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Broken bones and apple brandy: resilience and sensemaking of general practitioners and their at-risk patients during the COVID-19 pandemic in Switzerland

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ABSTRACT

In early 2020, when the first COVID-19 cases were confirmed in Switzerland, the federal government started implementing measures such as national stay-at-home recommendations and a strict limitation of health care services use. General practitioners (GPs) and their at-risk patients faced similar uncertainties and grappled with subsequent sensemaking of the unprecedented situation. Qualitative interviews with 24 GPs and 37 at-risk patients were conducted which were analyzed using thematic analysis. Weick's (1993) four sources of resilience – *improvisation, virtual role systems, attitudes of wisdom* and *respectful interaction* – heuristically guide the exploration of on-the-ground experiences and informal ways GPs and their at-risk patients sought to ensure continuity of primary care. GPs used their metaphorical Swiss army knives of learned tools as well as existing knowledge and relationships to adapt to the extenuating circumstances. Through *improvisation,* GPs and patients found pragmatic solutions, such as using local farmer apple brandy as disinfectant or at-home treatments of clavicle fractures. Through *virtual role systems*, GPs and patients came to terms with new and shifting roles, such as "good soldier" and "at-risk patient" categorizations. Both parties adopted *attitudes of wisdom* by accepting that they could not know everything. They also diversified their sources of information through personal relationships, formal networks, and the internet. The GP-patient relationship grew in importance through *respectful interaction*, and intersubjective reflection helped make sense of shifting roles and ambiguous guidelines. The empirical analysis of this paper contributes to theoretical considerations of sensemaking, resilience, crisis settings and health systems.

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Introduction

Before 2020, it would have been unheard of for doctors in Switzerland to use apple brandy as disinfectant or fixing broken bones in patients' homes. However, the COVID-19 pandemic was an unprecedented situation which flipped general operating procedure on its head. During the first wave of the COVID-19 pandemic, healthcare workers had to grapple with shortages in staff and protective equipment, their own anxieties of infection or spread amongst their loved ones, and the implementation of rarely used healthcare policies and measures (Amin 2020; Greenberg et al. 2020). While the responsibility of healthcare usually fell under the government of 26 state-like bodies referred to as cantons, Switzerland's Federal government initially centralized the response to implement measures in attempts to contain the virus on a national level due to the emergency situation at hand. A stay-at-home recommendation was issued for the entire population, which meant a closure of schools, restaurants, and non-essential shops. In addition, non-urgent health care services were prohibited. This continued until the federal government implemented loosened measures in Switzerland in April 2020 (FOPH 2020).

People who were considered particularly vulnerable or at a heightened risk of infection (further referred to as 'at-risk patients') were doubly affected by these measures. On the one hand, they were at higher risk of serious health outcomes and even death if infected with COVID-19. On the other hand, many often relied on continuous forms of contact with their healthcare professionals for their pre-existing conditions. In March 2020, the Federal Office of Public Health (FOPH) defined people especially at risk for severe COVID-19 to include those aged ≥65 years and those with the following conditions: high blood pressure, diabetes, cardiovascular disease, chronic respiratory diseases, conditions and therapies that weaken the immune system and cancer (FOPH 2020). Prior to this time, at-risk patients frequently consulted with their general practitioners (GPs) due to their often more complex health care needs requiring chronic disease monitoring or intensive treatment regimens (Cassell et al. 2018). Any delays of medical appointments could lead to unfavorable health outcomes for these patients (Khera et al. 2020; Chan et al. 2021). Notwithstanding, at-risk patients were reluctant to seek help in the early phase of the pandemic due to fear of contracting the virus or burdening their GPs, sometimes even in urgent cases, but still looked to their GPs for guidance during this time (Deml et al. 2022). Health care professionals noted a decreased use of health care services and expressed concerns of missed appointments for chronic disease care in general practice (Wong et al. 2020; Deml et al. 2022).

