BMA

Over-exposed and under-protected: the long-term impact of COVID-19 on doctors

British Medical Association
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About the paper

A significant number of doctors and other healthcare workers have developed post-acute COVID, including a large number who developed it as a result of workplace exposure to COVID-19. This paper examines the impact post-acute COVID symptoms have had on the medical workforce, personally and professionally. It provides a unique and valuable insight into the experience of UK doctors suffering from post-acute COVID.

It has been informed by a UK survey of over 600 doctors suffering from the continuing effects of an infection with COVID-19, as well as wider research of the issues. The survey was undertaken by the BMA in partnership with Long COVID Doctors for Action. This is the first comprehensive survey of doctors with post-acute COVID health complications.

This paper should inform the support needed by current sufferers of post-acute COVID in the NHS workforce, and help protect services and patients now and in the future.

Executive summary

The debilitating effects of post-acute COVID have had significant impacts on doctors, both professionally and personally. Post-acute COVID affects the lives of doctors. It is also leading to a loss of health service staff and continues to put health service delivery and patient safety at risk.

For the purposes of this report, post-acute COVID refers to the signs and symptoms that continue or develop after acute COVID-19. It includes both ongoing symptomatic COVID-19 (from 4 to 12 weeks) and post COVID-19 syndrome (12 weeks or more). This is consistent with NICE and ONS definition of long-COVID.

Carrying out essential daily activities such as getting dressed, household activities and childcare has become difficult or not possible for as many as 60% of the doctors with post-acute COVID responding to our survey, leading to greater dependence on others such as family and friends.

The impact on doctors' ability to work is considerable and devasting, with nearly 1 in 5 responding doctors left unable to work and many having to significantly reduce their hours, contributing to the loss of UK health service staff at a time when we can least afford it.

Post-acute COVID has also resulted in significant financial penalties and insecurity for doctors suffering from post-acute COVID, with nearly half (49%) of responding doctors experiencing decreased (or even no) income, requiring those with savings to use them to make ends meet and increased personal debt.

A lack of preparedness for a pandemic, and poor prevention and risk management in health services contributed to many doctors contracting COVID-19 at work. This was particularly the case during the first wave of the pandemic and before the first vaccine was launched – something UK Governments should learn from to prepare appropriately for future events. However, the risk that doctors faced (and continue to face) whilst carrying out their crucial role during the pandemic is still not fully recognised nor compensated for by UK Governments.

The UK needs to urgently recognise post-acute COVID – and all of its symptoms – as an occupational disease to help doctors and healthcare workers receive the support and financial aid they need. In addition, to quickly support those doctors and healthcare workers who have experienced financial loss as a result of developing post-acute COVID, UK Government should urgently work to develop and implement an appropriate package of financial support to compensate for loss of earnings of those who are unable to work/ work full time.

Additional effort needs to be made to help doctors access the clinical treatment they need. Access to NHS COVID clinics for treatment is inconsistent and multidisciplinary care must be better linked up to provide both the physical and mental health treatment many sufferers need.

More must also be done to support doctors with post-acute COVID to return to work in a way that is safe for them and for patients. Access to support, such as phased returns and occupational health assessments, is varied and often not available at all. Worryingly in some cases, doctors report having to continue to work whilst still very unwell, leading to fears of making a medical error.

Doctors managing the uncertain and sometimes debilitating effects of post-acute COVID, as a result of workplace exposure to COVID-19, cannot be forgotten. During the pandemic doctors put their lives on the line for us. In carrying out their vital roles during the pandemic, doctors were often exposed to unnecessary risk and, as our study has found, often without adequate protection. This should widely be recognised and compensated for.

Importantly, doctors and healthcare workers still face the risk of infection from COVID-19 and developing post-acute COVID now. They and their colleagues need effective mitigation of occupational risk to ensure that they will not continue to be put in harm's way again. Otherwise, this country risks losing even more – already scarce – doctors.

What we want

The lives of many doctors have been significantly impacted by contracting COVID-19, with a large number of these doctors contracting it whilst doing their jobs during the pandemic. Therefore, the BMA is calling for:

- Financial support for doctors and healthcare staff with post-acute COVID
- Post-acute COVID to be recognised as an occupational disease in healthcare workers, with a definition that covers all of the debilitating symptoms that people with post-acute covid experience
- Improved access to physical and mental health services to aid comprehensive assessment, appropriate investigations and treatment
- Greater workplace protection for healthcare staff risking their lives for others
- Better support for post-acute COVID sufferers to return to work safely, including a flexible approach to the use of workplace adjustments

These actions are developed further through specific recommendations.

Recommendations

Recommendation 1: The Department of Work and Pensions must act without delay on current IIAC (Industrial Injuries Advisory Council) recommendations for the specific circumstances where Long COVID should be recognised as an occupational disease for healthcare workers. Alongside this, there must be investment in research to support the additional designation as an occupational disease of the broader range of post-acute COVID symptoms this report shows are highly prevalent among sufferers.

