RESEARCH ARTICLE

CHALLENGING TIMES

A phenomenological exploration of the impact of COVID-19 on the medical education community

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Abstract

Introduction: The COVID-19 pandemic has caused unprecedented stress to the medical education community, potentially worsening problems like burnout and work-life imbalance that its members have long been grappling with. However, the collective struggle sparked by the pandemic could generate the critical reflection necessary for transforming professional values and practices for the better. In this hermeneutic phenomenological study, we explore how the community is adapting— and even reconceptualising—their personal and professional roles amidst the COVID-19 crisis.

Method: Between April and October 2020, we conducted 27 (17F, 10M) semi-structured interviews with medical trainees (8), physicians (8), graduate students (3) and PhD scientists (8) working in medical education in Canada, the United States and Switzerland. Data analysis involved a variety of strategies, including coding for van Manen’s four lifeworld existentials, reflexive writing and multiple team meetings.

Results: Participants experienced grief related to the loss of long-established personal and professional structures and boundaries, relationships and plans for the future. However, experiences of grief were often conflicting. Some participants also experienced moments of relief, perceiving some losses as metaphorical permissions slips to slow down and focus on their well-being. In turn, many reflected on the opportunity they were being offered to re-imagine the nature of their work.

Discussion: Participants’ experiences with grief, relief and opportunity resonate with Ratcliffe’s account of grief as a process of relearning the world after a significant loss. The dismantling of prior life structures and possibilities incited in participants critical reflection on the nature of the medical education community’s professional practices. Participants demonstrated their desire for more flexibility and autonomy in the workplace and a re-adjustment of the values and expectations inherent to their profession. On both individual and systems levels, the community must ensure that long-standing calls for wellness and work-life integration are realised—and persist—after the pandemic is over.
1 | INTRODUCTION

The medical education community has been grappling with a wellness crisis for decades, with alarming rates of burnout and other forms of impaired wellness persisting among students, staff and faculty alike.1-7 Better work-life integration is an oft-posed solution,8,9 but once established, professional boundaries can be ‘institutionalized to the point that they are very difficult to change or erase.’10(p706) Consequently, although wellness initiatives aimed at fostering better work-life integration abound in medical faculties, they have been widely criticised for being overly simplistic solutions to deeply-rooted sociocultural and systems-level problems.1,2,11

Attempts at improving wellness appear to be stymied by a pervasive sense that as long as the professional culture continues to reward overwork,12 and stigmatise struggles and vulnerabilities,12,13 achieving wellness through work-life integration will not be a tangible possibility. The rapid-fire and evolving changes sparked by the COVID-19 pandemic have, however, jolted the global community out of the status quo. For instance, the sudden disturbance of traditional, in-person learning necessitated the rapid development of online educational tools that many claim could propel medical education into a new—and perhaps better—era.16-19 There are other signals that the community may be challenging entrenched professional values that, for some, can feel dehumanising.11 Many seem to be re-imagining the structure of their personal and professional lives, creating space for vulnerability and wellness, openly conversing about struggles with burnout and prioritising self-care across social media and in formal institutional communiques.9,20-23

The pandemic is serving as a living laboratory, forcing the medical education community to experiment with reconfigured personal and professional boundaries. Although discussions about the transformational effects of COVID-19 on professional values and wellness are gaining traction within the medical education community,9,23-29 it is unclear whether the COVID-19 pandemic will be a blip of disruption or an event of global transformation. Amidst competing narratives calling for either a return to normality or for a ‘new normal’, our purpose was to examine this liminal space. Specifically, since work-life integration is a socially constructed negotiation between workforces and workplaces,10,30,31 we sought to explore not only how members of the medical education community have experienced the pandemic’s disruption to their personal and professional lives but also what their experiences might teach us about renegotiating our professional values, structures and practices once the pandemic ends.

