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Post Pandemic Physician Vulnerability

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Abstract

Clinicians have adapted robustly since the first outbreak of COVID 19 in Ireland. This piece highlights physician vulnerability in a new era of telemedicine and explores the challenges we face in terms of stigma and burnout. It explores the consequences, both positive and negative, of living and working in a virtual world recommending strategies to optimise patient care, training and clinician wellbeing.

There is no end in sight with COVID-19. Six months ago, the Irish government's mantra was to "hold firm" and "stay together by staying apart". We presumed this was a finite recommendation and a gradual return to normal would ensue. It is now increasingly clear that normal is not coming back. There have been almost 60,000 cases in Ireland and over 1800 deaths[1]. On 21st October Ireland moved to level 5 restrictions for a six-week period to curb rising case numbers.

The lack of return to normality for clinicians has been noticeable with the landscape of our day to day work changing dramatically. Outpatient clinics in most specialties are operating at a fraction of their previous capacity due to need for social distancing, enhanced cleaning regimens and patient non-attendance for fear of contracting the virus. Attendance at emergency departments (EDs) initially dropped at the outset of the pandemic mirroring trends seen with MERS and SARS[2]. At the end of those outbreaks, attendance increased to previous levels but in the absence of a clear endpoint with COVID-19 the trajectory is harder to predict.

Clinicians have been rapidly innovating to meet the needs of a variety of stakeholders; patients, teams and trainees. One example of this is the overnight shift to telemedicine – a hot topic among psychiatrists prior to COVID 19. There was understandable apprehension given its limitations.

How do you perform a comprehensive mental state examination remotely? Patients must have adequate IT skills and hardware such as a smart phone with a camera function. Patients with disabilities may be disadvantaged while interactions requiring an interpreter bring another level of complexity to the process. Multi-disciplinary team (MDT) meetings form a core aspect of delivery of care across all specialties. These moved online in March and many continue to take place remotely avoiding unnecessary clinician contact. Challenges include maintaining confidentiality and paucity of infrastructure and technology to support remote working in our health care system.

There is pressure on clinicians to adapt quickly and seamlessly to telemedicine as an integral part of service delivery. Much administrative work is required to effectively set it up, and huge efforts have been made across disciplines in learning to use various tools. The paucity of equipment in services has been thrown into sharp relief - never before was the dearth of video cameras such a barrier. Enhanced verbal communication skills are necessary to navigate the “virtual appointment”. Troubleshooting potential problems in advance is advisable such as a plan of action if the connection fails. In the early stages of the COVID 19 outbreak clinicians were busy drafting local guidelines for conducting remote care with no clear centralised guidance. Formal training in this area is necessary to enhance clinician confidence and skillset allowing the healthcare system to maximise the benefit of this valuable tool.

While telemedicine remains a work in progress, there is no doubt that it allows us to access more patients. We can continue to provide essential support prior to next available “face to face” review and troubleshoot a number of issues. In psychiatry specialties it may reduce the risk of relapse of mental illness and number of crisis admissions. A hybrid of face to face and online interactions will be necessary for some time. Despite our most valiant attempts, there will always be a proportion of patients for whom telemedicine will not be a viable option. It is crucial that a small number of face to face sessions are safeguarded for this vulnerable cohort regardless of restriction level. Without these measures, patients are more likely to present in crisis putting more pressure on an already squeezed emergency and inpatient service.

This hybrid approach aims to maintain optimum levels of patient care but also allows continued learning and professional development which arrested temporarily at the outset of the pandemic. National training days were initially cancelled; examinations were moved online. Conferences have been either deferred or moved online and previous “in person” teaching sessions at all levels have been transformed into webinars. Networking has changed completely with virtual sessions favouring tech savvy, confident characters with strong verbal communication skills. Others risk being just one of the crowd and may be left behind in this virtual takeover. Strong chairs can transform a session but again skills training is needed across the board to even the playing field.

