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RESEARCH ARTICLE

Experiences of junior doctors who shielded during the COVID-19 pandemic

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Abstract

Background: Shielding was introduced to protect clinically extremely vulnerable people during the COVID-19 pandemic. For junior doctors who had to shield, this meant pausing in-person clinical duties to protect their health. There is limited literature regarding this, and the available evidence is predominantly surveys or blogs that describe mainly negative experiences including guilt, isolation, inadequate support and Return To Work (RTW) concerns. Exploring the experiences of this group is valuable to understand the impact on them, and their support needs moving forward.

Methods: This was a qualitative study using individual semi-structured interviews. Three junior doctors were recruited using volunteer and snowball sampling. Interview transcripts were analysed using thematic analysis.

Findings: Seven themes were finalised: (1) Professional value, (2) Threatened autonomy, (3) Self-motivated, (4) Educational impact, (5) Mental health, (6) Inadequate support and (7) Return To Work concerns.

Discussion: Participant experiences largely reflected the evidence base including increased skill and knowledge acquisition, alongside guilt, isolation and inadequate support whilst shielding and upon RTW. These findings add valuable qualitative data to a scarcity of literature. However, caution should be applied when transferring these findings to other junior doctors, noting the small sample and regional setting. A small research grant has been secured for further research with a larger sample size incorporating the supervisor perspective.

Conclusion: These findings demonstrate that shielding was a challenging experience for these junior doctors including impacts on mental health and insufficient support. This lack of support requires further attention to refine and strengthen available support structures.

1 | BACKGROUND

In March 2020, 'shielding' was introduced in the United Kingdom (UK) as an attempt to protect individuals classified as clinically extremely vulnerable (CEV) to severe illness from COVID-19. Shielding guidance was more severe than the lockdown guidance applied to the general population of the UK. Those impacted were unable to leave the house for anything other than urgent medical issues. Shielding was initially advised for 12 weeks but was later extended until August 2020, and then further paused and restarted coinciding with levels of infection.[1] The shielding programme formally ended in September 2021, at which point approximately 3.7 million people were shielding in the UK.[2]

Reasons for CEV status included health conditions such as respiratory illness, high-risk pregnancies and medications such as immunosuppressants.[3] In addition, some were shielding-by-proxy, meaning they followed shielding guidance to protect a CEV member of their household.[4] For the estimated 1343 junior doctors who were identified as CEV,[5] following shielding guidance meant a significant and abrupt professional change as they left the clinical environment, moving to remote clinical and non-clinical roles,[6] or not working at all.[7]

From a service perspective, junior doctors who were shielding held varied responsibilities such as remote prescribing, providing pastoral support, managing rotas,[8] teaching, quality improvement, leadership and research.[9] In terms of their professional development, those who were shielding reported benefits such as increased empathy for patients, problem-solving skills,[10] proficiency in conducting remote consultations,[11] time for professional development that would not have otherwise been possible[9] and enhanced accessibility of educational sessions.[12] Looking at Postgraduate Medical Education (PGME) more broadly, shielding illuminated longstanding challenges faced by some junior doctors providing insight into potential areas for improvement.[11] This was illustrated by Maitra[4] in their paper on shielding-by-proxy. They considered the National Health Service (NHS) staff who are informal carers and how they may benefit from continuing flexible WFH practices beyond the pandemic.[4]

Alongside these perceived benefits, junior doctors reported negative impacts on their career progression.[13] Shielding was described as 'unfair and discriminatory' by junior doctors who were told that WFH duties were not counted towards training progression.[14] Shielding was also associated with negative impacts to mental health including anxiety, guilt and isolation. In a survey of 59 junior doctors, some of this anxiety was ascribed to the uncertainty and poor organisation from their departments when WFH.[15] Almost all available evidence details feelings of guilt linked to not being able to work on the 'front-line',[7–9,13] or help the NHS.[6] Shielding was described as an immediate and dramatic change from clinical doctor to vulnerable individual.[6] One junior doctor described the guilt that she was not fulfilling her oath as 'almost overwhelming'.[10] Shielding was posited as particularly challenging for junior doctors because it contradicted these vocational beliefs.[9]