When conducting qualitative interviews with GPs and their at-risk patients for a larger mixed-methods research project investigating the impact of the COVID-19 pandemic on primary care for at-risk patients in Switzerland (Deml et al. 2022), we were struck by their creative and innovative approaches in the face of the extenuating circumstances. The titular apple brandy being used as disinfectant and an at-home treatment of a clavicle fracture are but two examples of such on-the-ground responses. This paper thus aims to examine the strategies employed by both GPs and their at-risk patients to build resilience and make sense of their places in this unprecedented situation. With this in mind, we aim to answer the following research question: How did GPs and at-risk patients make sense of the uncertain situation, particularly through the informal ways they sought to build resilience and ensure continuity of primary care?

Continuing care and making sense during crises

Continuity of care (Gray et al. 2003) is considered a 'cornerstone of primary care' (Jee and Cabana 2006; Chan et al. 2021). Of particular interest here is how continuity of care is ensured during crisis situations. Crisis settings such as displacement (Lafta and Al-Nuaimi 2019), war (El Saghir et al. 2018) and natural disasters (Icenogle, Eastburn, and Arrieta 2016) all have grave impacts on the health care systems in place, posing a threat to routine patient care that is unrelated to the crisis itself. Jones et al. (2016), for instance, point out that during the outbreak of Ebola, pregnant women and babies were dying at an increased rate due to the weakened health care system and decrease in resources, and not due to the infectious Ebola outbreak itself. Such research sheds light on the importance of a better grasp on how health care systems work during extenuating circumstances.

Qualitative and quantitative research alike has shown that the use of non-COVID-19 related health care services during the pandemic tended to decrease rather than increase since the beginning of 2020. In some countries such as Ghana for example, regular check-ups increased, but overall health care services use decreased (Saah et al. 2021). In others such as Argentina (Loza et al. 2021), Nepal (Singh et al. 2021), the United States (Birkmeyer et al. 2020) and Australia (Sutherland et al. 2020), a significant decrease in health care services use was found. A quantitative study conducted as part of our research project in Switzerland found a decrease in GP consultation counts during the first months of the COVID-19 pandemic, which then quickly rebounded after the measures were loosened (Rachamin et al. 2021). Patients reported that they opted out of medical appointments due to fear of contracting the virus or burdening their GPs (Deml et al. 2022; Wong et al. 2020). Notwithstanding, in both Germany (Reitzle et al. 2021) and Switzerland (Deml et al. 2022), patients perceived that their access to medical care was guaranteed despite the change and uncertainty brought by the COVID-19 pandemic.

The pandemic also brought a shift in the understanding of humans in relation to each other and their social and ecological worlds (Higgins, Martin, and Vesperi 2020). It particularly highlighted the way in which social activity changed and went beyond physical interaction (Fuentes 2020). This extended to health care and the continuity of care, too. In Switzerland for example, WhatsApp messaging allowed for swift responses when needed during postpartum care, even before the pandemic (Perrenoud, Chautems, and Kaech 2022). However, non-physical interactions in the context of health care such as text messaging and video consultations are not accessible to everyone (Perrenoud, Chautems, and Kaech 2022). For at-risk patients who were 65 years old or above, consultations by telephone were the preferred method and viewed as complimentary to in-person consultations rather than a suitable replacement (Reitzle et al. 2021).

Within this crisis setting, the failures and tensions in governance gained an unprecedented global visibility (Irons and Gibbon 2022). Usually successful institutions and organizations such as hospitals or other healthcare providers in countries such as Switzerland struggled with a constant flow of new information and changing regulations, as well as feelings of helplessness (Wuropulos 2020). GPs in Switzerland became frustrated that "public health authorities did not recognize them as major health providers in the management of the pandemic" (Cohidon, El Hakmaoui, and Senn 2022). As a result, new strategies for building resilience and making sense of the situation emerged in healthcare settings (Haldane et al. 2021; Juvet et al. 2021). The literature on the effects of and response to

COVID-19 is yet lacking an in-depth, bottom-up analysis of resilience and sensemaking strategies employed by GPs and their at-risk patients requiring continuity of care.