Recommendation 2: UK Government must urgently develop a package of financial support for doctors and healthcare workers with post-acute COVID.

Recommendation 3: Health and Safety Executive must provide clear guidance to health service employers on the legal requirements to carry out risk assessments and report instances of infection under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations).

Recommendation 4: The Department of Health and Social Care must ensure funding is allocated for appropriate PPE (Personal Protective Equipment) and RPE (Respiratory Protective Equipment) in health and care services to ensure staff are protected.

Recommendation 5: UK health services must increase access and improve waiting times to post-acute COVID care such as NHS COVID clinics.

Recommendation 6: UK health services must ensure care for those with post-acute COVID, such as that delivered through NHS COVID clinics, is multidisciplinary and offers access to both physical and mental healthcare.

Recommendation 7: Health education bodies across the UK must fund increased occupational medicine training posts.

Recommendation 8: UK health service employers must prioritise timely access to occupational health services and assessments for staff with post-acute COVID.

Recommendation 9: UK health service employers must promote greater awareness amongst managers of the needs of staff with post-acute COVID and support measures required.

Recommendation 10: UK governments and health systems must ensure health service estates are safe for staff and that the risk of infection from infectious diseases, like COVID-19, is reduced, including ensuring improved and appropriate ventilation.

The impact of post-acute COVID on doctors' lives has been far reaching

Persistent health complications resulting from post-acute COVID have had a significant impact on doctors' lives both professionally and personally.

Doctors and other healthcare workers are a group that is disproportionately impacted by post-acute COVID as a result of their occupational exposure. ONS data has consistently reported higher prevalence of long COVID in those working in healthcare compared with the general population,[1] as has previous research in the field.[2]

Although many doctors have reported recovering from their post-acute COVID symptoms, there is a significant proportion of doctors who are continuing to experience ongoing symptoms and recurring health complications, impacting their lives profoundly.

Daily tasks have become a struggle

Many doctors now find their ability to carry out day-to-day tasks, such as dressing themselves and even counting loose change, has been impaired, sometimes severely.[3] Around 60% of doctors responding to our survey told the BMA that post-acute COVID ill health impacts on their ability to carry out day-to-day activities on a regular basis and over a third (35%) of doctors told us that their ill health has had a negative impact on their social lives, including their ability to continue with hobbies.

> 'My ability to tolerate any kind of exertion is significantly affected – I get postural and inappropriate tachycardia/shortness of breath symptoms with simple activities like dressing, rolling over in bed, doing my hair etc. I have become very weak compared to previous and struggle with many household activities (doing bins, laundry etc). Due to cognitive symptoms I often struggle with following many step recipes/instructions.'
> **Junior doctor**

> 'I used to be the sporty person dragging my partner out, enjoying long cycles and running – I cannot do that anymore. I used to enjoy reading multiple. Books [sic] on the go and being on the go, but I can't do this anymore. My life has shrunk and I grieve for this.'
> **Junior doctor**

The reduced ability to carry out daily tasks not only impacts doctors but extends to others around them, such as family members. For example, being unable to care for their children and leaving the caring responsibilities and household chores to their partners or extended family due to exhaustion and disability.

> 'I am unable to carry out most activities of daily living and my children are having to help me around the house. I am almost housebound, and have had to buy a mobility scooter for the few occasions that I am well enough to get out. For the last 6 weeks I have been relying on family members to help me look after my children.'
> **Consultant**

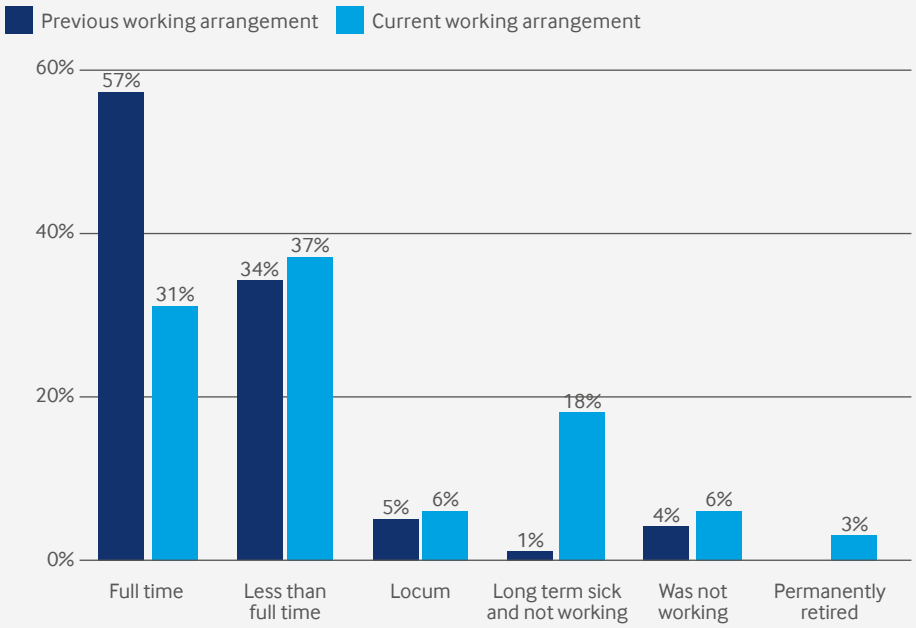
> 'My partner is burning out trying to keep us going.'
> **GP trainee**

