

Guest Editorial

Clinician Mental Health and Well-Being During Global Healthcare Crises: Evidence Learned From Prior Epidemics for COVID-19 Pandemic

Novel coronavirus disease 2019 (COVID-19) is sweeping across the globe, having sickened more than 640,000 people and claimed over 30,000 lives in approximately 202 countries at the time of writing with no sign of slowing down (World Health Organization, 2020). Each time, a pandemic or an epidemic disease occurs, such as measles, scarlet fever, HIV/AIDS, Ebola, or the flu of 2013, and healthcare professionals are on the front lines, battling diseases and caring for sick and dying patients, even while knowingly putting themselves at risk (Borghese, Di Donato, Ruotolo, & Fiegenger, 2020). An increasing number of healthcare professionals are being infected with COVID-19, and some paid the ultimate price, including the assistant nurse manager in New York who died in March (Genzlinger, 2020). Unfortunately, this number continues to rise, given that healthcare professionals are at such high risk for exposure (Gamio, 2020). A recent photograph of a nurse in Italy collapsed on her desk while still donning protective gear (Pisa, 2020) went viral on Twitter and other social media platforms. While the collective response to this image was positive, eliciting praise for nurses and doctors as unsung heroes, a closer examination of the photograph reveals the “absolutely shattered” nurses, doctors, and other healthcare professionals who are struggling to manage this crisis (Pisa, 2020). Exhausted providers amid the COVID-19 pandemic feel the heavy burden of their professional duty to serve while running thin on personnel and making do with little rest and insufficient time for recovery, not to mention having to put aside professional standards, such as evidence-based practice, in the face of personal protective equipment shortages (Stockman & Baker, 2020). Such conditions, especially when experienced in high-risk settings, render healthcare professionals increasingly more susceptible to the disease. What’s more, even if healthcare professionals manage to avoid infection themselves, the psychological distress associated with an infectious disease outbreak and the fear of spreading the virus to their families remain serious concerns (Maunder et al., 2006; McAlonan et al., 2007). To date, two nurses who were positive for COVID-19 have committed suicide, one in France and one in Italy. Typically manifested as insomnia, anxiety, fear of illness, frustration, anger, and depression, these

psychological effects also can linger long after the danger has passed (Maunder et al., 2006; McAlonan et al., 2007). This does not even consider the multiple other stressors in their lives that existed before the crisis, nor the effects of social isolation, which has become a governing norm for safety. With suicide on the rise for physicians and nurses (Davidson, Proudfoot, Lee, Terterian, & Zisook, 2020) before this pandemic, healthcare systems must act now to put preventive and early intervention strategies in place to promote the health, well-being, and retention of their workforce.

Based on the evidence from past epidemics, healthcare leaders and providers could manage acute work demands and psychological distress in several ways. The most fundamental step starts with the provision of adequate personal protective equipment with clear guidelines and training before interacting with patients. Several major news outlets, including *The New York Times*, report inadequate or insufficient protective equipment. With the provision of personal protective equipment, basic self-care—such as adequate sleep, nutrition, and hydration—also is central in maintaining and supporting healthcare professionals to remain effective. Prolonged shift times may not only reduce work efficiency and increase the risk of medical errors (Melnyk et al., 2018), but may also place clinicians at higher risk for exposures. Working night and rotating shifts adds additional risks for adverse effects on clinicians’ health and well-being (Books, Coody, Kauffman, & Abraham, 2017).

To support clinicians to have necessary self-care while remaining vigilant, adequate staffing is essential. Many hospitals were experiencing close to maximum capacity and a severe nursing shortage (American Nurses Association, 2019) even before the COVID-19 pandemic; now, the situation is even direr. Thus, pragmatic measures to allocate resources such as postponing elective procedures and using telemedicine can relieve some degree of burden for existing personnel. Furthermore, allowing emergency licensures, such as the one-day licensure approval in Massachusetts and New York, for nurses and other medical professionals from other states should be expanded to all states to bring in and mobilize clinicians ahead of what could be significant shortages in hospitals and clinics. In addition, following

the National Guard and Reserve model, a healthcare reserve corps should be developed to include licensed, skilled, and knowledgeable but no-longer-active professionals living in the community, for these individuals could be “on call” in times of crisis. Especially given the perhaps prohibitive cost of agency nurses for some hospitals, a coordinated network of trained providers funded by the government could profoundly assist in recovery efforts while relieving staff but still ensuring patient care. Partnerships with agencies may also introduce different payment structures during this crisis. Additionally, the expertise of military healthcare staff regarding triaging could offer a systematic process to meeting healthcare demands during the crisis.

