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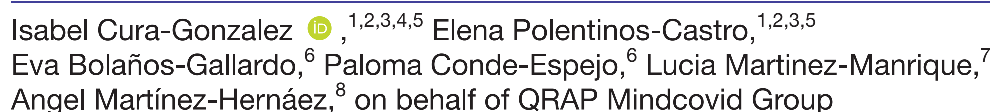
From unconditionality to disenchantment among primary healthcare professionals during the COVID-19 pandemic: a qualitative study from Madrid, Spain



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ABSTRACT

Objectives To explore the experience of primary healthcare (PHC) professionals in their professional role during the pandemic and to describe collective coping strategies.

Design We conducted a qualitative study using interviews, focus groups and photovoice techniques from February to September 2021. The qualitative data were transcribed, aggregated and analysed, from a hermeneutic perspective, using applied thematic analysis and ethnographic approaches.

Setting Primary Care Health Madrid region (Spain).

Participants Convenience sampling was used to select 71 multidisciplinary primary care professionals who were working in 12 PHCs representing diverse socioeconomic, social vulnerability and COVID impact levels in the Madrid region (Spain).

Results Findings from this study show how lack of protection in the early days, uncertainty about how the disease would evolve and the daily challenges they faced have had an impact on the participants' perceptions of their professional role. Nuanced differences in impact were found between men and women, age groups, professional roles and territories. The questioning of the basic foundations of primary care and the lack of prospects led to a feeling of demotivation. They perceive a wide gap between their levels of involvement and commitment, the recognition they receive and the attention to resources they need to do their work to a high standard. The support of their colleagues was seen as the most valuable resource for coping with the crisis.

Conclusions The practitioners' discourses offer knowledge that could help to face new global health threats; they also identify an urgent need to restore the role and motivation of PHC professionals as part of a wider regeneration of health systems.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The inclusion of multiple primary care professional profiles favours the incorporation of different perspectives.
⇒ The use of virtual interviews, necessary for health reasons, may have affected the spontaneity and depth of the interactions.
⇒ The fact that the interviewers did not belong to the health system facilitated an atmosphere of trust and openness for the participants.
⇒ The analysis was conducted by a multidisciplinary research team which allowed for a more comprehensive approach and reduced interpretative biases.
⇒ Due to the qualitative nature, the study findings may not be generalisable to primary care professionals as a whole, although they do provide an in-depth and contextualised understanding.

INTRODUCTION

The recent COVID-19 pandemic gave rise to a global health crisis that has impacted public health systems worldwide.[1] It was assumed that health systems in the global north would be prepared to cope with the problem as they had in previous epidemics.[2] In the first wave in Europe, Human Development Index indicators—life expectancy, urbanisation and health expenditure—showed positive correlations with standardised mortality rates, reversing in later waves. The highest rates were found in Belgium, the UK and Spain[3] in the first wave and in Hungary, the Czech Republic and Slovakia in the waves after 23 June 2021, when countries with more resources and better health status performed better than Eastern European countries.[4] Recommendations from the WHO[5] and the European Commission were based on population-based screening coupled with high investment in hospital care and insisted from the beginning of the pandemic on the need to strengthen primary healthcare (PHC).[6]

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The outbreak of the pandemic in March 2020 overwhelmed the capacity of the Spanish healthcare system and forced organisational changes at all levels of care. Attention to COVID pathology was prioritised over attention to other health problems.[7] As in many other European countries, the Spanish PHC system, considered since the 1990s to be one of the best in the world,[8] was responsible for the screening and diagnosis of COVID-19 patients, the non-hospital treatment of patients and, in the initial moments of the collapse of the health system, the complex home care of patients with acute and chronic pathologies and palliative care.[9] At the same time, many public health professionals were relocated to different jobs with new tasks, such as working in nursing homes, field hospitals, hospital services[10 11] and field work in the national seroprevalence study.[3] However, for many months, the health system response was measured only by process indicators of hospital activity, absolute numbers of admissions, intensive care unit patients and deaths. Hardly any PHC activity figures were published, despite the fact that, from the early stages, most COVID cases were mild-moderate or asymptomatic and only one-tenth of the infected population required hospital care.[7 11–13] This increased the hospital-centric view as the best response to the pandemic and at the same time helped to discredit PHC.[14]

