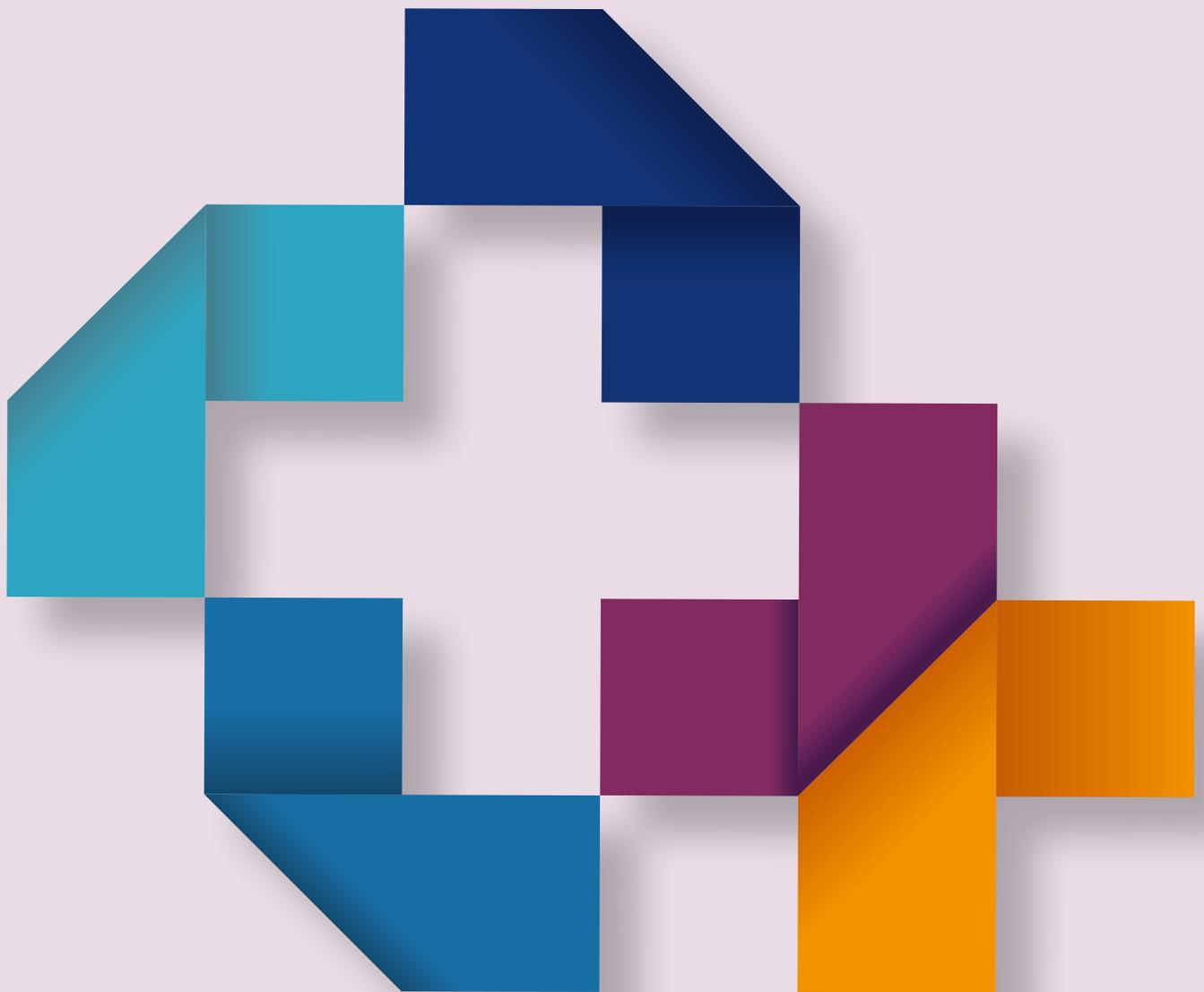
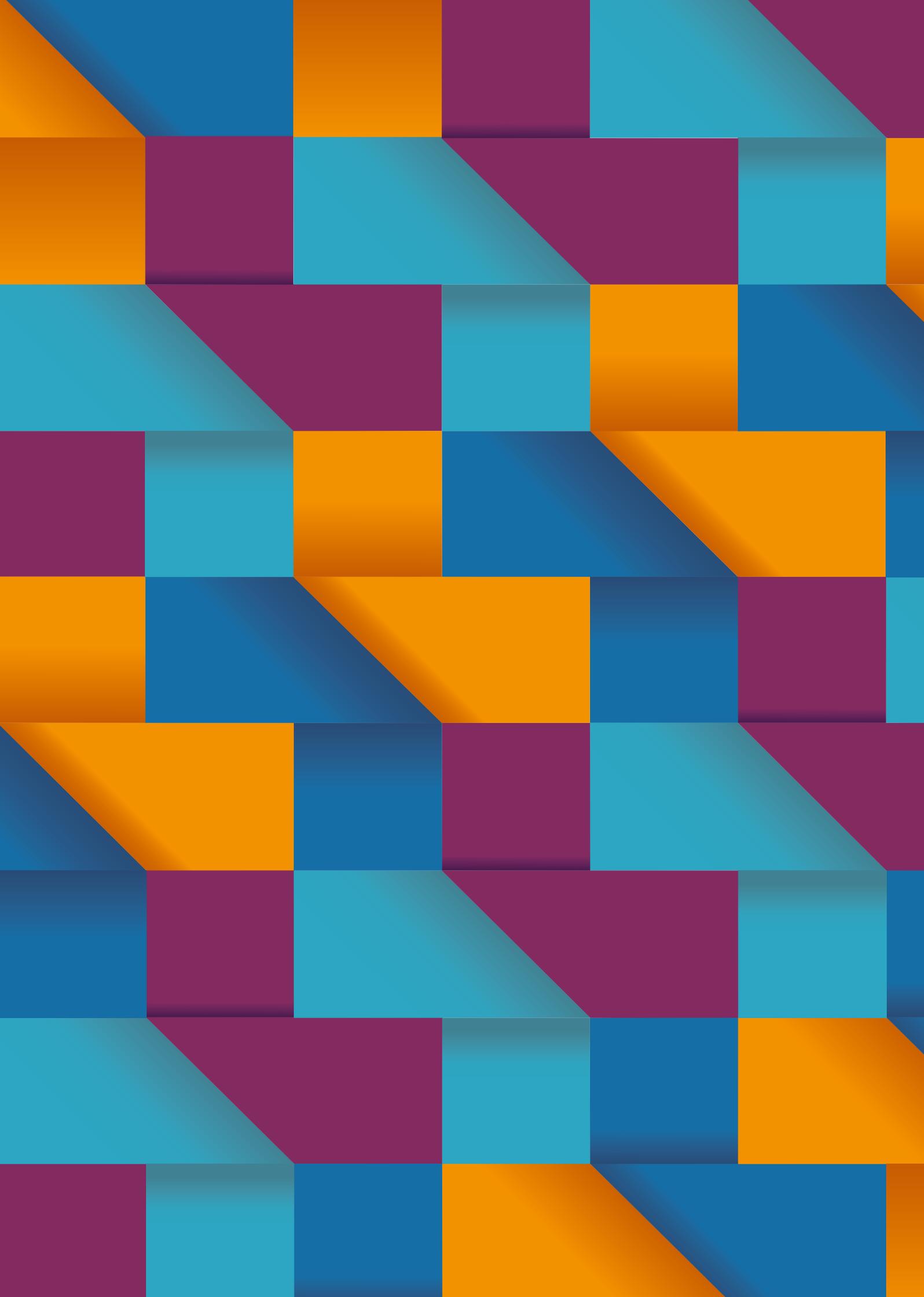


