



BMA Covid Review 2

The impact of the pandemic on the medical profession

Executive summary

The COVID-19 pandemic has had a significant impact on everyone, but medical professionals bore a particular burden. In late 2021 the BMA conducted a call for evidence survey to set out the experience of the medical profession during the pandemic and to learn lessons for future pandemics. We found that the pandemic seriously impacted the health and wellbeing, and financial and career prospects of medical professionals:

The pandemic seriously impacted the physical health of medical professionals.

- Healthcare workers were among those with higher infection rates, with many and more than in the general population, now dealing with the ongoing effects of long COVID.
- Ethnic minority doctors and disabled doctors were among those whose physical health was more negatively impacted by the pandemic than their peers.

The mental health and emotional wellbeing of medical professionals suffered considerably

- Burnout, overwork, distress, trauma, and isolation have all been serious issues, with calls to the BMA's counselling service increasing by over a third (37%) in the first year of the pandemic, and several respondents to our survey stating they had left or would be leaving the profession.
- Exhaustion was found to be higher among female respondents (62% compared to 53% for male respondents) and amongst respondents with a disability or LTC (62% versus 57% of those without).

The medical profession rarely received the support they needed

- The UK government's failure to vocally support doctors as the pandemic went on was damaging and cannot be ignored in the face of reported instances of abuse rising from 10% in August 2020 to 48% barely a year later.
- Employers missed opportunities to mitigate the negative impact of COVID-19 on doctors.

The pandemic also led to some practical positive changes in the UK's health services

- Remote working and hybrid working was better facilitated, morale improved especially at the beginning of the pandemic, and the appraisal process was better streamlined.

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Acknowledgments

We would like to thank everybody who responded to our survey detailing their experiences of the pandemic. The BMA understands the immense sacrifice that continues to be made by medical professionals. If you do not see any of the text from your response included in our reports, please do know that every response was read and used to inform our conclusions. We are very grateful indeed.

Our second COVID review report is the work of Olivia Clark, Margot Kuylen, Claire Chivers, Duncan Bland, Suzanne Wood, Lena Levy, Alex Gay and the BMA Wales, Scotland, and Northern Ireland teams. Contributions have come from BMA elected members and chief officers. A huge team of people in our Communications and Policy Directorate and staff across the BMA made publication and promotion possible, including our strategic communications, media, public affairs and content and audience teams.

Foreword



For most doctors, the COVID-19 pandemic has been the most gruelling and challenging experience in their professional lives.

This report describes the profound impact of the pandemic on the physical and emotional health of doctors. It shares their experiences of working on the frontline throughout the pandemic, including during the first wave of the pandemic before the protection of vaccines and treatments for COVID-19 and being exposed to the virus daily while most of the population were locked down.

The traumatic circumstances faced by doctors will live with many for years to come. Circumstances that saw doctors forced to see patients without adequate protective equipment or proper risk assessments. Working in a dystopian environment of no hospital visitors, passing final words between patients and their loved ones via smartphones in their dying days – amid levels of illness and death never experienced before – doctors abandoned contractual protections and worked outside their specialties to go beyond the call of duty to care for the sick. Doctors were afraid not for just their own health, but also terrified of passing on the virus to their families and loved ones at home. This report highlights how doctors subsequently suffered and became ill, with levels of infection among healthcare workers higher than the general population. It also highlights the tragedy of doctors dying, predominantly those from ethnic minorities, reinforcing the harsh reality of inequalities that pervade our medical workforce.

These experiences have had a clear impact on the mental health and emotional wellbeing of doctors. The stress of the unknown, the overwhelming pressure and the compromises that had to be made as the virus spiralled out of control are well documented. The moral distress caused by lack of resources, alongside caring for colleagues in intensive care, are all factors resulting in a demoralised medical workforce.

Alongside the acute mental and emotional trauma, physical exhaustion and the toil of long hours in full PPE, lack of rest and higher workloads have been relentless. Burnout has been rising while the effects of long COVID on staff have left some debilitated, unable to work or live the full lives they once knew.

Careers have also suffered detriment due to disruption in training, causing a reduction in opportunities. For many junior doctors and medical students exams were suspended or cancelled just days before they were due to take place, compounding feelings of anxiety and uncertainty.

Amidst the uncertainty and exhaustion, the report highlights the remarkable efforts of doctors rising to the challenge, adapting, and working with camaraderie. But it also shows how quickly the goodwill which powered doctors and the NHS through the darker days of the pandemic was eroded by the Government's failure to adequately recognise their efforts, instead presiding over inappropriate media assaults, such as those undermining the hard work of GPs. While the pandemic is slowly retreating today, it leaves a profession deeply scarred and affected by the experiences of the past two years. At a time when the collateral damage of COVID-19 has amounted to the biggest backlog of care in the NHS's history, doctors see no end in sight to the challenges ahead. With significant numbers intending to leave or reduce their hours, exacerbating the workforce crisis further, this report's recommendations need to be learnt and acted on now.

As the UK's health services face their greatest ever burden of unmet need, it is vital that the detriment that doctors have suffered to their health and wellbeing is recognised and addressed as a priority. The medical profession deserves to feel confident and comforted that in the event of any further surge of infection – COVID-19 or otherwise – they will be given the right protection, security, and support.

A handwritten signature in black ink that reads "Chaand Nagpal". The signature is written in a cursive, flowing style.

Chaand Nagpal, BMA council chair

The BMA's COVID-19 review and research included in this report

Throughout the pandemic, the BMA has been critical of many elements of the UK governments' decisions and handling of the pandemic response for patients, the population's health, and healthcare workers. The handling of the pandemic was [described by a cross-party select committee](#) last October as 'one of the most important public health failures the United Kingdom has ever experienced', reflecting on inadequate supplies and procurement of PPE; a test and trace system that failed to deliver; and delays in implementing public infection control measures to prevent the virus spreading.

It is important to learn lessons from the pandemic response so that action can be taken in the immediate future – as the UK's health services grapple with several pressures because of the pandemic and the biggest backlog of care in their history – and to be best prepared for future pandemics and avoid repeating past mistakes.

During November and December 2021, the BMA contacted its members and other key stakeholders, including Royal Colleges and leading think tanks, to understand the impact of the UK and devolved governments' handling of the COVID-19 crisis. We wanted to hear how it affected the lives of doctors, the health service, patient care, and the public's health. Our survey was largely qualitative, providing us with the voices from frontline doctors that we quote verbatim in this report, while we also include quantitative data from other research conducted by the BMA during the pandemic, including COVID tracker surveys and viewpoint surveys (more information about these resources can be found in Appendix A). Overall we want to help inform a robust review into the handling of the pandemic, ahead of the statutory inquiries starting in 2022.

We are publishing five reports, each focusing on a particular aspect of the pandemic response.

- The protection of the medical profession from COVID-19
- The impact of the pandemic on the medical profession
- Delivery of healthcare during the pandemic
- The effectiveness of the public health response to the pandemic
- The impact of the pandemic on population health and inequalities

Introduction

At the beginning of 2020, the medical profession in the UK was struggling. Doctors were overworked and overstretched, with many considering leaving the health service altogether. Stress-related sickness absence rates were high and workforce planning was inadequate. The idea of having to work harder still, and in more dangerous conditions, seemed impossible. And yet that is exactly what doctors have had to do for the past two years since the COVID-19 pandemic arrived on UK shores.

In 2022, the experience of the pandemic among medical professionals remains varied. Some have had their livelihoods affected, many their health, and most their morale. Each experience has been unique, and in some cases influenced by their ethnicity, gender, or disability status. There is one word, however, which is used repeatedly by medical professionals to describe the last two years: 'devastating'. Doctors have been left exhausted, demoralised, and unwell.

UK health services will never quite be the same. Doctors have been significantly impacted by the pandemic, as this report sets out. However, while we may be out of the acute phase of the pandemic – largely due to the successful rollout of the national vaccination programme – doctors' jobs are not becoming any easier, as they begin to address the mounting backlog of care. Burnout, exhaustion, and poor mental health are therefore unlikely to improve overnight, and the intention to leave is high. Against this context, a key challenge for health services over the coming weeks, months, and years is ensuring there are enough staff to ensure every patient who needs help receives it promptly.

This report examines how medical professionals were impacted by the pandemic and outlines the lessons to be learned, asking us to consider how death, illness, financial harm, and threats to professional life may be mitigated in the future. The public inquiries into COVID-19 must continue to address these questions thoroughly to honour the victims of the pandemic. At the centre of the inquiries must be a willingness to allow their families and loved ones a deeper understanding of what happened, and if anything could be done differently next time to avoid so much suffering.

The pandemic seriously affected the physical health of medical professionals

The COVID-19 pandemic has had an enormous impact on both the physical and mental health of the medical profession. By October 2020, more than six months into the pandemic, over 60% of respondents to our COVID tracker survey told us they were concerned about their health and wellbeing.¹

In the first instance, the pandemic posed an immediate threat to the physical health of doctors. Those working on the frontline have been particularly at risk of COVID-19 infection, with many having caught the virus. In addition, a significant proportion have experienced or continue to experience severe and long-term symptoms. Tragically, some doctors lost their lives.

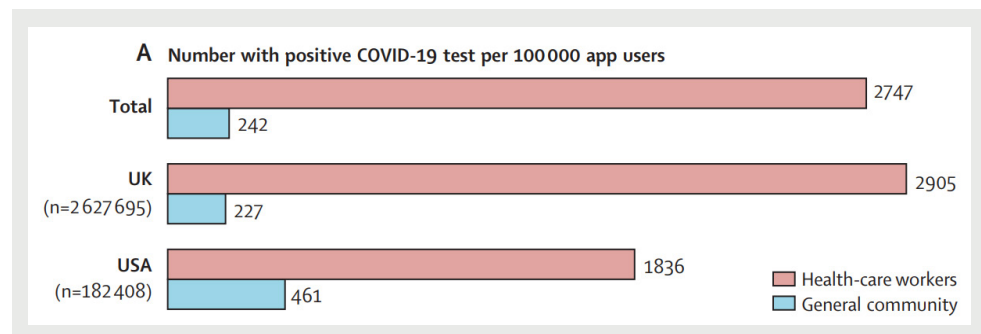
Beyond the immediate effects of infection, working during the pandemic has required enormous physical toil of medical professionals. For those on the frontline, working long hours in full PPE, having fewer opportunities to rest due to emergency redeployment of break spaces, and responding to higher workloads, has been exhausting. For everyone working in the UK's health services, the workload has been relentless and seemingly never-ending. Levels of stress, fatigue, and burnout have been steadily rising within the medical profession as a result.

Many medical professionals caught COVID-19 at work, sometimes resulting in long COVID or even death

Medical professionals were amongst those more at risk of infection

From the beginning of the pandemic, those working in the UK's health services have been at higher risk of infection with SARS-CoV-2, the virus which causes COVID-19. As discussed in our first report from this review, medical professionals were working without sufficient infection protection, including inadequate PPE, particularly in the first wave of the pandemic when many others could work from home. A study conducted in the UK and the US found that, compared with the general population, healthcare workers with direct patient contact were at a twelvefold increased risk of testing positive for COVID-19.² Similarly, data from Scotland showed that healthcare workers working in a patient-facing role were at a threefold increased risk of hospital admission due to COVID-19.³ This data also showed an increased risk for their household members, which explains the feelings of poor psychological safety among many medical professionals, a topic discussed later in this report.

Figure 1 (Source: Nguyen et al. 2020)



Many members of the medical profession have served in patient-facing roles during the pandemic and have therefore been at risk of COVID-19 infection. Although no national data is available on infection rates for doctors specifically, their increased vulnerability to COVID-19 infection was apparent in our surveys. By April 2021, one in five respondents said they had contracted coronavirus.⁴ This included both those working in patient-facing and non-patient-facing roles, so the proportion was likely higher among doctors working in higher-risk settings.

With national data scarce it is difficult to fully understand the pathway of COVID-19 infection within the UK's health services. We know from NHS data that by late 2021, over 40,000 people had caught COVID-19 while in hospital in England alone.⁵ However, much less is known about infections at a staff level. Collecting this data has been hindered by the underreporting of workplace-acquired COVID-19 infections to either the HSE (Health and Safety Executive) or local authorities as required by RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013)⁶. This reporting is crucial to understanding how infection spreads within healthcare settings and how to better protect staff and patients. It would also have helped to identify more unsafe workplaces, which will be discussed later in the report.

Doctors experienced the debilitating effects of long COVID

As healthcare workers have been at high risk of COVID-19 infection, they have also been at high risk of developing long COVID. Patients with this condition have reported symptoms ranging from more common post-viral complaints such as fatigue, brain fog, and depression, to more immediately life-threatening symptoms such as prolonged respiratory problems, blood clots, and new cardiac conditions.

Long COVID can deeply affect quality of life. Among the general population, those who self-reported having long COVID were almost twice as likely to experience moderate to severe depressive symptoms in the last two weeks compared with those who had not had COVID-19.⁷ An in-depth study of long COVID also revealed the condition can cause anxiety and self-doubt in doctors due to the prognostic uncertainty and sometimes disbelief of colleagues.⁸

ONS data from March 2022 shows that the prevalence of long COVID is higher in those working in healthcare than in the general population (3.78% compared to 2.67% on average).⁹ In a BMA survey in February 2022, 11% of respondents who had developed long COVID reported working reduced hours or having reduced responsibilities, while 51% reported that, while still able to work, long COVID had impacted their quality of life¹⁰.

