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Clinical academics' experiences during the COVID-19 pandemic: a qualitative study of challenges and opportunities when working at the clinical frontline

Diane Trusson ●,[1] Emma Rowley,[2] Louise Bramley[3]

[1]NIHR Applied Research Collaboration for East Midlands (ARC EM), School of Medicine, University of Nottingham Faculty of Medicine and Health Sciences, Nottingham, UK
[2]NIHR Applied Research Collaboration for East Midlands (ARC EM), School of Medicine, University of Nottingham, Nottingham, UK
[3]Institute of Nursing and Midwifery Care Excellence, Nottingham University Hospitals NHS Trust, Nottingham, UK

Correspondence to
Dr Diane Trusson, School of Medicine, University of Nottingham Faculty of Medicine and Health Sciences, Nottingham, NG7 2TU, UK; diane.trusson@nottingham.ac.uk

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ABSTRACT

Objectives This study explored the experiences of clinical academics during the COVID-19 pandemic. The aim was to identify challenges and benefits associated with returning to, or increasing hours at, the clinical frontline.

Design Qualitative data were gathered from a combination of written responses to questions posed in an email and 10 semi-structured interviews between May and September 2020.

Setting Two higher education institutions and three NHS Trusts in the East Midlands of England.

Participants Written responses were received from 34 clinical academics including doctors, nurses, midwives and allied health professionals. A further 10 participants were interviewed either by telephone or online, via Microsoft Teams.

Results Participants described challenges experienced in returning full-time to the clinical frontline. These included having to refresh or learn new skills and the pressure of managing the competing priorities of NHS and higher education institutions. Benefits of being on the frontline included having the confidence and flexibility to deal with an evolving situation. Also, the ability to quickly assess and communicate the latest research and guidance to colleagues and patients. In addition, participants reported identifying areas for research during this time.

Conclusion Clinical academics can contribute their knowledge and skills to frontline patient care in times of pandemic. It is therefore important to ease that process in preparation for potential future pandemics.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Clinical academics possess valuable knowledge and skills which are vital in a rapidly evolving situation. This study aimed to explore the differences in experiences between medical and non-medical clinical academics during the COVID-19 pandemic.

WHAT THIS STUDY ADDS

⇒ Medical clinical academics found it easier to return to the clinical frontline when compared with nurses, midwives and allied health professionals due to differences in their contracts.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Findings support proposals for contracts with similar conditions for all clinical academics. This will ease their transition to full-time clinical duties when needed, maximising their potential for patient care and research opportunities.

INTRODUCTION

In the UK, the term clinician refers to a healthcare professional who provides patient care, for example, a doctor, nurse, pharmacist or physiotherapist.[1] Clinical academics usually combine clinical practice with academic research and/or teaching, although the time spent in each role can vary. There are particular differences between medical clinical academics (henceforth MCAs) and nurses, midwives and allied health professionals (AHPs) (henceforth NMAHPs), in that MCAs are usually employed by a university with an honorary hospital trust contract or vice versa, whereas there are usually no such reciprocal arrangements for NMAHPs.[2] Therefore, while MCAs retain clinical aspects of their role alongside their academic responsibilities, many NMAHPs manage complex working arrangements and contracts across NHS and higher education institutions (HEIs). Consequently, maintaining clinical skills/training in an ever-evolving healthcare system can sometimes be challenging. Clinical academic training programmes also differ; MCAs undertake clinical and academic training in tandem, taking time away from clinical practice for research. In contrast, NMAHPs embark on clinical academic training after qualifying clinically, often stepping out of their clinical role to pursue research training.[3] For both MCAs and NMAHPs, combining clinical and academic roles has been shown to be beneficial in many ways, but also prone to challenges such as balancing responsibilities between university and healthcare organisations.[3 4]

In line with other healthcare staff, many clinical academics have responded to the call for doctors, nurses and AHPs to deliver frontline services during the COVID-19 pandemic to provide urgent patient care and cover staff shortages due to illness or needing to shield. Previous studies exploring the impact of the COVID-19 pandemic on the research activity and working experience of clinical academics have either focused exclusively on doctors and dentists (MCAs)[5] or single professions (eg, ophthalmology,[6] nursing[7]). However, this empirical research explores the experiences of MCAs and also NMAHPs from a range of professions. The focus is the different experiences of medical and non-MCAs returning full-time to the clinical frontline during the COVID-19 pandemic. The aim is to inform

recommendations for easing clinical academics' transition back to increased clinical practice when required.

