model of burnout and perceived organizational support. *Journal of Organizational Change Management*, *33*(7), 1431–1447. https://doi.org/10.1108/JOCM-02-2020-0063

Stanton, J., & Randal, P. (2016). Developing a psychiatrist-patient relationship when both people are doctors: A qualitative study. *British Medical Journal Open*, *6*(5). https://doi.org/10.1136/bmjopen-2015-010216

Starfield, B. (1998). *Primary care: balancing health needs, services, and technology*. Oxford University Press.

Staten, A., & Lawson, E. (2018). *GP wellbeing: Combatting burnout in general practice*. CRC Press Taylor & Fransis Group. https://doi.org/10.1201/9781315159218

Staw, B. M., Sutton, R. I., & Pelled, L. H. (1994). Employee positive emotion and favorable outcomes at the workplace. *Organization Science*, *5*(1), 51–71. https://doi.org/10.1287/orsc.5.1.51

Stenlund, T., Nordin, M., & Järvholm, L. S. (2012). Effects of rehabilitation programs for patients with burnout: A 3-year follow-up. *Journal of Rehabilitation Medicine*, *44*, 684–690. https://doi.org/10.2340/16501977-1003

Stevenson, A. D., Phillips, C. B., & Anderson, K. J. (2011). Resilience among doctors who work in challenging areas: A qualitative study. *British Journal of General Practice, 61*(588), e404–e410. https://doi.org/10.3399/bjgp11X583182

Stewart-Brown, S., & Janmohamed, K. (2008). *Warwick-Edinburgh mental well-being scale. User Guide. Version 1* (J. Parkinson (Ed.)). NHS Health Scotland. http://www.ocagingservicescollaborative.org/wp-content/uploads/2014/07/WEMWBS-User-Guide-Version-1-June-2008.pdf

Stewart-Brown, S., Platt, S., Tennant, A., Maheswaran, H., Parkinson, J., Weich, S., Tennant, R., Taggart, F., & Clarke, A. (2011). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): A valid and reliable tool for measuring mental well-being in diverse populations and projects. *Journal of Epidemiology & Community Health*, *65*(Suppl 2), A38–A39. https://doi.org/10.1136/jech.2011.143586.86

Stewart, C. W. (2019). Coexisting values in healthcare and the leadership practices that were found to inspire followership among healthcare practitioners. *The Journal of Values-Based Leadership*, *12*(2), 12. https://doi.org/10.22543/0733.122.1282

Stewart, D. E., Ahmad, F., Cheung, A. M., Bergman, B., & Dell, D. L. (2000). Women physicians and stress. *Journal of Women's Health and Gender-Based Medicine*, *9*(2), 185–190. https://doi.org/10.1089/152460900318687

Stodel, J. M., & Stewart-Smith, A. (2011). The influence of burnout on skills retention of junior doctors at Red Cross War Memorial Children's Hospital: A case study. *South African Medical Journal*, *101*(2), 115–118. https://doi.org/ISSN 2078-5235

Stolorow, R. D. (2013). Intersubjective-systems theory: A phenomenological-contextualist psychoanalytic perspective. *Psychoanalytic Dialogues*, *23*(4), 383–389. https://doi.org/10.1080/10481885.2013.810486

Stone, L., Phillips, C., & Douglas, K. A. (2019). Sexual assault and harassment of doctors, by doctors: A qualitative study. *Medical Education*, *53*(8), 833–843. https://doi.org/10.1111/medu.13912

Strauss, A., & Corbin, J. M. (1997). *Grounded theory in practice*. Sage Publications.

