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Restructuring in a GP practice during the COVID-19 pandemic – a focus-group study

ORIGINAL ARTICLE

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BACKGROUND

Outside the cities, the medical services in the municipality are often centred around one GP practice. The local medical service is key to the municipality's healthcare preparedness. We wished to investigate how the healthcare

personnel perceived the restructuring at their GP practice during the COVID-19 outbreak in March 2020, and the factors that facilitated and impeded the process.

MATERIAL AND METHOD

The article is based on a focus group interview that was conducted with eight nurses and medical secretaries at Otta GP practice in June 2020. The interview was transcribed and analysed using systematic text condensation.

RESULTS

The informants described a chaotic and demanding situation, in which they had to deal with their own as well as the patients' fears. They found crisis management to be difficult in a situation where the leadership in the municipality were unaware of the challenges of the GP practice. Lack of guidelines from the authorities at the start of the outbreak gave rise to considerable uncertainty. Through collaboration and flexibility, the practice arrived at new ways of working in order to safeguard its running. This gave a strong feeling of coping and fellowship, and a greater awareness of the informants' own importance in the front line of crisis management.

INTERPRETATION

The study elucidates the role of support staff in the face of a crisis for the GP practice. Competent employees with the latitude and tools to tackle the challenges quickly guided the practice from chaos to a new type of working day. The municipality could have supported the process by ensuring the necessary resources and general guidelines for prioritisation of tasks.

Main message

A major early outbreak of COVID-19 put considerable pressure on the GP practice in Otta, and the support staff found the necessary restructuring to be demanding.

The local knowledge, professional skills, flexibility, communication skills and sense of responsibility of the support staff were key tools for a rapid restructuring process.

In emergency preparedness, it is a general principle that crises should be dealt with by those who are closest to the incident and with the same organisational approach as in regular operations (1).

The local GP practice is the first point of contact for most patients and plays a strategic role in combatting disease, in 'peacetime' as well as during health crises, such as major pandemics (2–4). The Norwegian healthcare system rests on the shoulders of the GP service, and the local GP practice is the cornerstone of emergency health preparedness in most of the smaller municipalities. A

Norwegian study shows that the influenza outbreak in 2009 placed considerably increased demands on the GP practices and out-of-hours services, but also that these services were able to meet these demands (5).

Sel municipality in the Gudbrandsdalen valley was struck by COVID-19 in early March 2020. This was one of the first major outbreaks in Norway, and central-level guidelines were still in the making. The municipality has 5 700 inhabitants and is located in the midst of a mountainous area, with the nearest hospital 110 kilometres away. The local GP practice, which is operated by the local authority, was charged with a key role in the management of the outbreak. During its first stage only two out of six GPs worked full time at the practice, and they had little time to focus on organisational and operational matters.

We wished to examine how the staff at the GP practice perceived the restructuring, and learn what factors helped the transition from regular operations to an emergency situation succeed, and what factors impeded it.

Material and method

In June 2020 we conducted a focus-group interview with eight nurses and health secretaries employed at Otta medical centre. All the nurses and health secretaries participated in the focus group, including temporary and part-time staff. All were recruited by the first author. All wished to participate in the study, and nobody wanted to withdraw after the interview session. The participants signed a declaration of consent and were informed of their opportunity to withdraw without having to give a reason.

The interview was conducted by the second author, who is an experienced GP and academic with no relationship to the medical centre employees. The project was presented to the participants through information on the consent form and a brief oral presentation at the start of the interview session.

The semi-structured interview was conducted on the basis of three main questions:

1. How did you perceive the restructuring of the GP practice in connection with the outbreak of COVID-19 in March?

2. What factors facilitated the restructuring?

3. What factors impeded the restructuring?

The interview was conducted at the medical centre and lasted for one hour. Only the interviewer and the focus-group participants were present during the interview session. The material in the article is based exclusively on the interview. The participants have not had the opportunity to read or comment on the transcribed interview, but they have read the article before publication.