The state of medical education and practice in the UK 2020

Case studies





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Introduction

Alongside the data and research we include in 'The state of medical education and practice in the UK', this year, we present 13 case studies in which doctors describe their experiences during the coronavirus (COVID-19) pandemic.

We commissioned an independent author to conduct one-to-one interviews with 13 doctors to learn about their diverse experiences throughout the first peak of the pandemic. The interviews took place in July and August 2020.

The case studies based on these interviews reflect a diverse range of experiences across the medical workforce in 2020. These doctors were found using GMC network contacts with participants opting in to participate in the case studies. It is acknowledged that this process did not have the rigour of a research project, such as 'the Barometer survey 2020' but an effort was made to find doctors who represented variety across a range of different factors, such as register type, specialty, the nation of the UK in which they practice, and personal attributes, such as age and ethnicity.

We have not used the doctors' real names in the case studies.

As the number of doctors interviewed was small, the case studies haven't been given undue weight and have not been used to make inferences about the overall UK doctor population. Rather, 'the Barometer survey 2020' enabled analysis of the overall workforce. This analysis can be found in '[The state of medical education and practice in the UK: 2020](#)'. The case studies presented here illustrate and add insight to the Barometer findings.

We would like to thank the doctors who participated in these case studies for their time and for sharing their powerful experiences with us.

Dr A – Technology and remote working

Dr A is the senior partner in a GP practice, which employs three part-time salaried GPs.

He has a strong personal interest in technology. His practice had been triaging patients via telephone calls or online forms for 12-18 months before the pandemic. Patients were then directed to self-care, the pharmacist, a nurse or, where appropriate, a GP. The practice was also already booking in video consultations between 6-8.30pm for those who could only attend in the evening.

During the pandemic, Dr A was able to tweak this system to adapt to the changing scenario. He explained, 'it was a very, very easy switch because it was effectively business as usual, but with a slightly different [focus]'

In the first wave of the pandemic, GP consultations were mostly carried out via telephone, but some were by video. There were very few face-to-face appointments. Nurses were taking detailed histories and sometimes asking for photos of, for example, rashes. The doctor was then able to give advice on the condition, without actually having to contact the patient. Even physiotherapy was delivered digitally.

Dr A said, 'COVID has catalysed everything for me. It's just brought everything forward. It's made everything quicker. It's made everything more acceptable.'

He appreciates that for other practices, the transformation may have been more challenging. But 2020 has allowed GPs to see how technology can be safely used.

He described, 'The silver lining of this particularly dark cloud is that it's enabled us to transform the delivery of patient care that was planned to take months and years in a matter of days and weeks and months. It's made us realise that it is ultimately safe to deliver consultations via video, via telephone. We can triage very effectively. Actually, not that many people really do need a face-to-face appointment.'

However, there have been some resulting demand issues – doing things more quickly by phone or digitally can subsequently generate more work. He said, 'if I see 40 patients in a morning rather than 20, suddenly I've got 40 blood results rather than 20 to look at the next day. Efficiency breeds more work.'

Also, while there has been huge digital uptake, at the same time many potential patients have stayed away, leading to a build-up of demand. 'It's [the pandemic] massively polarised. By that I mean that COVID has made people stay away because of fear and necessity and all those negative things associated with that. There's suddenly significant unmet demand.'

While it's been slightly less busy, it has still been busy. Catching up with things they couldn't normally do, doctors had the opportunity to go through reports, review Quality Outcomes Framework* populations, make sure chronic diseases are being monitored correctly, and carry out Primary Care Network (PCN) work. 'I wouldn't say there is huge amounts of slack, but there was some slack there. General practice was probably running at 125%, so even that 25% reduction just still felt like a normal day,' he says. 'It's enabled them [GPs] maybe to get out of the trenches a little bit and see that life doesn't have to be as quite as hard and arduous as life has been in the past.'

Technology also enabled staff to keep in touch and attend meetings while homeworking or isolating. But this was one area where digital was not as effective – team working was 'difficult' as relationships and interactions were more 'transactional,' losing the usual conversations over coffee.

Going forward, Dr A would like to extend primary care triage into 'smart triage' using artificial intelligence, with people triaged initially electronically and in an automated way. 'It's a balance between making people's journey far too complicated and needing to have 52 touchpoints before you see the right person, versus getting somebody in at the right place at the right time.'

He thinks video consultations should be kept too as they benefit both patients and doctors. By mixing them in with usual practice, they make working life less monotonous and therefore less stressful than continual face-to-face appointments. They also give doctors a new challenge.

Dr A said, 'It's much better to use than the telephone, because of course we've now just got an interaction, which feels entirely different. I can see you, which for a human interaction is massively important. But to bridge how you're interacting, what you look like, are you well-kept, etc it adds a real richness.' For the patients, he described, 'Your day isn't interrupted at all, other than the 20 minutes we're having a conversation.' Video is better than telephone, he feels, because patients feel less short changed, having an 'in the flesh' doctor in front of them.

The 'new normal' for him would ideally be a hybrid between, 'the good stuff pre-pandemic and the good stuff from now, [delivering] a service that is flexible for all, enabling digital, enabling triage, enabling people to be seen by the right person at the right time.'

* The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.

Dr B – Consultant experience

Dr B is an Intensive Care Consultant. During spring 2020, he worked in an Intensive Care Unit treating acutely unwell patients with COVID-19.

Dr B described how clinically challenging treating COVID-19 patients has been. Despite seeing the pandemic coming, the scale of illness left him feeling unprepared. 'We always knew a pandemic was coming, and we've had pandemic plans... But COVID-19 as an illness is like nothing else really... a lot of our plans were [not applicable], because of how severe the ITU* patients were. They were so delicate it was unbelievable.'

