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Covid-19 and Healthcare Workers

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Covid-19 has posed many challenges for healthcare workers. The very nature of medical care has placed them at the centre of the pandemic. They are now practicing differently to the way that they normally do. The high infectivity of the virus has necessitated the placement of barrier precautions including masks, gloves, gowns, and eye-wear between their patients and themselves. Reduced contact has been advised in the delivery of care. The mantra is to make every interaction count. This is very alien to the way that medicine is practiced. Normally, patients are provided with frequent and close professional contact.

The isolation among staff themselves is another source of anxiety. The normal close communication lines and camaraderie with colleagues has been interrupted. The social interaction at meal breaks has been reduced. In other word, an important psychological, support system has been abruptly removed[1].

A recurring theme among healthcare workers is the anxiety that one will contract the virus at work, or else pass the virus on to a family member. These concerns are accentuated when the healthcare worker is living with someone who is elderly, immunocompromised, or has a chronic medical condition. These fears are well founded. Data from a number of countries has found that healthcare workers are more likely to contract the virus. They account for 25% of the positive cases although they represent under 3% of the general population.

The common sources of anxiety and requests for help that have been articulated as follows- hear me, protect me, prepare me, support me, and care for me[2]. Concerns that have hitherto received less attention include- access to childcare during increased work hours and school closures, or being deployed to a new area for example a non-ICU nurse having to work in the ICU.

Gavin et al[3] have pointed out that during a pandemic, the demands on healthcare staff are extraordinary and long lasting. During the SARS epidemic half of the healthcare workers experienced psychological stress. One of the issues about the current crisis is that the normal stress coping mechanisms such as exercise, sport, and leisure time are severely restricted. Good organizational support is an important antidote is these difficult times.

The issue of deaths among staff from Covid-19 is a constant worry. The UK has provided some of the best data. Cook et al[4] on 22/4 reported that there have been 106 deaths among NHS staff. Of these, 98 had patient-facing roles. The preponderance of deaths were in nurses 33%, healthcare support workers 25%, and doctors 17%. Sixty one per cent were hospital based, 5% community based, the remainder being in a variety of settings. The median age of the deceased was 54 years.

Among the doctors, the specialties involved were surgery 5, GP 4, ED and medicine 4, and one each from paediatrics, psychiatry, geriatrics, histopathology, and neurorehabilitation. There were no anaesthetists or intensivists identified, although they would have been considered to be at high risk of viral exposure. One suggested explanation is that this group of doctors are rigorous about the use of PPEs and the procedures that reduce the risk of transmission. If this is the case, it is an argument for the wider use of more rigorous use of protective equipment. 94% of the deceased doctors were of BAME ethnicity, although they comprise 44% of the workforce. A similar pattern was encountered among nurses, where 71% of the fatalities were in the BAME group, despite that they account for only 20% of the nurses.

A similar picture has emerged for the general population. BAME patients account for 34% of patients admitted to ICU despite being just 17% of the UK population.

The causes for the excess mortality among BAME staff is unclear. The options are biological, medical, or sociological. It is frequently stated that they have higher rates of diabetes and hypertension. However, few experts believe that there will be simple answers. Dr. Chaand Nagpaul, the head of the BMA has recently called on the government to urgently investigate if and why BAME individuals are more vulnerable Covid-19.

On a more reassuring note, the overall death rate among healthcare workers of 0.5% of all deaths suggests that they are not overrepresented.

Similar patterns in relation to BAME ethnicity have been encountered in other countries. The Financial Times 29/4 reported that Norway has recorded that Covid-19 infection rates are 10 times higher in people born in Somalia. Possible factors are that they are poorer, live in tight family units, and have frontline jobs such as taxi drivers.

The relationship between Vitamin D concentrations and Covid-19 has been debated in both the previous and current issue of the Journal.

In the US, Black Americans represent 30% of those who have contracted the virus although they represent only 14% of the population.

There is no data from France because it prohibits the gathering of data based on ethnicity.

The Irish data, 30/4, reported that 5627 healthcare workers have contracted Covid-19. 7% were doctors, 34% were nurses, and 24% were healthcare assistants. 3.7% were hospitalised and 0.6% required ICU. There have been 5 deaths[5].

Uncertainty is a common cause of concern. Healthcare workers need clear and frequent communication about what will happen next. There is uncertainty on what the lifting of the lockdown will look like for the health services. It needs to be clearly set down what services will return immediately, what ones will return over time, and what ones will have changed forever.

Many media commentators have suggested that technology will increasingly be adopted into medicine and that consultations through video or over the phone will become commonplace. However, there are very good reasons why this hasn't happened over the last few decades. It requires a new skill-set. Any move away from the hitherto normal doctor-patient physical consultation brings risks. In a tele-communication one is relying solely on the patient's narrative. The clinical examination and clinical measurements have been removed from the evaluation. It is unsuitable for a new patient. It is problematic in the evaluation of a new symptom in an existing patient. It does require great attention to the documentation of the consultation. The State Claims Agency has recently issued some helpful guidance[6]. It must be kept in mind that tort law and the duty of care have not changed since the advent of the pandemic. If there is an adverse event following a tele-consultation it can be always leveled at the doctor that he should have seen the patient. One feels that if there is to be any significant developments, the medico-legal background will need to be reviewed. In addition, the clinical implications of the Supreme Court's decision 19/3/20 on upholding 'absolute confidence' needs to be considered.

It seems inevitable that Covid-19 will continue to cause clinical and personal difficulties for healthcare workers for many weeks and months into the future.

References:

1. Rimmer A. How can I feel less isolated from colleagues. BMJ 2020;369:April 16
2. Shanafelt T, Ripp J, Trockel M. Understanding and addressing sources of anxiety among health care professionals during the Covid-19 pandemic. JAMA 2020.5893 April 7
3. Gavin B, Hayden J, Adamis D, McNicholas F. Caring for the psychological well-being of healthcare professionals in the Covid-19 pandemic crisis. Ir Med J 2020:113;51-53
4. Cook T, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from Covid-19 analysed. HSC 2020:April 22
5. Latest updates on Covid-19 (Coronovirus). Gov.ie April 30, 2020
6. SCA risk advisory notice: providing telehealth: virtual sessions. 2020: April 17. Ref: sca-cis-ran-01-01