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RESEARCH ARTICLE

WELL-BEING

Heard, valued, supported? Doctors' wellbeing during transitions triggered by COVID-19

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Abstract

Introduction: Supporting doctors' wellbeing is crucial for medical education to help minimise negative long-term impacts on medical workforce retention and ultimately patient care. There is limited study of how doctors' transitions experiences impact wellbeing, particularly socially and culturally. Multiple Multidimensional Transitions (MMT) theory views transitions as dynamic, incorporating multiple contexts and multiple domains. Using MMT as our lens, we report a qualitative analysis of how transitions experienced by doctors during the pandemic impacted on social and cultural aspects of wellbeing.

Methods: Longitudinal narrative inquiry was employed, using interviews and audio-diaries. Data were collected over 6 months in three phases: (i) interviews with doctors from across the career spectrum ($n = 98$); (ii) longitudinal audio-diaries for 2–4 months ($n = 71$); (iii) second interviews ($n = 83$). Data were analysed abductively, narrowing focus to factors important to social and cultural wellbeing.

Results: Doctors described experiencing multiple interacting transitions triggered by the pandemic in multiple contexts (workplace, role, homelife and education). Patterns identifiable across the dataset allowed us to explore social and cultural wellbeing cross-cutting beyond individual experience. Three critical factors contributed to social and cultural wellbeing both positively and negatively: *being heard* (e.g., by colleagues asking how they are); *being valued* (e.g., removal of rest spaces by organisations showing lack of value); *and being supported* (e.g., through regular briefing by education bodies).

Conclusions: This study is the first to longitudinally explore the multiple-multidimensional transitions experienced by doctors during the COVID-19 pandemic. Our data analysis helped us move beyond existing perceptions around wellbeing and articulate multiple factors that contribute to social and cultural wellbeing. It is vital that medical educators consider the learning from these experiences to help pinpoint what aspects of support might be beneficial to trainee doctors and their trainers. This study forms the basis for developing evidenced-based interventions that ensure doctors are heard, valued and supported.

1 | INTRODUCTION

Transitions are an inevitable part of any medical career.[1–3] Transitions are defined by Jindal-Snape as *'ongoing processes of psychological, social and educational adaptation over time due to changes in context, interpersonal relationships and identities'* which can be both positive and negative experiences.[4,5 p1007] The increased risk of burnout and potential for challenges to wellbeing during times of intense transitions (such as the move from university to clinical practice or the move from trainee doctor to trained doctor) is well documented in the medical education literature.[1–5] The global response to the COVID-19 pandemic created unprecedented transitions in the provision of healthcare and healthcare education, as well as transitions beyond the work context in everyday living, to which doctors have had to adapt personally, professionally and educationally.[6] Consequently, the pandemic has focused concern to the effect of these changes on doctors' wellbeing (across the career spectrum).[7] Whilst the definition of 'wellbeing' remains unsettled, a growing body of empirical literature has studied physical and psychological wellbeing of doctors and other healthcare professionals.[8–11] This research has highlighted that healthcare professionals are at increased risk of physical and mental exhaustion, stress and burnout, which can affect patient safety and workforce retention.[8–11] Supporting the wellbeing of doctors across the career spectrum, both as learners and educators, is crucial for medical education to minimise negative long-term impact on medical workforce retention, access to medical education, and ultimately patient care.[7]

Psychological and physical wellbeing are known vital components for the medical workforce; however, the wellbeing literature is limited by a tendency to focus on the individual, and ways in which mental and physical wellbeing can be supported through building individual resilience.[9,10,12] In medical education there are calls for broader definitions of wellbeing that move beyond the individual and solving individual problems.[13] We support this view and suggest that conceptualisations of wellbeing should consider the deeper, more complex, social and cultural aspects that stretch beyond the individual, and place the responsibility for wellbeing onto groups, organisations, educational institutions and society.[13,14]

In order to access and understand better these multiple facets of wellbeing, this paper reports a qualitative analysis of the transitions experienced by doctors across the career spectrum during the pandemic and how these transitions impacted on doctors' wellbeing, with particular focus on social and cultural aspects. In the following section, we articulate in detail the conceptual framing of this study.

1.1 | Conceptual framework: Multiple Multidimensional Transitions

Multiple Multidimensional Transitions (MMT) is a theoretical framework used in medical education for articulating doctors' transitions beyond the individual, taking a more complex view that transitions are dynamic, incorporating multiple contexts (role, workplace, home and education) and multiple domains (physical, psychological, social and cultural).[1,4] Previous research using MMT has unearthed the complexity of doctors' educational transitions (e.g., from trainee doctor to trained specialist), allowing for consideration of how transitions in one area of an individual's life (e.g., new job role) will impact on other areas (e.g., a resulting home move) and an individual's significant others (e.g., new work colleagues or a child moving schools).[1,4] Transitions researchers have also argued that during periods of significant transitions, it is important that opportunities for learning and development are maximised whilst the potential for negative impacts on wellbeing are minimised.[2,15–17] We chose to use MMT for this study to provide a conceptual framework during data collection that explored the complexity of doctors' experiences in multiple contexts (e.g., role, workplace, homelife and educational) and how these experiences might be affecting doctors in social and cultural domains.[17]

1.2 | Defining social and cultural wellbeing

In this section, we define current thinking about social and cultural wellbeing. Later in the paper when describing our data analysis, we will articulate how our analysis had led us to re-explore the literature on wellbeing and refine definitions to include aspects related to social and cultural wellbeing (as presented here).

