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Qualitative Research

Strategies to improve general practitioner well-being: findings from a focus group study

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Abstract

Background. Primary care physicians are particularly prone to high levels of burnout and poor well-being. Despite this, no qualitative studies have specifically investigated the best ways to improve well-being and prevent burnout in primary care physicians. Previous interventions within primary care have been person-oriented and mainly focused on mindfulness, but there has been no prior research on whether general practitioners (GPs) deem this to be the best approach.

Objectives. To explore strategies that could improve GP well-being and reduce or prevent burnout, based on GP perceptions of the workplace factors that affect their levels of well-being and burnout.

Methods. Five focus groups were conducted, with 25 GPs (locums, salaried, trainees, and partners) in the UK, between September 2015 and February 2016. Focus groups took place in GP practices and private meeting rooms. Discussions were centered on the workplace factors that they perceived to influence their well-being, along with strategies that they use either personally, or as a practice, to try and prevent burnout. Furthermore, strategies that could feasibly be implemented by individuals and practices to improve well-being, as well as changes that are needed by groups or organizations that are external to their practice (e.g., the government) to improve the working conditions, were explored. Thematic analysis was conducted on the transcripts.

Results. Based on the contributors to burnout and workplace well-being that the participants identified, the following feasible strategies were suggested: compulsory daily coffee breaks, increasing self- and organizational awareness of the risks of burnout and mentoring or buddy systems. System-level organizational changes were voiced as vital, however, to improve the well-being of all primary care physicians. Increasing resources seemed to be the ideal solution, to allow for more administrative staff and GPs.

Conclusion. These strategies merit further consideration by researchers, physicians, healthcare organizations and policy makers both in the UK and beyond. Failure to do so may result in healthcare staff becoming even more burntout, potentially leading to a loss of doctors from the workforce.

Key words: Depression, health services research, mental health, primary care, quality of care, qualitative research/study, stress, work-related stress.

Introduction

Burnout and poor mental well-being in healthcare professionals are rising internationally (1–3). Burnout, 'a state of vital exhaustion' (4) can be characterized by feelings of emotional exhaustion, depersonalization and reduced personal accomplishment (5). Well-being is a broader concept, with clinicians often viewing it as a spectrum from low to high (6). Low well-being includes symptoms or diagnoses of depression and/or anxiety, and high well-being as feelings of happiness and flourishing (7). Primary care physicians are at high risk of these ailments (8,9). Rates of burnout in UK General Practitioners (GPs) are particularly high compared with other European countries and similar to rates within the US and Canada (10–12), leading to concerns that UK general practice is currently 'in crisis' (13). Negative implications of burnout and poor well-being for the individual include an unfavourable work-life balance, poorer quality of life, substance abuse and suicidality (12, 14). Implications of staff burnout and poor well-being on healthcare organizations include high staff turnover, increased sickness absence, poorer quality of care (e.g., negative attitudes towards patients and reduced patient satisfaction) and poorer patient safety outcomes (e.g., increased likelihood of making a wrong diagnosis or medication error) (15–17). All of these outcomes also cost healthcare organizations billions of pounds or dollars annually (18, 19).

Several studies have investigated the factors contributing to stress, burnout and depression within primary care physicians. They have suggested that causes include high workload, difficult patients, lack of support, and lack of control (8, 10, 20). The majority of research, however, has been survey based, lacking the depth and explanatory power that qualitative methods provide. In some instances, little justification was provided for why particular organizational variables were measured. Although one study by Fisher et al. (21) has taken a qualitative approach, they focused solely on workload stressors and strategies to deal specifically with workload. Our study aims to build upon these findings and extend them by focusing on general workplace stressors (including but not limited to workload), along with potential strategies to deal with these stressors and their effects on the individuals.

Despite similar demands amongst healthcare staff, not all practitioners experience such problems. Strategies used by resilient physicians and practices to cope with workplace demands include limiting one's practice or reducing work hours, improving communication and team functioning, having job control and seeking peer as well as personal support (21–23). Although these strategies have been found useful, they mostly rely on the physician themselves to

ensure implementation. This requires individuals to have the relevant resources (time, support, and flexibility) to make changes to their routines. Those who are already struggling and therefore have limited resources are less able to make these amendments, keeping them trapped in a negative feedback loop.

Regarding formal interventions to reduce physician burnout, both organizational and individual approaches have been successful; however, no organizational interventions have been trialed in primary care (24). Organizational interventions are warranted so that (i) the responsibility for burnout reduction is shared between the practitioner and the organization and (ii) working conditions improve for all staff. Furthermore, many interventions simply aim to treat outcomes, without addressing the cause of the problem. As such, our aim was to explore potential strategies that GPs think could improve their well-being and reduce or prevent burnout, based on their perceptions of the workplace factors that affect their levels of well-being and burnout. To accomplish this, we took a two-part approach to meet the following objectives:

(i) To understand which workplace factors GPs perceive to influence their levels of well-being and burnout.
(ii) To explore strategies and changes that GPs think could improve their well-being or prevent burnout.

Methods

Participants

Five focus groups were conducted with a total of 25 practicing GPs who worked in the North of England. Each group consisted of three to six GPs. Three focus groups consisted of GPs working within the same practices, the other two consisted of locum GPs. Participant and focus group characteristics are displayed in Table 1.

