The impact of COVID-19 on primary care practitioners: transformation, upheaval and uncertainty

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Introduction

A system in flux

The COVID-19 pandemic led to a wholesale re-ordering in 2020 of primary care service delivery both in the UK and other countries. Virtually overnight, general practices radically re-structured care provision, and consultations moved from face-to-face to telephone calls or online interactions wherever possible (Thornton, 2020; Clarke *et al.*, 2020). Service changes which had been the source of protracted debate, and which would ordinarily have taken years to implement, quickly became normal practice (Brant, et al., 2016; Marshall et al., 2020; Lay, 2020). At the same time, other challenges and changes included the development of 'hot hubs' for COVID-19-related primary care across cities or districts, and the addition of new staff and roles into what became large extended general practice teams (including formerly retired staff, part-time staff working full-time and extra hours, clinical academics, and volunteers).

While primary care was braced for a large wave of COVID-19-related workload, as the pandemic evolved in the UK, concern emerged that patients who needed to seek help for non-COVID-19 conditions were not doing so, and a backlog of ill-health was building rapidly in the community (NHS England and Improvement, 2020a; Spencer and Oung, 2020). Primary care staff then faced a new series of challenges as the government issued guidelines in the summer of 2020 for a gradual return to restoring practices to their full range of services, also recommending that some new ways of working – including offering a greater proportion of phone or on-line consultations – should continue to be part of the offer (NHS England and Improvement, 2020b).

We view this as an example of 'punctuated equilibrium' in both national policy and local practice. Punctuated equilibrium is a metaphor borrowed originally from evolutionary biology, where it described long periods of evolutionary stability 'punctuated' by sudden rapid change in the fossil record, before the re-establishment of a new stability. In social theory, Baumgartner and Jones (1993; 2010) borrowed the term to explain shifts in American policymaking. They argued that 'the course of public policy in the United States is not gradual and incremental, but rather is disjoint and episodic. Long periods of stability are interrupted by bursts of frenetic policy activity' (2010 p.xvii). While the causes of such bursts of change might sometimes be because of electoral shifts, more often than not they are observed to result from the confluence of multiple factors in specific policy arenas, where 'the stars can align' (p.xxv) for a change to break through. Health policy is frequently subject to reform. COVID-19, however, created a very different context compared to the usual fluidity of health policy. COVID-19 initiated a violent rupture where all-encompassing changes had to be made to local practice at extraordinary speed. These circumstances were exceptional in modern times, and created a great sense of initial uncertainty.

This chapter presents the initial findings of a study, started in early spring 2020, that has captured the narratives of primary care practitioners during a time of pandemic. General practitioners, practice nurses, and practice managers were invited to participate in the study to ensure a range of experiences were documented. The research team periodically sent questions for participants to consider, these being designed to reflect topical discussion points as the response to the pandemic progressed. Participants were able to contribute as frequently as they wished and could also choose how they shared their experiences. Some participants decided to record voice notes on their phone which were then sent securely to the research team, whereas others contributed written notes or via a telephone or online interview with a member of the research team. Narratives are still being collected from 16 participants and thematically analysed at the time of writing, reflecting the ongoing pandemic.

COVID-19 represents a fascinating intersection between the biological and social theory versions of punctuated equilibrium. A powerful virus emerged in a landscape where the advent of digital technologies was already, gradually, reshaping healthcare and its forms of communication and consultation, and accelerated this process at previously unimaginable speed. Whereas before much of the discussion about 'modernising primary care service delivery' was couched in terms of – for example – organisational facilitators and barriers to change, resistance to new ways of working, incremental adoption, and professional identities, a tiny invisible organism caused a sudden and major acceleration of this change. This has resulted both in enforced, unplanned service transformation and the emergence of 'policy windows' (Kingdon, 2002) which have given policy actors an opportunity to pursue intended change. Tuohy (1999) uses the term 'accidental logics' to describe how external events can create unanticipated windows to implement change within health systems.

Individuals in transition

Such upheaval has profound consequences not just for organisational systems but also for individual people. It is undoubtedly the case that changes arising from COVID-19 have been disconcerting, stressful and emotional for general practice team members. As one GP colleague observed to us, 'I've been a GP for 25 years, and overnight I felt I didn't know how to do my job any more' (personal communication). In his work on role transitions, Ashforth (2000) examined how people move between role identities - sometimes just as day-to-day transitions (for example transitioning between work and home life personas) but sometimes as a result of changes within their work environment. He considers the use of Lewin's (1951) model of change (unfreeze-change-refreeze) to articulate how a previously stable state becomes fluid and disrupted before resettling into equilibrium, although both Lewin and Ashforth note that there may be repeated fluctuation and blurring between change and stability along the way. The predicted waves of COVID-19 infections until the discovery of a vaccine, and associated impact on health services, makes this repetition and cycles of change very likely.