Undoubtedly, the pandemic has modified the framework of relationships with patients[15] and has exacerbated the crisis of the PHC model in many countries and the impact on their professionals.[16–18] Most of these studies, such as those we have carried out in Spain, have focused on the impact of the pandemic on professionals' mental health,[19 20] but the impact on the professional role remains to be analysed. To this end, an ethnographic approach[21] was needed to study the role of multicausal networks and to address the impact of the pandemic, understanding health professionals as a group with shared knowledge and expertise. The aim of the study was to explore the experience of PHC professionals in the Community of Madrid in the performance of their professional role during the pandemic and to describe the collective coping strategies they implemented in the health centres (PCHC).

METHODS

Design

Qualitative research was conducted with focus groups, in-depth interviews and photovoice techniques. We selected focus groups because they allow for the exploration of group dynamics and the understanding of shared perspectives, offering a broader view of collective experiences. Individual interviews enabled an in-depth exploration of the experiences of participants who had faced more severe situations and allowed us to include the perspectives of professional profiles that could not be explored in the group setting. Regarding photovoice, this technique allowed us to combine photography with oral narratives. It enabled participants to visually capture their experiences and realities, reflecting on them in a shared space. This approach facilitated the communication of aspects that might be challenging to express solely through words. The Consolidated criteria for Reporting Qualitative research checklist is provided as supporting information (online supplemental file 1).

Setting and participants

The study context was PHC in the Community of Madrid (Spain), which had a population of 6 751 251 inhabitants in 2021 (INE 2021) and a COVID-19 prevalence of 11.3% in the first wave.[3] Spain's national health system is publicly funded, providing universal healthcare coverage free of charge at the point of use. Convenience sampling was carried out considering criteria of age, gender, profession and health centre. Between February and September 2021, 71 health and non-health professionals were recruited in the 12 PCHCs included in the MINDCOVID (https://www.mindcovid.org/) and QRAP-MINDCOVID projects, representing diverse socioeconomic, social vulnerability and COVID impact levels across the region.[22] The participants were approached by telephone and mail. Informed consent was obtained from each participant for the interview and audio recording. The description of the participants is presented in table 1.

Patient and public involvement

Patients and/or the public were not involved in the design, undertaking, reporting or dissemination plans of this research. The subjects of the study were the professionals. The interview and focus group scripts were discussed with two general practitioners (GPs) and two nurses, and they evaluated the dissemination plans of our research.

Data collection and analysis

Data were collected through 6 focus groups, 14 virtual interviews and 3 groups using photovoice methodology.[23] The groups and interviews were conducted by a psychologist specialised in qualitative research, and the photovoice groups by a sociologist and a photographer with experience in the technique; both women, neither of them was affiliated with the health system. The photographic material produced in the photovoice technique and the development of the methodology form part of a different case study; only the recordings of the group discussions were used in this research. The interview and focus group scripts were discussed with two GPs and two nurses, and they evaluated the dissemination plans of our research and proposed modifications. They identified priorities and potential outcomes that added significant value for the study subjects. They also contributed to reviewing the participant information sheet and informed consent form, focusing on content, language and presentation. For each professional group involved, a representative was designated to establish recruitment channels and enhance the information provided to participants. The

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Table 1 Characteristics of the participants

