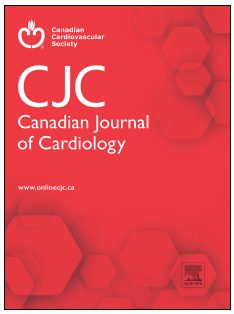

Burnout and Distress Amongst Healthcare Workers During COVID-19: Can We Offer More than Band-Aid Solutions?

Suze G. Berkhout, MD, PhD, FRCPC, Susan Abbey, MD, FRCPC, Kathleen A. Sheehan, MD, DPhil, FRCPC

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Title:
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Running Head (short title):
Burnout and Distress Amongst Healthcare Workers

Authors:
Suze G. Berkhout, MD, PhD, FRCPC
University of Toronto, Department of Psychiatry
University Health Network Centre for Mental Health

Susan Abbey, MD, FRCPC
University of Toronto, Department of Psychiatry
University Health Network Centre for Mental Health

Kathleen A. Sheehan, MD, DPhil, FRCPC
University of Toronto, Department of Psychiatry
University Health Network Centre for Mental Health

Corresponding Author:
Suze G. Berkhout, Toronto General Hospital, 200 Elizabeth St. 8th Floor Eaton North, Toronto, Ontario Canada, M5G2C4
Phone: 416 340 3762
Fax: 416 340 4198
Email: suze.berkhout@uhn.ca

As the COVID-19 pandemic continues through successive waves, health systems are strained by rising admission rates, high illness acuity, waitlists for postponed procedures and growing worker attrition. Anger and frustration over workloads, institutional and governmental COVID-19 policies, and public apathy (and antagonism) toward health professions have contributed to a complex constellation of emotional experiences amongst healthcare workers (HCW): burnout, fatigue, distress, and moral injury. These have been accompanied by increases in HCW visits for mental health and substance use support.[1,2] A confluence of factors make meaningful responses to HCW distress challenging, but opportunities exist to provide more than band-aid solutions.

What Does Distress Look Like?

It is well-documented that pandemics (e.g. SARS, MERS, H1N1, COVID-19) generate and exacerbate conditions in healthcare that contribute to HCW vulnerability to burnout and distress. The clinical manifestations of this vulnerability include experiences of anxiety, depression, insomnia and posttraumatic stress disorder (PTSD); in Ontario, visits by physicians for mental health and addictions supports have increased significantly over the course of the pandemic, alongside these stressors.[2] As with psychological distress amongst HCW, the issue of burnout (a work-related syndrome with dimensions of emotional exhaustion, detachment-depersonalization, and decreased personal efficacy) is neither new nor COVID-19-specific. Burnout has been studied amongst a range of HCW including nurses, physicians, and allied health professionals and has become more pressing and topical since the pandemic was declared in March 2020.[1,3]

Three aspects of the current moment make responding to HCW distress particularly vexing: (1) HCW continue to be challenged by a range of intersecting issues that exist across an individual-level to institutional and structural-level spectrum, such that an intervention at one level may incompletely address the complex aetiologies of distress; (2) the sources and intensity of distress have evolved during the pandemic, leading those who offer interventions to struggle with a continually moving target; (3) the pandemic has contributed to an evolving source of distress—workload challenges are exacerbated as health human resources have diminished concurrent with rising demand for clinical services, sparked in part by a combination of pandemic-related illnesses, care delays and increased medical complexity in community settings. This confluence of factors further accentuates barriers to HCW accessing support for their own needs.

