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Original Research

# Emerging from the pandemic and reflecting on change: public health doctors in Ireland

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ABSTRACT

*Objectives:* This study aimed to generate insights into the working lives of Public Health doctors as they worked through a period of immense change relating to their roles within the COVID-19 pandemic and the (long-anticipated) public health reforms that followed.
*Study design:* This study used a qualitative study design.
*Methods:* Using an innovative method of remote ethnography (Mobile Instant Messaging Ethnography), this paper presents the work related reflections of 13 Public Health doctors in Ireland. Participant doctors were recruited to the study via advertising on social media, on the project website and via professional networks. The method involved an online in-depth qualitative interview; a six week conversation with the researcher via WhatsApp and a final online qualitative interview with participants. Data collection was conducted June to August 2023 and the data was analysed using MaxQDA.
*Results:* The data presented illustrates the significant work-related changes experienced by Public Health doctors (N = 13) in Ireland. These changes related to the introduction of consultant status for Public Health doctors and public health reforms. They also related to the COVID-19 pandemic and the associated increase in workloads and work intensity experienced by public health doctors in the Irish health system.
*Conclusion:* While most of the changes were positive, for instance the pandemic-related recognition of the role of Public Health doctors and the subsequent introduction of consultant status, the level of change in a relatively short space of time, was nevertheless significant. As our paper illustrates, the onus is on the employing organizations to recognize the impact of these changes on Public Health doctors and to ensure that their employees feel valued and heard at all times, particularly during times of significant change. To achieve this, employers should invest in research-informed interventions to improve psychological safety and team culture for public health doctors within the new organisational structures.

## 1. Introduction

Public health doctors in Ireland are emerging from a period of immense change. The most significant change to their ways of working resulted from COVID-19 and the leading role played by public health doctors in the pandemic response. In the UK, the COVID-19 pandemic (the pandemic) was found to have had a huge impact on the mental and physical health of the public health workforce.[1] A survey of Faculty of Public Health (UK) members in 2021-22 revealed that 64 % were experiencing moral distress.[2] Research with primary care doctors in the UK described how '*COVID-19 initiated a violent rupture where all-encompassing changes had to be made to local practice at extraordinary speed*'.[3] Researchers described how the rapid changes in healthcare delivery necessitated by the pandemic were felt at individual, team and organisational levels and how they left doctors feeling that they had lost their professional bearings[3] in having to respond to so much change in a short space of time.

This study followed on from a largescale research project on hospital doctor retention (2018-24) in the Irish context which identified challenges in relation to working conditions[4,5] as a significant challenge to doctor wellbeing and retention, particularly in the aftermath of the pandemic. The team wanted to consider whether similar challenges

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were faced by public health doctors. Although widely considered the cornerstone of the national pandemic response, media reporting in 2021 indicated that public health doctors, too, were struggling to cope in an under-resourced and under-staffed system.[6] Our aim was to conduct a small-scale study to see whether public health doctors were supported to be the best that they could be at work as they worked through a period of considerable change.

In Ireland, the pandemic provided the impetus for long-anticipated[7,8] reform of public health as the Irish government moved to strengthen the public health workforce to improve its capacity and to provide a robust health protection response.[9] Reform measures initially proposed in 2001[7] were finally initiated in 2021. Meanwhile, Specialists in Public Health Medicine agreed to changes in service provision e.g. their participation in an out-of-hours rota for Health Protection necessary for Ireland to meet its international obligations under the International Health Regulations. This interim on call service, intended to be in place for six months, was established in 2009 and still exists today. It is difficult to say why the public health reforms took so long (two decades) to materialize, but it may relate to the fact that public health medicine is not clinical or patient facing, that it is prevention-focused and that it is a female dominated specialty.[10] In the absence of reform, the specialty struggled with recruitment, retention and staffing levels.[7] Public health doctors undertook industrial action in 2003[7] and voted in support of industrial action in 2020,[11] reachingagreement in 2021. The reforms, initiated in the 2021 sought to deliver a *'radically different organizational model for the delivery of public health services'*.[8] The first step in the reform process was the introduction of a consultant delivered model of Public Health[9] which saw Public Health doctors eligible for consultant status for the first time – bringing them in line with all other medical specialties in Ireland. Consultants in public health medicine were to lead multidisciplinary teams of surveillance scientists/epidemiologists, senior medical officers, trained contact tracers alongside administrative and management staff.[9] The reform process also involved a reconfiguration with the establishment of six new public health areas in 2022, each with an area Director of Public Health. These regions are aligned with the six new Regional Health Areas (RHAs) established by the national health reform programme (Sláintecare).[12] Since the establishment of the Health Regions, regional Public Health Departments have been placed in these regional structures. Directors of Public Health now sit on regional Executive Management team and, report to their Regional Executive Officer, thereby furthering regional integration.