Before the pandemic, Dr B might see one very sick patient who is ventilated and prone† when he arrived in the evening on call. Whereas during the pandemic, he recalled, 'there was an evening I walked on [to the ward] with 16 ITU beds, every single one of them prone, ventilated, very hypoxic.‡'

Doctors treating patients with COVID-19 have faced many challenges. In particular, Dr B described the difficulties of treating an emerging unknown disease. 'A lot of the stuff we thought initially was nonsense... An expert opinion is the lowest tier of medical evidence. When it's all you've got, you've got to use it. But the initial stuff we got was completely different on how we manage these patients now, and you can see the

mortality drop through the pandemic. Part of that is patients, because the very, very vulnerable people got it first, died quickly. But part of it is we got a lot better at looking after it.'

Dr B also described the emotional toll of losing patients in unique circumstances where bereaved families were unable to visit. 'The first five or six [patients] we looked after died, and we were starting to wonder if this was completely futile... People were handing us their beloved relative who had a cough, and they were getting a sealed casket back, three weeks later, and not allowed to see anything in between.'

Throughout the pandemic, doctors have been dealing with the personal impact as well as the professional. Dr B described how difficult it was being unable to see his family, especially his father who was shielding due to illness. He also watched colleagues deal with bereavement from afar as they were unable to return to their families to grieve. 'We have people from all over Europe as consultants and they started losing relatives and couldn't go back for funerals, because they wouldn't be allowed out of their home country again.'

* Intensive Therapy Unit is another name for an Intensive Care Unit.

† Proning is the precise process of turning patients so they're lying on their stomachs. It is used as part of COVID-19 treatment.

‡ Hypoxia is a dangerous condition that occurs when there's an insufficient supply of oxygen to tissues in the body.

Despite the personal and professional challenges doctors have faced, they have continued to show immense dedication, bravery and professionalism. Dr B is proud of how his team responded to the challenges during the spring peak of the pandemic, especially their energy and can-do attitude in the early stages. However, he is fearful of the future and the consequences of a second peak of infections. 'If we get another spike, and we get up to where we thought we were going to be, it is going to [be] harder'.... if we have a huge second wave, you can't just walk away.'

Dr C – High pressure experience

Dr C is a Consultant in an acute environment. She leads a large team in a specialist unit.

She found the first wave of the pandemic exhausting – developing new procedures and policies, responding to the personal protective equipment (PPE) requirements, and working beyond her hours regularly. 'I did that in droves. I would always be here for just after 7:00 [AM], and you'd just work until you were tired. I never left with things not to do. I remember leaving here once at 11:00 [PM].'

Part of the tiring nature was managing the concerns of her team, who were very anxious over possible COVID-19 infections in patients and themselves. She said, 'There was so much fear. Our first positive [COVID-19 test] sent the whole place into a tailspin...'

Even though there were minimal COVID-19 cases in patients, 'the angst it generated [among staff] was just unbelievable.'

As a result of this, Dr C decided against following the national guidance to step down PPE in lower risk clinical areas. The fear was particularly acute in black and minority ethnic (BME) doctors. 'I knew they were really scared. I was trying to have one-to-one meetings to try and allay anxiety and ask them why they were that concerned.'

Initially, Dr C was so busy she didn't stop to think how she felt and she just kept going. On the third weekend into the pandemic, she heard a Bill Withers' song being played on the radio shortly after his death and she broke down.

'I just felt I had to cry, because I was just so exhausted and overwhelmed, and it just seemed such a nice thing to do. It just provided a period of release.'

'But until that point, I hadn't really stopped and thought about how I felt about it all. The pressure to make sure that I kept the staff safe, the [patients] safe, whether the calls you made were the right ones. I know the buck doesn't stop with you, but at times, I felt it did.'

The emergence of the Black Lives Matter protests, spurred by several racially-charged incidents, compounded the existing stresses Dr C was feeling. To the extent it resulted in her taking a day's leave. 'It almost seemed, just as I was getting into the recovery phase, then that happened. It was additive, for me. I started to think about all the ways in which the Health Service or the society in which I live, and health, because that's part of the society, is unequal.'

'I just had to take a day out, once, just for me, and do nothing, and just lie in bed, and just meditate, because I needed to do that.'

Dr C described how she had witnessed casual racism and 'unfair and unpleasant' encounters. While people were not directly offensive to her, it still had an impact on her.

She said, 'In the end, I got a group of my colleagues and my consultant colleagues and just told them how I was feeling, because we never have discussed race. I've been here for 18 years. It gave me an avenue to tell them how some of the care that happens, even in our organisation, affects me.'

Home working saved her some time, so she was able to take up yoga – once she had persuaded herself not to fill that time with work emails. 'You felt that you gained a few hours in the day. And what did you do with those extra hours? You just did more emails. And then I thought, I need to look after myself, I'm not going to give that extra half an hour back to more emails, I'm going to give them to me.'

Dr E – SAS doctor experience

Dr E is a SAS doctor and tutor who has worked at the same acute care hospital for many years and is now considering working outside the NHS or even retiring because of their experiences during the pandemic.

Dr E took on leadership roles which were fulfilling and enjoyable but also increased their frustration in a number of aspects.

They say: 'I was probably thinking this way anyway, but I've started to think about... how long do I want to continue to work in the NHS like this? Should I be looking at something outside? Should I retire and do something different altogether?

'I've never thought of retiring before I was 60, but I've actually considered that more seriously than ever before.'

However, they have also felt mentally and physically drained and say post COVID-19 exhaustion may make retirement more likely than another job. Dr E wonders whether they have 'another change left in me.'

They felt mentally prepared for the challenge, but having to think 'out of the box' all the time was mentally exhausting, coupled with fragility. 'I've never felt quite so vulnerable at work for a long, long time.'

Dr E expected to be asked to do a registrar role, as there were lots of redeployment - surgical colleagues 'who deal in the neck upwards' were working as medical registrars - but in fact after being asked to help to develop coronavirus (COVID-19) pandemic guidelines for their department, they found themselves in a leadership role.

This meant attending ward rounds which they were not normally part of, checking in with trainee doctors to find out how everyone was, did they have enough PPE etc. They found they were looked to as a point of continuity in a fluid situation where the consultants were often locums.

Dr E held daily meetings, worked out patient flow pathways with Emergency Medicine consultants and were invited to the Clinical Director's meetings to brainstorm ideas. 'It was exhausting, but it was so good to feel I could make a positive difference. I absolutely loved it.' They worked longer hours and on Bank Holidays. 'I was going in earlier, and I was working later. I was eating, sleeping, drinking the guideline.'