METHODS

This manuscript has been prepared according to the Standards for Reporting Qualitative Research.[8]

Our research was conducted during the first wave of the COVID-19 pandemic, between May and September 2020. Qualitative, in-depth case study data were collected using two methods; responses to emails and individual, semi-structured interviews.[9] Participants were contacted initially by e-mail. They self-identified as clinical academics by virtue of their membership of a professional network of clinical academics in the East Midlands, including trainees, through which they were accessed. Members had already agreed to be contacted in this way when joining the network.[10] In addition, emails were sent to participants from previous studies,[2 3] who had offered to be involved in future research. Participants were then asked to cascade the email to clinical academic colleagues to create a snowball sample.[9]

Participants were invited to either submit written responses or take part in a short interview where the same questions were posed (see online supplemental file 1). The interview sample consisted of seven women and three men working within three different NHS Trusts in the East Midlands of England. Four were AHPs, three were nurses and three were MCAs.

All interviews were conducted by the lead researcher. Telephone or online interviews (via Microsoft Teams) lasted on average 35 min to avoid adding to the burden of frontline staff. They were digitally recorded with the participants' consent and transcribed professionally.

Research team

The research team was led by the first author, a medical sociologist with wide experience of conducting social research, including studies of clinical academics' experiences. The other researchers are a clinical academic nurse, working in a leadership position in a large NHS Trust, and a capacity development manager, both qualified to PhD level, with extensive knowledge about clinical academic careers. There were no known relationships between the researchers and participants.

Analysis

Anonymised data from the written accounts and interview transcripts were combined and analysed using thematic analysis.[11] The lead author conducted the initial analysis which involved reading the data multiple times. This allowed recurring themes to be identified through an inductive process.[9] These themes, which were discussed and agreed with the other members of the research team, were categorised around challenges (in resuming full-time, or increasing hours of, clinical duties) and perceived benefits of being part of frontline patient care during the pandemic.

Ethics

Participants were assured that all their responses would be treated with confidentiality and that any identifying data would be removed prior to analysis.

Data were stored anonymously and securely on University systems.

Patient and public involvement

No patients were involved.

Table 1 Participant details

Email respondent number	Role
R1	Midwife
R2	Midwife
R3	AHP
R4	Physiotherapist
R5	Physiotherapist
R6	MCA
R7	AHP
R8	AHP
R9	AHP
R10	AHP physiotherapist
R11	AHP occupational therapist
R12	AHP physiotherapist
R13	AHP physiotherapist
R14	AHP physiotherapist
R15	MCA
R16	MCA
R17	MCA
R18	AHP
R19	Nurse
R20	MCA
R21	AHP speech and language therapist
R22	AHP speech and language therapist
R23	AHP physiotherapist
R24	AHP SLT
R25	AHP physiotherapist
R26	AHP occupational therapist
R27	Midwife
R28	Nurse
R29	AHP
R30	Nurse
R31	AHP speech and language therapist
R32	AHP speech and language therapist
R33	AHP
R34	MCA
Interview participant number	**Role**
P1	Nurse
P2	AHP
P3	AHP
P4	AHP
P5	Nurse
P6	AHP
P7	MCA
P8	Nurse
P9	MCA
P10	MCA

AHP, allied health professional; MCA, medical clinical academic.

RESULTS

We received 34 email responses with an average word count (excluding the questions posed) of 195 words. Five respondents came from outside of the East Midlands as a result of using the snowballing sampling technique.

Table 1 shows the demographics of the email respondents (R) and interview participants (P). Some of their precise roles are not included to prevent them being identifiable.