	Professional	Gender	Profession
Interviews	I1	Woman	General practitioner
	I2	Man	General practitioner
	I3	Woman	Physiotherapist
	I4	Woman	Home palliative care nurse
	I5	Woman	Home palliative care doctor
	I6	Woman	Social worker
	I7	Woman	Social worker
	I8	Man	Dentist
	I9	Woman	Nurse
	I10	Woman	Midwife
	I11	Man	Nurse
	I12	Man	Paediatrician
	I13	Woman	Psychologist
	FFFFGA1	Man	Nurse
	FGA2	Woman	Nurse
	FGA3	Woman	Nurse
	FGA4	Woman	Nurse
	FGA5	Woman	Nurse
	FGA6	Man	Nurse
	FGA7	Man	Nurse
	FGB1	Woman	Nurse
	FGB2	Woman	Nurse
	FGB3	Woman	Nurse
	FGB4	Man	Nurse
	FGB5	Woman	Nurse
	FGB6	Woman	Nurse
	FGD1	Man	General practitioner
	FGD2	Woman	General practitioner
	FGD3	Woman	General practitioner
	FGD4	Man	General practitioner
	FGD5	Man	General practitioner
	FGD6	Woman	Paediatrician
	FGD7	Woman	Health centre administrator
	FGE1	Man	Health centre administrator
	FGE2	Woman	Health centre administrator
	FGE3	Woman	Porter
	FGE4	Woman	Health centre administrator
	FGE5	Man	Porter
	FGE6	Woman	Dentist
Photovoice	PVA1	Woman	Nurse
	PVA2	Woman	General practitioner
	PVA3	Woman	General practitioner
	PVA4	Man	General practitioner
	PVA5	Woman	General practitioner
	PVA6	Woman	General practitioner
	PVA7	Woman	General practitioner
	PVB1	Woman	General practitioner
	PVB2	Woman	General practitioner
	PVB3	Man	General practitioner
	PVB4	Woman	General practitioner
	PVB5	Woman	General practitioner
	PVB6	Man	General practitioner

Continued

I:interviews
FG:Focus group
PV:photovoice

results were presented to the participants, emphasising the value these findings held for them. Based on these insights, new lines of research were opened. The script with the main themes explored in the groups is presented in online supplemental file 2.

The two principal investigators of the project participated as observers in the groups; their role was to take field notes and keep a methodological notebook on critical reflections and analytical inferences for subsequent discussion. All the recordings were transcribed and analysed to identify the main themes and subthemes and prepare an index with identification codes from a hermeneutic perspective, using applied thematic analysis and ethnographic approaches. The three main researchers then triangulated the analysis, and once it had been agreed, a workshop was held with the PHC informants.

RESULTS

We identified five central themes describing the experiences of PHC professionals in carrying out their role during the various waves of the pandemic. Aspects such as health system management and the relationship with patients and citizens cut across the different themes (see table 2). The participants' discourse was presented as a transition along the timeline (labelled by the waves), which served to structure the topics gathered in table 2. They describe their experience starting with the initial disbelief at what was happening, the reality that only allowed them to endure with a commitment and unconditional loyalty to the healthcare system and the population of the country, and later how the daily routine and the caregiving and emotional burden in the context of a macromanagement they considered detached from reality, very hierarchical and lacking participation, led to

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Table 2 Themes and subthemes

Topics	Subthemes
Uncertainty and sense of unreality (online supplemental file 3)	As if no one had expected it
	A life with everything on hold
Resist (online supplemental file 3)	Unprotected
	Barriers
	no diagnostic tests, no treatment
	No oxygen
One day, then another day, then another (online supplemental file 4)	In the territory/on the ground
	Virtual environments and homes
	Overload
Management of the pandemic (online supplemental file 4)	Those at the top
	Small-scale management and self-management
	The value of equipment
	Leadership
	Meeting places
From unconditionality to disenchantment (online supplemental file 5)	Commitment
	Exhaustion, weariness, frustration and anger
	Invisible. We were never closed
	Neither heroes nor villains
	The future to come

the disenchantment they were experiencing at the time of the research. A comprehensive list of the verbatims is provided in online supplemental files 3–5 by theme and subtheme.