Resilience is usually understood as "the processes and capacities that enable individuals, or human, technical or natural systems, to overcome, resist, adapt to and recover from deep crises" (Juvet et al. 2021). When conceptualizing a framework for health system resilience, Anderson et al. (2020) refer to situated resilience as "the management of unexpected events that occurs in relatively small scales of time and space and unfolds by drawing on pre-existing sociotechnical resources and practices (such as skills, knowledge, tools, data) to respond to and address some disruption or source of stress." Such a disruption occurred in massive scales, time, and space during the COVID-19 pandemic's first wave, and we examine how GPs expanded on pre-existing tools, relationships and knowledge as a response. Additionally, we draw on Weick's notion of sensemaking as a "process of social construction that occurs when discrepant cues interrupt individuals' ongoing activity, and involves the retrospective development of plausible meanings that rationalize what people are doing" (Maitlis and Sonenshein 2010). In the wake of a disruption in sensemaking, Weick proposes four sources of resilience: *improvisation*, *virtual role systems*, *the attitude of wisdom*, and *respectful interaction* (Weick 1993). We employ these concepts heuristically to guide the examination of GP and at-risk patient strategies when dealing with extenuating circumstances brought on by the COVID-19 pandemic. Doing so allows us to expand on Weick's concepts of sensemaking in organizations to include GP-patient relationships during primary care as well as GPs as part of a larger system. The above-mentioned four sources of resilience are described in more detail further below.

Methods

This study presents qualitative results from the larger mixed-methods research project investigating the impact of the COVID-19 pandemic on primary care for at-risk patients in Swiss primary care settings (Deml et al. 2022). Our study team has focused on related questions in the Swiss context and has previously published conceptual considerations (Deml and Jungo 2022), qualitative study results about shifting understandings of the at-risk construct from patient and GP perspectives (Dubois 2022) and changing doctor-patient relations during the pandemic (Gicquel 2022). We have also published quantitative findings about changes in consultation frequency in Switzerland (Rachamin et al. 2021). This paper adds to these findings by specifically focusing on the strategies employed by GPs and their at-risk patients to build resilience and make sense of uncertain guidelines and definitions.

Due to the mitigation measures in place during the coronavirus pandemic, social scientist researchers had to shift away from the 'disciplinary bread and butter of social interaction' for data collection (Irons and Gibbon 2022). The same was true for this study, as 37 semi-structured interviews were conducted *via* Zoom video call with at-risk patients and 24 with GPs between December 2020 and March 2021 in the German- and French-speaking parts of Switzerland (Cantons of GE, VD, FR, BE, VS, and AG). The GPs were recruited through research networks by sending recruitment letters and study flyers *via* e-mail and through snowball sampling. Patients were then recruited through their GPs and according to the categories for at-risk patients at the time this study was designed.

The interview guide for GPs included open-ended questions allowing respondents to answer in their own words and covered questions concerning: (1) GPs' background, training and working environments, (2) information they consulted about COVID-19, (3) work experiences during the pandemic, (4) treatment of at-risk patients during the pandemic, and (5) recommendations to improve practices and lessons learned. The interview guide for patients included open-ended questions covering: (1) patients' background and health status, (2) health services use during the pandemic, and (3) experiences as at-risk patients during the pandemic. The Swiss German interviews were conducted by a psychology Master student from the University of Bern, and the French interviews by six sociology Master students from the University of Geneva. All interviews were transcribed into French, which was the working language of the data collectors working on this research. All quoted segments of text presented in this paper have been translated into English, and we use pseudonyms for all study participants. We use the prefix "Dr." for GPs and "Mr.", "Mrs." or "Ms." for at-risk patients in this paper.

We applied thematic analysis to our data by identifying possible themes and codes in the transcribed interviews, comparing and contrasting these themes, and identifying structure among them (Guest, MacQueen, and Namey 2012). Multiple members of our research team read the transcripts and subsequently discussed and compared their results from the data. This allowed for a more flexible approach and consideration of our roles as researchers while identifying patterns and themes among our data (Braun and Clarke 2006). With a team consisting of social scientists, epidemiologists, and GPs, our meetings provided space for a fruitful exchange and critical reflection on our data. The interdisciplinary nature of our research team as well as the range of professional and research experiences allowed us to collectively think about how our different backgrounds, previous experiences, beliefs, and knowledge may have affected the analysis of the results and the conclusions we drew. For example, during one such exchange, one of our members remarked how GPs were constantly referring to their learned tools to adapt to the situation at hand, which was much like possessing a Swiss army knife. Being a GP himself, the experiences we had heard from our interview partners were similar to his own. This allowed us to consider our data from multiple perspectives, which varied in proximity to the data collection and strategies of making sense of the unfolding events. Drawing on situated resilience in Anderson et al. (2020), the GP's "Swiss army knife" consisted of sociotechnical resources and practices to respond to and cope with the disruption of standard operating procedure. In this paper, we use the metaphor of the Swiss army knife to highlight these different resources.