We identified three main themes through analysis of the combination of email and interview data: (1) The

experience of returning to the clinical frontline; (2) Challenges; (3) Opportunities.

Sub-themes under challenges were: Changes to clinical practice (Updating knowledge, skills and procedures; Change of clinical duties; Psychological issues); Impact on research; Competing pressures.

Sub-themes under opportunities were: Using clinical academic skills: Flexibility and management skills; Appraising, utilising, and sharing latest research and evidence; Developing skills; Identifying areas for new research; Advocacy of the clinical academic role.

The experience of returning to the frontline

Most respondents had already been working some hours of their week clinically as part of their clinical academic role. They described how they had increased their hours, often returning to full-time clinical duties. In these cases, their clinical training was up to date, which enabled a seamless transition:

> I'd had one clinical day a week prior to COVID-19, so…whilst specialist nurses and managers were undertaking refresher training and supernumerary shifts, I was able to return to practice with 12 hours' notice (R19-Nurse).

Although most respondents maintained some clinical aspects to their role, some had only been working in an academic environment prior to the pandemic. Of these, only two participants reported that they had not returned to the clinical frontline due to having full-time teaching commitments.

Two MCAs who had been out of clinical practice for research for several months reported that they were happy to volunteer:

> I would've felt very guilty not going back…my job ultimately is a doctor and it was nice going back to do that…there was a good camaraderie…you're being part of a bigger effort to help out (P9-MCA).

However, there were also examples where participants volunteered to return to full-time clinical practice but were not called on:

> I offered to go back to help my team – with 100% of my time clinical, whatever was needed…I received my 'upskill' training ready for re-deployment to the wards… and pulled out of my research and teaching duties in preparation. In the end I wasn't needed (R5-AHP).
> I was asked to catch up on mandatory training and given a couple of small tasks but then nothing else …I'm sure my hours can be used in some way at this time and that I can contribute as a clinical academic (R8-AHP).

In these cases, participants were willing and able to contribute to frontline care but the opportunity to do so was not available to them.

Challenges

Table 2 summarises the main challenges reported and the number of participants who cited a particular issue:

Changes to clinical practice
Updating knowledge, skills and procedures

Some participants were ill-prepared for returning to the clinical frontline at a time of crisis. For example, a specialist nurse who usually dedicated more time to research than frontline care

Table 2 Challenges

Challenges	
Changes to clinical practice	**Example quotes**
Updating knowledge, skills and procedures (n=16)	The biggest challenge was reacting to the shifting sands…For example, personal protective equipment changed about 15 times within the first 3 weeks (P5-Nurse) I needed to relearn skills such as IV drug admin (R28-Nurse) I didn't receive any communication regarding new policies, for example, PPE, treating COVID-19 (R16-MCA) I needed to update training; I hadn't been on ITU for over 4 years (R1-Nurse) It was a very steep learning curve, you had to hit the ground running quite quickly (P9-MCA). Clinical activity is now mainly by means of telephone, its hard when contacting patients for the first time (R6- MCA) There were logistical issues…like how my salary was paid as I have no substantive role within the hospital (R19-Nurse). Access to clinical systems needed to be reinstated (R4-AHP). Difficulties getting a uniform (R10-AHP).
Change of clinical duties (n=16)	For the first 6 weeks of the pandemic I literally did nothing that I'd normally do (P6-AHP) The type of work has changed. I'm covering wards I wouldn't normally work on (R3- AHP) As OTs (occupational therapists) …our role was changed to being discharge facilitators to speed up patient flow and increase capacity…(instead of) a week before discharge, we were now anticipating discharge for the same or next day (R26-AHP).
Psychological issues (n=8)	I'll never forget hearing a patient, so sick with COVID-19…speaking to his family on the phone…knowing he was likely to die…I came away from the shift thinking "what can we do as clinical academics to support our staff in these difficult times"? (P1-Nurse) I worked with COVID-19 positive patients…It was very challenging. After the peak, there was decline in my mental health…I'm still undergoing counselling (R34-MCA)
Impact on research (n=13)	I had to halt all my research endeavours…which was disappointing to say the least. I feel I have gained nothing out of the academic foundation programme…I was looking forward to completing my research (R15-MCA). Everything ground to a halt with my research activity (P8-Nurse)
Competing pressures (n=10)	It does feel like I am trying to squeeze two full-time jobs into one working week. I have found it quite challenging…I get full time responsibilities for both jobs but only half the time to do it (R23-AHP). Although I was on essentially unpaid leave from the university…I was still having demands…it just added to the stress of the situation. They wanted research papers rewritten…but when you're working on average a 60 hour week, when you had free time you weren't necessarily wanting to do that (P9-MCA). I was encouraged to continue with my research in my spare time… but this wasn't possible due to the exhaustion of working clinically (R26-AHP). They (university) don't understand how much planning/forewarning is needed to notify clinical managers to take NHS staff off the rota (R27-Midwife).
AHP, allied health professional; MCA, medical clinical academic.	

