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On the Front Line

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An NHS Doctor's Lived Experience of Burnout during the First Wave of Covid-19

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Abstract

This article offers the lived experiences of an NHS doctor working on the front line in an English NHS Trust during the first wave of the Covid-19 pandemic. The overall aim of the article is to offer a context-specific perspective on the employee experience of burnout by drawing out the interplay of organisational and external/socio-political factors during an atypical time. The narrative also highlights an as yet unexplored pattern of burnout with active maintenance of professional efficacy as the starting point which then interacts with high levels of work intensification prevalent in the NHS, leading to the coping mechanisms of depersonalisation and detachment. Existing research has predominantly focused on how/why employees experience burnout at the organisational level of analysis, leaving a gap in the literature on how external/socio-political *and* time contexts may impact employee burnout.

Keywords

burnout, Covid-19, NHS, pandemic, professional efficacy

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Introduction

This personal account of Dr Elizabeth Waterson's work on the front line in an English NHS Trust during the first wave of the Covid-19 pandemic, including her contracting the virus, aims to highlight the unique manifestation of burnout during atypical times. Job burnout refers to mental, emotional and physical exhaustion (Cordes and Dougherty, 1993) and is seen less as a medical condition and more as a syndrome specifically tied to occupational stressors (World Health Organization (WHO), 2019). This emphasis on job-related stress distinguishes burnout from the more meta-category of stress and emphasises specific types/patterns of stress that arise in response to high levels of uncertainty or because highly significant work outcomes are at stake (Cordes and Dougherty, 1993). Burnout is commonly conceptualised through three key components: emotional exhaustion and energy depletion, depersonalisation and increased mental distance from one's job, as well as diminished professional efficacy, including reduced employee expectations from the organisation (Cordes and Dougherty, 1993; Maslach, 1998; Maslach and Jackson, 1981; WHO, 2019). Extant research has effectively highlighted how burnout has serious, long-term consequences such as depleted energy levels (Deery et al., 2011), loss of creativity and commitment (Cordes and Dougherty, 1993; Moore, 2000), disengagement (Schaufeli and Bakker, 2004), absenteeism (Firth and Britton, 1989), and decline in job performance (Maslach and Jackson, 1981). In this article Dr Waterson's lived experience is mobilised to extend burnout research in two key ways.

Burnout is highlighted as being intrinsically tied to context, which requires going beyond the oft-considered organisational context, to also consider socio-political narratives and time. Much of the extant burnout literature predominantly focuses on the organisational level of analysis, highlighting the implications of different occupational and/or workplace contexts, organisational policies and the nature of work on burnout (Castanheira and Chambel, 2010; Deery et al., 2011; Fan et al., 2014; WHO, 2019). Some research has explored the impact of extra-organisational shocks such as financial uncertainty, market collapses, and weak labour markets on employee experience of burnout (Hyman et al., 2005; Strauss-Kahn, 2020). However, it is argued here that a much broader range of socio-political factors such as changes in public policy, the degree of governmental support/lack thereof for the employer, public opinion and so on may also impact employee experience of burnout.

An emphasis on context specificity also necessitates an explicit acknowledgement of time, since both organisational policies and environmental factors are rarely static over time. Given this theoretical objective, an NHS frontline employee's experience of burnout, specifically during the first wave of the Covid-19 pandemic in the UK (that is, the March–July 2020 period – Davillas and Jones, 2021), is uniquely suited to simultaneously exploring organisational, environmental *and* time contexts. Therefore, this first-person account highlights the specific organisational backdrop of the NHS, which is typified by high workloads, funding pressures, shortages of essential equipment and supplies, high levels of burnout, and secondary traumatic stress (British Medical Association (BMA), 2020; McKinley et al., 2020; Montgomery et al., 2019), as well as a multi-dimensional experience of work intensification (Granter et al., 2019), even pre-pandemic.