But one plus was the relationships Dr E had built up with other members of staff across the trust which led to informal adaptations to help manage emergency patients. 'You've got longstanding, mutually respectful relationships that were so useful when the crisis hit.'

They felt that nationally some fellow SAS doctors were treated a little unfairly when it came to redeployment, 'acting up, down and sideways' but sometimes were not recognised for their huge experience. One senior SAS colleague, who helps run the oncology clinics and stands in when the consultant is away, was told they could be an SHO if needed. Dr E is now concerned about a second wave, making them 'rattier and grumpier.' They admit: 'I'm a bit fed up now when we're getting into the marathon, rather than a sprint.... we're all thinking, "What will we do if there's a second wave?" Because, we just haven't got anything left in the reserve now.'

Dr F – Impact on teaching

Dr F1 is doing her specialty training in neonatal intensive care and aims to become a Consultant Paediatrician. At the start of the pandemic, her unit made a lot of preparations, thinking they may have to take older children. It turned out that they didn't need to.

During the first wave of the pandemic, Dr F's hours didn't change, as the planned emergency rota was never required. The situation was assessed every day and discussed by email and in person with the consultants and trainees.

One of the biggest impacts was on teaching, which was cancelled. Normally, there was lunchtime teaching from consultants and specialists visiting from elsewhere.

However, during the pandemic, visiting specialties didn't come over as before, and eventually, they were replaced by video calls. For example, if a baby had an infectious disease, there was a virtual consultant-to-consultant meeting.

She described this as unfortunate, though understandable, in the context. She said, 'It's a shame for us, because that tertiary neonatal experience, for me, that is my neonatal experience, and once I leave now in August, that can lead me right through to [when] I'm a consultant.'

'So that is my six months to get that experience, and so I would say that actually not having teaching in that time probably has had a negative impact on myself... I'm not getting to see knowledge and skill from the consultants that I would be there to get ordinarily.'

There were lots of changes for the parents of the patients. Rooming in – when parents stay at the hospital overnight when their baby was due to leave, to build up their confidence – was stopped.

'Wobble rooms' were set up to support staff, and while Dr F doesn't know how much they were used, she described it as being a shame that they're being taken away. She thinks there is a permanent need for these rooms, given that staff deal with the emotional toll of the death of a baby on the unit, on average, once a week one.

She said, 'we do work in a very intense and emotionally intense environment anyway, and there's very little psychological support there for both staff and parents. We don't have a psychologist for the parents, certainly not for the staff. So for us, it seemed a bit strange, actually, that the wobble rooms and things would only come in at the time of the pandemic when actually, we would appreciate it all the time.'

'It's just going to be taken away now despite the fact our job would probably demand it on a regular basis.'

In some respects, Dr F described less pressures outside of work as offsetting the increased stresses at work.

'You don't have the same stresses outside of work at the minute. You weren't expected to go to the gym every day. You weren't expected to go to the shops. You weren't expected to do everything.'

But there were some new stressors, not least personal protective equipment (PPE), which affects doctors' abilities to communicate with babies when assessing their development.

She said, 'one of the first things they do when they're around eight weeks old...is smile. They obviously don't smile back at us anymore because we're wearing masks. It's heartbreaking. I actually need to find a clear mask somewhere.'

The pandemic has re-enforced Dr F's sense of responsibility to her patients, in terms of what it means to be a doctor.

'As a doctor, then as a person, [I] see it as really important to protect my babies. For example, before things were put into lockdown, you had the gyms and things. I was being really cautious. I stopped going before lockdown. I was wearing a surgical mask around Tesco's even when nobody else was advised to because I was so conscious that I could bring it to my patients. I would hate for that to happen. I would hate to infect my patients... I'm part responsible for these little, tiny patients.'

Dr G – Team working experience

Dr G is a community-based trainee Psychiatrist. His practice has been fundamentally altered by the pandemic.

He has stopped home visits, which previously made up 90% of his work, and face-to-face clinics. He only saw a 'handful' of patients between March and August.

His practice has seen changes, some for the better and some a compromise. But there's one particular area that has been enhanced by the pandemic – communication with colleagues and teamworking. He believes this had a direct impact on patient care.

During the first peak of the pandemic, the video and phone calls he had with consultants for clinical patient discussions were more regular, detailed and effective than catching up in a corridor as before. He said, 'I capture more. We're conscious that we all try and stay in touch a bit more.'

Working primarily in the community meant that, in the past, team members were all over the place geographically. This meant that meetings with the wider team were difficult to achieve. Now, with homeworking and use of video conference calls, meetings are virtual and there's better attendance. Dr G described, 'it's given people more flexibility to attend, rather than having to be in a certain location at a certain time.'

As a result, he's seen his team members more, not less. He said, 'I've actually got to know the community team, bizarrely, more during COVID than I did in the first six months, which is really odd. You wouldn't think that that would be the case, but because we've been on more calls together, whereas previously, people might not have come to certain meetings. And you wouldn't have crossed over because everyone's getting dragged in different directions.'

Previously there had been a bit of a barrier between the medics and the community team as they were physically in different places and this has 'disappeared a bit.'

He believes this had a direct impact on patient care. He explained, 'when you know people, it's very easy just to go, "Oh, can I just discuss this person with you? Can we have a chat about what the options might be?" Rather than specifically sending a referral and saying, "Please can you do this?" You can have a bit more of an open discussion about whether it's appropriate or not. I think that certainly helps the patient in being able to access what's going to best meet their needs.'

Dr G also found virtual teaching a positive experience, both for reducing travelling time – saving 4 hours every Tuesday – and keeping in touch with his professional network.

He said, 'It's much easier to catch up with people, because you don't have to drive somewhere to catch up.'

'Having that time when you meet face-to-face is quite important for networking and maintaining professional relationships with others, especially because we're such a small specialty, and helping reduce that feeling of isolation.'

The pandemic has enabled Dr G to switch to homeworking, which has been a 'massive bonus' in terms of his wellbeing. It's also freed up time for him to do research and time-consuming in-depth medication reviews.

Going forward, he'd like video consultations to replace in-person home visits. This would be more efficient and convenient for doctors and less disruptive for patients. He tends to make two home visits a year to his patients, he recommends that one of these could be done by video.

With the extra time saved, Dr G would like to see more patients and be able to spend more time with existing ones – avoiding cutting corners and rushing things. 'It's everywhere in the NHS, you have to cut corners at times to do things as best [as] possible without causing any problems, but there might be other things you might want to look into in a bit more detail if you had that time.'

Dr H – Positive leadership experience

Dr H is a hospital consultant with some formal leadership responsibilities. During the pandemic, he faced some very busy times with emergencies and COVID-19 admissions, as well as difficulties, such as practicing in the absence of evidence. But there were some positives too. The experience, while very different from normal, was not as bad as he expected.