Responses to our call for evidence painted a devastating picture of the debilitating effects of long COVID suffered by some.

'I caught covid in March 2020 from a colleague at work. I have been mostly bedbound since. My life as I knew it had ended. These are supposed to be the best years of my life but I'm spending them alone, in bed, feeling like I'm dying almost all the time.'

(Junior doctor, Scotland)

'I have long COVID and have been off work for 12 months, not well enough to fulfil my role as mother to my 2 young children.'

(Consultant, England)

'My second COVID infection (both infections occupationally acquired) has left me with damage to my spinal cord. I now walk with crutches and cannot walk more than about 200m without them. I also have bladder and bowel problems and have to intermittently catheterise. There is not a day that goes by where I don't have some form of pain.'

(Medical academic trainee, England)

Long COVID symptoms can last for significant periods and sometimes result in lasting disability. Therefore, doctors suffering from long COVID may need ongoing support to manage the condition, including adjustments to their working patterns and activities. Previous BMA research found that even before the pandemic some doctors struggled to secure the reasonable adjustments they needed and access appropriate occupational health advice.¹¹ As a greater number of doctors may now need this type of support, the importance of removing any barriers to support has increased since the pandemic.

Beyond its effect on the lives of individual health workers, long COVID also has influenced the health services in which they work. In some cases, those affected are unable to work for long periods, and recent estimates suggest that 1.82m working days were lost by healthcare

workers with long COVID between March 2020 and September 2021.¹² Had we been better able to protect staff (as set out in the first report of the BMA COVID-19 review) we may have seen fewer long-term absences due to long COVID and consequently, less capacity lost to health services across the UK.

Some doctors died from COVID-19 infection

During the pandemic, more than 50 doctors have tragically lost their lives caring for others.¹³ As the first report of the BMA's COVID-19 review concluded, medical professionals were too often left unprotected and exposed, suggesting these deaths were not inevitable. The public inquiries into the pandemic must examine what more could have been done to protect staff to avoid other families facing so much grief in future pandemics. The doctors who died and their families must be afforded proper accountability.

Beyond the human cost, the emotional toll placed on medical professionals after seeing their colleagues die or undergoing acute treatment after contracting severe symptoms in such circumstances has been significant, as will be discussed later in this report.

It is important to look at the deaths among the medical profession from COVID-19 in the context of the workforce crisis facing the UK's health services. If services had been better staffed going into the pandemic, it is possible that deaths among patients and the medical profession would have been lower. Firstly, fewer staff may have felt pressured to work even when unwell because of how understaffed services were. This sense of responsibility may have led staff to inadvertently spread the virus further.

'I [...] contracted what I subsequently realised was Covid at that time, which was the onset of the lockdown. [...] At that time the advice was to self-isolate for a week. [...] I was worried about taking time off as the practice was under so much pressure given Covid, so I continued working. [...] With hindsight, under normal circumstances I might have/should have taken time off work, but because of the Pandemic I just felt I couldn't...'

(Retired doctor returning to NHS (working in general practice), England)

Secondly, if there had been more staff to cover on-site work, medical professionals at higher risk of infection from the virus may have found their requests for remote working or redeployment were more easily granted.

'Even if [you were] assessed as higher risk [you] still had to get on with seeing respiratory patients as too many other staff [were] self-isolating.'

(GP contractor/principal, England)

Certain groups within the medical profession were at higher risk of COVID-19

Ethnic minority doctors and disabled doctors are some of the groups who were more negatively impacted by the pandemic than their peers. Opportunities were missed to mitigate the inequitable impact of the pandemic on the medical profession, such as providing better protection for doctors at risk of infection from the virus or more often allowing remote working options. There were also reported issues with ensuring that previously agreed reasonable adjustments to working practices could still be accommodated.

Medical professionals from an ethnic minority background

People from Black and South Asian ethnic backgrounds were more likely to be infected with COVID-19 during the first stages of the pandemic¹⁴ and people from certain ethnic backgrounds more often died from COVID-19 infection.¹⁵ During the first wave, Black African people were 3.7 times more likely to die than white men.¹⁶ We can deduce a similar pattern within the medical profession. In April 2020, an analysis found that 95% of doctors in England who had died from coronavirus were from ethnic minority backgrounds, even though this group makes up 44% of NHS medical staff.¹⁷ This gave us an early indication of certain groups being at higher risk of death, and these results are reflected in current data, with the vast majority of the total number of doctors who died from COVID-19 being from an ethnic minority background.¹⁸

The inequitable impact of the pandemic on ethnic minority doctors and other healthcare staff may partly be due to how they have been treated by their employers. An ITV survey in May 2020 reported that NHS staff from ethnic minority backgrounds were more often deployed to frontline roles than their white colleagues.¹⁹ The survey focused on healthcare workers rather than the medical professions specifically, but BMA research suggests that doctors also experienced discriminatory treatment during the pandemic. We found that respondents from an ethnic minority background more often encountered COVID-19 related workplace issues, for example regarding their health or redeployment.²⁰ In our call for evidence survey, twice as many ethnic minority doctors as white doctors felt pressured to work in settings with inadequate PPE where aerosol-generating procedures were carried out, exposing them to risk of infection.²¹ Ethnic minority doctors also reported more pressure from employers and colleagues to work additional hours than their white peers. In general practice, only 59% of ethnic minority doctors said they always or usually had sufficient PPE for safe contact with patients, compared with 77% of white doctors.²²

In our call for evidence, some respondents from ethnic minority backgrounds said they felt their protection, despite being at higher risk from the virus, was sacrificed to maintain staffing levels.

'Risk assessment was not carried out. I think this was because high BAME staff numbers which would have led to more staff being off isolating. Option for working from home wasn't explored so we still don't know if this would be doable.'
(Salaried GP, England, African)

Ethnic minority staff often felt unable to speak out in these situations. We found that doctors from ethnic minority backgrounds reported COVID-related issues to their employers more often than white respondents (possibly because they experienced more issues in the first place). However, when they chose *not* to report something, this was more often because they were worried it would negatively impact their career or training progression because they did not believe there was sufficient protection and support for reporting. In our call for evidence, similar concerns were raised about other ethnic minority healthcare staff feeling unable to speak up.

'Often the most vulnerable are at most risk of exposure due to economic and other pressures not allowing them the privilege of asking for protection. I am very aware of the large number of Filipino nursing staff who died from COVID-19 and there is anecdotal evidence that they did not feel they could say no to working in hazardous situations because of a lack of understanding of their employment rights and fears of their immigration status.'
(GP contractor/principal, England, Pakistani)

The BMA believes the experiences of ethnic minority staff during the pandemic provide further evidence of a wider problem within the UK's health services. If staff from ethnic minorities do not feel they will receive the same treatment as their white peers, this suggests that institutional racism is at play. The existence of this racism does not only affect their psychological wellbeing but puts them in acute physical danger, especially during a pandemic. Whatever the circumstances, no one should feel their safety or wellbeing is compromised by their ethnicity. We are calling for the experiences of ethnic minority doctors to be examined closely by the public inquiries into COVID-19.

Doctors with a disability or long-term health condition

The pandemic has also disproportionately affected doctors with a disability or LTC (long-term health condition). Since many of these doctors are at greater risk of infection, living and working during a global pandemic has been especially challenging for them.

Our call for evidence showed that respondents with a disability or LTC felt less protected than other respondents. Only 56% of this group felt either fully or partly protected during the first wave, compared to 62% of those without a disability or LTC.

Doctors with a disability or LTC told us the pandemic has exposed a problem within the medical profession and its attitude to disability and ill-health. For example, some disabled doctors were made to feel like a burden to the health service and were not always adequately supported. Some respondents with disabilities or LTCs also told us they were not allowed to work remotely.

'My line manager told me I had to work in the office even though I could do my job as effectively from home. This put my health at risk.'

(Public health consultant, Scotland, has a disability/LTC)

'[Risk assessment] was not automatically initiated, when pushed to get assessed, was initially taken as trying to get out of work. As a BAME, >45 yrs, [Diabetes] and Asthma, I was expected to continue doing home visit[s].'

(Salaried GP, England, has a Disability/LTC, Indian)

Doctors with a disability or LTC comprise an important part of the workforce, yet UK health services appear unequipped to support them effectively. The GMC updated its guidance and policy to become more inclusive of disabled doctors just before the pandemic, but the BMA understands from wider engagement with disabled members that the culture of the NHS is still to follow suit.²³ This culture change is more urgent than ever since the number of doctors with a disability or LTC has likely increased since the pandemic because of the rates of long COVID. The experiences of these doctors must be recognised and gaps in occupational health provision tackled as a priority.

The pandemic necessitated the implementation of wide-ranging changes to working practices, often at considerable speed, but these happened without adequate assessment of the impact of these changes on disabled staff. Shifts to remote working, while of benefit to some, also introduced new issues for groups of disabled doctors. For example, there were reports of equipment supplied for remote working not having the necessary adaptations for some disabled people. There were also practical challenges for some working on the frontline. For example, the universal need for face masks in clinical settings caused difficulties for Deaf healthcare workers who relied on lipreading for communication. While steps were taken to mitigate such issues, such as clear face masks, progress was painfully slow.²⁴

CEV (clinically extremely vulnerable) staff were in a particularly unenviable position. There were delays in establishing effective risk assessment processes and developing the shielding list and guidance. In addition, some doctors were not supported by their place of work.

'Clinically extremely vulnerable have been effectively abandoned in the workplace – I have received pressure from my line manager to return to environment verging on harassment.'

(Public health consultant, Scotland)

At the same time, discussions of treatment allocation in the event of overwhelming demand caused deep anxiety for some CEV healthcare staff. They were more likely to become infected and unwell because of occupational exposure but were also hearing that if services became overwhelmed, they may be more likely to have treatment withdrawn. These concerns were compounded by reports that some disabled people were being given inappropriate Do Not Resuscitate orders.²⁵

Significant changes to the system are required to reduce inequalities within the UK's health services

In our call for evidence, we asked respondents what could be done to ensure inequalities in the medical profession are better mitigated in the future. Many responses called for improved health and safety policies. Specifically, respondents asked for better and more consistent risk assessments, so that people could be protected more quickly (this is something the first report in this series looks at in greater detail).

'Risk assessments should be mandatory as soon as a person is employed. Policies should be in place for pregnant women, age ranges and ethnic minorities prior to any pandemic.'

(GP contractor/principal, Scotland)

'Identify those at higher risk and provide specific support and advice to them. Identify them as high risk and ask if they'd like to work in other low risk settings.'

(Medical student (studying not working), England)

Others called for increased resources, specifically more and better PPE, and improved staffing levels. Some pointed out that adequate PPE supplies and staffing levels would have facilitated the proper implementation of risk assessments and that it is easier to protect colleagues if there are more staff available to cover for shielding colleagues. A well-resourced health system has more capacity, which allows for better protection of at-risk staff members when needed. The third report in this series will look more closely at this topic.

'We desperately need to prioritise safe staffing levels. If we are already on minimum staffing, if anyone goes off sick the workload is extremely unmanageable, patient safety suffers and our wellbeing suffers. If we had better baseline staffing levels, we would be better prepared when staff need to isolate.'

(Junior doctor, England)

'Without increased staffing, it is hard to protect some staff without adversely affecting remaining staff by hazardous workload levels.'

(GP contractor/principal, Scotland)

Finally, respondents called for culture change within the UK's health services. For example, they wanted to see a culture in which all groups can speak up without feeling guilty and no one is discriminated against.

'Each group or individual needs to have their needs assessed and addressed. They need to have an effective voice at the table to express their group's needs. We need an open and blame free culture to allow them to speak up.'

(GP contractor/principal, Scotland)

'Treat all equally and protect the vulnerable without making them feel guilty.'

(GP contractor/principal, England)

As indicated above, some noted that change requires better representation of minority groups at all levels of the UK's health services.

'We will never get completely equitable protection until we have equitable representation – sadly, many of our medical institutions are still dominated by white men.'

(Salaried GP, Wales)

Some also pointed out the need for more or better staff training around issues of inequality.

'Openness and honesty about the disadvantages and additional prejudice people of colour and other minority groups already experience in healthcare profession. More education for workforce at large on this.'

(Junior doctor, England)

Mechanisms must be introduced to make the experience of working in the UK's health services less variable by background and protected characteristic. There must be greater understanding of the problem, and proper support in place for ethnic minority and disabled medical professionals who are concerned about working on the frontline.

The pandemic caused physical harm beyond COVID-19 infection

Medical work during the pandemic also caused physical harm beyond COVID-19 infection. For example, respondents to our call for evidence spoke about stress-induced migraines, sleep deprivation, and physical exhaustion. Those who worked on the frontline worked long hours in full PPE, which was challenging. Those who were able to work remotely reported suffering from ailments associated with excessive screen time, such as headaches and eyestrain, neck and back pain, and decreased fitness.

'I experienced a significant increase in hemiplegic migraine (several per week).'
(Salaried GP, England)

'It was so difficult to wear PPE all day and do all the procedures and come back again the next day...'
(SAS doctor, Wales)



Recommendations

1. For doctors with a disability or LTC, remote working, when accessed, has been hugely beneficial. A hybrid working model for doctors must be more seriously considered within the NHS.
2. To mitigate inequity in the future, mechanisms must be introduced to make the experience of working in the NHS less variable by background or protected characteristic.
3. Health services in the UK need good occupational health systems that can act quickly to protect staff both during and outside health emergencies. Health education bodies across the UK must fund occupational medicine training posts to meet the level of demand in the UK's health services and population more widely, now and in the future. This will be examined in more detail later in the report.