Moreover, multiple accounts from shielding junior doctors described isolation.[7,10,13,14] Only one of 17 shielding junior doctors in a qualitative study reported regular interactions with management staff.[13] Insufficient workplace support was implicated in exacerbating isolation.[16] Several sources demonstrate that support was either variable or insufficient for shielding junior doctors.[14] For example, 42% of 195 respondents to a British Medical Association (BMA) survey reported 'unsatisfactory' departmental support whilst shielding.[17] Furthermore, 21% of 99 junior doctors and other Healthcare Professionals (HCPs) were unable to WFH because of inadequate resources.[8] For those who were able to WFH, 43% felt their contribution was perceived to be undervalued or unacknowledged.[8] In a number of reports, junior doctors who were shielding described feeling forgotten.[14,15]

Junior doctors who were shielding were routinely omitted from key guidance from governing bodies such as Health Education England (HEE)[18] and the General Medical Council (GMC).[19] National guidance specific to the needs of this cohort was released months after general guidance,[5] which represented delays in addressing the needs of these junior doctors. Conversely, in a case study, Oxleas Trust described having a prompt, structured approach, with clear leadership, regular communication and established community for those shielding. They concluded that when adequate support such as RTW planning and reasonable adjustments were provided, there was opportunity for positive shielding experiences.[20]

Yet, one of the main challenges of shielding for junior doctors was RTW. Inadequate RTW support has been implicated as a contributing factor in patient safety incidents, such as the high-profile example involving Dr Bawa-Garba.[21] There was anxiety[6] and uncertainty amongst junior doctors who were shielding about what measures would be implemented to protect their health upon RTW.[15] In a BMA survey in July 2020, 70% of a sample of 194 junior doctors did not have an RTW date.[17]

A key difference in RTW support between Scotland and England is the SuppoRTT programme introduced in England in 2018.[22] It provides 3-month support[22] available to the roughly 5000 junior doctors out of the clinical setting at any one time.[23] An evaluation of the service that surveyed junior doctors reported reduction in feelings of isolation, especially in those who were shielding.[23] The Scotland deanery gave Training Programme Directors (TPDs) a list of people who had responded to a survey about shielding and advised Occupational Health (OH) assessment, regular supervisor meetings and an educational development plan.[24] Although it is possible that a more systematic approach occurred in practice, a clear limitation to this approach is the dependence on survey responses to receive support.

There is minimal research published on the impacts of shielding specific to junior doctors. There are six empirical articles including one interview-based study.[13] The rest are cross-sectional surveys that are susceptible to self-selection bias potentially impacting the representativeness of the sample.[25] Empirical research would offer valuable insight into the impacts of shielding on factors such as PGME and health. This could inform our understanding of the support needs of these junior doctors going forward. Despite the end of the shielding programme, we cannot guarantee that it will not return with the resurgence of COVID-19, or another pandemic. Beyond the pandemic, the findings are potentially transferrable to other situations where junior doctors take protracted clinical leave, such as maternity leave or illness.

This study aimed to understand the impact of shielding on junior doctors in Scotland during the COVID-19 pandemic. The research questions were as follows:

1. What were the experiences of junior doctors who were shielding during the COVID-19 pandemic?
2. What were the perceived impacts of shielding on PGME?
3. What were the perceived impacts of shielding on health?

4. What were the perceived support needs of junior doctors who were shielding?

2 | METHODS

This study was a qualitative investigation. Participants were based at a local NHS board in the West of Scotland, employing approximately 12,000 staff providing care to the local population of around 500,000 people.[26] Based on anecdotal estimates from the Scotland Postgraduate Deanery, there were approximately 25 junior doctors who were shielding locally.

The total sample of three was recruited via volunteer and snowball recruitment methods. Recruitment information was disseminated via email to local junior doctors. Two follow-up reminders were sent after 3 and 5 weeks. The target sample size was 8–10, but there were recruitment challenges; thus, approval was granted from the Research Ethics Committee (REC) to add snowball methods and include the pilot interview in the dataset.

Qualitative methodology was chosen in line with the research aim to explore and understand experiences.[27] Semi-structured interviews allowed for rich data collection, and dependability via use of an interview guide, with flexibility to expand on discussion points. Virtual interviews intended to enhance participant safety, comfort and convenience. A pilot interview was conducted to test the interview guide and identify any potential issues with wording or content. Interviews were conducted virtually on Microsoft Teams between June and September 2021, approximately 45-minute duration, and were audio-video recorded. Written consent was obtained in advance of, and verbal consent was obtained at the start of the interview. Interviews were transcribed by the primary researcher, and participants were invited to partake in member checking, but all declined.