Although Public Health doctors welcome the enhanced status of public health medicine, there is a risk that they may struggle to adapt to significant workplace change while simultaneously recovering from the many work-related changes necessitated by the pandemic. The type of change initiated in 2021-22, which involved new roles, new multidisciplinary teams and geographic reconfigurations, are notoriously difficult to adapt to, as Allan et al. explain:

> '*integrating new interprofessional teams is a slow process especially if structures in place do not acknowledge the painful feelings involved in change and do not support staff during uncertainty*'.[13]

Drawing on qualitative data comprising of in-depth interviews and a 6-week remote ethnography, this paper presents the experiences of 13 Public Health doctors working in Ireland as they reflect on three years of pandemic working; which coincided with two years of significant organizational reform. During their interviews, participant doctors reflected on both the positive and negative components of change and its implications for the future of public health medicine in Ireland.

## 2. Methods

Using a qualitative study design and an innovative remote ethnographic research method (Mobile Instant Mesaging Ethnography),[14,15] research ethics approval for this study was granted by the institutional ethics committee in May 2023. Participants were recruited to the study via advertising on social media and on the project website as well as via public health professional networks. Data collection was conducted between June and August 2023 and 13 public health doctors participated (see Table 1). A method of remote ethnography was used which involved an online in-depth qualitative interview; a 6 week conversation between researcher and participant via WhatsApp and a final online qualitative interview with each participant,[14,15] in line with the teams previous experience of using this method.[14,15] The interviews were conducted online (using Zoom or Teams) and were guided by a theme sheet. The first interview gathered background information on participants; asked about their place of work and asked them to describe a typical working day. The interview also invited participants to reflect on their experience of working through the COVID-19 pandemic. The WhatsApp conversation was also guided by a theme sheet arranged by topics, such as work life balance, work-related support, working during the pandemic. Each week the researcher (MAI) would send 2–3 messages to each participant, inviting them to respond and to draw on their experiences that day. An example of a message on the theme of workplace culture was: 'How was your communication with other people at work today? (giving specific examples if possible)'. Finally, each participant was invited to participate in a closing qualitative interview, held online. The final interview provided an opportunity to delve into some of the topics discussed over the course of the WhatsApp conversations, as well as an opportunity to invite participants to reflect back on broader topics, e.g. 'Has the pandemic changed the way you feel about working as a doctor?'. All theme sheets were developed in consultation with public health doctors, informed by the literature and by a previous project which used this method.[14,15] Data collection was conducted by MAI. Transcription was undertaken by a third party. Transcripts were de-identified (by MAI) and participants were offered an opportunity to review/amend their transcripts. Once approval was obtained, coding, analysis using MaxQDA and write-up was undertaken by NH in consultation with MAI and MC.

## 3. Results

### 3.1. Recognition-related change

Participants were keenly aware of the impact that the COVID-19 pandemic on their specialty. The pandemic brought with it a sudden and widespread recognition of the importance of public health medicine and its relevance to the everyday life of the population:

> *'the pandemic shone a spotlight on our profession as suddenly such work had … relevance for the whole population. I think it enhanced our profile and gave public health a stronger voice than before'* (Participant 9).

Public Health doctors obtained consultant status, in line with other medical specialties, in 2021. Participants explained that it was a hard-won battle for recognition for public health; *'it was just nasty … fighting for the health security of the state* [and also]*… with the state for*

**Table 1**
Respondent table HDRM public health (N = 13).

| Respondent Table HDRM Public Health (N = 13) | | | |
|---|---|---|---|
| Gender | Male | 8 | 13 |
| | Female | 5 | |
| Grade | Consultant | 5 | 13 |
| | Specialist in Public Health | 4 | |
| | Senior Medical Officer | 2 | |
| | Specialist Registrar (SPR) | 2 | |
| Country of training | Ireland | 10 | 13 |
| | Outside Ireland | 3 | |
| Data Collection log | Interview 1 | 13 | 13 |
| | WhatsApp/MIME | 12 | |
| | Interview 2 | 9 | |

*our security'* (Participant 5). There was a feeling that the recognition could (and should) have happened sooner.

*'it has taken a global pandemic to get the Department of Health to appreciate finally that there is an important role for Public Health Doctors in this country, a role that has been recognised and rewarded in most other countries for at least thirty years.'* (Participant 13).