It is also crucial to consider qualitative data within a continuous feedback relationship that is influenced by a specific time and social context (Andersen and Risør 2014). In analyzing this data, we consider how the interviewee is speaking retrospectively in an ongoing context and how previous experience shapes the understanding of these memories (Garro 2001). In the period these interviews were conducted, Switzerland was experiencing the second wave of COVID-19 cases, and the 26 cantons (each with their own constitution, legislature, courts and police) had tightened measures to contain the spread of the virus once again. When this proved to be ineffective, the federal government passed another set of nation-wide measures in late 2020 (Swissinfo.ch 2021). Both interviewers and interviewees were thus asked to remember the beginning of an unprecedented event while still grappling with uncertainty in the present.

Results & discussion

When writing about a loss of sensemaking among a team of firefighters during a 1940s wildfire in Montana, USA, Weick (1993) postulates that "what makes such an episode so shattering is that both the sense of what is occurring and the means to rebuild that sense collapse together" (p. 633). In early 2020, we were experiencing such a double collapse on a global scale. The GPs we interviewed often referred to the beginning of the pandemic as an emergency situation. For example, Dr. Manzoni unknowingly made a striking link to Weick's example as he described what it was like to be a primary care physician during the first stages of the COVID-19 pandemic: "We were like firefighters putting out those fires." One GP, Dr. Chaudet, stated that "everything that was usually simple became complicated" and you just had to "figure it out." The crisis at hand became palpable with the need for an emergency response to an increasingly complicated situation. Minimal resources, longer working hours and conflicting information flows when faced with a troubling and uncertain situation made it difficult for GPs and their at-risk patients to make sense of the pandemic and rebuild that sense during the first wave.

After examining how the loss of sensemaking during the wildfire interrupted the standard procedure and organizational structure of the firefighters, Weick (1993) conceptualizes four sources of resilience in the wake of such a disruption: *improvisation*, *virtual role systems*, *attitudes of wisdom* and *respectful interaction*. In the following sections, we examine the informal ways and strategies GPs and their at-risk patients dealt with the uncertain situation and consider how they functioned as sources of resilience in the wake of a loss of sensemaking.

Figuring it out through improvisation

The first strategy employed by GPs and their at-risk patients was to 'figure it out' in the face of the uncertain situation. As such, we analyze how participants engaged in Weick's first source of resilience: *improvisation,* or using the tools or relationships available to come up with creative solutions. This meant going beyond officially mandated measures such as promoting hand sanitizer use in practices, installing Plexiglass partitions and respecting physical distance in the GP practices. An example of implementing individual solutions was Mrs. Eichenberger's, 75, appointment schedule. She remembered: 'We made an appointment when there weren't many people in the morning. And after 9am I took the bus and then the tram because during that time there were a lot less people.' Not only were less people using public transport, but in the mornings, less patients were at GP practices as well. Some GPs and their at-risk patients decided that rather than sit in the waiting room, at-risk patients were safer waiting outside and getting called in when the appointment started.

For a time, GP practices were the only point of contact with the health care system for many at-risk patients, either voluntarily or not (Deml et al. 2022). The ambiguity of what counted as an 'urgent' healthcare matter lead many patients to stay at home, even when they depended on continued care due to their chronic illnesses. This meant that GPs sometimes did home visits, and at other times conducted procedures in their practices or their patients' homes which would normally be handled in an emergency room. Dr. Paccot recalled:

> During the first shutdown, […] I treated a lot of falls. I had a patient who refused to go to the hospital, so I had to treat her clavicle fracture at home as best I could, for a patient who was 97 years old. So that was *sportif* [not translated from French due to multiple interpretations – we discuss this below], wasn't it?