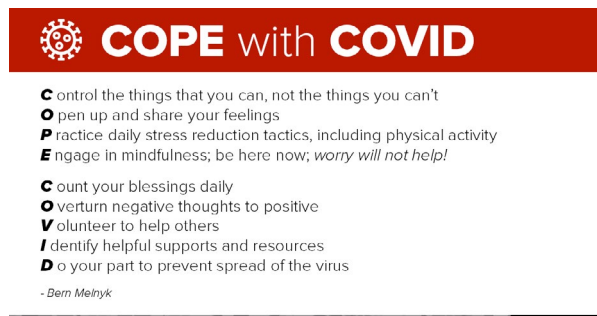
More than ever, nurses, physicians, and other healthcare professionals must work together as a team. As a nurse from the aforementioned photograph puts it, “That night had been really tough, but we are all working together. If we manage to help and save people, then it’s because we are all working together as a team.” Unit cohesion has never been more important than the time of crisis as it promotes social support, facilitates appropriate help-seeking, and reduces the stigma of stress, which, in turn, improves coping, encourages adaptation, and fosters resilience (McAlonan et al., 2007).




Lastly, short-term and long-term mental health services should be available to all healthcare professionals, starting now. Following the outbreak of severe acute respiratory syndrome in 2003, direct-care providers reported high levels of post-traumatic stress disorders, which persisted long after the crisis was over (Maunder et al., 2006). One in four healthcare professionals taking care of patients with Ebola demonstrated psychological symptoms, including obsessive-compulsive tendencies, interpersonal sensitivity, depression, and paranoid ideation (McAlonan et al., 2007). A recent study from China also found that front-line clinicians, especially nurses, caring for patients with COVID-19 are at high risk for anxiety and depression (Lai et al., 2020). Such symptoms were likely due to healthcare professionals coping with the deaths of colleagues, losing control, feeling vulnerable, working excessive hours, and witnessing the breakdown of social support systems, all the while fearing for their health and safety (Maunder et al., 2006), not to mention managing family responsibilities and other life stressors that do not dissipate during the infectious outbreaks. Acceptance, active coping, cognitive-behavioral skills building, stress-reduction strategies, mindfulness, deep breathing, gratitude, positive framing, and health coaching, along with programs such as MINDBODYSTRONG (Sampson, Melnyk, & Hoying, 2020), have been shown through research to be successful strategies to improve mental health and well-being (Melnyk et al., in press). We also must reduce stigma and increase awareness of and screening for depression and post-traumatic stress disorder among healthcare professionals and put systems in place to deal effectively with them. As the crisis continues, encrypted screening for depression and

suicidal ideation, along with evidence-based interventions, must be included (Melnyk, 2020). The National Academies of Sciences, Engineering, and Medicine (2019) has already identified clinician burnout and well-being as a priority, and this initiative will need to be accelerated further and ever more urgently as a result of this pandemic.

Recent events highlight the professional and organizational commitment of healthcare professionals in times of need. However, this engagement and dedication come at a cost, namely clinicians’ (and their loved ones) well-being. The public can help healthcare professionals who are committed to fighting this pandemic by flattening the curve with evidence-based strategies known to prevent the spread of infection. Proactive social distancing, while promoting human connection through social media and other technologies and maintaining necessary infection control, will contribute to maintaining the safety, protection, and well-being of healthcare professionals and their families and loved ones.

Additional strategies for how to COPE with COVID are in Figure 1.



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