Strazdins, E., Dwan, K., Pescud, M., & Strazdins, L. (2019). Part-time in general practice - A remedy to a time-based problem? *Family Practice*, *34*(4), 511–515.

https://doi.org/10.1093/fampra/cmy116

Summers, J. K., & Vivian, D. N. (2018). Ecotherapy – A forgotten ecosystem service: A review. *Frontiers in Psychology*, *9*, 1389. https://doi.org/10.3389/FPSYG.2018.01389

Svedahl, E. R., Pape, K., Toch-Marquardt, M., Skarshaug, L. J., Kaspersen, S. L., Bjørngaard, J. H., & Austad, B. (2019). Increasing workload in Norwegian general practice - A qualitative study. *Biomed Central Family Practice*, *20*(68). https://doi.org/10.1186/s12875-019-0952-5

Swift, T. L., Ashcroft, R. E., Tadd, W., Campbell, A. V., & Dieppe, P. A. (2002). Living well through chronic illness: The relevance of virtue theory to patients with chronic osteoarthritis. *Arthritis & Rheumatism*, *47*(5), 474–478. https://doi.org/10.1002/art.10664

Tajuria, G. (2018). *Bereavement and loss support for adults with learning disabilities: An exploratory study using Photovoice*. Keele University. http://eprints.keele.ac.uk/5177/

Taku, K. (2013). Relationships among perceived psychological growth, resilience and burnout in physicians. *Personality and Individual Differences*, *59*, 120–123. https://doi.org/10.1016/j.paid.2013.11.003

Taubert, M., & Nelson, A. (2011). Heartsink encounters: A qualitative study of end-of-life care in out-of-hours general practice. *Journal Of The Royal Society Of Medicine Short Reports*, *2*(9), 1–9. https://doi.org/10.1258/shorts.2011.011020

Tavazza, G. (2007). Oltre il “camice” [Beyond the doctor’s overalls]. *Interazioni*, *2*, 56–76.

Tavella, G., & Parker, G. (2020). Distinguishing burnout from depression: An exploratory qualitative study. *Psychiatry Research*, *291*. https://doi.org/10.1016/j.psychres.2020.113212

Taylor, D., & Radley, A. (2003). Images of recovery: A photo-elicitation study on the hospital ward. *Qualitative Health Research*, *13*(1), 77–99. https://doi.org/10.1177/1049732302239412

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh mental well-being scale (WEMWBS): Development and UK validation. *Health and Quality of Life Outcomes, 5*(1), 63. https://doi.org/10.1186/1477-7525-5-63

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: A review of the evidence. *The British Journal of Social Work*, *42*(3), 443–460. https://doi.org/10.1093/BJSW/BCR076

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *Biomed Central Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Thompson, N., Corbett, S., & Welfare, M. (2013). A qualitative study of how doctors use impression management when they talk about stress in the UK. *International Journal of Medical Education* , *4*, 236–246. https://doi.org/10.5116/ijme.5274.f445

Thomson, S., Osborn, R., Squires, D., & Reed, S. (2011). *International profiles of health care systems 2011: Australia, Canada, Denmark, England, France, Germany, Iceland, Italy, Japan, the Netherlands, New Zealand*. http://eprints.lse.ac.uk/id/eprint/50562

Thorne, S. (2017). Metasynthetic madness. *Qualitative Health Research*, *27*(1), 3–12. https://doi.org/10.1177/1049732316679370

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda.

Qualitative Health Research, *14*(10), 1342–1365. https://doi.org/10.1177/1049732304269888

Tolentino, J. C., Guo, W. A., Ricca, R. L., Vazquez, D., Martins, N., Sweeney, J., Moalem, J., Derrick, E. L. T., Sholevar, F., Marchionni, C., Wagner, V., Orlando, J., Paul, E., Psaila, J., Papadimos, T. J., & Stawicki, S. P. (2017). What's new in academic medicine: Can we effectively address the burnout epidemic in healthcare? *International Journal of Academic Medicine*, *3*(3), 1. https://doi.org/10.4103/IJAM.IJAM_47_17

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *Biomed Central Medical Research Methodology*, *12*(1), 181. https://doi.org/10.1186/1471-2288-12-181

