Work-life integration in interprofessional general practice collaboration: a qualitative exploration of different trends among Bavarian general practitioners

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ABSTRACT

Objectives Problems with healthcare provision in general practice are already present and expected to worsen in the future. Therefore, retaining medical professionals in the long-term. An important factor in deciding on a profession is its compatibility with one's own life. This study aimed to examine general practitioners' working environment, social environment, their current work-life integration and potential changes enabled by interprofessional working concepts.

Design A qualitative approach was used, with guided focus group interviews with 37 general practitioners followed by individual interviews with 10 general practitioners. The interviews were verbatim transcribed and analysed using the framework method. The primary analyses were conducted, overall and separately for each gender. A professional group also carried out analyses. The subgroup analyses are based purely on qualitative trends.

Results Both genders and all professional groups perceived work-life integration as necessary. Men tended to report a better work-life integration than women. Women were more likely to work part-time and emphasised difficulties with childcare. When establishing interprofessional concepts, participants hope for more opportunities for delegation and co-determination, which can go hand in hand with reduced workload.

Conclusions In this current study, women tended to perceive a greater degree of double burden both in their job and leisure time than men did. Beyond these gender and professional group differences, there were also tendencies towards differences between women with and without children. The findings indicate that work-life integration is an important factor in the professional setting of general practice. Particularly given the increasing number of female general practitioners, the establishment of part-time and childcare options is necessary.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The study includes extensive data material from 32 interview participants.
⇒ The study paid attention to independent reviews of transcription, coding and evaluation of data material in a research team with medical and non-medical research assistants.
⇒ The study was conducted exclusively with general practitioners from Bavaria, which limits its transferability to other regions.
⇒ The study participants showed little variation in terms of their social environment and family life (mostly in partnerships, with one to three children).

BACKGROUND

Introduction

Providing comprehensive medical care close to home is a fundamental goal of general practice.[1] However, demographic changes and existing challenges in healthcare provision[1 2] make it increasingly difficult to ensure this care in the long-term. Doctors, particularly general practitioners (GPs), also fear that this will pose a significant challenge to patient care.[3] To address this, it is crucial to retain existing healthcare professionals[2] and to implement sustainable, interprofessional care models.[3] Interprofessional care models and collaboration can be defined as the involvement of different professional backgrounds to provide holistic healthcare.[4 5] General practice plays a key role in this transformation and must therefore adapt to societal developments, particularly the growing importance of work-life integration.[6] A team-based general practice is one way to implement interprofessional care models in a general practice setting, involving non-medical, academically trained healthcare professionals, such as physician assistants and primary care managers. It also offers a promising framework enabling both high-quality care and more flexible, family-friendly working conditions.

State of research

A key factor that motivates medical students to choose general practice is the potential for good work-life integration.[3 7] People currently working', especially the next generation, attach great importance to work-life integration.[8 9] Work-life integration can be defined as the individual perception that professional and non-professional activities are compatible.[10] An adequate work-life integration is not only crucial for one's mental health, but also for the containment of stress and anxiety.[11 12] Measures aimed at promoting a high level of work-life integration may also lead to increased productivity, engagement and motivation.[13] Additionally, factors such as low job satisfaction, high stress levels and an imbalance between work and leisure time can affect the quality of care provided to patients.[14 15] To improve work-life integration and reduce stress, GPs are now increasingly turning to part-time working arrangements.[11]

However, as practising physicians try to fulfil several roles simultaneously,[16] they face tension between their work and private life.[11] This challenge is exacerbated by the fact that, even in studies conducted in the past few years, female doctors attach great importance to both their careers and their own families.[17] Accordingly, a high degree of work flexibility is necessary to improve personal work-life integration.[8 18] However, flexibility is limited by the fact that, despite the increased use of digital applications, a large proportion of general practice work still needs to be done on-site and not from home.[19] In addition, doctors' work-life integration is limited by long working hours, the prevailing unpredictability of working hours, a high proportion of administrative work and a lack of time for their own families.[16] According to the Job Demands-Resources Model,[20] the profession of a GP can be characterised by particularly high responsibility, emotional strain and complexity. Although physicians exhibit higher levels of resilience than the general population, they also show higher rates of burnout and emotional exhaustion, even among those with high resilience scores.[21 22] Given the specific working conditions of GPs, it cannot be assumed that findings from studies on work-life integration in other professional groups can be directly transferred to GPs.

