‘We are in for a culture change’: continuing professional development leaders’ perspectives on COVID-19, burn-out and structural inequities

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ABSTRACT

Introduction The COVID-19 pandemic positioned healthcare systems in North America at the epicentre of the crisis, placing inordinate stress on clinicians. Concurrently, discussions about structural racism, social justice and health inequities permeated the field of medicine, and society more broadly. The confluence of these phenomena required rapid action from continuing professional development (CPD) leaders to respond to emerging needs and challenges.

Methods In this qualitative study, researchers conducted 23 virtual semistructured interviews with CPD leaders in Canada and the USA. Interview audio recordings were transcribed, deidentified and thematically analysed.

Results This study revealed that the CPD leaders attributed the pandemic as illuminating and exacerbating problems related to clinician wellness; equity, diversity and inclusion; and health inequities already prevalent in the healthcare system and within CPD. Analysis generated two themes: (1) From heroes to humans: the shifting view of clinicians and (2) Melding of crises: an opportunity for systemic change in CPD.

Discussion The COVID-19 pandemic increased recognition of burn-out and health inequities creating momentum in the field to prioritise and restructure to address these converging public health crises. There is an urgent need for CPD to move beyond mere discourse on these topics towards holistic and sustainable actionable measures.

INTRODUCTION

In March 2020, the WHO declared the COVID-19 as a pandemic.1 In the early stages of the emergency, public health measures were implemented in North America to control community transmission.2 Nevertheless, COVID-19 infections surged, forcing healthcare systems to the epicentre. Front-line clinicians were particularly impacted by these capricious conditions, enduring physical exposure to the virus, stress, anxiety and depression.3 The intersection of physical and mental stressors in medical institutions exacerbated clinician burn-out4 (ie, feelings of exhaustion, depersonalisation and reduced accomplishment in one’s work).4 In this challenging landscape, continuing professional development (CPD) for medical education took on new importance as clinician learners required support to navigate the evolving crisis. Accordingly, CPD leaders were tasked with balancing support for the overwhelmed healthcare systems with the needs of healthcare workers.

As the world was grappling with the pandemic, several socio-political movements including the resurgence of Black Lives Matter (BLM), exposed systemic racial inequality and discrimination, igniting widespread public discourse around equity, diversity and inclusion (EDI). Founded in 2013, BLM gained momentum in May 2020 after the murder of George Floyd.5 Alongside a series of high-profile police killings of black Americans, the incident prompted global demonstrations against anti-black racism, and prompted contemplation about the role of institutions, including medical institutions, in its perpetuation.6 This situation created an opportunity for CPD leadership to reflect on and attempt to redress power structures and health inequities across the medical continuum.

This article explores how the pandemic impelled CPD leaders to address neglected areas within the field. We use the term CPD to refer to all continuing education/developmental activities that health professionals undertake to maintain and improve their knowledge, skills, performance and relationships with the goal of enhancing the quality

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The COVID-19 pandemic transformed the field of continuing professional development (CPD) for medical education, necessitating an innovative reconceptualisation of programme design.

WHAT THIS STUDY ADDS

⇒ The findings indicate that the pandemic exacerbated clinician burn-out which, in conjunction with the coinciding Black Lives Matter resurgence, prompted leaders to redefine priorities in the field of CPD. This created momentum to address neglected systemic issues including clinician burn-out, health inequity and social injustice.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ CPD leaders must implement policy and programming that address clinician burn-out and health inequities at the system level.

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and safety of patient care and health outcomes. We discuss the perspectives of CPD leaders on the shift in CPD culture towards enhancing clinician wellness and addressing health inequities that developed in response to the pandemic and other converging public health crises (systemic racism, clinician burn-out). To our knowledge, this is the first qualitative study reporting on the perspectives of key leaders in CPD on the impact of the pandemic on EDI and clinician wellness.