Both home visits and treating her patient's clavicle fracture were in Dr. Paccot's set of skills, just usually not employed at the same time. Her use of the word *sportif* (in French) can be interpreted in different ways. While some of us read it as being 'physically intense', others interpreted it as meaning 'unorthodox, daring.' The patient was 97 years old, making this a riskier procedure than it would be for a younger patient. But in all interpretations, the language referred to an irregular emergency situation which had to be responded to in a pragmatic way. In this case, it meant treating the at-risk patient at home for something that would usually require a hospital visit.

Protective equipment such as disinfectant, surgical masks and gowns were often in short supply in spring 2020. Some GP practices were able to come up with solutions to these shortages by using unorthodox replacements. In a rural practice, for example, Dr. Stohler was able to rely on his relationships with local farmers to provide distilled apple brandy to use as disinfectant:

> For now, we have been able to do some tinkering thanks to different relationships. A farmer burned some alcohol, some brandy. It smelled marvelously well in the practice. It smelled of apple, even if it was alcohol, because it was distilled in these barrels.

The use of the word "tinkering" reflects Dr. Stohler's approach in this situation, which was to use whatever was at his disposal at the time. He was, in Weick's (1993) concept, a "bricoleur," who remained creative under pressure and able to form "novel combinations" based on his skill-set and those of others. Bricoleurs and bricoleuses routinely act in chaotic circumstances, which is not a far stretch for healthcare workers in general but especially during the first months of the pandemic. Improvisation allows for creativity in unexpected places, drawing on what the bricoleur already knows to come up with out of the box ideas (Weick 1993). Dr. Paccot and Dr. Stohler, as well as Mrs. Eichenberger and her GP, did not reinvent the wheel so to speak, but fell back on their Swiss army knives of learned tools, existing knowledge and previous relationships to come up with creative solutions.

Another example of improvisation involved emergency infrastructures being set up from scratch in order to adapt to the current needs with the help of local structures and relationships. Dr. Imboden, a GP in a rural area, told us about setting up a "clarification center" in a closed cultural center, for which she depended upon the civil service's help. In this particular canton, testing centers had not been put into place yet and the GPs had to mobilize themselves and others to set one up. The civil service members helped Dr. Imboden and her colleagues with tasks such as blood pressure and fever measurements. While the civil service is a government regulated body, Dr. Imboden told us that this was an emergency set-up not directly organized by the federal government. Regional solutions were required to fit in with the Swiss system of government and the delayed official infrastructures. Similar to Weick's bricoleur, Dr. Imboden relied on local relationships and existing knowledge of testing centers to set up the clarification center.

The good soldier and role systems

During the first wave of the COVID-19 pandemic, the role systems in governance, households and everything in between were faced with – while maybe not a complete collapse as in Weick – a consequential shake-up. For healthcare workers in Switzerland, this meant spatial, labor and personnel reorganizations (Juvet et al. 2021). GPs reported serious communication gaps and a lack of consistent guidance from authorities in regard to new regulations, procedures and categorizations during the first months of the COVID-19 pandemic in Switzerland, while roles and responsibilities were being clarified on a federal level amongst politicians, administrators and scientists. During this period, information was often reaching GPs at the same time as their patients, who turned to their doctors for guidance and clear instructions on how to handle the uncertain situation (Deml et al. 2022). For at-risk patients, suddenly being confronted by the label "at-risk" and "vulnerable" led to rethinking their identities and health (Dubois 2022). As a result, GPs and at-risk patients had to reorient themselves within their respective role systems and come to terms with entirely new roles. Here, Weick's (1993) second source of resilience came into play: virtual role systems. Weick suggests that as long as the role system remains intact in the individual's mind, disaster can be averted. For the first wave of the pandemic, this meant adapting to role system shifts in a short period of time.

While some GPs were comfortable being in a more dependent role, others felt they were being pushed down the food chain and decisions were being made for them. As an example of the former, Dr. Paccot said:

> I was being a good soldier! I did what they told me to do and that's it. I didn't think any further than that! […] As long as it was not in contradiction with my own convictions. But until now, I do what I do, what I'm asked to do and I'm fine with that.