Although integration between private and professional life is a decisive factor for a satisfying GP practice,[11 23] previous studies indicate that doctors' work-life integration is somewhat unsatisfactory. A study of 417 British doctors found that only 26% of participants were satisfied with their work-life integration.[24] In another study, more than one-third of 214 German GPs reported a high level of emotional exhaustion.[25] Subsequently, in a survey of 548 German GPs, one-third reported a high personal prevalence of burnout.[15]

Derivation of the research questions

On the one hand, research and the testing of improved general practice concepts are necessary to maintain primary medical care. At the same time, the importance of reconciling work and family life is increasing. Work-life integration is an important factor in enabling people to perform their work productively and satisfactorily over the long-term. Furthermore, due to skills shortages and demographic change, it is important to retain and support trained healthcare personnel in this profession over the long-term.

As the establishment of new organisational and work concepts also creates new demands on those working in general practice,[26] it is necessary to conduct qualitative research into what is essential to GPs in establishing interprofessional practice concepts, including their work-life integration.[25] Due to the existing shortage of GPs, factors that increase satisfaction with one's work should therefore be identified and strengthened.[3 27]

The work-life integration of doctors from Germany has already been analysed in the inpatient setting.[28] There are also systematic reviews on current work-life integration among doctors in Asia.[29] Furthermore, there are findings on the work-life integration of women and men in medicine and psychology, although these date back more than 20 years.[30] As a result, there is a lack of current studies of outpatient GPs regarding work-life integration, especially in relation to current social challenges and transitions to interprofessional collaboration.

The following research questions were therefore formulated as part of this study:

- How do the participating GPs assess their current work-life integration?
- How do they describe their everyday working life and their social environment (eg, the presence of and relationship with family, friends, work colleagues and neighbours)?
- How do the participating GPs assess their future work-life integration? What changes in the work-life integration and the everyday working life do the GPs anticipate from interprofessional concepts of general practice collaboration?

To answer the questions, participants were asked about both their current and future situations regarding work-life integration. The results were to be presented in terms of qualitative trends for the entire sample and in relation to specific characteristics, such as gender and professional group.

METHODS

Study design, data collection, processing and analysis

The study described here is categorised as a substudy of an overall project conducted by the Bavarian General Practitioners' Association and the Institute of General Practice in Augsburg. The overall project focused on the willingness of Bavarian GPs and non-physician healthcare professionals, both academic and non-academic, to transform their practices regarding interprofessional teamwork. The qualitative subsurveys of the medical professional groups are reported below.

In the substudy reported here, semi-structured guideline-based focus group interviews and individual interviews with GPs were conducted virtually via the online platform Zoom from April 2024 to July 2024. The respective guidelines were formulated deductively based on the preceding literature research and checked for content and technical quality as part of a pre-test with employees of the Institute of General Practice in Augsburg (see online supplemental file guidelines). The focus group guidelines included questions on communication, organisation, framework conditions and practice visions. As a further development, previously known interprofessional concepts and best-practice criteria of a future general practice approach were queried during the individual interviews. Furthermore, the interviewers asked in-depth questions depending on the information provided by the participants. In addition, both interview formats gave participants the opportunity to raise their own open topics. It was estimated in advance that the focus group interviews would last approximately 60–90 min and the individual interviews approximately 45 min. The actual duration ranged from 30 to 105 min, with individual interviews tending to be shorter than focus group interviews.

All interviews were audio-recorded using a recording device. The recordings were verbatim transcribed and pseudonymised using the noScribe software. The transcripts were coded and analysed using MAXQDA software in accordance with the topic blocks listed in the guidelines. Both the transcriptions and the analyses were carried out by one member of the project team, consisting of four people and checked independently by another person. The independently performed codings that did not match were then discussed and agreed on. The content analysis was primarily conducted deductively, following the principles of the framework method.[31] Excel was used for the category-specific and content-specific summaries. As gender-specific differences were already apparent in the category-based evaluation and are also evident in the existing literature on perceived work-life integration,[2 6 12 15 25 32–34] the primary analyses were conducted separately by gender. In addition to the participants' gender, there were differences in their career stages, which is why profession-specific analyses should complement the gender-specific perspective. Even though these are qualitative analyses with a smaller sample size, the aim of the study was to analyse the research questions in a differentiated manner based on the gender and professional group differences known from the literature regarding other topics. It is important to note that the study can only highlight trends in the differences between genders and professional groups, as the analyses were conducted on a purely qualitative basis.

