**Occupational isolation among general practitioners in Finland**

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**Background**

It is proposed that isolation in general practice is one of the factors that leads to work-related stress and the low attraction of this work. In Finland, 71% of physicians who worked or had worked in a primary health care centre agreed with the statement 'working as a doctor in a health centre is too often isolated work'.

**Aims**

To gain a deeper understanding of this feeling and to find out which factors constitute it.

**Methods**

A qualitative in-depth interview study of 32 physicians working in a primary health care centre in Finland. Qualitative analysis of transcribed verbatim interviews using a constant comparison method.

**Results**

The main components of isolation were making decisions alone, lack of collaboration with other workers in the health centre and secondary care specialists, not being a part of the work community and lack of mentoring at work.

**Conclusions**

Enabling flexible teamwork and social and professional support networks are the key issues in solving the problem of occupational isolation in general practice.

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**Key words**

Isolation; primary care physicians; qualitative research.

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**Introduction**

Many countries have experienced increasing difficulties in recruiting general practitioners (GPs) in primary care [1]. A heavy workload, low job control, increased and inappropriate demands from patients and an administrative burden have been considered barriers to primary care work [2–4]. Organizational factors may lead to retirement intentions [5]. A good team climate has been found to improve retention of rural GPs [6]. Furthermore, it has been suggested that working alone, without any backup from co-workers, is one of the negative factors that make primary care a less attractive opportunity for physicians [7].

In Finland, primary health care is provided by municipalities. The number of GPs working in these health centres varies considerably from one to two GPs to many dozens. There are many professional groups and the centres are well equipped (laboratory, x-ray and minor surgical facilities).

In a Finnish national survey, 71% of physicians who worked or had worked in a primary health care centre in 2000 agreed with the statement 'working as a doctor in a health centre is too often isolated work' [8]. It is important to define the causes of feelings of isolation in more detail in order to better tailor working conditions to GPs’ needs.

The aims of this study were to find out which factors constitute feelings of occupational isolation among Finnish GPs working in health centres and to gain a deeper understanding of this feeling by using a qualitative interview method.

**Methods**

The focus of this qualitative in-depth interview study in 2004 was on investigating the supporting and demoralizing factors of working in health centres as perceived by GPs. Isolation was one of the themes that emerged from GP interviews, and it was further analysed with qualitative data analysis methods with the intent of allowing new viewpoints to emerge freely.

Primary health care physicians were interviewed in six different communities: two small-sized (<5000 inhabitants), two medium-sized (>10 000 inhabitants) and two large (>50 000 inhabitants) communities. All
the interviews were done by one interviewer (M.A.) with knowledge of qualitative research methods and many years’ experience as a GP in health centres but not in these research health centres. We obtained the contact information of interviewee candidates from the chief physician. The physicians were chosen purposefully to obtain the most diversified sample of interviewees [9,10]. Consent for participation and tape recording was obtained before the interviews. A loose interview schedule was designed on the basis of key themes identified from the issues prevalent in former studies on the topic. Emerging new ideas that were not anticipated with the initial schedule were followed in subsequent interviews [11,12].

The interviews were carried out in Finnish in the physicians’ workplace. Their duration varied between 49 and 90 min, and they were tape-recorded and transcribed verbatim.

The interviewer listened to all the audio recordings and verified the precision of the transcription. All the data were entered into a QSRNVivo7 computer software package and examined line-by-line by two researchers (M.A. and P.M.) separately, and the main categories and themes were identified and coded using thematic analysis and constant comparison of the data. We searched thoroughly for all divergent views to form a rich description of different factors. Saturation of data was achieved when no new themes emerged [13].

The study was approved by the ethics committee of Kuopio University Hospital.

**Results**

Thirty-two physicians participated. There were 10 men (31%) and 22 women (69%), and their mean age was 45 years (27–60 years). Many GPs experienced deep feelings of being totally alone the first time they went to a primary health care centre. Introduction to GP work during the first days of work was often scanty. They had attained their theoretical medical knowledge in a hospital environment, working mostly in teams, but now they had to apply their skills in a totally new framework. They had to make many decisions alone, which provoked feelings of uncertainty. On the other hand, they mentioned that the autonomy of a GP was also a good thing.