Questions for the inquiries to answer

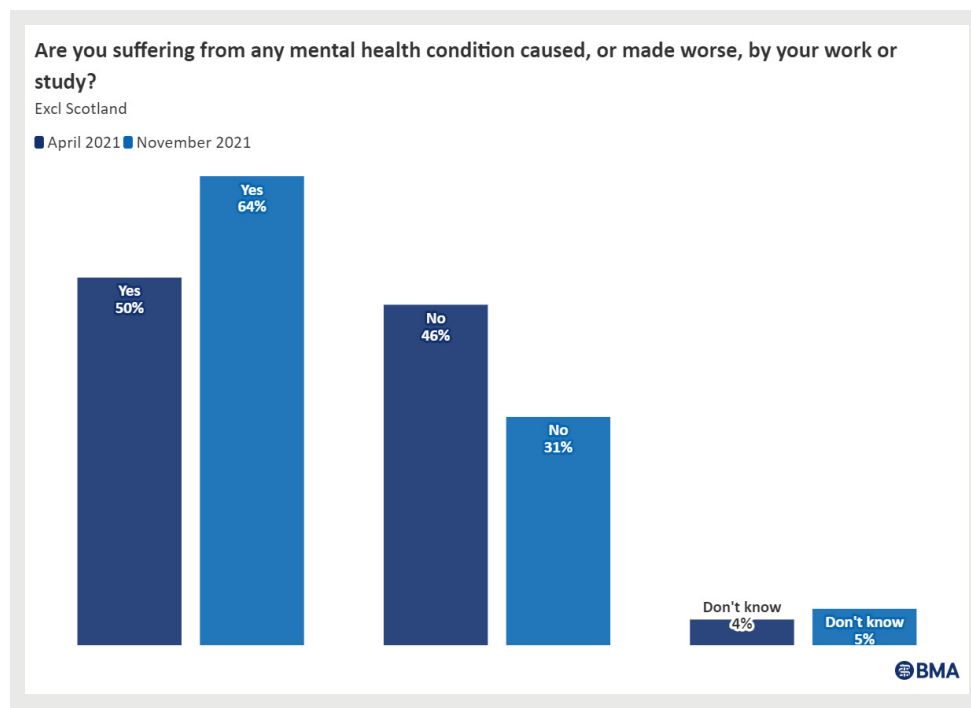
1. What can be learned from the experiences of ethnic minority doctors, disabled doctors, and other protected groups during the pandemic? How can we mitigate inequality in future crises faced by the UK's health services?
2. How well was the system able to support medical professionals who suffered from the short or long-term health effects of COVID-19?

The mental health and emotional wellbeing of medical professionals suffered considerably

The pandemic had a considerable impact on the mental health and emotional wellbeing of the medical profession. Besides burnout and overwork, factors like poor psychological safety, moral injury or distress, trauma, and isolation all contributed to poorer mental health outcomes.

The impact on staff mental health worsened as the pandemic progressed. In April 2021, one year into the pandemic, half of the respondents to our COVID tracker survey said their mental health suffered because of their work or study.²⁶ By November 2021, the percentage of respondents suffering from a work or study-related mental health condition had grown to 64% (see Figure 2).²⁷

Figure 2



The BMA's wellbeing support service and membership services providing support to doctors and medical students saw a striking increase in calls for support. Between February 2021 and January 2022, the BMA's counselling service saw a 173% increase in calls compared to the period between February 2019 and January 2020.

Many doctors suffered from anxiety or depression

In our call for evidence, respondents described the negative impact of the pandemic on their mental health.

'Psychologically it was one of the worst periods of my life. I received private therapy throughout the pandemic and that helped tremendously but I have felt suicidal at times.'

(SAS doctor, England)

'I found the experience to be most disturbing of my career because of the stress of the unknown, the frustration around slow national response, the overwhelming pressure we were under and the emotional toll on almost everyone I was working with. I didn't sleep, often felt angry and suffered post-traumatic stress for a period.'

(Consultant, Scotland)

'I had to stop working as my mental health was so impacted. I have now resigned and feel I am unlikely to return.'

(Salaried GP, Wales)

'Made already poor mental and physical health worse.'

(Consultant, Northern Ireland)

In some cases, anxiety was exacerbated by worries about mistakes and liability, for example, if working remotely or in an unfamiliar area without sufficient training or if having to prioritise limited resources.

'Virtual clinics unsatisfactory as afraid of missing something because unable to examine patient - results in more requests for imaging and blood tests because you want to be safe.'

(Consultant, Wales)

'Very stressed and anxious with the rapid change of practices. Main anxiety was the complete lack of pragmatic advice as to how to triage care if this were to be necessary. [...] I work in ITU and the predictions of numbers of critically sick patients were way above the ITU capacity. Little in the way of advice as to how to ration treatment if this was required. My fears came to be correct after the first wave when complaints/coroners started to come in and [we] were held accountable as if there was no global pandemic or resource issues.'

(Consultant, England)

Poor mental health was compounded by feelings of isolation

While the social distancing restrictions designed to contain the virus were necessary, isolation often compounded the mental and emotional suffering of doctors.

'I became depressed due to the workload and lack of social support and having had to move away from my family and friends due to allocation of jobs. My anxiety was very bad as I was so worried about spreading the virus.'

(Junior doctor, England)

'I went home and cried a lot. I was away from my family as I didn't want to put them at risk. I lost my personal support network and there was no support at all from work.'

(Locum junior doctor, England)

An acute sense of isolation was also felt among IMGs (international medical graduates). Being unable to visit families abroad meant a usual source of comfort was taken away for many.

'Unable to see family abroad for 2 years. No consideration given to international medical graduates for quarantine time as forced to include it in annual leave or go unpaid. Unable to visit family and affected morale really bad.'

(Medical academic trainee, England, Pakistani)

Doctors experienced grief and trauma when witnessing COVID-19 related deaths

Several respondents spoke about the grief and trauma they experienced when caring for patients who had severe symptoms of COVID-19, some of whom were colleagues.

'Honestly, it was horrific. The patients were incredibly sick, there was a general feeling of being helpless, [...] you'd do everything you could, and they'd just suddenly die, and there was nothing you could do. Having to do end of life discussions over the phone, family members being unable to visit. It was bad, very bad.'

(Locally employed/trust grade doctor, Wales)

'Horrified to find myself caring for friends and colleagues on ITU. I'm tired of being the last person to ever speak to people before I anaesthetise, intubate and ventilate them and for them then to die. Tired of passing last words between husbands and wives, parents and children. There is no escape from it. I see dead colleagues in the Trust News emails, local and national press. I dream about it intermittently at night. I'm intermittently consumed by the ocean of sadness it has caused.'

(SAS doctor, England)

'I have flashbacks to wheeling patients to an overfull morgue and denying relatives entry to ED during the first wave as their relatives were dying.'

(GP contractor/principal, Scotland)

'On reading a BBC news piece, I saw a picture of a paramedic I had worked with who had died from covid and could not stop crying for a day.'

(GP contractor/principal, Scotland)

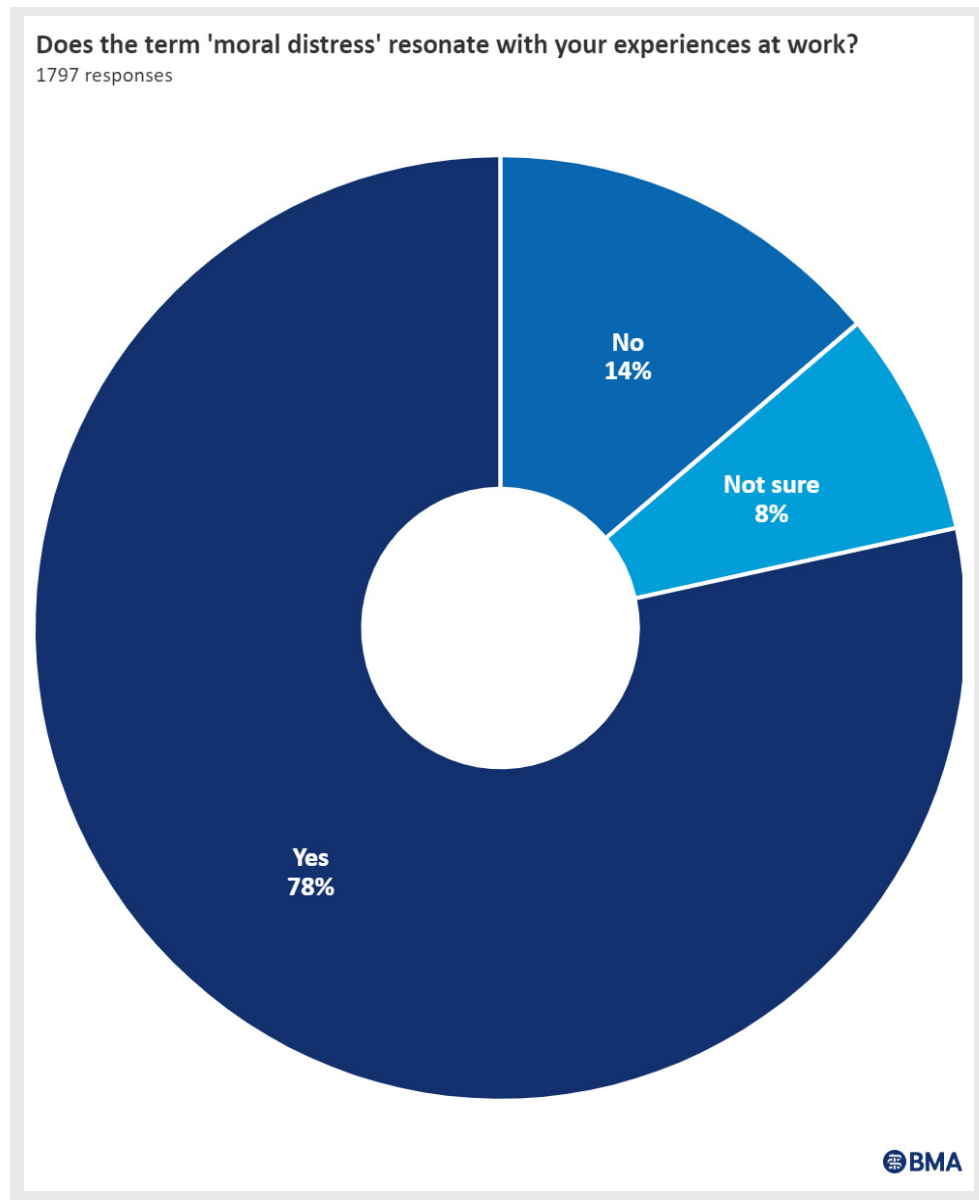
'Losing so many patients and some colleagues was very hard. The day that I signed 3 death certificates for the residential home in one day, I cried.'

(Salaried GP, Wales)

The medical profession experienced moral distress and moral injury working under pandemic conditions, largely caused by a lack of adequate resources

Moral distress is defined in this report as the feeling of unease stemming from feeling unable to undertake an ethically correct action due to institutional or resource constraints. Moral injury can arise where sustained moral distress leads to impaired function or longer-term psychological harm. During the pandemic, experiences of moral distress became more common as this feeling of unease became more widespread. In December 2020, most respondents to our COVID tracker survey (92%) said they had been unable to provide patients with the right care at the right time at some point during the pandemic.²⁸ Consequently, research conducted on moral distress by the BMA in spring 2021 found that, for over three quarters (78%) of respondents, moral distress resonated with their experiences at work (see Figure 3).²⁹

Figure 3



Moral distress and injury are not inevitable but occur when certain conditions are in place. When asked about the causes of their moral distress, over half of doctors (53%) cited insufficient staffing to suitably treat all patients as one of the leading causes of their moral distress, with individual mental fatigue as the second most significant contributing factor (41%). A lack of time to provide adequate emotional support to patients and an inability to provide timely treatment were both cited as the third leading causes, showing clearly how these experiences have had a serious impact on doctors (see Figure 4).³⁰

In our call for evidence, some respondents spoke about the difficult experience of not being able to deliver the level of care they wanted.

'I have seen some difficult things in the past few years. I have made some decisions that I would not have had to make in pre-pandemic times. These have all caused me significant moral injury.'

(Salaried GP, Scotland)

'Moral distress. Being forced to practice in ways I would never believe I would have accepted. Contributed to me leaving clinical medicine.'