Procedure

We recruited GPs via an existing network and then by a snowballing method between August 2015 and February 2016. Participants who took part in the first focus group put the researchers in contact with the practice managers in their associated practices. They also gave the researchers contact details of their personal contacts within local locum groups. Potential participants were fully informed of the topics to be discussed during the recruitment stage. LHH conducted the semi-structured focus groups either in practice premises, or at a mutually convenient alternative location. Once written informed

Table 1. Focus group characteristics

Focus group	GP surgery/ Locums	Number of partners	Patient list size	Number of participants	Sex	Job roles	Part/full-time work	Mean age (range)	Mean no. years as registered GP (range)
1	GP surgery	2	45 000	6	2M, 4F	2 trainees, 2 partners, 1 salaried, 1 unknown	3 FT, 1 PT, 2 unknown	35 (29–40)[a]	3.5 (0–11)[a]
2	Locums	–	–	4	2M, 2F	4 locums	4 PT	47 (36–57)	17.5 (4–28)
3	Locums	–	–	5	2M, 3F	5 locums	4 PT, 1FT	42.2 (34–56)	10.4 (0–28)
4	GP surgery	7	15 000	6	4M, 2F	6 partners	6 FT	46 (35–55)	17.2 (8–28)
5	GP surgery	5	11 000	4	1M, 3F	3 salaried, 1 partner	3 PT, 1FT	38.75 (33–44)	9.5 (4–17)

M, male; F, female.
[a]Missing two participants' data.

consent had been given by each participant, the questions listed in Box 1 were asked, with some room for emerging discussions. The transcripts were audio-recorded and then transcribed verbatim. Focus groups lasted 45 minutes to 1.5 hours.

Analysis

Thematic analysis was conducted based on the six-phase guidelines of Braun and Clarke (25). The transcripts were coded by hand, based on inductive, semantic principles, from the first author's realist epistemological approach. All transcripts were coded by LHH, with 20% double coded by JH to provide outside insight, allow discussions about the emerging themes and guard against investigator bias. After initial coding of all the transcripts, codes were grouped into themes and subthemes. Any disagreements regarding themes were discussed with one or more additional author until a consensus was agreed. Once a thematic map had been generated, the authors revisited the entire data set to check that the themes accurately reflected the majority of the data.

Results

The focus groups were heterogeneous with regards to job position (partner, locum, etc.), but all discussed very similar themes.

Objective 1: Contributors to well-being and burnout

When discussing which workplace factors contribute to their sense of well-being and levels of burnout, two distinct themes emerged: Those that were internal to their practice and/or the individual and those that were external to their practice that they had no control over.

Internal influencers of well-being comprised *Team support, Variety (*within their roles, practices, or patients), *Control (*over their work environment and/or timetable) and an *Intense and unmanageable workload*. The importance of working within a supportive, interactive team was mentioned by all focus groups as particularly vital for good well-being. Those who felt like they did not receive peer support or have the time to interact with their team described how it could have very negative effects on their well-being.

Box 1. Discussion topic guide

Questions (prompts)

- How would you define well-being?
- How would you define burnout?
- What would you consider to be the main contributors to well-being at work? *(Positive and negative contributors)*
- Do you have a way to try and minimize the impact these issues have on your well-being? *(Personally, as a practice)*
- Would you say that burnout is a worry generally among doctors?
- Do you do anything to try and prevent burnout occurring?
- Are you aware of any services or coping mechanisms that could help prevent burnout?
- Do you think that burnout and/or poor well-being is increasing among doctors? *(Why? What's changed?)*
- Are you encouraged to talk about your own well-being? *(To your colleagues, professionals, family. Is it a taboo?)*
- What, in your opinion, would be the best way to improve the well-being of GPs, and prevent burnout? *(Feasible ideas, if the sky was the limit)*

External influencers of well-being were discussed in negative terms. These consisted of *Increases in pressures and workload, Increases in patients' expectations and complaints*, the *Negative portrayal of general practice* (in the media, by patients and the government) and a *Lack of support* (from the public, patients, the government and the media). An increase in the amount of administrative work that GPs have to do for external regulating organizations was described as adding to their workload, adding stress and taking away their time which would be better spent on direct patient care.

Objective 2: Strategies to improve well-being

Participants discussed possible strategies to improve well-being and prevent burnout in two similar themes to the first objective: Strategies that could be implemented at an individual or practice level, and changes needed at a higher, organizational or policy level.

Individual and practice-level strategies

GPs discussed strategies that fell under the following categories: *Breaks, Support, Physical needs, Psychological strategies,* and *Control*. There was some overlap between these subthemes, particularly between *Breaks* and *Psychological strategies* and *Physical needs*.

Breaks

Scheduling a coffee and/or lunch break into the working day was viewed as a feasible strategy that would be very beneficial to their well-being. Having the opportunity and being encouraged to leave their individual and often isolated offices, interact with their colleagues and have a short respite from work was seen as something that positively affected GPs' well-being in practices where this was already implemented, and something that those who did not get the chance to, wished they did.