In the analysis of the qualitative data, we found a rich description of four main themes of feeling isolated: making decisions alone, lack of collaboration with other workers in the health centre and secondary care, not being a part of the work community and lack of mentoring at work. From the organizational point of view, there were four different levels that were common to most of the components of feeling isolated (Table 1). These levels were related not only to colleagues but also to the health care system, specialist health care and the nursing team.

In most cases, GPs made decisions on examination and treatment of patients alone and at a rapid pace. They felt that this necessarily belonged to a GP’s work. However, every one of them had occasions when it would have been indispensable to have been able to consult with another physician. Young doctors especially wished they had a backup.

Consultations by phone were often difficult due to a lack of time or difficulties in contacting specialists in the hospital. For this reason, GPs sometimes made referrals to the hospital in the hope of getting advice in the form of written feedback. However, there was often no feedback to the sender. Doctors also said that sometimes there were inappropriate comments in the consultation answers or there was no adequate answer at all to their

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Table 1. Components of isolation perceived by Finnish primary health care centre physicians at different levels of the health care organization.
problem. GPs felt their work was not always appreciated by hospital specialists. In some health centres, consultations were facilitated by electronic referral feedback systems and having clear agreement on how and when GPs could find consultations in each specialty.

Some health centres bought consultations from private specialists or hired specialists to work in their health centre. GPs thought this arrangement was very good. The consultations were made by an experienced doctor and feedback was given within a couple of days. The patient’s care was not interrupted. If the GPs had an opportunity to attend these consultation sessions, they could absorb information that would help them solve a similar case in the future.

Younger GPs especially appreciated the opportunity to consult with a more experienced GP. However, there was a lack of opportunities to meet each other during the workday. On the other hand, young doctors were unwilling to disturb a busy colleague. In some health centres, younger doctors had a personally named tutoring GP who had a prescheduled appointment time for these consultations. These senior GPs were given remuneration for the time they spent in these sessions, and the young doctors felt they were easier to approach. Some more experienced physicians were concerned that young doctors were anxious about showing their ignorance. A few older female physicians had created a mutual informal email consultation system (Box 1).

GPs had a feeling that distribution of work was done on the terms of secondary care. Many tasks were relegated to primary care without knowledge of their capacity to do them. Instructions were sometimes missing. There was no agreement on distribution of work and further training was needed. On the other hand, it was rewarding to be capable of managing many patients independently without help from others (Box 2).

In small workplaces, the GPs had to do general medical work, which was generally thought to be reasonable and rewarding. However, the possibility of distributing some tasks among GP colleagues helped them in maintaining and improving their special skills.

Some GPs said collaboration with the nursing staff was sometimes deficient. For example, they had difficulties in getting assistance in operations. The doctors felt they could not control their work because receptionists filled the appointment list with more extra patients than they could handle. However, in some health centres, distribution of work between physicians and nurses was more advanced. In these health centres, nurses could have appointments with some chronically ill patients and practice autonomously. Physicians felt this approach was of great help to their workload and appreciated it. Each physician–nurse pair tailored their working methods to suit them both.

Secondary health care was felt to be far away ‘somewhere’. Communication with it was mainly in the form of referrals and written feedback. The health care system was not seen as a shared community of physicians. The GPs felt hospital doctors did not always understand the working conditions in health centres. Some GPs had made personal acquaintances by having worked earlier in the nearby hospital, and this greatly facilitated cooperation with them. Some health care centres had visiting consultants or permanent specialist office-holders. These specialists were felt to be more a part of the working health care community (Box 2).