Respondents were proud of this newfound recognition of the importance of public health. They explained that it had enhanced the perception of their specialty with members of the public and also improved their standing within the wider medical profession.

### 3.2. Workload related change

Participants reflected on the pandemic and what it had meant for them in terms of increased workload and work intensity. Although there was pride in what had been achieved, participants also noted just how challenging the pandemic had been for them.

'*You knew that you were doing important work. But I lived at work. I was in work until 10 or 11 o'clock every night, for something like 14 weeks in a row, with very occasional days off. It was non-stop for the first wave*' (Participant 1).

This high intensity work continued for years, as this participant explains: *'We worked very, very long hours for a long, long time during COVID. Maybe two years'* (Participant 5).

Few participants missed the work rate of the initial pandemic period. The public nature of the work added to the pressure as participants found that they were *'in the media a lot, it was very political, it was very stressful'* (Participant 10).

They spoke about feeling burnt out and overwhelmed throughout that time, noting that they continued to feel that for some time afterwards.

*'there's a certain hangover effect with it. But I always try to remind myself that 2020, 2021, that, those couple of years, like, that's, that's where the intensity was here. Everything else should definitely be … a level below that'* (Participant 9).

At the time of interview (2023), participants had had time to reflect on the changes that had resulted from the pandemic and the impact on their lives, their work and their wellbeing. Several participants mentioned burnout.

*'it was particularly intense and busy throughout the pandemic … And I don't think we necessarily had any formal debrief … nobody ever sat down … with the version of, like, "Right, how's everybody doing … how are you feeling?" 'Cause I'd say a lot of people were … if not burnt out, they were quite close to it'* (Participant 9).

There was a sense that there had had been insufficient time set aside to reflect, recover or debrief from the intensity of pandemic work.

### 3.3. Reflections on pandemic and reform-related change

In their interactions with researchers, participants highlighted the significant levels of change undertaken in a relatively short space of time. From the initial stage of the pandemic (2020) to the introduction of consultant status (2021) and associated restructuring and reform of public health structures. Although these changes began in 2021/22, their roll out continued (at the time of interview in 2023) and change was a topic weaved throughout every interview.

*'It is difficult to tease out what changes are attributable to Covid as there have been the coincident issues of a cyber-attack and the ongoing changes in relation to the Departments of Public Health and Public Health as a specialty. There has been phenomenal change in my work over the last few years.'* (Participant 6).

The most significant change was, inevitably, the pandemic. While participants were proud of the pandemic response, they were also concerned that public health medicine was (and remains) under-resourced relative to need:

*'there was a strong sense of purpose … fantastic work was done. Colleagues were absolutely amazing. We did great partnership work with a lot of different agencies. But … sometimes, the expectations of public health as well, relative to the resources that we had, were totally unrealistic'* (Participant 1).

Participants spoke about the impact of under-staffing and under-resourcing on their working lives, with Public Health doctors taking on additional work and/or working longer hours to complete the workload:

*'those of us remaining on the ground are expected to do more/deliver more, but with less, and on more onerous rotas. That makes me feel unsupported and it can be a bit deflating when national structures keep asking us to deliver more'* (Participant 1).

There was a feeling that under-staffing was an impediment to undertaking strategic work, or to plan for the future, something critical in public health, particularly in terms of future pandemic preparedness.

*'We don't know what the future looks like and how we're going to do anything other than just keep the service running, keep our heads above water and our ability to do any strategic level work is going to be significantly impaired'* (Participant 7).

At the same time as they adapted to the changes resulting from the pandemic, public health structures were reformed and re-organized, necessitating significant levels of organisational change. Participants articulated a sense of change fatigue.

*'I think with all the changes in public health, there's definitely a sense of, there's been a lot of changes to process and … it feels disorganized at times. People don't know exactly what their role is or how it fits in, or who they report to'* (Participant 3).

Other participants were concerned that their input to (or feedback on) the change process was not heard or welcomed. This led some participants to question their sense of psychological safety at work.

*'I feel very … unsafe and insecure … in this organization'* (Participant 4).

'*The tenor of change management meetings is … to pathologise any dissent. So if … I do not think this is a good idea because of A, B, or C … any kind of dissent tends to be ascribed to stress*' (Participant 6).

This indicates a need for enhanced lines of communication around the various change processes as well as a need to ensure that staff are listened to (and feel heard) when they raise concerns about the changes and their impact on their working lives.

## 4. Discussion

For public health doctors, as for all health workers, the pandemic represented a significant change to ways of working. When we consider the pandemic as a significant work-related change, the focus changes from how individual doctors managed to 'get through' the additional hours, workload and associated stress that came with pandemic-working, but also how their employers and the health system supported and resourced them to do so.