Doctors' ability to work and train has been affected

The debilitating effects of post-acute COVID have left many doctors unable to work and suffering, representing an important loss to the health service workforce. This comes on top of and is exacerbating the severe workforce crisis the NHS was already experiencing before the pandemic, with the NHS across the UK continually having a high number of unfulfilled vacancies (e.g. as of March 2023 England had over 8,549 medical vacancies) and the number of doctors relative to our population significantly lower than international averages. For example, the average number of doctors per 1,000 people in OECD EU nations is 3.7, but England has just 2.9.[4]

Almost 1 in every 5 doctors (18%) responding to the BMA survey reported that they were now unable to work due to their post-acute COVID ill-health. There has also been a reduction in the number of doctors that are working full-time (31% of respondents now work full-time, down from 57% before their infection).

Working arrangements of respondents at the time of and since acute Covid-19



> 'I can barely work at all. I only do 8 hours [a week] as that is all I feel well enough to do. And most of that is telephone consulting. It's devastating.'
>
> **Locum GP**

Many doctors working in UK health services are in post-graduate medical training posts. For example, medical graduates undergoing their foundation training, or doctors continuing training in either a specialist area of medicine or in general practice. However, many doctors in training posts have been unable to work to the extent that they did previously or remain in their training post. This has impacted career progression, the speed of career progression and the training pathways that respondents have been able to seek.

> 'Unable to complete CESR [Certificate of Eligibility for Specialist Registration] application which I had already started and am too ill to complete. Therefore [sic] at a lower pay grade and not progressing with my career. Only able to work part time, admin takes twice as long.'
>
> **SAS doctor**

> 'Cannot progress in training and withdrawn from sitting exit exam a few times.'
> **Junior doctor**

> 'I had to leave a training programme I loved, to a speciality with less physical work and regular work hours. My entire plan for my professional career had to change, against my wishes.'
> **GP trainee**

Due to understaffing, the running of health services relies heavily on the good will of doctors going 'over and above' in their roles, taking on extra responsibilities and working overtime, often unpaid. Post-acute COVID has not just impacted the number of doctors working full time, it has also prevented many doctors from carrying out the vast number of additional tasks that they previously took on.

> 'I do not have capacity to go the extra mile in the way that I always used to, which causes professional guilt and frustration.'
> **SAS doctor**

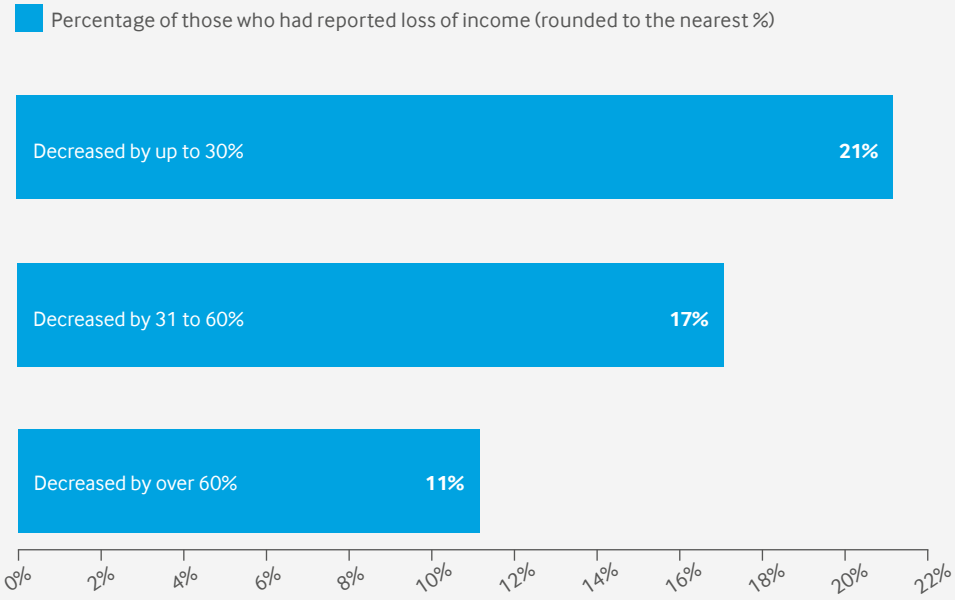
> 'I can do only about 50% of what I was capable of before. May be [sic] even less as I used to do so many hours more than I was paid for.'
> **Consultant**

> 'I can still do my clinical work, but my teaching work had to stop for a year as I was unable to cognitively manage remote teaching.'
> **Locum GP**

Doctors are experiencing serious financial impacts as a result of post-acute COVID

As many doctors with post-acute COVID are unable to work or have had to significantly reduce their hours or responsibilities, they are suffering a loss of income. Nearly one in every two (49%) doctors responding to our survey told us that they have experienced some form of loss of earnings as a result of post-acute COVID.