The interview was recorded and subsequently transcribed verbatim. The further processing of the material was based on the systematic text condensation method (6). Both authors jointly analysed the material in the following stages: First, both authors read and re-read the text several times to obtain a general impression and identify preliminary topics. The meaningful

units were subsequently identified and coded, and the codes were sorted into categories and sub-categories. The contents of each code group were condensed, i.e. reformulated from the text into more general statements. Illustrative quotes were identified. The condensates of each code group were then synthesised into general topics. The topics arose out of the data and were not pre-determined. The analysis was done manually with the aid of colour coding, with no use of software tools. The participants were not given an opportunity to comment on the choice of topics or the results of the analysis.

The methodology and the results are presented in accordance with the COREQ checklist (Consolidated criteria for reporting qualitative research) (7).

The project was approved by the Norwegian Centre for Research Data (ref. no. 544221). The Regional Committee for Medical and Health Research gave the advance assessment that the project was not subject to approval (REK South-East A, ref. no 129162).

Results

In unknown terrain

The initial period was characterised by fear and uncertainty. Although the COVID-19 situation in the world was known from media reports, it felt surreal and shocking to see that your own local community was suddenly affected.

'I felt that the outbreak was thrown at us. In the beginning there were some patients who mentioned it, and we chatted a little about it, but then suddenly one day we had it – right here.' (Participant no. 6)

Many described fear for their own health and thoughts of becoming infected by or infecting others. However, there was also frustration over the interpretation of unclear quarantine rules. Those who had to stay away because of quarantine felt uncomfortable about increasing the workload of those who remained at work. A high level of fear in the population caused many to contact the GP practice by telephone, and responding to all these inquiries was a challenge. The waiting time on the telephone was long. On the most hectic days, the staff were only able to respond to less than one-third of the inquiries. At the same time, many patients called to cancel their appointments, and all other work in the GP practice came to a halt. The general anxiety gave rise to a large workload and was found to be hard to deal with.

'People were extremely anxious. We noticed that many patients were terrified, and this showed itself not only in matters related to COVID-19, but also in all other kinds of questions they had. There was a lot of anxiety going around.' (Participant no. 3)

It quickly became clear that the activities of the GP practice had to be reorganised to be able to function during the outbreak. The staff were redeployed from taking blood tests, administering injections and dressing wounds to answering telephone calls. The physiotherapy and occupational therapy services were closed, and the staff were recruited to maintain access

control and triage the patients who showed up at the GP practice. They also helped physically arrange the patients in the waiting room so as to comply with social distancing rules.

'At first it was very unstructured, as we didn't really quite know how to begin, I felt. However, with many clever heads working together we were able to come up with something. For example, how to manage the waiting room, and the telephone service. Part of the problem was that there weren't very many of us, because there were some who were quarantined, so we weren't that many.' (Participant no. 3)

It took one week before the local authority was able to establish an information hotline to handle questions related to COVID-19. During that week, the GP practice staff were pushed to breaking point. They felt responsible for appearing confident and accessible to alleviate the anxiety in the population, but the massive pressure of questions and concerns, combined with unclear guidelines, reinforced their own feeling of insecurity.

'We felt that the pressure was on us, with lots of questions. We were not quite prepared for the suddenness with which it hit us, and it was hard to know how we should respond to many of the callers.' (Participant no. 6)

With no map or guide

The absence of guidelines from the authorities heightened the sense of uncertainty in the encounter with the patients, and some respondents described their sense of discomfort about providing advice that was not based on solid evidence.

'At first I didn't know what to say on the telephone. At first ... So some were probably just as uncertain after the call as they had been before calling.' (Participant no. 1)

It was also difficult to stay updated with regard to the constant changes to the guidelines. During the first weeks of March, the main features of the government pandemic guidelines were still being drawn up, and specifications and amendments were coming in from the Norwegian Institute of Public Health and the Norwegian Directorate of Health on a daily basis. Close contact with the chief infection control officer made for essential support.

'We didn't quite know what to answer, and there were constant questions about what we should do in such and such a situation. Having the chief infection control officer here was a real support. I think of those who didn't have the chief infection control officer close by, poor them. In the beginning that is, because she answered all our questions, If we asked her ten times, she answered. Because we were constantly in situations where we didn't know how to respond.' (Participant no 3)

It also turned out that the general planning framework did not provide any roadmap for restructuring the activities. The specific changes to procedures and priorities had to be done continuously and adapted to the prevailing situation. In this context, the participants voiced frustration about the local council administration. Many noted that those who had the authority to make decisions had little knowledge about the activities of a GP practice, and the administration was perceived as distant and not very engaged. The

administration had little direct communication with the staff, and in several cases it happened that issues were communicated to the administration, but no concrete measures were taken. For example, the local council administration had assumed the task of organising a reception centre for patients with fever and respiratory symptoms, but nothing was put in place before the GP practice staff organised it themselves.

