GPs’ experiences of primary care mental health research: a qualitative study of the barriers to recruitment

VL Masona, A Shawb, NJ Wiles, J Mulligan, TJ Petersb, D Sharpb and G Lewis


Objective. To investigate the perceived barriers among GPs towards introducing participation in randomized controlled trials (RCTs) to patients presenting with depression during consultations.

Methods. Qualitative study using semi-structured interviews. Interviews were recorded using a digital voice recorder, transcribed verbatim and analysed using the Framework Approach. The participants were 41 GPs from five primary care trusts in the South West who were collaborating with the University of Bristol on an RCT recruiting patients with depression.

Results. Three themes were identified: (i) concern about protecting the vulnerable patient and the impact on the doctor–patient relationship; (ii) the perceived lack of skill and confidence of GPs to introduce a request for research participation within a potentially sensitive consultation; and (iii) the priority given to clinical and administrative issues over research participation. These themes were underpinned by GPs’ observations that consultations with people about depression differed in content, style and perceived difficulty compared to other types of consultations.

Conclusion. Depressed patients were often viewed as vulnerable and in need of protection and it was seen as difficult and intrusive to introduce research. Patients were not always given the choice to participate in research in the same way that they are encouraged to participate in treatment decision making. A lack of skills in introducing research could be addressed with training through the new Primary Care Research Network. A more radical change in clinician attitudes and policy may be needed in order to give research a higher priority within primary care.

Keywords. Attitudes, depression, GPs, qualitative research, randomized controlled trials.

Introduction

Depression is a common and disabling condition, mostly treated in primary care, with over 27 million prescriptions for antidepressants issued annually.1 Despite this considerable burden, few randomized controlled trials (RCTs) have focused on depression in primary care and existing trials have often failed to recruit to target.2 It is recognized that high-quality RCTs are needed to provide evidence for clinical decision making, but that successful recruitment can be challenging. Although a range of recruitment methods is available, particular difficulties arise when GPs are required to introduce a trial to patients during the consultation.

Considerable effort has been expended in trying to understand the barriers to collaborative research within primary care. A small study of GPs from rural and metropolitan Australia suggested that these barriers can be divided into ‘individual issues’ (for example, lack of research training and experience, attitudes towards research and individual interests) and ‘systems issues’ (for example, funding arrangements, access to...
resources and publication opportunities).\textsuperscript{3} GPs have reported being overwhelmed by requests to collaborate in research\textsuperscript{4–6} and while research can fall low on a GP's list of priorities,\textsuperscript{7} collective ownership, greater perceived relevance and interest in the scientific question increase the acceptability of research.\textsuperscript{8,9} GPs may also feel that researchers have unrealistic expectations and emphasize the need for good communication,\textsuperscript{10} particularly about the administrative aspects of the study.\textsuperscript{7} A number of other factors to encourage GPs' active participation in research and help to improve patient recruitment have been identified and these have been discussed elsewhere.\textsuperscript{11–17}

Although these studies provide insights into engaging health professionals in research, rather less is known about the barriers to recruiting patients once the clinician has agreed to collaborate.\textsuperscript{18} Furthermore, these studies have mainly been conducted in cancer trials in the US\textsuperscript{10} and assume a certain level of motivation and enthusiasm among clinicians involved in recruitment. Their findings therefore may well not be generalizable to GPs recruiting depressed patients in UK primary care. Assumptions about motivation among GPs to participate in research have been challenged by a study showing that despite favourable attitudes towards research among 84% of GPs surveyed in Australia, only 29% wanted more personal involvement.\textsuperscript{11} Of the studies addressing recruitment in primary care, we are aware of only one that focuses on mental health.\textsuperscript{20} and research on recruitment to mental health RCTs in other settings has not focused specifically on patients with depression, despite the notorious difficulty of recruiting patients with depression into RCTs. The aim of this study was to investigate the views of GPs towards recruiting patients presenting with depression into RCTs during primary care consultations, in order to identify the particular barriers to recruiting this patient group.

Methods

Setting

The Medical Research Council (MRC) GenPod trial (ISRCTN 31345163) is investigating genetic and clinical predictors of treatment response in depression. Patients are randomized to receive one of two different classes of antidepressants. Collaborating GPs introduce the study to potentially eligible participants during a consultation and gain permission from them to be contacted by the research team. Formal consent to participate in the trial is secured later by a researcher. It became apparent that even though some GPs appeared keen to collaborate, many had not identified any patients. This situation provided an opportunity to explore the process of recruiting patients to a trial during consultations.