Data were analysed using thematic analysis. This method was chosen because of its flexibility, which is appropriate for the exploration of experiences and seeking new meaning.[28] The most well-known framework is arguably the six-step approach by Braun and Clarke.[29] This entails familiarisation with data, generating codes, searching for, reviewing and refining themes, before finally reporting findings.

Ethical approval was granted from the University of Glasgow College of Medical and Veterinary Life Sciences REC. Data were stored in accordance with the General Data Protection Regulation. No significant power issues were present. An administrator disseminated the participant recruitment email, and the primary researcher had no influence or authority over the participants' career progression or role.

3 | FINDINGS

All participants were women working in the West of Scotland as junior doctors whilst shielding. Interviewee 1 (I1) and interviewee 2 (I2) were shielding because of pregnancy and interviewee 3 (I3) because of a medical condition. Stage of training ranged from foundation programme to specialty training. Although it is typical to include further participant demographics, it is felt that the population of junior doctors who were shielding is sufficiently small that further identifying details would compromise participant pseudo-anonymity and confidentiality.

After analysing the transcripts, 153 codes were generated and informed seven final themes:

1. Perceptions of professional role
2. Threatened autonomy
3. Self-motivated
4. Educational impact
5. Mental health
6. Inadequate support
7. Return To Work concerns

3.1 | Theme 1: Perceptions of professional role

All described difficulties adjusting to their new roles, which included teaching, management, administration, public health work and remote clinics. I2 missed patient contact and the camaraderie of working in a clinical team. I3 described the experience of shielding as 'stressful' from its instigation, commencing with the sudden instruction to leave work immediately mid-shift. All expressed sentiments that frontline clinical work is more valuable than remote clinical or non-clinical work. I1 felt that junior doctors who were shielding were underutilised, undervalued, and forgotten: 'I could be useful here. I'm an asset. But I'm going to sit on my bum in an office.'

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3.2 | Theme 2: Threatened autonomy

All participants reported infringement on their autonomy. They used language that reflected a lack of control over their situation and described being told to do things they did not want to do. I1 described herself as 'very very very much not wanting to shield' but that she was not given any choice at work. She felt she would have been judged as 'reckless' for continuing clinical work.

3.3 | Theme 3: Self-motivated

I1 said the only reason she was able to work whilst shielding was because of her self-motivation to seek work. I2 also described taking active steps to repeatedly insist that work be assigned to her. I3 was motivated to keep working and requested opportunities from her supervisors, yet she was told WFH resources would not be provided. Therefore, I3 could not work whilst shielding.

3.4 | Theme 4: Educational impact

I2 and I3 had to extend their training. I2 did not perceive training extension negatively, whereas I3 described a significant impact on her confidence saying she was left 'feeling a bit lost' after a protracted period away from the clinical environment. She was not informed about any remote educational opportunities or provided with information when she requested it. For I1, her shielding experience highlighted perceived limitations to PGME beyond the pandemic, such as insufficient opportunities to develop leadership, management or teaching skills.

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Despite negative impacts, all participants reported benefits of shielding. I1 attributed her subsequent professional success to opportunities she had that were only possible whilst shielding including leadership, management and teaching responsibilities. I2 expressed the same sentiment, and I3 felt more empathic towards patients and thus felt shielding made her a better doctor.

3.5 | Theme 5: Mental health

The commonest mental health impacts were anxiety, guilt and isolation. I1 was anxious about the risk to her health and her pregnancy. I3 felt that RTW was 'scary' because of the risk to her health. All participants felt guilty about not being able to work clinically. I3 felt guilty about the reasonable adjustments made for her RTW saying '… it always felt like I was making a fuss'. I2 and I3 reported significant isolation with I3 describing that a lack of support from her colleagues worsened this. For example, she was part of a WhatsApp group with colleagues who jokingly called her 'rota gap'.