Ashforth argues that 'one may need a mechanism – a *transition bridge* - to preserve a sense of personal continuity as one moves between roles [….] even if the transition is welcomed as a means of furthering personal development' (p. 12). Transition bridges may include identity narratives, transitional roles, grieving and mementos, which help maintain attachment to the past while performing in a new role. However, 'a particularly disruptive transition […], typically a high magnitude, socially undesirable, and involuntary transition, may simply overwhelm the efficacy of bridging

mechanisms precisely when they are most needed' (p. 12), leading to potential heightened 'role shock' or the discontinuity generated through a 'discrepancy between expectations and experiences' (p. 159).

Ashforth argues that when workplace roles are in flux, a series of 'psychological motives' come into play. Team members have to work to create and maintain: a sense of workplace identity; meaning; control; and belonging. The better each individual is able to resolve these motives at a personal level, the better they will be able to deal with disruption to their role and organisational upheaval. Reflecting on the COVID-19 pandemic, Wiedner et al. (2020) explore how crises can lead to 'improvised innovation' – innovation borne from 'dealing with unforeseen events without the benefit of preparation' (p. 1). Wiedner et al. note how the shared experience of responding to the pressures of a crisis can facilitate a positive 'collective identity'. Despite the potential for the COVID-19 pandemic to fragment primary care teams, there is also potential for healthcare workers to feel a strengthening of team identity and shared purpose, and greater affinity with the wider health system which can challenge silo working and encourage greater support for change.

At a more experiential level, Bury's (1982) concept of biographical disruption offers an additional lens through which to understand individual transitions. This concept was originally derived from studying the diagnosis of chronic illness and how this disrupts one's sense of self, one's anticipated trajectory in life and one's ability to maintain relationships and activities. People who experience biographical disruption, Bury suggests, will work hard to mobilise material and social resources to restore or repair their biography, and find a new way of being. Whilst they may normalise their new situation, further changes in health status may require repeated adaptations and repair work.

In the case of primary care workers, the source of the disruption is not personal illness but rather the dramatic effects of a virus and associated pandemic on society, which has transformed primary care staff's working lives, and left them scrambling to regroup in a situation of ongoing radical uncertainty.

In this chapter we first outline the changes that took place in primary care during 2020 and continue to take place at the time of writing. We then present findings from a small longitudinal study of the experiences of individual primary care staff, including GPs, practice nurses and practice managers. These narratives were collected from April 2020 onwards, and were therefore able to capture in real time the evolving lockdown of UK society and health service re-opening situation. In this analysis we focus particularly on what the virus enabled, enforced and prevented, and how this has affected the lives, work and professional identities of individual primary care staff.

Findings

A reduction in GP consultations since the start of the pandemic has been widely reported, and has led to concerns about the care of non-COVID-19 patients, people with long-term health conditions, and the potential for delayed diagnoses. In April 2020 – the first full month of UK 'lockdown' - there were 8.7million GP consultations, compared with 12.4million in the same month in 2019. The proportion of consultations taking place by telephone jumped significantly, as the number of face-to-face consultations fell (NHS Digital, 2020). Health Foundation analysis of data from the clinical practice research datalink (CPRD) shows that over the period from March – June 2020 there was a fall in the number of referrals, medical tests, new prescriptions and immunisations in general practice. As time,

and the pandemic, have progressed, the number of GP appointments carried out in England has risen again. In October 2020 there were 13.2m GP appointments – 1.2m fewer than in the same month in 2019, but a sustained increase from the low point of April 2020.