A word of warning however in this sea of virtual possibilities. We need to be mindful that as our virtual access improves, our ability to disconnect reduces. Clinicians may notice that the lines between work and home are becoming blurred. It is paramount that we safeguard our work life balance - something clinicians have seen diminish in recent months and others never had in the first place. It matters not only for clinician wellbeing but to allow us to remain effective in our clinical roles thus maintaining patient safety.

There are additional pressures on the clinician in this "new normal" environment. Mask wearing has become standard practice in healthcare settings. This has an impact on ease of communication with patients particularly paediatric patients, elderly patients or those with an intellectual or physical disability. The "new normal" also affects communication between co-workers and colleagues. Strict guidance around coffee and lunch breaks by design reduces social contact opportunities. While this is necessary from an infection control perspective, clinicians may find themselves more isolated in the workplace with reduced outlets to discuss complex cases, ethical dilemmas or simply catch up. This is likely to put further pressure on an already vulnerable cohort[3].

Another issue is that of "COVID-stigma". Back in February, healthcare workers (HCWs) were lauded as heroes. As Ireland opened up again many clinicians reported informal requests not to attend sports clubs or social gatherings. Fear and avoidance of HCWs is a global issue with a recent Canadian study reporting 1 in 3 survey respondents actively avoided HCWs[4]. Clapping for HCWs is all very well; but adequate supports are also needed. If HCWs are frozen out of their usual social outlets this will have a detrimental impact on their mental health and wellbeing leading to reduced ability to function effectively in their clinical role.

Unfortunately, in Ireland these challenges occur at a time when our health service and staff are already under pressure. Burnout and clinician distress are recognised globally. In the 11th revision of the International Classification of Diseases (ICD 11), Burnout syndrome is classified as an occupational phenomenon resulting from chronic workplace stress. It is characterised by three dimensions: feelings of exhaustion, increased mental distance from one's job, or feelings of cynicism related to one's job and reduced professional efficacy[5]. Burnout impacts negatively on psychological wellbeing, which if not addressed, may deteriorate into a defined mental disorder. In Ireland we have long recognised these issues with studies indicating burnout rates of up to 42% amongst consultants and non-consultant hospital doctors (NCHDs)[6,7].

Prevention is better than cure. Greenberg at al offer a number of strategies to address this including formally thanking HCWs for their efforts during the crisis[8]. Several Irish hospitals have already distributed commemorative medals to staff. Return to work interviews are encouraged as the pandemic eases but given the unclear trajectory of COVID-19, timing these may be a challenge. The benefit of Schwartz rounds is also highlighted as a space for staff to share their experiences – these are already in practice across Ireland[9,10]. They aim to promote communication and foster positive interdisciplinary engagement. Balint groups are small reflective groups which aim to validate emotional experiences. Again, these have already been positively received and integrated into Irish training[11], and have shown some promise in reducing physician burnout[12]. Protected time for clinicians is needed at organisational level to allow busy clinicians to avail of these resources.

Staffing is a major issue in Ireland – we have one of the lowest consultant numbers in Europe[13]. The mental health budget in Ireland is 6% of the total budget – less than half of the EU average of 13%[14]. Retention of doctors remains difficult with better working conditions and quality of life luring doctors further afield. Appropriate staffing levels, funding and focus on retaining graduates in Ireland are key aims to prevent burnout in our existing workforce.

Clinicians and healthcare teams have proven agile, innovative and adaptive. We have shown resilience in the face of an array of challenges. There is apprehension in the air as we face into winter. Can we count on systemic support to face what lies ahead? Good communication across services, adequate support of staffing and resourcing, systemic supports bolstering resilience and making meaning of experiences, acknowledging stigma and its impact, and extra individual supports where necessary, must be widely available. We held firm. Now we need more to keep fighting the good fight without falling victim to it.

Declaration of Conflicts of Interest:
The authors have no conflicts of interest to declare.

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