3.6 | Theme 6: Support

I1 perceived that shielding junior doctors were given insufficient support and were not provided with the resources needed to WFH, describing it as ' … nigh-on impossible' to attain. There was a lack of educational support, structure or planning to I1's work whilst shielding. Nor did she receive pastoral support or contact with OH. I1 believed she was only prioritised for access to a laptop to WFH because she was integral in coordination of junior doctor shift planning. I1 also highlighted the insufficient support available for junior doctors requiring reasonable adjustments when on maternity or sick leave beyond the pandemic. She said there are junior doctors'… that will have health conditions that will prevent them from working in a normal way. Medicine hasn't adapted to allow these junior doctors to still train … that's not fair'.

… [doctors] will have health conditions that will prevent them from working in a normal way. Medicine hasn't adapted to allow these junior doctors to still train … that's not fair.

I3 felt strongly that she received almost no support during shielding and could have WFH and felt less isolated with more support from supervisors. Despite not hearing from her supervisor, she did contact her TPD who responded in a supportive manner. In contrast, I2 reported feeling well-supported by her department. She was provided with daily educational support from colleagues.

3.7 | Theme 7: Return To Work concerns

I1 briefly mentioned RTW but was still on maternity leave at the time of interview. I2 was glad to be back at work but experienced challenges because of inadequate formal support. She was given no

induction despite requesting one, saying '… [induction] didn't obviously happen because it never does'. I2 would have felt more supported by a formal induction and keep-in-touch days and felt her learning needs were not met or recognised.

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I2 felt her RTW shifts were inappropriate, given her low confidence and knowledge about treating patients with COVID-19. Informal support was given if she requested it, and she felt it was her responsibility to pursue support. However, I2 was not supported to receive her COVID-19 vaccinations before RTW, and this made her feel unsafe. She felt she had good pastoral support from her TPD; however, the lack of educational support left her feeling unprepared to RTW. I3 wanted more check-ins from supervisors throughout her RTW educationally and pastorally and was disappointed that no one monitored her well-being after shielding. I3 had challenges confirming her RTW date and worried that her department did not want her to RTW because they saw her as a burden.

4 | DISCUSSION

These findings show that junior doctors who were shielding faced challenging circumstances. This is unsurprising in view of the disruption, fear and uncertainty caused by the pandemic on a global scale. However, in line with existing literature, this group of junior doctors reported significant isolation, feelings of guilt and inadequate support throughout shielding and upon RTW.

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Guidance from specialty organisations recommended that regular support such as team interaction could mitigate against isolation.[16] Unfortunately, this guidance was not consistently applied in these participants. The benefits gained from shielding appeared to be contingent on the support provided. I2 reported the most positive experiences of shielding and received the most regular workplace support. I3, who received no significant support, was not privy to the professional development opportunities of I1 and I2 and reported the most negative experiences. Furthermore, I3 was the least clinically experienced. Applying Bourdieu's[30] concepts of capital and field, one could posit that I3 had less capital in the medical field. Thus, where I1 and I2 successfully sought out work via insistence, I3's request to work was refused. It is important to consider the stage of training when planning support for junior doctors. Early career trainees might not feel as empowered to self-advocate.

Another key difference between I3 and the other participants is their reason for shielding. I1 and I2 were shielding because of pregnancy and said that people were very understanding about the importance of protecting their pregnancy. In contrast, I3 who was shielding because of a health condition was called 'rota gap'. For I3, it might also have felt too personal to talk about a medical condition, thereby limiting communication and support. This potentially highlights a key difference in the support needs for junior doctors RTW after illness versus maternity.

None of the participants perceived their RTW support as satisfactory or received the support recommended by the Scotland Deanery—OH risk assessment, regular supervisor meetings and an educational development plan.[24] These measures could have been associated with more positive experiences of reliable high-quality support. Particularly given the implications of poor RTW support on patient safety and physician mental health,[21] it is important to ensure that these processes are as robust as possible. For instance, the Bawa-Garba case in England was a high-profile example of the links between insufficient RTW procedures and patient mortality. Significant events are an essential chance to take stock and implement learning to minimise future risks. The SuppoRTT programme was introduced in England partially in response to this event to improve RTW experiences.[22]

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Furthermore, although views differ on the likelihood, it is possible we will experience another pandemic event in the coming years. It is vital to learn from our experiences to go forward better prepared with readily available and scale-able structures in place to support junior doctors in unpredictable situations.