2 | METHOD

Phenomenology is a qualitative research methodology aimed at constructing ‘a possible interpretation of the nature of a certain human experience.’32(p431) Phenomenological inquiry may generate either a pure description (i.e. transcendent phenomenology) or an interpretation (i.e. hermeneutic phenomenology) of an experience as lived.32 We chose a hermeneutic approach not only because of its focus on meaning-making in the context of participants’ everyday lives but also because it recognises that researchers’ reflexive engagement with their own experiences enriches analysis.32,33

2.1 | Data collection

Between April and October 2020, we invited medical education community members—including undergraduate and postgraduate medical trainees, graduate students, PhD scientists and clinician researchers and educators—from across the globe to participate, sampling broadly by recruiting participants on Twitter, by word-of-mouth, and via emails to interest groups, societies and university faculties. A total of 27 participants consented to participate (Table 1).

| Career stage/specialty | Medical trainees | Graduate students | Physicians (including clinician scientists) | PhD scientists |
|------------------------|------------------|-------------------|-------------------------------------------|---------------|
| Number of participants | 8                | 3                 | 8                                         | 8             |
| Gender (M:F)           | 4:4              | 0:3               | 5:3                                       | 1:7           |
| Location               | 7 Canada         | 3 Canada          | 5 Canada                                  | 7 Canada      |
|                        | 1 Switzerland    |                   | 1 USA                                     | 1 USA         |
|                        |                  |                   | 2 Switzerland                             |               |
| Career stage/specialty | 6 medical students | 1 MSc student | 1 family medicine | 2 early-career researchers |
|                        | 2 residents      | 2 PhD students | 3 general surgery | 2 associate professors |
|                        |                  |                   | 4 other specialties | 1 research |
|                        |                  |                   |                                           | psychometrician |
|                        |                  |                   |                                           | 3 full professors |
| Number of participants with children | 0          | 1                  | 5                                         | 6             |
well as changes in priorities and work-life integration. The interview guide (Appendix A in the supporting information) was tailored to participant role (trainee, physician or PhD scientist) and was continuously revised to account for developing interpretations.

2.2 | Data analysis

We used van Manen’s hermeneutic phenomenological approach to guide analysis, drawing on his four lifeworld existentials. Specifically, we examined how COVID-19 was experienced physically (e.g. fear and exhaustion), spatially (e.g. working from home versus campus/hospital), relationally (e.g. with family or colleagues) and temporally (e.g. time slowing down during lockdown). Our approach attuned to the whole-part-whole cycle of phenomenological analysis, which entails constant movement between whole transcripts, specific sentences or parts and the entirety of the dataset. This ensured that individual experiences were understood in relation to their context.

Specifically, in keeping with van Manen’s method, VL and BB first read all transcripts in full, summarising each into an overarching story. For instance, ‘finding greater work-life balance amid worries about career uncertainty’ seemed to capture one PhD student’s experience of the COVID-19 crisis. The full team then read a selection of transcripts using van Manen’s lifeworld existentials as an initial coding framework. Next, VL, BB and LC used qualitative data analysis software to code each data source in a more detailed, segment-by-segment fashion to inductively identify themes. Team subgroups met regularly to lead various phases of the research, and the full team met five times (60 to 90 minutes per meeting) to discuss evolving codes, themes and interpretations. As analysis progressed, writing was integral for deepening our interpretive understanding. All study procedures were approved by the Research Ethics Boards at Dalhousie University and the University of Ottawa (H-04-20-5752).

Since reflexivity is a key component of rigorous qualitative research, all members wrote reflexive memos, and reflexive engagement was an essential component of both large and small group analytical sessions. Additionally, one full, 90-minute team meeting was solely devoted to unpacking how our experiences either resonated (or not) with participants’ experiences and how our individual lenses might alter our view of the data. Our research team consisted of PhD or masters trained scientists (AM, JK, KL, LC and SB), physicians (JK) and trainees (BB and VL), reflecting the diversity of roles and expertise found in the medical education research community. Some team members analysed the data through the lens of multiple professional and personal roles.

