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'We are largely left out': workplace and psychosocial experiences of Australian general practitioners during the initial months of the COVID-19 pandemic

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ABSTRACT

Background. The COVID-19 pandemic continues to exert a significant toll on the Australian primary healthcare system. Although wellbeing challenges faced by hospital-based healthcare workers are widely discussed, less is known about the experiences of general practitioners (GPs) during the initial phases of the pandemic. This paper reports qualitative survey data from Australian GPs, examining their workplace and psychosocial experiences during the initial months of the pandemic. **Methods.** An Australia-wide, cross-sectional, online survey of frontline healthcare workers was conducted in 2020. A qualitative approach using content analysis was utilised to examine responses to four free-text questions from GPs. **Results.** A total of 299 GPs provided 888 free-text responses. The findings reveal that general practice was overlooked and undervalued within the pandemic response, resulting in negative impacts on GP wellbeing. Four themes were identified: (1) marginalisation of GPs; (2) uncertainty, undersupported and undervalued in the workplace; (3) isolation and disrupted personal lives; and (4) strategies to support GPs during times of crises. Key concerns included poor access to personal protective equipment, occupational burnout and poor wellbeing, insufficient workplace support, and conflicting or confusing medical guidelines. **Conclusions.** Primary healthcare constitutes an essential pillar of the Australian healthcare system. This study presents the many factors that impacted on GP wellbeing during the COVID-19 pandemic. Enabling GP voices to be heard and including GPs in decision-making in preparation for future crises will enhance the delivery of primary care, reducing the burden on hospital services, and help sustain a safe and effective health workforce long term.

Keywords: coronavirus, COVID-19, frontline, general practice, healthcare workers, mental health, pandemic, primary health care, qualitative research.

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Introduction

The COVID-19 pandemic caused by the SARS-CoV-2 coronavirus presents a global health emergency on a magnitude rarely encountered (Nkengasong 2021). The initial months of the pandemic in Australia saw the healthcare system scrambling to organise responses and adapt within the context of immense social change and increasing case numbers. General practitioners (GPs) are the first point of contact with health care for most patients (Royal Australian College of General Practitioners 2020). Therefore, GPs have been particularly affected by the pandemic and the associated disruptions, together with challenges for staff safety and patient care.

Specifically, workplace stressors and challenges to personal wellbeing for primary care clinicians have been reported prior in international and Australian studies (Haldane *et al.* 2020; Li *et al.* 2021; Smyrnakis *et al.* 2021). One quantitative survey of 2235 Australian GPs conducted in May 2020 identified issues such as reduced income, inadequate personal protective equipment (PPE) and increased workload (Scott 2020). Workplace stressors included challenging working conditions characterised by longer hours, fewer breaks

and less opportunity for peer connectedness amidst pandemic restrictions (Kippen *et al.* 2020; Scott 2020). Importantly, the research identified an association between workplace disruption and mental health symptoms, including burnout and anxiety in GPs (Scott 2020). However, there exists a gap in the literature around qualitative findings from GP surveys, which may offer deeper and richer insights into their experiences.

In 2020, the Australian COVID-19 Frontline Healthcare Workers study (ACFHWS; Smallwood *et al.* 2021*a*) surveyed healthcare workers (HCWs) to examine the psychosocial and workplace impacts of the COVID-19 pandemic on their wellbeing. Data from the ACFHWS were previously used for quantitative (Smallwood *et al.* 2021*a*, 2021*b*) and qualitative (Willis *et al.* 2021) analyses into HCWs as a whole.

The substudy reported here aimed to isolate GP participants from the ACFHWS as a population for qualitative analysis. As GPs specialise in providing primary health care directly to the community, it was expected that ACFHWS responses from GPs would contain unique insights distinct from other HCWs. Indeed, understanding their specific experiences and recommendations are critical to improving health care for the community, and ensuring a sustainable GP workforce into the future.