The World Health Organisation describes wellbeing as a 'resource for healthy living' and a 'positive state of health' that is 'more than the absence of an illness' such that we are able to thrive physically, emotionally and socially.[18,p1] As previously stated, physical and psychological wellbeing are well researched and not the focus of this paper.[19–27] However, at this point, we acknowledge the interconnections and relationships between social and cultural wellbeing and good physical and psychological health.

Social wellbeing has been defined as the perception of support from others and a sense of belonging, inclusivity and social stability.[28,29] Culture and *cultural wellbeing* is dependent upon the context in which an individual identifies or the context under study.[30–32] For example, culture can be related to an individual's ethnicity but equally can be related to a profession to which an individual belongs (e.g., the medical profession or a specialty such as surgery). Therefore, one way in which social and cultural wellbeing may be felt is if an individual or group of individuals feel connected to the community (or organisation) to which they identify and share the same values, thus creating a sense of belonging.[30–32] Conversely, unresolved conflict in social and cultural expectations can lead to an individual or group questioning their own notions of belonging and values, which in turn can have a detrimental impact on the wellbeing of a community or organisation.[30–32] Whilst the focus of this paper is social and cultural wellbeing, we acknowledge that the multiple facets of wellbeing are integrated and often hard to separate. For example, a lack of provision of support for physical wellbeing (such as adequate hydration) could be perceived as an indication of a lack of concern on the part of the organisation for the employee, potentially affecting their

psychological and social wellbeing and furthermore establishing cultural markers about how an organisation prioritises staff wellbeing.

1.3 | Study aims and research questions

By exploring doctors' experiences in a time of profound and sustained transitions (triggered by the pandemic), this study aimed to inform and build on knowledge about social and cultural aspects of wellbeing in the medical workforce across the career continuum (i.e., both learners and their educators). We asked how doctors' experiences of transitions during the pandemic impacted on social and cultural wellbeing and what was perceived to be important to sustain support for social and cultural wellbeing?

2 | METHODS

2.1 | Study context and study design

In Scotland, the location of this study, the pandemic triggered wide-ranging changes to the way healthcare and healthcare education was, and continues to be, delivered.[33] For example, the reorganisation of hospitals into COVID and non-COVID spaces, virtual patient care, a pause or delay in routine procedures and appointments, shifts to home working, virtual learning and redeployment to COVID wards were commonplace as the health service responded to the potential for significant and ongoing increases in COVID-19 in-patients during the first (March to May 2020) and second (December 2020 to April 2021) waves.[33]

This paper reports on the empirical data collection workstream of a wider project that aimed to develop evidence-based interventions to support doctors' wellbeing and promote resilience during and beyond COVID-19.[7,12,34,35] Longitudinal narrative inquiry was employed to explore the experiences of doctors' transitions during the pandemic.[36,37] This approach, through multiple interviews and longitudinal audio-diaries (LADs), enables participants to describe and make sense of their experiences in-the-moment and over time.[5,37]

The research team, part of the Scottish Medical Education Research Consortium (SMERC), represented all five medical schools in Scotland and NHS Education for Scotland (a Special Health Board with responsibility to develop the Scottish healthcare workforce and support education and training for doctors). Our multidisciplinary research team, consisting of 12 white women and two white men, are clinicians and academics with a diversity of experience and expertise in research, publishing and clinical work in the areas of medical education; transitions; general practice; management; health psychology; behaviour change; behavioural science, clinical physiotherapy; evidence and theory based intervention development; qualitative interview techniques, audio diary methods and evidence synthesis. Whilst the diversity in our experiences in this large team is a strength, we acknowledge that our analysis would have been affected by our own backgrounds and experiences. Indeed, we were all experiencing changes because of the pandemic during this study. To encourage team reflexivity, the whole team met on a weekly basis to discuss data collection, analysis and our own experiences and understandings. In addition to full team meetings, those undertaking data collection met at least weekly (sometimes twice weekly) throughout the study.

2.2 | Participant recruitment

Following appropriate ethical and institutional approvals, all doctors working in Scotland (in May/June 2020) across the career continuum, specialties, and geographic locations (including remote and rural) were invited via email and social media to participate in a three-stage longitudinal study. This included the following: (1) an entrance interview (May/June 2020); (2) a LAD phase (May to October 2020); and (3) a second interview (September/October 2020). A total of 98 doctors participated in the entrance interview, of these 71 submitted diaries for (2–4 months), and 83 of the 98 undertook a second interview.