METHODS

Design and sample
We conducted semistructured interviews with CPD leaders from Canada and the USA to elicit perspectives on the impact of the pandemic on CPD organisations. A sample of the questions extracted from the study’s broader interview guide are presented in Box 1. We define CPD leaders as individuals engaged in CPD scholarship (discovery, integration, application, teaching) who hold a leadership role or have more than 10 years of experience in the field. Participants were recruited through purposive and convenience sampling, and consultation with a CPD professional organisation to validate inclusion criteria (see Table 1).

Data collection
Interviews were conducted between April and September 2022 via WebEx virtual conferencing and Research Electronic Data Capture (REDCap) software was used to obtain e-consent from participants. Interviews were approximately 60 min, audio-recorded and transcribed manually by a professional transcriptionist. In total, 23 participants were recruited via email, 12 of whom were medical doctors. Professional experience in CPD ranged from 2 to 35 years, with the majority having worked in the field for 15+ years. Thirteen participants were from Canada (British Columbia, Manitoba, Nova Scotia, Ontario, Quebec) and 10 were from the USA (California, Illinois, Kentucky, Maryland, Ohio, Tennessee, Wisconsin).

Analysis
Interviews were transcribed, deidentified and thematically analysed on Dedoose V9.0.54 as detailed by Braun and Clarke. Our analysis was inductive, as it was grounded in the interview data and did not rely on a pre-existing coding matrix. After a period of familiarisation, a subset of authors independently reviewed three transcripts before conferring to generate an initial codebook, which was then used to guide analysis of the remaining transcripts. Interencoder reliability practices (ie, double-coding) were applied to three subsequent transcripts in order to enhance team dialogue and reflexivity. Throughout the coding and analysis phase, the authors met routinely to discuss codes and theme development. Next, authors organised codes into five preliminary themes, ensuring that all codes captured under one theme were related to one another and to the theme generally. Iterative recoding and analysis was employed to refine themes and subthemes until they accurately reflected the entire data set. This article presents a subset of the data focusing on two significant themes generated from the interviews. Both themes pertain to participant commentary that arose organically, without prompting, and were emphasised as priorities for CPD leaders. Given the relevance of these themes in the current political climate, it is imperative to address them comprehensively.

It is helpful to understand our lens on the data is North American, encompassing both Anglophone and Francophone professional identities, we actively engaged in reflection and intentional discussion to select the research paradigms that best aligned with our research objectives.

RESULTS

The vast majority of participants discussed the prioritisation of clinician wellness and health inequities in CPD. The following two themes were generated: (1) Solidarity in struggle: individual and organisational responses to burn-out during COVID-19 and (2) Melding of crises: an opportunity for systemic change in CPD.

Solidarity in struggle: individual and organisational responses to burn-out during COVID-19

Drawing on their dual roles as clinicians and CPD professionals, many of our participants offered first-hand experience of the impact of the pandemic on clinicians’ well-being. They described these experiences as exhausting, both emotionally and physically, as they placed themselves in harm’s way to serve patients.

P004: Very early on in the pandemic, panic was everywhere. People were scared for themselves, for their family, we didn’t know what was happening.

Many participants explained how the enduring nature of the pandemic aggravated existing deficiencies and inequities in the healthcare system. They described the conditions and factors that increased clinician burn-out and stress:

P009: The healthcare system in Canada prior to the pandemic was not in great shape in terms of people being overworked, lack of beds [...] delay[s] in surgeries and so on [...] COVID has just

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<th>Table 1 Inclusion criteria</th>
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<tr>
<td><strong>Inclusion criteria</strong></td>
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<td>An individual who holds a leadership role or has 10+ years of experience in an organisation involved in CPD.</td>
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<td>Example positions include:</td>
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<td>University CPD office chair</td>
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<td>National society CPD office director</td>
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<td>Accrediting body leadership position</td>
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<tr>
<td>Working in Canada or the United States</td>
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<td>Involved in CPD scholarship (discovery, integration, application, teaching)</td>
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<tr>
<td>Fluent in written and verbal English</td>
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<td>Over age 18</td>
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<td>CPD, continuing professional development</td>
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Box 1. Sample interview questions

1. What impact has the COVID-19 pandemic had on CPD in your organisation?
   - From your perspective, how did COVID affect CPD program engagement/participation?
2. Has the role for innovating in CPD taken on new urgency or meaning for you during this rapidly changing time?
   - What changes need to happen to adapt to these changes in teaching and learning?
3. What is the single most important trend/innovation in CPD research/scholarship that you think those in the field need to know about?
   - Are there gaps in our understanding in the delivery or effectiveness of CPD that have emerged because of this pandemic?
obviously amplified those existing problems. Plus, you now have an entire workforce that is burnt out.