'And it's essential that those who know how a GP practice operates are included when decisions are made. Because it's unfortunate that decisions are made higher up by people unfamiliar with the activities of a GP practice. (Participant no. 8)

The staff themselves could best see what was needed to make the practice function. However, they had no authority to implement the necessary changes.

'We have acted as the hub. We have been the key personnel. We are the ones whom the population has contacted during the daytime. ... I've seen what was needed, but I have not had any authority to decide. But things have been implemented all the same, because we saw that this just needs to happen. After all, we simply need to make things work.' (Participant no. 3)

When the local council administration made decisions and implemented measures that had not been endorsed by the GP practice, this caused irritation and was regarded as an additional burden.

Strengthened solidarity in coping

The participants agreed that the crisis had strengthened the solidarity among the GP practice staff, and perhaps also slightly shifted the balance of power between the doctors and the support staff.

'I'm thinking of how we have treated each other. Of how the doctors have treated us, but also how we have treated each other. I feel that everybody has been more considerate and more grateful.' (Participant no. 8)

The staff members described an increased awareness of their own importance and of the role of the GP practice in the management of the crisis.

'We need to acknowledge that we're important. We have shown ourselves to be accommodating and flexible, and that we do the job that's expected of us, no matter what. As long as we march in step and in conformity with the person leading us, that is.' (Participant no 7)

They could clearly see that together they had good tools to face challenges, but also a shared value base and perseverance. Characteristics such as flexibility and stamina were highlighted, but also the care and support they gave each other in a difficult situation. Since all of them could cope with the different job tasks at the GP practice, the absence of some staff members became less consequential.

'I wish to mention the collaboration in the practice. Everybody's ability to adapt, from today onwards we do it like this, tomorrow there could be new plans. These were real challenges, but I for one think that we have done really well through this situation. Yes, with the solidarity between us in the office and the doctors and everyone else, I feel that things have gone well, and it's all been positive.' (Participant no. 5)

All the respondents agreed that their main job was to take care of the patients in the best possible way. As the patients started returning, a number of measures were introduced to reduce the risk of infection in the GP practice. The efforts to ensure the flow of patients were highlighted as particularly important, but also as difficult. The objective was to ensure that a limited number of patients would sit in the waiting room at the same time while waiting for their appointment, blood tests, examination or transport. The management of the waiting room required constant vigilance and gave rise to some logistical challenges.

Healthcare personnel who had been relocated from the physiotherapy service ensured access control to the GP practice for a period of time. Gradually, this function was assumed by volunteers. Patients with fever, respiratory symptoms or abdominal pain were handled in premises that were physically separated from the GP practice.

The staff felt that many of the new procedures were useful and sustainable over time. They wished to continue working in the same way also after the end of the outbreak. The joint morning meeting was highlighted by many as a necessary success criterion for the management of the crisis. Previously, meetings had been held a couple of times per week, but now, the entire staff of the GP practice convened for fifteen minutes before the work started. The brief meeting ensured that everybody was updated regarding the work of the day, as well as any absences. Even more importantly, the meeting reinforced the sense of unity and solidarity between the doctors and the other staff.

'And then we started to have a joint meeting in the morning, where all the doctors and all the office staff attended. I felt that this was a great help, because then we could have a review in the morning. What has happened? How are things developing at the moment? How should we organise ourselves today?' (Participant no. 6)

The interviewees also had some ideas about things that could have been done differently, in particular to divide the doctors and other staff into cohorts to ensure that the practice could continue to operate in case of an infection outbreak among staff member

Even months after the outbreak, daily life in the GP practice is still marked by COVID-19.