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Toppinen-Tanner, S., Ojajärvi, A., Väänaänen, A., Kalimo, R., & Jäppinen, P. (2005). Burnout as a predictor of medically certified sick-leave absences and their diagnosed causes. *Behavioral Medicine*, *31*(1), 18–32. https://doi.org/10.3200/BMED.31.1.18-32

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: Challenges and insights for synthesising a large number of qualitative studies. *Biomed Central Medical Research Methodology*, *14*(1). https://doi.org/10.1186/1471-2288-14-80

Toye, F., Williamson, E., Williams, M. A., Fairbank, J., & Lamb, S. E. (2016). What value can qualitative research add to quantitative research design? An example from an adolescent idiopathic scoliosis trial feasibility study. *Qualitative Health Research*, *26*(13), 1838–1850. https://doi.org/10.1177/1049732316662446

Trollope-Kumar, K. (2012). Do we overdramatize family physician burnout?: NO. *Canadian Family Physician*, *58*(7), 731–733. https://www.cfp.ca/content/58/7/731.short

Turner-Crowson, J., & Wallcraft, J. (2002). The recovery vision for mental health services and research: A British perspective. *Psychiatric Rehabilitation Journal*, *25*(3), 245–254. Boston University. https://doi.org/10.1037/h0095018

Turner III, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, *15*(3), 754–760. https://nsuworks.nova.edu/tqr/vol15/iss3/19/

Twellaar, M., Winants, Y., & Houkes, I. (2008). How healthy are Dutch general practitioners? Self-reported (mental) health among Dutch general practitioners. *European Journal of General Practice*, *14*(1), 4–9. https://doi.org/10.1080/13814780701814911

Twohig-Bennett, C., & Jones, A. (2018). The health benefits of the great outdoors: A systematic review and meta-analysis of greenspace exposure and health outcomes. *Environmental Research*, *166*, 628–637. https://doi.org/10.1016/j.envres.2018.06.030

Uallachain, G. N. (2007). Attitudes towards self-health care: a survey of GP trainees. *Irish Medical Journal*, *100*(6), 489–491. https://pubmed.ncbi.nlm.nih.gov/17668680/

Unrath, M., Zeeb, H., Letzel, S., Claus, M., Carlos, L., & Pinzón, E. (2012). Identification of possible risk factors for alcohol use disorders among general practitioners in Rhineland-Palatinate, Germany. *Swiss Medical Weekly*, *142*, w13334. https://doi.org/10.4414/smw.2012.13664

Uygur, J., Brown, J. B., & Herbert, C. (2019). Understanding compassion in family medicine: A qualitative study. *British Journal of General Practice*, *69*(680), e208–e216. https://doi.org/10.3399/bjgp19X701285

Uygur, J. M. (2012). *Understanding compassion in family medicine: A qualitative study* The University of Western Ontario.

van Dierendonck, D., Schaufeli, W. B., & Buunk, B. P. (2001). Toward a process model of burnout: Results from a secondary analysis. *European Journal of Work and Organizational Psychology*, *10*(1), 41–52. https://doi.org/10.1080/13594320042000025

Van Schalkwyk, M. C. I., Jarman, H., Hervey, T., Wouters, O. J., Barlow, P., & Mckee, M. (2020). Risks to health and the NHS in the post-Brexit era. *British Medical Journal*, *369*, 1–3. https://doi.org/10.1136/bmj.m2307

Vanagas, G., & Bihari-Axelsson, S. (2005). The factors associated to psychosocial stress among general practitioners in Lithuania. Cross-sectional study. *Biomed Central Health Services Research*, *5*(1), 45. https://doi.org/10.1186/1472-6963-5-45

Vaughan, C. M. (2011). *A picture of health: Participation, photovoice and preventing HIV among Papua New Guinean youth*. The London School of Economics and Political Science. http://etheses.lse.ac.uk/160/

Verweij, H., Waumans, R., Smeijers, D., Speckens, A., Lucassen, P., Donders, A., & Van Der Horst, H. (2016). Mindfulness-based stress reduction for GPS: Results of a controlled mixed methods pilot study in Dutch primary care. *British Journal of General Practice*, *66*(643), e99–e105. https://doi.org/10.3399/bjgp16X683497