2.3 | Data collection

Due to COVID-19 restrictions, interactions with participants were undertaken virtually, using Microsoft Teams, email and telephone. The data collection team consisted of six of the authors (LG, GS, TT, KW, PC and JF). What participants were asked at each data collection point was influenced by our conceptual framework (MMT). During the entrance interview, doctors were asked to share their experiences of the multiple transitions they had experienced during the COVID-19 pandemic including changes at work, to their role, at home and in their educational context. Additionally, they were asked about the support they received or accessed for these transitions and what they anticipated the next few months were going to be like (at this point Scotland was exiting the first wave of the pandemic, but it was yet unclear whether a second wave would occur). All of those participating in this initial interview were invited to take part in the LAD phase for 2–4 months.

In the LAD phase, participants were asked to record stories, incidents and thoughts pertaining to their transitions experiences during the pandemic and were encouraged to share experiences that occurred in multiple contexts (i.e., workplace, individual role, home or educational contexts). Participants that found audio-recording difficult were given the option to submit written diaries. Participants used their smart phones to record their diary entries and these were then emailed to their designated researcher (LG, GS, TT, KW, PC or JF). Participants were provided with a prompt sheet and were emailed regular reminders to submit a diary. The prompt sheets asked participants to describe their experiences, discuss how this affected their overall experiences of transitions during COVID-19, how they had been supported and whether their wellbeing had been affected. The entry interviews sensitised the participants to the types of experiences they might wish to share. Participants were emailed the transcripts of their diaries for their own records. Furthermore, researchers responded to the content of each diary entry in the reminder emails, which helped maintain the researcher and participant relationship as well as sensitising the researchers to doctors' ongoing experiences.[5]

All participants who undertook the entrance interview were invited to undertake a second interview in September/October 2020 (just as the second wave of the pandemic was taking hold in Scotland). In this interview, the focus was on the longitudinal story of their transition experiences over the last months. Where possible, diary and interview transcripts were used to prompt the discussion. Participants were asked to reflect on their experiences over the prior 6 months as well as consider how they felt about the approaching 6 months. Participants were also asked about support for the transitions they had and were experiencing, as well as how these experiences were affecting their health and wellbeing long-term. All interviews were audio-recorded, and along with the diaries, were transcribed by an experienced, approved and confidential transcription service.

2.4 | Data analysis

Our approach to data analysis was abductive which promotes moving between data and the literature including our conceptual framework (i.e., MMT).[38] First, the research team sensitised themselves to the data set by reading through excerpts of data, and regular team discussion. Through these discussions and our conceptual framing, we developed an initial coding framework based on the MMT domains.[17] This framework was then utilised to code a sub-section of data (by JF, PC and GS) using NVivo 12 qualitative data analysis software. Coding was then verified with the lead author in a coding session where coding meanings and data examples of these codes were discussed. Following this initial coding exercise, all entrance and second interviews and a subsection of LADs (from 44 participants) were reviewed and coded using this framework (by JF, PC and GS). To code this large data set, we began by coding a diverse range of participants' transcripts (this diversity included gender, career stage, ethnicity, specialty and geographic location). The team's deep familiarity with the whole data set allowed us to determine that coding of transcripts was sufficient in terms of research rigour and that relevant data excerpts could be located in uncoded data if required.

Finally, through repeated (weekly) discussion within the data collection team (LG, GS, TT, KW, PC and JF) we undertook more in-depth analysis of the coded dataset to focus on the impact of these transitions to doctors' wellbeing. Through this analysis, we identified the importance of social and cultural aspects which led us to return to the wellbeing literature and to develop our understanding of social and cultural wellbeing definitions as described above.

2.5 | Findings

Table 1 shows details of the participants. Doctors were from all 14 territorial boards in Scotland and were diverse in terms of gender, ethnicity, career stage, specialty and geography (e.g., urban, remote or rural). Entrance interviews ($n = 98$) lasted (to the nearest minute) between 24 and 97 min (average 56). Those that completed audio-diaries ($n = 71$) submitted between 1 and 18 diaries (average 4.6) over a period of 2 to 4 months. Second interviews ($n = 83$) lasted between 27 and 123 min (average 61). This totalled over 12,620 min of transcribed data in addition to 26 written diaries submitted by six participants.