Participants

GPs were recruited from practices that had agreed to take part in the GenPod trial from the five Primary Care trusts (PCTs) operating at that time (Bristol North, Bristol South and West, Bath and North East Somerset, South Gloucestershire and North Somerset). Maximum variation sampling\textsuperscript{21} was used to identify GPs from a range of practices (urban, suburban and rural) with a variety of experiences of recruiting patients with depression into GenPod. The sample was structured by whether the GP was full time or part time (less than or equal to five sessions per week) and the number of patients identified for GenPod (0, 1–2 and \( \geq 3 \)).

Data collection

Semi-structured interviews were conducted to elicit GPs' views about introducing a trial to patients with depression during consultations. A topic guide was developed, drawing on the literature and issues of interest emerging from initial recruitment to GenPod (see Box 1). This was refined in response to issues emerging in later interviews. GPs were also asked structured questions about personal and practice characteristics.

The interviews took place in a location that suited the GP (usually at their surgery) and were recorded using a digital voice recorder and lasted between 17 and 46 minutes. All interviews were transcribed verbatim and the transcripts anonymized. Interviews were conducted until no new themes were emerging from the data, indicating that saturation had been reached.

Analysis

Transcripts were analysed using the Framework Approach, which is a way of organizing and synthesizing qualitative data using a matrix or framework.\textsuperscript{22} There are two stages to the process: data management and making sense of the data through descriptive accounts. A framework is developed from reading the transcripts and coding the data. Within the framework, each respondent has a row and each column is a theme.

<table>
<thead>
<tr>
<th>Box 1 Topics covered in the GP interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>• General views about research and recruitment in primary care.</td>
</tr>
<tr>
<td>• Views about, and experience of, recruitment of patients into trials during consultations.</td>
</tr>
<tr>
<td>• GP's most recent consultation with a patient presenting with a new episode of depression and how the GP decided whether or not to invite the patient to participate.</td>
</tr>
<tr>
<td>• Barriers to recruitment of patients with depression into RCTs compared to other patient groups, for example patients with diabetes or coronary artery disease.</td>
</tr>
<tr>
<td>• Perceived skill deficits, training and resource needs among GPs to enable identification and recruitment of patients with depression into trials.</td>
</tr>
</tbody>
</table>
or subtheme. Raw data, along with some description and interpretation of the data, are included in the relevant cells for each respondent/theme. Thus, the range of perspectives within each theme can be charted. VLM (a health psychologist and psychiatric researcher) led the analysis, but the wider research team discussed the interview topics and emerging themes on an ongoing basis and new lines of questioning were incorporated into subsequent interviews in an iterative process. A subset of transcripts were independently coded by AS (a social scientist and primary care researcher) and Zelda Tomlin (a social scientist and health services researcher). The extent of agreement and variation between the three sets of coding was discussed for each of these transcripts. All authors reviewed and agreed the final broad coding framework to be applied across all transcripts.

Results

Fifty-four GPs were invited to participate. Eight were not contactable (four males and four females) and five refused to participate (three males and two females). The main reason given for not participating was lack of time. Interviews were conducted with 41 GPs (Table 1).

A number of themes emerging from the data relating to GPs’ general experiences of participating in research have been reported by other authors and these are not repeated here.³ This paper describes the three superordinate themes that emerged from the transcripts concerning the barriers to recruiting patients with depression into RCTs during primary care consultations. For each theme, illustrative quotes are provided, representing the full range of expressed views (summary: Box 2; illustrative quotes: Boxes 3–5). Underpinning each theme are views about the content and style of consultations with patients presenting with depression, which shape GPs’ willingness to introduce research in the context of these consultations.

Although we have concentrated here on barriers towards recruiting patients into studies involving patients with depression, it is important to emphasize that the GenPod trial has been exceptionally well supported by the participating GPs, who between them have referred over 600 patients to the study.

