

Caring for the Psychological Well-Being of Healthcare Professionals in the Covid-19 Pandemic Crisis

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During a pandemic, the demands on healthcare staff are extraordinary and long lasting. Successful public health outcomes are hugely contingent on effective functioning of the healthcare workforce, notwithstanding the absolute need for a whole-of-society response. A full complement of staff with minimum infection-related absenteeism, working to their maximum potential, with low level of work-related burnout is optimal. Attending to staff psychological well-being becomes imperative.

Work-related stress disproportionately affects healthcare workers¹ and is linked to excessive workloads, working in emotionally charged environments and where demand outweighs capacity². In Ireland, clinician-perceived lack of management and government support, coupled with unrealistic public expectations and cynicism about the possibility of change, compound the issue³. Increased patient safety incidents, medical errors, lower quality service provision, along with issues regarding staff retention and psychological ill-health follow³.

During the recent pandemic, severe acute respiratory syndrome (SARS) in 2003, half of healthcare workers experienced psychological distress⁴. Risk factors included quarantine, interpersonal isolation, treating colleagues who were infected, fear of contagion, job stress, perception of stigma, and concerns for family well-being⁵. Similar findings were reported by nurses in Ireland on their preparedness for an influenza epidemic⁶, with a commitment to continuing to provide care, while reporting apprehension relating to risk of infection, increased work conflict and stress, worries about their children's/partner's well-being and a perception of inadequate staffing and hospital support. A cycle of fear of their families/children and partners relating to perceived risks of infection was also highlighted.

Two aspects of the healthcare work during the SARS epidemic differentiated its psychological impact from other disasters⁷. Importantly, both aspects resonate with the current pandemic, applying even to a greater extent. Firstly, the experience of social isolation: the necessity for interpersonal distancing, infection control procedures, diminished collegial social interaction and assignment to work in unfamiliar environments/with unfamiliar colleagues^{7 8}. Secondly, while family support is protective against occupational stress in the 'ordinary' course of events, in the context of a pandemic, staff with children experience increased psychological distress^{4 5 9}. This is inferred to relate to the aforementioned fears of healthcare workers that may become ill and unable to care for or risk infecting their children. Both of these factors, prevalent in Covid-19, are likely to herald high level of psychological distress among healthcare staff. At the time of writing, 25% of confirmed cases in Ireland are health workers, higher than Italy and Spain. The government is seeking child care solutions to support healthcare workers following crèche closures.

During Covid-19, healthcare workers are exposed to unprecedented demands encompassing high mortality, rationing of Personal Protective Equipment and profound ethical dilemmas of rationing access to ventilators and other essential healthcare supplies. Personal worries include infection risk to self and others, and concerns regarding

the well-being of family members who are 'home-schooled', quarantined or infected are real. Given this context, it is not surprising that in the only study to date reporting on the psychological impact on Covid-19 frontline healthcare workers, high rates of depression, distress, anxiety and insomnia were reported¹⁰.

Normal adaptive coping strategies such as social connections, exercises, leisure time are severely restricted. The adverse psychological impact of managing this 'perfect storm' of stressful work/life factors amidst a sea of unknown variables has very significant implications for healthcare not just in the height of the pandemic but in its aftermath. Burnout, thought to occur when the demands of work surpass capacity, pathognomonic of Covid-19, place healthcare workers at risk for occupational stress³. It is highly likely that once the pandemic is over, resources will be even more constrained, presenting a ripe breeding ground for burnout. The situation in Ireland, where healthcare workers have already been identified to report the highest rate of burnout¹, and pre-existing concerns of health resource adequacy exist⁶, make this an extremely concerning probability

In the aftermath of SARS pandemic, and in preparation for future pandemics, enhancing workforce resilience was recommended to avoid future absenteeism⁷. Unfortunately, as with myriad other aspects of pandemic preparedness, this proactive protective approach for staff well-being has not been acted on in most jurisdictions.

Longer term data also suggests healthcare workers enacting maladaptive coping strategies such as self-blame and avoidance may lead to concerning patterns⁵. Absenteeism is significantly more prevalent and is akin to a 'second hit' to the healthcare system typically already compromised with post-pandemic resource reduction¹¹. Significantly, higher rates of burnout, depression and anxiety symptoms and maladaptive behaviours including substance misuse are seen, even compared to the high baseline levels in healthcare peers in SARS⁵ and now Covid-19¹⁰. In addition to absenteeism, the phenomenon of *presenteeism* is evident in the data, with personal commitment to attend work at the expense of personal distress and lower productivity¹².

Encouragingly however, protective factors have also been identified post-SARS⁵. These include duration of healthcare experience, perception of adequate training and individual perception of organisational support. The role of societal support to healthcare workers during a pandemic, quality of clinical, managerial and ministerial leadership, and credible measured media coverage, particularly evident in Ireland in recent weeks, but never specifically explored, may be hypothesised as important and modifiable mitigating factors.

Post-pandemic research suggests any psychological supports should be based on models of adaptation and resilience and may assist with post-pandemic absenteeism.¹¹ Counter perhaps to expectation, such support is considered more pertinent by staff who considered themselves to report to duty during an event¹³. Debriefing and psychological first aid (RAPID-PFA), helplines and support groups for professionals have also been found helpful¹⁴. One study found computer-assisted pre-pandemic training, increased staff 'pandemic related self-efficacy' and confidence¹¹. This feasibility trial incorporated tools to enhance coping styles and reduce maladaptive escape-avoidance patterns. The results are encouraging, although the intervention is intended to occur prior to the pandemic as a means of enhancing resilience and pandemic preparedness. Aspects of this training may be useful in the future stress-proofing of healthcare staff, and the computer assisted delivery model would facilitate widespread provision in a climate that is likely to be marked by even fewer resources than before. We have an ethical duty post Covid-19 to reflect on the seismic and rapid work-related enforced changes and stressors, and the impact of these on staff well-being so that we can better equip ourselves for future disasters, unfortunately likely to happen. Forewarned is forearmed.

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