EDITORIAL

COVID Collateral: "Don't Forget the Diligent Healthcare Worker"

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Indian Journal of Critical Care Medicine (2020): 10.5005/jp-journals-10071-23542

The novel coronavirus, SARS-COV-2, has changed our world like never before. COVID-19 infection has now affected more than 16 million people across the world and India has contributed almost 1.4 million patients so far. Most infections have been mild and the infection fatality rate is about 1.4%.[1] In addition to this direct assault, COVID-19 has affected health care in myriad ways. COVID collateral refers not only to the economic hardship caused by the pandemic but also the health consequences in various domains like cardiovascular diseases, cancer care, and public health, to name just a few. The collateral damage is not only limited to the patients but also healthcare workers (HCWs), who have a threefold higher incidence of acquiring COVID-19 infection as compared to the general public. In addition, the pressure of working with critically ill patients imposes significant stress on the caregiver. Working in an intensive care unit (ICU) can be extremely stressful due to high morbidity and mortality. The tension and anxiety associated with providing care are by no means a reflection of the HCW's ability or weakness; they are intrinsic to the job. Mental health and psychosocial well-being during this time are as important as physical health.[2]

Burnout syndrome (BOS) is a well-described phenomenon and is a constellation of symptoms occurring in individuals without any previous psychiatric or psychological disorders.[3] In this extreme environment of inadequate beds and excessive patient loads, the HCWs are exposed to a discrepancy between the expectations and ideals of the patients, families, and employer and the actual requirements of their position in the caregiving process. Initially, individuals feel only emotional stress and a sense of disillusionment, which if unrecognized over a period leads to the three classical BOS symptoms. The triumvirates of BOS symptoms are exhaustion, depersonalization, and decreased sense of personal achievement. Exhaustion manifests as generalized tiredness/fatigue and stems from providing time and effort to a task that most of the time is fruitless. Depersonalization is the negative attitude toward work and can lead to cynical and callous behavior. The cynicism and callousness can be directed toward other colleagues and the patient himself. The lack of empathy toward family members in times of loss/grief is also a manifestation of depersonalization. Last, it is the feeling of a low self-esteem, a negativity while evaluating one's work, and a feeling of insufficiency while performing one's job, which define the feeling of reduced personal accomplishment.

In this edition of the Indian Society of Critical Care Medicine, Khasne et al. have published the results of their prospective, cross-sectional, online survey on prevalence of burnout among HCWs during the current pandemic.[4] Traditionally, BOS is measured with the Maslach Burnout Inventory (MBI-HS), which involves three independently scored dimensions, i.e., emotional exhaustion, depersonalization, and personal accomplishment. The authors veered away from tradition and used the Copenhagen Burnout Inventory (CBI), which has the right mix of positive and negative phrases and encompasses the physical and cognitive aspects of exhaustion and more importantly is a free-to-use tool.[5] With this tool, they surveyed three domains, a personal burnout, work-related and client-related/pandemic-related burnout domain in addition to general questions. In each domain, a score >50 defined burnouts. The authors were able to demonstrate a significantly higher pandemic-related burnout than personal and work-related burnout scores, and more than half of the respondents experienced pandemic-related burnout. Pandemic-related burnout was highest in a high-risk hospital environment like intensive care.

This study highlights one more aspect of the COVID battles, collateral damage to the psyche of the HCWs. Burnout syndrome results in poor work performance leading to decreased clinical effectiveness that impacts clinical care. Burnout syndrome among critical care nurses has an even higher impact on clinical performance: patient care suffers, patient satisfaction score decreases, there is increased rates of infections and higher mortality. Medical errors and BOS have an almost linear and bidirectional relationship; errors lead to more symptoms of BOS and BOS leads to errors.[6]

The findings of this study are pointing in the same direction as other international burnout surveys have pointed out that burnout is on the rise.[7] Worldwide, it is the fear of contracting the disease, spreading it to their loved ones, the need to make life-prioritizing decisions, and a feeling of being pushed beyond limits of their training that seem to be the driver for BOS during this pandemic.

Increased prevalence of burnout during a pandemic is due to the stressors imposed by the disease on all of us. As pointed out by the authors in their study, the personal and work-related burnout domains are lower than the pandemic-related domains, thus focusing on organizational risk factors as a means to mitigate BOS. The survey also points toward these organizational factors especially the feeling of inadequate protection offered by the organization, as an important cause of BOS. The heavy workload,

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How to cite this article: Suresh Ramasubban. COVID Collateral: "Don't Forget the Diligent Healthcare Worker". Indian J Crit Care Med 2020;24(8):613–614.

Source of support: Nil

Conflict of interest: None

lack of control, and an effort–reward imbalance, all these also seem to be increasing the risk for BOS.

Resilience, the ability to quickly recover from illness, change, or misfortune, is a psychological characteristic that is a major mechanism to prevent and treat BOS. A majority of us, like our innate immunity, have an inbuilt psychological resilience that prevents us from falling prey to BOS; others need to learn to become resilient. Resilience training has been studied among ICU nurses in a randomized controlled trial and has shown to be effective.[8] Resiliency techniques include being optimistic, exercising, and encouraging social and supportive networks.

However, organizational interventions are the key to reduce pandemic burnout and the stressors associated with the pandemic. The American Association of Critical Care Nurses (AACN) has identified six interventions as the main target for a healthy organization. The six standards are the following:

- Skilled communication
- Appropriate staffing
- Collaboration
- Meaningful recognition
- Effective decision-making
- Authentic leadership

The authors have done a commendable job of highlighting the oftneglected issue of BOS during the pandemic, when most of the research is focused on clinical treatment.[4] Organizational intervention as highlighted by the authors[4] and the AACN guidelines should form the backbone to fight against this collateral damage.[8]

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