Impact of post-acute COVID on doctor's earnings



This visualisation only includes those 49% of respondents who had reported loss of income. Please note that 17% of respondents reported they were likely to experience decreased or no income soon, 34% of respondents reported no impact, and fewer than 1% reported increased income eg due to working longer hours/change of job

Inconsistent access to COVID special leave provisions and the eventual ending of these schemes by NHS employers across the UK have caused many doctors with post-acute COVID to struggle financially. It also means many have now used up all their statutory sick leave entitlement or have had to use their annual leave entitlement. Some even had to take unpaid leave.

In addition, for doctors in training, any sick leave taken that exceeds a certain annual allowance will likely trigger an extension of training – regardless of whether COVID special leave was taken or not. This not only impacts on the time taken to qualify in a specialist area, but also impacts on pay progression.

COVID special leave provisions ended on 1 September 2022 in England and Scotland, on 1 July 2022 in Wales and on 1 October 2022 in Northern Ireland

Financial assistance schemes such as NHS Injury Allowance may be available for some doctors with post-acute COVID. However, other schemes such as Industrial Injuries Disablement Benefit are not available due to post-acute COVID not currently being recognised as an occupational disease. This has all contributed to many doctors experiencing a significant loss of income and financial difficulties, including reduced personal savings, increased personal debt and reduced pension funds.

'Lost my job. Struggling to afford my mortgage'.
GP contractor

'I can no longer work, finances are ruined. I didn't have employment protection so am now unemployed and penniless'.
Salaried GP

'No ability to earn, no savings remaining, relying on benefits and benevolent funds'.
Locum GP

'I've had to use up all my savings and am in £3k debt because I couldn't work locum shifts to cover recent expenses'.
Junior doctor

NHS Injury Allowance provides support for staff who sustain an injury, disease or other health condition which is attributable to their employment. It is a payment made by NHS employers to eligible staff that tops up sick pay, or earnings when on a phased return to work, to 85% of pay and is payable for a period of up to 12 months per episode.

The employer is responsible for determining entitlement for injury allowance. Therefore, having COVID reported by an employer to the Health and Safety Executive under the terms of the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) may assist with claims. However, there was gross underreporting of these cases through RIDDOR making access to NHS Injury Allowance more difficult for staff who should receive it, and importantly payments run out after a year.

Industrial Injuries Disablement Benefit is a non-means-tested, tax-free, non-contributory benefit payable to people who have become disabled as a result of an accident at work, or because of one of over 70 prescribed diseases known to be a risk from certain jobs.

The level of disability will affect the amount of benefit received. This will be assessed by a medical advisor on a scale of 1 to 100%. Normally employees must be assessed as 14% disabled or more to get the benefit.

Weekly payments range from £41.52 for those assessed as 20% level of disability to £207.60 for those assessed as 100% level of disability.

As post-acute COVID is not listed as one of the prescribed diseases yet – despite IIAC recommending this to UK Government back in November 2022, employees with this condition cannot claim this benefit. It is also worth noting that the current recommendation by the IIAC is limited, in that it does not cover all of the symptoms that the doctors responding to our survey describe and that, indeed, are the most prevalent symptoms among our survey respondents.

Many doctors contracted COVID-19 whilst at work due to inadequate protections

The highest proportion of respondents to our survey (54%) acquired COVID-19 during the first wave of the pandemic in 2020, and 77% of these believe that they contracted COVID-19 in the workplace.

The highest proportion of respondents to our survey (**54%**) acquired COVID-19 during the first wave of the pandemic in 2020

This is very likely, as during this time doctors' contact outside the workplace was limited, with UK governments implementing some of the most severe non-pharmaceutical interventions (NPIs) of the acute phase of pandemic. The first lockdown in March 2020 saw the closure of non-essential high street businesses, schools and indoor sports venues and people were advised to avoid public transport, socially distance and required to stay at home unless they were a key worker and travelling to work.[5] By contrast, the COVID-19 vaccination programme did not start until December 2020 for healthcare workers and, although it does not necessarily prevent post-acute Covid, vaccination is associated with a lower likelihood of developing post-acute COVID and lower severity of symptoms.[6]

In addition, many doctors and healthcare professionals were more exposed to the virus than the general population, with 64% of doctors responding to our survey reporting working in areas with patients who were COVID positive or suspected positive. Yet, despite this increased exposure, effective procedures needed to protect the health service workforce from the impact of the pandemic – from risk assessments to access to adequate PPE – were either not in place when COVID-19 arrived in the UK, especially in 2020, or not implemented quickly enough. This resulted in professionals on the frontline often having to go without PPE, reuse single-use items or use homemade or donated items.[7]

The risks to doctors were often not assessed or reported

Risk assessments are an integral part of IPC (Infection Prevention and Control) practice and are an important tool in ensuring that employees are safe and protected at work. Health and Safety law imposes a duty on all employers to undertake a 'suitable and sufficient risk assessment' proportionate to the risk arising from exposure at work, however many doctors did not receive these at the start of the pandemic.