Describing change

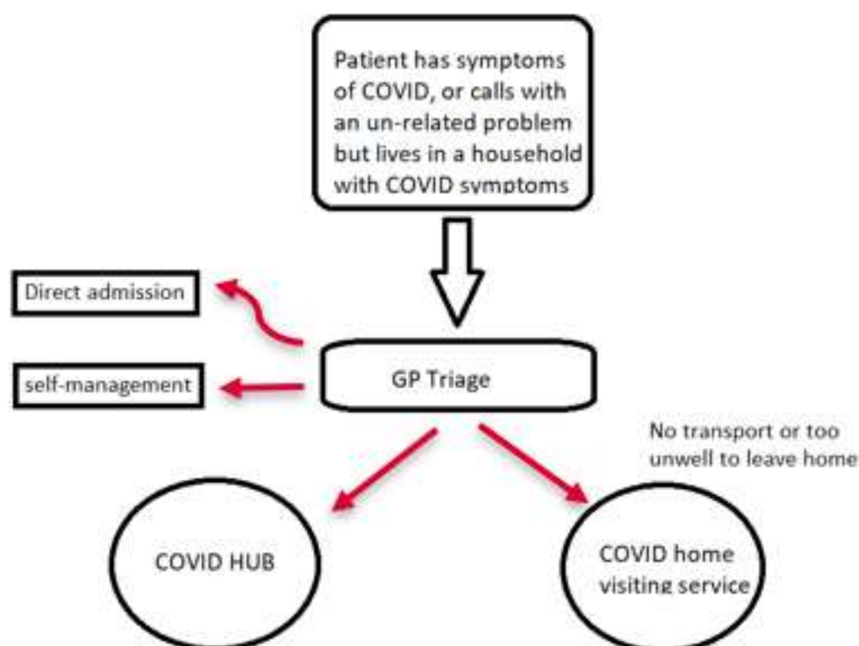
The participants in this study all highlighted the vast array of changes that were made to general practice during the first half of 2020. These changes included: the advancement of digital consultations, primary care practitioners working remotely, restructuring and adapting the physical layout of practices to maintain social distancing, and the increased use of personal protective equipment. Box 1 provides an in-depth contribution from one of the chapter's authors, Dr. Becks Fisher, a practising GP, which describes the establishment of COVID-19 hubs in Oxford, along with other aspects of change to general practice as the pandemic progressed and attempts were made to restore non-COVID-19 primary care services.

Box 1: Creating a COVID-19 primary care service

Since 2014, GP practices in Oxford have collaborated through OxFed, a not-for-profit healthcare organisation owned by Oxford's NHS GP practices. Prior to the COVID-19 pandemic OxFed ran several services, shared by practices across the city. This included a 7-day access service (allowing practices to meet their extended hours commitments), and a home visiting service. In early March, as COVID-19 loomed large, OxFed rapidly re-configured services to provide COVID hubs and a COVID home visiting service.

What happened?

Almost overnight OxFed worked with a variety of local stakeholders, including GP practices and the CCG to develop an entirely new service. This aimed to provide excellent primary medical care for



patients with COVID-19, and people with COVID-19 symptoms in the household, and to do so in a separate location from GP surgeries in the city. This allowed practices to keep their sites as safe as possible for staff and for patients without COVID-19 symptom. Three sites were found and were turned in to 'COVID-19 hubs'. These were staffed by a mix of GPs who usually work for the (temporarily paused) 7 day access service, and GPs who agreed to work for the service as additional hours. Patients were triaged in to the service via their own GP practice as shown in Figure 1:

Triaging GPs at city surgeries booked patients in to COVID-19 clinics, whereupon clinic admin staff phoned the patient, ascertained that they had their own transport (important for infection control), and offered a specific appointment time and location. COVID-19 hub sites were set up to maximise infection control, with minimal contact-time between patients and GPs. Most history was ascertained by telephone with the patient in their car, and patients were examined face to face only where necessary. Staff observed social distancing within hub sites to try and minimise spread of infection, with GPs working in separate rooms where possible, and an infection control lead at each site. GPs working at COVID-19 hubs had full read and write access in to the patient's usual medical notes, and so informational continuity of care was preserved.

OxFed additionally re-purposed their home visiting service, to become a COVID-19 home visiting service – seeing patients with probable COVID-19 who either did not have their own transport to enable safe attendance at a hub, or who were housebound. Initially this meant the temporary suspension of the usual home visiting service, and individual practices resumed responsibility for all non-COVID-19-related home visits to their patients. In April 2020 the Oxford COVID-19 hubs saw 354 patients in clinic, and 190 patients via the COVID-19 home visiting service, and 342 patients were seen in clinic and 206 on home visits in May.

As demand for COVID-19 services dropped in May 2020, the three COVID-19 hub sites were condensed to a single site. OxFed have divided their home visiting service in to 'green' (non-COVID-19) and 'red' (possible COVID-19 symptoms) patients, releasing some capacity back to routine general practice. This enables general practice in the city to continue to operate a 'hot' and 'cold' site system, where patients' with possible COVID-19 are seen outside of their usual GP surgeries.

Throughout this period GP surgeries in Oxford continued to 'see' patients, but with a 'telephone first' approach. Patients requesting appointments would have an initial telephone or e-consultation with a clinician, through which their concern would either be addressed, or a face-to-face appointment arranged at their practice if required.