described the experience of returning to working on a ward as 'daunting'. Similarly, a doctor who was redeployed from a community practice to a hospital described feeling unprepared to deal with patients with COVID-19. However, both participants described being supported to update their skills and knowledge.

Along with needing to update their clinical training, some participants experienced practical issues, such as access to IT systems and delays in organising their pay or providing uniforms.

A senior clinical academic described how working clinically at a more junior level had entailed a steep learning curve, including re-familiarising herself with the 'clinical lingo'. She suggested that:

> Every year I should do a real immersive two-weeks clinical hands-on everyday seeing patients. Because even though I do one day a week [clinical practice] I get dragged off into doing strategic stuff (P6-AHP).

These experiences support suggestions that NMAHPs would particularly benefit from retaining an element of practical clinical duties within their role.[12]

Change of clinical duties

The nature of the pandemic meant that participants were dealing with rapid changes to processes and procedures. For some participants, this entailed changes to aspects of their clinical role. For example, occupational therapists described having to discharge patients much more quickly.

Some participants were assigned to a different area of the hospital which was sometimes experienced as traumatic. For example, a speech and language therapist described feeling 'frightened' when she was asked to treat patients in a critical care ward. However, she described receiving support from other AHPs which she replicated:

> [The physios said] "we'll do it together" the first few times, and then I repeated that model with my colleagues, "let's go and do it jointly"… so we supported each other (P4-AHP).

Psychological issues

Although peer support was important for mitigating stress, it was not always enough. One participant, a clinical psychologist explained that during the pandemic she had switched from treating patients to focusing on helping frontline medical staff.

The negative impact of dealing with patients with COVID-19 on healthcare workers' mental health is a widely reported phenomena.[13 14] In this respect, some participants believed that having dual roles (clinical and academic) was helpful. One said:

> Having a different [role] to think 'I've got to go and write this paper'…helps shift your focus. I think we've all had middle of the night worries about patients, but if you've got something else to focus on, it just shifts that (P7-MCA).

This was one example of how being a clinical academic was experienced as being beneficial during the pandemic.

Impact on research

Although happy to help out, the pandemic often had a significant impact on respondents' research activities which had to be paused as they returned to the clinical frontline. For example, medical trainees on the Academic Foundation Programme would normally have protected, dedicated time away from clinical practice for research,[15] but this was not possible during the pandemic.

For these respondents, the well-documented difficulty in balancing clinical and academic roles[4] was intensified during the pandemic, potentially impacting on completion of their PhDs.

Competing pressures

As the above experiences suggest, having responsibilities to the NHS and an HEI resulted in competing time demands from two organisations. Some participants reported pressure from the university to continue their academic work. However, they found it unfeasible when working long shifts which left them 'exhausted'.

One NMAHP participant reported that she was asked to increase her clinical commitment. However, having separate contracts was beneficial 'for once', enabling her to protect her academic time. Nevertheless, she used her clinical academic skills in a service evaluation to justify recruiting more staff, thus providing a longer-term solution.