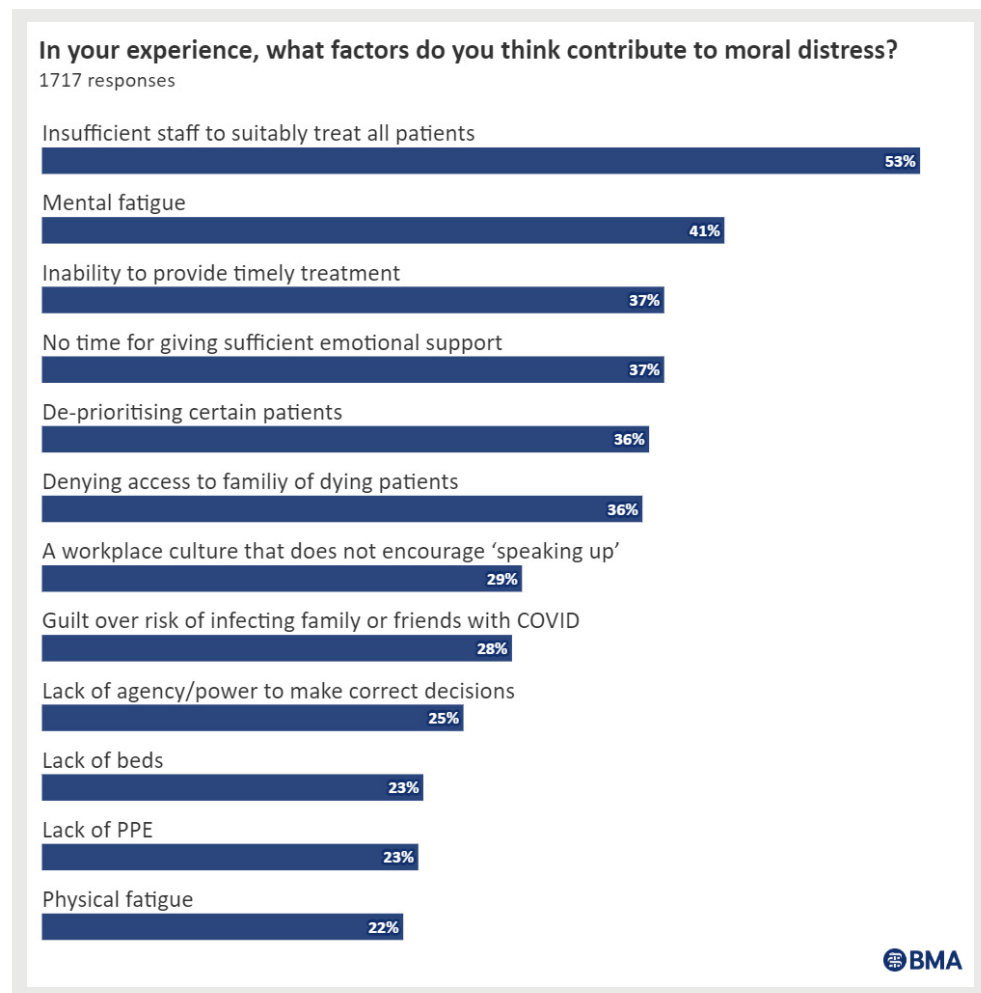
(Salaried GP, England)

'I wasn't prepared for the level of anxiety that prevailed at the start in March 2020, no one knew what to expect, there were patients who were simply dying which was harrowing to watch. At that time, the escalation policy hadn't been fully established, ITUs were full, there was a subtle assumption that only limited number of patients should be escalated for ITU care! Other than giving patients oxygen, nothing was done for some patients who simply died. This was very upsetting.'

(Consultant, Scotland)

Indeed, much of the moral distress, and the associated emotional and mental health consequences experienced by the medical profession during the pandemic would have been limited had the UK's health services been better resourced with sufficient capacity.

Figure 4



There was a sense of poor psychological safety within the medical profession

As discussed in the first report of the BMA's COVID-19 review, medical professionals were not always adequately protected from COVID-19 during the pandemic. The possibility of contracting coronavirus was high and undoubtedly worrying, resulting in a sense of poor psychological safety. A 24/7 helpline was set up by the BMA after doctors reported distress caused by the inadequacy of their PPE and corresponding personal safety.

This sense of poor psychological safety was made worse by the fear of passing the virus on to loved ones.

'Scared of bringing home infection from workplace and infecting my family. Unable to visit elderly parents in India for last 2yrs - worried about their safety.'
(Consultant, Wales)

'My partner is clinically vulnerable as are my elderly parents. I have been afraid throughout at the possibility of catching covid and risking the wellbeing of those I love.'
(Salaried GP, England)

Several studies have documented a rise in anxiety among doctors during the pandemic, which is associated with fear of infection.^{31'32'33} This suggests a strong correlation between poor psychological safety and poor mental health.

Fear of infection was of particular concern for medical professionals who are CEV. Once shielding policies were lifted, many CEV medical professionals felt anxious going back to work.

'Extremely frightened and vulnerable on returning to workplace. Now under huge pressures and getting exposed to Covid due to crowding. Feel burned out and want to leave medicine.'
(SAS doctor, England)

'I was shielding so had to work from home which was difficult and then when shielding ended had to return to work but was worried about exposure to covid'
(GP contractor/principal, England)

Some doctors from ethnic minority backgrounds also felt unsafe given the higher infection and mortality rates in certain ethnic groups. This experience was described in our call for evidence.

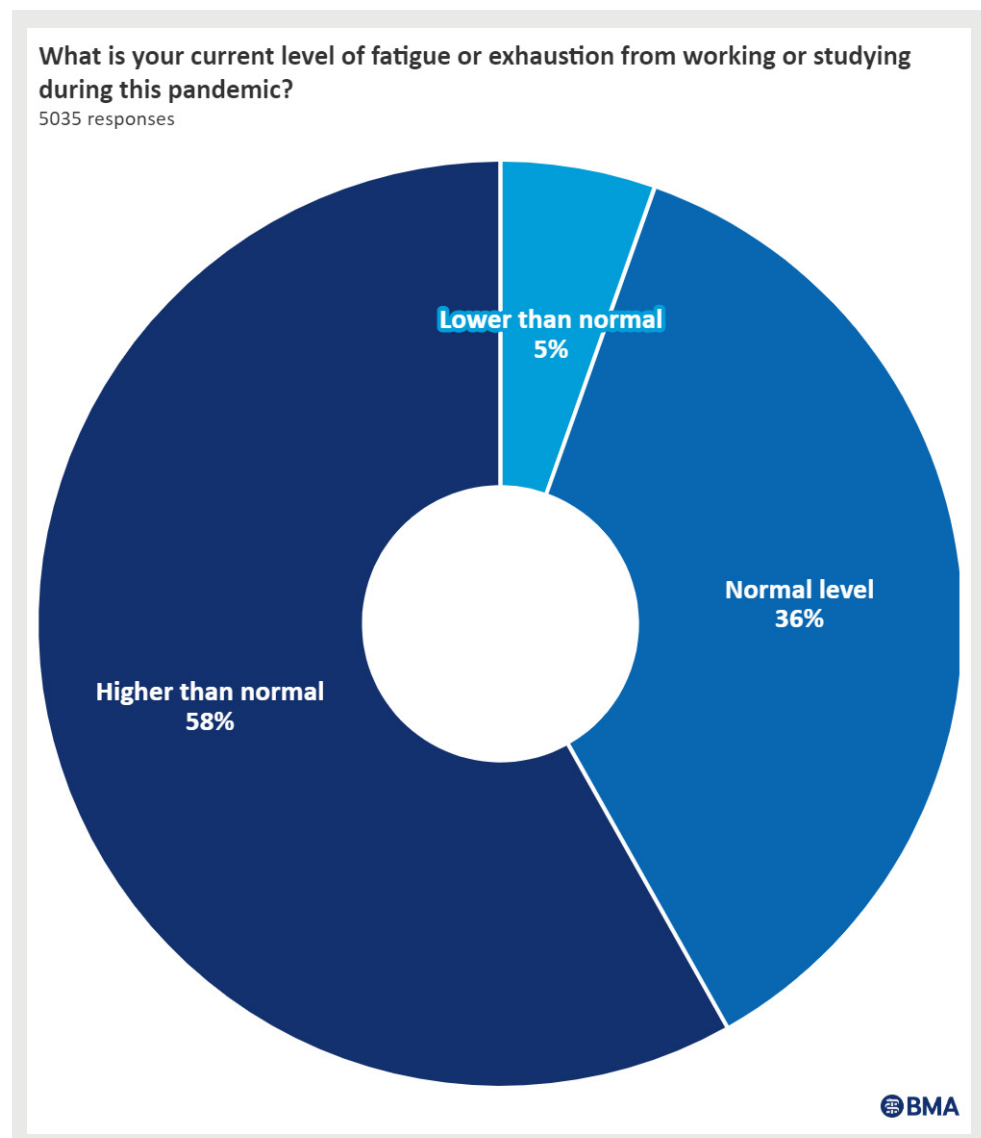
'I caught Covid in March 2020. This was frightening as I was ill on my own at home [...] listening to news stories about how many Asian men (my demographic) were dying from Covid.'
(Junior doctor, Scotland)

'I was [...] worried for my own mortality [and] more so for my family's. I didn't physically go inside their house for at least 6 months [...] This upset my parents quite a lot as they were constantly watching the news, BAME healthcare workers were dying. One day I arrived to my father crying in the window waving at me, he opened the front door and asked me to quit my job, he was worried I would also die as a result of Covid exposure at work.'
(Locally employed/trust grade doctor, England)

Burnout and overwork were common during the pandemic

Medical professionals working in the UK's health services were overworked before the pandemic, but COVID-19 has made the problem worse. GMC findings from the three years before the pandemic show that around a quarter of UK trainees felt burnt out to a high or very high degree because of their work; by July 2021, this had risen to a third.³⁴ These high levels of overwork took a great toll on the rest of the medical profession also. One year into the pandemic, nearly 60% of respondents to our April 2021 COVID tracker survey said their level of fatigue or exhaustion during the pandemic was higher than normal (see Figure 5).³⁵

Figure 5



These experiences of burnout and exhaustion were commonly described by respondents to our call for evidence.

'I feel burnt out and everybody I work with seems tired and finding it difficult to deal with the backlog of patients.'

(GP trainee, Wales)

'I have reached burnout and am considering leaving medicine after 30 years.'

(Consultant, Scotland)

'I was beginning to feel mentally, physically and professionally exhausted before the pandemic and this has simply exacerbated it.'

(Consultant, England)

During a health crisis, some degree of overwork in the health service may seem inevitable. However, as the UK health workforce was already overstretched before the pandemic, this rise in reported feelings of burnout represents an extraordinary and debilitating level of overwork. In our call for evidence, many respondents highlighted increased staffing levels as a key solution to reduce the impact of the pandemic on the medical profession. Our third report in this series cites the need for increased staffing levels.

'I am going to keep saying this. Staffing. Get vacancies filled and stop lying about the numbers of those. Pay, leave, pension etc are part of sorting that but what I needed most during the pandemic were the colleagues I was already missing.'
(Consultant, England)

'Fix the staffing crisis and the disparity in under-doctored areas, increase admin or allied healthcare professional support for doctors where their workload is unmanageable - half of the vicarious trauma was because of no beds/staff.'
(Salaried GP, England)

Doctors working directly with patients certainly suffered, as did public health doctors who were working hard behind the scenes. Two-thirds of respondents to a survey of public health doctors in January 2021 said they had regularly worked additional hours during the pandemic.³⁶ In line with other doctors, public health doctors reported high rates of poor mental health and wellbeing. 75% described their levels of fatigue and exhaustion as higher than normal, and 48% reported feelings of depression, anxiety, stress, or other mental health conditions. Unlike some other doctors who received more attention and recognition working on the frontline, public health doctors reported feeling invisible despite the overwork and sacrifices they had made.

In addition to the burden placed upon individuals, burnout experienced by overworked staff may compound an already critical retention problem by increasing the number of staff leaving the health service. High levels of staff burnout and stress, therefore, present a threat not only to individuals' wellbeing but also to the functioning of the UK's health and care systems and safe patient care. The BMA and others have called for continuous and transparent assessments of workforce shortages and future staffing requirements in all UK nations. There has been varying progress towards this across the UK but to date, no nation has safe staffing legislation that covers the whole healthcare workforce, and which has been fully implemented.

Progress across the UK towards establishing safe staffing legislation

Scotland has led the way on safe staffing, with the Scottish Parliament passing a bill in 2019 that now makes providing safe staffing in Scotland's health and care services the law. While this was an important step, the law has yet to be implemented, and it is vital the Scottish Government rectifies this quickly.

In Wales, there is safe staffing legislation for nurses, but not for doctors. While the Welsh Government has since extended the Nurse Staffing Levels Act to cover more wards, it has not yet committed to ensuring that safe staffing across the whole of the Welsh NHS is made law. The Welsh Government did previously state that other, non-legislative, action could be taken to ensure safe and appropriate levels of doctors and other frontline healthcare staff, however, no further progress has yet been made.