For Dr H, there was an easing of day-to-day pressures – a strange paradox in that, for a period of time, things weren't easier but the usual challenges of day-to-day practice, such as training, service needs, leadership roles, service development, meeting targets, were reduced. Activity was down, lengths of stay in hospital improved and doctors were able to give more of their focus to clinical work. At times, there were some doctors who didn't have a lot to do.

Dr H said, 'Everything stopped. All meetings stopped. A lot of the other activities and other things that would normally put pressure on your time and efforts were not there. So a lot of doctors were able to just purely focus on inpatient care.'

There was a feeling that doctors had more time to put into their activity. 'We found that actually we had time to do the things that we would like to do properly. I guess that you don't normally get in normal work. Towards the tail end [of the spring peak], people were quite happy with that way of working and felt actually, "Could we not just keep this way of going on with things?"'

Having said that, at the beginning of the pandemic, there was huge amounts of guidance and advice to digest. Dr H described, 'My email inbox is overloaded anyway, but during COVID I think it just went crazy... It was almost impossible to keep up and make any sense of it all. Early on I just gave up trying to keep up with things because there was so much stuff flying around.... Every Royal College, every national body had their guidance and everything was very slightly different from what everyone else was saying.'

Another challenge was lack of evidence around how to handle the coronavirus pandemic, for example effective treatments. 'A lot of our practice is based on experience of doing something or on evidence showing that this is the right thing to do. There was literally nothing to use as a comparative for this. Things obviously changed quite often and often quite suddenly... we had to be quite ready to adapt to that and change the way we were doing things.'

In some ways doctors found using their clinical judgements helpful, as they had to use their instincts and experience. Dr H said, 'we've had to make changes really just based on what we feel is the right thing to do. That's not always a bad thing.'

'I think there is probably a little bit more leeway now to say, "Well, we're not sure if this is proven or demonstrated or evidence-based but it certainly feels like the right thing to do, so let's give it a try."

Another challenge he faced was working out who needed a risk assessment. 'For the managers trying to pick out who needed risk assessing wasn't a straight forward thing to do.'

At the peak, there was increased multi-specialty working in COVID-19 and non-COVID-19 areas, which had happened pre-pandemic, but was heightened. Each inpatient ward team had input from every specialty, a regular daily review of patients. There was a collective sense of working as one big team, rather than in their own departments, which was 'refreshing and quite a positive experience.'

Dr H wants to continue this way of working as there appeared to be better patient outcomes. Although with different patient populations and higher activity this might not be possible.

He was impressed with how doctors early in their careers responded 'very well' and really contributed to how the consultants coped – it was 'striking.' He noted, 'They really threw themselves into it, I think maybe because there was no other option. I think they showed a lot of initiative, they went over and above.'

'They came up with ideas and suggestions for how we can improve things. I know a lot of them, obviously, had extended periods in those placements because the rotations didn't happen as planned. So I think they just got on with it. But I think I'm very impressed with how they overall managed.'

Overall, Dr H described how he couldn't use the word enjoy, but that he found the experience of working in the early stages of the pandemic rewarding. 'Being able to have a role in managing what was quite a major challenge and helping to contribute to that effort...it's something I'm certainly keen to continue.'

Dr J – GP experience

Dr J is the senior partner at a two-surgery GP practice. She found the pandemic 'draining and exhausting'... 'strangely different but still busy.'

The doctors in her practice had to quickly change how they worked, with rapid use of telephone and video consulting; and the location where they worked. Home working, and multi-practice based working at hot and cold sites, within a Primary Care Network 'mega-rotas.'

Dr J also had to work out how to protect staff, some of whom were off shielding, considering infection control and availability of PPE, with guidance on safe working changing regularly.

Generally working through this initial phase of the pandemic was tiring just being 'human,' looking at the lack of control around the world, as the virus took hold, and attempting to understand some of the science and the projections. 'We're all members of the public as well as professionals....wondering what will be happening next.'

On a day-to-day basis, everything took much longer to do - using the technology, putting on PPE, measuring temperatures, meeting and greet patients differently. 'It all adds up,' she said.

Although there were fewer face to face consultations, consulting with patients took more time too. 'A normal consultation was split into three – a telephone call explaining the symptoms, an examination in person if needed, then a feedback telephone call with the patients in the car or back at home – but the three 'thirds' added up to longer than the whole.'

Like many GP practices, they had had a long history of difficulty in recruiting new doctors, and were already stretched for manpower. As a result, she says 'we entered this quite tired.'

Before the pandemic, she tended to use newly qualified or recently retired doctors as locums to fill the gaps in the past.

She believes the positive of the pandemic is potentially more young doctors choosing to become salaried GPs, because of the team spirit imbued.

She explains, 'Over the last few years because of challenges in recruitment for leaving GPs, we have been thin on the ground and we try and work as a team, rather than as individuals.'

'There are silver linings in the pandemic. It might mean that people rethink their career plans and think they need to commit to one particular practice rather than going from one place to another. We rely on locums who have their many strengths but their flexibility is to themselves.'

'We filled a post or created a post for one of our former trainees, who's now doing some regular salary work for us, but also going out to do locums in the area. She gets to experience how other practices work. We are happy to be creative.'

Another big shift has been the changing nature of conversations with patients to determine if they need to be seen, not by whom. She says, 'before COVID-19 we had already been doing "what is the problem, who is the right person for you to see? The nurse practitioner rather than the GP?" It was turning it around with COVID-19 thinking actually, "what would we gain by seeing you [at all]?"'

The government's message of only contacting doctors if symptoms were getting worse 'turned everything around.'

She says if that message continues to have force in the months to come, that will be a very novel way of working to most winters.

She is unlikely to see it, though. She had intended to retire in Spring 2020 after three decades in the NHS but postponed her leaving date because of the need during the pandemic and particularly because retired doctors were being asked to come back into the workforce.

'I'm retiring to give myself a breathing space, but watching - and I might well be back if a second wave comes.'

Dr K – 2020 graduate experience

Dr K was due to graduate from medical school on July 7 2020; instead he graduated on April 1, and was given GMC registration 48 hours later. Shortly afterwards he was working in an acute care hospital as a 2020 UK graduate on a three month placement.

Departmental teaching for foundation doctors was cancelled at the hospital and core teaching went virtual. Instead Dr K described how he had the 'steepest of learning curves' on a COVID-19 admissions medical ward, clerking patients.

Despite the lack of formal tuition, he said the hands-on teaching, coupled with support from F1 doctors to consultants, meant that he had the best learning experience possible.

He says, 'I think we are probably the best prepared cohort of F1's there has ever been. I'm going to be a very strong advocate for this role continuing in years to come, even if there isn't a pandemic.'