3 | RESULTS

Participants’ experiences of forced cancellations, social distancing and virtual work often seemed rooted in grief. While accompanied by a wide range of emotions from resignation to exhaustion and anxiety, we found that grief was experienced most universally as a loss of habitual structures and routines that rattled participants’ sense of certainty about the world. Grief was, however, experienced in complex, often conflicting ways—sometimes interspersed with moments of relief whereby participants expressed both frustration over the loss of how things used to be and gratitude for a new way of living and working. Although we often present this tension as an either/or phenomenon for clarity, it was commonly described as a both/and experience that undulated over the course of the pandemic. For all participants, experiences of grief and relief sparked critical reflections about how they want to live and work once the pandemic is over, suggesting that participants experienced COVID-19 as an opportunity for transformation.

3.1 | A complex tension between grief and relief

The spatial bleeding between work and home created both new temporal pressures to be constantly available for work (including for spontaneous after-hour meetings) and blurred relational boundaries that for some were simultaneously experienced not only as physically restrictive and disorienting, but also rejuvenating. For instance, some participants valued having more time with their family, yet struggled to manage expectations for work availability and productivity amidst frequent interruptions and demanding childcare responsibilities. For others, the spatial dismantling of their work and home lives was primarily experienced as loss. They mourned the social connections that ‘replenish us’ and ‘make us feel like humans,’ (P22, MD/PhD), missing the engagement, the ease of conversation and sense of ‘community (that comes from) working in the same physical space.’ (P22, MD/PhD). The loss of clear demarcations between work and home felt violating for one physician participant who perceived that virtual consultations threatened her relational boundary with a patient:

“One of my patients] makes me uncomfortable to be around him … I had a telephone consult with him, and I just did not like the way that I felt afterwards … like his voice was like in my ears, like in my headphones, in my house. I felt like I could not … I did not like that that transaction happened in my house. (P20, MD)

This physician’s experience resonated with another participant who expressed their grief over the loss of spatial separation between work and home, by saying: ‘I used to look at my [home space as] a refuge … It’s not my little personal refuge anymore’ (P19, PhD).

The complex tension between grief and relief was also evident in how participants experienced work-related cancellations generated by public health measures. Most participants, particularly those who were either trainees or early-career faculty, not only expressed disappointment about lost social opportunities but also worried that cancellations might adversely affect their professional futures. For instance, prior to the pandemic, medical student participants planned to rely on electives to help them make career-altering decisions about which residency programmes to pursue. The pandemic also...
heightened insecurities for graduate students and early-career researchers, who were already experiencing uncertainty around their future careers:

The biggest thing has been the uncertainty, especially being at the end of my PhD … what’s going to happen to my career … I had definitely been in discussions with people and just being uncertain around well now what’s going to happen to those opportunities …? (P1, PhD trainee)

Others, however, experienced these cancellations as part of a pandemic-related temporal shift where ‘the whole world like slowed down a little bit, you know? You started to think about other stuff than just work and speed and going faster...’ (P24, MD). In other words, although some experienced cancellations as anxiety-provoking, others likened them to a metaphorical permission slip that granted a formal excuse to slow down.

I think before the pandemic hit, I was feeling a little bit… I would not say fully burned out, but I was definitely feeling kind of tired. And I think I realized that with everything that had been lifted that there were a lot of things that were just taking up my time … and with those being gone, I felt a sense of relief. (P1, PhD Trainee)

Participant 27 encapsulated the affordances and limitations of the pandemic expressed by others, describing that it ‘stagnated time for me. It slowed down the progression of research. But it’s also helped bring a kind of clarity to my thinking, which has been sort of an unintended benefit’ (P27, MD, PhD trainee).

