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Learning from pandemic precarity: The future of early career researchers in qualitative health research

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ABSTRACT

This commentary is a critical reflection by early career researchers (ECRs) working in qualitative health research (QHR) during the COVID-19 pandemic. The consequences of the pandemic have been acutely felt by ECRs working in QHR. Many studies stopped, almost overnight, as healthcare institutions restricted access and redeployed staff, forcing researchers to redesign or even abandon projects. We reflect on the burden of these challenges for insecurely employed QHR ECRs and discuss the approaches adopted to retain scientific integrity and redesign studies. We also highlight the impact of COVID-19 on career development and relationship building – both during the emergency pandemic period and in the reshaped context of academia that continues to operate under the long shadow of COVID-19. We conclude by outlining a programme of change for how the practice and organisation of QHR could be reshaped, identifying opportunities for learning from the pandemic. Embracing these learnings will benefit not only the careers and wellbeing of QHR ECRs, but also universities, funders and the overall health and future of QHR.

Contributions

Madeleine Tremblett: project administration; conceptualization; writing – original draft (section 2 and 3); writing – review and editing, Tom Douglass: project administration; conceptualization; writing – original draft (section 2 and 3); writing – review and editing, Jack B. Joyce: project administration – initial development; conceptualization; writing – original draft (introduction); writing – review and editing, Alistair Anderson: writing – review and editing, Natalie Flint: writing – review and editing, Tanisha Spratt: writing – review and editing.

1. Introduction

The COVID-19 pandemic caused unprecedented disruption to, and changes in, global healthcare (see Roy et al., 2021). Entire treatment facilities were temporarily closed, and staff seconded to treat COVID-19 patients or deliver vaccines (Vera San Juan et al., 2022). Universities also experienced a unique set of challenges – developing new ways of delivering teaching and continuing research,[1] whilst medical academics returned to the NHS and nursing and social work students were thrust onto the frontline. Against this backdrop, the pandemic had important consequences for qualitative health researchers. In one sense, it provided impactful research opportunities to contribute to understanding and combating a novel virus, with researchers developing new approaches, skills and resilience in a crisis context. However, for many COVID-19 has had a long-lasting negative effect on their lives, career and field – in some instances damaging the feasibility of important non-COVID-19 health research. Wider problems relating to building scholarly community have developed from the pandemic context. Meanwhile, conversations continue about the form and organisation of

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[1] These experiences have resulted in a positive revaluation of pedagogical practice and new ways of working within universities that are unlikely to ever fully revert.

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research and academic life; notably, pre-existing problems have been reconstituted or recontextualised – such as the precarious nature of the employment of many (particularly junior) academics.[2]

In this commentary, we discuss how the challenges and changes of the pandemic have been keenly felt within qualitative health research (QHR) and for qualitative health researchers due to the unique nature of this type of research. Indeed, the demands of QHR, such as its use of sensitive data from settings that became harder to access, as well as QHR's reliance on strong relationships between researchers, healthcare practitioners, and participants meant the COVID-19 pandemic had ruinous effects on many studies. We argue that early career researchers (ECRs) have been disproportionately impacted by the pandemic and bore the brunt of QHR studies being redesigned, paused or abandoned altogether. Looking across the new and reconstituted problems of the pandemic, and centring our own experiences working in a number of different British universities, we critically reflect on our role as ECRs in QHR during the COVID-19 pandemic and in the emergency period's aftermath.[3] We conclude by outlining a programme of change that we argue would be beneficial not only for the careers and wellbeing of ECRs in QHR but also for our institutions, funders and the overall health and future of QHR.

1.1. Problematising the 'early Career Researcher'

Before examining challenges and changes, it is necessary to explain what we mean by 'early career researcher'. The term varies in definition. Typical criteria often reflects years since viva voce (eg. The British Academy Postdoc fellowship stipulates applicants must be < 3 years post viva). Other criteria considers someone to be an 'ECR' not in terms of years but in funding accrued to date (e.g. National Institute for Health and Care Research). In our view, it is not only time or money that delimits progression beyond 'early career'. Employment on precarious contracts is often core to the ECR label. The issues outlined herein impact scholars precariously employed irrespective of how long they are post PhD completion and what funding they have been awarded.[4]

2. The challenges and changes of the pandemic

Evidence shows that ECRs were exposed to rampant job insecurity, increased workloads and isolation as a result of the COVID-19 pandemic (Jackman et al., 2021; López-Vergès et al., 2021). While we (the authors of this commentary) were spared the harshest consequences of the pandemic (such as redundancy) – often with sincere thanks to our supervisors fighting for us – some did not enjoy the same fate. Indeed, even with supportive supervisors, the anxiety over immediate job security loomed large, and the impact of delays and restricted opportunities remains felt to this day. From our collective experience in the period of the COVID-19 pandemic and its aftermath, QHR projects that were in the process of collecting data abruptly stopped, whilst newly initiated projects found data collection significantly restricted – such as interviews with healthcare staff not taking place because of secondments or the inability to conduct direct observations.