Sample description and recruitment

Participants were recruited through short articles on flyers and homepages, existing networks and direct mailing lists of Bavarian general practitioners. The homepages in question were websites belonging to the Bavarian Association of General Practitioners e.V. (BHÄV), which referred to the project, provided information on the study's content and methodology and included links to the contact details of those conducting the study. Initial contact was mostly made via email. The dates for the focus group and individual interviews were chosen based on the time preferences of the interested parties. All participants in the interviews provided a signed, informed declaration of consent. People who did not meet the target population criteria or did not respond could not be included in the study. Overall, the drop-out rate was approximately one-third. Recruitment was discontinued when no new topics arose during the interviews.

A total of n=37 doctors participated in the focus group interviews. Most participants (n=23) were doctors in further training (GP trainees). Additionally, n=6 employed and n=8 self-employed GPs participated. For the individual interviews, participants from the focus group interviews were requested who expressed a high degree of openness towards new concepts and showed interest in the above-mentioned research topic. Individual interviews were conducted with n=10 GPs. Table 1 summarises the characteristics of the focus group and individual interviews.

Patient and public involvement statement

The research questions, outcome measures and study design were formulated based on the existing literature, comprising research findings and practical experience. Literature addressing the patient's perspective was also consulted for this purpose. However, there was no further active patient involvement in this regard. Similarly, no patients were involved in the recruitment or conduct of the study, as the study was limited to healthcare professionals and their views.

The participants, healthcare professionals involved in this study, had the opportunity to check the status of the evaluation at any time. A summary of the initial results was sent to participants who had indicated that they wished to be informed of the results, for their information and to give them the opportunity to comment and criticise. Participants also had the opportunity to view their own transcripts, after which they could have had text passages deleted. None of the participants took advantage of it.

RESULTS

Results of the overall sample

The overall topic of work-life integration was surveyed among participants who are currently practising. Participants were asked to rate their current work-life integration, their everyday work life and their social environment. They were also asked to outline positive and negative predictions of change resulting from the introduction of interprofessional collaboration concepts. Participants also had the opportunity to express any existing wishes and provide additional comments.

Table 1 Characteristics of the participants in the focus group and individual interviews

Characteristics		Female	Male	Overall
Focus group interviews				
	Self-employed	n=4 (10.81%)	n=4 (10.81%)	n=8 (21.62%)
	Employed	n=4 (10.81%)	n=2 (5.41%)	n=6 (16.22%)
	GP trainees	n=17 (45.94%)	n=6 (16.22%)	n=23 (62.16%)
	Overall	n=25 (67.56%)	n=12 (32.44%)	n=37 (100.00%)
Individual interviews				
	Self-employed	n=1 (10.00%)	n=1 (10.00%)	n=2 (20.00%)
	Employed	n=1 (10.00%)	n=1 (10.00%)	n=2 (20.00%)
	GP trainees	n=4 (40.00%)	n=2 (20.00%)	n=6 (60.00%)
	Overall	n=6 (60.00%)	n=4 (40.00%)	n=10 (100.00%)
Focus group interviews				
	Age (in years)	M=37.72 SD=8.91	M=37.08 SD=4.83	M=37.51 SD=7.76
Individual interviews				
	Age (in years)	M=35.83 SD=4.88	M=36.25 SD=3.10	M=36.00 SD=4.06

GP, general practitioner; M, mean; n, quantity; SD, standard deviation.

The results of the overall sample, comprising focus group and individual interviews, are presented in tabular form (table 2) below, followed by a detailed consideration of gender-specific and profession-specific trends.

Results by gender and professional group

The results are presented below by gender and professional group. The subgroup analyses are based solely on qualitative trends. Overall, there were only minor differences between the medical professional groups (self-employed GPs, employed GPs and GP trainees). The trends regarding differences between the genders were more pronounced. Whenever differences between professional groups in individual categories became apparent, these are listed in the following text.

It was noticeable that men more frequently expressed ego-related wishes, while women tended to express more neutral arguments in response to the questions posed. Women were more critical of their behaviour, stating, for example, that they could not be a perfect doctor and a perfect mother at the same time. In the case of employed and self-employed doctors, the proportion of women and men speaking during the focus group and individual interviews was notably higher than that of men. In addition, female GP trainees explicitly expressed the wish that male colleagues should be more engaged in matters relating to the compatibility of work, family and leisure time.

