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Perspective

Preventing a Parallel Pandemic — A National Strategy to Protect Clinicians' Well-Being

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The Covid-19 pandemic, which had killed more than 60,000 Americans by May 1, has been compared with Pearl Harbor and September 11 — cataclysmic events that left indelible imprints on the U.S. national psyche. Like the volunteers who flooded into Manhattan after the World Trade Center attacks, the health care providers working on the front lines of the Covid-19 pandemic will be remembered by history as heroes.

These courageous people are risking their lives, threatened not only by exposure to the virus but also by pervasive and deleterious effects on their mental health. Tragically, we are already seeing reports of clinicians dying by suicide amid the pandemic, including the highly publicized death of a prominent emergency medicine physician in Manhattan, the epicenter of the U.S. Covid-19 outbreak.[1] Before the virus struck, the U.S. clinical workforce was already experiencing a crisis of burnout. We are now facing a surge of physical and emotional harm that amounts to a parallel pandemic.

Just as the country rallied to care for September 11 first responders who suffered long-term health effects, we must take responsibility for the well-being of clinician first responders to Covid-19 — now and in the long run. We are calling for several immediate actions to lay the groundwork for a clear and accountable national strategy to safeguard the health and well-being of our clinician workforce (see box).

The first locus of responsibility is health systems and other employers of clinicians. Organization leaders need to understand and squarely confront the unprecedented strains on their workforce. Underlying clinicians' anxieties over the scarcity of personal protective equipment and limited availability of testing is the fear of spreading the disease among patients and coworkers or bringing it home to their families. Clinicians have expressed uncertainty about whether employers would support them if they got sick. Amid extra-long work hours, many are also being asked to fill emergency roles for which they feel underprepared.[2] As the Covid-19 crisis stretches on, the burden of stress will only mount.

After the 2003 SARS outbreak in Toronto, studies found high levels of emotional distress among hospital workers — stemming from social isolation, the pain of losing colleagues to the disease, and social stigma associated with exposure to SARS, among other factors.[3] Stigma, including self-stigmatization, was also a problem

Five High-Priority Actions to Protect Clinicians' Well-Being during and after the Covid-19 Crisis.

Organizational Level

Integrate the work of chief wellness officers or clinician well-being programs into Covid-19 "command centers" or other organizational decision-making bodies for the duration of the crisis.

Ensure the psychological safety of clinicians through anonymous reporting mechanisms that allow them to advocate for themselves and their patients without fear of reprisal.

Sustain and supplement existing well-being programs.

National Level

Allocate federal funding to care for clinicians who experience physical and mental health effects of Covid-19 service.

Allocate federal funding to set up a national epidemiologic tracking program to measure clinician well-being and report on the outcomes of interventions.

for nurses surveyed after the 2011 Fukushima Daiichi nuclear disaster, who described the emotional turmoil of being forced to choose between protecting themselves and their loved ones and doing their duty as caregivers during a national crisis.[4]

The inability to do their duty may be at the heart of the moral distress experienced by Covid-19 clinicians. With overwhelming numbers of seriously ill patients and shortages of essential supplies, providing the optimal standard of care becomes a mathematical impossibility. People who feel that they are called as healers in the altruistic Hippocratic tradition must stand by powerlessly as their patients sicken and die — a tragedy that can cause serious moral injury. Such injury may be most acute and long lasting in the young physicians, nurses, and other health professionals serving on the front lines during their formative years of training.

How should health systems respond to such a formidable challenge? Many organizations have already created a chief wellness officer (CWO) position at the highest executive level. As a first immediate action at the organizational level, CWOs should be given a powerful voice in "command centers" or decision-making bodies that their organizations have assembled to respond to the pandemic. Furthermore, organizations can sustain and supplement existing well-being programs, which can also provide a "playbook" for groups that have yet to bring such programing online (https://nam.edu/clinicianwellbeing/case-studies). Although Covid-19 presents a monumental "excuse," now is not the time to divert resources from clinician well-being or delay the establishment of new activities.

As a second immediate action, organizations can empower and encourage clinicians to speak freely about the stressors they face and to advocate for their own health as well as that of their patients. This effort might include the use of anonymous hotline systems to allow clinicians to voice their concerns without fear of reprisal. For such systems to be meaningful, leaders must be prepared to respond transparently and proactively to feedback.

The final set of actions will have to be taken by the U.S. Congress. Our clinician workforce is an exhaustible national resource, and it is already stretched to the breaking point in many locations. The Covid-19 crisis comes as a blow to a population already at heightened risk for psychological distress and mental health problems. Even before the pandemic, alarmingly high numbers of health professionals were suffering from burnout — according to some studies, as many as 45 to 55%. Burnout is associated with higher rates of anxiety disorders, depression, substance abuse, and suicidality — trends that will be aggravated by the pandemic. And the cost for clinicians will become a cost for patients, as sick and burned-out caregivers leave the workforce at a time when they're desperately needed.[5] We need a national solution that acknowledges the scale of the crisis, and we cannot afford to wait.

The Coronavirus Aid, Relief, and Economic Security Act and follow-on legislation appropriated billions of dollars to support hospitals, health systems, and providers in bearing the financial costs of the pandemic. Although they represent an important start, these funds are unlikely to cover the projected losses of these institutions — let alone meet the enormous need to care for Covid-19 clinicians experiencing long-term physical and mental health consequences. We face the paradox of ongoing activity of the virus, even as institutions begin to furlough employees in response to the economic ramifications of the pandemic for our health care delivery system.

The September 11 attacks again provide a useful comparison. Confronted by chronic conditions such as post-traumatic stress disorder among 9/11 first responders, Congress established the federal World Trade Center Health Program, which provides medical monitoring and treatment for nearly 78,000 responders and 24,000 survivors. The number of clinicians experiencing long-term harms from the Covid-19 pandemic is likely to be much greater. As Congress considers additional pandemic-related appro-

priations, we advocate inclusion of specific funding for the well-being of clinicians affected by the pandemic, similar to the fund established for World Trade Center first responders.

Another urgent need is for a national epidemiologic tracking program to measure clinician well-being during and after the Covid-19 crisis. Ideally, such a program would be led by the Centers for Disease Control and Prevention and would use random sampling and standardized instruments to assess acute and long-term effects of Covid-19 service on clinicians. Robust data are essential to understanding the scope of the challenge and to reporting the outcomes of interventions. Here, too, congressional appropriations could set the wheels in motion.

The Covid-19 crisis has revealed with painful clarity the fraying threads of the U.S. clinician workforce. Repairing the fabric will take all of us. Clinician well-being is a complex systems issue with multiple responsible parties, including employers, professional associations, insurers, quality-improvement organizations, and state and federal government. The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience offers a wealth of actionable resources to support the development of well-being–focused programs and policies across sectors. There has never been a more important time to invest in the clinician workforce.

We have a brief window of opportunity to get ahead of two pandemics, the spread of the virus today and the harm to clinician well-being tomorrow. If we fail, we will pay the price for years to come. In the race to respond to the Covid-19 crisis, we must not neglect to care for those who care for us.

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