TABLE 1 Participant characteristics

Characteristic	Number	% (nearest 0.1)
Gender		
Male	33	33.7
Female	65	66.3
Age (years)		
25 and Under	12	12.2
26–34	26	26.5
35–44	26	26.5
45–54	17	17.3
55–64	8	8.2
65–74	2	2
Not answered	7	7.1
Self-identified ethnicity/race		
Arabic	1	1
Asian/Asian British	6	6.1
Black	1	1
Mixed race	4	4.1
White	79	80.6
Not answered	6	6.1
Career stage		
Consultant (Specialist Doctor)	20	20.4
General Practitioner (family doctor)	27	27.6
Staff Grade Doctor (in non-training role)	3	3
Foundation doctor (first 2 years post-graduation)	19	19.3
Early stage specialty trainee	15	15.3
Late Stage specialty trainee	14	14.3
Broad specialty (for rotating trainees, specialty at start of study)		
Medicine	24	24.4
Surgery	12	12.2
General Practice (GP, family medicine)	29	29.6
Community (e.g., psychiatry, public health)	8	8.1
Other specialties (e.g., anaesthesia and lab-based specialties)	12	12.3
Not answered	13	13.3

Whilst we recognise and acknowledge that all perceptions of experiences are unique, patterns were identifiable across this large dataset allowing us to make broader conclusions about social and cultural wellbeing that crosscut the dataset beyond individual experience. Through analysis of the data we were able to prioritise three critical factors that contribute to social and cultural wellbeing: *being heard; being valued; and being supported*. Before we present this detailed analysis, we will present what transitions doctors perceived

to have been triggered by the pandemic. Then we will consider each of the three factors, being heard, being valued, and being supported, and how they impacted doctors' social and cultural wellbeing. Throughout, to illustrate our findings, we have used selected quotes that have been chosen because they are compelling yet pithy examples of our findings and are typical of the data.[39]

Perhaps unsurprisingly, all doctors described considerable transitions triggered by the pandemic and our questioning using MMT as our framing allowed participants to depict transitions in multiple contexts (including role, workplace, home and education). In the workplace, doctors described operational and structural changes within their organisation, the cancellation of routine procedures and reallocation of staff. In secondary care (hospital- based), many doctors were redeployed across specialties and departments. These workplace changes led to multiple transitions in doctors' individual roles and responsibilities as illustrated in the quote below.

> We had a relatively short period of time in which to be able to cancel routine activity. As somebody whose work is almost entirely outpatient-based, that was big … everything stopped. Then, there was the transition around well, where were we going to be deployed and being deployed to doing General Medicine, which I have not done for 20 years … became very apparent that actually on the COVID wards, my skills would be fine, … okay with being deployed to the COVID wards if that let me off the hook of having to do Acute Medical Receiving, which would have been well outside my comfort zone …. having [a] very different daily routine, looking after patients with COVID … (Consultant, First Interview).

Following governmental guidance, primary care (e.g., general practice/family medicine) and community-based specialties (e.g., psychiatry) shifted to predominantly virtual or telephone consultations. Doctors providing community-based care described discussing sensitive issues with patients whilst having to work at home. This could lead to 'merging' between work and family roles, as seen in the quote below.

> … the emotional content of what you deal with at work … it feels quite intrusive for that to be at home … I'm taking [patient] calls … it feels quite jarring to have my two year old having a great time playing with his train set in the next room. (Specialty trainee, LAD).

As with many worldwide, participants experienced major homelife transitions due to lockdown rules, home-schooling children and, as in the example above, traditional boundaries between home and work became blurred for some specialties.

Physically, doctors described the difficulties of wearing personal protective equipment (PPE) and the consequential limits to patient communication, the physical discomfort of long periods in PPE and concerns that the equipment was not secure enough to protect them.

> I had to wear my glasses and a visor and the visor's a bit foggy, it's not quite crystal clear like glass, and then because you are wearing so much gear my glasses started to fog up … then I became anxious that my mask wasn't properly sealed and that air was leaking out, so that made me more hot and anxious, which fogged up my glasses more (Foundation doctor, First Interview).

The high proportion of changes in workplace practices (e.g., shifting PPE policies; dealing with an unknown virus) and the intensity of psychological experiences was, at times, overwhelming. For some this caused physical and psychological fatigue that affected their relationships with patients, colleagues, and significant others. A particular source of psychological strain was the inability to allow visitors to be with dying relatives. Many participants found this difficult to process and repeated exposure to these and similar experiences exacted a psychological toll.

> The actual seeing patients on the COVID wards, pretty upsetting: really old people, a lot of them confused in rooms on their own with very little human contact, dying on their own. That was grim. And actually, I'm heartbroken by it. (Consultant, First Interview).

Participants reported a sense of guilt in that they had to grapple with their own understandings of what it meant to be a 'good doctor'. For example, GPs expressed the negative effect that physical distancing had on relationships with patients, something they have seen as central to their role as family doctors.

> [I] had one patient complain that we cannot be that busy as the waiting room is empty. I tried to explain that we still have the same number of patient contacts if not more, but they have been done remotely, but he did not seem to grasp this. Conversely when I've referred patients on to secondary care … It appears that the public have had no concept that primary care has had to make significant changes to deal with the … pandemic (GP, LAD3).