Protecting the patient and the doctor–patient relationship

GPs described the presenting symptoms of depression, such as lack of concentration and confidence and low motivation, as barriers to patients agreeing to take part in research (Box 3). Some patients were characterized as too ill, distressed, distracted, inward focused and indecisive to be involved in research and this sometimes constrained GPs’ willingness to introduce the study to them. Many, but not all, thought depression-related consultations were different from other types of consultation, as they were highly complex and often lengthy, personal, emotional and exhausting (both for the patient and the GP). Patients with depression were usually characterized as vulnerable, often leading to protectiveness on the part of the GP. Several GPs saw research as an extra demand that would overburden patients and generate more distress. Concerns were expressed that patients would feel pressurized to participate to please their GP or that patients might not be able to give adequate informed consent because of their level of distress. There were also worries that the RCT may not benefit the patient. In contrast, other GPs stated that trial participation could be a positive experience for the patient and that trial participants might actually fare better.

Among some GPs, there was anxiety that participating in a trial would take the patient out of their direct care, so the patient would feel ‘rejected’ or ‘pushed

<table>
<thead>
<tr>
<th>Table 1  GP characteristics (n = 41)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Mean age (years)</td>
</tr>
<tr>
<td>Mean number of sessions per week</td>
</tr>
<tr>
<td>From a research practicea</td>
</tr>
<tr>
<td>From a training practice</td>
</tr>
<tr>
<td>Research interests</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Number of studies involved in during previous 12 months</td>
</tr>
<tr>
<td>&lt;=3</td>
</tr>
<tr>
<td>4–9</td>
</tr>
<tr>
<td>&gt;=10</td>
</tr>
<tr>
<td>Patients identified for GenPod (range 0–12)</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1–2</td>
</tr>
<tr>
<td>&gt;3</td>
</tr>
<tr>
<td>Patients randomized for GenPod</td>
</tr>
</tbody>
</table>

³Avon Research Primary Care Collaborative practices received NHS R&D funding to support research hosted by their practice.

Box 2 Themes

- Protecting the patient and the doctor–patient relationship.
- Skill, confidence and experience.
- Priority given to clinical and administrative matters over research.
I think it’s particularly difficult sometimes in mental health because the consultations can be quite long and quite emotional anyway… I think it’s been relatively straightforward really. I don’t think I tend to be running 10–15 minutes late on average, and when somebody comes along, during a 10 minute consultation, to have that sort of quantum leap of thought to sort of go from what the patient’s talking about to pursuing something that is entirely your own agenda halfway through a 10 minute consultation, is a tricky one, and to sort of stop and put everything on hold and keep the waiting room delayed for another 20 minutes on top of the 10 minutes that you’re running late already is difficult… to actually sway the conversation over to asking them to participate in a research trial halfway through the consultation is a tricky one. (0704 Male)

I could see that there would be merit perhaps in looking at other ways of being able to introduce this topic to the patients so that it’s not in the consultation and you know I haven’t because I think that as I say I find it very intrusive and but that’s just me. I mean probably lots of other people do it well… I do have a very intimate consulting style, I know I do. And so yes, and so this does feel like a big interruption on it and it feels like it’s tearing away from the rapport that’s been hopefully there throughout a consultation. (3004 Female)

I think it’s been relatively straightforward really. I don’t think… they haven’t shown any… I think the more confident you get about the study, I think that comes across to the patients as well so I think the first recruitment is always the hardest and then after that you feel more confident and then you see the patient come through and you know that they haven’t been abused. (2306 Male)

If you introduced it in such a way and probably just go step by step and see if they are with you, and then it is probably no different to any other sort of consultation process and whether you both think along the same lines. (0202 Male)
Skill, confidence and experience

GPs varied in their perceived ease or difficulty of introducing research to patients in a seamless way, often describing it as a ‘sales pitch’ (Box 4). Confidence related to both their knowledge of the trial and remembering the trial criteria, familiarity with the paperwork, belief in the purpose and clinical relevance of the trial and the acceptability of the interventions. GPs described how confidence was enhanced through improved knowledge of the trial and the protocol and through having a ‘stock phrase’ or ‘patter’ about the study that they felt comfortable with.

Prior responses of patients invited to participate in research, and the manner in which they agreed or declined, impacted on GPs’ willingness to introduce research to subsequent patients. Some GPs described feeling inept, rejected or uncomfortable if patients declined or were not eligible to participate or if they had not introduced the research seamlessly or confidently. If patients detected their GP’s uncertainty about introducing research, there was some concern that this might compromise their trust and confidence in the GP.