'I felt supported in that learning, not just dumped in at the deep end and get on with the job.'

He says every patient he saw was then reviewed by a more experienced doctor. 'That is the best learning experience you can have, because you've just seen a patient, you've gone through a series of thought processes in your head, and then you're with a consultant or a registrar, who's perhaps got a little bit more time, who can go through the same thought process as you've had and pick out perhaps where they might have thought something different or changed something.'

Three months on, he has just begun his Foundation 1 placement within the same NHS health board. 'It meant that starting day one on Wednesday, it was just like another day in the office. And that's how I think it should feel after six years of medical school.'

He found that because of the coronavirus (COVID-19) pandemic, there were actually more 'hands on deck' – the registrars who had been doing lab/research work came back to clinical duties; the consultants were doing more telephone clinics and so had more time.

The F1 doctors were particularly helpful to him, answering questions when he got stuck, and preventing him feel out of his depth – which he understood was not the norm.

'We had this amazing safety blanket of having the people who had just done that job for eight months around us, which you don't normally get when you start on day one in August, because they have then moved on to a different job. Although I've never done it the other way around, from my experience speaking to other people, the level of support, even though we were in the middle of a pandemic, was so much greater than it normally is.'

Consultants were supportive, both clinically - with an acute medical consultant on 24 hours a day, seven days a week – and in terms of trainees' welfare. A pre-ward round chat was established, not to discuss clinical matters or handover but to ask how everyone was doing. Some consultants were better than others but the fact that they made that effort was appreciated and novel.

This empathy for trainees may have been generated in part because consultants were having to make decisions on little evidence in stressful situations, bringing back memories of feeling a little out of their depth as trainees themselves. This brought them closer together.

He says, 'I think they were aware of how strange a time it was, and even for them, they were feeling stresses that they perhaps hadn't felt in their careers for a while. Not having clear guidelines on how to make quite important decisions, and actually, some things being a case of, "I've read a few papers that said this has worked, so we're going to try that."

'But perhaps, that made them feel a little bit close to us, maybe, because a lot of the time, we're making decisions that, even though they might be guideline driven, we haven't actually implemented them before, we haven't seen the results, that we feel very out of our depth a lot of the time.'

He felt part of the medical team, being rota-ed, paid and relied upon by the other doctors rather than just a medical student on an apprenticeship on the periphery. The wider team of nurses and allied health professionals worked well with them and everyone looked out for each other.

Dr K, who gone straight from A levels to medical school without travelling, intends to take a pause in his training after Foundation stage 2 because opportunities to travel were cut when his elective was cancelled due to the pandemic.

But his career plans – to become an ENT surgeon - have not changed. He admits that he was considering not going into medicine after medical school because he assumed it was going to be 'very scary and very unsupported' to the point where he was very close to doing a PhD. The reality has been very different. 'I've had a fantastic experience.'

Dr L – Foundation Year 1 experience

Dr L is a Foundation Year 1 doctor who started his intensive care rotation in December 2019. In April 2020, when he should have been moving to his next training post, he was told his rotation would not be changing until August. As he had recent intensive care experience, he has been training other trainees and some consultants during the pandemic.

He described going into the pandemic as facing the unknown, a bit like going into a war – with individual doctors having very different emotions at the outset. He says, 'It's a real mixed bag of stuff that happened, kind of a roller-coaster. Some of them are obviously really frightened. Some of them are a bit excited that this is a big thing that's happening that they're going to be a part of. For me, it was a little bit like that, to be honest.'

His unit benefitted from being well-led already, with the head preparing for the pandemic, buying extra ventilators, and taking control when it landed.

But he says it was still tricky for consultants who went from managing a unit of 15 beds to having patient in three different locations spread across the hospital, with very sick patients in areas that weren't kitted out for intensive care initially. 'That's not easy, and it's really hard to get across what that feels like.'

There were lots of extra doctors brought in to help out but often they had little experience in the specialty. As a result there were many

rota changes, including for consultants who were resident on call at nights, not at home, which made the trainees feel well supported. Consultants generally worked harder and for longer hours. Rather than trainee doctors, it was the nursing roles that the unit was most in need of.

Dr L was transferred from days and some weekends to some nights, which he had not done on the intensive care rotation before. 'It messes with your body clock and everything feels a bit different at night.'

It was 'really distressing' seeing patients either very sick and dying with no family present, and at times, it was emotionally gruelling, with a 'really rough period' when none of the patients were doing well.

He says, 'This was over a period of nights, so I probably was feeling slightly more emotional, because nights make me feel a bit weird sometimes, but certainly, that string of nights, quite a few people died. That was difficult. They're young people...or people who didn't really have very much wrong with them.'

He also found it frightening seeing his medical colleagues becoming sick with COVID-19. 'We had one colleague who got very unwell and had to go to our intensive care...his shoes that he would change into are still sitting in the box. He hasn't come back to work yet, obviously, because he's gone through the whole process of being in intensive care, and being super unwell, and trying to recover. His shoes are still sitting there for the day that he does come back to work, but when will that be? You don't know.'

Dr L took it upon himself to work out of his role, learning nursing work in preparation for when it got busy. As a result he was able to give nurses breaks. 'In the height of this, I found myself doing the range of stuff that in one day, went from helping move patients, cleaning them, flipping, we did proning, helping people clean, doing mouth care, things like that.'

'All this stuff that's super important, and changing syringes, to then being like, "Oh, okay, well now I need to do a central line." That's a big procedure, and what is typically defined as a very, is obviously, it's a bit of a doctor-y thing to do.'

At the same time he was impressed by intensive care nurses also working out of role, stepping up overseeing the huge influx of staff sent into help, teaching and managing patients.

In working outside his role, Dr L said how communications from the GMC were helpful in acknowledging the adaptations people were making. 'The statement we had from GMC saying, "It's going to be tough, and you're going to be working in places where you're not used to, we acknowledge that," I think that was really positive...''

Because he already had experience of the intensive care software, he ran informal surgeries to teach people how to use it, including consultant anaesthetists. He also worked with the simulation (medical education) team running PPE donning and doffing training. 'I ended up teaching 50-odd people one day about how to put on and off the PPE, things like that,' he says.

By the end of the first wave, he admits he was 'fed up' with COVID-19 and has concerns that in a second wave others will be similarly fed up and exhausted.

But generally, he enjoyed the camaraderie between the professions and the 'can do' attitude and hopes these can be maintained in the future. The whole experience has reinforced his desire to become intensive care consultant, and the specialty has greater visibility.

'I think broadly, I've felt very positive that, yes, I'm doing a job that is key to society. It is productive. It is of value, and that's nice. I mean, I don't think you can deny the fact that.'

