Peering through the barriers in GPs’ explanations for declining to participate in research: the role of professional autonomy and the economy of time

Peter Salmona, Sarah Petersb, Anne Rogersc, Linda Gaskc, Rebecca Cliffordo, Wendy Iredaleb, Christopher Dowrickd and Richard Morrisse


Background. The level of participation in research by GPs is low internationally. Previous reports of the reasons why practitioners decline opportunities for research participation have tended to recount the barriers that they describe as if they are objective accounts.

Objective. By theoretical sampling of practitioners who had declined to participate in a research trial, we sought to interpret the functional significance and interrelationship of the barriers that they reported.

Methods. Twenty-three GPs who had declined to participate in a trial of training to manage medically unexplained symptoms were interviewed and their accounts analysed interpretatively.

Results. The practitioners described general practice and research as alien fields. Research lacked intrinsic, clinical or professional value and was linked to evidence-based medicine which they rejected as incompatible with person-centered care. Every doctor described a lack of time for research, but time was an elastic resource that payment could release from the reservoir of their ‘own time’.

Conclusion. The findings should inform the design and interpretation of future quantitative surveys to identify how common the attitudes that we report are. Doctors with the attitudes of those whom we interviewed will not be drawn into research by measures predicated on the assumption that it is intrinsically, clinically or professionally valuable. If they cannot be convinced of its utility, value could be conferred by payment for participation.

Keywords. Barriers, family practice, research, time.
Methods

Sample and recruitment

After ethical approval, letters were sent to 1934 GPs in Liverpool, Manchester and Lancashire (all GPs in training practices and all GPs in 12 out of 37 primary care trusts) providing information about MUST, and specifically that it involved practice-based training in reattribution treatment for managing unexplained symptoms, and seeking expressions of interest in finding out more. Of these, 1429 (74%) did not reply and 269 (14%) replied indicating no interest. Of 236 (12%) who replied indicating interest, 67 confirmed agreement when visited by one of the research team, and were eligible to participate.

For the present study, we purposively sampled from the GPs who did not participate, including GPs of both genders, from rural and urban practices, from each participating area (Merseyside, Greater Manchester, Lancashire and Cheshire), from training and non-training practices and who declined to take part in the trial at different stages (letter of invitation, subsequent visit from one of the research team). We first wrote to 76 GPs and invited them to take part in an interview about their views of the trial and the reasons why they could not participate, for which they were offered £30. Of these, 39 declined, 21 did not reply and 16 agreed to interview. From the 21 GPs who had not replied, subsequent telephone calls led to a further seven interviews. Attempts at recruitment ended when no new information was emerging. The final sample is described in Table 1.

Interviews

Following a review of literature and team discussion based on this and on previous research experience in primary care, a draft interview guide was designed and piloted. Although the reason for interviewing GPs was that they had declined to participate, the interviewers (RC, WI) avoided an accusatory stance and emphasized their acceptance and understanding of GPs’ decisions and their belief that the research team had much to learn from those who could not participate. The interviewer reminded GPs about the purpose and design of the MUST trial, then sought their views of (i) this trial, and why they declined to participate; (ii) the role, value and feasibility of research in primary care; and (iii) other information relevant to their decision not to take part. The interviewers avoided closed questions, using open questions, prompts and reflection. Interviews lasted from 20 to 55 minutes. The interview guide was subsequently modified in order to test or develop aspects of the analysis, particularly by exploring in more detail reports of constraints on time. Interviews were face-to-face, audio-recorded, anonymized and transcribed before recordings were erased.
Barriers to research participation

The lack of time for research characterized all GPs’ accounts. Language was emphatic ‘Well I would simply say I have no time, I can’t take part in the research. We’ve got no time, lack of time. It’s basically a time factor, no time’ (GP15), supported by gestures, by exhibiting interruptions of the interview as evidence of work pressure and by detailed accounts of work stress: ‘I’m out of the house twelve hours a day here… I’m here usually about half past seven… [detailed account of daily activity removed] so it’s quite a long day… I had a CVA three years ago… Dr X also had major surgery. … As a result I had to return early as a result of him being off, so the stresses tell’ (GP3). The same GP showed his concern with a broader audience for his protests about time, suggesting that his accounts of workload ‘might surprise the people listening to this tape’ (GP3). The lack of time was routinely deployed at the start of the interview, after GPs were first prompted for their reasons for not participating. Repeatedly testing the developing analysis against the data, the use of authors from different disciplinary backgrounds in different roles and presentation of relevant transcript have long been regarded as procedural sources of trustworthiness of qualitative analyses. Procedures alone are, however, insufficient to guarantee trustworthy findings. Additional perspectives from which we discussed and assessed the developing analysis included its coherence, theoretical validity, whereby it should connect with ideas outside the study, and ‘catalytic validity’, whereby the analysis should not merely describe, but should have the potential to change, clinical practice or research.