Some GPs described the introduction of research as intrusive. Intrusiveness related to how and when during a consultation the research was introduced to the patient, and how comfortable GPs felt about stepping outside their usual clinical role. There was considerable diversity in views. Some GPs perceived it as disrupting the normal ‘flow’ of a consultation, particularly when the patient was very distressed. Alternatively, research was something introduced at the end of the consultation, adding to an already complicated encounter. Some GPs did not want to introduce their own or the researcher’s agenda, as they saw this as diverting attention from the patient’s needs. GPs with less experience of introducing research to patients tended to view it as more intrusive and were more cautious. Those with more experience also expressed some misgivings about intrusiveness, both within the consultation and to the smooth running of the practice.

The extent to which GPs felt at ease introducing research depended partly on the broader culture of their practice. Those from less research active practices sometimes perceived that patients did not expect to be asked to participate in research, contrasting with those from practices with an active research culture, where patients were used to such invitations.

Priority given to clinical and administrative matters over research participation

This theme relates to the perceived role and responsibilities of GPs, the competing demands of clinical practice and views about the value of RCT evidence for patients with depression (Box 5). GPs from a range of practices expressed commitment and a strong belief in the value of research, which was accompanied by evidence that they had recruited patients into the trial. However, many GPs reported a perceived degree of divergence between their clinical goals and responsibilities and the goals and responsibilities of researchers. GPs saw their primary role as caring for and treating the depressed patient, which some perceived to conflict with researchers’ aims of collecting data and even ‘furthering their own careers’. Thus, some GPs questioned whether there was any long-term benefit to patients who participated in research.

While the majority of GPs acknowledged the value of research in principle, some expressed unwillingness...
to engage in research or take responsibility for it themselves in practice, particularly because of the length and perceived complexity of consultations with patients with depression. They often expressed positive views about others doing so, for example enthusiastic and keen colleagues or GPs in other practices, and expressed a preference for recruitment to studies to take place without direct GP involvement. For some GPs, research was not perceived to be part of their role, professional identity or practice culture, and they did not feel a particular responsibility for creating an evidence base.

Some GPs were less likely to collaborate in research projects because they did not regard most research as valuable for clinical practice in primary care. Both RCTs and clinical experience were seen as valuable sources of evidence on which to base clinical decisions for treating patients with depression. For example, GPs perceived that RCT evidence was difficult to apply to individual patients, particularly given the complexity, variability and subjective nature of mental health problems. It was suggested that what works for the ‘average’ patient, as identified in trial evidence, is not always a helpful form of evidence compared to their own clinical experience, for example, of tailoring treatment to individual patients through their knowledge and experience of the way patients respond. For depression, a GP’s knowledge and experience of their patient was important, including previous response to antidepressants.

Thus, experiential knowledge was often seen as more accessible and relevant than scientific knowledge, which might not apply to all patients. Views about the importance of RCTs and their position as the ‘gold standard’ were held simultaneously with a questioning of the relevance of RCT findings in general practice and cynicism about the value of published research.

Other demands competing with research included time pressures, competing service delivery demands [including collecting information for the Quality and Outcomes Framework (QoF)], administrative tasks and increasing bureaucracy, short appointment times and the pressure to avoid delay, disruption and overrun. Agreeing to participate in too many research studies was also an issue. These were particularly true of consultations with patients presenting with depression because they were perceived to take up more time because of their complexity.

Discussion

Three themes relating to perceived barriers were identified. These themes were as follows: (i) a desire to protect the doctor–patient relationship; (ii) perceived lack of skill and confidence in introducing research in a seamless fashion; and (iii) the priority given to clinical and administrative matters over research participation. Although diverse views were expressed, including positive attitudes, this paper has given greater coverage to the negative views expressed by GPs, which, it is hoped, will lead to enhanced understanding of the barriers to recruiting depressed patients into RCTs. Furthermore, the heterogeneous views expressed appeared to relate more to the individual GP than to gender or type of practice. Similar themes have been identified previously in a study investigating GPs’ views on failure to recruit. However, only the views of six GPs were represented and that study focused on the nature of the intervention (comparison of Beat the Blues, cognitive behaviour therapy from a clinical psychologist and usual care from GP) and the need to engage GPs through evidence about equal efficacy. We have found additional issues relating to skill and confidence.

Underpinning the themes is the view that the content and style of consultations with depressed patients are different from, and sometimes more difficult than, other consultations in primary care. The problems associated with fixed consultation length are particularly salient in the case of patients with depression, because of the greater demands on GPs’ time that such patients can make. This supports the findings from previous studies that the structural constraints of general practice can present problems for GPs recruiting patients into studies. However, our study suggests that in consultations with patients about depression, such constraints can be compounded by the perceived vulnerability of patients.