> M1: The coffee break in the middle of morning surgery. We try and get here and meet for a bit of rest and recuperation. … I've definitely recognized that it is a positive factor for our well-being and therefore it's something that we need to maintain and cherish. *[FG4]*

Breaks served as fulfilling psychological needs by having that mental break from 'being the doctor' [M2, FG1], physical needs by having the chance to have a drink, some food, perhaps some fresh air, a toilet break and social needs through interacting with colleagues. Lunch breaks were not viewed as a realistic option that could be implemented; however, one short coffee break a day was deemed feasible. Participants voiced that even if GPs only briefly left their office to make a cup of tea and take it back to their office, this very short respite and chance of interaction could be enough to make a big change to their well-being.

Support (social, supervisory, workload and from patients)

Having social support within the practice, peer-to-peer and from both medics and nonmedics outside of their practice was found to be useful for preventing burnout. To improve support at the practice level, buddying and mentoring systems were suggested, along with regular meetings to 'check in' with how team members are doing.

> F1: But I think also, looking after each other…. I think we're quite good at looking over our shoulder at the other person (…) if you see somebody's got a really full load, getting them a cup of tea, or going and seeing one of their extras, (…) is quite a positive thing about our team that we tend to do. [FG1]

A suggestion for improving support from patients was to communicate the state of the surgery with them and ask for their patience and support.

Physical needs

In addition to the physical needs within the breaks theme (food and drink), participants discussed the need to make time for exercise to support physical and psychological well-being. Exercise additionally served their social needs through team sports, and as a psychological strategy through being a form of 'escapism'.

Psychological strategies

Strategies that participants used to deal with the emotional toll of patient contact included being emotionally guarded or setting boundaries and isolating themselves. The latter approach, however, was acknowledged to be unhealthy and did indeed worsen one participant's ability to cope. Maintaining awareness of the risk of burnout was voiced as a useful strategy that some participants used. Additionally, it was mentioned that this could be implemented in practices through discussions and meetings, and externally at the training stage. It was evident that awareness was needed at the individual, practice and external levels.

> F1: I agree. Self-awareness is often the key thing. I certainly wasn't taught that in a training stage. I think if trainees are taught or encouraged to be more self-aware so they know what their personal stresses are, how to manage them, how to identify them (…). I suppose that's actually resilience isn't it, it probably makes people feel more resilient because they're more aware of their limits. [FG 2]

Control

Control over how much, where, and when they worked was seen as a positive strategy that some GPs (mostly locums) used to prevent burnout. Many had chosen this manner of work specifically to prevent them from burning out. Or it was chosen as a way forward to protect their well-being after previously working full-time and suffering from burnout or depression.

External changes

Despite the positive changes that could be implemented within practices at a team or individual level, it was evident that system-level changes are needed to have a larger impact on GPs' work environment and their well-being. The need for more *Support*, a *Reduction in pressures* and an *Increase in resources*, was discussed.

Support

Participants voiced the need for support from the government, their patients, the healthcare organization as a whole and the wider public and press through a reduction in negative media portrayal. Additionally, a need for support from other services was discussed, for example, from social services, to ensure that patients only presented with medical problems and could go to social services in other instances. However, this may be an issue with (a lack of) funding and access also within those organizations.

> 'F1: But wider support about if it's an over the counter medication that you can buy from the chemist please don't request it from your doctor'. [FG3]

Reduction in pressure

Participants stated the need for a reduction in the tasks that decrease their time that should be spent on direct patient care, such as administrative work, quality assessment exercises and additional work pushed onto them from secondary care.

> F1: they [secondary care] treat us like um;
> F3: yeah like can you recheck this and do that and
> F1: they give us lots of menial, not menial tasks but things that they should be doing themselves they're pushing onto us all, so if they stopped doing that. [FG5]

Increase in resources

Increasing resources for primary care was seen as an ideal solution that would help us to improve all the previous factors mentioned, such as reducing pressures and enabling time for breaks. Ideally, having more GPs and funding to pay for more administrative staff would improve the well-being of the GPs and also the quality of care by enabling GPs to offer longer appointments. Increasing funding in other sectors (such as social care and mental healthcare) would also reduce the added pressure currently within primary care.

> F1: So your options are you could increase funding in general practice back to the 11% it should be at, which would be a 3% or 4% rise, and that additional resource would pay for either more doctors or more staff within practices to do the things actually you don't need a doctor to do, and free up the doctors to then treat patients (…) it's better for the doctors but it's better for the patients as well. [FG3]

Additional quotes for each theme and subtheme can be found in Supplementary Tables S1–S4.

Discussion

Summary

Five focus groups of GPs discussed issues that they perceived contributed to their well-being and levels of burnout. They also considered possible strategies to improve well-being and prevent burnout. Their responses fell under two main themes: those that were internal to the individual and practice, and those that were external to themselves and their practice and therefore perceived to be outside of their direct control. Internal influencers of well-being mainly consisted of having good team support, variation within the job, job control, and unmanageable workloads. Individual and practice strategies to improve well-being and prevent burnout tied in with these. In particular, participants noted strategies to look after their physical needs (e.g., exercising), to have control (e.g., through choosing to locum), having breaks, offering support and psychological strategies such as increasing their self-awareness. External influencers of well-being were framed in negative terms and comprised perceived increases in pressure and workload, increasing patient expectations and complaints, lack of support from multiple sources and a perceived negative portrayal of general practice. External changes to improve well-being also drew a parallel with these. Increases in support from the public, patients, media and the government; reduction in pressures and increases in resources (e.g., funding) were stated as the three main external changes that would be needed to improve well-being. It is important to note that control was seen as an important contributor to well-being, and yet, the changes most likely to have a big impact on improving all GPs' well-being were mainly things outside of their control, suggesting a state of helplessness and vulnerability to burnout with primary care physicians.