Educationally, doctors at all career stages saw reduced (or for some removal of) formal educational opportunities. Doctors highlighted that a shift to online education allowed for more flexible learning approaches as doctors could learn at their own pace and at a convenient time through recorded educational sessions or blended learning approaches. Others found the ease of setting up online meeting meant an increase in frequency of meetings in the evening and reduced downtime at home. For some early career doctors there was uncertainty about whether specialty training would need to be extended to achieve core capabilities:

> … every single projected teaching was cancelled … A lot of specialty taster days and jobs that you want to

> do beyond FY2 were cancelled which has not been great and some people have been left at a critical point … (Foundation doctor, First Interview).

2.6 | Impact of transitions on aspects of social and cultural wellbeing

In this section, we present how social and cultural wellbeing was be impacted by the three factors: being heard; being valued; and being supported. We explore these three factors in terms of the positive impact on participants' wellbeing of the presence of each dimension and the negative impact in the absence of each dimension.

2.7 | Being heard

Doctors' descriptions of *being heard* in relation to social and cultural wellbeing focussed on immediate workplace relationships. The importance of relationships with immediate work colleagues during the pandemic was a strong influence on social and cultural aspects wellbeing. Important interactions involved being invited by others to express how they were feeling and working with colleagues in an environment that was open to providing support. Making time to talk to each other, intentional social connection and check-ins between colleagues were deemed important to maintaining wellbeing, particularly for trainee doctors. For example, trainee doctors articulated how this invitation to voice how they were came from senior colleagues actively checking in with them. The impact of these check-ins is articulated well by the trainee doctor in the following quote who comments that these check-ins gave them 'quite a boost'.

> I felt a lot of people would … be like, 'How are you doing? Are you okay? Do you need a hand with anything?' … to be very contactable, very easy to ask for help from and willing to give help, that was quite a boost. (Foundation doctor, First Interview).

Absence of these interactions with participants' immediate colleagues were perceived to be problematic. For example, doctors' who were asked to work from home, without these face-to-face interactions, identified feeling isolated and lacking belonging and connection with their organisational community. For example, the trainee below who was working from home during the first wave of the pandemic found reaching out for support difficult:

> When I'm at work if I have a tough phone call or a tough appointment it's … acceptable for me to go into the next room and access kind of informal support from a colleague … I felt very distanced from the team, very kind of disconnected … missed physically going into work, seeing my colleagues, seeing patients. (Specialty trainee [community specialty], Second Interview).

Furthermore, for senior staff (as trainers) this level of social support was not always available. Indeed, some senior doctors, whilst aware of their role in supporting more junior staff, felt 'unheard':

> Nobody's asked me how I am … nobody actually stops and says, 'Are you alright?' and I think that went on for weeks where I spent a lot of time checking with the [trainee] doctors, … who actually looks after the looker afters? (Consultant, First Interview).

Some doctors commented on a feeling of *not* 'being heard' by their organisations (healthcare or educational), which was a source of frustration for many. Indeed, communications between staff and organisations were described from a unidirectional, top down perspective. Furthermore, across both primary and secondary care, there was a perceived lack of clear direction in communications to staff. Participants described poor coordination and late notice of, for example, rota changes. This sat alongside a perceived increase in organisational instability and lack of clarity, leading to untenable levels of uncertainty. Doctors reported conflicting and rapidly changing advice coming from organisations, particularly at the start of the pandemic. The resultant uncertainty manifested in a feeling of lack of control. For example, the participant below described being 'told' what to do and discussed how 'rules' are changed resulting in a lack of understanding of these rules at ground level:

> Somebody came down and told us 'You're not supposed to be doing that, it's clear from the emails that you should not be doing that. They changed the rules day in, day out. Every time I came in there was some other rule that nobody seemed to understand'. (Consultant, First Interview).

Perhaps the biggest barrier to *being heard* that the pandemic highlighted and magnified, was a perceived stigma culturally within medicine around seeking wellbeing support. It was widely understood by our participants that there has been a long-standing expectation, sometimes explicit but also tacit, within medical culture for self-sufficiency and the ability to endure challenges. This meant that participants described purposively 'being quiet' about their wellbeing needs as the participant articulates below:

> … if you say, I'm just struggling … I'm feeling a bit stressed and anxious about this … that's still frowned upon. That's still not allowable [they] say. 'Well, just buck your ideas up and grit your teeth, because everybody else is doing it, so why aren't you?' But of course, everybody else could be feeling exactly the same but nobody else is putting their head above the parapet. (GP, Second Interview).