Methods

A nationwide, anonymous, online, cross-sectional survey of self-identified Australian frontline HCWs was conducted between 27 August and 23 October 2020. Full details of the methods for the ACFHWS were previously published (Smallwood *et al.* 2021*b*). In short, eligible participants were self-identified 'frontline HCWs' in Australia, who accessed the REDCap-hosted survey via a purpose-built website (https://covid-19-frontline.com.au/) or through a direct link. Invitations to participate were disseminated through several networking sites and professional organisations, including the Australian Medical Association, the 'GPs Down Under' Facebook group and the VicREN practice research network.

The survey collected data regarding demographics and home life, workplace situation and change, organisational leadership and communication, mental health symptoms (both subjectively determined and assessed using five validated mental health survey tools), and coping strategies. Participants were invited to complete four optional free-text questions (Table 1) regarding pandemic-related challenges and stressors.

To understand GPs' experiences, this qualitative study examined ACFHWS responses provided by GPs who answered at least one of the free-text questions. Data were analysed using an inductive qualitative content approach that identified patterns and meaning from the data (Morgan 1993; Green *et al.* 2007).

One author (AG) thoroughly read through all responses and assigned an initial code to each response. These codes were used to generate a codebook. Through an iterative process, codes were added and the meaning of each code refined as the data was re-read. Codes with similar meanings were grouped together to enable the identification of overarching themes. Weekly meetings between authors enabled clarification of the codes and consensus on key themes to be achieved.

Ethics approval

Ethics approval was granted by the Royal Melbourne Hospital Human Research Ethics Committee (HREC/67074/MH-2020). All participants provided consent to this study prior to the completion of the survey.

Results

Participant characteristics

Of 9518 frontline HCWs who responded to the survey, 7846 participants provided complete responses, of whom 389 were GPs. Of these, 299 GPs (77%) provided at least one response to any of the four optional free-text questions (Table 1), totalling 888 written free-text responses for analysis in this study.

Of the 299 GPs (Table 2), the participants were disproportionately female (84%, n = 251/299) compared with the national average of GPs (44.2% female; Australian Health Practitioner Regulation Agency 2021). Participants were also disproportionately more likely (55%, n = 163/299) to originate from Victoria (compared with Victorian GPs accounting for only 7128/29 014 = 25% of the national total; Australian Health Practitioner Regulation Agency 2021). Length of responses varied considerably between one word and multiple sentences.

Four themes were identified. First, GPs wrote about being marginalised during the pandemic response; second, they described the feelings of uncertainty, undersupport and undervalue within the workplace during this time of rapid change; third, they reflected on the personal impact on their lives, including their mental health; and finally, they provided specific strategies for supporting GPs during times of crisis.

Theme 1: marginalisation of GPs

GPs recognised that primary care plays a pivotal role in the pandemic response, being positioned at the intersection between the community and hospital system. They expected to be proactively involved in the integration of primary care

Table 1. Free-text questions and number of responses from GP participants ($n = 299$).

Question	No. participants responding
Q1: What do you think would help you most in dealing with stress, anxieties and other mental health issues (including burnout) related to the COVID-19 pandemic?	258
Q2: What did you find to be the main challenges that you faced during the COVID-19 pandemic?	280
Q3: What strategies might be helpful to assist frontline healthcare workers during future crisis events like pandemics, disasters etc?	249
Q4: Is there is anything else that you would like to tell us about the impact of the COVID-19 pandemic or regarding supports that you feel are useful for wellbeing?	101
Total	888

Table 2. Participating GP demographic details ($n = 299$).

Characteristic	*n* (%)
Age (years)	
20–30	10 (3)
31–40	99 (33)
41–50	89 (30)
51–64	90 (30)
65–70	8 (3)
≥71	3 (1)
Gender	
Female	251 (84)
Male	46 (15)
Non-binary	0 (0)
Prefer not to say	2 (1)
State/Territory	
Victoria	163 (55)
New South Wales	63 (21)
Queensland	37 (12)
South Australia	15 (5)
Western Australia	9 (3)
Tasmania	6 (2)
Australian Capital Territory	4 (1)
Northern Territory	2 (1)
Region	
Metropolitan area	223 (75)
Regional area	66 (22)
Remote area	10 (3)

into the pandemic response, with an emphasis on allowing GPs' 'local knowledge [to] inform response' (Q3, 41–50 years, female, WA). However, they consistently described feeling marginalised as the public health response unfolded.