Indeed, cancellations and more malleable boundaries between work and home felt freeing for participants who perceived they were afforded the flexibility—often for the first time—to construct their work or school schedules to fit with their personal lives. For example, trainees reported enjoying online learning because they no longer had to wake early to travel to school for morning lectures, and most participants reported engaging in self-care activities that had previously taken a backseat to other obligations. Some described letting go of traditional work schedules, taking more breaks and choosing to work not on a specific timetable but when they felt most productive:

If you are an academic, you are always kind of like, I need to not work today. But then, I’ll make it up in the evening, and there’s something nice about just being like … I’m entitled to just not work today. (P15, PhD)

Many also appreciated being given more latitude to absent themselves from meetings, to submit work later than was planned and to take time off from work altogether. Many, like Participant 18, embraced this new-found autonomy over their work lives, suggesting ‘If we’ve learned anything from COVID, it’s that people can work flexibly and from home. And they can be trusted to do that’ (P18, PhD).

In many ways, the pandemic seemed to be experienced as a movement of shared humanity, sparking conversations about well-being that had not previously occurred in their workplaces. For a time, participants reported experiencing a strong sense of empathy from their colleagues and clinician teachers who, in turn, were more flexible in their expectations and offered greater support. One physician participant prioritised making time for personal check-ins with colleagues, noting, ‘it’s funny actually, as a group we started to talk about things we haven’t talked about before … we have never talked about wellness. We’ve never talked about how we’re doing and we actually got to talk about that’ (P25, MD). Some also experienced a loosening of hierarchical boundaries between teachers and learners, characterised by trainee participants as the ability to push back against medicine’s professional culture in ways that were experienced as both uncomfortable and empowering:

It wasn’t in my schedule to do Obstetrics call, but [my preceptor] asked me, if anyone came in, if I’d want her to call me. And [I said], actually, ‘No. Please don’t call me.’ … And for a moment there I was like, ‘Am I being a bad student? ...’ [But] then I was like, no, I was at the hospital and doing work all day, I really need some time to rest in the evening ... So I feel like I’m getting more comfortable at actually setting these boundaries. (P5, medical student)

These shifts seemed to reflect a re-examination of medical education’s unhealthy relationship with productivity, with participants hoping the pandemic would catalyse change:

Even before this, I was recognizing a sort of obsession with productivity and business and a sense [of] people not being sure when it’s appropriate to say no … I think sometimes it takes an event like this to really solidify the realization that you do need to slow down. (P1, PhD trainee)

3.2 Opportunity for transformation

Although all participants experienced COVID-19 as a type of purgatory where ‘we don’t know where we’re standing now. If this was just the beginning? Is this the end? Is ... how long will all these measurements keep on?’ (P24, MD), resultant experiences with both grief and relief seemed to inspire critical reflection about drastically redefining sociocultural values:

The whole in medicine of work-life balance is a bit of a delusion because there is not balance … But [since the pandemic], for the first time there was a sense of this
is not sustainable. Like this is not, this is barely surviving... (P27, MD, PhD trainee)

The dismantling of old possibilities for living and working forced participants to create new structures and boundaries—but, this time, participants perceived they had some control of what those would look like. For instance, participants who started taking better care of their health, eating better, engaging in more physical activity and spending more time with friends and family were determined to continue prioritising their relationships and well-being beyond the end of the pandemic.

I think it’s caused me to look at how I spend my time... is this the way that I want to be spending my time. (P20, MD)

Participants were, however, acutely aware that the changes they perceived as beneficial might not last. For instance, one participant, interviewed prior to Ontario’s second wave, noted that the spirit of support, empathy and shared humanity was already beginning to wane:

... I’m finding that now that flexibility has sort of decreased. There’s... it’s more back to an expectation of you are working kind of 9 to 5 Monday to Friday, and we’ll be available for any meetings we want to have during that time. (P14, PhD)

Participants recognised that it would take immense effort to not simply return to ‘business as usual’ once the pandemic is over. Indeed, being forced to slow down reminded one participant about what life could be if restructured boundaries formed during the pandemic became a normalised feature of post-COVID normality.