Sudden and unsettling change

Narratives were collected throughout the pandemic, as such they captured the reorganisation of practices, along with primary care practitioners' response to the pandemic at both a professional and personal level. Recurrent themes throughout the initial narratives were the great speed at which changes were made to primary care, and the profound consequences for professional identity.

Frequently, participants discussed feeling lost as they had little choice but to get used to a new approach to consulting. Remote consultations often denied primary care professionals access to some

of their much-honed skills to detect subtle signs and clues – for example, someone's gait when entering the consultation room – that could inform their investigations. As a result of the fast-changing character of the pandemic participants highlighted that initially there was not a key, overarching guideline or policy that could inform practices' response. Some participants noted that guidance and plans were shared by clinical commissioning groups (CCGs) and health boards, with practices at times working with others within the primary care network to create their own plans. At the initial stages of the pandemic, these plans frequently changed according to the shifting situation. As demonstrated by the participant below, there was frequent acknowledgement of an early overload of information in some areas, but limited guidance on others. Participants reported that the pace of change did decrease as the pandemic progressed but that there was a continual need to plan for the future delivery of care (for example the delivery of the flu vaccination programme, and eventual roll-out of a COVID-19 vaccine).

I think the volume of stuff to read to keep up, certainly in the first phase, felt pretty overwhelming. There was this kind of, on some levels, complete silence in that there was no national guidance for what to do, on numerous levels, so both how we should structure our services, but also what we should do about specific treatment decisions. – Participant 1

While practices developed their own response in respect of how to organise patient services in a time of societal lockdown, some participants discussed how the subsequent release of local or national NHS guidance meant that such plans had to be revised on multiple occasions, leading to further uncertainty, as identified here:

Initially it felt very much like we were trying to build something and make changes on shifting sands. Every day there was new guidance coming out, there were new rules coming out, there were new definitions coming out, and we had to rethink our plans all the time. – Participant 7

There's lots of information coming out, it was very information overload. You'd read one thing one day and it all changed the next…Do you follow your local guidelines? Do you follow your national guidelines? Medically, legally where do you stand? It was very difficult. – Participant 12

This sense of uncertainty was also expressed when discussing the move from face-to-face to remote consulting in primary care. One participant framed the role of GPs as being similar to a detective [participant 1], working with patients to take a medical history and make inferences from their observations. Working remotely was suggested to reduce the number of senses that primary care practitioners could call upon within their diagnostic role. Participants frequently reported that the effects of the pandemic meant they could no longer rely on their experience, succinctly articulated by one GP [participant 5] as '*we're all beginners together*' and also expressed in the quotation below:

But I think the main difficulty has been in the way that we think and work. We've had to completely change our normal thought processes, whether it be simple things like getting investigations, radiology or referrals done, or even whether we assess people face to face, has all had to have been viewed through the lens of the coronavirus. And this is proving really hard, because you can't fall back on the heuristics built up over years of experience, because they're all now wrong. We're having to relearn them, have to do a lot of type two thinking and it's effortful. So although demand has been lower, the

effort involved in work has been high and it's really quite stressful, and exhausting working in this environment. – Participant 7

So it was very difficult to know whether we were giving people the right advice or not and I found it really unsettling and very anxiety provoking really as to whether I was telling people, you know, 'actually no you don't need to be shielding' and then leaving them vulnerable, that was my worry, that I was mis-, you know, advising them incorrectly, that was not a comfortable place to be. – Participant 12

We're very much sort of controlling – we are the best, we are the perfectionists, and then all of a sudden to be put in a place of deep uncertainty and doubt, is quite – has a quite sort of existential sort of moments of what is the point of me? Why did I think I could do this? And that kind of really questioning what your core reason for being in general practice, or not just in general practice, but I think particularly general practice, because so much of what we do is relationship based medicine. So much of what we do is around establishing those relationships with trust. And I don't know, all of a sudden everything changed, and we had to get our heads around everybody being safe and us being safe. And I think we lost something in that moment initially. – Participant 10

The changes involved were thus unsettling in several ways – not just in terms of disrupting routines and ways of practising, and facing a new, baffling condition, but also in terms of emotion and a fundamentally disrupted sense of self, as the above quotation reveals. GPs described feeling they had lost their professional bearings, cast adrift without their normal navigational aids.

While participants highlighted the confusion and difficulties of the initial phase of the pandemic, some also welcomed a new sense of liberation to pursue innovation. It was also noted that pre-pandemic attempts to pursue change in general practice service delivery had at times been frustrated due to professional resistance or other factors. While some participants felt that progress had already been beginning to be made within some of these areas (for example, phone triage of GP appointments, on-line consultations), the pandemic had *'added an impetus that wasn't there previously'* [participant 7].