Current situation

While most of the participating men worked full-time, half of the women reported working part-time. Part-time employment was only reported by the participating male employed GP, who had a 90% employment rate. Female GP trainees reported working part-time (mostly 50% employment). These differences were evident even though the social environment, regardless of gender or professional group, was described similarly by almost all participants: living in a partnership with one to three children to care for.

Although men also mentioned the challenge of balancing job work and care work, women tended to emphasise having little free time and problems with childcare. Women leaned to report a higher level of double workload in their job and leisure time. However, men were also concerned about childcare; for example, one employed doctor expressed the need to make decisions with his wife regarding childcare. Across professional groups, men gave the impression of being more satisfied with their existing social networks than women.

Overall, female GPs rated their own work-life integration from a subjective point of view as average to good, while male GPs rated it from a subjective point of view as good to very good. Self-employed GPs tended to report the lowest work-life integration, regardless of gender. Employed GPs and GP trainees tended to report feeling relieved by their employment, with this effect more pronounced among men. While it seemed as though women had hardly any time for leisure activities and friendships, men seemed as if they were able to achieve a sufficient work-life integration:

> But my current work-life integration as an employed doctor is very, very good. (GP trainee, male, 30s)

In principle, the female GPs tended to express a desire to manage and organise their practice and the independence this would entail. Female GP trainees also often

Table 2 Results of the overall sample of focus group and individual interviews

Categories	Results of the overall sample	Interview examples
1 current situation		
1.1 everyday working life	Working in different practice systems Working in urban and rural regions possibility of home office for a small proportion of work	
1.2 social environment	Most participants in partnership Most have children of their own (from infancy to adulthood)	
1.3 current work-life integration	Well-being: high awareness of work-life integration; greater well-being in employment than in self-employment Workload: high workload; improved ability to plan in the outpatient sector compared with clinical routine Family: need for childcare support Leisure time: difficulties in balancing work and leisure time	'The working hours are such that I can also see my family and have something to do with my children.' (GP trainee, male, 30s) 'I work full-time, have three children of my own aged four, six and eight. I'm married and do a bit of music on the side and yes, there's not much time left over apart from family and work.' (Self-employed, male, 30s)
2 future situation		
2.1 positive changes due to interprofessional collaboration	Well-being: greater satisfaction Workload: increased opportunities for delegation Quality of care: possibility of increased and more intensive patient contact	'Everyone can concentrate on what they want to do, what they have learnt, what they can do and then have more resources and capacity to continue their training, think further, develop new ideas, devote more time to patients.' (Employed, female, 40s)
2.2 negative changes due to interprofessional collaboration	Workload: increased time spent on bureaucracy and meeting	'(I)would personally get more involved with my character and my approach and then of course I would be a bit more involved and live it more at home.' (GP trainee, female, 30s)
2.3 existing wishes	Well-being: co-determination of work organisation; flexibility of working hours; separation of professional and private matters; increased rest breaks; improved childcare in practices Workload: short journey to the workplace	'My bosses decide when the practice is closed for holidays. I don't really have a say in that.' (GP trainee, female, 30s) 'If I was alone in the practice, I wouldn't want to be called every weekend.' (Employed, male, 30s)

GP, general practitioner.

expressed the desire to run or help shape a practice. However, they are concerned about losing their work-life integration as their responsibilities increase. One female GP, who has been self-employed for several decades, also expressed her concerns in this regard:

> It's difficult with small children and being self-employed. (Self-employed, female, 60s)

Self-employed and employed GPs, as well as GP trainees, tended to report fears about the possibility of an increasing workload in the future:

> I have great fears as to whether it can continue to be sustainable as a practice owner, that I can still have this work-life integration. (Self-employed, female, 40s)

Even though male GPs, especially self-employed GPs, also tended to complain about a subjectively high workload and found self-employment particularly challenging in the first few years after the birth of their child, they showed fewer fears regarding their self-employment compared with their female counterparts. In addition, both male self-employed and employed GPs reported difficulties working with part-time staff and tended to be more critical of the part-time concept than female GPs.

Regarding their own families, employed GPs, especially the male ones, leaned to emphasise the importance of deciding within their own families to organise their private lives. Male employed GPs and male GP trainees suggested they could see a particular difficulty when both parents want to or must work in the context of parenthood. On the other hand, regardless of professional group, women tended to emphasise that their child planning was sometimes held back by their professional situation.

