Tidsskriftet
DEN NORSKE LEGEFORENING

GPs' experiences of the COVID-19 pandemic – a focus group study

ORIGINAL ARTICLE

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BACKGROUND

The working day of Norwegian GPs was turned on its head during the COVID-19 pandemic due to the extreme, ongoing pressure the GP service was under. We conducted a qualitative study of the GPs' perceptions of the challenges they faced and of how they coped during the pandemic.

MATERIAL AND METHOD

Focus group interviews were conducted with 19 GPs from four medical practices in the county of Innlandet. The interviews were analysed using the systematic text condensation method.

RESULTS

The GPs described how they have coped with the extremely challenging demands on them. They expressed an expectation of rapid adaptability, and considered this a fundamental characteristic of the role of the GP. They felt an enormous responsibility for their own patients and that in a time of crisis this responsibility was extended to include the entire

population. They saw themselves as an important part of the local authority's public health preparedness, even though they had not reflected on this to any great extent prior to the pandemic.

INTERPRETATION

The GP service's adaptability during times of crisis depends on the GPs' strong individual and collective sense of responsibility and their ability to cope. The latter is the GP service's great strength, but it also represents a vulnerability due to the camouflaging of the overburdening of the service. This can lead to local authorities failing to take responsibility for their statutory duties.

MAIN FINDINGS

GPs felt that they coped well during the COVID-19 pandemic, despite the enormous pressure they were under.

Self-efficacy is a typical trait of GPs, but it can also lead to the overburdening of the GP service.

Little was known about the SARS-CoV-2 virus at the start of the pandemic, and knowledge was lacking about the routes of infection, the potential severity of illness and what infection control measures would be appropriate. There were no national codes of practice or guidelines, and the authorities' recommendations were constantly changing. GPs' patients were contacting their practice for advice, and in the first few months of the pandemic the GP service spent considerable time reassuring patients.

Meanwhile, GPs had to reorganise their practices in order to meet the population's need for health care (1, 2). This included rearranging the premises, with separate areas for potentially infected patients. In many places, regular morning meetings provided a platform for internal communication in GP practices. A lack of personal protective equipment (PPE) for healthcare personnel gave rise to concern. At many GP practices, doctors and support staff were divided into cohorts in order to prevent a situation where the entire practice would have to close in the event of infection. Many GPs worked from home, and the number of video consultations and telephone consultations increased. The authorities quickly put in place arrangements for the remuneration of remote consultations and provided compensation for infection prevention measures (3).

The primary health service plays a key role in dealing with incidents that affect global public health (4). Experiences from previous crises highlight the need for preparedness planning in the primary health service (5–7). Studies have been conducted of the primary health service during the COVID-19 pandemic in other countries (8–11), but little is known about how the Norwegian GP service functions during a crisis. In small and medium-sized municipalities, GPs form the backbone of public health preparedness, as they provide emergency health care during the daytime, in the evenings and at the weekend (12). GPs are self-employed, and as such are often not an integral part of the local authority's administration. Municipal management often lacks knowledge about the running of a GP practice. The duty of local authorities in relation to preparedness requires them to put in place plans to protect the public in the event of a crisis or disaster (13). Nevertheless, prior to the COVID-19 pandemic, few local authorities had plans and agreements in place that safeguarded the inhabitants' need for medical services during a crisis. The GP regulations also fail to mention preparedness (14).

The authors observed that the GP service continued to function during the pandemic, and we were curious about the GPs' ability to cope with the crisis. We have both worked in primary health care for many years. We therefore have an expectation that GPs will exercise strong coping skills in times of crises, and consider the ability to adapt quickly to be of fundamental importance in the GP role. The American psychologist Albert Bandura has formulated a widely used theory of self-efficacy expectancy (15). According to this theory, previous experiences and motivation form the starting point for how we meet challenges, and self-efficacy is crucial to success. The background for this qualitative study was our desire to examine how crisis management in GP practices during the COVID-19 pandemic could be understood based on the self-efficacy theory.

Material and method

The data were collected by means of focus group interviews at four GP practices in the county of Innlandet in the period June 2020 to September 2021. The GP practices were situated in one small, two medium-sized and one large municipality. The participants were recruited via email. The GP practices that were selected were located in municipalities that had experienced large outbreaks of COVID-19, and an effort was made to vary the size and geographical distribution of the municipalities in the county.

All doctors at the GP practices, a total of 19 doctors aged 26–65, were invited to participate in the focus groups and they all agreed. Ten of the doctors were women, and nine of the doctors were specialists in general practice. At three of the practices, the municipality covered overheads, while the fourth was privately funded. Fourteen of the doctors were self-employed, and five received a fixed salary. The latter group was mainly made up of specialty registrars and locums. Everyone participated actively in the focus groups, but the locums participated in the discussions to a lesser extent than others. One interview was conducted by the second author, and the first author did the other three. The interviews lasted just over one hour.