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**Box 1. Making decisions alone**

*Nowadays this is quite lonely work, lonely and resembling an assembly line. . . . Its good sides are independence and being close to the patients’ life and problems, but it also brings more responsibility, as no one else but you yourself will see the patients. L8*

*Anyway, the work is done alone. There are no possibilities for consultation. And yet the decisions that must be made are major decisions. If you can’t share with someone. If you are a young house officer in hospital you usually make the rounds with a specialist or you can go to the polyclinic and ask, and get support. This is surely a significant thing. L28*

*That you could get help, that you could ask if problems arise. But to go and ask someone, having asked a couple of times and you notice the third time that he/she sighs ‘oh no, I’m already so late and I have to find time to look at someone else’s work, too’. So in such a case no one really wants to go and ask. L1*

**Box 2. Insufficient collaboration**

*And that specialised care would serve us more. And not that they dictate to us to do this and do that. And ‘here’s these follow ups for you and these instructions, now follow them’, and so on. If this relationship were to be turned around, it would affect their attitude towards health care centres, health care centre work and health care centre doctors. Then we would be kings. L21*

*We have specialists come here, consultants. I feel these specialists are like a part of this work community even though we don’t see them all. I don’t see them and I have no personal contacts with them. They feel like the same team, and I get the feeling that we’re doing this work together. And you get correct, good feedback. The feedback from the hospital is mainly on paper, sometimes you get it, sometimes you don’t. But there are no personal relationships, of course not, because they’re out there somewhere. So, very, very rarely, sometimes medical doctors or cardiologists come here. I don’t have personal acquaintances there. L13*
The physicians expected to be able to contribute to their workplace organization and hoped to be kept in touch with what was going on. They valued personal discussions with the chief physician and managers. However, they rarely met and communicated directly. All the physicians could not even name the persons on the management team of their organization.

In some health centres, there were very concise GP communities. They met regularly and spent time together during their spare time. Singly working GPs in a remote satellite workplace tried hard to attend GP meetings in an attempt to be a part of the GP community. On the other hand, in some workplaces, GPs felt they were totally alone even though there were several physicians working in the same health centre. This happened because there was no opportunity to see the other doctors during the course of the working day (Box 3).

Some physicians felt the nursing staff walked over them. Their working pace was dictated by receptionists who did not take into account the physician’s personal needs. They also felt they were isolated workers. However, in some systems with well established physician–nurse relations, the doctors felt they were a concise part of their smaller unit of work. Such teams could also assemble informally and sometimes also met in their spare time.

Box 3. Not being a part of the work community and lack of mentoring at work

Loneliness was a problem where I previously worked at X. I was alone there six years. One of my workmates asked why I came here, was it so I'd have workmates? But I said I’m really almost as much alone here as I was there, (laughter) even though I have a workmate in the next room. Of course, sometimes I feel there are others and I see them, but sometimes it seems it’s all the same whether I’m here or there. So, if there’s someone in the next room, it doesn’t necessarily mean one doesn’t feel alone (laughter) . . . the work is your own work. And you don’t see anyone else unless you go visit them. So it’s lonely work. I guess you have to get used to it in this work. L23

I wish these working conditions would go in a direction where there would be more time also in primary health care to go over some of my own patients. That there would be some kind of workplace meeting where everyone could bring up problem cases and such. That's what they do in oncology, for example. And I think they are very relieved that they can always decide together in difficult matters. I sort of hope for support from my colleagues, even though I am competent enough to work alone. So I guess there'll always be a lonely feeling in some matters. L31

GPs had very few experiences of official mentoring, i.e. Balint groups, and they thought it could become a burden, as the meetings were fixed beforehand and it was hard to withdraw from clinical work. The GPs felt an outside mentor could not fathom the working conditions of GPs. Mentoring in some form was nevertheless seen as necessary.

Other GPs were an important peer support group in difficult cases for instance. Meetings scheduled for other purposes (i.e. drug information meetings) were also used to unburden difficult situations. Shared lunch and coffee breaks were also seen as an important opportunity for confidential discussions between peers. Unfortunately, there was seldom time to have such meetings together. Besides, in some places, the administration had sought to reduce all kinds of meetings. They also lacked feedback on how their work was seen by others. The GPs said that in hospitals where the work was more in teams with many doctors, comments on success or failure were given directly (Box 3).

In health centres where there were well organized work teams, the support given by other team members was seen as very important. All the members of the team had the same patients and could easily discuss clinical and other problems. Teams especially helped GPs who did not have colleagues at their workplace.