Future situation

Self-employed GPs tended to hope that switching to a team practice concept would improve patient care,

enhance care quality and increase satisfaction within the practice team. A male self-employed GP expected, above all, increased resilience in the entire work team and an associated sense of togetherness:

> But it was really, really important for me that I'm no longer the lone wolf that I once imagined myself to be. (Self-employed, male, 30s)

Employed GPs and GP trainees primarily cited a desire for improved work-life integration, specifically through optimised collaboration and task distribution. GP trainees in particular primarily cited greater personal satisfaction as a possible positive outcome, driven by the interprofessional concept of collaboration.

In terms of workload, female GP trainees tended to express interest in a 4-day work week, improved work distribution and greater autonomy in time management. According to the participating employed women, these factors would increase their chances of becoming self-employed. Although men already tended to rate their work-life integration higher than women did, they tended to express hope for improved work-life integration through interprofessional team practices.

Both women and men, regardless of professional group, hoped for improved quality of care, with male participants specifically aiming to optimise patient management and to allocate appointments more quickly.

Female self-employed GPs tended to fear that the switch to a team practice would not lead to greater freedom for practice managers. Instead, they tended to fear being assigned additional management tasks. Male self-employed GPs did not express these fears in the interviews of this study. Female GP trainees tended to fear the blurring of boundaries between work and leisure time as a possible negative change. They also expressed concern that new concepts would not relieve the burden on practice owners and that additional management tasks could increase the workload. In contrast, the male GP trainees tended to speculate that the individual practice staff would have a narrower field of expertise due to the increased distribution of tasks and would gain less insight into different subject areas.

Regarding the future development potential of women in the professional context, female self-employed GPs would tend to prefer to see a stronger gender-specific focus in the creation of general practice framework conditions and the organisation of GP practices. In addition, they would tend to like to see improved childcare options, the ability to plan the working hours well in advance and greater involvement of men in women-centred topics:

> So, this is incomprehensible to me, why it must be like this at all, begging for childcare. And that also makes me angry, quite honestly. (Self-employed, female, 40s)

This also aligns with the statement that female GP trainees tend to consider it necessary to agree on procedures, work schedules and work tasks. Planning well in advance tended to play an important role for female GP trainees in the interviews.

On the other hand, men, regardless of their professional group, tended to quote enjoyment of work and the most essential possible degree of freedom as desirable. For example, one male GP trainee expressed a wish to be able to take his own child to the doctor's surgery without having to make an appointment. Specifically, regarding male GPs, they would like more options, such as working from home, and a positive working atmosphere across the team. The male employed GPs tended to hope that digital structures will be put in place to reduce workload, and would like to involve as many different professional groups as possible in team practice concepts. This contrasts with the opinions of the participating women, who expressed a particular desire to exchange ideas with their professional peers.

DISCUSSION

Statement of the principal findings

A total of 37 participants (self-employed GPs, employed GPs and GP trainees) were interviewed in focus groups and individual interviews. Taking socio-demographic differences into account, participants showed gender-specific varying trends. Different trends across professional groups were relatively rare and primarily reflected the fact that self-employed GPs tended to make relatively more statements about the entire practice team, while employed GPs and GP trainees mainly spoke about themselves. The participating doctors worked in various practice systems, both in urban and rural areas of Bavaria. Female doctors were more likely than male doctors to work part-time. Female GP trainees worked part-time. Whether the participants worked full-time or part-time did not necessarily depend on their private situation: regardless of gender and professional group, most respondents were currently in a permanent partnership and had children of their own. Overall, there was a high level of awareness of the concept of work-life integration. Participants' work-life integration was rated subjectively as average to very good, with men tending to report slightly more favourably than women. Regardless of gender, self-employed GPs tended to show the lowest level of work-life integration. Women reported having hardly any free time and were facing childcare challenges. It also happened that women postponed having children due to their professional situation. Through interprofessional collaboration, the participants expected greater satisfaction, increased delegation options and an improved quality of care. However, women—especially self-employed ones—tended to fear that more time would be spent on new management tasks and meetings. There was an increased desire to organise everyday working life and to have greater flexibility in terms of time and place, especially among female GP trainees.