2.8 | Being valued

In contrast to being heard, participants' perceptions of *being valued* and lack of being valued centred on how they were treated by organisations (both healthcare and educational). A key example, which was repeatedly discussed across the data set, was the provision of access to water and nutritious food in new rest and relaxation (R&R) spaces which were created in the early days of the first wave for hospital-based staff. In addition to physical sustenance, these spaces offered the option for healthcare professionals to regroup and debrief after a challenging shift. This, in turn, helped minimise feelings of psychological and social isolation. As a result, the R&R spaces provided a safe place for doctors to tend to their wellbeing needs as well as a means for interpersonal support in the workplace. Furthermore, doctors explained that the R&R spaces signalled that the organisation valued their staff's wellbeing.

> That was probably the most welcome change, having a space to relax and eat and drink … having an area that you can go to speak to colleagues … have a cup of tea, have a sit down, have five minutes … that was really good … that was useful to have. (Foundation doctor, First Interview).

However, doctors who were not directly 'COVID-facing', whilst having similar support needs, reported that provision of such support was inconsistent. This was interpreted by participants as failing to display to staff how much they were valued.

> … and they are [COVID-facing doctors] getting loads of things, hand cream and people bringing stuff in, and we do not get anything here, no, nothing. I think we got a box of fruit once, and it's not about the thing, it's not about the thing, it's just the thought that people are thinking about you. (Staff Grade Doctor, First Interview).

Some doctors reported that many were removed between the first and second waves which led to a feeling that they were not being 'prioritised'.

> … I'm sad to say they are taking them away now they were gone yesterday, they were taking all the bean bags out … and we were told that R&R rooms were no longer necessary. We're going back to you know, we are not being prioritised. (Foundation doctor, First Interview).

Participants expressed concern around the longevity of support mechanisms that had been put in place by organisations. There was a concern that the consideration of doctors' wellbeing was 'just for COVID' and that long term this support would evaporate.

> There's a lot being said at the moment and sent out in emails about emotional wellbeing and support … it's very visible that there's an effort towards looking after mental wellbeing in employees, and it's a good start. But I think that a lot of people are thinking, 'Well, this is just what's fashionable to do whilst we're in this pandemic'. (GP, First Interview).

This is a striking example of the perception of the temporary nature of wellbeing interventions that manifested in a sense of lack of value and priority given to healthcare staff and their wellbeing long term.

2.9 | Being supported

The third and final dimension of social and cultural wellbeing reflects both being heard by colleagues and being valued by their organisations and centres around the ways in which doctors perceived that they were *being supported*.

Support was found in numerous places. Personal and informal support channels were particularly important. Family and friends were regularly identified as key to providing physical, psychological and social support. Some doctors relied on those at home as a source of help by providing an escape from workplace stresses. Many highlighted informal online platforms, such as WhatsApp groups with colleagues and other profession-specific social media channels, as useful and safe ways to seek out understanding from those who directly understood their experiences.

> I've probably spoken to my family more than usual and had support from them, did Zoom sort of video things … Spoke to a lot of my friends, either via media or, like, just by texting and still have support from them. So I think, yeah, I was pretty much psychologically supported. (Foundation doctor, First Interview).

In work, collegial working relationships were perceived by doctors as central to being supported. The need to respond quickly to rapidly evolving situations required effective teamwork and elicited positive interprofessional relationships both within the immediate work environment as well as across traditional boundaries. For example, the primary and secondary care interface:

> I really think what's been amazing is the teamwork between primary and secondary has been absolutely brilliant. I have not had a conversation with a colleague in hospital that has not been helpful this entire time. (GP, First Interview).

However, some senior doctors experienced mounting pressure to support and promote a safe working and learning environment for trainees and students, alongside ensuring safe service provision, which felt like a difficult and unending task. Some senior doctors noted how the combined physical, emotional and social impacts affected their ability to switch off and process what was happening at home

> I suppose in reality with all the constant changes we are having to deal with, junior doctor rostering and training and trying to keep something going, I've just been feeling pretty constantly 'on' over the last few months, and well, mentally at least, and I've really struggled to switch off during my time at home (Consultant, LAD).

Educationally, the pandemic had specific implications for trainee doctors at pivotal stages in their careers. Whilst they understood the reasons, there was concern about the long-term impact of reduced support for routine learning opportunities. Some identified that there was a lack of recognition of learning experiences obtained during the pandemic. For some, this meant no longer being eligible to apply for a preferred specialty due to lack of exposure resulting in negative implications for career progression.

> … just had an email from the department planning our training for the next year … confirms that the time I've spent in intensive care over the last three months … will not count … towards my training and I will have to repeat … which is a real kick in the teeth … It prolongs my training. (Specialty trainee, LAD).

In contrast, many trainee doctors identified the support of educational bodies, which led to a feeling of understanding of their circumstances and highlighted the importance of regular supportive communication:

> help … is always available [from the educational body]. Regular briefing … online sessions for questions and answers every week, followed by reports for trainees … They quite understand how this uncertainty affects the trainees. (Specialty trainee, First Interview).