The semi-structured interview was based on the three following questions:

1. What was your experience with the reorganisation of your GP practice in connection with the COVID-19 pandemic?

2. What factors aided or hindered the reorganisation of your GP practice?

3. What role do you think GPs should play in preparedness situations?

An audio recording was made of the interviews, and these were subsequently transcribed and anonymised. The respondents were assigned a number between L1 and L19. We used systematic text condensation in the analysis (16), and the transcribed texts were read and analysed in order to identify meaning units. The first and second authors identified meaning units independently of each other and sorted them into code groups. The authors then discussed the findings and adjusted the code groups. The essence of the meaning units in each code group was condensed into a single statement. We selected quotes from the text that illustrated the main findings. During the analysis, we selected statements that expressed shared values among the participants in the study since we were interested in studying the basis for collective self-efficacy.

The study was approved by the Norwegian Centre for Research Data, and approval by the Regional Committee for Medical and Health Research Ethics (Ref. 129162/20) was not deemed necessary. The study was carried out with support from the Norwegian Committee on Research in General Practice.

Results

MAJOR BURDEN, BUT HIGH SELF-EFFICACY

The GPs described the pandemic as a major burden, but felt that they coped well and derived satisfaction from how they had managed to find good solutions to addressing the challenges. They described the situation as particularly challenging at the start of the pandemic, when the GP practices were overwhelmed by the large number of enquiries from the public and the need to adapt quickly to the ongoing and extensive changes. The pressure on GP practices was mainly a result of the large volume of telephone enquiries at the start of the pandemic. Many patients cancelled their appointments, both out of fear of being infected and out of consideration for the doctors. Several GPs found that their appointment diaries were almost empty in the first weeks. The patients gradually returned, but by then most GP practices had introduced infection control measures that reduced physical patient contact. Although there was less direct contact in certain periods, the level of activity increased overall.

Some GPs disagreed with the infection control measures and feared losing a large portion of their income when they had to reduce the number of consultations. In addition, the work involved in reorganisation did not generate income for the self-employed doctors, as only patient contact was remunerated.

Getting patients to accept the new ways of working took time, and several of the GPs found it challenging. The GPs had different views on the value of video consultations. It was agreed that video consultation was best suited for certain patient groups, particularly younger people who were more familiar with the technology. Some patients considered video consultations to be positive, and asked that it be continued.

Several GPs expressed concern that the reduction in patient contact would lead to serious illnesses not being discovered and treated. Some went through their patient lists and visited their patients at home to ensure they were receiving the health care they needed:

'We've been working with our patients for many years after all, so we're very well informed about them, which is a major advantage. We contacted those who stayed away. That was important.' (L16)
All GP practices were pushed to breaking point during the first phase of the pandemic. The pressure eased somewhat when the local authorities introduced external testing and helplines. This freed up time for the GPs to carry out more of their regular duties. The GP practices had managed to continue functioning during the first acute phase, but it took its toll on the staff.

Our focus group participants considered it natural that GPs coped with the challenges during the pandemic. For most, their self-efficacy and sense of responsibility towards the patients was so implicit that it was not something they gave much thought to. Several of the doctors described the ability to cope as a core value in the GP service.

'As GPs, we feel that we have a great responsibility. The GP directive does not make it optional. We're good at adapting. Getting things done is quicker than complaining to the powers that be. I think we're exceptional in that respect.' (L17)
Some doctors described self-efficacy expectancy in light of the GP's role in emergency public health preparedness and their sense of ownership of events that affect the public.

Being self-employed and their large degree of self-determination were highlighted as key factors for being able to quickly reorganise the GP service during the pandemic.

In addition to the individual sense of responsibility for their practice, several GPs emphasised how the comradeship at their practice was a strength. The doctors received support and shared information in regular meetings with colleagues. Information letters from the Norwegian Medical Association and online discussion groups reinforced the collective self-efficacy.

The GPs also felt that society expected them to be able to cope with the crisis. Some doctors perceived this expectation as unreasonable. They explained how the acute crisis had come on top of an existing chronic crisis, in which the GP service is constantly expected to take

on more work without receiving more resources. They found that one of the disadvantages of their ability to cope was that it camouflaged the strain on the service.

SELF-DETERMINATION

The GPs considered self-determination to be a prerequisite for being able to make quick decisions and adapt to new ways of working at short notice. There was no clear difference between the self-employed doctors and the salaried doctors in terms of their desire for self-determination in practice. Several GPs negotiated agreements with the local authority for work on a salary basis to cover the additional need for medical services during the pandemic. The fixed salary from the local authority was lower than self-employment income from practice, and the GPs therefore regarded this as a loss of income, even though it provided a degree of financial security. The disadvantages of the financial vulnerability were nevertheless secondary to the importance of freedom and self-determination as a self-employed person, and even though a large share of several doctors' income was on a salary basis for a period of time, they did not want to change their form of employment.