Being a good soldier for Dr. Paccot meant doing what she was told by the authorities. In her war analogy, she sees her role in the crisis of the pandemic as a soldier and not a high-ranking official or decision-maker. She depended on top-down structures and waited for clear instruction. In her interview she went on to state that she did not sit idly by while everything was happening, but her words shed light on the lack of decision-making power that GPs had. They had to rethink their roles within the larger health system of Switzerland during this new crisis.

Other GPs, such as Dr. Müller, were frustrated with the way GPs were being treated at the beginning of the pandemic. 'Let doctors take care of their patients. Do not block them in doing so. It's their field already. […] It's the goal. They should listen to us because we have a lot to say.' Dr. Müller felt that GPs were being hindered in doing their jobs with changing and sometimes conflicting top-down messages. In his eyes, the FOPH did not acknowledge the GPs' role as important enough when figuring out how to deal with the pandemic. He goes on to state that the FOPH should have listened to them when making decisions about health care policies, and 'not just the hospital directors, not just the statisticians, not just the economists.' A perceived hierarchy is apparent in his words, and subsequent barriers to spaces in which GPs have no power. Dr. Müller made it clear that GPs were a resource for policy makers to consider from a more bottom-up perspective. He did not perceive his role within the shaken-up system to be important enough.

The majority of at-risk patients we interviewed reported feeling isolated from the outside world. While this was for their own protection, it actually made them feel more vulnerable.

Ms. Ambergen, 75, noted, 'We almost didn't dare go outside. People said, "You old lady, you have to stay inside."' Mrs. Ferreti, 78, concurred, 'When people met an elderly person with a cane, they changed the side of the street. I saw it from my window and thought, "You'd think we had rabies."' The social and political context of the COVID-19 pandemic thus influenced the way patients experienced their everyday health care and their sense of vulnerability. While many considered themselves healthy, the social stigmatization and subsequent isolation that came from being categorized as 'at risk' led to a feeling of vulnerability which they did not have before. They had to reimagine and come to terms with this new categorization within the new system of the COVID-19 pandemic.

"Did you know that?": wisdom

Weick (1993) refers to wisdom as avoiding extremes and remaining adaptable, because "extreme confidence and extreme caution both can destroy what organizations most need in changing times, namely curiosity, openness" (p. 641) During the ever-changing rush of information during the pandemic, curiosity and openness were difficult to maintain. As Dr. Zumthor exclaimed, "I invested hours and hours looking for information online. In the beginning we read and looked for what was available. But even the Federal Office of Public Health didn't know a lot then. Patients were asking questions, but we hadn't received that information either." In order to deal with this, medical groups such as quality circles kept GPs up to date. In some cases, new groups were set up for this very reason. As Dr. Meyer notes, 'We had a good exchange between colleagues, because at first, we were lost.' GPs of course were not exempt from the uncertainty that we faced on a global scale in the beginning of 2020, and the pressure of being the main contact point for patients looking for a more consistent source of information weighed on many. In an effort to navigate these trying times and provide the best possible care for their patients, GPs had to diversify their sources of information to keep up to date.

Some GPs reported relying on their significant others to keep them informed about current events, news and changing regulations from the Federal Council, as they were not able to do so themselves *and* keep up their practices at the same time. Dr. Werder, for example, recalled:

> My husband is not a doctor and reads and listens to the newspaper and the radio a little more than I do. And I worked with the patients, and I just worked, and I came home, and he said "Yeah, I heard this and that. Did you know that?" And I had no idea what he was talking about.

Dr. Werder relied on clear top-down communication, which contrasts to her husband knowing things before she did just by watching the news. This was a source of frustration, but eventually also a way for her to get the information she needed. Dr. Paccot was in a similar situation, where her husband sometimes informed her of 'two to three things, because I didn't have the time to look.' This attitude of accepting that they did not have the time and energy to read and reflect on all the available sources allowed them to adapt more easily, which is what Weick calls an attitude of wisdom.