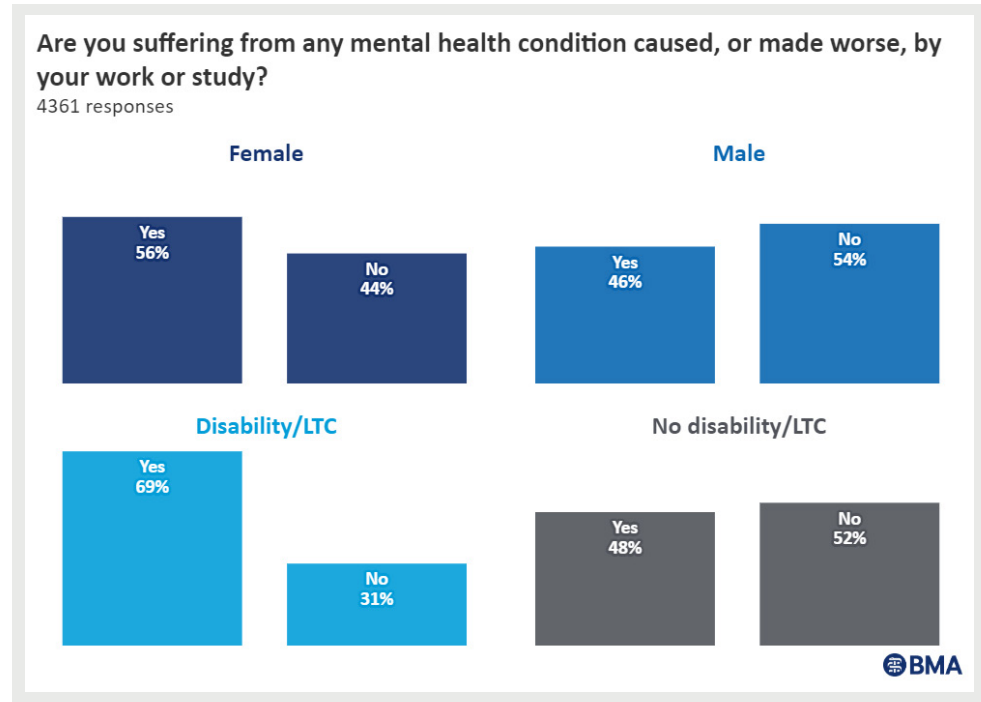
In Northern Ireland, the Government was developing safe staffing legislation before the Executive collapsed in February 2022. It must therefore prioritise the introduction of legislation as soon as possible after the formation of a new Executive, including the need for regular updates on workforce planning, reporting mechanisms and accountability. The legislation must also define how vacancies are measured across health and social care to provide an accurate measure of vacancy levels.

England is the furthest behind across the UK. There is currently no safe staffing legislation or desire by the Government to introduce any, but also no public data on how many healthcare staff England needs. There are significant vacancies across health and care, and previous NHS and Health Education England workforce documents have failed to set out how many staff are required to meet demand. As the BMA and others have repeatedly called for, a requirement for the secretary of state to publish independently verified assessments of current and future workforce numbers every two years is the only way to ensure the UK Government takes accountability for providing safe staffing levels and adequate funds and resources for that.

There were inequalities in the impact of the pandemic on the mental health and emotional wellbeing of medical professionals

As with physical health, inequalities were found in medical professionals' experiences with mental health. A decline in good mental health was more common in female respondents (56%) than in male respondents (46%), and more common among those with a disability or LTC (69%) than those without (48%) (see Figure 6).³⁷

Figure 6



Many doctors who were shielding were also profoundly affected, as some felt guilty for not being able to work on the frontline.

'The main issue for me was coping with being isolated from my team. I felt guilty that I couldn't work at the front line. I struggled with shielding mentally.'
(Consultant, Scotland)

'I had loss of self-esteem and feelings of guilt from being a WFH shielder, aggravated by colleague resentment of my shielder status.'
(Salaried GP, England)

Similarly, not all doctors have been equally affected by stress and burnout over the COVID-19 pandemic. Our survey found higher than normal levels of exhaustion were more common among females (62%) than males (53%) and among those with a disability or LTC (62% versus 57% of those without). This is likely due to the additional challenge of managing a disability or LTC in the context of overwork and burnout.

The gender discrepancy may have been partly due to additional commitments outside work, such as childcare or other caring responsibilities, a duty still largely borne by women. Some respondents to our call for evidence also noted that women were particularly affected by the pandemic.

'There has been a significant toll amongst the women Consultants in our Department. It is of note, we all have children of school age and at some point have been in tears after meetings with our Clinical Lead and Management when requesting a bit of flexibility. In a department where we used to pride equality, our opinion is that we were treated differently during the pandemic because we couldn't always toe the line with regards to extra workload owing to childcare.'
(Consultant, Scotland)

'Women NHS workers have suffered hugely due to the added responsibility of childcare that typically falls at our feet.'

(Consultant, England)

In our February 2021 COVID tracker survey, female respondents who took on extra work were also more likely to say they felt 'significant' pressure to do so from their employer and themselves.³⁸

Flexible working patterns would have benefitted everyone and particularly those with caring responsibilities who are disproportionately women. This would have helped to ease the pressure on parents who faced significant disruptions to their usual childcare arrangements during the pandemic and needed more childcare provision because of the additional hours they were working. Some parents experienced additional stress due to the challenges of finding new and sometimes costly childcare and leaving children in new and unfamiliar settings.

The wider implications on the UK's health services of the impact of the pandemic on the health and wellbeing of the medical profession will be significant

While we may no longer be in the acute phase of the pandemic in the UK – largely due to the successful rollout of the vaccine – hospitalisations and staff absences due to COVID-19 remain high at the time of writing and given the backlog in non-COVID care, there will be no imminent respite for the medical profession. We are being advised by the UK Government to 'live with COVID', but we cannot ignore the virus' impact on health services and doctors. Additionally, many doctors continue to be on the frontline of the pandemic, risking serious illness to themselves and their families. It is therefore likely that the pandemic will continue to affect the mental and physical health of medical professionals. The medical profession is exhausted and needs to be supported. If this does not happen, we risk more doctors leaving, which is a threat to patient safety we cannot afford.

The medical profession was chronically understaffed before the pandemic. Vacancies had been rising for several years across all four nations³⁹ alongside the normalising of excessive workloads and the expectation of regular overtime to cover gaps (report three in this series looks at the delivery of healthcare in greater detail). This has been exacerbated by the pandemic and the pressures on staff will not become any easier given the need to recover levels of elective activity.

Each nation has set out its own ambitious approach to elective recovery. In comparison to activity levels before the pandemic, England is aiming for a 30% increase by 2024/25⁴⁰, Scotland is aiming to deliver at least 40,000 additional elective surgeries and procedures per year by 2025/26⁴¹, Northern Ireland is aiming to deliver an additional 120,000 elective assessments and 42,000 elective treatments by 2025/26⁴², while Wales has a strong focus on significantly reducing waiting times by 2025 through a range of measures including improving community diagnostic capacity.⁴³ Achieving these would have been very challenging before the pandemic but asking staff to deliver these following two years of going above and beyond is an almost impossible task.

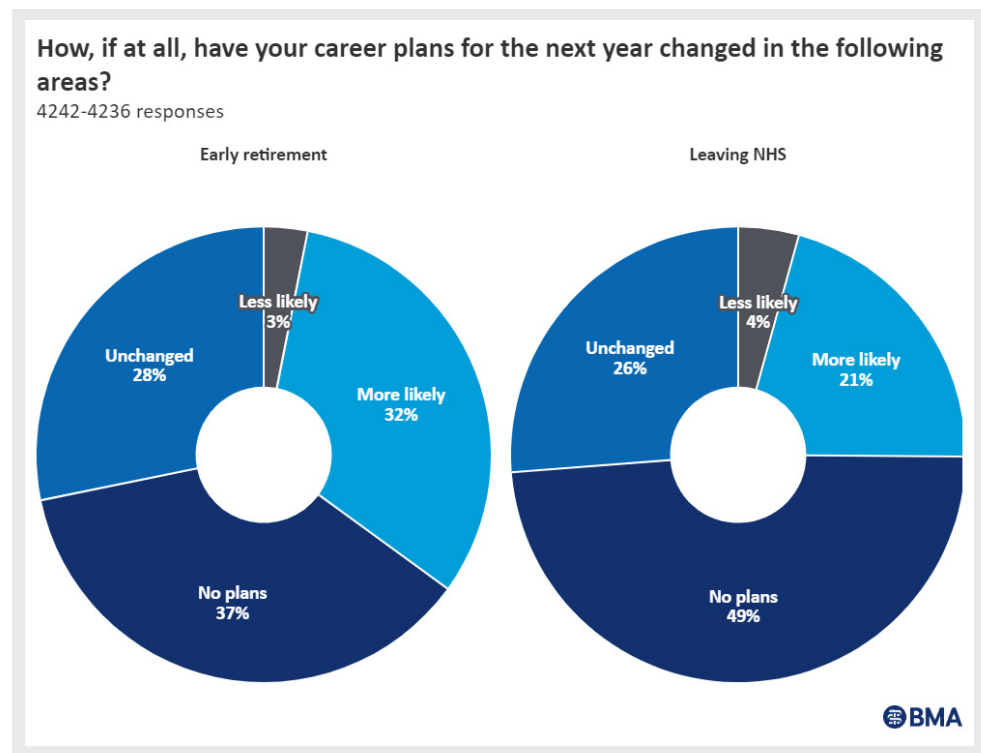
Governments and system leaders across the UK must be prepared to have an honest conversation with the public about the need for a realistic approach to restoring non-COVID care, and support for systems to tackle the backlog. The wellbeing of the medical profession must be viewed as a critical priority for the effectiveness of health services both now and in the future. Asking too much of doctors too soon could not only negatively impact patient safety but could potentially increase already lengthy waiting times if staff leave or are signed off due to exhaustion – something both patients and doctors want to avoid. When staff decide to leave, remaining staff become more emotionally distressed due to the higher workload, which leads to increased pressure and more staff leaving, and the problem continues.

This vicious cycle of poor retention and staff mental health and wellbeing existed before the pandemic (report 3 in this series looks at this in more detail), making the UK's health services notoriously 'leaky buckets'. In 2019/20 the NHS staff turnover rate in Scotland already was 6.7%⁴⁴ and 10.5% in England⁴⁵. While turnover data is not available for Northern Ireland and

Wales, the need to retain staff was included in the workforce strategies of both nations^{46, 47}. Care must now be taken not to make it worse. This is particularly important because, in comparison with other nations, the UK already has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but the UK has just 3.0. Germany, by comparison, has 4.5.⁴⁸

One year into the pandemic, one in three respondents to our COVID tracker survey (32%) said they were more likely to take early retirement, and one in five (21%) said they were more likely to leave the NHS for another career (see Figure 7).⁴⁹ While we cannot definitively conclude these changing career plans are due to the pandemic alone (other longstanding issues such as already high workload, pay and pensions will also play a role), the unprecedented challenge faced by the medical profession over the past two years must be at least partly responsible. Moreover, this data was gathered from a survey specifically about doctors' experiences of working during the COVID-19 pandemic.

Figure 7



When asked about the reasons behind their changed career plans, respondents most mentioned workload and personal wellbeing (see Figure 8).⁵⁰

Figure 8



In our call for evidence, several respondents also said they were seeking to leave, or had already left, the profession because of pandemic pressures.

'I had to stop working as my mental health was so impacted. I have now resigned and feel I am unlikely to return.'

(Salaried GP, Wales)

'Severe impact. Physical health has deteriorated and psychologically am close to burnout. I coped for almost a year but it's now taken a toll and I don't know how much longer I can keep working as a doctor.'

(GP contractor/principal, England)

'Physically and mentally draining. The pandemic has removed any pleasure I used to get from my work and left me feeling exhausted and desperate to retire.'
(Consultant, Scotland)



Recommendations

1. General wellbeing support including timely and accessible occupational health assessments and support to access psychological support services must be made available for staff at all levels across all health services, with specific support also offered to ensure staff can recover from the pressure of delivering care during a pandemic.
2. The BMA and others have called for continuous and transparent assessments of workforce shortages and future staffing requirements. This is the only way to ensure that governments take accountability for providing safe staffing levels and adequate funds and resources to staff health services so they can deliver safe care.
3. All governments and system leaders across the UK must have an honest conversation with the public about the need to balance service recovery with staff wellbeing while we are tackling the backlog.



Questions for the inquiries to answer

1. How did the state of the UK's health services going into the pandemic contribute to the impact of COVID-19 on the medical profession?
2. Poor physical and mental health within the medical profession might be expected in a pandemic. To what extent could this negative impact have been mitigated?

The medical profession too often did not receive the support they needed

As set out so far, the COVID-19 pandemic has been a traumatic experience for the medical profession. In such circumstances, support from those in power is needed more than ever. Too often, however, this support was not forthcoming. A lack of publicly declared UK government support for doctors has damaged the morale of staff working in the UK's health services and has resulted in medical professionals being subject to unrealistic expectations, leading in some cases to abuse. Had doctors felt better valued and protected by the UK Government and in some cases their employers, staff morale and wellbeing would have been less affected and fewer staff would be considering leaving the health service.

The UK Government too often failed to protect, promote, and support the interests of the medical profession

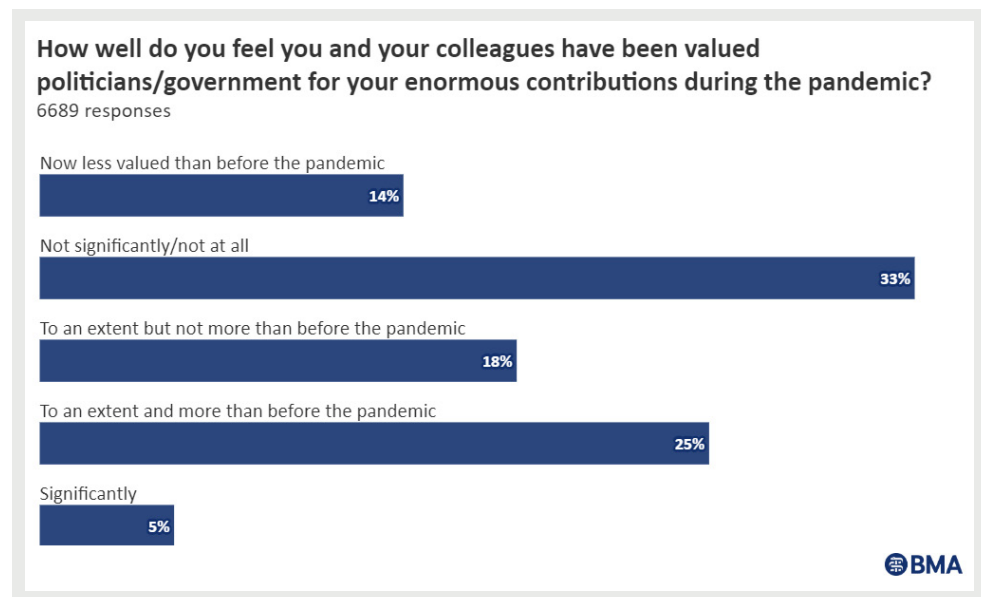
During the pandemic, the UK Government increasingly failed to signal its support for the medical profession. As initial and universal enthusiasm for acknowledging the sacrifices and hardships of staff within the UK health services waned, the medical profession failed to receive vocal support from the UK Government when it was most needed. This is in addition to the lack of practical support given to doctors, such as sufficient PPE, which a theme discussed in report one of this series.