Some GPs did not introduce research in order to avoid making extra demands on the already distressed patient. However, this suggests that patients may not be given a choice about taking part in research. These paternalistic attitudes run counter to repeated calls for an increase in shared decision making in treatment decisions. Although it has been suggested that paternalism is justified if patients are not of ‘sound mind’, most patients presenting with depression in primary care can make informed choices about the options available to them, and this could also include considering participation in research. It appeared that the paternalism was usually unintentional and rationalized as a concern about introducing the GP’s own agenda. We suspect that many patients would like to be given the opportunity to decide themselves about taking part in research, though there is little research on this topic.

The Evidence-Based Medicine movement has tried to argue that research, particularly RCTs, provides better evidence than clinical experience but we came across much scepticism among GPs about the value of research evidence. We were surprised that some GPs were so confident about decisions made upon the basis
of individual clinical experience, though this supports the notion of ‘tacit knowledge’ in guiding clinical judgement.\textsuperscript{26} The view that what works for the average patient does not necessarily translate to specific patients might be particularly important in depression.

For some doctors, there was a belief in the value of research along with a simultaneous and potentially contradictory wish to avoid active participation. This presents a barrier to recruitment and supports the findings of Askew et al.\textsuperscript{11} from Australian GPs. This ambivalence echoes the NIMBYism (‘Not In My Back Yard’) found in environmental contexts, whereby regardless of how favourably an issue is viewed, individuals do not want it to occur in their own environment. Such attitudes are worthy of further investigation given that ambivalence has been shown to attenuate the relationship between intention and behaviour in other contexts.\textsuperscript{27}

Embedding this study within the GenPod trial enabled exploration of GPs’ actual experiences of recruiting, attempting to recruit patients and of agreeing to recruit but, in practice, not recruiting, rather than questioning GPs about hypothetical situations. The interviewer was a previous GenPod researcher, which may have influenced the openness of GPs. However, participants were assured about confidentiality and were open and frank in their comments. A maximum variation sample was obtained, although those not wishing to participate or who could not be contacted may have held different views. However, saturation was reached, with no new themes emerging from additional interviews. All GPs were from practices that had agreed to participate in GenPod, so it is likely that those with more sceptical views of research were not represented. We therefore think that our conclusions will be reasonably transferable to other primary care-based trials involving patients with depression and may also be relevant to trials in other areas of medicine within both primary and secondary care and to other countries.

Three key recommendations emerge from this work. First, GPs described several reasons why they believed that patients did not wish to participate in research. The perspective of patients with depression who are invited to take part in RCTs should be investigated to address some of these assumptions about the expectations held by patients. This could be a useful way of tackling perceived barriers to research participation. It also has implications for clinical practice; the drive for joint decision making also applies to research participation as well as choice of treatment. Second, we identified a need to develop skills training in how to introduce research into consultations. This appears to be particularly difficult in consultations for mental health problems but, as far as we are aware, clinical training at an undergraduate or postgraduate level has not addressed this issue.

Our third recommendation concerns the need for cultural change. Research is given a low, perhaps the lowest, priority within clinical settings. Finding out what benefits patients and improving our understanding of disease is an essential part of health care. There is a sense in which health services are urgently carrying out activities of unknown benefit or harm, leaving no time for the research that might discover those treatments that truly improve outcomes. The Department of Health, the General Medical Council (GMC) and other professional bodies could adopt policies, for example using the QoF or GMC guidance on conduct and training, that could have a profound influence on the culture surrounding research participation in the UK. More broadly, the scientific basis of medical practice is as important as care informed by humanitarian concern. Caring for patients also involves discovering what treatments are effective and what is harmful. Providing patients with an opportunity to take part in research studies is a role for all medical practitioners that will contribute towards the knowledge that is needed to properly treat and care for sick people.

Acknowledgements

The authors wish to thank all the participating GPs, Professor Jenny Donovan for discussion regarding study design and Zelda Tomlin for independent coding of transcripts and for commenting on an earlier draft. Contributors: VLM conducted the interviews. VLM, AS and Zelda Tomlin analysed the data. VLM wrote the first draft. All authors were involved in interpreting the data and preparation of the manuscript.

Declaration


References