Such attitudes and solutions to issues of information flows were not uncommon amongst our interview partners. Dr. Müller even cited YouTube as a valuable resource to keep informed on the infectious disease. This of course is a double-edged sword, because on the one hand, it highlights how quickly the information needed to be conveyed in order for

GPs to be able to process it and do their job, and on the other, it poses a possible threat to the continuity and quality of care of patients if the information is not critically reflected upon and may not be evidence-based. Many GPs did not have a lot of experience with infectious diseases, as the pandemic setting was new to everyone, and needed to learn about it on the go with limited time. In Weick's attitudes of wisdom, an openness to sources such as YouTube remains an asset, but need to be taken with a grain of salt. Diversifying their sources of information was made possible by GPs' Swiss army knives of existing relationships and previous knowledge building. They were not entirely new to them, but gained in significance due to the all-encompassing pandemic setting.

"Call on me": respectful interaction

During the early months of the coronavirus in Switzerland, many at-risk patients reported a worsening feeling of isolation and ostracization. Their GPs were sometimes the only place they could physically see another person and have any social contact. Mr. Raiser, 82, who often sees his GP with his wife, described his relationship with his GP:

> I have to not get too euphoric. Um… simply put, he's very good. He's personally very pleasant. He's always well prepared as well. He's clear. He's just good. And we feel appreciated. And we possibly even have a bit of a *special relationship*.

The emphasis on 'personally pleasant' and the feeling of appreciation, as well as the mention of a 'special relationship' point to a strong basis of trust, but also a bond that goes beyond the medical aspect of the patient-provider relationship. Mrs. Cossy, 68 and living with multiple chronic illnesses, emphasized that "[my GP] is attentive, she listens to me, she addresses my concerns, she meets me halfway. I feel very well looked after by her. And understood, you know?"

The examples above illustrate what Weick (1993) calls respectful interaction, the fourth source of resilience. It is based on the interaction of two or more people and the construction of shared meanings, all the while adhering to "the tringle of trust, honesty, and self respect" (p. 643). The resulting intersubjectivity is key in respectful interaction, and Weick (1993) postulates that "perhaps it's more important that you have a partner than an organization when you fight fires" (p. 642). During the first wave of the COVID-19 pandemic, both GPs and their at-risk patients needed to come to terms with changing role systems and a lack of guidance. As a result, they were able to find shared meaning in their doctor-patient interactions *via* telephone or in person. This interpersonal exchange alleviated the uncertainty for both GPs and their at-risk patients alike and aided in making sense of the situation.

In an effort to continue patient care during lockdown, telemedicine – defined as the remote diagnosis and treatment of patients using different telecommunications technologies (Roy, Levy, and Senathirajah 2022) – became increasingly important for Swiss GP practices during March and April 2020 (Deml et al. 2022; Gicquel 2022). While GP practices had already used this as a tool in the past, it became one of their main modes of communication during the COVID-19 pandemic. For telemedicine to succeed, a pre-existing relationship and basis of trust between GP and patient is key (Kludacz-Alessandri et al. 2021; Gicquel 2022). Many patients we interviewed felt that they had a good relationship to their GPs and could call at any time. GPs and their staff members were already familiar with most of their patients, which created a sense of security. In some cases, GPs even gave their patients their

private home or cell phone numbers. As for example Ms. Hofer, 63, in cancer remission and living alone, explained:

> [My GP] told me that if I panicked, either because of COVID or something else, I could always call her on her cell phone, every hour, always. And just the fact that she gave me her cell phone number was a safety factor. Although I never used it, it was extremely reassuring.

Not only could Ms. Hofer call her GP in case of COVID-related emergencies, but also other concerns she might have had. As an at-risk patient living alone, this increased her sense of safety during a crisis setting in which she was defined by guidelines as 'particularly vulnerable.' While the pre-existing relationship was fundamental, giving a private cell phone number was an act of trust in itself, which in turn strengthened the patient-provider relationship. Many other patients reported having received their GP's private numbers, and many GPs explained that they did not in fact get many calls outside of office hours.