There were no obvious differences between or within groups based on job role, gender or number of years working as a GP. The only difference was in the language used: focus groups with locum workers were more willing to discuss personal experiences of poor well-being or burnout, whereas groups run with colleagues in the

same practices spoke about more general workplace contributors to stress, with fewer participants sharing their personal experiences of burnout or depression. This is unsurprising given the potential stigma attached to discussing personal mental health issues in front of colleagues. However, this could also be explained by their current roles, as many of the locum workers had chosen that line of work in a concerted effort to prevent burnout, or as a way to improve their well-being after experiencing burnout or poor well-being when previously working full-time.

Previous literature

Similar contributors to well-being have previously been reported across various countries, including America, Canada and the UK ([10], [20], [26], [27]). Some of these factors have also been cited as reasons why UK GPs have left general practice in recent years ([28]). Our study complements their findings, giving further evidence for the lack of support within primary care in the UK, showing that these issues are widespread and geographically generalizable. Furthermore, our study extends these findings by shifting the focus away from strategies to deal specifically with workload, and instead offering practical recommendations for individuals and practices to implement in the workplace to prevent burnout and improve well-being generally. Additionally, our findings put forward system-level changes that are needed to improve working conditions.

Interventions

Improving self-awareness of personal stressors and signs of stress was a strategy suggested by our participants. This has been successfully trialed within healthcare staff, through mindfulness training courses, as an effective way to reduce burnout ([29], [30]). The GPs also discussed the need for more self-awareness and stress management coaching from their education providers during the early stages of professional training. This could encourage practitioner awareness of burnout while simultaneously encouraging a wider, organizational understanding. Additionally, participants suggested various strategies to foster peer-support. Balint groups (a group of clinicians or doctors who regularly meet to discuss their difficult patient cases in a safe and supportive environment) could be one way of increasing both peer-support while also increasing competence and are used by some physicians as a means to prevent burnout ([31]). The primary novel strategy suggested by the participants of this study was the need for regular coffee or lunch breaks. These were believed to help improve both physical and psychological well-being while also fostering a better team culture.

Implications

There are some practical strategies that individuals and practices can implement to reduce burnout, such as introducing compulsory coffee breaks, and mentoring or buddying systems. However, it is evident that system-level changes may also be valuable. These could include training future GPs and organizations to be aware of the signs of burnout and evaluating the impact this has on workforce well-being. The changes that are likely to have the biggest impact on well-being, however, such as increases in funding, resources and staff, are those that are the most challenging to implement.

Strengths and limitations

All participants were working within UK general practice, which challenges the representativeness and generalizability of the sample and results. However, many of the themes discussed were of international relevance, particularly regarding the need for increases in support, resources and breaks. The primary strength of this study is the practical and feasible strategies that could be implemented within practices immediately to improve workplace well-being in the interim before organizational change can be implemented.

Conclusion

GPs identified both practice-level and organizational-level factors that influenced their well-being. They suggested that the best feasible way to reduce the negative impact of these factors on their well-being is through daily breaks. However, external changes were deemed vital to provide increases in resources to allow for more administrative staff, GPs and time for patient contact, as well as an increase in support from various sources. These factors all merit further consideration by researchers, physicians, healthcare organizations and policy makers worldwide. Failure to do so may result in the primary care workforce becoming even more burntout, depressed, and a subsequent increase in sick leave and early retirement.

Supplementary material

Supplementary material is available at *Family Practice* online.

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Supplementary Table S1. Additional supporting quotes for Section 1: Internal Influencers theme

Sub-theme	Focus Group	Quote
Team Support	FG4	*M1: We used to get a lot more [time to interact with each other] than we do now and we still make a concerted effort when we can but it's much more difficult to, and I think that has had a slight negative impact on my wellbeing. I think you know, it was a lot better when we could spend more time together.*
	FG1	*F1: But we're part of a team, the thing that reassures me is that we're part of a team, and actually that's what makes it OK, is that when things do seem.. sort of for example, you've got several off sick, or um you feel like you can't keep up with the volume of work, because it's part of a bigger team, because it's not just us, there's the [xxx] part as well, if we're really struggling, there is actually a capacity to say 'help us'.*
	FG2	*F2: I think the friendliness of the staff can make a difference. So as a locum you go to different places and you don't know anybody, nobody knows you and you can be treated very differently in different places. So it's a positive thing when people make you feel welcome, they might make you a cup of tea or just check that you're ok do you need any support. So extra support from [indecipherable] that's a positive.*
	FG5	*F1: Having good relationships with your colleagues. Feeling like you can communicate well with your colleagues, feeling like you can go to people if you're having problems.*
Variety	FG1	*F3: I mean, we have an advantage in this centre, we have three different sites… that's something I find quite good, and different timetables, so you're not stuck to (inaudible). Yes a lot of senior GPs do do something else like training, or infants or specialities like minor surgery or family planning, but a few things how we do in this surgery breaks that, er, monotony, and I find that quite good*
	FG1	*F1: Something that prevents burnout is having um, a varied portfolio for what you do. So, for example, being a trainer, or um, doing something else like minor surgery or family planning means not just seeing patients all the time so you've got a slight variation in what you do, um definitely helps, sort of the mundane everyday-ness of it.*
	FG5	*F3: But, do you know, by separating the GP practices, perhaps its because I go off and do something completely different, actually, you add up all the hours it's loads, but I find it easier having the GP bit separated.* *I: mm, so different roles help*
Control	FG1	*F1: So we're in control of the situation, I think being in control is quite, um when I think about the negatives, being in control of your environment makes a huge difference to how things are and how you feel about it….* *M2: We still see the same number of patients but we can add an extra break in if we want one and finish a bit later depending on how we feel so we have that freedom*
	FG2	*I: that sense of control in that way that you can choose which practices you go to, does that, would you say that contributes to your sense of wellbeing?* *M1: it does considerably*