Last night, my partner and I were out walking and colleagues rode by on their bikes, and they are both physicians. And we started to talk and I [asked them], ‘Do you guys fantasize about retirement?’ And... one said, ‘Oh yeah, I could easily imagine a life now that really was ushered in by COVID-19, of you know, making cocktails and playing guitar and learning how to cook better.’ And in some ways, it was a shared joke but also this idea that life was kind of given back to us if we were there to take it. (P27, MD, PhD trainee)

4 | DISCUSSION

Participants experienced the COVID-19 pandemic as a complex tension between grief and relief, characterised by both mourning and reimagining routine ways of living, learning and working. We discovered Ratcliffe’s phenomenology of grief during the analytic process, finding his framework useful for critically examining this complex grief response. Although it was developed in the context of grieving the death of a loved one, Ratcliffe’s theories resonate with the lived experiences of medical education community members grappling with the radical disturbances triggered by COVID-19. Our research thus contributes a critical examination of both retrofitted work-life boundaries and how they may alter post-pandemic professional values and practices.

Like participants, Ratcliffe conceives of grief as less of an ‘episodic’ emotional experience than as a process that unfolds over a long period of time. At its core, grief is not only about feelings of sadness, anger, gratitude or confusion; it can be composed of any of those emotions or none of them. Rather, according to Ratcliffe, grief may be better conceptualised as a ‘gradual recognition of loss’ that generates an ‘all-enveloping, dynamic disturbance of life possibility.’

For participants, this grief process started with the sudden and unexpected shock of having to reconfigure their daily lives, seemingly overnight, throwing participants into what Ratcliffe refers to as a state of indeterminacy—or the loss of familiarity and routine where:

It is not just that one cannot find a path to follow; the paths have gone. There is no fact of the matter concerning how things fit together, no pattern, nothing to specify what is to be done.

Although Ratcliffe’s phenomenology of grief primarily explores grief as it relates to loss, our findings expand on this framework by suggesting that, for some participants, losses triggered by the pandemic could be experienced as gains. For instance, many welcomed the flexibility to build self-care into their daily routines generated by cancellations and the loss of rigid work schedules. In the current study, grief and relief were thus in tension rather than dichotomous. That is, many participants grieved pre-pandemic aspects of their lives that they valued such as structure and professional communities, yet also discovered that having more permeable work boundaries made their personal and professional lives better.

Despite this important nuance, both experiences of grief and relief were inextricably tied to a wider disassembly of the experiential world, compelling participants to find ways to restore coherence in the structure of their lives. This resonates with Ratcliffe’s notion that ‘When the habitual world is somehow disturbed, what was previously taken as given becomes salient. The ‘intentional threads’ ‘loosen,’ facilitating reflective access to something we and our words might otherwise overlook.’ In this manner, participants’ experiences of the pandemic allowed them, for instance, to imagine opportunities to establish healthier work-life boundaries rather than returning to a pre-pandemic sense of normality that, for many, was perceived to interfere with their wellness.

Work-life imbalance is not a novel issue for the medical education community; in fact, as participants noted, an unhealthy preoccupation with productivity has long characterised the professional culture of medicine and academia more generally. Prior to the pandemic, solutions for better work-life integration were proposed but rarely meaningfully actioned. However, since the start of the pandemic, conversations about
wellness and burnout seem to have gained a new sense of urgency—and perhaps even legitimacy. Institutions have recognised the impact of the ongoing public health crisis, initiating meaningful actions such as regular staff check-ins, virtual social events or communiques promoting well-being and sharing mental health resources. The community is also having new conversations about burnout and even finding new terms to describe how we are feeling, like languishing.