Comparison with other studies

In this study, participants perceived of work-life integration as essential and demonstrated a high level of awareness of

it. Consistent with the current study situation, the general work-life integration was rated subjectively as average to good.[12] Contrary to previous findings,[6] in which women rated the compatibility of work and private life as more important than men did, no different trends by gender were found in this regard in the present study. In addition, previous studies have shown that women are more likely than men to reduce their working hours under the same family circumstances.[23] This tendency was also not found in this study. Since gender-specific differences perceptions of work-life integration have already been identified in the existing literature,[2 6 12 15 25 32–34] and general practice is increasingly interested in female physicians,[2] this study employed analyses that included gender-specific trends. Previous findings showed that men had a better work-life integration than women.[12] Following this, women reported more frequently feeling a double burden of work and family.[30] A similar pattern was also observed in this study. This is consistent with earlier findings indicating that female physicians are at a higher risk of burnout than their male counterparts, with burnout risk in women being predicted by levels of control in the workplace.[35] The fact that women are more likely to feel a double burden of work and private life may also explain why women work fewer hours and do less overtime than men.[23] Regardless of gender, self-employed GPs tended to report the lowest work-life integration among the professional groups in the interviews. The fact that female GPs and GP trainees in this study worked part-time more frequently and considered part-time concepts to be more important is reflected in previous findings:[6 30] the opportunity to work part-time seems to be more important for women than for men. Additionally, 80% of male medical students surveyed after their practical year stated that they wanted to work full-time, whereas only 40% of female medical students did so.[36] In this context, one's family model appears to play a role: while in a survey of female urologists, over 90% of women without children worked full-time, only 36% of female urologists with children reported working full-time.[19] These findings are also consistent with the fact that raising children plays a greater role in the career decisions of female doctors than male doctors.[23] Regarding the desire for increased opportunities for part-time work, it should be noted that part-time employment is associated with a lower income than full-time work. The extent to which this phenomenon influences the desire for more part-time opportunities remains unclear in the current literature. Some findings suggest that women in leadership positions, in particular—a category that may include GPs—perceive a financial loss when working part-time.[37] In contrast, other studies indicate that concerns about financial decline are primarily observed among lower-income groups, to which GPs do not belong.[38] Despite the reduction in income, a decrease in working hours may be associated with an overall improvement in quality of life, better health and more time for social relationships.[38] Thus, despite the potential tension between reduced working hours and reduced income, and the expansion of part-time work options can still be considered beneficial.

In contrast to previous research,[12 33] this study did not tend to show higher levels of work stress among women than among men. Consistent with previous findings, satisfaction with one's own work cannot be explained by working hours. Doctors who work fewer hours are therefore not more satisfied than doctors who work more hours.[39] In this study, the workload, in relation to professional work, was rated subjectively as similarly high by both genders. Although there were no different trends by gender, there were different trends by professional group: self-employed GPs tended to rate their work-life integration worse than employed GPs and GP trainees. However, the results on work-life integration align with previous scientific findings: work-life integration is perceived as a greater challenge for women than for men.[40] In addition, women feel more stressed by the interface between work and private life, whereas men are more likely to be stressed by primarily work-related factors.[34] Female doctors prioritise their family's living conditions when considering their professional activities.[2] Even though the traditional division of labour between women and men in the private sphere has been broken down to some extent, society tends to assign women the role of childcare and men the role of financial security.[32] This may explain why women are more likely to emphasise childcare problems when discussing their work-life integration. In this context, some female GPs expressed a desire for increased availability of external childcare. However, this should not be regarded as a universal solution for all families. A tension may arise between the wish for external childcare and feelings of guilt. Accordingly, increased provision of external childcare may not be suitable or beneficial for every family; nevertheless, expanding structural provision in this area may still provide relief for some families.[35] The analyses by *Parida et al*[24] also showed that women tended to report more job-related losses in their leisure time than men: 87% of the participating women reported that work had a negative impact on their hobbies. In addition, 64% of the women had already postponed starting a family due to their work situation.[24] This study did not find that female doctors have higher satisfaction levels than male doctors.[15] In this study, both women and men tended to report a desire for greater personal satisfaction through the establishment of interprofessional general practice teams. Female GP trainees tend to hope for concrete changes, such as a 4-day work week, a more equitable distribution of tasks and optimised time management. Whether satisfaction will increase in larger team practices with interprofessional co-operation within the practice team needs to be investigated. The results of studies to date have been mixed: while one study found that GPs in joint practices were happier than those in individual practices,[15] another study reported higher burnout prevalence among participants in joint practices.[25] Regarding ensuring future care and recruiting staff in the general practice sector, it is