	FG1	*F1: We do have bad spells, when y'know things that have really hit us are when again I suppose it's stuff that's outside your control (...) when an unhappy patients goes on a facebook site and slags you off, in public, and there's absolutely nothing you can do about it.*
	FG4	*"M1: The number of decisions that have to be made in a day, the complexity of those decisions, that's what tires me out, rather than the number of hours sitting at my desk.* *I: So it's the, would it be then the type of work?* *M1: The intensity.* *I: Okay* *F1: Yeah, I would agree with that."*
Intense and unmanageable workload	FG4	*F1: Workload I think impacts.* *M1: I would suggest it's the workload rather than the hours worked*
	FG2	*F2: Finishing on time is a positive one as well. You can finish sometimes with a load of paperwork to do. So it's managing workload, I think that if you feel like you've got the job done that day, you can go home having finished that day's work that contributes to a sense of wellbeing*
	FG3	*M2: I think I'd put a manageable workload in there as well contributing to wellbeing, so something that isn't overwhelming, beginning of the day looking at a list and thinking, oh my god, so something that's… seems I don't know, weighted to your capabilities.*
	FG5	*F2: well the nature of the work is that there's never an end to it. And my other half his job, he's an engineer, so they have a project, which they can see the start, they can see the end goal, reach it, job done. Whereas with ours you never get that feeling of there being a light at the end of the tunnel* *F1 + M: mmm no* *F2: because there never is! Even if you clear your task box, clear your blood results, you come back the next day (...): and it's full again so there's never any light at the end of it. That's why you can never feel like it's getting better, cos you never do complete it.* *F1: yeah and there is no completion yeah* *F2: and that's that's a bit demoralising.* *M: But that's all consultants are all like that as well, but I suppose that's medicine* *F2: it is, yeah yeah. But when you're feeling like you're just keeping your head above water, sometimes it's nice to feel like you've completed something, do you know what I mean? We never get that feeling do we.*
	FG4	*M: you'll have six different inboxes for different things that you try and keep on top of, as soon as you clear one you can look back and there'll be ten more in it, and so you can sit there just all day if you wanted to just trying to clear your boxes going around in circles, and always tripping, and it gives you a sense of you don't get that feeling of completion, I've cleared this, I've done that, you don't get that, (...)* *M: Yeah, emails, blood tests, letters, they're just all flowing in continuously.*

Supplementary Table S2. Additional supporting quotes for Section 1: External Influencers theme

Sub-theme	Focus Group	Quote
Increase in pressure and workload	FG5	*F1: I would say I would say that there is definitely a negative feeling out there about the NHS and General Practice and the future of General Practice and the pressures on… I suppose financial… From a partners point of view, there is a big financial squeeze, um, those sorts of financial pressures, contract pressures, and a lot of stuff from outside really. So not just patient care, it's like running the business and keeping primary care going. (…) Primary Care is on the brink and that we're only just keeping afloat and you know it won't take much more to make Primary Care start to fail.. can't say how long it will take but.. And I think ultimately that negative stuff seeps into the way you feel about your job and day to day working. (…) You're not unaware of the pressures* *F2: But the negative attitude towards general practice in terms of, we can't see it getting any better and all of the extra demands that are being put on, I think that influences us, cos I think…*
	FG3	*M1: I think the respect for the profession has gone, I think that for me that's the biggest thing, whereas in the past you used to have that respect for the profession, so people used to think, I don't want to go and waste the doctor's time with silly things, I'm going to try and manage these myself, I've got people around me who I can speak to, we can do things at home, but that's completely gone now, that's doctors gone, so anything happens run to the GP.*
	FG5	*F2: and I think there's pressures in in other places as well. Nursing homes and things they're being inspected and having to so all things differently and having all different bits of paperwork and stuff. And that's having an impact on us cos then they're on the phone a lot more than they used to be putting a lot more demand on us than they were cos they've got to have it documented and all the eyes and t's crossed as it were, that the doctors were informed and you know, that's because of the pressures they're under, but impacting on us yeah.*
	FG1	*M1: (…) and practices are struggling, getting more and more patients, and less and less doctors*
	FG3	*M2: the target driven culture and all that is coming into play, general practice is nothing like that now, it's a kind of slog each day to get through everything*
Increase in patient expectations and complaints	FG3	*F3: But I think yes, I think the government has raised expectations of what patients should do.*
	FG3	*M2: the volume of complaints has risen, I think that has… I've certainly seen that, the way we have to deal with them has changed (…) but I think certainly the volume of complaints, people seem much more ready to complain about a missed appointment, a late running surgery or much more trivial things, (…) but it seems that patients are happier now to complain about much more trivial things.* *M1: I think the respect for the profession has gone, I think that for me that's the biggest thing, whereas in the past you used to have that respect for the profession, so people used to think, I don't want to go and waste the doctor's time with silly things, I'm going to try and manage these myself, I've got people around me who I can speak to, we can do things at home, but that's completely gone now, that's doctors gone, so anything happens run to the GP.*