> As GPs, we are largely left out of the public health approach. (Q2, 50–64 years, female, Vic.)

> Incredibly frustrating the way GPs are the foundation of the healthcare system, but constantly overlooked (Q4, 41–50 years, female, NSW)

They argued that marginalisation of general practice increased the cost burden of the pandemic response.

> The Department of Health [should] use and mobilise GPs' knowledge in [and] of their communities to support us to test, treat and follow up patients. (Q3, 20–30 years, female, Vic.)

> I strongly feel that us GPs could have been more involved in testing and tracing ... What a shame that we, the primary care providers, have once again been overlooked; yet we remain the most cost-effective aspect of the health system! (Q4, 41–50 years, female, Vic.)

Failing to engage with GPs effectively meant that the public health response was unable to leverage the unique benefits of GPs' existing relationships with the communities they serve.

> We know our patients, the community and they trust us. [Do not] solely rely on hospital/research doctors to make plans about public health that really only looked at hospitals and did not understand [that] every GP clinic saves patients going to hospital. (Q3, 31–40 years, female, Vic.)

Finding themselves at the periphery of the pandemic response resulted in disillusionment.

> I now feel very cynical and let down by the government with its total abandonment and lack of respect/resources for general practice (Q4, 41–50 years, female, NSW)

> Too much of health is designed around the tertiary hospital setting – I think we need to seriously review this and properly position public health. (Q3, 50–64 years, female, Vic.)

GPs also felt that they were 'scapegoated', rather than supported, as GPs were blamed for spreading the virus.

> Anxiety skyrocketed when Dr [name removed] was treated the way he was by both politicians and media. It made me feel that I was exposing myself to significant risk (risks of telehealth, risks of contracting COVID) for a

system that would not hesitate to use me as a scapegoat. (Q4, 31–40 years, female, Vic.)

Would be really helpful ... being supported by government (state and federal) rather than scapegoated. Currently no faith that government would have the back of any healthcare worker. (Q3, 41–50 years, female, Vic.)

Two specific examples of marginalisation were frequently raised: failure in communication between government and general practice and the lack of PPE.

(1) Failure of communication

The failure to include GPs effectively within the public health response resulted from a failure to communicate with GPs. GPs who held leadership roles within their practices described a lack of clear, timely information from authoritative bodies

I wrote my first pandemic protocol for our clinic in January [2020] – at that stage I was doing so blind! Guidance from the [relevant authorities] came far too late. (Q2, 41–50 years, female, Vic.)

They wrote about:

Often finding out updates through the media rather than the right channels first. (Q2, 31–40 years, female, Vic.)

They described needing to filter media, professional and scientific statements, as well as public health messaging to develop their own workplace protocols for their staff. Moreover, GPs wrote about the need to support their patients using up-to-date information. The lack of clear guidance meant they had to scramble to develop their own guidelines, which increased GPs' anxiety about maintaining personal and patient safety.

Too many sources of info (state/federal/RACGP/etc.) (GP, 41–50 years, female, NSW)

Clear communication, acknowledge that guidelines change, where to find updates, access to higher level information – would be really helpful to get information that we could disseminate to our patients. (Q3, 41–50 years, female, Vic)

Trying to sort out protocols to keep the community (in a town on the edge of the metropolitan area) and ourselves safe. (Q2, 50–64 years, male, Vic.)

The above quotes demonstrated the paradoxical phenomenon where too much information resulted in insufficient information. What was needed was clarity of communication.

(2) PPE

GPs wrote at length about the struggles and challenges of accessing PPE, which was made all the more difficult for not being perceived as being on the frontline of care. The challenges they wrote about confirmed to them that their contribution to the pandemic response was not valued. Participants understood the PPE shortage (and hence their feeling of compromised personal safety) to be beyond their control, and variously attributed the responsibility for PPE supply to practice management, the government and primary health networks.