important to consider work-life integration as a decisive factor in GP care.[11 23] Considering the needs of female and male GPs is therefore important for future workforce planning in the healthcare sector.[23] At present, it is difficult to predict the impact of ongoing developments, such as the increasing feminisation of the GP profession, on the availability of primary healthcare services.[23] The current study situation is ambiguous in this respect, and findings on possible different trends by gender, particularly regarding the quality of care, are rare.[23] Some results indicate that GPs working part-time can have a negative impact on patient care in terms of accessibility and continuity.[39] There is also research showing that GPs with longer working hours have better doctor–patient communication.[39] However, these findings are offset by the lack of differences in patient satisfaction between full-time and part-time workers.[39] To guarantee comprehensive care in the future, it is important that existing different trends by gender in care are considered. For example, women in Europe currently practise less often in rural areas than their male colleagues.[23] In addition, female GPs tend to treat younger patients, while male GPs tend to care for a higher proportion of older patients.[23] As the proportion of older patients in the healthcare system increases, a redistribution is necessary.

In the broader societal context, the study examined only one specific aspect relevant to work within the healthcare system and to future developments. Other factors, such as education, family status, age and household income, also play a role in working conditions and in the subjective experience of work and leisure. However, it should be emphasised that individual well-being and health are particularly important for enabling individuals to sustain long, successful careers.[41] As well-being and health are strongly associated with subjective perceptions of work-life integration,[41] the chosen approach in this study appears beneficial.

Limitations and future research

It should be critically emphasised that the study can only make statements about Bavarian general practitioners. Transferability to other regions of Germany is therefore only possible to a limited extent. For example, parameters of job satisfaction, effort and reward were compared for German and Norwegian doctors.[42] Job satisfaction was lower in Germany than in Norway.[42] Even though healthcare systems have often been compared across countries, as in,[42] it cannot be ruled out that regional differences also exist within a country. Regarding the study participants, it is crucial to note that those selected for the individual interviews were also participants in the focus group interviews. An attempt was made to recruit participants who expressed a high degree of openness towards new concepts and showed interest in the above-mentioned research topic. It should also be noted that most of the study participants had children of their own, toddlers and school-age children. GPs without children of their own or with grown-up children might have expressed different needs. It is conceivable that the topic of childcare would have been less critical to GPs without children of their own. Additionally, the majority reported being in a stable partnership. This means that childcare is usually provided by both parents, particularly for doctors with children. If single parents had also been surveyed in this study, the assessment of the current work-life integration might have been more negative. It can also be assumed that the issue of external childcare would have been even more critical. Methodologically, the substudy's qualitative approach did not aim to collect quantitative data or perform statistical gender analyses. Instead, the study aimed to gain a detailed insight into the everyday work and professional life of practicing GPs in Bavaria to determine the importance of work-life integration, including interprofessional practice concepts. The study attempted to present results broken down by gender and professional group; however, given the purely qualitative nature of the analyses, these findings should be interpreted as trends only. In a further study using a quantitative approach, it would be conceivable to conduct more in-depth analyses of the results found here.

The findings can largely be reconciled with existing theoretical and practical knowledge. Although similar findings have already been observed in other professional groups, there is a pressing need to present the subjective assessment of work-life integration from the perspective of those working in primary care—this is particularly the case because, based on the Job Demands-Resources Model,[20] it is plausible that findings from previous studies cannot be automatically transferred to the professional group of GPs. In Germany, new care models for general practices are currently being discussed and trialled. As general practice is undergoing a period of radical change, it is particularly important to survey and document the conditions—including the views of those working within the system—in advance.

It is also essential to note that working people, such as GPs, are constantly caught between their professional and personal lives. It is therefore realistic to assume that, while tensions may be reduced, they will persist even if greater support and flexibility—such as childcare and part-time options—are put in place.

CONCLUSION AND IMPLICATIONS

For Bavarian GPs, the compatibility of their own professional and private lives is essential. Women tend to report a higher level of double workload in their job and leisure time. The establishment of childcare facilities is crucial in the general practice work setting. Given the high proportion of women within the GP sector, more concepts for part-time work in the practice team should be trialled. GPs hope that interprofessional practice concepts will reduce workload by increasing opportunities for delegation and co-determination in everyday working life.

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