P016: We used to have space in our work where you could stop and […] take a break together and have tea and cookies […] All of that time has been squeezed out of our lives by overwork […] I think the attention to wellness and how stretched people are is another thing that COVID exposed that the systems we’ve built around us of pressure and overwork, that they might save dollars, but they are costing us wellness.

Some participants believed that the strain on an already ‘broken’ healthcare system along with sustained high levels of stress and burn-out propelled an exodus of clinicians from their profession. Those who remained had to work in the midst of inadequate staffing and other key resources:

P019: There is a marked increase of people leaving the workforce […] There is a lot more burnout […] Whether it’s because COVID itself, or how the health system has handled COVID, or how many hours they’ve had to work, or any of the different political things going around it either […] I think there is something there.

P016: I think COVID has taxed us all, made us exhausted and made a lot of people walk, and the number of people leaving the medical profession is huge. We can’t train them fast enough […] In emergency we’ve lost 60% of our nurses […] So I think wellness and all of that is a big need that has come out of COVID that, again, we kind of ignored.

Participants emphasised that because clinician experiences were largely commensurable with that of the public, collective concern over the virus ignited empathy humanising clinicians:

P009: I think [the pandemic] created greater empathy and greater awareness […] I supposed it actually humanised physicians […] it really brought that sense of we’re all experiencing this as humans in different ways, but we are all having the same experience.

Against this backdrop, participants stated that wellness should be prioritised in the CPD mandate and underscored the need for a targeted response to this exigency. Some participants shared how their organisations strategically responded to clinician learners’ wellness needs:

P009: We started hearing more from the physicians we have on staff about their experience, and looking at what that means for us in terms of translating into our practices […] We tried to shorten committee times, decrease our ask in terms of the workload, provide things differently for the size of our meeting packages, that kind of thing.

P004: We did forums at the beginning of the pandemic to support different groups of physicians who would have different challenges […] We did some community group practice so people could meet and talk virtually, about what they were experiencing.

P017: We put out a member survey, and asked them very directly, how are you doing? […] So we put together our first virtual webinar on wellness, and how to encourage people to stop, and take a moment, and breath, and get themselves into a space of comfort and safety.

The reaction to these initiatives was not entirely positive. Although participants described some interventions as valuable, the initiatives also evoked frustration. In particular, one participant raised concerns about interventions focused solely on individual-level resilience, underscoring how they were disconnected from the realities of clinician experiences:

P016: If you get into medical school and you get out of medical school and you’re in clinical practice, you’re resilient. I’ve worked 110-hour weeks, and they’re trying to teach me resilience? […] There’s a lot of frustration in healthcare professionals around some of the wellness undertakings that feel disingenuous, and from people who have never walked in our shoes and absolutely don’t get it […] Some of it is that they haven’t really grasped the true needs and don’t know what they’re talking about, and then other bits are really helpful.

Nevertheless, burn-out could no longer be ignored within CPD. The field has recognised its responsibility to address this ongoing crisis.

P004: [N]ow we understand that wellness of the physicians is part of a successful healthcare program. It’s there. It’s necessary.

Melding of crises: an opportunity for systemic change in CPD

Several participants discussed the temporal convergence of COVID-19 and other prominent social incidents as a ‘melding together’ that CPD leaders needed to address:

P013: The pandemic and social change issues got melded together […] social change issues and issues around equity and diversity really came to the floor in CPD more than I think they may have without the pandemic. So, in a strange way the pandemic served in some ways to isolate those who needed care the most, and in some ways helped to bring their situation to the floor, especially from a CPD perspective.