'We could have perhaps wished for better compensation for the loss of income for a period, but we would not have given up our self-determination, because it counts for so much, that we decide for ourselves and have short lines of command. I wouldn't have given that up for a fixed salary. Yes to better compensation schemes, but we want to retain our right to decide.' (L16)

The GPs also emphasised other qualities such as interpersonal skills and creativity:

'We've been doing this a long time, we know each other well, have a good team, and already had good routines. That has made it easier to introduce things during the pandemic, we're in synch and good friends.' (L16)

The GPs were of the clear opinion that greater interference from the local authority would have reduced the effectiveness of the reorganisation. The municipal administration did not have the necessary knowledge about how a GP practice operates, and its attempts at micro-management caused irritation. The best way for the local authority to assist was by giving the GPs room to manoeuvre by ensuring that they had the necessary resources and by relieving them of COVID-19-related tasks.

OBLIGATION TO THE PUBLIC

The GPs expressed that it was their job to help their patients during the pandemic:

'I drew up a list, all patients over a certain age, and ticked off those who had not been here and called them. My elderly patients didn't dare come here, they barely went out to get their shopping. I visited those who were most sick.' (L18)

The GPs were aware that they had an important front-line role to play in mitigating the effects of the pandemic. In addition to the responsibility for their patients, they felt that they had a shared responsibility for the entire population. The doctors felt it was natural for them to assume responsibility for patients from GP practices that had closed. Their working methods were adapted to serve society and safeguard public health preparedness during a crisis.

The interviewees' opinions on the GP's role in an emergency situation differed. Most believed that it is natural for them to play a leading role and that they are the ones who are best suited to providing medical care during a crisis. Some GPs were critical to the local authority's expectation that they would take on more work when it was not clearly defined in existing agreements.

'I feel that's often how it is – the GP is tasked with the work, without any say in the matter. Because the GP knows the patient, that's it, there's nothing else to discuss, it's your responsibility. I think that's one of the aspects of the GP crisis.' (L14)

Opinions also differed between the locums on a fixed salary and GPs who had been treating their patients for a long time and felt a strong sense of ownership towards the practice. The locums, who were hired to meet the local authority's temporary demand for doctors, did not express the same sense of responsibility for the situation.

Discussion

The GPs who took part in the study described their experience of the COVID-19 pandemic as challenging, but they also felt that they coped well. This was consistent with our expectations. This is the first Norwegian study of GPs' experiences during the COVID-19 pandemic. It was carried out during the ongoing pandemic, and the GPs' experiences were fresh in their minds. The interviews were conducted over a period of 13 months, and we met GPs in various phases of the pandemic, which of course affected their perceptions of the situation. We believe that other GPs will be able to relate to the experiences and opinions expressed by our informants.

The first author is a GP and district medical officer, and the second author has worked as a GP for many years and as a district medical officer for a few years. This means that our points of reference when analysing the data were the same as those of the study participants. The image of GPs as solution-oriented practitioners with a strong sense of loyalty to their patients and high self-efficacy resonated with us.

Viewed in the light of Bandura's theory of self-efficacy expectancy, we recognised self-efficacy at both an individual and collective level (15). GPs feel a great sense of responsibility for their patients and ownership of their role as a GP. They are used to solving practical problems and addressing challenges when pressed for time. The collegial cooperation empowers them to deal with a crisis, and gives them a sense of control over their working day. Their self-determination motives them and provides room to manoeuvre. The study deepens the understanding of how GPs handle a crisis and identifies factors that aid and hinder effective reorganisation of the GP service. The findings largely confirmed our preconceptions.

However, we had not expected the analysis of the data to show that the ability to cope also has a clearly negative side. The informants and authors all agreed that the GP service's greatest strength is the GPs' sense of responsibility and ability to cope, but this also turned out to be the service's greatest vulnerability. Although many local authorities provided resources and practical help, they had insufficient competence to support the GP service adequately and to prevent it from being overburdened. The connection between self-efficacy and being overburdened was most clearly observed and formulated by doctors who did not have a close and long-term relationship with their patients, such as specialty registrars and locums.

The responsibility for ensuring that patients receive health care lies with the local authorities, but is largely left to GPs. The GPs deliver a service to the public on behalf of the local authority, and the local authority should be an important partner in the development of a high-quality GP service that is an integral party of the primary health service. Successful management of the GP service in the local authority requires doctors to be willing to let themselves be led (17). It also requires the local authorities' to be interested in and understand the complexities of the GPs' work and respect their need for autonomy. In our opinion, the local authorities should increase their competence in relation to the GP service and ensure that GPs' needs are taken into account in preparedness plans. By doing so, the public can be assured of a well-functioning health service in times of crisis.

The article has been peer-reviewed.

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Publisert: 1 September 2022. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.22.0069
Received 24.1.2022, first revision submitted 27.4.2022, accepted 5.8.2022.