Findings

Analysis first focused on the response made by every GP we interviewed: that they had ‘no time for research’. However, other aspects of the data suggested that this kind of statement was best interpreted as justifying, rather than explaining, not participating. Therefore, after examining this and other presented barriers, we went on to consider what research signified to the GPs.

Time and money

The lack of time for research characterized all GPs’ accounts. Language was emphatic ‘Well I would simply say I have no time, I can’t take part in the research. We’ve got no time, lack of time. It’s basically a time factor, no time’ (GP15), supported by gestures, by exhibiting interruptions of the interview as evidence of work pressure and by detailed accounts of work stress: ‘I’m out of the house twelve hours a day here… I’m here usually about half past seven… [detailed account of daily activity removed] so it’s quite a long day… I had a CVA three years ago… Dr X also had major surgery. … As a result I had to return early as a result of him being off, so the stresses tell’ (GP3). The same GP showed his concern with a broader audience for his protests about time, suggesting that his accounts of workload ‘might surprise the people listening to this tape’ (GP3). The lack of time was routinely deployed at the start of the interview, after GPs were first prompted for their reasons for not participating, and then typically at points when an implied obligation for research arose: Interviewer: ‘Do you think that GPs have a responsibility to do research?’ GP10: [laughs] ‘No. I don’t think they have a responsibility under the present terms, well they don’t under the contract. … Do they have a moral responsibility, I don’t know. Most GPs will tell you and I think quite honestly that they just haven’t got time to do it’.

Analysis

Analysis, which proceeded in parallel with the interviews, was inductive. Transcripts were read and discussed by RC, LG, SP, AR, PS and WI, who encompassed expertise in psychological, sociological, medical and psychiatric studies in primary care. Group discussion was informed by reading new transcripts and by continued open coding of these by the two researchers who conducted the interviews. The analysis emerging from each group discussion was recorded by PS, who tested it by applying it to the transcripts and further developed it as a result. Periodically, the analysis was referred to RM and CFD. Analysis focused on patterns that were apparent across more than one interview. In reporting the final analysis, excerpts from interview transcripts are presented to illustrate the range and commonality of meaning of each category of the analysis.

Initial analysis was descriptive, identifying barriers as described by GPs. However, emerging contradictions concerning the nature of time constraints indicated that it was implausible to analyse GPs’ accounts at a purely literal level and that the interview should be regarded as one in which GPs were prompted to draw on narratives about research. Therefore, we examined the ways in which their accounts constructed research and we considered the function that these constructions had for the GP in the interview and more generally.

Repeatedly testing the developing analysis against the data, the use of authors from different disciplinary backgrounds in different roles and presentation of relevant transcript have long been regarded as procedural sources of trustworthiness of qualitative analyses. Procedures alone are, however, insufficient to guarantee trustworthy findings. Additional perspectives from which we discussed and assessed the developing analysis included its coherence, theoretical validity, whereby it should connect with ideas outside the study, and ‘catalytic validity’, whereby the analysis should not merely describe, but should have the potential to change, clinical practice or research.