Theme 1: uncertainty and sense of unreality: as if no one had expected it

Most of the professionals describe the initial moment as a sudden event, in which they were unprepared to act. Only when the government declared a state of alarm did they become aware of what was happening and the scale of the emergency. Their memories of those early days are marked by fear, chaos and uncertainty, which they experienced with a sense of unreality.

> We saw what happened in China, […] what was happening in Italy, and we were incapable of accepting that the next day it would be in Spain, we would have it here, we didn't want to see it (E3.F).
>
> The first thing: the shock, the not knowing, the stress, the mess, the fear, the fear of the unknown, of not knowing what to do, how to dress, how to manage everything (E9).

One of the most recurrent images in their memories is the unexpected vanishing of normality, the loneliness of the deserted streets: a reality in which life seemed to have come to a standstill, and that evoked apocalyptic representations of the world from cinema or literature. The silence before the battle.

Theme 2: resist

The professionals used the metaphor of war in their narratives to summarise feelings of fear, menacing danger and vulnerability. Their perception was of being in the midst of the battle where the only thing they could do was fight and resist, dig 'the trench', act quickly, without protection and prioritise without the necessary resources. Probably the main contributor to this experience of defencelessness was the lack of protection (sufficient suitable masks, personal protective equipment) during the first weeks; it was one of the most difficult episodes to take on board and one that has caused the most anger and frustration. Many of the testimonies we collected are filled with intense emotion, and in the groups, it generated moments of collective indignation:

> I often felt I was acting as though I was in a war, I was prioritising in that way, [that] the priority is to keep them calm. They are dying; let them be as calm as possible. We have to get on with things quickly (E5. MFAD).
>
> You had a coffee or you greeted your colleague, in your mask, with your disinfectant, keeping your distance and all that, they could see who the casualties were, couldn't they? This [is] like war. "Who has gone down today? Does anyone have a fever?" (E3. F).

Building barriers and defending against the virus inside the health centre led to ambivalent feelings:

> We have never worked like this! […] Working at a distance, not being able to get close to the patient, putting more barriers between us and the patients again. This is not the medicine I learnt, but this is what we have to do now (G.PHT2).

No diagnostic tests were available outside hospitals until 11 May, 2020, which they consider led to a lack of recognition that most COVID patients were being managed in the community setting. Although they are aware that initially no evidence was available on the treatments that were being implemented, the fact that some of them, such as chloroquine, were only prescribed in the hospital setting was another source of anxiety and helplessness. With hindsight, the discourse is much more reflective. The saturation of the various health services had a knock-on effect on all levels of care, symbolised by having 'no oxygen'. 'We were there with them, and that's all there is to it' is an often-repeated phrase. In general, they share that this initial feeling of a battle with a quick start and end transformed into the sensation of facing a prolonged and unfinished phenomenon, which changed their daily lives and whose effects and experiences have varied over time.

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Theme 3: the day-to-day: one day, then another, then another…

They relate their experiences by referring to the timeline that marks the pandemic: the beginning of the state of alarm; the summer and the subsequent wave; the post-Christmas wave, storm Filomena (which brought heavy snow to parts of Spain in January 2021 and disrupted transport and services in the region of Madrid for several days) and, finally, the present (spring-autumn 2021), when the last groups and some of the interviews took place.

> It depends on which phase […] I think it depends a lot on the moment, we've been through a very intense year, very long with many phases […] they went a bit in parallel to the waves of COVID and, from that perspective, your experience changes (GP group 2).

One of the factors that condition their experiences is the location of the health centre. Those who worked in heavily affected and more disadvantaged areas suffered greater exhaustion because of the high pressure of care, overwhelmed hospitals and the higher needs of the population. The impact was also greater for those working the late shifts.

> When they come, it's often not just for medical consultations, but they have nowhere else to go. It's soul-destroying and it's hard one day after another… Then you get home late at night and you can't switch off [….]. Of course, the good thing is that communities have organised to rally round, to share; where there's less, there's more sharing (G.PHT 2).