Primary care is often regarded as an essential fundamental service ... but when it comes to supply of PPE or funding for adaptation, it's left to fend for itself with scraps for rebates. (Q4, 50–64 years, female, Vic.)

Consider GPs as front line might be a good start. Stop treating us as second-class doctors. Give us PPE and support. Not all doctors work in hospitals (Q3, 41–50 years, female, Qld)

Lack of PPE, (the local [primary health network] gave us access to four masks for a five-doctor clinic to last us the duration of the pandemic) (Q2, 31–40 years, female, Qld.)

No PPE gear supplied from the government to GPs, as we are not considered front line. (Q2, 41–50 years, female, Vic.)

These quotes reflect a sense that that GPs were in competition with other HCWss for essential PPE. They also specifically wrote about the inequity of access to PPE and fit testing.

Very frustrating to have to source our own ... [we] feel left out of all the planning. Involve community health in response – ludicrous that GPs were left out of the response in terms of involvement and PPE (Q3, 31–40 years, male, Vic.)

Fit-testing never talks about general practice, although we are [COVID] testing and seeing symptomatic patients. (Q3, 50–64 years, female, Vic.)

Theme 2: uncertainty, undersupported and undervalued in the workplace

The rapidly changing work environment also posed unique challenges. GPs' concerns traversed struggles with leadership, business concerns, and the challenges of keeping themselves, their staff and their patients safe while simultaneously attempting to maintain a high standard of care to their communities.

> Constant changes, lack of clear guidance early on with managing patients, constant changing of practice guidelines (GP, 31–40 years, female, NSW)

GPs described struggles within their workplace as they navigated crucial issues of safety at work. They were critical of leadership that downplayed workplace safety.

> Poor leadership at work – reluctant to change practices to ensure COVID safe workplace (Q2, 50–64 years, female, Vic.)

> Workplace downplaying risk and making me feel alone in my concerns about the pandemic. (Q2, 50–64 years, female, Vic.)

> Senior management gaslighting of staff concerns (Q2, 31–40 years, female, Vic.)

Many GPs reported 'feeling unsupported and undervalued at work' (Q2, 31–40 years, female, NSW), and desiring 'more professional clinical support' (Q1, 31–40 years, female, Vic.), with the business model of general practice exacerbating these issues:

> Working in private general practice feels as though we are not really supported by any organisations. State Health Departments have a hands-off approach to us, as we work for Medicare. Medicare sees us a private business. The people that run the business are not medical, so don't understand our needs. It feels very unsupported and yet we do a lot of the primary work dealing with all this. (Q2, 41–50 years, female, NSW)

In addition to feeling unsupported, GPs described bearing the brunt of patient behaviours, which, at times, amplified their exposure to risk:

> Patients lying about respiratory symptoms and travel history, and still presenting to clinic in person (Q2, 20–30 years, female, Qld)

> Lots of anxiety about someone coming in my room and infecting me. Some patients thought it was funny to cough on me as a joke. I have had to stop seeing infants and children, because I couldn't cope with them touching things in my room and no parental control. (Q2, 50–64 years, female, Vic.)

Beyond the risk of acquiring SARS-CoV infection, GPs described other significant stressors. For instance, presentations to general practice changed in response to the impact of the pandemic on the community. Participants reported increased emotional exhaustion, as they responded to more patients presenting with mental health issues and social isolation.

> In the second wave, the challenge has been the mental anguish and emerging mental health issues in my patients. New eating disorders in young people. Parents on the brink. New mothers isolated and alone sobbing down the phone. (Q2, 41–50 years, female, Vic.)

> Patient anxiety, especially isolated elderly, several cases of COVID paranoia (Q2, 50–64 years, female, Vic.)

For practice owners, the management of general practice also took its toll.

> Owning a practice, rapidly changing the business in a physical sense and business sense, and how we practiced medicine. It changed overnight to keep everyone as safe as possible, but it took a long time for other [doctors], employees and patients to get it. I had many sleepless nights worrying about everyone's safety and keeping the business going. (Q2, 50–64 years, female, Vic.)

The above quote demonstrated the complex nature of the pandemic response, including the unique challenges faced by GPs in leadership roles.