Until recently, little was known about how to best support HCW during a pandemic. Even now, very few interventions delivered during the COVID-19 pandemic have included evaluation (in part due to the urgency of delivering these), and so there remains uncertainty as to how to best support the wellbeing of HCW in the context of a global pandemic.[3,4] Our own research investigating HCW distress has found that distress and burnout are related to a range of issues across a spectrum of individual-level to structural-level concerns that are themselves intersecting—individual fears about safety and contamination, for instance, are intimately related to larger workplace culture issues such as whether one feels valued versus expendable in their workplace.[5] Fear and anxiety are also linked to structural issues such as personal protective equipment (PPE) supply chains and to institutional trust, such as whether a healthcare system was felt to be transparent about reasons for decisions around who might access which type of PPE. As with other published literature on HCW distress in COVID-19, we have seen these

concerns evolving as the pandemic continues, shifting toward themes of burnout, anger, fatigue, and moral injury. These vulnerabilities to distress are also modified by institutional practices and policies (see Box 1). Importantly, the burdens on HCW are situated within a healthcare system that has chronically underfunded primary and community care, with limited continuity between acute and community settings. This exacerbates workload, patient flow challenges, and the ability to provide timely and comprehensive care in both settings.

How to Respond?

In light of the wide range of distress experiences that HCW face and ongoing the health systems challenges that these exist in, we remain faced with a question of how to best provide mental health support as the pandemic continues and as our larger healthcare system continues to struggle with fragmentation between acute and community care sectors. The context described above calls for flexible, low-barrier services. And given that distress is generated at different intersecting levels (individual, institutional, societal), it is imperative to consider how these intersections might be addressed such that seeking care and receiving an intervention do not simply download an obligation to be "well" onto service users and individualize responsibility for structural contributors of distress. Furthermore, we might also ask whether it is possible to provide support through processes that don't simply rely on the goodwill of other individuals who are also taxed by current healthcare systems issues.

Looking across several different mental health support programs for HCW in COVID-19, we see a number of shared features among programs that do more than offer a temporary band-aid at the individual level. Foremost, these programs take a stepped, multi-level approach to *both* the support offered and to understanding the sources of distress in a particular context.[4] A quality improvement framework is one important aspect of design that can assess local needs and iterate

program development: needs assessment as well as evaluation data can support the implementation and modification of interventions while also informing broader policy and practice change in the institutions the data is generated in. Moreover, quality improvement frameworks improve not only the individual-level supports—they contribute to advocacy for systems-level improvements while ensuring that data collected is in the service of those who are using the program.

Interventions themselves can address issues at various levels, from individual to team/clinical unit to institutional. At the individual level, supports that are guided by clinical indication rather than by a specific modality or a set number of sessions enables a framework for care that is relational and adaptive to service users' needs. One-size-fits-all approaches can be experienced as invalidating and exacerbate the tension between identifying and responding to individual distress and recognizing sources of that distress that sit outside of individual experience. In our own setting, a relational therapeutic focus and the provision of high-quality of care from a healthcare provider from within the same institution provided a powerful counterpoint to the sense of not being valued and feeling expendable to the larger health system, a significant source of HCW distress. At the same time, as suggested in the literature, we heard how care that is embedded in one's own institution needs to be provided in a manner that emphasizes confidentiality (e.g. providing care that is distinct from workplace occupational services and maintaining separate medical records).[5] Where evaluation data for COVID-19-specific program does exist, individual supports are valued for their timeliness, ease of access, perceived high quality of care/skill of provider, flexibility of appointments, and responsiveness to urgent concerns. Many of these features of successful individual HCW support programs are also ones that begin to address broader structural and institutional-level sources of distress.

In acute care settings, team-based interventions that are easily accessible and embedded in pre-existing relationships can also lower barriers to accessing supports while contributing to resiliency and building strengths in workplace culture. At the same time these interventions create opportunities for institutional advocacy and facilitate the provision of further resources to areas that are especially struggling.

Sustaining the Support

As the pandemic has continued, the strain on hospital staffing levels has resulted in the redeployment of many mental health professionals to support other clinical areas. Volumes of patients accessing mental health supports have rebounded and those involved in research have seen other projects resume, all of which has meant that fewer providers are available to carry out the support when a program is embedded in one's own institution. Transition plans are invaluable for time-limited programs and need to be discussed within the larger operations of the hospital system.