Doctors with long term conditions at higher risk from COVID (as with others in the United Kingdom with high risk conditions) were asked to self-isolate for an extended period (termed shielding). They described uncomfortable, unsupportive conversations with their colleagues about their physical and mental health. Having to negotiate separate work conditions was perceived as having a negative impact on their professional relationships. Shielding doctors also reported a lack of communication and support from regulatory bodies and felt a sense of pressure to return to work. They were often expected to negotiate their own workplace conditions, whether that was working from home, staying in the workplace, or returning to work following a period at home. The lack of clear communication added further burden to their wellbeing as their physical safety was already at higher risk because of COVID-19.

> … the BMA [British Medical Association] will not speak to me until I've had a risk assessment because it's my legal requirement to have one done. Occupational health will not speak to me until I've had a risk assessment and the guidance from the board has said that it should only be complex cases … The Deanery have said it's not their problem. My training programme director is not replying to emails. It feels quite lonely and it feels really uncertain. (Specialty trainee, LAD).

3 | DISCUSSION

Our study first asked how doctors' experiences of transitions during COVID-19 had impacted on wellbeing. We also asked what was perceived to be important to sustain support for social and cultural wellbeing. Perhaps unsurprisingly, we found that multiple transitions were triggered for doctors across the career continuum. These transitions affected multiple domains and impacted them in multiple contexts: workplace, role, home and educational. In line with previous studies, using an MMT lens allowed us to explore the transitions happening in multiple contexts.[1,5,17]

Through this initial analysis, we ascertained that doctors had a broad range of experiences that had both supported and challenged their social and cultural wellbeing. Through further analysis, we identified three key factors that facilitate social and cultural wellbeing: *being heard*, *being valued* and *being supported*. We were also able to explore the consequences of not being heard, valued and supported. These data contribute a deep understanding of participants' experiences during the pandemic, how these transitions have affected their wellbeing, allowing for a more nuanced consideration of ways in which interventions might be developed and how medical education may assist future doctors to feel heard and generate an environment for being valued and supported. Furthermore, our findings indicate that beyond individuals and groups, organisations and societal expectations can also affect wellbeing. For example, whilst participants felt heard by colleagues immediately around them, they felt less heard by organisations, indeed organisational communication was perceived to be top-down and instructional. Our analysis also highlighted the cultural stigma related to doctors engaging in help seeking behaviour. There was concern that if they revealed their needs it could be damaging for their ongoing training and career-status. Whilst this is not new in the medical education literature, for example, in previous works,[40,41] our study brings into sharp focus that even in the exceptional circumstances of a global pandemic, unwillingness to reveal a need to 'be heard' and ask for help persists.

Furthermore, actions of organisations were perceived to contribute to doctors' feeling less valued. Participants could identify specific examples of the removal of wellbeing interventions (e.g., R&R spaces) and the lack of attention for those in non-COVID facing roles. This led to participants narrating that they felt undervalued by their organisation, which impacted on social and cultural wellbeing. The ability to feel connected and identify with a cultural community (such as a healthcare organisation) allows individuals and teams to flourish.[3]

Finally, support for doctors was mixed; some experiencing positive support mechanisms (often from individuals and groups nearby)

and others left feeling unsupported (by organisations). Whilst support measures in place were appreciated, there was concern (possibly through lack of organisational trust) about the longevity and sincerity of the support offered by the organisation.[22] Thus, people become disconnected and question their unity and connection with that organisation.[30–32] Our data revealed signs of such disconnect and a lack of clear communication from organisations. This is an important contribution to the literature, which has been previously criticised for expecting the responsibility for wellbeing to lie only with the individual.[1] We found the types of support doctors accessed differed, suggesting a one-size-fits all approach to supporting trainees and their educators might not be effective moving forward. This aligns with ongoing arguments in medical education for a move away from the focus on single solutions to consider multiple influences and aspects.[13] It is vital that medical educators and managers consider the learning from these experiences to help pinpoint what aspects of support might be beneficial to maintain, and indeed may need to be introduced or continued beyond the pandemic. This study forms the basis for evidenced-based interventions for supporting doctors that target different groups' needs appropriately.[34,35]

3.1 | Contribution to the literature on transitions and wellbeing

This research extends previous work using MMT as a lens for analysis of doctors' transitions, which focussed on the career transitions of trainee doctors moving into a senior doctor role, showing that there is utility of this theory to explore doctors transitions across career grades.[1,5,17] Furthermore, our work extends the extant wellbeing literature by considering broader definitions and meanings of wellbeing and responds to calls for clarity in defining the term.[13] Our data analysis helped us move beyond existing perceptions around wellbeing and articulate multiple domains that contribute to social and cultural wellbeing, namely, being heard; being valued; and being supported. This approach to analysis contributes to the conceptual literature on wellbeing by providing a framework to consider these multiple interacting factors. Furthermore, our qualitative, longitudinal approach allowed us to delve deeply into participants lived experiences, something that is often lacking and problematised in the predominantly objective-deductive wellbeing literature.[12,13]

To summarise, this study is the first to longitudinally explore the multiple-multidimensional transitions experienced by doctors during the COVID-19 pandemic. Furthermore, our findings make a novel contribution to the literature on MMT and wellbeing.