The shifting roles and regulations increased the importance of GP-patient relationships during the first months of the pandemic. While the importance of such relationships is not new (Hemmings 2005), it gained a new significance within a new role system. The GPs we interviewed agreed that it was their main resource when providing care to their patients. Again, GPs could fall back on their Swiss army knives of tools, knowledge and relationships to facilitate their response to the emergency situation. Our interview partners' sensemaking during the pandemic was not limited to GP-patient interactions of course. As mentioned above, GPs exchanged amongst themselves, their spouses and regional networks to name a few. At-risk patients could depend on their loved ones and other medical professionals for support. For our interview partners and us as researchers, unlike in Weick's organizational sensemaking during an isolated crisis setting, the pandemic meant a longer period of extraordinary circumstances and uncertainty for the whole population. Respectful interaction was thus vital in more than one area of GPs' and at-risk patients' lives.

Limitations

Our research is subject to certain limitations. Firstly, we cannot draw generalizing conclusions about all GPs and at-risk patients in Switzerland from our analysis, as it is based on individual qualitative interviews which provide a bottom-up perspective on strategies employed during the first months of the COVID-19 pandemic. In addition, we only interviewed GPs and at-risk patients, excluding other healthcare workers and patients. Secondly, while technology allowed for long video and phone interviews, the extenuating circumstances, especially when it came to at-risk patients and their illnesses, did not permit more in-depth in-person research which would have otherwise been possible. Thirdly, for reasons of scope we have illustrated sources of resilience and strategies of sensemaking of GPs and at-risk patients in this paper without further elaborating on socio-economic backgrounds or gender.

Concluding remarks

Researchers are now beginning to grasp the direct and indirect social and psychological consequences linked to the COVID-19 pandemic. In this context, a broader understanding of such a crisis setting beyond the public health sector is needed. Our study has aimed to

do so from a bottom-up perspective, where GPs and at-risk patients' strategies to navigate and make sense of the beginning of the coronavirus pandemic were put into focus. Weick's (1993) description of four sources of resilience guided the exploration of on-the-ground experiences and informal ways GPs and their at-risk patients sought to ensure continuity of primary care. To begin with, GPs were able to make use of their metaphorical Swiss army knives, their learned tools as well as existing knowledge and relationships, to cope with and adapt to the uncertain circumstances of the first COVID-19 wave in the form of *improvisation*. This was highlighted in creative and "bricolage" solutions such as local farmers' apple brandy as disinfectant, at-home treatments of clavicle fractures and the set-up emergency infrastructures. Through *virtual role systems*, GPs and patients were able to come to terms with new and shifting categories such as "at-risk patient" or "urgent care." The situation was in constant flux, of which the Swiss healthcare system was not exempt. GPs navigated their roles within the continuously evolving healthcare system, by reorienting themselves in positions such as "good soldiers" or underappreciated resources. Grappling with gaps in information flows meant GPs developed Weick's *attitudes of wisdom*, accepting the fact that they could not know everything but making efforts to diversify their sources. Personal relationships, formal networks and the internet were fallen back on as a result. The GP-patient relationship gained an even greater significance than before through *respectful interaction* and shared meaning during the first months of the pandemic. Trust and honesty were vital in making sense of shifting roles and uncertain guidelines.

Building resilience and making sense of an unprecedented circumstance such as the COVID-19 pandemic were vital in ensuring the continuity of primary care of at-risk patients. This study has shown the potential in creative, bottom-up strategies in the face of uncertainty, and our findings highlight the potential adaptability of the Swiss health care system when official guidelines are initially absent. However, they also point to the need for mechanisms that allow for early and ongoing dialogue between health authorities, health workers, and concerned patients during ongoing crises. Remarkable as it may be to see how GP practices and their at-risk patients made sense of the pandemic crisis setting, more consistent guidance in such situations is necessary to ensure that GPs have a more stable framework within which to continue to provide primary care to their patients (at-risk or not) when faced with extraordinary situations such as the COVID-19 pandemic.

Ethical approval

This study was waived by the Ethics Committee of the Canton of Bern (BASEC-NR. 2020–02288).

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Data availability statement

Pseudonymized data from this study is available on reasonable request from the corresponding author.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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