Table 1 Details of participating GPs

<table>
<thead>
<tr>
<th>GP ID</th>
<th>Gender</th>
<th>No. of years worked in general practice</th>
<th>No. of GPs in practice</th>
<th>Urban/ rural practice</th>
<th>Training practice</th>
<th>Stage of declining participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>11</td>
<td>4</td>
<td>U</td>
<td>No</td>
<td>Non-response</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>6</td>
<td>4</td>
<td>R</td>
<td>No</td>
<td>Non-response</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>27</td>
<td>3</td>
<td>U</td>
<td>No</td>
<td>Non-response</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>17</td>
<td>4</td>
<td>R</td>
<td>Yes</td>
<td>Negative</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>14</td>
<td>5</td>
<td>U</td>
<td>No</td>
<td>Non-response</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>27</td>
<td>4</td>
<td>R</td>
<td>No</td>
<td>Non-response</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>29</td>
<td>2</td>
<td>U</td>
<td>No</td>
<td>Withdrew</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>16</td>
<td>5</td>
<td>R</td>
<td>Yes</td>
<td>Non-response</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>17</td>
<td>2</td>
<td>U</td>
<td>No</td>
<td>Withdraw</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>31</td>
<td>1</td>
<td>U</td>
<td>No</td>
<td>Negative</td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>23</td>
<td>1</td>
<td>U</td>
<td>Yes</td>
<td>Non-response</td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>20</td>
<td>4</td>
<td>U</td>
<td>Yes</td>
<td>Non-response</td>
</tr>
<tr>
<td>13</td>
<td>F</td>
<td>30</td>
<td>3</td>
<td>R</td>
<td>No</td>
<td>Negative</td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>19</td>
<td>2</td>
<td>U</td>
<td>No</td>
<td>Withdrew</td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>31</td>
<td>3</td>
<td>U</td>
<td>Yes</td>
<td>Withdrew</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>26</td>
<td>5</td>
<td>U</td>
<td>No</td>
<td>Negative</td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>18</td>
<td>3</td>
<td>R</td>
<td>Yes</td>
<td>Non-response</td>
</tr>
<tr>
<td>18</td>
<td>M</td>
<td>15</td>
<td>4</td>
<td>U</td>
<td>No</td>
<td>Withdraw</td>
</tr>
<tr>
<td>19</td>
<td>M</td>
<td>21</td>
<td>3</td>
<td>U</td>
<td>Yes</td>
<td>Negative</td>
</tr>
<tr>
<td>20</td>
<td>M</td>
<td>23</td>
<td>2</td>
<td>R</td>
<td>No</td>
<td>Negative</td>
</tr>
<tr>
<td>21</td>
<td>M</td>
<td>24</td>
<td>3</td>
<td>U</td>
<td>Yes</td>
<td>Withdraw</td>
</tr>
<tr>
<td>22</td>
<td>M</td>
<td>29</td>
<td>2</td>
<td>U</td>
<td>Yes</td>
<td>Non-response</td>
</tr>
<tr>
<td>23</td>
<td>M</td>
<td>18</td>
<td>4</td>
<td>U</td>
<td>Yes</td>
<td>Negative</td>
</tr>
</tbody>
</table>

*Non-response or negative response to initial letter or withdrew interest after visit from research team.
Time was, however, not the finite resource that these comments implied. Time not currently allocated to work was the GPs’ ‘own time’, so that ‘If it [research] involves doing things in our own time . . . no’ (GP16). Payment, the lack of which was widely cited as a barrier, could increase the supply of research time by releasing it from the reservoir of own time: ‘To be honest you will only get GPs to do it if you give them some financially make it worth their while because they will say that their time is precious, that their time is their spare time that they want to do something else, you know even if it’s just going out with the family, whatever. They will say they should be getting paid for it’ (GP2). Payment could release interest as well as time: ‘The payment’s the first thing you look at basically. Is it worth me looking any further and if it is then you look further . . . or you might not, I can’t do the time, I’m not interested’ (GP4).

*Patients need GPs’ protection from researchers*

Several comments implied the potential for research to be unethical ‘[One would hope that the research was ethical’ (GP5)], referring specifically to threats around confidentiality, coercion (‘it sounds a little bit as though you pounce on them when they come out’, GP12) or damage: ‘I’d rather use something that’s tried and tested, I’m not sure I want to try new things out on my patients’ (GP7). No GP, however, recounted a problem arising from previous research.

*Lack of research skills and professional status*

Two GPs described having insufficient skill to perform research. Another linked lack of research skill in the profession to its low status: ‘some of the stuff that gets into the British Journal of General Practice . . . it’s not really worth the paper it’s written on. . . . People often see [general practice] as a second best option. . . . It’s a problem with the profession’ (GP1).

*Research had little intrinsic, clinical or professional value*

In a hierarchy of actual or potential activities for these GPs, research was low in its clinical or professional value. Comments that ‘you can’t just swan out and do it’ (GP11) indicated its low status, as did contrasts with the ‘real’ work of clinical practice: ‘it’s not as serious as patient care’ (GP20). Even where GPs had participated in research, they considered that ‘the benefits would be elsewhere’ (GP13).

Further analysis identified reasons why research had little value (Box 1). It was intrinsically uninteresting. Language of clinical and scientific puzzlement was absent in discussing potential research topics. Research was irrelevant to GPs’ career or esteem; they were not concerned with authorship of research papers. Overwhelmingly, these GPs described general practice as an art linked to experience, rather than a scientific endeavour informed by research (Box 1), one commenting that ‘we do research all the time, but not formally’ (GP22). Because indications of value of research were rare, we explicitly prompted GPs about its professional relevance. Most indicated that ‘We don’t have the responsibility to do it’ (GP11).