	FG5	*F1: Patients can be quite negative about the service we provide, when I still feel that we provide a good service. But patients' expectations seem to be going up. And I think they feed off some of the stuff that's in the press*
	FG3	*F1: Yeah, but it's this expectation that your GP is the answer to everything, if you're not sure go and see your GP and also this expectation that has been driven I think by the government that patients expect a world class top notch private level American service from a state funded NHS, and the reality that those two just don't match,*
Negative portrayal of general practice	FG5	*F1: I would say I would say that there is definitely a negative feeling out there about the NHS and General Practice and the future of General Practice (...) you know it won't take much more to make Primary Care start to fail.. can't say how long it will take but.. And I think ultimately that negative stuff seeps into the way you feel about your job and day to day working. I know these guys probably don't have the same business pressures, but they're totally aware of it aren't you* *F2 & M1: yeah* *F1: You're not unaware of the pressures* *F2: But the negative attitude towards general practice in terms of, we can't see it getting any better and all of the extra demands that are being put on, I think that influences us, cos I think…*
	FG3	*F1: Everybody hates you.* *F2: And that's the other thing, the media perception of you is actually that you earn far too much money and you're lazy 'cos you aren't prepared to work nights and weekends.* *(...)* *F1: It's the feeling that nobody's backing you up, and that yeah inevitably it results in a complaint*
Lack of support (from the media, government, public, patients, other organisations)	FG3	*F3: I think one of the things I've found when patients are very challenging is if there is no wider system to support them and particularly with mental health problems, if you don't have very good mental health support it can be much more challenging.*
	FG3	*F1: Everybody hates you.* *F2: And that's the other thing, the media perception of you is actually that you earn far too much money and you're lazy 'cos you aren't prepared to work nights and weekends.*
	FG1	*F1: We do have bad spells, when y'know things that have really hit us are when again I suppose it's stuff that's outside your control when patients aren't satis- when an unhappy patients goes on a facebook site and slags you off, in public, and there's absolutely nothing you can do about it.*

Supplementary Table S3. Additional supporting quotes for Section 2: Individual and Practice Level Strategies theme

Sub-theme	Focus Group	Quote
Breaks	FG2	*F1: If the sky was the limit?* *I: umm both, why not?* *F1: The lunch breaks were if the sky's the limit (chuckles)* *M1: Yeah, because joking apart, there's many things that could be done, but with the current resource can't be done. So, lunch breaks, adequate time for refreshment, for all GPs, not just those who work to a [locum] type contract* *F1: yeah yeah*
	FG3	*F2: We made it compulsory to have coffee break and it's just 15 minutes, 15 minutes before second surgery starts so we can't extend any longer than that, (…) everyone goes up to at quarter to 11 in the morning knowing that they're going to have to come back down at 11, but the coffee's made and it's like 15 minutes, right, well everybody can do 15, you know, it's you can take your tea back down with you if you haven't time to drink it, you're there, you're making it, you're interacting. (…) You actually can go the whole day without really seeing anyone except patients constantly and just seeing other people that you know and can just talk nothing with, (…), just makes a massive difference, at the end of the day you feel less… you feel shattered but you feel less shattered. (….) and the value has been seen immediately by people who even, you know, initially were sceptical.* *M2: And the problem is people don't see it as productive, but actually it's much more productive than the opposite of everyone working in a silo way 'cos you get refreshed don't you?*
	FG3	*F3: Coffee break.* *I: Coffee break.* *F1: Coffee and cake I would suggest.* *F3: Oh yeah.* *I: So just coffee and cake [laughs]?* *F1: Yeah [all laugh].* *F2: 15 minutes just to be able to…* *F1: Compulsory 15 minutes.* *F2: Compulsory 15 minutes where everything stops before a session starts and you have to go up and meet. (…)* *F1: I mean straightaway that's one thing you can realistically do. Coffee breaks for everyone, notice up.*