Government regulations reduced the options for billing private fees, reducing the remuneration for many consultations. This was especially the case for telehealth consultations (Royal Australian College of General Practitioners 2022). Reduced payments increased the financial stress experienced by individual GPs, as well as the practices themselves.

> Financial stress is huge in general practice, Billings have been affected, meaning longer hours at work with little reward. This is scarcely sustainable and adds additional worry to already stretched practitioners. (Q4, 41–50 years, female, WA)

> I am working more, because [I am] forced to bulk bill because of telehealth ... I get zero government help – really unfair. (Q1, 41–50 years, female, Vic.)

> Enforced bulk billing was a dreadful thing to impose on practices when we were already faced with increased costs ... therefore, a reduction in income. (Q4, 41–50 years, female, NSW)

With the changes to the Medicare Item numbers came new compliance requirements that further increased the workload for the doctors and the practice staff.

> [Medicare] item numbers changing suddenly with loss of income, but more responsibility. (Q2, 50–64 years, female, NSW)

> [Need] adequate remuneration for time spent – many, many unpaid overtime hours. (Q1, 31–40 years, female, Vic.)

In addition to the financial stress, the rapid adoption of telehealth also posed challenges for general practice with the introduction of novel technologies impacting the delivery of care:

> Managing risks of telehealth, lack of examination capacity with risk of bringing individuals into the practice. (Q2, 31–40 years, female, Vic.)

> I find the telehealth challenging and exhausting, it contributes to burnout. I eel I am more likely to miss something important, and also that I order more tests. (Q1, 41–50 years, female, Vic.)

Another financial burden discussed by many participants was the lack of sick leave for GPs.

> GPs don't have paid sick leave. If we get sick from this virus, or get exposed and need quarantine, we will have zero income. (Q1, 41–50 years, female, NSW)

The triad of decreased income, increased workload and needing to manage more emotional health issues contributed to poor psychological wellbeing of GPs.

> Loss of motivation to work due to reduced income – very unmotivated to attend. (Q2, 50–64 years, female, Vic.)

> Combating increasing emotional fatigue caring for those affected by COVID takes a toll of me as a primary care physician. (Q2, 41–50 years, female, WA)

Theme 3: isolation and disrupted personal lives

GPs described the impact of the pandemic on their personal lives, including the impact on their mental health. Many were isolated from their usual social and family supports, because they were a health worker.

> As a health worker [I was] asked to go away from social supports, furloughed and quarantined due to close contact, and living alone and subsequently working from home alone for a period of time. (Q2, 31–40 years, female, Tas.)

> Being able to see my children would help, but the closure of state borders has made this impossible. (Q1, 65–70 years, female, Vic.)

Lockdowns and quarantine increased home duties as well, with home schooling and supervising children who would normally be at school or in childcare occurring alongside delivery of patient care:

> Increased demands of childcare/schooling/single parenting. Knock on impacts in terms of managing (not managing) my own workload. (Q2, 41–50 years, female, Vic.)

> Increased workload due to adoption of additional positions as a result of COVID-19, and trying to juggle this with supervising children (especially during that period of online learning) (Q2, 41–50 years, female, NSW)

Although some GPs recognised their personal need for formal health care, their increased work and home responsibilities created barriers to accessing this care. Often patient care was prioritised over self-care.

> I simply don't have time to consult with a psychologist or do any of the things that I advise my patients to do for their mental health! (Q1, 65–70 years, female, Vic.)

When asked about methods for coping with stress in Question 1, GPs offered several personal strategies.

> Diet, exercise, mindfulness, sunlight, sleep, creative outlets, connection with family, friends, culture, nature. (Q1, 31–40 years, male, Vic.)

> Increase sleep, time in nature, decreased [alcohol] helped, psychologist is helping (Q1, 31–40 years, female, Vic.)

Theme 4: strategies to support GPs during times of crisis

Throughout their responses, GPs described the strategies that worked, and those that they wished to see implemented. Participants provided specific examples regarding what enabled them to surmount the difficulties they faced as the pandemic unfolded.