Additionally, the specific environmental and time context of the pandemic's first wave, characterised by a lack of understanding of the virus itself, and slow governmental response is explored. Differential organisational practices, the rapid spread of the virus and high death rates, alongside severe shortages of personal protective equipment (PPE) for medical staff and inadequate acute/intensive care facilities (Costello, 2020; Krishna, 2020; Lovett, 2021; The Guardian, 2021) are also investigated. Most notably in the first wave of Covid-19 in the UK, there was no available vaccine, and people were entering lockdown for the first time. There were no previous wave reference points or previous learnings from the NHS context specifically, as the virus began to spread around the world.

A second theoretical objective of this article is to highlight a previously unexplored *pattern of burnout.* Burnout research highlights that all three components (highlighted in the definition) are distinctive (Cordes and Dougherty, 1993) and interact with each other to create varied patterns of burnout. For example, research has shown that emotional exhaustion because of excessive work demands can lead to depersonalisation as a coping mechanism which, in turn, may result in feelings of professional inadequacy and reduced professional efficacy (Leiter and Maslach, 1988). Golembiewski (1989) highlighted an alternative pattern whereby high levels of depersonalisation reduce personal/professional efficacy, which in turn may induce emotional exhaustion. We contend that rather than adopting extant work's treatment of reduced professional efficacy as an *outcome* of job burnout (Greenglass et al., 2003; Hsieh and Chao, 2004; Jung and Kim, 2012), professional efficacy should instead be reconceptualised as a key factor in the *process* of burnout itself (Handy, 1988; Leiter, 1992).

Dr Waterson's account highlights a distinctive and previously unconsidered pattern of burnout whereby active preservation/maintenance of professional efficacy was in fact the starting point of her experience of burnout. This maintenance of, rather than reduction in, professional efficacy necessitates a more expansive re-conceptualisation of this particular dimension of burnout. Professional efficacy has been defined as 'a sense of professional accomplishment and competence' which diminishes because of burnout, thus reducing employees' ability to perform their job tasks, negatively impacting perceptions of their own role performance and productivity, and engendering feelings of personal deficiency (Greenglass et al., 2003: 582). This emphasis on *reduced* professional efficacy within the Maslach Burnout Inventory (MBI) (Maslach, 1998; Maslach and Jackson, 1981), considered the gold standard of burnout research, is problematic because it does not account for broader 'social and non-social aspects of professional accomplishment' (Bresó et al., 2007: 462). Therefore, the extant literature fails to recognise how in certain work contexts, such as those characterised by highly significant work outcomes like the loss of/preservation of human life, a strong professional identity, and the application of a moral code at work, there may be active preservation/maintenance of professional efficacy.

The first section below highlights the specific context of Dr Waterson's experience of burnout – with organisational factors such as longer working hours, changes in job roles, different shift patterns and work procedures, intra-organisational differentials (between an acute unit and palliative care), and difficulty in establishing rapport with patients and families, interacting with environmental factors (that is, delayed/inconsistent

governmental response, inadequate provision of PPE and testing and, low public compliance during lockdowns). This multi-dimensional context of burnout is embedded within the specific time context of the first wave of the Covid-19 pandemic in the UK. The second section highlights Dr Waterson's unique pattern of burnout with active maintenance of professional efficacy as the starting point, which then interacted with work intensification involving both high emotional intensity, given the uncertainty surrounding the virus, and organisational intensity of changed work processes and longer work hours (Granter et al., 2019), to induce depersonalisation and detachment as a coping mechanism.

Factors affecting burnout – A context-based narrative

I'm a junior doctor. I'd been interested in medicine since I was a child. My parents were also keen for me to be a doctor but I wanted to do other stuff. So, I did a different undergraduate degree and then a post-grad in another area. Eventually I did medicine. . . . I qualified more than five years ago, and I've been working in this NHS Trust since then. I'm on a rotational job, so I swap jobs every six months and work in different departments.