The pandemic was hard for many different people in universities and healthcare settings. Disruption to QHR projects was felt by all involved – including research participants. For ECRs this often meant the burden of finding creative solutions to collect data, requiring new and appropriate ethical protocols. The associated concern about what would happen if a research project was abandoned often fell to ECRs whilst more senior members were seeking innovative solutions to other crisis related dilemmas (e.g. online teaching). Thus, whilst navigating personal circumstances impacted by COVID-19 (which at times meant confinement to a single house/room and potentially managing caring responsibilities alongside work in one space), ECRs often felt much of the brunt of responsibility for project success– particularly to ensure their own continued academic employment.[5] With little certainty on what might happen next in the pandemic it was necessary to plan for a range of scenarios (one of our projects had three different protocols ranging in terms of context and government policy!).

Though precarious, fixed term contracts for ECRs have been standard practice in universities for many years. The pandemic importantly served to reveal, or at least reinforce, just how unstable academic working arrangements can be for ECRs working in QHR. From our experience, even on projects that survived the pandemic, the time spent on problem solving reduced the opportunity to complete data analysis prior to contract completion. Unable to wait for potential contract extensions, many ECRs working in QHR had to move on to new positions. Often this led to diminished returns and a lack of publications from these projects, which are crucial to the future success of ECRs.[6]

Moreover, both during the emergency period of the pandemic, but also in a context of continued home working (which, in all our institutions, continues in at least a blended manner), all our authors have experienced feelings of disconnect from colleagues. The associated consequences of this isolation include experiences of mental health and wellbeing decline. This disconnection has additionally meant that the usual formal and informal interpersonal strategies for building relationships and connections have not been available, diminishing means of academic progression for some (Oliver & Morris, 2022). Increasingly flexible working arrangements can make academic life more accessible for some,[7] encouraging a healthier work-life balance as well as allowing scholarly employment to be less constrained by geography (though there are caring and digital inequalities that make home working harder or less desirable for some colleagues). Flexible working also functions as a counter to presenteeism and the toll that hot desking and commuting can take on one's time and wellbeing. In our experience, however, integration into teams and departments/schools in both emergency and blended working contexts has been difficult.[8] Of course, the impacts of lockdown restrictions and new ways of working were not experienced equally within the ECR community. Indeed, ethnically minoritized groups are underrepresented in academia in general and can be particularly reliant on networking opportunities and ECR events to form collaborations and showcase their work.

Qualitative researchers rely on accessing the people (both staff and patients) that constitute healthcare institutions. Limited access to healthcare organisations posed a particular problem for some qualitative approaches (e.g. observational work) forcing a rethink in how to continue a study while retaining scientific integrity. Lockdown

[2] We recognise the pandemic created new challenges and exacerbated existing inequalities generally in society. The risks of COVID-19 and impact of policy were distributed unequally between people of different gender, ethnicity, age and class.

[3] We recognise that some of the discussion will apply to ECRs working in disciplines beyond QHR but this does not diminish the importance of our experiences *within* QHR.

[4] We do, however, recognise that the experience and duration of employment is likely to be shaped by socioeconomic status.

[5] The time and effort it takes to locate and apply for new academic employment opportunities is a considerable burden and source of anxiety for ECRs which was exacerbated by the uncertainty caused by the pandemic.

[6] Where research has not been disseminated or its dissemination has been impeded by these contractual obstacles there is a related ethical dilemma about the use of time and effort dedicated by participants to research during the pandemic.

[7] The power also remains with institutions to dictate the terms of working arrangements or potentially treat staff wishing to work from home/flexibly unequally compared with colleagues who are more likely to attend campus in-person.

[8] It can feel difficult to integrate into departments/schools generally because of the specific focus of the work undertaken by ECRs and due to fixed term employment.

restrictions and stay at home policies removed in person access to healthcare settings. In other words, the people or settings where we intended to collect data were also on the frontline of the fight against COVID-19. A range of negative impacts were experienced as a result. Research not exploring COVID-19 inevitably became a low priority for funders and publishers, which could be attributed to an artefact of priorities in academic publishing where research considered new and topical is prioritised. Additionally, when access was possible to healthcare staff for data collection or patient access, stress levels and workload were at an unprecedented high (Kapil et al., 2022). Healthcare workers' capacity for engagement, as gatekeepers or participants, was, as such, understandably diminished. We experienced the result of this diminished capacity through a lack of response or outright rejections to our enquiries, contributing to the anxieties of working in QHR during the uncertainties of the emergency period of the pandemic.