**Discussion**

The GPs in this study presented barriers to research participation that have been described previously: the irrelevance of research to clinical practice, the need to protect their patients and their lack of skills and time. However, to take all these barriers purely at face value means neglecting why GPs deployed them. The GPs in this study presented a strong sense of entitlement not to be involved in research, which they expressed by reference to professional values, motivations and tasks.

*The lack of value of research*

Taken literally, the barriers that GPs described could simply be listed as objective barriers that need to be overcome, for example, by ensuring the relevance of research to primary care, guaranteeing its ethical standards, improving GPs’ training in research methods...
Barriers to research participation

To a large extent, GPs’ accounts of their intuitive and individualistic practice describe the way that professional practice must occur in the surgery.22 However, the ‘relationship’ that is emphasized by GPs in this and other studies may not have the objective quality that is claimed for it.22,24 For instance, GPs’ warning in the present study that patients would be more open to them than to researchers is inconsistent with interview studies in which patients have told researchers information that their doctors do not hear, describe withholding information from GPs or criticize GPs.25–27 Moreover, in asserting the importance of the clinical relationship, GPs described dangers from researchers that were apparently not based in their experience; in particular, that research might be unethical or damaging to patients. In a qualitative study of GPs and patients who had participated in a research study, both described how research improved the relationship, in particular because patients felt more valued.4 The emphasis of GPs in the present study on the clinical relationship might therefore be partly a justification rather than simply an explanation for non-participation.28

Armstrong22 observed that, whereas professions have been traditionally defined by their autonomy, the autonomy of Western medicine has been challenged in recent decades by economic pressures and managerialism, publicity about malpractice and patient consumerism. Although evidence-based medicine has provided a defence of autonomy at the level of the profession, Armstrong22 suggests that this further disempowers individual practitioners who, as the GPs in our study may illustrate, maintain their sense of autonomy by emphasizing the individuality of their clinical work. Therefore, a substantive barrier to these GPs’ participation could be their need to maintain their sense of individual professional autonomy. That is, their decision not to participate in activity seen as allied with evidence-based medicine might be a way in which they maintain their professional identity as autonomous practitioners.29

Time and money

The lack of time was central to GPs’ accounts in the present study, and GPs in many other studies have blamed lack of time for not practicing evidence-based medicine9,30,31 or health promotion,12,24 as well as for not researching or implementing research findings.3,4,6,10,18 Time has, therefore, become widely accepted as a critical barrier to research and other developments in clinical practice. The present analysis, however, showed time to have a more complex function in GPs’ accounts than previously described.

Marks32 observed that, in ordinary language, appeals to the finitude of time are culturally honourable excuses—that is, vocabularies for mitigating responsibilities when behaviour is questioned. That is, ‘having no time’ for something typically means that it is of lower priority than other activities. Horobin and McIntosh33 noted this use of the language of limited time in primary care to justify, rather than explain, the pattern of GPs’ activities. Consistent with this view, GPs in the present study used the discourse of time pressure demonstratively, and particularly at the start of the interview and at other points during it when the implied obligation to participate was probably acute.

In the ‘economy of time’ that developed in UK general practice in the later 20th century,34 time is a resource that is bought and sold. The change in location of practice from home to health centre during the later 20th century established a boundary between the GP’s private and professional life, which was mirrored in the distinction between ‘work time’ and ‘own time’.34 Therefore, GPs in the present study could describe time as a finite quantity while also acknowledging that financial payment would release more time from the reservoir of their own time. That is, deploying time as

and protecting their time for research. These have, indeed, been conclusions of previous studies. However, our findings show the need for a less literal analysis of these barriers.

The concept of ‘barriers to research’ implies an assumption that research is intrinsically valuable. Our data show no such assumption in these GPs. Although research is celebrated in universities and hospital medicine as a way to inform practice, more tangible rewards maintain it. Apart from assuaging curiosity and informing practice, research enhances career, status and, ultimately, remuneration. By contrast, the starting point for discussion about how to involve GPs such as those we interviewed in research should be the general lack of value that it had for them in all these respects. Consistent with previous reports,19,20 the language of puzzlement and curiosity was absent. Formal research lacked professional or career value, some having chosen general practice to escape the ‘rat race’ of hospital medicine in which research propelled careers.