Vijendren, A., Yung, M., & Sanchez, J. (2015). Occupational health issues amongst UK doctors: A literature review. *Occupational Medicine*, *65*(7). https://doi.org/10.1093/occmed/kqv088

Wade, D. T., & Halligan, P. W. (2004). Do biomedical models of illness make for good healthcare systems? *British Medical Journal*, *329*, 1398–1401. https://doi.org/10.1136/bmj.329.7479.1398

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., & Holland, F. (2014). The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. *The Qualitative Report*, *19*(24), 1–15. https://nsuworks.nova.edu/tqr/vol19/iss24/1/

Wallace, J. E., & Lemaire, J. (2007). On physician well being—You'll get by with a little help from your friends. *Social Science & Medicine*, *64*(12), 2565–2577. https://doi.org/10.1016/j.socscimed.2007.03.016

Wallace, J. E., & Lemaire, J. (2009). *Physician well being and quality of patient care: An exploratory study of the missing link*. *14*(5), 545–552. https://doi.org/10.1080/13548500903012871

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: A literature review. *Journal of Advanced Nursing*, *50*(2), 204–211. https://doi.org/10.1111/j.1365-2648.2005.03380.x

Walter, I., Nutley, S., & Davies, H. (2003). Research impact: A cross sector review. In *ESRC Network for Evidence Based Policy and Practice*. University of St. Andrews, Research Unit for Research Utilisation.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education and Behavior*, *24*(3), 369–387. https://doi.org/10.1177/109019819702400309

Wang, L. W., Miller, M. J., Schmitt, M. R., & Wen, F. K. (2013). Assessing readability formula differences with written health information materials: Application, results, and recommendations. *Research in Social and Administrative Pharmacy*, *9*(5), 503–

516. https://doi.org/10.1016/j.sapharm.2012.05.009

Warr, P., & Nielsen, K. (2018). Wellbeing and work performance. In E. Diener, S. Oishi, & L. Tay (Eds.), *Subjective Wellbeing*. NobaScholar.

Watson, J., Humphrey, A., Peters-Klimm, F., & Hamilton, W. (2011). Motivation and satisfaction in GP training: A UK cross-sectional survey. *British Journal of General Practice, 61*(591), e645–e649. https://doi.org/10.3399/BJGP11X601352

Weiner, E. L., Swain, G. R., Wolf, B., & Gottlieb, M. (2001). A qualitative study of physicians' own wellness-promotion practices. *Western Journal of Medicine, 174*(1), 19–23. https://doi.org/10.1136/ewjm.174.1.19

Weiss, T., & Berger, R. (2010). *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe*. John Wiley & Sons, Inc.

Welch, E. (2018). *The NHS at 70: a living history*. Pen and Sword.

Wessely, A., & Gerada, C. (2013). When doctors need treatment: An anthropological approach to why doctors make bad patients. *British Medical Journal*, f6644. https://doi.org/10.1136/bmj.f6644

West, C. P., Dyrbye, L. N., Erwin, P. J., & Shanafelt, T. D. (2016). Interventions to prevent and reduce physician burnout: A systematic review and meta-analysis. *The Lancet, 388*(10057). https://doi.org/10.1016/S0140-6736(16)31279-X

West, M., & Coia, D. (2019). *Caring for doctors Caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patient*. https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

West of England Academic Health Science Network. (2015). *Measuring Demand in General Practice: An exploratory study across the West of England Academic Health*

Science Network (AHSN) region. https://www.weahsn.net/wp-content/uploads/Measuring-Demand-in-General-Practice.pdf

Whitehead, P. R. (2014). The lived experience of physicians dealing with patient death. *British Medical Journal Supportive and Palliative Care*, *4*(3), 271–276. https://doi.org/10.1136/bmjspcare-2012-000326

Williams, E. S., Manwell, L. B., Konrad, T. R., & Linzer, M. (2007). The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO. *Healthcare Management Review*, *32*(3), 203–212. https://doi.org/10.1097/01.HMR.0000281626.28363.59

Williams Jr, J. W., Pignone, M., Ramirez, G., & Stellato, C. P. (2002). Identifying depression in primary care: A literature synthesis of case-finding instruments. *General Hospital Psychiatry*, *24*(4), 225–237.