A senior clinical academic responded to an urgent need for full-time occupational therapists in the community; a need intensified by patients being discharged from hospital earlier than they would have, pre-pandemic. She described her reaction to the University's request that she holds weekly supervisions with her 10 PhD students:

> I thought 'you must be joking…that's 10 hours work!'…all my PhD students are NHS staff anyway (P6-AHP).

Where university courses had paused at the start of the pandemic, trainees described their frustration about being expected to return at short notice, including during the summer break.

These examples reveal a tension between pressures on HEIs to reinstate courses and pressures on staff and students who have clinical responsibilities as part of their roles.

Opportunities

Although some participants discussed problems with the way the response to the pandemic was co-ordinated, an associated benefit was less workplace bureaucracy:

> What was good in the first wave of the pandemic is we didn't have all these meetings…[it] was absolutely fantastic, because it meant that we could concentrate on what we were doing clinically (P4-AHP).

> I realised how much of my life was monopolised by meetings… it's a bit cheesy but it's been an opportunity to review what you've been doing and think, 'why are we doing that'?…it's been very liberating (P5-Nurse).

Table 3 summarises other opportunities reported by participants and how many did so:

Developing skills

Along with challenges, participants described innovative ways of working during the pandemic. These included new ways of providing patient care such as telephone follow-up appointments and using video calls for online consultations and rehabilitation exercises. Although these methods were not always suitable (eg, for initial psychiatric assessments), many respondents found them more convenient for both staff and patients.

New ways of teaching were also explored, such as virtual simulation training. Also, technology helped clinical academic trainees to engage with each other through an online journal club.

Consequently, it seems that participants found ways of ensuring that patient care and students' training could continue, and even improve, despite difficult circumstances.

Table 3 Opportunities

Opportunities	
Sub-theme	**Example quotes**
Developing skills (n=6)	We've been able to give some people a lot more rehab…We'd ring them every day saying, "come on, do your exercises now!" Pre-COVID we would see them twice a week maybe, if that (P6-AHP). We had to quickly convert simulation training from face-to-face…we did it virtually via Teams, and that worked really well…Students loved it (P3-AHP). I have started a remote journal club as people are keen to learn, even if normal in-service training isn't available (R13-AHP).
Identifying areas for new research and collaborations (n=17)	There's a particular interest in this group of patients around rehabilitation and problems with long-term recovery from COVID-19. So, we're working with the respiratory medicine team as a collaboration that we weren't working with before (P3-AHP). I listened to a lot of problems that would lead to really good research projects (P6-AHP). (It's about) liberating the frontline workers' voice in identifying key questions they have from their practice; what do they think are the priorities during the pandemic and going forward into this new normal? And then driving the research agenda to try and answer those priority questions (P8-Nurse).
Using clinical academic skills	Being flexible and responding to new information honed from academia prepared me for the continually evolving situation with new guidelines for clinical practice for COVID-19 (R34-MCA).
Flexibility and management skills (n=17)	There are over 5500 nurses (in the organisation) …we used a database that enabled us to skills match so we could redeploy groups of nurses…that was coordinated very much by clinical academics. Doing a PhD, a viva, helps in times like this (because) you know how to work under incredible pressure (P5-Nurse). Leadership and management skills have been useful (R33 -MCA).
Appraising, utilising and sharing latest research and evidence (n=26)	A key to the COVID-19 crisis is evaluating and adjusting strategies quickly…This kind of mindset was already instilled in me…it made a big difference to how responsive we could be (R9-MCA). I think being a clinical academic during a pandemic where little is known about the condition is a superpower. I've been able to research what rehabilitation needs to look like as well as implementing it (R23-AHP). I often receive information about resources, for example, webinars, new papers, that I share with my NHS colleagues (R6-MCA). I can explain research findings in a language other staff and patients can understand (R19-Nurse). I'm able to discuss with patients that the Daily Mail version of vascular medicine is probably not correct (P7-MCA).
Advocacy of the clinical academic role (n=6)	We had a golden opportunity for (nurses) to see research in action…that was a joy to see that lightbulb of how research can really transform patient care, that was pretty good (P5-Nurse). They recognise you as one of them, in the same uniform, in their environment (P1-Nurse). Lots of them want to be a clinical academic. The negatives they saw were how hard work it is, they were gobsmacked…when they went home, I'd still be there catching up on my academic work (P6-AHP).