Dr M – Senior leader experience

Dr M is a senior clinical leader in an acute hospital setting who retains some clinical practice as a consultant. The coronavirus (COVID-19) pandemic has affected the trust root and branch, workloads increasing significantly for certain doctors, and some medical teams struggling.

Prior to the coronavirus (COVID-19) pandemic, Dr M described how he tended to stay in his office developing policy, preferring the governance part of his role. However, his experiences of working during the pandemic led him to make the conscious decision to alter his leadership style, by involving his team of doctors more, becoming more compassionate, and showing understanding.

One of his first steps was to search for any available evidence on good medical leadership. 'I spent a lot of time looking at the ways that people lead through crisis - news articles from the British Medical Journal and others as well.'

Dr M also looked for helpful journal articles, on supporting doctors' physical and mental health. He then sent them out by email to the medical staff. He outlined emphasis in those communications was 'we will get through this together somehow,' and saying 'it's going to be really difficult and if you're afraid, I completely get that, and you're not alone in all this. My door is always open.'

But it was not just about understanding – it was doing, too.

'The wellbeing aspect for me is about listening and showing concern, and meaning concern, being seen to do something.'

'You've got to understand what people are going through really. Someone has to remain level-headed, but it's all right to weep and cry, it's all right to show emotions as well. I've had people coming back saying "Thank you very much, you're leading really well." And I'd think "am I leading well? All I've done is sent out an article." '

He also went on more walk arounds to engage with medical staff. 'I like sitting in the office and working through policies and I like governance and stuff like that. So if I'm really honest, getting out and about isn't always my natural style, but it is something I do try and do, and connect with.'

He says, 'Hopefully I've become a more compassionate leader, and I've taken a lot more trouble to engage with the medical workforce, more than I might've done previously, in terms of just listening to them and trying to understand their world. And I think realising that I might have a view from my ivory tower that actually is completely wrong, and so I've engaged a lot more.'

Dr M explained how the pandemic has 'lit up' problems that have existed for years, leading to clashes between specialties over changes to practice because of the pandemic, due to a lack of written agreements. He is trying to resolve this by facilitating constructive, collaborative discussions.

He has also had to deal with more issues of bullying and harassment – not necessarily because there are more, but because the situation has been so stressful for everyone doctors have emailed him directly, rather than being dealt with lower down. He sees them as requests for help, where once he might have brushed them away. 'Although I might not perceive it to be what they perceive it to be, I've realised that the leadership ask is just to show support for all sides in this disputes, as well and try and get them to work together.'

The executive team helped each other too. 'During COVID it's just bonded us together even more really. There were times when we got exhausted and occasionally we got a bit fractious. But we were checking in on each other and saying "Look, you look like you've had a really hard day, what can I do to support you?"'

All the changes he sees as permanent. 'I didn't think I was achieving very much because I wasn't on the front-line and a lot of my time was spent trying to sort out PPE and other stuff like that, but I got a really good reception actually.'

'I did get quite a few plaudits from people. And somewhat surprisingly, probably colleagues who didn't align to my way of thinking in a medical director, who I might've said something to in the past and said, "Well actually, no, I don't agree."

'I don't intend going back to the old ways, either.'

Dr N – Personal protective equipment

Dr N is a consultant who worked in different departments during the first wave of the pandemic. They described being particularly worried about a lack of personal protective equipment (PPE) in certain specialties, ill-fitting PPE and a lack of COVID-19 tests for patients. They were also highly concerned about the disproportionate impact COVID-19 was having on BME healthcare workers.

Initially, a lot of PPE resources went to Intensive Care because it was thought that's where the sickest and most contagious patients would be. Eventually, face masks and other PPE filtered through to further departments.

Dr N noted, 'initially nobody in the hospital was wearing face masks. Even at the height of the epidemic [pandemic] in the wards nobody was, and if you're not in actual theatre working with a patient, just walking through, nobody was wearing face masks.'

'The only place that face masks were mandatory, and this is just then normal surgical face masks, was intensive care. If you went into a room or ward where there was somebody who was known to be COVID-19 positive, then you put your PPE on. All of that has changed. Face masks have been a really late addition in the NHS.'

At one stage, Dr N was working in another unit, which wasn't considered a COVID-19 'receiving unit' – even though people were coming in off the street – so, in Dr N's opinion, they weren't given sufficient PPE. This was compounded by a lack of COVID-19 tests, so it wasn't known if patients were positive or negative.

Even if doctors had a mask, some did not fit. When that happened, not everyone had the option to get a respirator mask. 'Lots of people went through with ill-fitting masks for a long time until the respirators became available,' Dr N said. Dr N also felt that PPE not fitting was more problematic for black and minority ethnic (BME) staff.

Dr N said that 'Initially, because the tests were not readily available anywhere in the country, we couldn't swab everybody coming in. We only had to swab symptomatic patients.' So, it was harder for doctors to know who had COVID-19 and who didn't. As a result, they worked as if all patients were positive for COVID-19, but they didn't really have enough PPE to support that.

Dr N said generally everyone felt scared and confused. As a minority doctor, Dr N was 'absolutely petrified' but made a decision to get on with it. 'I said, "Look, I've still got to go work. One of three things will happen: I won't get it, I'll get it and I'll live, and I'll get it and I'll die." You had to come to terms with that.'

Towards the beginning of the pandemic, the hospital set up a wellbeing room and a drop-in centre when they realised how stressed people were. Dr N said, 'I made an appointment to see one of the psychologists because there was a point where things were really grim. I decided this is not working.

'I went in and I made use of it, but the follow-up is quite difficult. Yes, you can go talk to somebody but what do you say after that? The follow-up needs a bit better because it's still left in the same situation with the same people and there's nowhere, really, to go.'

Dr N didn't want to discuss their work with non-medical friends. 'The last thing you want to do is to be that person who goes on and on and on. If things are bad, you just don't want to be that person.'

Dr N described that their colleagues think the gratitude shown towards the NHS would be temporary – 'I think ordinary people...realised that they were protected from the things that we were going into. I think that they felt plenty grateful for that. I remember one of the people I work with, she was like, "Yeah, this isn't going to last long." She said, "They'll be coming in and swearing at me soon."'

Dr N is hopeful about the preparedness for the second peak, though. 'If we need to go and upscale again, and have more people on, we've already got the kit. We've already had the practice. So I think it will be better this time around.'

What of the future? Dr N said 'I hope that we take the positives out of this. The way that we work together and come together and realise that we're stronger together. I hope that the Government will realise what we're worth.'

Dr R – Trainee experience

Dr R was pausing her training in a non-clinical role when the pandemic began. She volunteered to return to clinical work and was appointed a medical registrar on an admissions unit.