The impact of COVID-19 is ongoing. Burnout and stress continue at high levels for healthcare staff, and service delivery remains under pressure (NHS England, 2023). From our experience this has ongoing implications for healthcare staff being able to engage with research. Without the social capital of prior relationships built over years of working with different networks of healthcare professionals, this is particularly difficult for ECRs to overcome. For QHR, collaborating with healthcare professionals is critically important at all stages of the research process. The pandemic and its aftermath have reduced opportunities to make connections with clinicians/practitioners (e.g. because of increased workload pressures for health professionals) and, for our generation of scholars, relationships with health professionals are often less developed than they otherwise might have been.

In circumstances where data collection was possible it often moved to online platforms (e.g. Teams or Zoom). ECRs had to quickly develop the skills to navigate and run effective data collection (e.g. interviews) using a new format (see Roberts, Pavlakis, & Richards (2021) for reflections on virtual qualitative research). Some of us had to learn new digital skills, whilst (as the only qualitative expert) facilitating the professional development of other team members to help assist online data collection.[9] QHRs often work in isolation within larger teams of quantitative methodologists. Upskilling other members of the team to, for example, effectively develop coding frameworks became a time-consuming task, made trickier by virtual settings. Yet, moving research online fostered new skill development and opportunities to collect data and engage participants – opportunities which exist beyond the pandemic and are a positive consequence of COVID-19. Nevertheless, there is a need to be mindful of the inequities new (use of) technologies in QHR may (re)produce for researchers and participants (such as limited or lack of access to computer technology or the internet).

3. Discussion: learning from pandemic precarity

As the emergency period of the COVID-19 pandemic recedes and reflection on the (re)organisation of academic life occurs, we wish to conclude this commentary with discussion of how QHR could be reshaped. We suggest that reorganising QHR and academic life will be beneficial not only for the careers and wellbeing of ECRs working in QHR but also for our institutions, funders and the overall health and future of QHR.

Firstly, though no one can easily predict the next major research disruption, institutions and funders must look at ways of increasing job security for ECRs. This could be done through developing substantially more bridging or dissemination funding and/or through the establishment of a researcher-bank employing ECRs on long term/permanent contracts (which will include the opportunity for researchers to have time bought out by external funding or be deployed on relevant projects). Additionally, ECRs forced into alternate employment by the pandemic should be supported to remain engaged with and/or return to QHR (e.g. through expedited publication opportunities, training and networking events). Approaches should be adopted to ensure that ECRs who collected data for projects slowed or impacted by the pandemic are included in outputs written beyond the lifespan of their contract.

It is also vital for the health of QHR that senior academics, universities and funders work with QHR ECRs to facilitate new research relationships both within and beyond universities. Importantly, though acknowledging the pressures on clinicians, connections between ECRs and clinicians need fostering through specially targeted networking events. One suggestion includes formal provision in research grants for project specific ECR networking events with healthcare professionals. Meanwhile, QHR conferences (both in person and online) could adopt a 'buddy' system where junior colleagues are partnered with a senior academic with similar research interests.

Finally, it is crucial that the QHR ECR community unites and empowers itself. One possible way forward for the community of QHR ECRs is to establish a society that seeks to maximise networking opportunities and share experiences, whilst working to ensure institutional change. Though systemic change is necessary, we believe that it is also essential for QHR ECRs to redress power imbalances through amplifying our own voices – something which can only be achieved as a united community.

Overall, the pandemic has reconstituted and recontextualised existing problems whilst creating new dilemmas. QHR ECRs, though certainly now possessing some new skills and heightened resilience, have had careers substantially impacted by the COVID-19 pandemic. The pandemic has shone a harsh light on the consequences of precarious working practices. A fundamental shift in views by both institutions and research funders to foster permanent change is needed. ECRs are the senior qualitative researchers of the future and nurturing and recognising this now will have long term benefits for QHR. Should the issues outlined continue it is difficult to imagine a sustainable future for research in which different views and perspectives are welcomed – and our generation of researchers may seek employment beyond the academy (as some authors have already done). Real change means job security, academic freedom, a work-life balance, and consequently fewer anxieties and uncertainties. This must happen before the onset of the next crisis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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[9] Increased adoption of digital data collection in healthcare means broader opportunities for research participation. However, we recognise that for many qualitative methods in-person collection cannot be substituted by digital data collection methods.

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