Related to this point about impetus and energy for change, participants often mentioned that there had been an initial welcome reduction in what was identified to be excessive monitoring by NHS England and Improvement and the local clinical commissioning group, and greater autonomy for practices and primary care networks to get on and make local decisions during the height of the pandemic. Reduced oversight facilitated the 'improvised innovation' (Wiedner et al., 2020) required by the COVID-19 pandemic. One participant discussed this in terms of their practice embedding the 'freedom to fail' [participant 1] when trying out new ways of working, with another reflecting that the pandemic had *'created an environment where basically nothing was sacred anymore'* [participant 11], a sentiment captured in the following quotation:

I think one thing I'd like to say actually is that what was really freeing was a bit of the not having problems with the bureaucracy. So normally if you'd wanted to make these changes, you'd have probably had to go through many layers of decision making and approval processes, but actually we just did it, now. Ideally, there are some things that do need approval and whatever, but actually shaking off some of the shackles of regulation, because that's actually been one of the things that has bogged practitioners down. – Participant 12

The speed at which the COVID-19 pandemic hit meant that primary care practitioners had little choice other than to devise responses to ensure that those patients experiencing both COVID-19 and non-COVID-19 symptoms received appropriate care. Services were redesigned rapidly in exceptional circumstances and it was clear from the study participants that there was an element of testing out new ways of doing things, adapting them so that they worked best, and trying to ensure that they met the requirements of evolving guidance. However, six months into the pandemic, there are signs of some return to centralised and sometimes contradictory oversight as seen in NHS England and Improvement's (2020c) letter advising that practices must prioritise face-to-face appointments. Although practices never stopped offering face-to-face appointments, this appears to conflict with a letter issued in July 2020 exhorting practices to ensure that online and phone appointments continue to be provided in future. Throughout the first six months of the pandemic, primary care practitioners operated within a complex and ever-shifting environment which generated much uncertainty within primary care. The character of this uncertainty, and the effects on primary care practitioners are explored in the following section.

The effects of uncertainty

The future evolution of the pandemic is impossible to predict and the resulting uncertainty is complex and multifaceted. As noted by Rutter et al. (2020) it is not possible to eradicate uncertainty within a pandemic and the focus should be on how to manage and respond to this uncertainty. Study participants' narratives reflect two distinct forms of uncertainty: 1. clinical uncertainty and 2. the effects of rapid service change on the primary care profession and the effects on their own role and team relationships.

Clinical uncertainty

Turning first to clinical uncertainty, participants frequently identified concerns about unmet patient need and potential high levels of future demand. The decrease in consultations at the start of the pandemic (outlined above) was noted by participants, who shared concerns that unmet need for health care was building in communities, worrying that primary care lacked capacity to respond to a potential surge in demand:

I'm really worried about unmet need. I think lots of us are, after that initial kind of burst of activity, general practice, in terms of patient demand, at least has been kind of eerily quiet and I'm worried about what's going on there. Because yeah, OK, some may be that people aren't getting, aren't coming to see us with mild self-resolving things that perhaps wouldn't have needed to be seen. But actually I really just don't believe that that accounts for the level of the drop off that we've seen, and I think there is an awful lot that we're not seeing and we should be seeing and I'm really worried about that. I'm also worried that we're generating a massive backlog that we won't necessarily have capacity to deal with. – Participant 1

Participants also highlighted the challenges of having to respond to a new disease when very little was known about the progression of a COVID-19 infection. As a result, participants frequently experienced clinical uncertainty and the potential for such uncertainty to threaten their professional identity.

Some participants highlighted that patients often expected GPs to offer reassurance and provide answers, however the novelty of COVID-19 meant that GPs felt they could not always meet this expectation. One participant made particular reference to the lack of knowledge on 'long COVID' (a condition where COVID-19 symptoms persist over many weeks or months) and being unable to advise patients on the likely duration and development of their symptoms:

The doctors don't know and that, that I think it's really hard for the patients because they've come to us, expecting us at least if we don't have a kind of 'I know that you will be better in X amount of time', we can say that 'Well, other patients I've met with this condition, this is how it usually goes' but I don't know, all I can say at the moment is 'I know there are lots of other people in your situation, but I don't know what happens next'. We haven't had a next yet. – Participant 16

In normal times, GPs may consider themselves to be defined by their professional ability to deal with uncertainty – to manage whatever comes in through the door. These new conditions of more radical uncertainty represent a fundamental challenge to GP and wider primary care team identity. COVID-19 also impacted relationships between primary and secondary care, with GPs unable to make anything except urgent referrals (for possible cancer) to hospitals from April – June 2020. Some participants discussed the initial closing of many areas of non-COVID-19 care and the inability to make onward referrals, meaning that *'other stuff that's not COVID [is] just kind of sitting on our doorstep'* [participant 16], representing a further degree of clinical uncertainty and anxiety for GPs, as well as having to respond to a sense of frustration from patients.