	FG3	F3: I did have an episode with depression which was probably a contribution of home life and work life, and at that point I just managed to shut myself off, nobody knew until I wasn't fit to walk, and I would walk out of the building sometimes, not to be there, and I think they were mortified that they hadn't spotted it, (…) so after that we introduced coffee break and it was in response to that, the fact that, you know, when you're just too busy you didn't see each other and nobody spotted, so I think it did make a big difference to how people worked, and I think you know, caring practice.
	FG4	[about coffee breaks to improve wellbeing] M: And we're in a similar situation I think, so yeah, yeah, that would be one thing that you could do reasonably simply.
Physical needs	FG5	F2: I might go home and go for a run or go and play netball or, and I feel like I've had 10 hours sleep after I've done it, so it's sort of like a way of making yourself feel better. It's not necessarily a conscious, 'I need to do this to prevent the stresses of the day from getting on top of me', it's just something I need to do to feel physically well you know… I: Yeah. But you do notice that it does make you feel better? F2: Yeah, yeah. And I think there's more to it than that, you're doing something again which is social, which is an escape from work, and a team sport
	FG1	M1: You can literally leave 9 hours later and the whole climate's changed, it's sometimes that, sometimes taking, even if you're on the same site, sometimes with visits you go out anyway, but going out for even that, just that to the shop for 5, just to rekindle, again reset your brain a little bit
	FG3	M1: I've actually made it a point nowadays [To drink water], I used to carry a 1.5 litre bottle(…) if I have that water in front of me I'm more inclined to drink it than if I don't.
	FG1	F3: I think having regular cups of tea on your breaks (all laugh). I do honestly! And having something to eat as well, if you've got a long day
Psychological strategies	FG5	F3: And actually, I say no with the boundaries probably more to protect me, definitely.
	FG1	M1: That's right, someone else was saying that, yes, getting somewhere where you're just in the zone where you're just, that that's all you can think about for that period of time F3: escapism M1: It just resets your brain a little bit.
	FG3	M2: I've seen a few different strategies, I've seen the doctors that actually become more reclusive and sort of barricade themselves almost into their room, so they're trying to keep all this stuff away and everything pushed away from them,
	FG5	F3: I do mindfulness.

	FG4	*M1: And I think it probably starts with a recognition of the concept of wellbeing and having burnout in our consciousness, as things get harder and harder I think it's more important to recognize that as a real threat to our business if you like, or certainly to our profession (…)* *I: So being more self-aware so that you protect staff against burnout?* *M1: Well as individuals but as a team as well, you know, about thinking about the risks to the team.* *M2: More corporate awareness of it all, from all teams actually.*
	FG2	*M1: If you brought it down to individuals, there's probably lots of things that individuals can do, either early in their career training or later on just to remind themselves... everything from learning to meditate, through becoming mindfulness practitioners through to just being empowered enough to say 'no' to a number of contractual obligations*
	FG3	*F2: I schedule a week off every two months which uses my annual leave effectively and it means that I know that within eight weeks I will get a week off, you know, and make sure that you take that time appropriately and recuperate, it's about being aware of burnout and doing what you can to prevent it.*
	FG5	*F2: Yeah, yeah. And I think there's to it than that, you're doing something again which is social, which is an escape from work, and a team sport. You're getting a chance to socialise with people who aren't medics. When you do socialise with other medics, no offence to you guys, but you just end up talking about medicine and I never found that very helpful myself, so I tend to not socialise with medics, just because then I feel like I get a bit of a more rounded view of the world, you know what I mean (haha)* *I: Yeah, a break from work properly* *F2: Yeah a break from work completely, yeah, and the stresses of medicine and everything that brings.*
Control	FG2	*M: An individual decision I made a while back now was looking at how much I was working in an average week and saying, "I don't really see myself sustaining this for another 34 years until I retire, how am I going to battle this work life balance?" and I cut down from nine clinics a week to eight and that made a big difference to me, having an extra day away from here, just recharge the batteries a bit.* *I: Okay.* *F: I dropped my out-of-hours work.*
	FG2	*M2: So I think salaried is becoming, became a much more, better option, but I think it's got quite a lot of problems to it personally. **At least with salaried you've got a bit of say.** So locuming to me, is the option, but I'm kind of unhappy with it really. Ideally I'd like a really functional practice, but I just don't think… they are very few and far between!*
	FG1	*M2: We still see the same number of patients but we can add an extra break in if we want one and finish a bit later depending on how we feel so we have that freedom. At (insert different practice name) it's 10 minute slots, which definitely does make a difference, just that couple of extra minutes.*

Support	FG1	F1: I did see, I saw something(...) about a practice that had er a monthly meeting where they literally talked about how they felt, about, what they were doing, and they talked about their emotions regarding particular consultations. Um, I can't remember what it was called M1: Is it like a balint group? There used to be those balint groups F2: oh yeah I: mm F1: No but it wasn't, it was something else. (...) it was quite interesting (...) And they did it on skype, between sites as well, and how it had improved about how they felt about what they were doing.... But thinking about it, to a certain extent it's what we're doing already, because if we're having a bad day and we've had a particularly difficult patient, I don't think we feel… shy about er, telling each other! (laughs)
	FG3	F1: I think communicate with patients better, I think we're not good at telling patients what's happening (...) there's very few practices that have put up on the noticeboard, "This surgery's at risk of closure in the next six months, this surgery's three doctors down, we are already short 50 appointments this week, your waits are longer because we're under…" you know, we're not telling patients, and most patients know the NHS is under pressure and actually when you talk to them one-on-one they're quite understanding about that and we need to ask for their help and say you might find the doctor directs you to the pharmacy, you might find that you're told to ring physio before you see the GP, please support us with this, and I think straightaway if you start doing that the majority of patients would be supportive.
	FG3	F2: Interestingly one thing that my practice did recently was we got all the partners together and sat down and asked each one of them how are you doing, what are you doing, what do you see yourself doing in five, ten years' time, around the table, which is the first time I think that they've ever done that. (...) M1: I'm sure anyone who's nearer to 40 and plus would be saying, yeah, retire [laughs]. F2: But it was a full sort of frank exchange and I think that it was with burnout in mind, and actually enabled, freed up a lot of people to sort of say, actually, you know, I'm not happy and I'm worried and I'm not sure how long I can maintain this and it's getting harder and changes were made.
	FG2	M: I just want to say a small thing, I am part of a study group with the people I left the VTS training scheme with about nine years ago, we meet once a month and although I know I've got colleagues in this room where I can talk about work stuff with, sometimes it's quite nice to have that peer group that I've come through training with, meet up with and it's amazing just how much I try not to miss those, they really mean a lot to me and I think it's a sign that I find them in terms of sharing and kind of unburdening both clinical cases and just the way things are going locally, we also work with insularly within the practice and having some things outside the practice just helps you get an overall feel that everybody's in the same boat and everyone's going through a similar kind of thing at the same time so I really value that.