Dr R amalgamated all the COVID-19 guidelines from the World Health Organization, NICE, and the government sources into a PowerPoint pack because she wanted it to learn for herself but realised it might help others.

With consultant/Clinical Director blessing, she updated doctors and other staff groups and then did the same with national ITU audit data.

She says, 'I wanted to learn about it anyway. I spoke to the consultant that designed the COVID service we were going to run...."I've got this idea, I've made this PowerPoint for myself, shall I deliver it to everybody else, do you think it would be useful?" '

She then did the same for putting on and taking off PPE safely, which was carried out face to face but socially distanced, and also by video.

Due to redeployment, consultant gynaecologists, dermatologists, ophthalmologists, and other specialties were concerned about being moved to the frontline and wanted COVID-19 training. She says. 'They were quite concerned about the role they may have to perform if redeployed, and wanted upskilling in procedures they may not

have had for a long time. As well as skills training they were keen for teaching about COVID itself.... I've been delivering that same talk to nurses, healthcare assistants, porters and caterers.'

Technology was a huge enabler, with Zoom sessions held for the redeployed staff. For example in one session a respiratory registrar taught how to interpret an X ray, which was recorded for later use, accessed via a link on WhatsApp, so people who were shielding or on nights could watch them and see the associated slides at home too.

The team then did the same for the ARCPs and clinical reflections. While virtual teaching is not ideal, she says there are other pluses such as flexibility so people could watch them at home. She says, 'I set up loads of Zoom meetings for the ARCPs, so all of the F1s and F2s could have their meetings.

'The other day we had a clinical reflection where ITU and medicine hosted a "what have we all learned", and you could patch in via Teams. This was also recorded and put on Microsoft Teams so all could access it.'

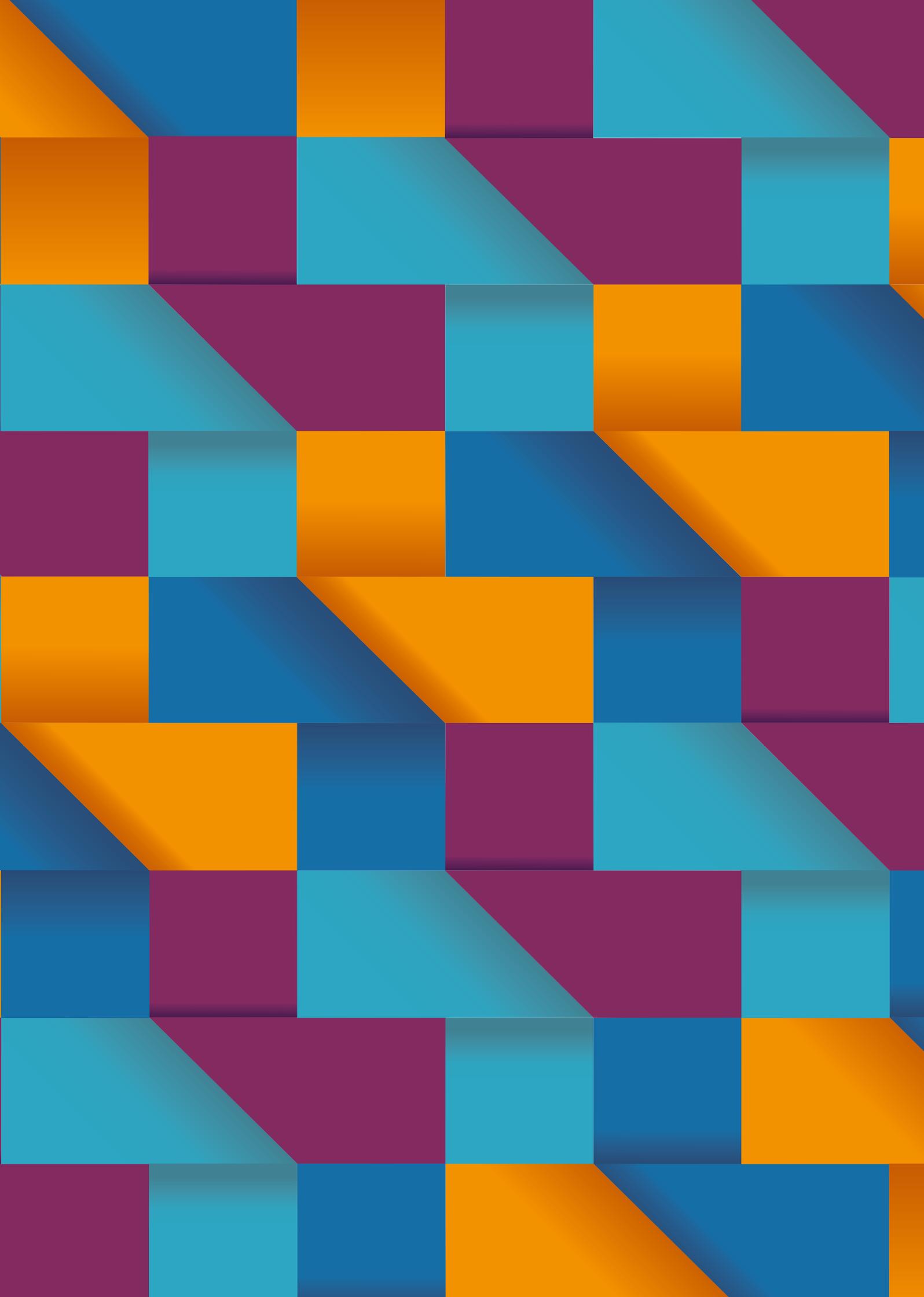
Another enabler was WhatsApp. At the beginning of the year she set up a WhatsApp group so that doctors in training could communicate with each other, especially helpful for people new to the area. This came into its own during the pandemic, with trainees feeling they had a level of control over events. She became a central point of contact, or a conduit, to ask questions which could be relayed up the chain, and to send out information down the chain.

She says, 'All of the juniors had one point of contact that was me.... I could either immediately reply because I knew the answer because I'd been in lots of the meetings, or I could then go and get the information from the different consultants and then they weren't being barraged with "what's going on?" Because I wasn't being clinical when I wasn't on call, I had the time and the capacity to soak that up and not overwhelm me. I became was the middle man for everything that was going on.'

Trainees liked it as they were having their questions answered. 'They had ownership over some of the changes that were happening to them, and they weren't just left in limbo for ages.'

She relished the experience and learnt more about medical leadership than if she had completed the whole year's course, but still wants to be a geriatrician.

'Is there a better time to learn about medical leadership than in the midst of a pandemic?' she asks. 'I feel like I've learned a lot actually, and I feel like being in this role has enabled me to do more leadership than I think I probably would have, had COVID not happened, and I think it was really lucky that I happened to be doing this job at this time.'



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