3.2 | Methodological strengths and limitations

Our study has many methodological strengths. First, our substantial longitudinal qualitative data set from a large and diverse sample (in terms of gender, age, career stage, ethnicity and geography) means our data brings a uniquely broad and rich perspective and thus a high likelihood of strongly resonating with other doctors and indeed the wider health workforce.[42] Second, the longitudinal nature of our study meant that we could explore doctors' unique experiences over the course of the first year of the global pandemic, allowing us to return to these experiences in second interviews to explore in more depth.[5,36,37] Furthermore, collecting diaries meant that thoughts and feelings about experiences were collected in the moment rather than filtered through memory.[5] Indeed, arguably the diaries themselves acted as 'safe spaces' for participants to reflect.[43] Third, our team-based approach to data analysis added rigour and reflexivity to our analysis.[44] Indeed the large research teams' diversity in terms of gender and background (e.g., psychology, management and clinicians) brought diversity of perspectives to our analysis and resulting interpretations of the data.[45]

As with all research, our study is not without limitations which should be accounted for when drawing conclusions. Whilst our sample is diverse, we acknowledge that most participants (80.6%) self-identified as white. This does reflect the workforce within the country that the data were collected; nevertheless, this may affect transferability of our findings to those of ethnicities other than white. This is particularly pertinent in the context of COVID-19 as a disease which is known to have a disproportionate effect on certain ethnic groups.[46] As previously articulated, we also acknowledge that analysis would have been iinfluenced by our own backgrounds and experiences, including our own ongoing experiences of the pandemic. Despite these limitations, our findings have implications for educational practice and future research discussed below.

3.3 | Implications for education practice

Unique to our data set was the exploration of the experiences of *both* trainee doctors and their educators. The potential long-term impact of these experiences on the whole medical workforce should not be underestimated. As medical educators it is vital that we are cognisant of how these experiences will affect medical education moving forward beyond the pandemic. Potential harm from doctor burnout, challenges to workforce retention and ultimately patient safety are ever present.[8–11] As with other studies into doctors' transitions, it is important for educators to be cognisant of the complex interplay of the multiple contexts and domains that can be affected.[1,5]

Lessons need to be learned from this study as to where the onus for wellbeing is placed and how the multiple facets of wellbeing interact.[1,5,17] Our findings suggest that social and cultural wellbeing should be considered, moving beyond individual responsibilities, and interconnected with organisations, communities, and social relationships. The study highlights the need for an organisational push to show value of staff across the organisation, including health professional students. This could be achieved through, for example, regular

listening exercises that cross-cut all staff and students within an organisation, such as a feedback app.[34] Accordingly, medical educators can develop learners' abilities to articulate their needs and openly discuss the multiple aspects of wellbeing (physical, psychological, social and cultural).

Finally, the 'stigma' identified around accessing support should be prioritised by medical educators as we move beyond the pandemic. Measures to reduce and ultimately eliminate the 'perceived concerns' associated with help seeking is critical moving forward. Indeed, the doctors in our study emphasised the beneficial nature of taking the time out to share and talk about their experiences with colleagues and peers. We advocate making time in the working day to discuss experiences with peers, and to ask each other 'how was your day'.[34] This could improve acceptability and accessibility of accessing support.[34] Perhaps the 'gift of time' within medical education to undertake supportive activities is key to creating a culture that encourages help seeking and provides supportive networks for this to take place. This could go a long way in encouraging wellbeing and foregrounding workforce value within organisations.

3.4 | Implications for further research

In the first instance, given the size of this data set, this analysis provides a mere snapshot. Further questions can be asked of this data set, for example, around how experiences have affected professional identities and professional identity development of trainees. Second, and in response to the limitation we identified around participant ethnic diversity, we would recommend consideration of future research that explores the experiences of doctors from those ethnic groups most affected by COVID-19. Third, we would recommend that further research is undertaken to explore the transitions experienced by other healthcare professional groups during this unique time. Finally, we recommend further research that explores organisational learning from changes to education and working practices. Monitoring what should be kept and implemented beyond COVID-19, and how these changes affect the social and cultural domains of health professionals' wellbeing long-term is crucial.

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CONFLICT OF INTEREST

None.

ETHICS STATEMENT

This study was approved by the University of Aberdeen Human Research Ethics Committee.

AUTHORS' CONTRIBUTIONS

All authors contributed to the conception and design of the study and secured funding. LG, GS, TT, KW, PC and JF undertook all data collection. All authors contributed to data analysis. LG, GS and TT wrote the first draft of the paper and LG and TT redrafted multiple iterations. All other authors edited multiple iterations of the paper. All authors approved the final manuscript prior to submission.

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