**Mental Health Support for Health Care Workers during COVID-19: Surge Edition**

**January 13, 2021 Summary**

**CLINICIANS’ EXPERIENCE DURING THE PANDEMIC:  
RESOURCE LIMITATION AND DISRUPTED ROLES**

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**Background:**

Dr. Butler will discuss some of the implications of her research for understanding moral distress and opportunities to support clinician wellbeing. Dr. Butler and her team have conducted a series of qualitative studies to better understand US clinicians' experiences and perspectives on providing care, managing resource scarcity, and navigating changes in their professional roles and relationships during the COVID-19 pandemic.

**Summary of Presentation:**

The presentation is divided into the following topics:

* Experience on the preparation as a community on how to adapt health care system to COVID
* Recent research on clinician experience
* Close the presentation with ideas on supporting clinicians going forward

Crisis Capacity planning:

Health care systems use three types of capacity planning: 1) conventional, 2) contingency and 3) crisis.

Ordinarily the capacity planning is organized to optimize resources for individual patient care (conventional), however, during COVID health care systems have had to consider additional planning for contingency and crisis. Contingency planning turned into flattening the curve, increasing or preserving resources (e.g. PPE and other supply) and re-allocation for resources (shifting resources from one area to another). Crisis planning involved standards of care as it pertains to rationing of resources and coming to decision on care. For example, a clinician can not use principles of care such as Shared-Decision Making to allocate care with an individual patient during a crisis. Instead, clinicians have to look at allocating care on a population level and during crisis that may involve rationing and withholding of care due to inadequate resources.

Allocations decisions should be separated from clinical decisions. The standard for this should be established by a different team than the team providing care. The criteria for allocating care need to be transparent and reflect the values of the community.

Regarding tools on how to do this, Dr. Butler’s team had a preplanned allocation algorithm to assign priority based on different criteria that are based on years of research and major national groups endorsements.

Additional issues the team had to consider around allocation: 1) Civil rights concerns and 2) Toll on clinicians of the pandemic (stress, burnout)

Dr. Butler’s study on clinician experiences regarding resources allocation during the pandemic:

The research included 61 clinicians spread over 50 states. Qualitative interviews were conducted.

The main question was around how triage teams were run, however, during the course of research, other questions came up.

The results are divided into two themes:

1. Practice settings for crisis planning
2. Impact on clinicians on professional roles and relationships

Planning for crisis capacity:

* Found a lot of enthusiasm among clinicians for planning and having structure
* Challenges with adapting from theory into practice
* Some disengaged from triage teams when capacity wasn’t reached
* Found ventilator availability was not an issue rather there were shortages in other resources which had to be determined how to reallocate
* The idea of rationing care caused distress and carried a bad connotation (Don’t want the institution to be associated with rationing so sometimes people stopped talking about it)
* Sometimes clinicians just used judgement calls based on different factors

Addressing barriers to care delivery:

* Happy to use any therapy even if risks or lead to lower quality of care
* Questions on how to explain barriers to patients

Unanticipated types of resource limitation:

* Dialysis equipment
* Staff availability
* Manner in which resource was available – stretching things thin even to provide minimal care

Other impacts on quality of care:

* Hard to isolate impact of resource on change in practice
* Even though substantial planning on capacity was done, the experiences in practice were different
* No rationing was done, but usual standards of care were not provided either – rather it was a spectrum
* Sometimes focused on individual needs, other times on resource allocation
* Resource limitation is driving factor on quality of care if no standard of care

Professional roles & relationships:

* Disruption to regular work
* Keeping boundaries between work and home life (clinical concerns – minimize the risk of infection both at home and work)
* Not cleaning equipment turned into a usual practice
* If staff at risk due to a health conditions – feeling guilty about not working and feeling that they should
* Leaders felt responsible for staff well-being - feeling guilty for overworking staff

Constructive adaptation:

* Some found new meaning in work
* Appreciation for direct care with patient, can see impact on patient
* High degree of collaboration not thought possible prior to pandemic,
* Better understanding of coming together, humble, appreciate everyone’s role
* Different backgrounds built mutual respect an camaraderie, hospitalist can see what’s done in ICU and gain appreciation
* Frontline workers felt more involved in decision-making

Discord and estrangement:

* Disruption in professional identity and values
* Power differentials
* New roles didn’t align with professional values
* Not sure what the goal of the job anymore
* Patient/doctor fear
* Not sure what the target of the day is anymore like it used to be
* Animosity between staff in different clinical roles
* Feeling of disempowerment
* Not sure if leadership had best interests at heart; admin seen as out of touch
* Cognitive dissonance – practice usual standard of care but have to grapple with limited resources

Value conflicts:

* Protecting oneself vs. supporting colleague and patient care
* Patient care vs. population health resource stewardship

Conclusion and future research questions:

* Hoping to generate some new approaches for crisis planning during pandemic
* More attention to contingency capacity planning
* What triggers crisis capacity
* Team-based care – seem to be valuable in settings of complexity from this experience
* Formal and informal support for clinician’s emotional well-being

**Next Meeting: Wed, Feb 3rd 12:15-1pm.**