In keeping with the evidence base, junior doctors who were shielding felt undervalued and forgotten. This is reaffirmed by the routine omission of CEV and shielding junior doctors from PGME guidance. They seemed to be overlooked as a valuable part of the workforce, having to repeatedly request work assignments, had difficulties securing reasonable adjustments and received limited contact

with their supervisors or wider team. This is disappointing and at odds with Scotland deanery recommendations.[24] Looking again to Bourdieu's[30] concepts of capital and field to explain this perception of reduced value, junior doctors who were shielding did not have the clinical experience of frontline workers that was highly respected by the medical field and the public, limiting access to this capital. Having to avoid the clinical environment, they might have felt or been perceived to have lost capital, and value as a result.

The implications to PGME more widely relate to the value we place on the contributions of junior doctors who must take time away from the clinical setting. In the context of a serious recruitment and retention crisis in medicine in the UK, it is more important than ever to drive a culture in PGME that recognises and utilises the assets of all junior doctors in the workforce. It is prudent that we do not inadvertently deter or make unwelcome these motivated and dedicated junior doctors.

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The mental health impacts in this sample were clear. Feelings of guilt were present throughout the interviews and the evidence base. The reasons in this sample were more varied such as guilt about RTW adjustments and having access to opportunities that other colleagues did not. However, common to all participants was guilt about not working in person clinically. Viewed through the lens of Professional Identity Formation,[31] it is not surprising that junior doctors who were unable to contribute to the national effort in the same way as their 'frontline' colleagues experienced guilt. Their need to WFH and protect their health was potentially at odds with their view of themselves and their identity as junior doctors. Addressing the guilt of not being able to work in the clinical environment is an important aspect of RTW support for those returning from sick leave or pregnancy.

4.1 | Strengths and limitations

This is the first qualitative study to explore the impact of shielding on junior doctors in Scotland, offering a depth of insight not currently available. These findings support and build on the cross-sectional surveys and grey literature such as blog articles. Transferability is limited by the sample size of three and the regional setting. However, qualitative investigations aim to understand phenomena to a satisfactory depth and complexity whilst balancing the volume of information.[32] There can be potentially rich data from three interviews, and there is no widely agreed ideal sample size for interviews analysed using thematic analysis.[33]

Considering self-selection bias, the sample who volunteered might have different characteristics than the target population of shielding junior doctors. For instance, no male participants were recruited.

4.2 | Further research

Given the small sample and dearth of research in this area, a larger study would add credibility to these findings. The primary researcher has secured a small research grant to expand the scope of the current investigation to all junior doctors in Scotland and consultants who supervised them to also understand experiences from a supervisory perspective.

4.3 | Implications for practice

These findings suggest that there are limitations around guidance and policy at an organisational level to support junior doctors who are returning to the clinical setting after a period of leave such as shielding, maternity leave or illness. It is hoped that these findings will prompt and support action to strengthen and more systematically implement such resources that are linked to physician well-being and patient safety. Implementation of support was by local departments and likely accounted for widespread variability and inconsistency at the expense of support for these junior doctors. It is important to consider if this would have been the case if a formal standardised programme were in place. Good progress has been made in recent years in recognising the importance of such measures such as the SuppoRTT programme in England.[22] However, there is clear scope for improvement such as regular and tailored educational, pastoral and RTW support that could have had a positive impact on junior doctor training and well-being.

... regular and tailored educational, pastoral, and RTW support ... could have had a positive impact on junior doctor training and well-being.

5 | CONCLUSION

These findings demonstrate that shielding was a challenging experience for this cohort of junior doctors. In line with existing literature, there were significant negative impacts on mental health and prominent descriptions of inadequate support. Despite this, junior doctors who were shielding and were supported to work from home, utilised their time valuably and developed important skills and experience. This study indicates that junior doctors with experience of shielding are motivated, dedicated and passionate individuals who achieved a great deal in the face of adversity. With the common experience of RTW after prolonged clinical leave and the possibility of another pandemic, more attention is needed to refine and strengthen RTW processes.

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CONFLICT OF INTEREST STATEMENT

I have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICAL APPROVAL

Ethical approval was granted from the University of Glasgow College of Medical and Veterinary Life Sciences REC. Data were stored in accordance with the General Data Protection Regulation. No significant power issues were present. An administrator disseminated the participant recruitment email, and the primary researcher had no influence or authority over the participants' career progression or role. All participants gave informed consent to participate and for their pseudo-anonymised responses to be used for publication.

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