However, it remains to be seen whether the medical education community will—or will feel permitted to—carry forward the increased flexibility and autonomy the COVID-19 pandemic provided for some. As one participant noted, the grace extended to colleagues at the beginning of the pandemic appears to be waning, suggesting that expectations for productivity may be returning to pre-pandemic levels. Along with participants, we worry that attention to wellness and the concrete actions individuals and institutions have taken to promote well-being may not outlive the pandemic. Thus, we implore faculties and institutions to make these novel offerings permanent and the concrete actions individuals and institutions have taken to promote well-being may not outlive the pandemic. Thus, we implore faculties and institutions to make these novel offerings permanent additions to their programmes while also ensuring these efforts dismantle, rather than obscure, systemic barriers to wellness.

Both emerging commentaries and our phenomenological study demonstrate that many in the field of medical education are ready for change. In this study, members of the medical education community communicated their desire for a drastic re-imagining of what it means to be productive and a greater ability to set healthy boundaries, as well as a level of work-life balance, that makes sense for them. They valued working towards attainable goals and maintaining strong relationships in their personal and professional lives. They expressed a desire to embrace slowing down, to feel more understood by their colleagues and to be trusted to flexibly manage their own time. And they wanted those things to be consistent with, and not in direct opposition to, the culture of medicine and medical education.

We recognise that participants’ experiences do not represent all possible experiences and that more permeable work-life boundaries may not be feasible for everyone. For instance, a PhD scientist may be able to transition to a more flexible work schedule while a trainee or a physician with significant clinical responsibilities may not. Rather, members of the medical education community, based on their own unique circumstances, personalities and desires to integrate work and home life, have different needs and preferences for the nature of their work. Our findings indicate that many in medical education can, and desperately want to, be trusted to work on their own terms. As the pandemic continues—and once it subsides—we encourage medical education workplaces to foster conversations that promote meaningful work-life integration, considering lessons learned amidst this global crisis. Further research should also explore how new types of work structures might cultivate the development of a culture of wellness within the medical education community.

4.1 | Strengths and limitations

Although we sampled internationally, medical education community members living outside of Canada, the United States and Switzerland may have experienced the pandemic differently, particularly amidst variable COVID-19 cases, restrictions and access to health resources. Furthermore, the pandemic continues to rapidly evolve, meaning that our findings only provide a snapshot of participants’ experiences. However, both our own lived experiences and our conversations with colleagues suggest that much of what participants described continues to be part of the COVID-19 experience. Our findings thus offer a path forward as the medical education community envisions and plans for a ‘new normal’.

4.2 | Conclusion

The COVID-19 crisis has been tragic, disorienting and often difficult to navigate for the medical education community. Although the community has had much to grieve since the beginning of the pandemic, the disruption caused by the pandemic introduced new possibilities for challenging the status quo. There is ongoing evidence that the pandemic is evolving in ways that are only worsening problems such as burnout and distress among our community; therefore, if the medical education community is to re-emerge from the pandemic stronger than when it began, it needs to consider how its current culture, structures and policies align with the values and experiences of those working within it.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to report in this study.

AUTHOR CONTRIBUTION

The study was conceived by SB and all authors contributed to its design. VL led data collection and analysis, and wrote the first draft of the manuscript. VL and KL led revisions of the manuscript with feedback from all other authors. VL, BB and SB participated in data collection, and all authors contributed to data analysis. All authors gave final approval to the submitted paper.