'It's not yet normal for us. The question is whether it ever will be, or so I think, regarding the access control, whether they will stand there every day and do a good job. And then there's the matter of disinfecting between each patient, we spend a lot more time on infection control measures. So it's not normal activity in this respect.' (Participant no. 3)

Discussion

The COVID-19 outbreak put pressure on the entire healthcare service. The authorities and the media have focused on the hospitals, especially on intensive care capacity. This is understandable, given how the pandemic has affected

other countries. There is much to indicate that the outbreak of the disease manifested itself differently in Norway. The GPs have handled the vast majority of those infected, and thereby shielded the hospitals' capacity to treat those who were most seriously ill. The same situation occurred during the swine flu pandemic in 2009 (5). A well-functioning primary health service is a precondition for effective management of pandemics (8–10).

In international studies, concepts such as *surge capacity* and *shock resilience* are used to describe the ability of health systems to restructure during crises (11–15). Patel and colleagues classify the challenges that general practice services face in a pandemic into five main groups: providing information to patients, protecting patients against infection in GP practices, ensuring examination of the infected, caring for patients with chronic diseases, and ensuring the mental health of the population (16). The same main topics emerged also in our study. The staff at the Otta medical centre describe a brutal restructuring process in the face of the pandemic. Their shared culture and identity helped them cope with this task. They underscored the importance of the work community, and the mental burden that was felt by those who for various reasons could not be at work. The expectation that each individual should deal with their own anxiety for the common good left little room for anxiety about one's own health and about infecting family members. From the very beginning, the staff group had a clear understanding of the task at hand. The objective was to safeguard the patients by providing good accessibility and correct and sufficient information. When the flood of inquiries exceeded the capacity to respond to them, this strengthened the sense of failing to manage the crisis. Uncertainty about whether correct advice was being given had the same effect, and this was highlighted as a major challenge, since the local outbreak occurred before the national guidelines had been prepared.

The absence of a clear and detail-oriented leadership made for a difficult field of action, but also promoted a sense of coping, since the group found out that they could find solutions themselves. The presence of the chief infection control officer guaranteed that the medical advice provided was correct and inspired confidence. In addition to the internal solidarity, the staff members highlighted individual characteristics as essential for the group to manage the crisis and tolerate the strain: solid professional skills, experience and flexibility.

The support staff expressed a strong shared identity and an understanding of their own importance. The GPs were noted as key collaboration partners, but the staff members did not focus mainly on the needs and working conditions of the GPs. Maintaining the activities of the practice appeared to be decoupled from the presence of the GPs.

Strengths and weaknesses

As far as we are aware, this is the first study that describes how the support staff in a GP practice perceived the challenges associated with the COVID-19 pandemic. We may assume that the informants have provided an open-minded and correct description of their own experiences. The GP practice that participated in the study does not differ significantly from other GP practices in Norway, with the exception that the nearest hospital is 110 kilometres away. The COVID-19 outbreak represents an extreme situation over a limited period

of time. We believe that the findings in the study have transfer value to situations where similar organisations are put under great strain and need to find new strategies to cope with a crisis.

The study describes the experiences from a single GP practice. When the study was planned in March 2020, the experience of a major local infection outbreak was still unique. Part of the main objective was to explore the ways in which the support staff perceived and tackled the challenges at a time they themselves, the doctors and the public were marked by great uncertainty and constantly shifting information. We therefore chose to limit our focus to Otta medical centre. It would have been desirable to explore the staff members' experiences in more detail. Individual interviews would have provided such an opportunity in ways that are not possible in a focus group.

In this study, the first author's role is potentially problematic. She has filled many roles during the management of the local outbreak of COVID-19; as chief medical officer, infection control officer and GP at the local medical centre. To prevent personal relationships from colouring the statements in the focus group, the focus-group interview was conducted by the second author, without the first author present. However, the analyses have mainly been undertaken by the first author, although in close collaboration with the second author, who has kept a critical eye on any possible information bias.

Conclusion

Outside the major cities in Norway, health preparedness is largely based on local GP practices. Although emergency preparedness plans ought to be formulated as far as possible in general terms, it is important and necessary to assign a key role to the support staff in the GP practice when converting a general plan to specific procedures. Local authorities will do well in assisting GP practices with necessary support and leadership in a crisis situation.

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The article has been peer reviewed.

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