At the start of the pandemic I was working in the acute medical unit, but then rotated in the middle of it so I now work in a hospice with palliative patients. But even after my rotation, I continued to do some locum shifts in my free time on the acute medical unit. We are only contracted for a certain number of hours. The European working regulations are set to 48 hours a week so, they couldn't break that. You can only break that by volunteering to do locum shifts. So, I did a few extras – quite a lot of people took on locum shifts wherever they could. I didn't feel forced into it at all . . . I did feel morally that I should make an effort to try and do more shifts because they were desperately short of staff as people started getting sick at a higher rate. But annual leave got cancelled. Shift patterns changed . . . lots of people were redeployed. Differences (from a normal working day) are. . . we have different assessments for the way we assess patients, shortened forms. We have different admissions criteria. We're Covid testing all patients when they arrive. We have limitations on visitors. We have much less staff in the department, because a lot of people are now working from home. We wear scrubs instead of normal clothes. Meetings and things are now at least two metres apart and we have people joining in via Zoom. The communication we've had from the General Medical Council about . . . exams and how things will change within GP practice and stuff suggests that we're still going to have significant differences in how we work for another year at least.

While working in the main hospital in my original department I felt supported and everybody was making a massive effort. But the job I moved into, where I work currently, I felt they were behind in following government advice . . . basically we were being told not to use PPE. They just kept saying, oh the nurses will get scared if you wear the PPE, because then they'll think they've got to wear it. And I was like, well I think they should be wearing it, the government says so. I just couldn't understand it. I sought advice from the Royal College of GPs, I sought advice from the British Medical Association about it, and they all came back with the same response. . . you should be wearing PPE, I don't know why you're being told specifically not to. I ended up getting so stressed I (had to) stay off work for a couple of weeks.

I don't know whether it was misinterpretation or whether it was financial. Their funding is different, therefore, they have to pay for all their masks and all that kind of stuff because they kept going on about that it's expensive. But I was dreading going into work when we had the issues of not having the PPE. I definitely felt unsafe. There were eight ward doctors in that department and six had been ill with Covid, two having (had to) go to hospital. Yet you're all sharing offices, sharing computers with no PPE. I got extremely stressed about that, and it tipped my mental health into a very bad place. I'd already been off sick (with Covid-19) so my fear was not of getting it again, because I'd already had it. . . (but) I found it difficult because nobody really had the balls to say anything. I tried to escalate the issue following the appropriate channels and I got lots of different answers and some conflict back at me and I actually got quite worried about it. My fear was, if nobody's wearing PPE, we're potentially spreading it to patients, to family that's still visiting. That felt unsafe and morally and ethically wrong. I became so stressed I even phoned the British Medical Association helpline to talk it through with somebody independent from work or home. I didn't find (that conversation) very helpful though.

Also, once we were in the masks that was really hard . . . it can be difficult communicating and establishing rapport or trust. We had for example in my department, a patient at the end of his life who was deaf, and could only lip read. He found it very difficult to read as well, so, holding up sign boards wouldn't work. It's even hard to talk to (other) staff when all you can see is their eyes, because you take a lot stuff from facial expression. Trying to get across empathy and understanding using only your eyes while you're wearing goggles. It is really hard to gain any kind of trust. (Also) we talked through. . . potentially stressful. . . scenarios. . . Like if somebody had a cardiac arrest, what do you do, do you go and treat them, or do you run off and get your PPE.

I think the government generally responded in the right direction. They talked to the right people and tried to get scientific answers. But I think the messages – how they communicated with the public wasn't particularly good or consistent. So, everybody just became confused and when people become confused they just go, f*** it! I'm also not convinced the general public really ever understood what 'flattening the curve' meant. As people started to come out and break the lockdown, yeah, of course it made us irritated and annoyed and frustrated that people weren't taking it seriously. Because you would be in hospital seeing patients really suffering and people being really sick and knowing that there's a lot of people outside just not taking it seriously. There'll be these traumatic shifts and traumatic deaths and people not being able to see their loved ones as they passed away . . . and then there were people sitting on the beach.