ETHICS STATEMENT

This study was approved by the Research Ethics Boards at Dalhousie University and the University of Ottawa (H-04-20-5752).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author, VL. The data are not publicly available because they contain information that could compromise the privacy of research participants.
REFERENCES
1. Bynum WE, Varpio L, Teunissen P. Why impaired wellness may be inevitable in medicine, and why that may not be a bad thing. Med Educ. 2021;55(1):16-22.
2. McKenna KM, Hashimoto DA, Maguire MS, Bynum WE. The missing link: Connection is the key to resilience in medical education. Acad Med. 2016;91(9):1197-1199.
3. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. Acad Med. 2006;81(4):354-373.
4. Galbraith N, Boyd D, McFeeters D, Hassan T. The mental health of doctors during the COVID-19 pandemic. B J Psych Bull. 2021;45(2):93-97.
5. Huffman EM, Athanasiadis DI, Anton NE, et al. How resilient is your team? Exploring healthcare providers’ well-being during the COVID-19 pandemic. Am J Surg. 2021;221(2):277-284.
6. Mateulevicius SA, Kho KA, Reisch J, Yin H. Academic medicine faculty perceptions of work-life balance before and since the COVID-19 pandemic. JAMA Netw. Open. 2021;4(6):1-10, e2113539.
7. Kee CE. The impact of COVID-19: Graduate students’ emotional and psychological experiences. J Hum Behav Soc Environ. 2021;31(1–4):476-488.
8. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general us working population between 2011 and 2014. Mayo Clin Proc. 2015;90(12):1600-1613.
9. Ghosh-Choudhary S, Carleton N, Flynn JL, Kliment CR. Strategies for achieving gender equity and work-life integration in physician-scientist training (published online ahead of print July 20, 2021). Acad Med. Publish Ahead of Print.
10. Kreiner G, Hollensbe E, Sheep M. Balancing borders and bridges: Negotiating the work-home interface via boundary work tactics. Acad Manag J. 2009;52(4):704-730.
11. LaDonna KA, Cowley L, Touchie C, LeBlanc VR, Spilg EG. Wrestling with the invincibility myth: Exploring physicians’ resistance to wellness and resilience-building interventions (published online ahead of print August 10, 2021). Acad Med. 97(3):436-443.
12. Bynum WE, Varpio L, Lagoe J, Teunissen PW. “I’m unworthy of being in this space”: The origins of shame in medical students. Med Educ. 2021;55(2):185-197.
13. Shepherd L, LaDonna KA, Cristancho SM, Chahine S. How medical error shapes physicians’ perceptions of learning: An exploratory study. Acad Med. 2019;94(8):1157-1163.
14. Ladonna KA, Ginsburg S, Watling C. “Rising to the level of your incompetence”: What physicians’ self-assessment of their performance reveals about the impostor syndrome in medicine. Acad Med. 2018;93(5):763-768.
15. LaDonna KA, Ginsburg S, Watling C. Shifting and sharing: Academic physicians’ strategies for navigating underperformance and failure. Acad Med. 2018;93(11):1713-1718.
16. Daniel M, Gordon M, Patricio M, et al. An update on developments in medical education in response to the COVID-19 pandemic: A BEME scoping review. BEME Guide No. 64. Med Teach. 2021;43(3):253-271.
17. Lubarsky S, Thomas A. Thinking inside the box: Using old tools to solve new problems in virtual learning. Med Educ. 2021;55(1):108-111.
18. Lucey CR, Johnston S. The transformational effects of COVID-19 on medical education. JAMA. 2020;323(21):2131-2132.
19. MacLeod A, Cameron P, Clow R, Li V, Luong V, Munroe-Lynds, C-L. Educating future physicians in the time of COVID: A scoping review of online medical education. Report Prepared for the Social Sciences and Humanities Research Council August 14, 2021. https://cdn.dal.ca/content/dam/dalhouse/pdf/faculty/medicine/departments/core-units/cpd/Research/Final2%Report_Scoping%review%20online%20medical%20education_MacLeod%20et%20al.pdf