Discussion

The qualitative data provided a rich description of occupational isolation experienced by GPs in Finnish primary health care centres. The analysis showed that isolation consisted of many factors. These included the necessity of making decisions alone without the possibility of consulting, feelings of not being a team member in the health centre and in the health care system, a lack of collaboration with other workers and a lack of feedback and mentoring. On the other hand, GPs also appreciated autonomy in doing their work.

The profession of the researcher has been shown to influence the results in qualitative interview research. Some researchers have stated that interviewees give more restricted answers if they think the interviewer does not understand the issue sufficiently [14]. In this research, all the interviews were performed by a GP. She had practiced general medicine for many years and thus knew the field well. Therefore, it was possible to use professional language in the interviews, and being a colleague also helped in gaining the interviewees’ confidence. On the other hand, being a part of the profession may cause some blind spots. The reliability of the qualitative data analysis was augmented by employing two analysts [15].

In a Swiss survey [16], stress from uncertainty was most prevalent among general physicians, women and junior physicians. They also found a significant relationship
between anxiety due to uncertainty and all dimensions of job satisfaction. In our study, we found insufficient opportunities to discuss clinical problems with colleagues and team members in the health centre organization, which will augment uncertainty and may provoke stress.

GPs encounter many emotionally difficult situations, which provokes a need for support [17,18]. Gardiner et al. [19] aimed to improve the psychological well-being of rural GPs with a programme that included formation of a peer support network of experienced GPs and development of networks of GPs and other professionals whom GPs could access. The results showed that the GPs had an increased level of social support and lower levels of rural doctor's distress than in baseline measurements. In our qualitative interviews, the GPs felt a lack of feedback and support in sharing emotionally difficult situations.

Our findings suggest that advanced teamwork could to some extent replace GP colleagues in alleviating feelings of loneliness. In an Australian survey, a good team climate was found to be related to job satisfaction but practice size was not. Rural GPs were more satisfied [20]. The researchers thought that facilitating teamwork may be a key strategy for both recruitment and retention of GPs. Our study found that consultations with peers and discussions of other problems were mostly held when needed, by interrupting the colleague's work or at meetings that were held for other purposes. Having no time to see each other or team members during the workday provoked loneliness, especially in young doctors. Improving partnership arrangements was also found to be a key intervention in a British qualitative study exploring morale among GPs [21]. As in our study, they found that building and maintaining strong and supportive partnerships and practices required protected time and 'space' for partners and practice staff to get together and some slack in daily work routines that allowed personal or group problems to be noticed and tackled proactively.

Physicians have social needs within the work community. The GPs felt they were a part of the GP community but less closely a part of the other personnel and health care organization. In Ireland, stress and morale in general practice were compared between the state monopoly and a mixed private and state funding system [22]. Both groups of GPs reported feeling highly stressed, but the GPs in the state monopoly appeared to be unhappy. In Norway, GPs report a higher level of job satisfaction than in general practice settings. Having no time to share personal or team problems was held for other purposes. Having no time to see each other or team members during the workday provoked loneliness, especially in young doctors. Improving partnership arrangements was also found to be a key intervention in a British qualitative study exploring morale among GPs [21]. As in our study, they found that building and maintaining strong and supportive partnerships and practices required protected time and 'space' for partners and practice staff to get together and some slack in daily work routines that allowed personal or group problems to be noticed and tackled proactively.

Finland is preparing health care reform that will combine smaller primary health care centres to form bigger ones [24]. Our study suggests that this reform should include possibilities to strengthen teamwork and networking and facilitate consultation with peers and specialists, as well as enable tutoring of young physicians and mentoring of all physicians.

### Key points

- In Finland, 71% of physicians who worked or had worked in a primary health care centre agreed with the statement ‘working as a doctor in a health centre is too often isolated work’.
- The analysis of qualitative in-depth interviews showed that isolation consisted of many factors that were related not only to colleagues but also to the health care system, specialist health care and the nursing team.
- Enabling flexible teamwork and social and professional support networks are the key issues in solving the problem of occupational isolation.

### Funding

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### Conflicts of interest

None declared.

### References

20. Ulmer B, Harris M. Australian GPs are satisfied with their job: even more so in rural areas. Fam Pract 2002;19:300–303.