AHP, allied health professional; MCA, medical clinical academic.

Identifying areas for new research and collaborations

Participants described how the pandemic had provided opportunities to be involved in new research projects, such as a study looking at the higher prevalence of COVID-19 in BAME patients and staff. In other cases, respondents described adapting their current research. For example, plans to study the long-term psychosocial effects on families of having a seriously ill child hospitalised, assumed added relevance during the pandemic.

Another respondent described how her study of the impact of a post-illness exercise intervention had gone from being 'defunct' to 'really important work'. During her time on the frontline, the physiotherapist recruited COVID-19 survivors and developed new collaborations with medical colleagues eager to study long-term recovery from COVID-19.

These examples illustrate ways in which clinical academics were able to seize opportunities to develop ideas for research when working clinically, potentially influencing future patient care (inter)nationally.[3]

Using clinical academic skills

Many respondents described skills obtained through clinical academic training as beneficial for coping with rapidly changing guidelines and procedures. They also reported that their experiences as a clinical academic helped them to use their organisational skills effectively by training staff who were being deployed.

By far the most often cited benefit of clinical academic training was being able to appraise, use and communicate the latest research and evidence to colleagues and patients.

Working alongside clinical colleagues revealed gaps in frontline workers' understanding. For example, an occupational therapist described training her colleagues to use assessments and equipment which she had seen demonstrated at conferences.

Frontline working presented an opportunity to try these new techniques and equipment that had been in a cupboard unused:

> We had some fantastic outcomes… we've now got [a patient] walking…and we got her arm working as well, by using [this equipment] (P6-AHP).

In addition, teaching videos were put online so that other occupational therapists could learn how to use the equipment. Consequently, there were benefits for patient care both directly and more widely, through knowledge dissemination.

Advocacy

The experiences discussed above show how working at the medical frontline presented clinical academics with opportunities for advocacy and dispelled some misconceptions around clinical academics.

One participant felt that it was important for research champions to be visible in the clinical setting so that colleagues could discuss the clinical academic route. Although working alongside them also showed the commitment needed, participants felt that being able to discuss and demonstrate the benefits of research while working at the frontline was an effective way of encouraging future clinical academics.

DISCUSSION

In this study, we used a qualitative research approach to explore participants' experiences of returning to the clinical frontline during the COVID-19 pandemic. The combination of written and oral interviews allowed individual experiences to be expressed while gathering a wide range of perspectives.[9] Analysis revealed the willingness and responsiveness of clinical academics to resume or increase their clinical practice during

an unprecedented medical emergency. However, the ease with which clinical duties could be taken up was dependent on having some element of clinical practice already incorporated into their job role. In this respect, MCAs were better able to return to the medical frontline due to having a dual contract (either honorary academic or clinical post). This was not always the case for NMAHPs who often leave clinical practice to get research training, particularly when undertaking a PhD.[3] As mandatory training can quickly become out of date, some NMAHPs are unable to respond to a pandemic without refreshing their training first.

In common with colleagues with a purely clinical role, challenges included working long shifts, often in a different role or setting to their usual one and dealing with an ever-evolving situation. In some cases, the experience was described as distressing. The prevalence of mental health issues in healthcare workers is a matter of concern and has led to calls for early interventions.[13] In this study, a clinical psychologist described switching care from patients to staff which is a welcome intervention which may need to continue if there are long-term psychological consequences as predicted.[14] Peer support is also valuable in dealing with stressful situations[14] as this study found. Furthermore, it was suggested that mixing clinical and academic roles may be helpful for dealing with anxiety and preventing burnout, which has been reported in studies of medical staff.[16]