From the outset, the testimonies reveal an overload of care, brought about by organisational changes, lack of resources at work and family burdens. Modifications to guidelines and protocols, and organisational changes in the form of telephone and virtual care were understood to be necessary but contributed to burnout among the professionals and lack of accessibility perceived by the public.

> The reality of our working day is an endless list of patients requesting telephone care (GPHT1).

Home visits were one of the most difficult moments. Outside their usual setting, where measures were in place to reduce risk, they lost some of the control they had over the situation. Home care was also an experience of death that has left its mark on the professionals. In some cases, they were the only witnesses to the death of their patients. Many of these deaths were experienced as close emotional losses following long clinical relationships with the patients.

> The dead are not numbers. The dead are patients and I can put names to many of those numbers; and their faces and stories stick with you (E1.GP).

Care overload appears in their narratives from the start. They mention a lack of human resources as one of the reasons for their frustration, and it emerges as the main cause of stress at work.

> The feeling that there is nothing else; and the feeling of being left with patients and more patients and people who are sick and sick and sick. And being incapable. I mean, I can't cope any more (GP group 1).

In addition, the women professionals recognise themselves as carers in their daily lives, both at home and at work, something which they generally see as positive, but which they identify as another aspect of their overload. They take on the responsibility of caring for older and/or sick family members or younger children, but this increases the feeling of 'just being there for others'.

They refer to all these experiences with a great distance from the managers and unanimously shared a sense of lack of institutional support.

Theme 4: management of the pandemic

They refer to the people in positions of responsibility and management as 'those at the top', which reflects the type of leadership in an exceptionally hierarchical, top-down organisation, a consequence of having one single management structure for such a large and diverse region. Although they understand the complexity of the situation for those who were managing the COVID-19 pandemic, they expressed their harshest criticism about the depersonalised way in which information was communicated during this time and the failure to listen to the opinions of frontline workers. The professionals were unanimous in emphasising the value of the team in managing the crisis. They questioned the usefulness of forming part of such a hierarchical structure when it was the capacity for team-level management and self-management, and the type of leadership within the team that helped the most in dealing with the crisis. They highlight listening, trust, availability and organisational skills as the main qualities in managing the crisis:

> I have a bit of an overview and the centres that have worked, have worked because their directors and management teams were people with integrity; strong, capable people (G.ADM).

They criticise the disparate treatment and recognition given to hospitals and to their own work. They blame both the administration, their managers, who failed to draw attention to the essential frontline work of PHC, and the media, which were more interested in hospital scenes but at the same time, failed to broadcast the extreme harshness of what was really happening.

Participants positively valued the meeting spaces, and the short daily meetings where they shared key information and organised the day, and at the same time encouraged interaction and contact that boosted morale and energy levels. Some workplaces used the meetings or purposely planned other times for activities to combat stress, reflect or pause, such as doing physical exercise at

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the end of the day, reading a daily poem or sharing a song before beginning work.

Theme 5: from unconditionality to disenchantment

All these prior conditions explain for them the shift from the initial unconditionality to the crisis and disillusionment they were experiencing in their present. The experience during the first wave of the pandemic was one of great anxiety, but also with a high degree of motivation, willingness and commitment to carry out such crucially important work.

> The first wave was like, a bit like, you have to get down to work, everyone is there to work, to work, even if it means leaving your usual workplace. There's like a personal and social responsibility that drove you to do everything you could (G. MF 1).

> For me, the first weeks were [a time of] absolute commitment (E9).

The professionals experienced the next wave, after the summer of 2020, almost as a time of expected death. While they can appreciate that the exceptional circumstances in the first months of the pandemic explain the lack of foresight and chaotic management, they do not understand why that summer was not used to reflect on what had happened. This was a pivotal moment that marked a new discourse of impotence and frustration.