Ultimately, I'll blame (the government) for leading our country into this. I think they were slow on isolating people coming into the country. I don't understand why throughout the whole spike. . . March, April we were still having airplanes land from all over the world and nobody was being quarantined. The NHS did planning exercises a couple of years ago and suggested we need this amount of PPE etc. Yet the government ignored that, and only bought some of the stuff and didn't buy the rest, and then we were short. Well, of course we were going to be short! So, that was really frustrating. There was also an awful lot of chat about testing . . . but the reality was very different from what they were announcing. Mistakes were made . . . we didn't buy the tests, we didn't have them, so you can't use something if you haven't got it! Then they said, oh yeah, now ALL

frontline staff are being tested. In our hospital we've got so many people. . . that includes porters, nurses, catering. . . (only) 20 staff per day were being tested to begin with. In my department that meant three members of staff per day . . . out of hundreds. They were dropping headlines saying, we're up to a hundred thousand tests per day. Now I knew that wasn't true, because a close friend of mine was working on the test roll-out for the government at the time. So, I had a bit of behind-the-scenes knowledge and how they were fudging the numbers on postal testing and things like that.

There was so much funding suddenly released for the NHS which you could be cynical about, because they've been withholding it for years and saying they didn't have it. I also got bored of watching press conferences. To begin with I really liked them, there was sense coming out of them. Then things start just going all over the place and you could see it was becoming more political than scientific-based. I just felt kind of helpless, frustrated. . . that everybody's arguing about all these different points. And in the end, I can't really do anything about it. So, for my own sanity and my own mental health and stress levels, it was a case for me of withdrawing. Because I can't change, in my level and my grade and my job, I can't change what they're going to do. All I can do is do my job and deal with what comes next.

Maintenance of professional efficacy and Dr Waterson's pattern of burnout

The pandemic doesn't make me regret being a doctor. The government's attitude towards the NHS. . .has made me question my career choice many times, but that was pre-Covid as well. Ultimately, we're all within our rights to not go to work if we don't want to . . . because we're scared. But I don't think any of us would do that. We all came into healthcare because we wanted to help people and so. . .you have to get on with it. . . (you've) got to have a professional face. So right now, I'm more irritable and impatient than I would have been before . . . but more so after work. At work I wouldn't let that happen. I don't get stressed or overwhelmed that often at work. I feel more stress when I'm at home, not related to home-life, but generally because I'm thinking about work then. When I'm at work I get on with it, it's only once I reflect afterwards that I can get quite stressed. I've always been very different around patients. I can be really low, irritable. . . around anybody, but if I'm put in front of a patient that I think actually needs looking at, I'm a very different person. I can have the patience of a saint around patients. When you join the NHS, you sign up to keep other people safe. I guess as a healthcare professional. . . *we're* not superheroes, but. . . the NHS is a bit of a superhero itself.

Working during the lockdown . . . I was relieved to begin with, before I was ill, because it gave me a sense of normality. I was still getting up and going to work. I enjoyed the fact that I had a job, you know I was a key worker, that I could try and make a difference. It feels nice when you were working really hard and you think. . . people are appreciating us . . . and recognise that our job is quite valuable. But, nothing's changed though. You did your job before, and you do your job now. Yes, our risk has gone up of being ill. But then, be it police, fire fighters, healthcare, armed forces we've always been at risk of diseases or injuries from work anyway.

There was so much change that had to happen so quickly that Covid just kind of took over. Things changed so quickly from one week to another, sometimes one day to another, so it was literally just work, sleep, work, sleep. And in the back of your mind you are just waiting – oh God is the next shift going to be the one where we're completely overwhelmed and completely flooded with patients. So, yeah, there was definitely anxiety and fear of the unknown before going into work sometimes. The patients and the staff . . . everybody has just got this level of fear and not understanding the complications that go with this illness. I think everybody's on edge. We've all got a background level of anxiety that's higher than what it would have been. Having to be professional, being at work longer, things being more intensive, generally more emotional. I've had to have more difficult conversations with patients, relatives and families. . . like, I'm sorry, you cannot come and see your dying mother because you're only allowed one visitor and that's the next of kin and that's your father, so you can't come. Or in the early days when nobody could come in the hospitals at all. It's difficult trying to explain why somebody who was very well, is suddenly very sick. Because it's not like they know they've had an accident or they. . . have cancer. It's a new disease and new circumstances.