20. Medical Students at the Frontline: Student Experiences From Around the World During the COVID-19 Pandemic. Imperial College London. May 26, 2021. https://www.imperial.ac.uk/events/133860/medical-students-at-the-frontline/
21. Faculty Wellness. Dalhousie University. Accessed August 26, 2021. https://medicine.dal.ca/departments/core-units/cpd/faculty-wellness.html
22. Jasmin B. Message from the dean: Summer of kindness. University of Ottawa May 26, 2021. https://med.uottawa.ca/en/message-from-the-dean/summer-of-kindness
23. Gewin V. Pandemic burnout is rampant in Academia. Nature. 2021; 591(7850):491-493.
24. Arora VM, Wray CM, O’Glasser AY, Shapiro M, Jain S. Leveling the playing field: Accounting for academic productivity during the COVID-19 pandemic. J Hosp Med. 2021;16(2):120-123.
25. Murray E, Kaufman KR, Williams R. Let us do better: Learning lessons for recovery of healthcare professionals during and after COVID-19. B J Psych Bull. 2021;7(5):1-9.
26. Cherak S, Brown A, Kashra R, et al. Exploring the impact of the COVID-19 pandemic on medical learner wellness: A needs assessment for the development of learner wellness interventions. Can Med Educ. 2021;12(3):54-69.
27. Brown A, Kassam A, Paget M, Blades K, Mercia M, Kashra R. Exploring the global impact of the COVID-19 pandemic on medical education: An international cross-sectional study of medical learners. Can Med Educ. 2018;9(4):102-110.
28. Zaidi Z, Razack S, Kumagai AK. Professionalism revisited during the pandemics of our time: COVID-19 and racism. Perspect Med Educ. 2021;10(4):238-244.
29. Burm S, Luong V, LaDonna K, et al. From struggle to opportunity: Reimagining medical education in a pandemic era. Perspect Med Educ. In press.
30. Clark SC. Work/family border theory: A new theory of work/family balance. Human Relat. 2000;53(6):747-770.
31. Kossek EE, Lautsch BA, Eaton SC. Flexibility enactment theory: Implications of flexibility type, control, and boundary management for work-family effectiveness. In: Kossek EE, Lambert SJ, eds. Work and Life Integration: Organizational, Cultural and Individual Perspectives. Lawrence Erlbaum Press; 2004:233-251.
32. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. Perspect Med Educ. 2019;8(2):90-97.
33. van Manen M. Phenomenology of Practice. London, UK: Routledge; 2016.
34. Ratcliffe M. Towards a phenomenology of grief: Insights from Merleau-Ponty. Eur J Philos. 2019;28(3):657-669.
35. Solomon RC. The Passions: Emotions and the Meaning of Life. Vol. 1993. Hackett; 1993.
36. Ratcliffe M. Grief and the unity of emotion. Midwest Studies in Philosophy. 2017;41(1):154-174.
37. Gibbs T. The COVID-19 pandemic: Provoking thought and encouraging change. Med Teach. 2020;42(7):738-740.
38. Klases JN, Vithayathpathy A, Zante B, Burm S. “The storm has arrived”: The impact of SARS-CoV-2 on medical students. Perspect Med Educ. 2020;9(3):181-185.
39. O’Byrne L, Gavin B, Adamis D, Lim YX, McNicholas F. Levels of stress in medical students due to COVID-19. *J Med Ethics*. 2020;47(6):383-388.
40. Mittal R, Su L, Jain R. COVID-19 mental health consequences on medical students worldwide. *J Community Hosp Intern Med Perspect*. 2021;11(3):296-298.
41. Chandratre S, Knight C, Dodson L. Supporting medical student mental health during COVID-19: Strategies implemented for an accelerated curriculum medical campus. *J Med Educ Curric Dev*. 2021;8:1-4, 238212052110063.
42. Tsang VWL, Yu A, Haines MJ, et al. Transforming disruption into innovation. *Acad Med*. 2021; Publish Ah 96(12):1650-1654.
43. Grant A. There’s a name for the blah you’re feeling: It’s called languishing. The New York Times April 19, 2021. https://www.nytimes.com/2021/04/19/well/mind/covid-mental-health-languishing.html

**SUPPORTING INFORMATION**

Additional supporting information may be found in the online version of the article at the publisher’s website.

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