> And when you realise that you can't, that's when you crack, and what has been wearing me down is the feeling that there is no kind of plan, no kind of intention by the higher authorities to propose or make changes to see how we can tackle this (GP group 1).

Nor do they understand the way in which some members of the public ignore the measures.

> I can't relax. I say, "I can't bear to see it", I mean, I saw people hugging, a couple kissing, I say, "Oh my God", I look the other way, I need… (NUR group 1).

By the time of the January 2021 wave, the commitment and responsibility with which they had tackled this crisis had turned into exhaustion and weariness. They recount the experience of working unceasingly, with no breaks to reflect or rest, which led to a sense of alienation and loss of identity.

> There are weeks with so much work where you have such a hard time and where I know I don't have my usual patience, and I ask, why, if I am the way I am, why do I have to become a different person because of this? (GP group 1).

They repeatedly detail all the activities they carried out: telephone follow-ups, tracing, testing, in-person care at the centre and home visits for those who require it, and vaccinations, among others. They report feeling invisible, to the extent that they frequently have to face comments, even from some hospital professionals, who demonstrate attitudes of contempt and ignorance about their work. The phrase 'we were never closed' is repeated in all the groups.

> "You're closed", that's it, humph. "You're already working". When they ask you that: "Are you back at work?", after what we have been through, your heart sinks. I was really hurt when they said, "The health centres are closed", I said, "Well, we never stop working" (GP group 1).

The participants were ambivalent about the daily public applause for health workers every evening at 20:00 hours, but they unanimously agreed that it was a passing response: *"I thought it was a nice gesture, but we knew it was a double-edged sword"* (E11). Others saw it not so much as a show of gratitude to health workers, but rather as a ritual for venting pent-up emotions and giving encouragement, and to create a space where people could meet and generate support.

> At the time it did help. But not just for health workers, for everyone. I think it was a way of saying: "Come on, we have to get through this". Right? (E4).

For other participants, health work during the pandemic was a question of responsibility, which, rather than awards and praise, calls for respect for their needs and adequate working conditions that should also be defended and demanded by the public, who are the first to be affected by the declining quality of PHC services.

> After such a difficult situation in which we had some social visibility, people came out to applaud us. In theory, everyone loved us and health workers were fantastic. Seeing all this collapsing […] that really hurts me and I don't know what the answer is (NUR group 1).

All the different professions were pessimistic about the present and future of PHC, which was already in a complex situation before the pandemic. The most frequently cited challenges are the lack of institutional support, social invisibility and insufficient human resources. They also point out that the pandemic has shattered some of the characteristic core values of PHC and made them question their choice of profession; in some cases, they have even considered a change of career. The contradiction between professional expectations and reality leads to a general feeling of dissatisfaction.

> How would I do it and how does what I would do differ from what's happening. And [all that] drives me mad (Nursing group 1).

Two discourses can be identified with regard to their professional motivation and future prospects: that of the administrative and nursing staff, who recognise their state of unease but perceive that their role can be strengthened; and that of the medical staff, who are more aware of the burnout:

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This is making me so angry with everything and so burned out, with the feeling of frustration and, above all, the lack of resources, to say: we're missing four doctors, we're seeing 60 [patients] every day. We can't cope anymore and nothing changes here. Does anyone help you? Management washes their hands, your colleagues are in the same boat as you, managing as best they can, and I don't know what the answer is, and I think that's when you wonder if maybe this job isn't for me (GP group 1).

There is a certain consensus that PHC needs to be restructured and that the crisis can be used as an opportunity for improvement. Telephone and virtual care should be strengthened in cases where it can safely respond to the demand, but face-to-face attention should be guaranteed as the central focus of care whenever necessary, with the anamnesis, physical examination and communication with the patient remaining the foundations of healthcare.