Nearly 7 in every 10 (69%) doctors responding to the survey who contracted COVID-19 in 2020 told the BMA that they had not been individually risk assessed before acquiring COVID-19. The effectiveness of the risk assessments carried out could also be questioned as around half (49%) of doctors reported self-completing their individual risk assessment.

69% of doctors who contracted COVID-19 in 2020 responding to the survey told the BMA that they had not been individually risk assessed before acquiring COVID-19

It is required by law for employers to report instances of COVID infections to the Health and Safety Executive under the terms of the RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). This reporting is crucial to understanding infections at health service staff level, how infection spreads within healthcare settings and how to better protect staff and patients. However, reporting practices varied throughout the pandemic, with reports of some doctors finding it "impossible" to get their workplace to report their COVID-19 infection under RIDDOR.[8] Only 3% of survey respondents said they were aware of their occupational exposure to COVID-19 and subsequent illness having been reported using RIDDOR.

Failure to report undermines efforts in the workplace to investigate and prevent harms but this lack of reporting may also have adverse implications for doctors seeking NHS Injury Allowance for which RIDDOR reporting is a criterion (see above).[9]

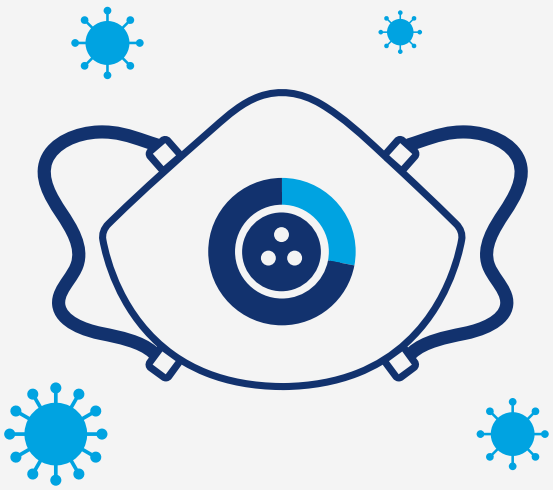
Vital safety procedures were not implemented

The lack of the UK's preparedness for a major Coronavirus pandemic resulted in doctors being systemically exposed to COVID-19 without being able to properly mitigate this risk with effective infection control procedures and PPE (Personal Protective Equipment), particularly during the first wave of the pandemic.

Supply of PPE in the initial stages of the pandemic was a major issue, with the PPE procurement process lacking transparency and consistency across the UK and UK Government failing to secure additional supplies of PPE for the NHS.[10] This meant that many staff did not have access to PPE. In the very early stages of the pandemic, some doctors were even explicitly forbidden from wearing PPE ostensibly for fear that it would scare patients, or because they had purchased it themselves and it wouldn't be fair for everyone else in their trust.[11]

RPE (Respiratory Protective Equipment) such as filtering face piece respirators (FFP2 and FFP3 respirators) are especially important to protect healthcare workers from COVID-19, given the evidence that COVID-19 is spread by aerosols not just droplets. RPE has been found to significantly reduce the risk of ward-based infection of healthcare workers from patients with COVID-19 compared to fluid-resistant surgical masks.[12]

However, across our entire survey only a small minority of doctors had access to respiratory protective equipment (RPE) around the time that they contracted Covid-19, with 11% reporting having access to FFP2 respirators and 16% FFP3 respirators. This figure is shockingly low. In 2020, when most respondents contracted COVID-19, the number of respondents who reported having access to FFP2 or FFP3 respirators was even lower. It is also noted that those working in hospitals were twice as likely to have access to RPE compared to those in general practice. Although this may reflect differences in risk, it accords with previous reports of GP surgeries initially being left outside the formal NHS supply chain leaving them to secure their PPE supplies from commercial suppliers.[13]



Only **16%** of respondents reported having access to FFP3 respirators around the time that they contracted COVID-19

These issues were compounded throughout the pandemic by infrastructure issues, such as unsuitable ventilation,[14] buildings that made infection control more difficult, high bed occupancy rates prior to the pandemic without planned surge capacity and significant deficiencies in the IPC (Infection Prevention and Control) guidance which aims to prevent and limit patient and healthcare worker exposure to avoidable infection in healthcare settings. For the majority of the pandemic, the IPC guidance has stated that a FRSM (fluid resistant surgical mask) is adequate protection for healthcare workers involved in the routine care of a patient with confirmed or suspected COVID-19. This persists in the existing IPC manual for England which has replaced the COVID-19 specific IPC guidance issued between 2020-2022. However, FRSM is not adequate PPE for healthcare professionals working with COVID-19 patients. Indeed, research conducted by the Health and Safety Executive long before the pandemic clearly showed the ineffectiveness of FRSM as 'protection' against inhaled viral aerosols.