	FG5	*F2: Could you have like a buddying system where you're buddied up with another colleague and you take it in turns every, or every few months you make, you have some time dedicated to coming together and asking about each other's' wellbeing or I don't know…*

Supplementary Table S4. Additional supporting quotes for Section 2: External Changes theme

Sub-theme	Focus Group	Quote
Support	FG2	*M1: Adequate support staff so the paperwork that could be, sorry the administrative work that could be done by the people, is done by them rather than ending up with the GPs.*
	FG5	*F1: And I think um, the press to stop bashing us so much* *(...)* *F1: yeah, I feel like we don't, we're constantly being kind of dragged down and just not respected as much really*
	FG3	*F1: It's not what you can do as an individual, but you know, it needs to be included in training, needs to be part of GP training.* *F2: They're starting to make it more... part of the... yeah, well, fitness to work is part of the syllabus isn't it, and that's about being aware of yourself and whether you are fit to continue to practice, reflecting on that, so yes to an extent, but I'm not sure that they're, apart from encouraging people to exercise they're really...*
	FG2	*F1: .. and maybe have sort of coaching mentoring type of support to identify how to handle things*
Reduction in pressure	FG3	*"F2: Get rid of ridiculous exercises like CQC [A public body, part of the Department of Health, which monitors, regulates, and inspects health and social care services in the UK] which really just they're designed to make practices jump through hoops.* *F1: It's a manager's job, it's got nothing to do with GPs." [FG3]*
	FG3	*F2: It's about releasing GPs to do what they do best and what they actually joined to do in the first place which is just deal with patients and help patients, not in a ten minute constrained time period because actually you've got to get X many patients in the door in one day because the demand is so great, and not in a rushed manner because actually you know that when you've finished one surgery before you start the next when are you going to spend that entire time doing prescriptions, visits, everything else that you've got to do in your day, letters, documents, whatever stuff you've taken on as a partner, all that stuff, you know, it's easing up on the, really the ticky box exercises and stuff that we have to do to enable us to do, which is one of the reasons why, and another reason why I still locum, even though I have a partnership, because when I go to do a locum job I go in there and I see patients and I have a break and I have my lunch and I see more patients and I don't have to do any of the other stuff and I come away thinking, oh it's so nice to see patients isn't it?* *F1: You do a better job don't you?* *F3: And that's what we're trained for.*

	FG2	*M1: Um, less [stuff] centrally imposed by the government, pushing off of work so everything's being dissolved to primary care where the nearest patient (inaudible) but it's also putting the workload on GPs where there is no force to do that*
	FG5	*F1: Um, and a change of patient expectation* *F3+2: Yeah* *F2: That's the big one for me, definitely* *F1: They've got to stop coming in and burdening us with –* *F2: - crap* *F1: crap yeah*
Increase in resources	FG2	*M1: Adequate support staff so the paperwork that could be, sorry the administrative work that could be done by the people, is done by them rather than ending up with the GPs.*
	FG4	*F: Magic wand?* *I: yeah magic wand what would be the best way.* *F: More resource.* *(...)* *I: So more resource, do you mean more GPs?* *M: Yeah.* *I: More funding?* *M: Yeah.* *I: More everything [laughs].* *F: More admin, more doctors.* *M: Yeah.*
	FG2	*M1: so there's lots of practical things, but they're not going to happen because there's not money for them.*
	FG5	*F1: More resource, More GPs, 20 minutes per patient* *I: mmhmm. So more GPs* *F3: definitely the gold fountain of 15 minutes*
	FG3	*F1: So your options are you could increase funding in general practice back to the 11% it should be at, which would be a 3 or 4% rise, and that additional resource would pay for either more doctors or more staff within practices to do the things actually you don't need a doctor to do, and free up the doctors to then treat patients (...) but those patients with these complex multi-morbidities that need that overview, that need the 20 minute consultation, the home visits that are complex and that need our intervention, that's what you need to do and that immediately is better for doctors but it's better for patients as well, satisfaction ratings are higher, and you're safer because you've got the time and the breathing space to actually concentrate on that patient.*