So we've got more people kind of perhaps slightly upset that they can't get the care that they feel they should receive, I think probably the majority of that is the expectation of when things will come back in secondary care. So a classic example is people waiting for hip and knee ops, you know, people who are in pain, and you've been waiting and in pain for a while and then to be told 'You got to wait longer' and I think it's one of those, in fact, it's quite disempowering because we know that there's nothing I can do to change that. Except potentially tinker with some meds or, you know, there's not much I can do and so I think that kind of natural frustration, I think, you know, I think we see it probably in the population in general, I think. – Participant 11

What was particularly striking in this respect was the sense of disempowerment felt by GPs, and feeling unable to do their normal job, with this leading to a profound sense of uncertainty and concern.

The effects of rapid service change on the primary care profession

Uncertainty was also reported in respect of rapid service reorganisation having an impact on the primary care profession. For example, some participants raised concerns that the prioritisation of remote consultations might be exacerbating health inequalities as not all patients had access to the technology and private space required for a virtual consultation to take place. Safeguarding of their patients was also a concern acknowledged by a number of participants, unable to be sure who else might be present during a phone or on-line consultation, and it proving difficult or impossible for a patient to report concerns. These changes could be viewed as challenging the responsibility participants felt towards their patients and as a potential threat to their ability to fulfil their

professional role. This example highlights the lack of control primary care practitioners felt about these difficulties:

I am worried about the things that I was worried about before – the big things, like child protection, intimate partner violence, consultations with people for whom English isn't a first language. I am worried about our kind of known unknowns in that, the stuff that is hard to, in some ways, be able to do anything about. If people aren't phoning into the practice, because they don't feel that they can communicate with us adequately, how do we know to what extent that's a problem? – Participant 1

As the pandemic progressed, participants raised in their narrative reports the challenges of deciding who needed to be seen face-to-face, as opposed to a virtual or phone consultation. This concern about ensuring an appropriate pattern of primary care services took place as patients began to come forward again, particularly those with a more complex mix of conditions, as illustrated here:

I mean, certainly the mix of cases that we're getting now on the telephone consultations are getting more difficult to manage just on the phone. I don't think it's just that my tolerance for the risk and the uncertainty has changed – I think people are ringing us with other things now that they've been hanging onto for a while. And some things you really can only resolve by seeing them face-to-face. – Participant 12

So it's been it's been very odd and it's, I think to start with, there's a kind of relatively easy bit where you, you are doing emergency triage you're taking calls from patients who are deciding, are you really ill. Do I have to see you to save your life now or prevent something drastic? And that's a relatively easy question to answer, but as it drags on over several months, that's not, that's not good enough really, you actually have to address all the other needs that there are and it becomes much more difficult to make that decision of who you see and who you don't need to see. – Participant 16

Frequently, participants praised the efforts of the wider practice team in working together to implement vast changes to service delivery. In particular, a renewed emphasis on checking in on colleagues' wellbeing and a collective sense that everyone was 'in it together' was often noted. Wiedner et al. (2020) highlight this shared experience can facilitate social bonding and, as captured in the following quotation, developing knowledge about COVID-19 precipitated increased discussion between colleagues:

One of the things as well is that as a team, actually one of the things I've benefited from, is more discussion around cases. So general practice can sometimes be quite isolating and you can feel, particularly when you've got a busy surgery, everybody else is busy too, you've just got to make these decisions. And sometimes you ruminate on them and worry about whether you've made the right ones. There isn't really time set aside in the day for you to discuss cases and talk about things, you're conscious everybody else is busy. But one of the things is that we've been better as a team I think in sharing our discomfort and saying 'Well what would you do?' – Participant 12

The sustainability of changes made to primary care

Turning to the uncertainty felt about the effects of the pandemic on the future organisation of primary care, narratives highlighted the value placed on positive relationships with patients. In the initial phase of the pandemic, some participants questioned whether remote consulting would challenge their consultation skills and their ability to develop rapport with patients. However, other participants highlighted that some patients would prefer remote consultation as appointments were potentially less time consuming and easier to schedule around work commitments. Both responses demonstrate how participants called upon the professional identity of a primary care practitioner – changes to practice were framed via their effect on the quality of relationships with patients. Some participants reflected that they felt the increased use of remote consulting was here to stay and that '*we won't probably go back to general practice as it was before*' [participant 14].

