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On behalf of shielded anaesthetists and intensivists in the UK

No competing interests are declared.

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‘Shielded’ anaesthetists and intensivists during the COVID-19 pandemic: a reply

We thank Dr Iliff et al. for raising the important issues affecting doctors who are, or have been, in the ‘shielded’ or ‘extremely vulnerable’ group during the COVID-19 pandemic [1].

We are aware that many colleagues, because of individual risk factors, have been community shielding, workplace shielding or have been undertaking duties vastly different from their usual scope of work. We recognise that some will feel lonely, forgotten, guilty or bored. Many may be anxious about returning to work, with concerns regarding their safety, combined with the challenge of managing constantly changing guidelines.

This is a time of immense change. Priorities could be different for shielding anaesthetists. Options include: giving up work; a sabbatical; working from home; returning to non-clinical work; returning to lower risk work; returning to work with mitigation; a career change; or even retiring. Shielding doctors might consider accessing an Association-trained mentor (https://anaesthetists.org/Home/Wellbeing-support/Mentoring/What-is-mentoring). This might help find a way through the current challenges supported by someone completely outside the process and therefore allowing a focus on individual needs. It is likely that individual doctors have many skills and there may be options that come to mind once time and space is given to consider what the real priorities are.

The Association has been involved in producing *Vital Signs*, a guide for anaesthetists seeking help and advice during the COVID crisis (https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Vital_Signs_in_Anaesthesia2020.pdf) and this contains much general information that returnees may find valuable. For colleagues who are shielding, our website has an article with simple strategies to maximise the day and maintain physical and mental well-being (https://anaesthetists.org/Home/Resources-publications/COVID-19-guidance/Maximise-your-day-while-shielding). The Association is currently preparing additional information to include in *Vital Signs* for returning clinicians and for those who are currently shielding. Dr Sethina Watson gave a talk about the impact

of shielding on anaesthetists in a recent Association webinar (at time-point 1:04:45) (https://tinyurl.com/y6n2rnmy). There is of course more general advice on the Association's well-being and support webpages (https://anaesthetists.org/Home/Wellbeing-support), including links to organisations that can provide emergency counselling services for those particularly struggling.

The Academy of Medical Royal Colleges has generic return to practice guidance intended for doctors who have been absent for 3 months or longer (https://www.aomrc.org.uk/wp-content/uploads/2017/06/Return_to_Practice_guidance_2017_Revison_0617-2.pdf). There is no specific guidance about returning a currently working colleague back to a role they have previously performed but the Royal College of Anaesthetists (RCoA) does have a generic webpage on returning to work (https://www.rcoa.ac.uk/sites/default/files/documents/2019-09/ReturnToWork2015.pdf). The principles are that it should be a customised journey supported by the employer (usually via your Clinical Director) with employee well-being, patient safety and a sustainable anaesthetic workforce as key factors to be agreed by both parties.

For trainees, there are clear guidelines provided by the RCoA on competencies required at various stages of training. There is no specific list of tasks and competencies for non-trainees but here are some suggested principles: examining modules in the RCoA syllabus to identify any areas that need to be actively addressed (the focus is likely to be much more on confidence); identifying a specific supervisor; negotiating using a small number of supportive colleagues to work with regularly during the return to work programme; agreeing a time frame for review ahead of returning to solo working; considering using a reflective journal; and establishing a formal support structure.

There is a risk reduction framework for NHS staff (https://www.fom.ac.uk/covid-19/update-risk-reduction-framework-for-nhs-staff-at-risk-of-covid-19-infection), produced by an independent group of experts and supported by the Faculty of Occupational Medicine. It is a pragmatic guide to workplace and workforce assessment, and has been designed to be applicable to all groups of staff, not just those with increased vulnerability. Some occupational health departments are using a tool called COVID Age (https://profile.covid-age.com/calculator) to help determine individual level of risk from COVID.

We recognise that the prospect of returning to work is a significant source of anxiety. There is the worry of exposure to infection, but also the prospect of unfamiliar work schedules, where previously routine and predictability were part and parcel of every day work. This is an understandable and appropriate response. We also acknowledge that many colleagues feel guilt for their absence from their usual roles. Guilt is a perceived feeling of deserving blame for imagined or real offences or from a sense of inadequacy. Sometimes guilt is socially useful, but we hope that colleagues will agree that those who have been quite rightly shielded by a responsible healthcare system should feel no guilt for this.

We will continue to work independently and with other organisations to provide support to colleagues in times of difficulty.

Subsequent guidance on shielding doctors returning to work will emerge and we encourage colleagues to keep an eye on the joint COVID guidance website (https://icmanaesthesiacovid-19.org) and the usual social media channels.

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