People are looking for someone to blame. . . so those conversations have been more difficult, because you're carrying a lot more of other people's anxieties a lot more of the time. Somebody would come into the acute hospital just slightly unwell, they'd be admitted with something non-Covid related, but the chances were they were going to potentially catch Covid and die very quickly if they did catch it. So, you're now trying to have a conversation with a patient and a family about, have you thought about dying? No, I'm 54, I'm 55, I've no thoughts of dying yet! Well, sorry but we're going to have to have that conversation now, because you're not going to have any relatives visiting you, you might get it and then you might die. So, then you try to encourage sensible conversations with family (of patients) about do they want to be on a ventilator, is there a will, have they written one, do they want a funeral, do they want to be buried or cremated? Trying to broach this with family and friends (of patients) is difficult. They're all appreciative of it in the end, because they're useful conversations, but it is stressful. These kind of things weigh on your shoulders quite a bit.

During the entire time there was also a sense of inevitability. I think we (medical staff) all just assumed that we were going to get it because you can't do social distancing at work in the hospital. You'll always be within two metres of somebody for more than 10 minutes. And if one person's got it, it spreads quite rapidly. So, in my department, of maybe about 60 of us, there was at least one person every couple of days having to go off and isolate. You obviously also think. . . oh God if they're sick, I was at work with them on their last shift, am I going to get it now kind of thing. So, we would just mutter our risk factors at each other. Well, I'm not diabetic, well I'm not this and not that, hopefully I'll be fine. It was like weighing up a probability, like you would with a patient. . . of risks, of. . . are they coming back, are they not? Through it all we just tried to keep each other buoyant with a lot of humour and videos and memes and dark humour and silly jokes.

Certainly, at the start, maybe a little less now though, it was very hard to switch off. Work became everything. Then sleeping in order to be ready for work again. Also dealing with the higher intensity and the worry. You get more tired and then getting Covid itself, that wiped me out for weeks. My mood's just flattened. I haven't done any exercise

since the lockdown. I'm either at work or in my spare time I was doing locums. Then once I was ill (with Covid-19) . . . it took me a long time to get over the fatigue from being ill. I've just lost the motivation to exercise and yeah, I eat a lot of sweets and chocolate as reward. So yes, I've put on weight. I've become more unhealthy. I also sleep worse than I used to. I don't know why, because I don't know that I'm particularly stressed but yeah, I sleep worse and I'm more tired now.

Because things are possibly a bit more intense at the moment, and therefore, I think about work stuff more so yeah, I've had to switch off from reading up about Covid constantly. I had become quite obsessive about that, especially when I was ill. I've switched off now. Before all of this I would have been on the phone quite a lot to friends and enjoyed video chats and stuff like that. I haven't phoned that many people. I've found now, I actively avoid it. I just try and protect myself more and commit to social things and stuff less. I don't really know why, but I just find it all a bit much, all a bit intense. Maybe I've withdrawn, I don't know.

Conclusion

Our context-based narrative of employee burnout highlights the inadequacy of the extant burnout literature's predominant emphasis on the organisational level of analysis, underlining the need for a more multi-dimensional consideration of the organisational, external/socio-political *and* time contexts. This more expansive approach to the context of burnout will be of relevance for a range of employees (such as healthcare, social care, local government, police force, firefighters and so on) whose work is heavily impacted by extra-organisational factors like changes in national policy, perceived lack of governmental support/funding, and unfavourable public opinion about their employing organisation. Additionally, this account also helps us consider burnout in the context of atypical, uncontrollable and fast-paced external shocks such as pandemics, recessions, natural disasters and so on. Furthermore, the unique pattern of burnout that emerged from this account which emphasised a maintenance of, rather than reduction in, professional efficacy signals the need to reconceptualise the dimension of professional efficacy as more than just an outcome of burnout (Greenglass et al., 2003; Hsieh and Chao, 2004; Jung and Kim, 2012). Crucially, this distinctive pattern of burnout is likely to be of relevance for other 'helping professions' or jobs involving 'people work', such as healthcare professionals, solicitors, teachers, and social workers (Cordes and Dougherty, 1993: 622) where employees may also actively seek to maintain professional efficacy.

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