I think it will suit a lot of people, I mean, just, you know, I've always been interested in health inequalities and there are lots of barriers to accessing healthcare for a group of people that I think that this sort of technology would be really helpful for. So the kind of people I'm talking about are the people in really low paid jobs who will get the sack if they take a day off, or who certainly won't get paid if they take a day off. And, you know, let's just say you're a labourer working on the roads for example, then you don't get paid if you take a day off and you might be working remotely, you might be staying in a caravan to do your job, you can't get away to see your GP. – Participant 2

As the pandemic progressed, a small number of participants did note that remote consulting, while based at home, could feel a little isolating, with some saying how much they appreciated the times when they did see patients face-to-face. Some participants raised concerns about how remote consultation affected their own perception of being a primary care practitioner, highlighting concerns that the future of primary care would be *'much more of a transactional role and almost call centre medicine'* [participant 12]

I think the only other thing I have to say about sort of remote first, when you are working from home, you do start to feel disenfranchised very quickly. So I had to do a week of sort of what I was waiting for swab results for my daughter and although you are sort of on the list, you don't really feel part of a team, you just feel like you're kind of going back to that. 'I'm just processing, I'm just getting through work', and I'm not having that shared interaction with my colleagues, I'm not going to coffee with them and those sorts of things. So it's difficult, because I think naturally there is a question mark over what can we do more of from home now, which I think we can at a push, but I don't think that should be what we're aiming for. We should be working in a virtual model, but actually, where we're in the same room together because I think that, you know, you're working in a hub, you're working as a core group working together. Participant 11

Participants' narrative accounts repeatedly highlighted the personal challenges presented by the initial stages of the pandemic. Participants referenced the difficulty of being able to switch-off from work and the challenges presented by living in lock-down which frequently obstructed the deployment of their usual coping methods. Participants frequently discussed the high level of exhaustion they were experiencing which was often linked to the difficulty of maintaining morale, both at an individual-level and also within practices. Those participants with school-age children also discussed the strain of

managing childcare and the difficulties of balancing the demands of work and home-life and the additional demands this could place on their partners. Our participants' narratives demonstrated that the challenges of responding to COVID-19 extended from the workplace into their home-life.

Discussion

The outbreak of the COVID-19 pandemic occurred rapidly and unexpectedly, throwing the usual procedures and routines of primary care up in the air, this disruption occurring within a wider societal and global context in which few areas of life were untouched by the sudden and yet sustained effects of COVID-19. Change in primary care took place at an organisational, team and personal level, impacting on the professional and home lives of all those working in general practice. In this way, the equilibrium of daily life and professional identity was truly punctuated and external influences created the conditions whereby, in Baumgartner and Jones' terms, there were 'bursts of frenetic policy activity' (2010, p. xvii). In parallel, individuals experienced disruption to both their professional identity and their personal sense of biography and life plans, with the extent of this becoming more evident as pandemic restrictions tightened (Bury, 1982).

This blending of policy and organisational change, with disruption and uncertainty at a personal and professional level, is interwoven in the narrative accounts given by the primary care practitioners in our study. It is important to note that alongside different degrees of uncertainty, anxiety and isolation, our research participants also reported a sense of liberation at times, being free to innovate in how primary care services are organised and delivered, seemingly released from what they previously considered the burden or constraint of regulation, performance monitoring, or policy control. Whilst inspection and regulation have as their intent the preservation and improvement of standards of quality and safety of care (Furnival et al., 2018), it has been noted in other studies of healthcare organisations that such scrutiny can be experienced by local managers and professionals as 'regulatory throttle' (Chambers et al, 2018).

The collected narratives of a group of primary care practitioners, recounting their individual story of the first six months of the COVID-19 pandemic reveal a complex set of paradoxes. Sudden change to the organisation of care delivery, yet such developments becoming sustained, and policy makers seeking increasingly to make them permanent. For clinicians, a strong sense of uncertainty about the treatment and course of COVID-19, alongside rising concern about all the non-COVID-19 patients who were not presenting for care, seemingly a ticking time bomb of morbidity and need. The service changes themselves appeared to be experienced in a paradoxical manner – sometimes energising, refreshing and different, and at others exhausting, worrying, and unsatisfactory in their apparent inability to meet the many and nuanced needs of the full population of patients. Furthermore, the effects of the pandemic are increasingly experienced as longer term, and likely to come in cycles of more or less virulence, societal restrictions, and attempts to 'control' infections and outbreaks. Hence general practice remains in a state of flux and uncertainty, the accounts of our study participants revealing their desire for a period of stabilisation, or equilibrium, and also a recognition that the long-term effects of the pandemic on primary care, and indeed its practitioners, are as yet unknown.