Doctors needed vocal support for the profession from the UK Government. At best, medical professionals were unhelpfully branded as heroes and heroines, capable of withstanding any pressure, as opposed to fallible human beings doing their best in the circumstances. Disabled doctors also emphasised their wish to see an end to the perception that doctors are superhuman and capable of working relentlessly whatever the circumstances.

As access to care became an increasing issue, doctors needed a defence from the UK Government against accusations from the media that this was due to incompetence or laziness among medical professionals. GPs, for example, were accused of being missing, with one article from a major newspaper asking, 'where have all our GPs gone?'.⁵¹ There was little to no acknowledgement that difficulties in access were because of staff shortages, increasing backlogs, the delivery of the COVID-19 vaccination programme, and an ongoing need to prevent COVID-19 infections in healthcare settings and protect those most at risk by reducing capacity to facilitate social distancing.

By February 2021, 33% of respondents to our COVID tracker survey felt 'not at all' valued by politicians and government, and a further 14% even felt less valued than before the pandemic (see Figure 9).⁵²

Figure 9



This sentiment was echoed in our call for evidence.

'The total disregard by government for our safety and cries for help has been so demoralising.'

(GP contractor/principal, England)

'Extremely demoralising as a GP to have worked very hard for the last 2 years adapting to a new world/technology and ways of seeing patients to help keep everybody safe and meet demand to then be derided in the press and by politicians as lazy and told to get our act together and see patients face to face. This attitude in press and by politicians is doing possibly irreparable damage to the morale of GPs and the respect/attitude patients have for us.'

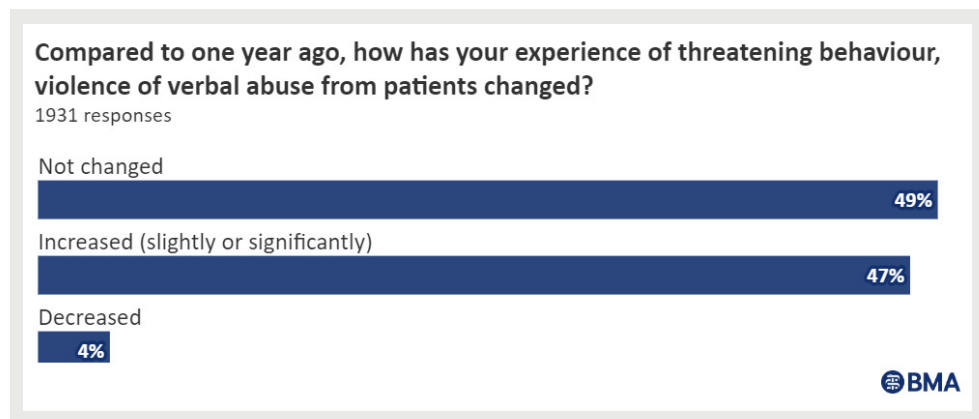
(GP contractor/principal, Scotland)

The UK Government's failure to support the medical profession cannot be ignored when discussing the abuse experienced by some staff

Rapid changes in how consultations were held in the UK's health services, and the failure of the UK Government to explain to the public why this was necessary, damaged the reputation of the medical profession, particularly within England.

In some cases, medical professionals experienced abuse, which appears to have arisen from patient frustration with access. In August 2020, BMA data showed that 10% of respondents to our COVID tracker survey had experienced unusual levels of bullying, harassment or discrimination from patients or the public within the last two weeks.⁵³ Nearly a year later, by July 2021, almost half of our survey respondents (48%) said that instances of threatening behaviour, violence, or verbal abuse had increased over the past year (see Figure 10).⁵⁴ The same survey found that more than a third of doctors had faced recent abuse from patients or those close to them. For GPs the number was higher, with half reporting verbal abuse in the past month.

Figure 10



The abuse of medical professionals could and should have been mitigated by more vocal support from the UK Government. In our call for evidence, a handful of respondents linked increased abuse by patients to poor government support.

'After the first wave of the pandemic, and after the "clap for the NHS" ended, the abuse of myself and staff has ramped up enormously, fuelled by governmental propaganda and briefing against General Practitioners.'
(GP contractor/principal, England)

'I am now finding demand from patients has risen exponentially and with long delays in referrals to secondary care, we are receiving a lot of verbal abuse from angry and frustrated patients. This has not been helped by the negative impression of primary care perpetuated in the media and by the comments of some politicians. It has made me question if I want to continue in primary care once the pandemic is over.'
(Salaried GP, England)

The abuse could also have been mitigated by the UK Government being honest about the systematic reasons for the delays in care, such as a growing backlog, historic lack of funding and workforce shortages. This lack of transparency resulted in a tendency to scapegoat the medical profession.

'The government have allowed GP a to be scapegoats of their dishonest lack of funding and now despite working long, long hours jumping through innumerable new hoops they have set the general public against us with their disgusting propaganda.'
(GP contractor/principal, Northern Ireland)

'If there really is no more money for the NHS, then politicians should be blunt with the population about the reality of the situation and not keep expecting NHS staff to deliver impossible targets.'
(Consultant, England)

General practice received a significant amount of abuse

As secondary care services reduced their capacity for non-COVID-19 patients (see also report three in this series), much of the workload shifted onto general practice. As the workload of general practice increased, staff bore the brunt of the UK Government's failure to explain that it was the system rather than individuals who were at fault for less accessible care.

The UK Government also consistently framed virtual appointments negatively. This is despite the Government initially calling for a shift to remote-by-default amidst the first wave in June 2020⁵⁵, before then insisting that GPs had to 'return' to face-to-face appointments. In May 2021, NHS England and NHS Improvement wrote to all GP surgeries instructing them that patients must be able to see a GP face to face if needed⁵⁶. Many in the profession saw this as

an insult, as it unfairly implied that face-to-face appointments were not already available for those that needed them and ignored the fact that many appointments took place virtually according to NHSEI's (NHS England and Improvement) own guidance. This contrasted with the more supportive and collaborative stance taken by other governments toward general practice and access. In Wales, for example, BMA Wales worked with the Welsh Government in July 2021 to communicate to GPs how best to manage patient expectations while responding to accumulating patient needs.⁵⁷

While devolved governments seemed more able to support their general practice physicians against this narrative, GPs outside of England weren't immune to this type of rhetoric from the UK Government given the relative dominance of London-based media and social media spreading that message to patients. A survey published in April 2022 for example found that three out of four GPs in Scotland had reported facing increased patient abuse during the COVID-19 pandemic.⁵⁸

The BMA challenged the UK Government's failure to publicly challenge the increasing incidents of abuse and misinformation directed toward those working in general practice. The secretary of state for health and social care's comments that GPs should be working 'in the way they did before the pandemic', for example, were unhelpful. GPs were navigating the extensive waiting lists of people who had been unable to get the care they needed since the pandemic began, resulting in a considerable backlog on top of backlogs that existed before the pandemic. Again, the UK Government appeared uninterested in correcting the narrative from sections of the media that GPs were to blame for a change in access to care. It appears this was more appealing than explaining its own shortcomings in resourcing the UK's health service adequately before the pandemic.

Facing such abuse has left doctors fearing for the safety of themselves and their colleagues, which has profoundly affected their wellbeing. As previously discussed, the mental health and emotional wellbeing of many medical professionals had already been significantly harmed during the pandemic, and so further pressure on their morale and psychological safety was a significant additional blow.

'It is busier, patients are angry, staff are facing abuse so morale is low.'
(Consultant, England)

Abuse has also left some staff feeling alienated and undervalued, leaving them questioning their career in the NHS.

'I have resigned from my GP partnership (age 49). I am exhausted, fed up with abuse from patients.'
(GP contractor/principal, England)

Beyond the effects on the medical profession – the impact of abuse on staff retention and patient care notwithstanding – being on the receiving end of bad behaviour can impact productivity and the quality of work, further threatening patient care.

The medical profession did not always get the support they needed from their employers

It was often difficult for medical professionals to access support via their employer. In our COVID Tracker survey, over half of respondents (56%) told us that, during the pandemic, they had not had access to NHS wellbeing support services, provided by their employer or a third party.⁵⁹ Respondents to the call for evidence also reported pressure from their employer to work when they felt it wasn't safe or went beyond what NHS guidance expected of them.

'Pressure to be seen in the workplace regardless of clinical need to set an example to others.'
(Retired doctor returning to work in a hospital, Wales)

'When I realised that other members of staff were not using PPE but were still required to work with patients at a distance smaller than 2m, I called my line manager who dismissed my concerns telling me that I should not create problems.'
(Consultant, Scotland)

Clinically vulnerable and shielding medical professionals encountered several challenges

The pandemic has been a particularly frightening time for medical professionals who are CEV and were required to shield. Though some CEV respondents felt well protected and supported, 30% reported receiving no support or an unsatisfactory level of support.⁶⁰ In our call for evidence, some CEV respondents also told us they were poorly supported by their place of work when shielding, with some pressured to return to work.

'I was bullied by line managers to try to make me come into work despite NHS Employers guidance stating otherwise. After 4 weeks of constantly requesting remote access to facilitate WFH I received a recorded delivery letter on Good Friday from the surgical service medical lead (who had not previously spoken with me) to either come in to do one emergency clinic a week or take 3 months unpaid leave.'
(Consultant, England)

'As my trust created their own risk table which missed out any question of shielding or immunosuppression I was told I was not able to shield. I had to refuse this risk assessment and fight hard to be allowed to shield even after I had received my shielding letter and sent it in. It was extremely stressful and unfair.'
(Consultant, England)

'Because I am extremely vulnerable to Covid I was on the shielded list, yet I felt constant pressure from my workplace to return to face to face working in unsafe conditions i.e. Poor room ventilation and inadequate PPE. I and the other shielding GP at my practice had to resist strongly with the help of shielding letters from the government.'
(Salaried GP, England)

Meanwhile, some disabled doctors who were at higher risk reported feeling they had simply been sent home rather than receiving adjustments to enable them to work effectively or putting into place alternative arrangements to redeploy them to less high-risk settings. They remain concerned that this only reinforced the idea among colleagues that they were not pulling their weight.

Some groups were denied benefits afforded to senior colleagues despite working in high-risk settings

Some groups did not have access to death-in-service payments despite working in high-risk settings. Death-in-service payments are a benefit of the NHS pension scheme but are severely reduced for doctors who have opted out of the pension scheme because of pensions tax issues or for other reasons. For example, despite initial enthusiasm from ministers to draft retired doctors back into the service to help the pandemic efforts, retired doctors cannot re-join the scheme and so their families would be ineligible for a death-in-service lump sum. Medical students and doctors who became foundation year 1 doctors in August 2018 or August 2019 did not have the two years of service required for long-term benefits to be paid to their dependents. Meanwhile, locum GPs did not qualify for full death-in-service benefits if they, for example, worked Mondays, Wednesdays, and Fridays but died on a Tuesday.

This generated a lot of unnecessary uncertainty for some medical professionals and their families. It was wrong that doctors, students, and others should risk their lives without adequate measures in place. While the Scottish Government announced a death-in-service package for all NHS workers comparatively early on, other UK governments were slow to follow suit.

The BMA wrote to the chancellor on 30 March 2020 to highlight these problems and call for the UK Government to ensure that in the case of death caused by COVID-19 during service, any individual working for the NHS would receive compensation. We then wrote again on 17 April 2020 stating that the BMA was at a loss for why the UK Government had not extended this benefit.

On 27 April 2020 the UK Government announced a new life assurance scheme which would be open to all frontline NHS and social care staff (including students and returning doctors who had previously retired) on their death from COVID-19 if they had contracted the virus in the course of their duties.⁶¹ The Government stated that this was in recognition of the increased risk faced by NHS and social care staff during the pandemic. This scheme included a one-off payment to the deceased's family and was in addition to payments linked to the NHS pension scheme death in service benefits. Funding was made available to the devolved administrations to establish subsequent schemes. There were however differences between these schemes. For example, England, Wales, and Northern Ireland required COVID-19 to be 'wholly or mainly' the cause of death, and covered deaths occurring until 31 March 2022 in England⁶² and Northern Ireland⁶³, and 30 June 2022 in Wales⁶⁴. The scheme in Scotland included deaths where COVID-19 was 'a factor' on the death certificate or the death was 'at least partially attributable' to COVID-19 and has not yet announced when it will come to an end⁶⁵. There was also variation in whether these schemes were in addition to, or subtracted from, death-in-service payments.