P023: Not only did we get hit with a pandemic […] we also saw other huge world events like Black Lives Matter […] We’ve been dealing with equity, diversity, and inclusivity on many fronts, on Indigenous, and Black Lives Matter, and gender bias, or gender equity in medicine, in fact. I would say […] [that is one of] the biggest trends that has come out of the last two years.

Many participants described how social determinants of health (SDOH) became exposed in ways not previously evident to many CPD leaders. They explained how the confluence of the pandemic and the increased awareness of social justice issues incited a call to action:

P002: It has been a huge opportunity for our field […] Every major organisation in organised healthcare has responded with strategies, committees, tools to ensure that we are meeting the needs of diverse populations. Just from a planning standpoint I think it’s heightened the awareness and importance of diversity in the selection of our faculty, in topics, in thinking about it from all dimensions to really be a part of the solution for disparate healthcare.

P001: The healthcare systems, at least in the United States, were basically punched in the face with social determinants of health issues […] to the point where they couldn’t treat it as a caveat […] They really are like, oh crap, there’s this thing and we have no choice but to deal with it […] I think there’s some research that we’re doing in that space that I’m very excited about, and how we meaningfully incorporate it in conversation that probably people are a little more open to because of the pandemic.

P016: There was a huge crack in the system that COVID just stressed it, taxed it, and exposed it […] I think [COVID-19] provided a needs assessment for CPD in areas that were selectively ignored before. I think it’s a good thing. It’s painful. It has been hard to watch, but […] I think we’re in for a culture change.

This engendered opportunities for CPD leaders to critically reflect on their own biases and assumptions in programming and delivery.

P003: [I]f CPD does not also fall in line with implementing best practices for how we plan and deliver education to address health equity, and make sure that we are not perpetuating our own racial and gender stereotypes in the types of activities we put on, we’re really missing a great opportunity.

Although participants spoke at length about heightened awareness of EDI and combating systemic discrimination within CPD, few participants specified how their organisations are taking concrete steps. Several participants indicated that CPD is in its
infancy with respect to implementing crucial systems change but are hopeful about future initiatives:

P022: Looking at our planning committees and how we can make our programs more diverse. I think we’re still at the very beginning stages of all of this because there is some stuff being written in the literature, but not so much within the CPD literature. I think there is more to come in the future.

P013: I don’t think we’re spending enough time in CPD talking about social and racial injustice. We do spend some time. I don’t know if we spend enough time there […] I hope people see it as an opportunity to change the way we do work to make things better for those who we serve.

DISCUSSION

CPD leaders attributed the pandemic as illuminating and exacerbating other public health crises, such as clinician burn-out and systemic racism.

Consistent with the broader literature, our study identified that COVID-19 exacerbated burn-out, in turn, clinician wellness emerged as a key priority for CPD. For instance, a 2021 survey found that numerous institutions ranked clinician wellness as a top priority: 69% of medical schools and 93% of specialty societies identified wellness and burn-out as a moderate or major focus for their CPD programming during the initial phase of the pandemic. This was a dramatic shift from 2018, when clinician wellness was listed as one of the lowest priorities for North American medical schools. It was encouraging that our participants, as leaders and critical agents in supporting organisational and cultural change, echoed these sentiments. As some of them were both healthcare practitioners and CPD leaders, they had a unique perspective about the impetus for this shift and the required interventions.