Our study confirmed previous research which showed benefits at multiple levels of having clinical academics at the frontline of clinical care,[3] particularly during periods of rapid change such as the COVID-19 pandemic.[5][7] Respondents described how clinical academic training enabled them to quickly respond to changing policies and guidelines; to evaluate and communicate latest research findings to colleagues and patients, and to use the latest evidence-based practice in their clinical role. They were resourceful, using technology to find new ways of teaching and providing patient care. Other authors suggest that such initiatives could possibly be sustained long-term.[6] Similarly, the reduction in workplace bureaucracy has been observed elsewhere, leading to speculation that 'non-essential meetings could be cancelled permanently'. (Wong and Bandello, pe52)[6]

The pandemic exacerbated previously discussed difficulties in managing competing priorities of HEIs and NHS providers.[5][17] Participants were also concerned about the loss of research time, with MCAs in particular, expressing concerns about the impact of the pandemic on their studies. These issues are echoed elsewhere, along with concerns for the long-term implications of reduced research outputs for future funding bids[18] and career progression.[5]

Although much of university-based research was paused, the pandemic also revealed new research priorities. Our findings echo previous research which described clinical academics taking opportunities while at the frontline to identify areas of research incorporating the voices of frontline staff, patients and their families.[5] Some of these areas of research (eg, the prevalence of COVID-19 in BAME patients and staff; the long-term psychosocial consequences of the pandemic) have already been identified as urgent research priorities.[5][19][20] In addition, our participants described developing their existing research in the context of the pandemic and undertaking multidisciplinary research. This will be necessary for understanding the complex effects of COVID-19 and its aftermath.[20]

Finally, spending time at the frontline enabled clinical academics to be visible role models which is important for encouraging others to embark on the clinical academic pathway.[17][21]

Strengths and weaknesses of the research

To our knowledge, this is the first empirical study to compare the experiences of MCAs and NMAHPs who returned to, or increased their, clinical practice during the COVID-19 pandemic. It is limited geographically to one area of England and by the relatively few participants that it was possible to recruit at the height of the pandemic. However, it illuminates the challenges faced by all clinicians during a crisis, especially those without formalised contracts. Consequently, the findings from our study are not limited to the COVID-19 crisis but are of equal relevance to any other healthcare crisis.

Lessons learnt and general recommendations

► Implementing contracts for NMAHPs which are similar to those held by MCAs will enable them to move seamlessly from one organisation to another.[12]
► Ensuring that clinical academics' skills and training remain up to date will allow easy transition to the clinical frontline.
► Greater communication between NHS and HEI organisations and universities would ease the pressure on clinical academics.
► NHS and HEI partners should work together to support clinical academics to resume research activities that were paused during the pandemic. Also, new research opportunities identified while working at the clinical frontline should be maximised.[5][12][22]

Unanswered questions and further research

The experiences of clinical academics with family responsibilities during the pandemic, including 'gendered dimensions of this problem', (Lambert *et al*, p583)[17] merit further research. Although these issues have been highlighted as problematic for female MCAs,[5] it is particularly relevant for NMAHP professions which are female-dominated.[3] Issues to consider include challenges (eg, women bearing the brunt of childcare and domestic responsibilities)[5][23] and opportunities (eg, greater acceptance of working from home).[5][6]

Another issue meriting further research is the finding that some NMAHPs consider themselves to be clinical academic despite not doing any regular clinical hours in practice.

CONCLUSION

Our study of clinical academics' experiences during the COVID-19 pandemic has revealed that although some challenges were encountered, respondents described multiple benefits of being on the clinical frontline. Recognising the value of their contributions, it is important to ensure that clinical academics' transition to full-time clinical duties when needed is as smooth as possible.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by University of Nottingham reference FMHS40-0620. Participants gave informed consent to participate in the study before taking part.