Therefore, there is a need to improve guidance on protective equipment and risk mitigation procedures to continue to protect the health service workforce, as well as continued efforts to ensure access to RPE is available. COVID-19 is not a historical issue as doctors and healthcare workers continue to face the risk of infection and development of post-acute COVID. Tackling these issues is also important for any future pandemic to reduce the risks to staff and patients.

Despite being placed at increased risk, doctors are not being appropriately compensated for these failures

Since being exposed to a higher risk of infection and without adequate protection, the support provided to doctors with post-acute COVID has been lacking. It is crucial that the UK Government acts now to support doctors who are experiencing the debilitating effects of post-acute COVID as a result of doing their jobs during the pandemic.

Post-acute COVID should be recognised as an occupational disease

Despite the clear increased risk of infection from COVID-19 for doctors and healthcare workers due to greater exposure and lack of protective procedures, post-acute COVID is still not recognised as an occupational disease, limiting healthcare workers' ability to receive compensation for contracting the condition at work.

The IIAC (Industrial Injuries Advisory Council) plays a crucial role. This independent scientific advisory body makes recommendations to Government on the diseases and the occupations that cause them for which Industrial Injuries Disablement Benefit can be paid. The IIAC has already presented research and evidence to UK Government recommending the specific circumstances where Long COVID (post-acute COVID) should be recognised as an occupational disease for healthcare workers. It is crucial that the UK Government now acts on these initial recommendations.

However, these recommendations only set out five post-acute COVID complications where occupational disease status should be recognised.

Industrial Injuries Advisory Council (IIAC) recommendations

5 conditions following infection with COVID-19 have been recommended be classed as an occupational diseases for healthcare workers by IIAC

1. Persistent pneumonitis or lung fibrosis following acute COVID-19 pneumonitis
2. Persisting pulmonary hypertension following a pulmonary embolism
3. Ischaemic stroke
4. Myocardial infarction
5. Symptoms of Post Intensive Care Syndrome following ventilatory support treatment for COVID-19.

The BMA survey demonstrates a far broader range of symptoms of how post-acute COVID has impacted doctors, with the majority of doctors reporting symptoms that are not yet covered by IIAC recommendations. Symptoms varied widely and included fatigue, headaches/migraines, muscular pain (myalgia), damage to nerves that control movement or bodily processes such as digestion, joint pain, ongoing respiratory symptoms and many more. The 3 most common symptoms/conditions reported by respondents were:

1. Post-acute COVID Post Exertional Malaise (PEM)/Post Exertional Symptom Exacerbation (PESE) (84%) e.g. reduced exercise tolerance
2. Post-acute COVID Central Nervous damage/dysfunction (75%) e.g. chronic loss of smell/taste, vocal cord dysfunction, memory deficit, loss of executive function
3. Post-acute COVID Autonomic Nervous System damage/dysfunction (57%) e.g. reflux, delayed gastric emptying, increased or slower than normal heart rate, temperature dysregulation.

Although there is broad agreement on the varying symptoms of post-acute COVID, there has been less agreement on a clinical definition of the condition.[15] Therefore, more in-depth research and enhancement of diagnostic criteria is needed to better inform the 'prescription' of post-acute COVID as an occupational disease.

In addition, the UK Government needs to act quickly and provide support now to the many doctors and healthcare workers and their families who have suffered significant financial losses as a result of contracting COVID-19 in the workplace and then developing post-acute COVID. Due to the ending of COVID special leave provisions and the severe lack of financial support, many doctors and healthcare workers suffering the impact of post-acute COVID are now facing unemployment.

Over 50 countries worldwide already provide formal legal recognition for key workers who contracted COVID-19 as a result of workplace exposure and offer corresponding compensation and support schemes.[16] The UK Government needs to match this support and urgently develop an appropriate financial scheme for doctors and other healthcare workers who are unable to work due to post-acute COVID. There are existing financial schemes in place such as the UK's Armed Forces compensation scheme[17] and previous schemes such as the NHS and Social Care Coronavirus Life Assurance Scheme (whereby £60,000 is paid to the family in the event of a staff member dying due to COVID-19), which could be used to inform future financial packages for healthcare staff. However, any financial package for healthcare staff with post-acute COVID must be tailored to their needs. Therefore, engagement with relevant stakeholders, such as doctor and healthcare worker representatives, is crucial to the development of effective financial packages.

Recommendations:

- The Department of Work and Pensions must act without delay on current IIAC (Industrial Injuries Advisory Council) recommendations for the specific circumstances where Long COVID should be recognised as an occupational disease for healthcare workers.
- UK Government must urgently develop a package of financial support for doctors and healthcare workers with post-acute COVID.
- Health and Safety Executive must provide clear guidance to health service employers on the legal requirements to carry out risk assessments and report instances of infection under RIDDOR.
- The Department of Health and Social Care must ensure funding is allocated for appropriate PPE (Personal Protective Equipment) and RPE (Respiratory Protective Equipment) in health and care services to ensure its availability for staff to be protected.