Primary care is accustomed to the management of uncertainty, for it is concerned with the diagnosis, management and treatment of undifferentiated illness and symptoms, being available to people as

their first point of contact with the health system, and having a concern for wider population and public health (Starfield, 1998). Our collected narratives of primary care practitioners demonstrate however the extent to which the COVID-19 pandemic has increased the level of uncertainty within general practice, and in complex and overlapping ways. From being unable to refer patients during the initial stages of the pandemic, having the 'heuristics' of consultation disrupted by the increased use of remote consultation, and concerns over virus transmission to themselves and others, primary care practitioners have had to respond to a high level of uncertainty within their practice, and in its impact on both their professional and personal life.

The uncertainty arising from COVID-19 marked a challenge to participants' ontological security, defined by Giddens (1991) as an individual's sense of continuity and certainty on which they ground their perceptions of who they are – their self-identity. Narratives from primary care practitioners reflected the discontinuities within participants' sense of their professional identity. Monrouxe (2010) notes that professional identities 'are not fixed cognitive schemas; rather, identities are what we do. Identities are asserted and claimed through continual interactions' (p.44). Arguably the fragmentation and physical dispersal of practice teams caused by COVID-19 interrupted this identity work – this process of mutual shaping and enactment of professional identity – just at the moment when GPs as a profession were most in need of ways to anchor to a new situation. Gordon et al. (2020) describe the transition from trainee to trained in medical education as a 'dynamic liminal phase, in which the sense of 'who I am' gives way to a sense of 'who I'm becoming' (p.1007). In some senses, primary care experienced COVID-19 as a reverse of this process, disrupting their collective professional biography as skilled managers of uncertainty and holistic face-to-face practitioners, leaving them uncertain how to practice and back to being 'beginners together' as one participant put it. For many, the identity work needed to regain a sense of who they were or who they are becoming is still work in progress. In Lewin's terms what has unfrozen remains fluid and may take some time to refreeze.

There are instances within the narrative accounts where Ashforth's concept of a 'transition bridge' (the mechanisms by which people process the disruption or role shock they experience) can be identified. For example, participants frequently highlighted their pride in the way the practice team had worked together to facilitate necessary changes during the pandemic response – fostering collective identity work despite the physical separation, in line with Wiedner et al (2020). Furthermore, some of them highlighted the potential positive long-term changes to primary care that might result from the response to COVID-19, such as greater ease of access to consultations through phone and online methods. And yet others reported on how the new ways of working had enabled a more measured and sometimes calmer experience of the working day, including the option to work from home. These forms of transition bridges facilitate individuals in making sense of the profoundly challenging situation in which they find themselves, as they foreground the perceived benefits that might arise from working through the COVID-19 pandemic.

As identified by Waring and Bishop (2011), clinicians who transitioned from the NHS to working within an independent sector treatment centre often interpreted the change in a way which maintained their biographical narratives. In a similar vein, often participants responded to the ontological insecurity surfaced by COVID-19 through the reconstruction and reassertion of their self-identity as a primary care practitioner. Participants address the ontological dilemmas of self-doubt and questions

surrounding the future of primary care through the construction of transition bridges. The transition bridges invoked are rooted in the participants' sense of what it is to work in primary care – they emphasise the relationship between practitioner and patient, along with the quality of care. This sense-making (Weick, 1995) is not however guaranteed to withstand the continued cycles of uncertainty and paradoxes of living and working with COVID-19 in the long-term.

The context in which primary care practitioners operate has changed in a sudden and disruptive manner, and some participants openly questioned whether changes might occur to professional identities within primary care, questioning how they personally might be able to adapt and fit in with a future form of primary care that was as yet unknown. Some questioned whether there might be a shift away from an emphasis on relational medicine which they saw as foundational to their identity. Other participants used their professional identity as a primary care practitioner as an anchor amidst the uncertainty. As we write at what we think is the beginning of a second surge of the COVID-19 pandemic, transformation, upheaval and uncertainty remain the watchwords. This chapter is a tribute to the diligence and willingness of a group of primary care professionals who have taken the time to reflect, record their experiences, and do so in the hope of making sense of global change experienced in their personal and professional lives, when almost everything is uncertain. As T. S. Eliot (1944) wrote 'And what you do not know is the only thing you know'.

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