Williams, M., & Penman, D. (2011). *Mindfulness: An eight-week plan for finding peace in a frantic world*. Rodale Books.

Williamson, M. K., Pirkis, J., Pfaff, J. J., Tyson, O., Sim, M., Kerse, N., Lautenschlager, N. T., Stocks, N. P., & Almeida, O. P. (2007). Recruiting and retaining GPs and patients in intervention studies: the DEPS-GP project as a case study. *Biomed Central Medical Research Methodology, 7*(1), 1–9. https://doi.org/10.1186/1471-2288-7-42

Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education.

Willig, C., & Wirth, L. (2018). A meta-synthesis of studies of patients' experience of living with terminal cancer. *Health Psychology*, *37*(3), 228. https://doi.org/10.1037/hea0000581

Wise, J. (2018). Survey of UK doctors highlights blame culture within the NHS. *British*

Medical Journal, *362*, k4001. https://doi.org/10.1136/bmj.k4001

Wojtyna, E., & Stawiarska, P. (2009). Humor styles and psychosocial working conditions in relation to occupational burnout among doctors. *Polish Psychological Bulletin*, *40*(1), 20–28. https://doi.org/10.2478/s10059-009-0004-4

Woodgate, R., West, C., & Tailor, K. (2014). Existential anxiety and growth: an exploration of computerized drawings and perspectives of children and adolescents with cancer. *Cancer Nursing*, *37*(2), 146–159. https://doi.org/10.1097/NCC.0b013e31829ded29

Woolgar, S. E. (1988). *Knowledge and reflexivity: New frontiers in the sociology of knowledge*. Sage Publications.

World Health Organisation. (2002). *The world health report 2002: reducing risks, promoting healthy life.* World Health Organization.

World Health Organization. (2020a). *Naming the coronavirus disease (COVID-19) and the virus that causes it*. Technical Guidance. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it

World Health Organization. (2020b). *Prevention, identification and management of health worker infection in the context of COVID-19: Interim Guidance*. https://www.who.int/publications/i/item/10665-336265

Wright, T., & Cropanzano, R. (1998). Emotional exhaustion as a predictor of job performance and voluntary turnover. *Journal of Applied Psychology* , *83*(3), 486. https://doi.org/10.1037/0021-9010.83.3.486

Wynn, A. T., Fassiotto, M., Simard, C., Raymond, J. L., & Valantine, H. (2018). Pulled in too many directions: The causes and consequences of work-work conflict.

Sociological Perspectives, *61*(5), 830–849. https://doi.org/10.1177/0731121418774568

Xie, A., & Carayon, P. (2015). A systematic review of human factors and ergonomics (HFE)-based healthcare system redesign for quality of care and patient safety. *Ergonomics*, *58*(1), 33–49. https://doi.org/10.1080/00140139.2014.959070

Zantinge, E. M., Verhaak, P. F., de Bakker, D. H., van der Meer, K., & Bensing, J. M. (2009). Does burnout among doctors affect their involvement in patients' mental health problems? A study of videotaped consultations. *Biomed Central Family Practice*, *10*(1), 60. https://doi.org/10.1186/1471-2296-10-60

Zenasni, F., Boujut, E., Woerner, A., & Sultan, S. (2012). Burnout and empathy in primary care: three hypotheses. *British Journal of General Practice*. https://doi.org/10.3399/bjgp12X652193

Zwack, J., & Schweitzer, J. (2013). If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Academic Medicine*, *88*(3), 382–389. https://doi.org/10.1097/ACM.0b013e318281696b