Wider support is needed to help doctors access the care they need

More needs to be done to help doctors recover from the physical and psychological impacts of post-acute COVID and assist them in returning to their roles within the health services in a way that is safe for them and patients.

Treatment pathways need improvement

There has been wide criticism of post-acute COVID treatment pathways across the UK. NHS long COVID clinics for example have been criticised for being fragmented and either having a lack of referrals or extremely long waiting times.[18,19,20]

These reports are supported by our survey as 66% of doctors referred to an NHS long COVID clinic/centre told us that their post-acute COVID symptoms had not been investigated thoroughly. In addition to this, almost half of doctors reported not even being referred to an NHS long COVID clinic in the first place.

> 'I can't believe after 12 months of asking it seems I'm no closer to seeing a long covid clinic, my GP told me they'd referred me at the end of January 2021 but in reality, the admin gave up trying as I'm out of area for seemingly everywhere. They just keep giving me sick notes instead of helping me get better.'
> **Consultant**

Treatment for post-acute COVID must also include a focus on mental health. It is not surprising that the combination of issues such as ill-health, reduced ability to work, reduced ability to carry out daily activities and financial difficulties has had a negative emotional and psychological impact on many doctors – over a quarter of responding doctors told the BMA they had been affected in this way.

> 'I nearly lost my life, my home, my partner and my career. I have received little support to help keep these. The impact on my mental health nearly cost my life again.'
> **Locum Junior doctor**

Access to post-acute COVID care through the health service must be made available to all healthcare workers who need it in a timely and consistent way across the UK. This must include access to specialist multidisciplinary teams such as doctors, nurses, physiotherapists and occupational therapists to offer both physical and psychological care – something that has been lacking so far.[21]

Recommendations:

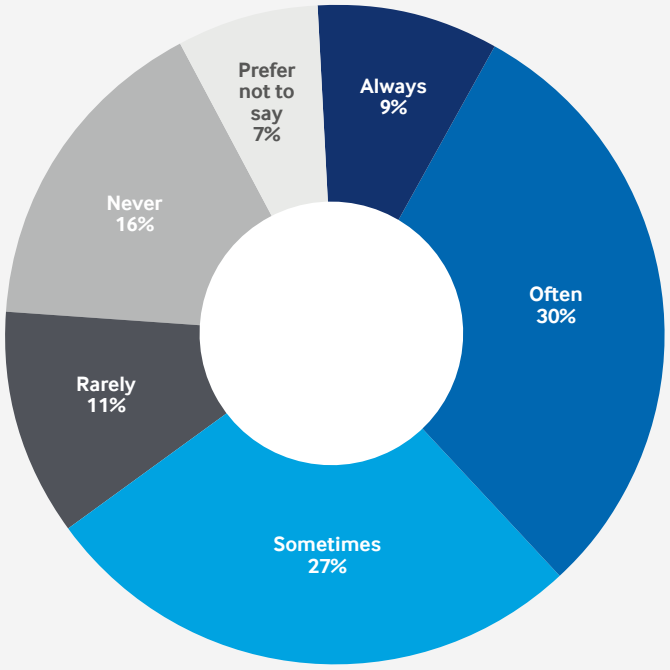
- UK health services must increase access and improve waiting times to post-acute COVID care such as NHS COVID clinics.
- UK health services must ensure care for those with post-acute COVID, such as that delivered through NHS COVID clinics, is multidisciplinary and offers access to both physical and mental healthcare.

Greater support is needed to help doctors return to work and keep them safe in the workplace

Just under 3 in every 10 (27%) doctors responding to our survey told the BMA that support and adjustments (such as phased returns, changes in shift patterns and use of mobility aids) had not been provided to them to help them return to work.

This has forced many doctors to return to a different role with fewer demands. Alternatively, it has resulted in many doctors (around 66% of survey respondents) continuing to work at least some times whilst still unwell or returning to work prematurely. This negatively impacts doctors' ability to carry out their work with many concerned about patient safety. It is thus unsurprising that over half of doctors responding to our survey reported that they have been fearful of making a medical error in work or training.

Doctors working despite not feeling well enough to perform their duties



'I had to give up clinical medicine and take up a non-clinical specialty due to inability to cope with demands of environment.'
Public Health trainee

'My main concerns have been brain fog and fatigue. With brain fog i worry all the time that i will make a mistake, i will think something and then forget it, even from speaking to a patient to coming back to the notes. I have to write everything myself and really concentrate to remember it all. This means i am slower than my colleagues and often feel guilty.'
Consultant

Providing adjustments such as phased returns to work and working with occupational health teams to implement adjustments will help to ensure doctors can continue to work at levels that are safe to them and patients.