The Irish Health Services Executive (HSE) recognize the importance of supporting staff through change as it is a key pillar of the 2018 HSE change guide;

*'We recognise that our staff are at the heart of our health services and their capacity to embrace change is critical to its success. Change can be challenging and having support is important throughout the process*'.[16]

Participants described 'pushing through' the pandemic as Public Health doctors – working the long hours, absorbing the additional work intensity and associated stress. They continued to work in this manner until the pandemic workload eased. They spoke about having had minimal opportunities to debrief and discuss the impact of the pandemic afterwards.

One possible reason for the lack of a pandemic-related debrief for Public Health doctors is that the specialty began a period of significant organizational change in 2021. Although the change was long-overdue, particularly in terms of assigning consultancy status to Public Health doctors, its introduction and roll out coincided with the pandemic, meaning that participants experienced overlapping change in several dimensions of their working lives at once. Data from participants suggests a degree of change exhaustion as a result. MacIntosh et al. describe a similar situation in the UK:

*'Many of the staff involved had … lived through several rounds of reorganization to stitch together or pull apart similar, but distinct, organizational forms. Suffice to say that staff were not overly enthusiastic about the prospect of another wave of reform*'.[17]

They explained how an organizational change *'process spanning between one and two years in duration actually felt frenetic'*[17] to those experiencing the change and they highlighted the vital role of communication throughout the change process.[17]

Without space to debrief on recent changes and the impact they have had (and continue to have) on staff, there is a risk that individual Public Health doctors will be left to cope alone. The change literature reminds us that *'change exhaustion is not an individual issue, but a collective one that needs to be addressed at the team or organization level'*.[9] Given that the changes underway (whether pandemic-related or organisational-related) are common to all Public Health doctors, it makes sense to set aside time/space to debrief on the change process and its impact on wellbeing, at a workforce and/or at specialty level.

Another reason for the need to improve communication at this critical juncture for Public Health is to ensure that those leading and driving the changes are aware of the impact the changes are having on the ground. As Amy Edmonson explains, *'the people on the front line … are privy to the most important strategic data'* available to the organization.[18] The importance of generating timely organizational intelligence on *'how well they are really doing as an organisation, and where they need to improve'*[19] is always important, but areparticularly critical during intense periods of transition and change.

The data presented in this paper indicates room for improvement when it comes to ensuring that Public Health doctors have sufficient psychological safety[18] within the new organizational structures to voice their concerns and have them heard. A recent study of hospital doctors in Ireland described organizations with poor voice culture in which there was a wide disconnect between management and frontline health workers, organizations in which their input was ignored or downplayed.[20] Public Health doctors need to be empowered to contribute both to the delivery of current services and also also to their improvement.

In conclusion, although welcomed, a new contract, improved status and largescale reconfiguration cannot be assumed to have 'fixed' all problems for the Public Health specialty or its workforce. As our paper has illustrated, Public Health doctors have been involved in significant amount of change in a relatively short space of time. As Barry et al. explain *'people mediate change in messy, complex and unpredictable ways'*[16] and the onus is on organizations and structures to ensure that their emloyees feel valued and heard at all times, particularly during times of significant change. In terms of specific measures to be undertaken by the employer, in line with the national and international literature[16,18,20–23] the authors suggest that the employer conduct research on culture, psychological safety and team work within the public health workforce in Ireland. Such research, if co-created, would provide an opportunity for public health doctors to debrief and reflect on change; while also generating evidence to inform the development of research-informed interventions to improve psychological safety and team culture for public health doctors within the new organisational structures.

### 4.1. Limitations

The relatively small number of participants in this research project (N = 13) could be considered a limitation of the study. At the end of a project focused on hospital doctors the study was designed a starting point for the research team to begin to explore the working conditions of doctors working outside of the hospital contexts. A further limitation of the study was that only 9/13 doctors completed the final interview. The authors speculate that a change of project staff at that time may have had an impact on the connection with all participants and on study completion rates. In terms of the positionality of the research team, one member of the team (MC) is a public health doctor and HSE employee; while two other members of the research team (NH, MAI) are social science researchers without a medical or public health background.

## Author statements

### Ethical approval

RCSI REC committee reference: REC202305002.

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### Competing interests

None.

### Author contributions/CRediT statement

NH: Conceptualization, Formal analysis, Funding acquisition, Methodology, Project administration, Supervision, Writing – original draft.

MAI: Data curation, Methodology, Writing – review and editing.

MC: Conceptualization, Writing – review and editing.

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