As mentioned previously, better RIDDOR reporting would have given the Health and Safety Executive a better idea of the prevalence of workplace-acquired COVID-19 infection in health settings. This did not take place as often as it should have despite it being a legal requirement. Because it is very difficult to prove that an infection has been caught in an occupational setting, the BMA called on the UK Government to provide compensation to the dependents of doctors who had died or suffered serious morbidity without needing to prove it through the courts that the disease was occupationally acquired. Regrettably, this request was not accepted, but there must be easier recourse to compensation in the future, with less burden of proof placed on the medical professional.

Opportunities were missed for employers to support medical professionals

The first report of our COVID-19 review discusses the failures of the system to adequately protect the medical profession from COVID-19, concluding that risk assessments weren't consistently carried out or implemented, that PPE supplies were insufficient, and that processes for training and ensuring safe fit were inadequate.

The public COVID-19 inquiries must also examine the extent to which 'the system' was able to protect staff from infection and help staff who suffered from any short or long-term health effects. From our call for evidence survey, it is clear this could have been mitigated by greater support for those affected, who had in some cases seen their lives devastated.

'Devastating. I have long Covid. It's been nearly two years and I am not getting better. I have lost out on training. Assistance both career wise and health wise has been non-existent. I do not know what the future holds...Twice my pay as been cut to statutory sick pay without warning...Unsure whether I will ever be able to work again; unlikely to be able to do so in the same capacity.'
(Junior doctor, Not currently working or studying)

In our call for evidence, there were some complaints about a lack of support provided for those who had become ill.

'I caught Covid in March 2020. [...] I am dismayed at the incredibly flippant way that my occupational illness was handled. The fact that a potentially fatal virus had infected a member of staff should at the very least cause an organisation to re-evaluate their policies and realise that their current level of "protection" was inadequate. In contrast, despite not even being able to stand up due to being unwell with acute covid, my educational supervisor tried to get me to do a clinic from home over the phone. I was pressurised to return to work, and did so long before I felt well enough to do so - and was put immediately back onto a 48h on call over a weekend.'

(Junior doctor, Scotland)

In April 2021, 9% of respondents to our COVID tracker survey said they had been referred, or self-referred, to OH (occupational health) services for a COVID-19 issue. For those respondents who got a referral (N=250), this took on average 26 days (the median was seven days). For 14 respondents, it took 100 days or more to be referred.⁶⁶ However, it is important to note that a referral is not the same as treatment, which can also take much longer to access, especially considering the small number of OH physicians.

Occupational health services had not been resourced adequately and this is likely to have had an impact on services' ability to respond to need

Workplace OH services ensure that staff can access specialist advice on improving and maintaining health in the workplace, preventing and managing any work-related ill health and support staff to return to work following any period of sickness absence.

OH services had been underfunded and under-resourced for so long that when the pandemic struck, the ability to support medical professionals was limited. In April 2021, 12% of respondents to our COVID tracker survey said they didn't know how to access occupational health/wellbeing services, and 4% said they did not know what services existed.⁶⁷ This represents a significant number of doctors who could have been benefiting from occupational health provision.

The occupational medicine workforce has been steadily declining since 2009. Overall, there were 92 FTE (full-time equivalent) doctors working in England in NHS occupational medicine in December 2021, compared to 172 in September 2009.⁶⁸ The number of FTE occupational medicine consultants in England has fallen from September 2009 to December 2021 by 40%, associate specialists by 46%, specialty doctors by 25% and specialty registrars by 25%.⁶⁹ In Scotland, there were 21 WTE (whole-time equivalent) doctors working in NHS occupational medicine in September 2021, compared to 31.8 in September 2011.⁷⁰ In Wales, 2.3 WTE doctors were working in NHS occupational health medicine in September 2021, compared to 8.6 in September 2011.^{71,72}

That OH services were under-resourced suggests occupational health services were less able to respond to the increase in health needs from the medical profession previously discussed.

'Our trust has outsourced everything so there is no in-house occupational health and infection control consists of 3 nurses. Covid really exposed this. No additional resources were drafted in to address this. Hard to get risk assessment done and hygiene measures woefully inadequate with a department that had no clout. Covid as an infectious disease was simply ignored.'

(Junior doctor, not currently working or studying)

'Didn't feel much protected and there was no timely response and advice received from the Occupational health department regarding my underlying condition.'

(Consultant, England)

Health Education bodies across the UK must fund a model that provides adequate occupational medicine training posts to meet the level of demand now and in the future. The recent Northern Ireland workforce strategy draft commits to the reintroduction of OH training, but the timescale is problematic, with the training pathway not being reintroduced until 2025.

The career prospects of medical professionals have been harmed by the pandemic

For some medical professionals, the pandemic has significantly impacted their financial and career prospects. Training for doctors was disrupted, causing a reduction in career progression opportunities, and making clearing the backlog more difficult because staff feel they lack the necessary skills.

The medical profession found themselves with fewer training opportunities and chances to progress in their career

For doctors, training does not end after medical school. To continue in their career, doctors must do further years of 'core' training before entering specialty training, which can last a further three years to become a GP or between five and eight years to become a consultant. Experience of certain training placements is often a requirement to progress in one's chosen specialty. Staff redeployment and a reduction over the pandemic of non-COVID-19 care has therefore had a significant impact on the career prospects of the NHS workforce.

Our research shows that 40% of doctors in training were unable to gain enough experience in non-urgent and scheduled care to fulfil the competencies required for progression in their career, and nearly 30% said the same about urgent and unscheduled care.⁷³ Until these competencies are met, doctors cannot and will not be able to progress at the usual speed.

Respondents to our call for evidence told us how their training had been impacted. Classes, conferences, and exams had often been cancelled.

'Assessments were rushed and minimal, no training or teaching. Lack of senior support and cancellation of training sessions during the first and second wave had a lot of impact on training.'

(GP trainee, England)

'Limited access to academic learning, clinical placements, assessments, disrupted semester dates (an extremely long year), both electives cancelled (we don't have any, putting us at a disadvantage for applying for training posts), interruption to courses such as BSS [Basic Surgical Skills].'

(Medical student working in the NHS, Scotland)

'Exams cancelled 4 days before they were due [...] Training sessions suspended and cancelled.'

(Junior doctor, England)

At times, mandatory courses were difficult to access or even unavailable.

'Unavailable and inadequate slots and training institutions for mandatory courses such as ATLS [Advanced Trauma Life Support].'

(Junior doctor, England)

In Northern Ireland, there was a particular issue with access to sometimes essential courses in England, due to travel restrictions.

When teaching did go ahead, this was usually done online. However, respondents often felt that online learning was not as good as face-to-face learning.

'I have done all my training and teaching sessions remotely since the beginning of the pandemic, which has been difficult. How can you learn patient communication skills via Zoom?'

(GP trainee, England)

'Teaching over Microsoft teams is worse in every way than in-person teaching.'

(Junior doctor, Wales)

'There have been no in person lectures and the online content has been shocking. Only provided with NICE guidelines to copy from rather than lectures.'
(Medical student working in the NHS, Scotland)

Respondents also told us that there were far fewer learning opportunities on placements.

'Disruption to clinical placements and also clinical education and simulation. When on placement the infection prevention and control measures make clinical education difficult as there is a significant decrease in clinical opportunities when compared to before the pandemic.'
(Medical student working in the NHS, Northern Ireland)

'Operating experience was reduced to a minimum, [...] training opportunities were few and all educational focus in the department disappeared during the first and second waves.'
(Locum junior doctor, England)

Due to redeployment and disrupted rotations, some respondents missed out altogether on placement and clinical exposure opportunities.

'Assessment and training halted for 12 months. My breadth of exposure to medicine has been significantly affected. At some points it felt all I saw was covid'
(Junior doctor, Wales)

'Complete lack of patient exposure. We did a 3 month placement (July-Sept 2020) mostly with an anaesthetist and we weren't allowed to go with them half the time because we hadn't been offered fit testing. We also had a 3 month placement in oncology (Oct-Dec 2020) where no patients were comfortable having anything more than totally necessary staff to see them, so essentially we saw/did nothing.'
(Medical student (studying not working), England)

This has had an impact on the future workforce and the ability of doctors to address the backlog

This widespread disruption in the training of medical students and junior doctors has led to worse learning outcomes. In April 2021, nearly one in three (27%) of survey respondents to our COVID tracker survey that were in training said they had not been able to gain enough experience in urgent and unscheduled care to fulfil the competencies required for a certificate of completed training or their expected stage of training.⁷⁴

In our call for evidence, some respondents reported failure to pass exams as a direct consequence of the pandemic, and some felt underprepared and underqualified for undertaking the next step in their career.

'I still feel like as we are approaching finals that I have barely had any patient exposure in the last 2 years and feel totally unprepared to work as an F1.'
(Junior doctor, England)

'The most concerning has been the lack of in person Anatomy teaching, we have had very little access to prosections, relying almost entirely on plastic models - this concerns me as I feel we are less prepared for our clinical years as the human body looks very different to a model.'
(Medical student studying not working, Wales)

Some reported wanting to leave the medical profession entirely.

'I want to leave the profession. The standard of training is zero. Basically, no training just service provision.'
(GP trainee, England)

Respondents who are involved in providing training also expressed concerns about the learning outcomes of trainees.

'They see very few patients, many seem to have massive gaps e.g. examination skills, and some really anxious with good reason about how they might cope with clinical work.'

(Salaried GP, Scotland)

Students and junior doctors not having sufficient experience and expertise to progress in their careers could have a significant impact on future workforce planning. Additionally, there may be anxiety amongst the public about being treated by a group of doctors who have not had the same training as previous cohorts.

As discussed earlier, the significant elective recovery backlog means doctors are under sustained pressure to provide care for patients promptly. Without the necessary training provided to the medical profession, this will be harder to achieve. In England, arrangements to mitigate delayed career progression and the subsequent loss of income for junior doctors have been secured after campaigning from BMA and others. This must be extended across the UK along with catch-up opportunities for training.

Medical professionals saw their financial lives impacted

Specific groups of doctors, such as locum GPs and those working in private practice, experienced a particularly detrimental impact on their finances over the pandemic.

The initial financial impact on locum GPs across the UK was acute. As fewer patients were visiting GP surgeries, and as GPs cancelled leave at the beginning of the pandemic to support the pandemic response, locum GPs were put in a difficult position, and many lost their income. These doctors could have been better used in the national pandemic response, redeploying them to services where they were needed more, for example in the COVID-19 clinical assessment service. Locums were also affected by a loss of income if they were unable to work due to personal circumstances.

'My work has changed beyond recognition. I have been unable to do any GP work due to being a Locum and having a 'shielding' husband.'

(GP locum, England)

Similarly, doctors in private practice across the UK were significantly affected by the pandemic. For example, when NHS England block-booked 100% of the facilities of many private hospital companies, many doctors working exclusively in private practice lost their income as they were unable to treat their patients. In a recent UK-wide BMA survey of doctors engaged in private practice, six in 10 of the respondents reported they were unable to provide any care at all during the first lockdown, and around one quarter reported that some of their patients were presenting later than they should as a result. Some of our members were offered no support from their hospitals, faced mounting pressure from their patients who wanted to be seen quickly, and experienced a significant reduction in their income, of up to 80%.

Students were also especially affected as the unpaid nature of student placements meant that they were not eligible for the isolation payment schemes available to the wider public in England⁷⁵, Scotland⁷⁶ and Wales⁷⁷ as these were based on loss of income (the scheme in Northern Ireland⁷⁸ operated differently and was based on financial hardship rather than loss of income). In some cases, students lost much-needed income from student jobs, which also often disappeared during the pandemic, to pay for their tuition fees or accommodation. In Northern Ireland, medical students were excluded from a payment of up to £2,000 from the Department of Health which was given to other student health professionals to recognise contributions to the pandemic response⁷⁹.

For some doctors or students who developed long COVID, the lack of financial support also caused considerable distress. This was a particular issue for the self-employed and students, with varying levels of sickness absence pay and some even losing their job because of the disease.

'I caught Covid at work prior to the March 2020 lockdown. I developed disabilities as a result of this. I have lost my job. I don't feel I have been supported in any of this.'

(Salaried GP, England)

'I am in bed with long Covid worrying about if I will be able to afford my mortgage. It is very distressing.'

(Consultant, England)

'Devastating not least because in the line of duty I caught covid 19 and have had multiple medical consequences for example myocarditis and POTs [postural tachycardia syndrome]. I am considered to have a disability and I am still housebound. Despite secondary care in most cases getting covid 19 related sick pay in the line of duty, primary care have been afforded none. Every GP partner I know with long covid has had their contract terminated at 6-12/12 [months] or been forced to resign. Certainly the cost of covid for many doctors has been at the expense of our health and our livelihood with little interest in protecting us. On the one hand we are demanded to see patients face to face with inadequate PPE (like other countries), but yet when in the line of duty we are not occupationally protected. Many feel utterly betrayed when their life has been one of service and commitment to others and yet their life in terms of mortality of morbidity is seen as so worthless, let alone their careers.'

(Salaried GP, England)



Recommendations

1. Health education bodies across the UK must fund adequate occupational medicine training posts to meet the level of demand in the UK's health services now and in the future.
2. Junior doctors and medical students must be assured that their efforts to support the delivery of care during the acute waves of the pandemic will not disproportionately impact their future careers due to time away from formal training and must be supported to flexibly access training opportunities to make up for those lost. If this is not addressed, it could have a significant and negative impact on the senior medical workforce in the future.