DISCUSSION

Comparison with other studies

This study covers the 18-month pandemic experience of PHC professionals in a national health service system in Europe. The expected resilience of health systems in the global north[24] and their capacity to respond effectively to crises while maintaining their basic functions was exceeded in the first weeks of the pandemic, although their subsequent response capacity and resilience allowed them to manage the crisis. The pandemic highlighted the weaknesses of the system: the centrality of the hospital, the lack of team autonomy, the top-down structure and the invisibility of PHC and public health professionals, among others; at the same time, it revealed the interdependence of health, social and economic structures.[25 26]

In the narratives, professionals expressed their disbelief at the unpreparedness in statements such as "*We are not an underdeveloped country*". It is clear from the pandemic that a certain sense of preparedness can be both a major risk for health services and a lesson in global health. In the first weeks, the lack of protective equipment in settings other than hospitals was a key stressor in the experiences of PHC professionals,[18 27] echoing other studies that have linked PPE shortages to greater impact on mental health and higher morbidity rates.[28]

According to the participants, the role of PHC was undervalued and hidden, in the same way as public health,[29] whereas the hospital-centric model was reinforced by institutions, the media and public culture.[30] In February 2021, the OECD in its report *Strengthening the frontline: How primary health care helps health systems adapt during the COVID 19 pandemic*[31] stressed the importance of a well-organised, technologically competent PHC, integrated with community health services, in order to successfully manage both the huge demand and the continuity of care. The involvement of PHC in COVID care in Europe varied widely across European countries. A study comparing national responses to COVID 19 in 28 countries found that the best performing countries had supported PHC,[32] reinforcing the essential role of PHC in any high-quality healthcare system, contributing to better system performance and having a particularly positive impact on the most vulnerable patients.[33 34] Both our study and others in North American[16 17 34] and in European[6 18 35] countries with very different healthcare models evidenced the enormous overload of care that the pandemic entailed for PHC and how its main activity had to shift to virtual and telephone care, drastically reducing face-to-face attendance. This situation shattered the foundations of PHC such as continuity of care, accessibility, longitudinality[35 36] and coordination with other services,[7] turning the focus of care towards solving specific problems, postponing chronic care and blurring its biopsychosocial vision. During lockdown, the population was sympathetic to these measures, and professionals perceived a greater solidarity from their patients, which has also been described in other studies in Spain,[37] Italy[18] and China.[38] All shared a common concern, generating a sense of community, understood as a transient personal experience of togetherness. However, as the months passed, many citizens felt neglected as they faced significant delays in arranging an appointment or diagnostic test.

Paradoxically, these accessibility problems led to the effective incorporation of some measures, long demanded by professionals, to reduce bureaucracy and digitalise consultations. The professionals interpreted the deployment of these measures as a clear sign that the administration had previously lacked any commitment to implement them. They positively value the incorporation of communication technologies,[39–42] but warn of the risk that physical distance may turn into social distance, and that these new conditions do not usually take into account the sociocultural dimensions that define the holistic context in which they work. Vulnerabilities and territories condition the distribution of diseases and professional practice[43] and make it necessary to address intercultural and structural competence within the health system.[44] COVID-19 disproportionately affected people in the most vulnerable situations. Much higher demand for healthcare and social care came from the poorest city neighbourhoods, where key workers—many of whom live in multigenerational households—often reside, rather than from the wealthiest neighbourhoods, not least because residents in poorer neighbourhoods do not have private insurance. In addition, we found that the female participants faced entrenched gender inequality, which leads to a double overload, at work and in the home, in many different contexts.[45 46]

Professionalism is a multidimensional and complex construct with meanings that vary across time and culture.[47] In the COVID-19 pandemic, health professionals faced a higher risk of contagion due to insufficient protection; they accepted more flexible working hours, de-specialisation or tasks outside their normal

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functions.[47 48] They responded to the high demands altruistically in line with the old social contract. But the mismatch between this implicit social contract (what society and individuals expect from doctors and healthcare workers) and the explicit social contract (professional practice, contractual and working conditions) could be underlying the growing malaise, with high rates of burnout, exhaustion and demotivation, particularly among medical personnel.[48 49]