GPs highlighted how peer support groups (including online support groups) provided both practical information and emotional support. Communication with peers who were confronting the same issues was especially helpful in the absence of clear public health guidance.

> I've learnt most from GPDU ['GPs Down Under'] Facebook group than anywhere else, certainly nothing from any government organisations. (Q4, 41–50 years, male, Qld)

> [GPDU] ... provided me with an enormous amount of timely information, support etc. 100 times that of any other group supposed to be advising or assisting. (Q4, 41–50 years, female, NSW)

Improving access to professional mental health support was suggested to help cope with workplace stressors.

> Psychologists/counsellors can help us fine tune and deal with stress better. (Q1, 31–40 years, male, Vic.)

> A mental support programme for health professionals. (Q1, 41–50 years, female, Vic.)

Participants felt that public health and other health leaders could provide better support for general practice. The simple suggestion that GPs should have received positive recognition of their service to the community mirrored previous statements regarding being ignored and marginalised by leadership.

> Better appreciation of GPs' role in COVID management to improve morale (Q1, 31–40 years, female, NSW)

> More appreciation from both government and patients ... and an acknowledgement that [health care workers] put themselves in harm's way on a daily basis. (Q1, 65–70 years, female, Vic.)

Pragmatic support was suggested, such as enabling GPs to have more time off with paid leave options, especially sick leave.

> Paid leave in general practice [or] some kind of safety net for income ... Impossible to take time off without significant financial detriment. (Q1, 20–30 years, female, SA)

> I would have preferred to have more time out of the workplace e.g. 1–2 days off, and be paid some subsidy so as to preserve my health and finances. It's been brutal. (Q4, 50–64 years, female, Vic.)

GPs offered suggestions for systemic change to improve future pandemic responses. Addressing deficiencies in key areas, such as PPE access for primary care providers, was a common suggestion.

> Ensuring the nation is better prepared with nationally manufactured stockpiles of almost everything (Q3, ≥71 years, female, NSW)

Most importantly, participants felt that future crisis planning should include GPs given their expertise, community engagement and 'local knowledge [to] inform response' (Q3, 41–50 years, female, WA).

> Use us as a resource and communicate with community-based care. (Q3, 50–64 years, female, Vic.)

Discussion

This qualitative study highlights the lived experiences of Australian GPs during the initial months of the COVID-19 pandemic. GPs felt marginalised from the initial pandemic response, even though they were keen to provide their expertise. Additionally, GPs experienced workplace changes, heightened workplace risks, increased workloads and financial instability. These issues had a negative impact on GP wellbeing.

A recent systematic review demonstrated how pandemic taskforces often include epidemiologists and virologists, but lack primary healthcare practitioners, thus resulting in a failure to integrate primary care within the overarching public health response (Desborough *et al.* 2021). A pandemic response requires community-based approaches where personalised care and community education are critical for preventing disease spread and hospital admission (Smyrnakis *et al.* 2021). In our study, GPs understood that their unique integration with their communities was a vital asset that would benefit pandemic responses, as they were best-placed to understand how to engage with their communities.

The marginalisation of GPs occurred at the public health level and at the level of individual or group general practices. This marginalisation manifested in many ways, with one example being poor communication from public health leaders. GPs relied on community information and spent many hours of unpaid work interpreting the impact of these messages on their delivery of patient care. This is consistent with quantitative findings (Kippen *et al.* 2020). GPs sought leadership that provided streamlined, timely information to support their delivery of effective care to the community, recognising that this would enhance safety and reduce the cost of care. The existence of previous calls for robust, effective, inclusive leadership as part of pandemic preparedness reinforced the frustration related to the marginalisation (Desborough *et al.* 2021; Sotomayor-Castillo *et al.* 2021). Interestingly and somewhat disappointingly, these sentiments that GPs were not supported arise not only in pandemics, but in other disaster scenarios, such as the 2019–2020 bushfires, further reinforcing that the marginalisation of GPs exists at a systemic level (Burns 2020).