For providers, being able to contribute to supporting colleagues in hard-hit areas of the health system has been identified as a high source of meaning and value for their participation in the program. Peer support/peer supervision has likewise been identified as valuable.[5] However, for a program to be sustainable, participation as a provider needs to not be overly burdensome. Ensuring strong administrative support and efficient methods for documentation is essential. A balance must be struck when planning how often providers will meet to share experiences and learnings, ensuring that program feedback is also circulated amongst providers but not adding to already pressed schedules. Similar to ensuring that those receiving support offer feedback in program evaluation, providers must also be able to deliver actionable feedback in program design.

Discussion

Within a framework of evidence-based medicine, we often treat what we can measure. While this may guide us away from unnecessary intervention, in mental health care it contributes to a tendency to focus on individual-level therapeutic targets, even when antecedent causes of distress are acknowledged to include institutional and structural factors. Mental health support programs to address HCW vulnerability to burnout and distress need to look simultaneously at the intersecting levels where sources and modifiers of that distress overlap. Providing more than band-aid solutions means having a support program that can adapt as the needs of the service user group evolves, lowering barriers to service access and use, delivering high quality clinical care that is itself attentive to the institutional context, and scaffolding individual care within approaches to support that address institutional-level challenges. These solutions enhance workplace culture as well as institutional change, though we acknowledge that this may still leave larger health systems challenges untouched. That said, a continuous quality improvement framework can facilitate shifts in institutional policy that extend beyond an individual site, and community of practice and peer supervision approaches are likewise helpful for sustaining support. In addition, an expansive approach to what data is tracked and measured (e.g. including qualitative and experiential data) ensures that actively assessing what and how we can best support HCW colleagues (see Box 1).

While burnout and distress may be experienced as individual emotional struggle, the pandemic has clearly demonstrated what has previously been discussed about workplace impacts on mental wellbeing: that broader institutional cultures, systems, and practices (e.g., communication approaches, perceived transparency, trust in leadership, opportunities to direct workplace change, workloads, and vacation and compensation policies) play a significant role.

An individualist orientation is frequently embedded in how distress is conceptualized (as clinical symptom), measured (through validated scales), and acted upon. Even within the CanMEDS framework, attending to one's wellness is considered a component of professionalism—a personal responsibility. Responding adequately to HCW vulnerabilities to burnout and distress means looking beyond the individual-level and thinking about how to embed attentiveness to institutional and structural considerations within our frameworks for care.

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Boxes

Box 1: What Do We Know about Supporting HCW Vulnerabilities in COVID-19?

- Supports for HCW have been called for during previous pandemics with limited evidence to substantiate what those should be
- Emotional experiences relating to healthcare work within the pandemic are multifaceted: grief, loss, despair, resentment, anger, compassion, pride often co-exist
- Sources of emotional distress overlap and span a spectrum of individual to institutional/structural levels such that constructs like anxiety, depression, or PTSD may not capture the complexity of the emotional experience or the intersecting sources of distress
- Individual supports should be stepped and guided by clinical indication rather than a specific therapeutic modality or a set number of sessions
- Needs assessments and team-based interventions enable programs to identify and address modifiers of distress such as workplace culture
- Program success can be enhanced by lowering structural barriers to utilization (free of charge, self-referral, flexible hours/days including evenings and weekends)
- Upward feedback to institutional leadership/administration can help to inform policy-related decisions, improving aspects of communication that are frequently a source of distress in pandemics

Box 2: Additional Supports for HCWs Experiencing Distress

Wellness Together Canada (wellnesstogether.ca)
Crisis Services Canada
talksuicide.ca
1-833-456-4566 (24/7)
Canadian Mental Health Association
Bounce Back (bounceback.cmha.ca)
Mental Health Commission of Canada
The Working Mind (theworkingmind.ca)
Distress line: Text WELLNESS to 741741
Canadian Medical Association
cma.ca/support provides a comprehensive and up-to-date listing of supports for physicians by region/territory

Self-Guided Online Resources:
Anxiety Canada (anxietycanada.ca)
Centre for Clinical Interventions (cci.health.wa.gov.au)