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ORCID iD
Diane Trusson http://orcid.org/0000-0002-6995-1192

REFERENCES

1. National institute for health and care excellence (NICE). n.d. Available: https://www.nice.org.uk/Glossary?letter=C
2. Trusson D, Rowley E, Barratt J. Multimethods study comparing the experiences of medical clinical academics with nurses, midwives and allied health professionals pursuing a clinical academic career. *BMJ Open* 2021.
3. Trusson D, Rowley E, Bramley L. 2019. *A mixed-methods study of challenges and benefits of clinical academic careers for nurses, midwives and allied health professionals*,
4. Clough S, Fenton J, Harris-Joseph H, *et al*. What impact has the NIHR academic clinical fellowship (ACF) scheme had on clinical academic careers in England over the last 10 years? A retrospective study. *BMJ Open* 2017;7:e015722.
5. Finn GM, Crampton P, Buchanan JA, *et al*. The impact of the COVID-19 pandemic on the research activity and working experience of clinical academics, with a focus on gender and ethnicity: a qualitative study in the UK. *BMJ Open* 2022;12:e057655.
6. Wong TY, Bandello F. Academic ophthalmology during and after the COVID-19 pandemic. *Ophthalmology* 2020;127:e51–2.
7. Coad J. Capturing the impact of children's nurse clinical academics during the COVID-19 pandemic. *Compr Child Adolesc Nurs* 2020;43:88–91.
8. O'Brien BC, Harris IB, Beckman TJ, *et al*. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med* 2014;89:1245–51.
9. Bryman A. *Social research methods*. 4th. Oxford: Oxford University Press, 2012.
10. East midlands clinical academic practitioner network. n.d. Available: https://arc-em.nihr.ac.uk/about/east-midlands-clinical-academic-practitioner-network
11. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006;3:77–101.
12. Association of UK University Hospitals (AUKUH) Clinical Academic Roles Development Group. Transforming healthcare through clinical academic roles in nursing, midwifery and allied health professions. 2022. Available: https://www.medschools.ac.uk/media/2325/aukuh-transforming-healthcare.pdf
13. Pappa S, Ntella V, Giannakas T, *et al*. Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: a systematic review and meta-analysis. *SSRN Journal* 2021;92:247.
14. Greenberg N, Docherty M, Gnanapragasam S, *et al*. Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ* 2020:m1211.
15. Health education england rough guide to the academic foundation programme. 2022. Available: https://foundationprogramme.nhs.uk/
16. Barello S, Palamenghi L, Graffigna G. Burnout and somatic symptoms among frontline healthcare professionals at the peak of the italian COVID-19 pandemic. *Psychiatry Res* 2020;290:113129.
17. Lambert TW, Smith F, Goldacre MJ. Making clinical academic careers more attractive: views from questionnaire surveys of senior UK doctors. *JRSM Open* 2015;6:2054270415602644.
18. Research and higher education in the time of COVID-19. *Lancet* 2020;396.
19. Hotopf M, Bullmore E, O'Connor RC, *et al*. The scope of mental health research during the COVID-19 pandemic and its aftermath. *Br J Psychiatry* 2020;217:540–2.
20. O'Connor RC, Hotopf M, Worthman CM, *et al*. Multidisciplinary research priorities for the COVID-19 pandemic - authors' reply. *Lancet Psychiatry* 2020;7:e44–5.
21. NIHR guide to national institute for health research integrated academic training. 2022. Available: https://www.qmul.ac.uk/smd/media/smd/integratedacademictraining programme/integratedacademictrainingprogramme-documents/NIHR_TCC-NIHR-IAT-GUIDE_2017.pdf
22. Westwood G, Richardson A, Latter S, *et al*. Building clinical academic leadership capacity: sustainability through partnership. *J Res Nurs* 2018;23:346–57.
23. Gabster BP, van Daalen K, Dhatt R, *et al*. Challenges for the female academic during the COVID-19 pandemic. *Lancet* 2020;395:1968–70.

1. How do you usually divide your time between clinical and academic commitments?

2. If you have just been working in an academic environment, how long is it since you practiced clinically?

3. Have you returned to a clinical role as a result of the pandemic? If so,
   a. At what level?
   b. To do what?
   c. What has this experience been like? For example, were there any particular challenges that you needed to overcome?
   d.
4. If not, were there specific reasons why not?

5. (How) have your skills as a clinical academic been useful when returning to the medical frontline?