Research was also described as having little relevance to clinical practice, which GPs generally described as ‘art’ rather than science,21 emphasizing intuitive knowledge learned through experience. They linked their research non-participation to their rejection of the validity of evidence-based medicine in making clinical decisions. The individual clinical relationship was central to GPs’ accounts and, like GPs in other studies of attitudes to research or evidence-based practice, they emphasized its importance in shaping or overriding the implementation of evidence.18,21–23 The clinical relationship was described as inaccessible to researchers and so could not be studied by them.

Barriers: real and constructed

To a large extent, GPs’ accounts of their intuitive and individualistic practice describe the way that professional practice must occur in the surgery.22 However, the ‘relationship’ that is emphasized by GPs in this and other studies may not have the objective quality that is claimed for it.22,24 For instance, GPs’ warning in the present study that patients would be more open to them than to researchers is inconsistent with interview studies in which patients have told researchers information that their doctors do not hear, describe withholding information from GPs or criticize GPs.25–27 Moreover, in asserting the importance of the clinical relationship, GPs described dangers from researchers that were apparently not based in their experience; in particular, that research might be unethical or damaging to patients. In a qualitative study of GPs and patients who had participated in a research study, both described how research improved the relationship, in particular because patients felt more valued.4 The emphasis of GPs in the present study on the
a barrier was, in effect, a proxy for other barriers, particularly lack of payment.

Strengths and limitations of the study
A strength of the study is that we interviewed doctors who had declined to participate in a research project, thereby avoiding idealized and generalized comments. While these qualitative findings therefore emerged from a specific research trial, and cannot automatically be generalized beyond it, this trial’s subject and methods were tailored to primary care, and doctors’ reactions to the opportunity to participate therefore potentially reveal core attitudes to research which would be of general relevance. It is possible that more sustained encouragement, or a different research topic or a different research method, would have engaged some of the doctors that we interviewed. Nevertheless, primary care participation in formal research is low generally and our findings therefore potentially concern normative behaviour. The GPs that we interviewed were necessarily those most willing to tell us why they could not participate, and cannot be assumed to represent the broader group. Conversely, as members of a rarely studied group defined by non-participation, they are potentially highly informative about barriers to be overcome if high levels of participation are desirable and to be achieved more generally.

Implications for increasing research participation
Our findings can inform the design and interpretation of surveys of larger samples of GPs to assess their generalizability. If their wider generalizability is confirmed, it will be important that researchers and policy-makers do not take completely literally the barriers that have been widely reported to GPs’ participation in research. To avoid further intensifying the construction of general practice and research as alien by GPs such as those we interviewed, those who seek GPs’ participation need to ensure that research is not seen by GPs as challenging their professional identity as autonomous practitioners. GPs also need to see research as having value. However, the factors that give research value in universities and hospital medicine do not generalize across primary care. The code of practice of the Royal College of General Practitioners states that the ‘excellent’ GP is one who ensures high standards of research and safeguards patients’ rights and confidentiality, but it does not establish expectations to perform or participate in research. GPs in the present study echoed this in describing their stance to protect patients from research rather than involve them in it. Change in the core values of general practice might therefore be necessary if research is to acquire professional significance for GPs such as these. Meanwhile, for those who, like most GPs in the present study, see research as having little clinical, professional or intrinsic value, an effective strategy might be to confer value on research by payment for participation. Within the UK, this strategy would be consistent both with the increased emphasis on primary care organizations as facilitators of large-scale clinical trials, and with the economic drivers inherent within the Quality Outcomes Framework. Financing is central in recent debate about the future of the discipline internationally and, in this context, it would be natural to consider the financial significance of research.

Acknowledgements
The study was supported by the UK Medical Research Council. We are grateful for the collaboration of Professor Francis Creed, Professor Graham Dunn and Dr Barry Lewis in the design of the MUST trial, to Ms Judith Hogg for management of the trial and for the cooperation of the participating family practitioners. We are grateful to Professor Carl May for astute comments on a draft of this paper.

Contributors: RM led the MUST study, from which this report arises, and LG, SP, CFD, PS and AR contributing to the overall design and management. PS led analysis of these data, to which SP, LG, AR, RC, WI and RM contributed, and drafting of this report, to which all authors contributed.

Declaration
Funding: None.
Ethical approval: This study was approved by the North West Multi-centre Research Ethics Committee. Conflicts of interest: No author is aware of any conflict of interest arising in relation to this work.

References


Thomsen JL, Jarbol D, Sondergaard J. Excessive workload, uncertain career opportunities and lack of funding are important barriers to recruiting and retaining primary care medical researchers: a qualitative interview study. Fam Pract 2006; 23: 545–549.