Questions for the inquiries to answer

1. The inquiries must examine the extent to which the system was able to financially support staff who suffered from any short- or long-term health effects. From our call for evidence survey, it is clear this could have been mitigated by greater support for those affected, who had in some cases seen their lives devastated.
2. The inquiries must examine the extent to which the UK Government's lack of vocal support for the medical profession over the pandemic contributed to media and public perceptions that doctors were not seeing patients when needed.

Despite the severe negative impact, the pandemic also led to some practical positive changes in the UK's health services

The medical profession has noticed some positive changes within the UK's health services as a result of the pandemic, such as improved morale at the outset of the crisis. Unfortunately, many of these have since waned. Where possible, changes to the UK's health services made since March 2020 which have worked for staff and patients should be maintained or restored to improve staff health and morale, and patient care.

Medical professionals experienced an initial sense of improved morale

At the beginning of the pandemic, the medical profession felt a sense of camaraderie, satisfaction from helping in a national emergency, and a sense of achievement from making radical changes to care delivery in a short amount of time. In May 2020, 65% of respondents to our COVID tracker survey agreed that there was a greater sense of teamworking, 45% agreed they felt more valued as a doctor, and 47% agreed they felt less burdened by bureaucracy.

In our call for evidence, some respondents highlighted improved overall morale.

'Was a positive experience of working with colleagues, the patient population (so many willing volunteers and helpers) and the wider practice staff. We all pulled together, and it has been in that sense a positive experience.'

(GP contractor/principal, England)

'It was positive – made me appreciate how hard the ITU nurses and doctors worked and it strengthened us as a team.'

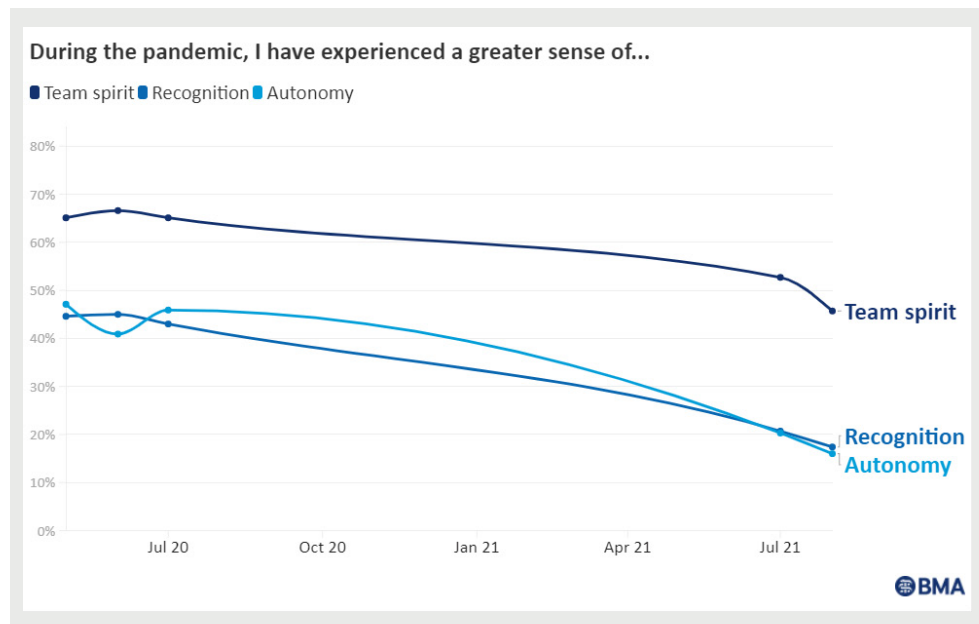
(SAS doctor, Wales)

'It may seem strange but I enjoyed some of the aspects of the pandemic - leading the practice to change the ways we delivered care to our patients so that it was safe but also accessible and keeping our patients informed and on board. Making big and fast changes using well-established change methods was the good bit and helped staff morale and our patients felt supported and cared for.'

(GP contractor/principal, England)

However, initial feelings of positivity and high morale amongst staff tended to wear off after the first wave. Longitudinal data from our surveys show that doctors' experiences of increased team spirit, recognition, and sense of autonomy decreased during the pandemic (see Figure 11).⁸⁰

Figure 11



This downward trend was also reflected in our call for evidence.

'Initially a very positive mutually supportive atmosphere in the practice but difficult to maintain this given the duration of the pandemic and the increasing workload. In the first wave all we were dealing with was the pandemic since then it has been on top of normal workload so more stressful and tiring.'

(GP contractor/principal, England)

'The impact by the end of the first wave was positive as there was a lot of focus on wellbeing and my workload reduced, but the second phase left me close to burnout because of the rota gaps, high workload and additional stresses at work. The workload in paediatrics is still increasing since then, and burnout is still something I worry about.'

(Medical academic trainee, England)

'At times (early on especially) it was very rewarding but this has faded a lot.'

(GP contractor/principal, Scotland)

Other positive developments came out of the pandemic

Remote working was better facilitated

Beyond initial improved morale, there were practical changes which improved doctors' experience of work. For some doctors, such as those with a disability or LTC, remote working (where it had been facilitated by an employer) has been hugely beneficial, ensuring doctors could be protected when needed. Some, such as disabled doctors, are concerned that adjustments put in place during the pandemic – for example, greater flexibility and remote working – will be removed as the system returns to 'normal'. The ability of some doctors to work remotely at certain times in the pandemic should be acknowledged, and a hybrid working model for doctors more seriously considered within UK health services. Moreover, in our call for evidence, 22% of respondents selected 'remote working' as one of their top three solutions to address the long-term impact of the pandemic on the workforce.

'Remote consultation really helped to show how much can be achieved without face-to-face appointment. Contrary to the government and media, this system was very effective way to triage and so option for the triaging clinician to work from home.'

(Salaried GP, England)

'Remote consultant ward rounds on a computer on wheels worked well for shielding consultants and the use of remote working had also helped to stem burn out hugely, especially for parents.'

(Salaried GP, England)

Beyond this, the medical profession should be consulted regarding long-term remote work. If working conditions could be improved for doctors, including disabled doctors or those with caring responsibilities, it should be considered. This would first and foremost require the provision of adequate IT equipment and the incorporation of remote working skills in relevant training packages.

The pandemic stimulated a new approach to appraisal

The medical profession has long held concerns about the burdensome nature of appraisal and revalidation.

Due to the COVID-19 pandemic, in March 2020 appraisals were paused across the UK to allow clinicians to focus on meeting frontline pressures. The resumption of appraisals in most of the UK from September/October 2020 took a new approach that was streamlined and had a greater emphasis on wellbeing, although revalidation requirements remained the same. There was a focus on how appraisees could meet revalidation requirements while stripping back extra and unnecessary facets of appraisal that had been added over the years.

In England, for example, NHSE/I recommends that the Appraisal 2020 format continues to be used for doctor's annual appraisals. An evaluation of the format led by the Academy of Medical Royal Colleges and including the BMA, GMC and NHSE/I and other stakeholders concluded that appraisals should not simply revert to the approaches used before the pandemic. Instead, the recommendation was to build on the success of the Appraisal 2020 format, be applicable across the UK, and be suitable for a context beyond the immediate pressures of the pandemic.

As such, the pandemic provided a much-needed opportunity to rethink appraisals and consider how the requirements of revalidation could be met in a way that better supports doctors' professional development and wellbeing.



Recommendations

1. As far as possible, changes to the UK's health services made since March 2020 that made a positive impact on doctors and their patients should be retained or brought back to improve staff health and morale, and retention rates. This should include an assessment of remote working, hybrid working, more appropriate appraisal processes, and of how morale can be improved.



Questions for the inquiries to answer

1. What were some of the positive changes to the UK's health services brought about because of COVID-19, and how might some of them be restored or maintained?

Conclusion

The experience of medical professionals during the COVID-19 pandemic has been universally disruptive. Notwithstanding a few positive changes, most doctors have been left devastated. Some have been affected more than others due to their ethnicity, disability status, or gender, and that is unacceptable. However, much of this was expected by those who had for too long experienced discrimination and inequality.

Doctors are under oath to treat the ill to the best of their ability and so during the worst public health crisis in living memory, it was never going to be easy. However, doctors and other healthcare workers were doing their best to help patients, which came with significant personal risk and sacrifice. Notably, this crisis occurred when health services were not prepared for such disruption. The extent to which medical professionals working in the UK's health services suffered was not inevitable. Workforce shortages going into the pandemic were acute, doctors were overworked, and capacity was limited. Had such issues been addressed by governments before 2020, it is likely the devastation to medical professionals would not have been as considerable.

While we are being advised by the UK Government to 'live with COVID', it doesn't mean we can ignore the virus altogether. This includes recognising the impact of the pandemic on the medical profession is far from over. Governments will need to monitor the health, wellbeing, support on offer and ensure they have adequate protection to work safely in the face of continued COVID-19 infections and future pandemics (see report one of this review). They also need to make sure doctors can develop their careers and earn a living. Learning to 'live with COVID' should not be at the expense of the medical profession who have sacrificed so much, and sometimes their lives, to care for their country.

We cannot predict the future, and we cannot change the past. What is within our power as a society is to learn from what worked and what didn't work so that when the next pandemic arrives, lessons have been learned to protect the future medical profession from the hardships endured by those who came before them.

Recommendations

The inquiries must consider the following questions

- Poor physical and mental health within the medical profession might be expected in a pandemic. To what extent could the negative impact experienced by doctors have been mitigated?
- How did the state of the UK's health services going into the pandemic contribute to the impact of COVID-19 on the medical profession?
- How well was the system able to support medical professionals who suffered from the short or long-term health effects of COVID-19?
- What can be learned from the experiences of ethnic minority doctors, disabled doctors, and other protected groups during the pandemic? How can we mitigate inequality in future crises faced by the UK's health services?
- What were some of the positive changes brought about because of COVID-19, and how might some of them be restored or maintained within the UK's health services?
- To what extent was the system able to financially support staff who suffered from any short or long-term health effects? How could these impacts have been mitigated by greater support?
- To what extent did the UK Government's lack of vocal support for the medical profession contribute to media and public perceptions that doctors were not seeing patients when needed?

Recommendations for the governments across the UK

- The BMA and others have called for continuous and transparent assessments of workforce shortages and future staffing requirements. This is the only way to ensure that Governments take accountability for providing safe staffing levels and adequate funds and resources to health services so they can deliver safe care.
- All governments and system leaders across the UK must have an honest conversation with the public about the need to balance service recovery with staff wellbeing.
- For doctors with a disability or LTC, remote working has been hugely beneficial. A hybrid working model for doctors must be more seriously considered within the NHS.
- To mitigate inequity in the future, mechanisms must be introduced to make the experience of working in the NHS less variable by background or protected characteristic.
- As far as possible, changes to the health services made since March 2020 that made a positive impact on doctors and their patients should be retained or brought back to improve staff health and morale, and retention rates. This should include an assessment of remote working, hybrid working, more appropriate appraisal processes, and how morale can be improved.
- Health services in the UK need good OH (occupational health) systems that can act quickly to protect staff both during and outside of health emergencies. Health education bodies across the UK must fund occupational medicine training posts that meet the level of demand in the UK's health services now and in the future.
- General wellbeing support, including timely and accessible occupational health assessments and support to access psychological support services, must be available for staff at all levels and across all health services, with specific support also offered to ensure staff can recover from the pressure of delivering care during a pandemic.
- Junior doctors and medical students must be assured that their efforts to support the delivery of care during the acute waves of the pandemic will not disproportionately impact their future careers due to time away from formal training and must be supported to flexibly access training opportunities to make up for those lost. If this is not addressed, it could have a significant and negative impact on the senior medical workforce in the future.

Appendix A

Overview of BMA COVID-19 research

| Title | Date | Responses | Coverage |
|-------------------------|------------------|-----------|--------------------------------|
| COVID Tracker survey 1 | 6 April 2020 | 1,924 | UK wide |
| COVID Tracker survey 2 | 16 April 2020 | 6,126 | UK wide |
| COVID Tracker survey 3 | 30 April 2020 | 16,343 | UK wide |
| COVID Tracker survey 4 | 14 May 2020 | 10,328 | UK wide |
| COVID Tracker survey 5 | 28 May 2020 | 8,455 | UK wide |
| COVID Tracker survey 6 | 18 June 2020 | 7,497 | UK wide |
| COVID Tracker survey 7 | 9 July 2020 | 5,905 | England/Wales |
| COVID Tracker survey 8 | 13 August 2020 | 4,279 | England/Wales |
| COVID Tracker survey 9 | 22 October 2020 | 7,820 | England/Wales/Northern Ireland |
| COVID Tracker survey 10 | 17 December 2020 | 7,776 | England/Wales/Northern Ireland |
| COVID Tracker survey 11 | 8 February 2021 | 8,153 | England/Wales/Northern Ireland |
| COVID Tracker survey 12 | 19 April 2021 | 5,521 | UK wide |
| Moral distress survey | June 2021 | 1,933 | UK wide |
| Viewpoint survey 1 | 8 July 2021 | 2,478 | England/Wales/Northern Ireland |
| Viewpoint survey 2 | 2 September 2021 | 1,749 | England/Wales/Northern Ireland |
| Viewpoint survey 3 | 26 November 2021 | 2,424 | England/Wales/Northern Ireland |
| Viewpoint survey 4 | 4 February 2022 | 1,320 | England/Wales/Northern Ireland |
| Call for evidence | 17 December 2021 | 2,484 | UK wide |

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British Medical Association
BMA House, Tavistock Square,
London WC1H 9JP
bma.org.uk

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