According to the professionals in our study, collaboration and teamwork[50] were fundamental in facing the clinical and emotional challenges, boosting professional motivation and improving patient-centred and family-centred care. The impact on motivation varied according to professional roles. Unlike physicians, administrative and nursing staff, while acknowledging their discomfort, perceive that their role could emerge strengthened from the pandemic, similar to the results of the other study.[50 51]

In the Spanish PHC model, teamwork in PCHCs remains one of the great strengths of the system and contrasts with the more individualistic clinical practice in other countries.[18]

Strengths and limitations

One of the limitations is the absence of PHC managers in the study. During the fieldwork and data analysis, we were aware that their narrative was missing, especially given the intense criticism directed towards them.

In our study, interviewer bias was minimised by incorporating a professional interviewer with extensive experience in this methodology, which allowed for a balanced moderation of the sessions, with no participant positioning themselves as an authority figure or adopting a dominant stance. Open-ended, non-directive questions were used to help reduce the interviewer's influence on responses. She was external to the healthcare service and conducted the interviews in a neutral and objective manner, also avoiding social desirability bias. This probably allowed participants to share their experiences without fear of judgement. Participants may have selectively remembered their lived experiences, which could have influenced the accuracy and richness of the data.

In terms of analysis, the principal investigators of this study are epidemiologists and family doctors. As such, they had easy access to the emic or native perspective of the participants, but at the same time, they had to make a greater effort to maintain analytical distance. The analysis was conducted by a multidisciplinary research team that was able to counteract these potential biases. Regarding the interpretation of results, multiple methods were used to gain a more comprehensive view and were triangulated to reduce the possibility of interpretative bias. Additionally, the researchers were made aware of how their own beliefs and preconceptions might have influenced the research process. The research took place in one of the focal points of the pandemic in Spain: the Community of Madrid. This circumscription, together with the relative autonomy of regional health systems in Spain, makes us cautious about generalising the results.

Implications for policy and practice and future research

The results of our study allow us to learn from the experience of a group of PHC professionals facing an unprecedented global health emergency. This knowledge should, on the one hand, help to improve the response to any new global health threat, and on the other, identify critical points to rebuild and improve health systems.[7 52–54] The 71 multidisciplinary primary care professionals participating in this study provided valuable insights into their experiences working during the first 18 months of the COVID-19 pandemic. Based on these perspectives, four key recommendations are identified to support professionals in responding to future pandemics within the primary care setting, which align with the Australian proposal[55]: (a) ensure access to adequate resources, such as personal protective equipment and testing, (b) provide a clear system of guidelines and updates to reduce uncertainty, (c) improve communication with managers, making it less hierarchical and more participatory and (d) encourage teamwork within centres through multidisciplinary teams.

Spain, which has a good health system, needs an urgent 'reconstruction' of its PHC model, which must go hand in hand with an increased percentage of the publicly funded health budget allocated to PHC, a sustainable design, and better governance, all with the clear objective of contributing to social welfare through the health system.[51] Although Spain is generally considered to have a robust health system, its PCH model is in urgent need of reform. Changes must go hand in hand with an increased share of the health budget allocated to PCH and an improved governance structure, in order to ensure that the health system contributes to social welfare in a sustainable way.[56]

The deepening PHC crisis is a global problem that has been highlighted in some countries with different healthcare models.[16 17 54 56] Canada, which is considered to have an exemplary PHC system, warns that the demands placed on professionals have led to burnout reaching health crisis levels and that if there is no rapid response to ensure the safety and well-being of healthcare team members at local, provincial and national levels, its health system will be the most serious victim of the pandemic.[17 45 48] A similar situation is currently perceived in Spain.[57] This means policy and research must address the other shaky pillar of PHC: the disillusionment and psychological distress affecting healthcare workers, which impacts their health, professional performance, quality of care and patient safety.[58]

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