GPs also perceived leadership failures as a cause for the lack of sufficient PPE acquisition, resulting in unsafe workplaces. The need to include PPE was already known since the SARS and H1N1 influenza pandemics to be a key factor in pandemic preparedness (Lee and Chuh 2010), yet nevertheless the lack of PPE during the COVID-19 pandemic proved a global problem (Yu *et al.* 2020; Miralles *et al.* 2021; Newton *et al.* 2021). GPs are frontline workers embedded within their communities and are at significant risk of infection, particularly as GPs are often caring for people with undifferentiated illness. Lack of PPE contributed to mental

distress and anxiety experienced by the GPs, increasing their experience of marginalisation.

Further challenges included a perceived lack of support, even within the workplace. Sotomayor-Castillo *et al.* (2021) found that only 43% of Australian GPs felt well supported initially during the pandemic. Lack of support being experienced at a time of increased workloads and longer working hours had an impact on GP wellbeing (Scott 2020). A part of this support needs to include ready access to support for personal wellbeing, especially during periods of social isolation through support systems, such as regular check-ins and access to counselling. Providing support for primary care workplaces is important in safeguarding GP resilience (Robertson *et al.* 2016).

Financial stress was also a key concern; some aspects of which were unique to GPs compared with other HCW groups. For instance, loss of income was magnified by changed billing practices, such as mandated bulk-billing of telehealth items (which was reversed on 1 October 2020, after the ACFHWS began collecting responses; Royal Australian College of General Practitioners 2022). GPs' contracted arrangements often had no provision for sick days or paid leave; overworked GPs felt they were forced to choose between inadequate rest or further losses to income. Some GPs called for access to paid leave in crisis situations.

Last, GPs provided pragmatic strategies to support future responses to pandemic crises. GPs confirmed their willingness and expectation to step in to support the work of the public health teams. Their intimate knowledge of and trusted role within local communities would enable them to assist in developing effective strategies to engage with the communities, especially with vulnerable peoples. GPs developed innovative ways to support each other to enhance their capacity to respond. Strategies to ensure better support for GPs would also improve the capacity to respond effectively to future crises, including pandemics. Such strategies should include support for GPs' wellbeing, including physical, mental, social and financial health.

Importantly, the qualitative results elucidated by this study are supported by quantitative analyses performed on GP responses to the non-free-text ACHFWS questions, which we have previously published (Ng *et al.* 2022). Key results obtained from the 389 surveyed GPs (of which this study's 299 GPs were a subset) include moderate-to-high rates of burnout (n = 225, 58%) and anxiety (n = 220, 57%). Moreover, significant changes were observed in the hours worked (n = 258, 66%, $P < 0.001$), with many reporting an increase in unpaid hours (n = 136, 35%, P = 0.017). A majority also reported decreased household income (n = 232, 60%).

Strengths and limitations

The ACFHWS was the largest multi-occupation study globally to examine the psychological, workplace and financial disruptions associated with the COVID-19 pandemic in both primary and secondary care (Smallwood *et al.* 2021*b*). This particular study is one of the first qualitative investigations where questions permitting free-text responses captured insights into GPs' experiences and concerns. The large number of free text comments provided a rich data set. Participation in this study was voluntary with the potential for participation bias to be a limitation. For example, Victorian GPs were overrepresented, as mentioned in the Results, possibly because the survey was issued during Victoria's 'second wave'. The data were gathered at a single timepoint, well into the first year of the pandemic when GPs had had time to reflect on the issues they were experiencing. Importantly, this was before COVID-19 vaccinations were available. This suggests that a longitudinal study would provide further understandings across different phases of the pandemic.

Conclusion

General practice is a critical pillar of the Australian healthcare system. As experts embedded within the communities they serve, GPs hold vital knowledge that will support public health measures to enable emergent issues to be addressed. This study highlights the consequences of the failure to adequately include GPs in pandemic preparedness processes and in the pandemic response itself. The marginalisation of GPs accentuated the personal and workplace challenges experienced. The potential impact on both the health care of the community as well as Australia's primary healthcare workforce are serious issues that need to be addressed. This study offers pragmatic advice crucial to future crisis planning.

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