Our study found that the pandemic compelled a reconceptualisation of the ‘clinician’, towards recognition of their multiple and holistic identities. Prior to the pandemic, there was criticism about the depersonalisation of clinicians, however, the image of clinicians has evolved substantially over the past 3 years. At the beginning of the pandemic, clinicians were exalted as ‘invincible superhumans’, setting aside their own needs to selflessly care for COVID-19 patients. Clinicians, however, felt burdened by the ‘hero’ discourse, which imposed social expectations of self-sacrifice for the common good and stifled meaningful discussion of their lived experience of the crisis. As the pandemic continued, media reports described their fear, sleeplessness, uncertainty, general exhaustion and the impact on their loved ones. These glimpses into the everyday work and personal lives of healthcare providers instigated a shift from ‘clinician-as-hero’ to ‘clinician-as-human’, which was reflected in our interviews with CPD leaders on clinician wellness and burn-out. Given this momentum, CPD leaders should advocate for recognition of clinicians’ humanity within educational frameworks—which is presently lacking. Furthermore, our findings signal the necessity of organisational and system-level interventions. As affirmed by our participants, it is important not to focus exclusively on individual-level solutions as systemic and organisational factors often produce burn-out. Individual-level approaches receive more attention, but they inadvertently place the onus of solving the problem on clinicians. Moreover, interventions that impede on a clinician’s personal time or that are not followed by clear action may exacerbate burn-out. Thus, CPD leaders should re-strategise towards a more holistic and sustainable approach to address root causes of burn-out.

Pertaining to the second theme, many participants associated the pandemic with increasing their awareness of health inequities, thus revitalising interest in SDOH in CPD initiatives. They described the impact of both the pandemic and social movements, such as BLK, on health professions education and discussed the role of CPD in addressing injustices through EDI initiatives. There is a need to implement EDI principles within CPD processes, requirements and standards.

Literature on the intersection of COVID-19 and increased awareness of inequities is scarce; however, several authors have suggested that BLK illuminated and created the necessary space to discuss racial inequities in health outcomes. Current evidence demonstrates that the pandemic disproportionately affected black Americans and Canadians with higher rates of morbidity and mortality. Structural oppression has been identified as a key contributor to these disparities. Many clinicians, in their role as stewards of health, openly supported the BLK protests, recognising structural inequalities as a public health crisis akin to COVID-19.

From a clinical practice perspective, clinicians grappled with how to best care for patients during the pandemic. Awareness grew of the adverse outcomes related to COVID-19 vary according to race and ethnicity, socioeconomic status, and housing conditions. At the same time, trust in health professionals eroded among many black and racially minoritised groups, resulting in vaccine hesitancy and lower level of participation in clinical trials among these communities. This situation reinforces the need for enhanced training on SDOH. Current medical education curricula are insufficient because they focus on raising awareness rather than building capacity to challenge inequalities.

In the wake of social unrest in North America, several medical associations and accreditation bodies released statements announcing their commitment to EDI. While these verbal commitments are an important step, systemic change requires actionable measures. Our study participants echoed the need for CPD to address health disparities and culturally sensitive care, and to select diverse faculty and programme committee members as an indication of their commitment to EDI. Given this is an emerging priority, more research is needed on assessing the design, development, implementation and outcomes of EDI-related CPD initiatives.

Limitations

The study had several limitations. First, while our sampling method was strategically chosen to obtain information rich sources of data representation from various CPD organisations allowing us to understand variations within this group, this method increases the risk of bias. Second, the findings of the study may be limited in scope, as the sample was restricted to participants from Canada and the USA. Finally, since the study did not focus directly on clinician wellness, EDI and health inequity, interview questions were not designed to elicit in-depth perspectives on these topics. Rather, participants organically discussed the intersection of the pandemic and BLK as related to CPD. Consequently, we centred our analysis and discussion on health inequities faced by black communities in Canada and the USA. Accordingly, the disproportionate impact of the pandemic on other racially minoritised and Indigenous groups is notably absent in our analysis.

CONCLUSION

Alongside the growing recognition of clinician burn-out, health inequity and social injustice among CPD leadership, this study underscores the importance of an integrative systems CPD approach to meaningfully address complex challenges and effectively implement change. An important future research direction...
is to identify the optimal response to clinician burn-out and systemic healthcare inequities; whether through a split approach or in junction—as clinicians experiencing burn-out may be limited in capacity to address complex health inequities. To support clinicians, patients and increasingly strained healthcare systems, it is imperative for CPD leaders to confront these challenges with an adaptive and growth-oriented disposition.

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