Occupational health teams have the necessary training in supporting doctors with post-acute COVID and play a vital role in helping them return to work safely. However, access and referrals to these services has reportedly been limited, with long waiting times due to under-resourcing and a declining occupational medicine workforce.[22] It is crucial that resources are available to increase the number of occupational medicine training posts in order to meet the needs of healthcare workers with post-acute COVID. Health service employers need to ensure that doctors and other healthcare workers have timely access to occupational health services and the ability to directly self-refer.

Greater awareness of post-acute COVID and the support needs of healthcare workers with the condition is needed within healthcare settings. Guidance on managing post-acute COVID in the workplace has been developed by organisations such as NHS England and the Society of Occupational Medicine and should be promoted amongst health service managers to increase understanding of the impacts of post-acute COVID, as well as the needs of colleagues with the condition and to encourage a supportive working environment.

More also needs to be done to protect against the ongoing risk of COVID-19 infection and the subsequent development of post-acute COVID. We are hearing anecdotally that some doctors are extremely concerned about the risks that they face of contracting COVID-19 when returning to work or exacerbating any existing post-acute COVID symptoms. We also know from a previous BMA survey that many doctors are not confident that their place of work would have appropriate ventilation in the event of a future wave of COVID-19 or another pandemic.

As previously mentioned, health and safety procedures must be properly implemented. Appropriate RPE equipment must be provided, health service estates must be improved, and employers must adhere to the legal requirement to carry out risk assessments and report instances of infection under RIDDOR. The Health and Safety Executive has a clear role to play in providing guidance and educating health services on what is required to protect the NHS workforce and patients.

If those members of the health service workforce with post-acute COVID are not adequately supported to return to work, this will not only impact their health and patient safety, but it could also result in the UK losing some doctors and healthcare workers completely from the health service at a time when we already do not have enough doctors; this is something we can ill afford.

Recommendations:

- Health education bodies across the UK must fund increased occupational medicine training posts to meet the level of demand in the UK's health services.
- UK health service employers must prioritise timely access to occupational health services and assessments for staff with post-acute COVID.
- UK health service employers must promote greater awareness amongst managers of the needs of staff with post-acute COVID and support measures required.
- UK governments and health systems must ensure health service estates are safe for staff and the risk of infection from infectious diseases, like COVID-19, is reduced, including improved ventilation.

Conclusion

Placing staff health and wellbeing at the heart of the health service benefits patients, staff and the health service as a whole. Yet, it is clear that this did not happen during the pandemic and continues to not happen post-pandemic. Doctors and healthcare workers were repeatedly let down, starting with a lack of protection, which was exacerbated by inadequate guidance and risk mitigation, and continued with a lack of support for post-acute COVID sufferers.

This research shines a light on the continuing debilitating impacts many doctors are experiencing as a result of carrying out their vital roles during a time when the country desperately needed them, which in turn exposed them to COVID-19 and developing post-acute COVID as a result. Their daily life has been transformed and their ability to continue to do their jobs has been reduced or in some cases, prevented completely.

The risk doctors were placed under must be formally recognised and the consequent issues many now face as a result of workplace exposure need to be compensated for. The UK health service must do more to understand the impact of post-acute COVID in its workforce and offer more flexible ways to support doctors within the workplace. It is crucial that the UK's governments, health service employers and policy makers act on the recommendations of this report to support the medical workforce and protect the future of the UK's health services.

> 'Life is absolutely miserable. Every day is a struggle. I wake up exhausted, the insomnia and night terrors are horrendous as I live through my worst fears every night. Any activity such as eating meals, washing etc will mean I have to go to bed for a few hours. I am unable to look after myself or my child, exercise or maintain social relationships. I have no financial security. Long COVID has totally destroyed my life. My child and I are in an incredibly vulnerable position and I am so worried for what the future holds. This is so difficult after working so hard to become a Consultant to be left shortly with no job, no income, no home and disabled. Long COVID needs to be classified as an occupational illness, special leave with pay must continue'.
>
> **Consultant**

Appendix

Acknowledgements

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Methodology

The survey was developed by a project advisory group formed by the British Medical Association and the online support group Long Covid Doctors for Action (LCDfA) to ensure that it was informed by lived experiences of doctors with post-acute COVID.

The survey enquired about health effects termed herein 'post-acute COVID', to capture a spectrum of symptoms/conditions and in recognition of there being no universal clinical agreement on what complications fall under the umbrella term Long Covid. The study was observational in its design and the population comprised of doctors who self-identified as experiencing post-acute Covid complications. Consequently, we have not attempted to extrapolate our findings to a wider group.

The survey was conducted online between December 2022 and January 2023 and was open to all medical doctors registered currently or previously with the UK General Medical Council (GMC). The survey was open to BMA members as well as non-members (approximately 25% responses were from non-members), and was distributed through the BMA website, emails, newsletters, and social media. The survey validated responses through the recording of GMC number.

The BMA ensured that the survey complied with GDPR and appropriate research practices. Formal Research Ethics Committee approval was not required, but the impact of any issues raised by the survey was considered by the team. Furthermore, additional support available to participants if they needed was set out.

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