Enhancing Preparedness Among Frontline Doctors During COVID-19 Pandemic: Learning from Experience

To the Editor,

The COVID-19 pandemic has significantly affected the lives, globally. Health care workers (HCWs) experience enormous challenges during the pandemic. The common causes of distress among HCWs during the COVID-19 pandemic are mental and physical exhaustion, isolation, stigma, and separation from family members.[1] Gaps between the need and supply of protective equipment and human resources are a challenge globally and more so in low- and middle-income countries.[1] Approximately 2.2%–14.5% of HCWs experience anxiety and depression in an intense form.[2] Studies reveal that HCWs who work at the frontline in the care of COVID-19 patients experience anxiety, mood disturbances, and sleep difficulties.[3,4]

Materials and Methods

A total of 13 frontline doctors from various disciplines of medicine (Psychiatry, Orthopedics, Ophthalmology, Pharmacology, Radiotherapy, Orthodontics, and Dental Sciences), working in COVID-19 patient care in an apex hospital and posted in three isolation wards during July 2020, shared their experience in a semi-structured format (Annexure 1 and 2). As doctors lead the team of HCWs and have to handle several responsibilities other than routine patient management, only their experience was evaluated. Of the 13 participants, 8 were males, and 5 were females, with age ranging from 24 to 43 years, with a median of 28 years. Two were faculty members, two were senior residents, and rest nine were postgraduate residents from the same institute.

The experiences were assessed in the following questionnaire. It was not validated and was intended to measure the experiences of the HCWs qualitatively.

Semistructured assessment questionnaire

1. What is the most common challenge in doing duties in the isolation ward?
2. What is the most important learning from duty in the isolation ward you want to convey to your coworkers?
3. What is the most common cause of your distress during the COVID-19 posting?

Assessment of overall satisfaction

Kindly rate your overall satisfaction related to COVID-19 duty in a Likert scale of 0–4. (0: not satisfied at all; 1: little satisfied; 2: somewhat satisfied; 3: mostly satisfied; 4: completely satisfied.)

Overall satisfaction: It refers to global satisfaction related to all dimensions of work (i.e., working environment, infrastructure, adequacy of support, adequacy of training, and other logistic issues).

Data is presented in word cloud format using online software *WordItOut* (https://worditout.com/). The size of the fonts directly reflects the frequency (i.e., more common responses are presented with larger fonts, and less common responses are presented with smaller fonts). Colors are used only to differentiate the words in these figures; they do not have any statistical significance. The keywords from each response were selected and enlisted according to frequency. Only keywords (that convey the causes of distress, challenges and learning during posing in COVID-isolation ward) were used in the word cloud analysis. Other words were cleaned due to lack of relevance. The minimum frequency of the keyword was one. No keyword was excluded. The number of keywords used to describe common challenges, learnings, and causes of distress was 11, 12, and 12, respectively.

Results

The health care professionals encountered various challenges (**Figure 1**) and reported several unique learning (**Figure 2**) during their posting in the isolation ward.

The participants had varying levels of satisfaction (23.1%: completely satisfied, 38.5%: mostly satisfied, 23.1%: somewhat satisfied, and 15.4%: little satisfied). The common causes of distress of the HCWs are summarized in **Figure 3**.

FIGURE 1.

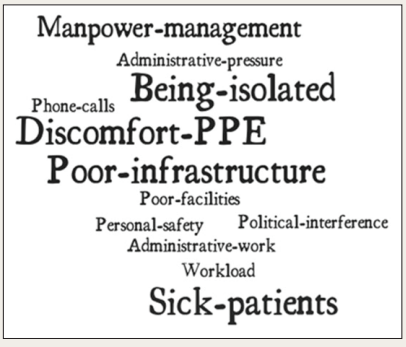
Word Cloud Showing the Most Common Challenges Faced by Health Care Workers During Duty in the Isolation Ward

FIGURE 2.

Word Cloud Showing the Most Common Learning of Health Care Workers During Duty in the Isolation Ward

FIGURE 3.

Word Cloud Showing the Most Common Cause of Distress Among Health Care Workers During Duty in the Isolation Ward



Recommendations

These aforementioned facts helped us to frame the following recommendations for the HCWs (particularly doctors) of developing countries expected to work in the COVID isolation wards in the coming days. Preparedness will help them to maintain the subjective well-being so that they can function optimally. The facts that are needed to be considered by the HCWs while preparing themselves for the management of COVID-19 in the isolation wards are as follows:

1. Uniform training modules on COVID-19 are designed for all the health care settings of the country (or world at large). But, the health care settings across countries and within the country are not uniform in terms of their infrastructure. An ideal health care setting and infrastructures mentioned in the protocols may not be available in all places. So, HCWs need to keep these things in mind before going to duty in the isolation wards.
2. The coronavirus is rapidly evolving, as are the protocols designed for the management of COVID-19 patients. The HCWs need to keep themselves updated with the training protocols for the effective management of COVID-19 patients.
3. The expectations of the HCWs from the working area, administration, colleagues, support staff as well as patients, should be realistic. Too much expectation may be a cause of distress. Hence, the expectation needs to be handled cautiously.
4. As the numbers of COVID-19 cases are increasing, the existing resources and infrastructures are gradually getting exhausted. Replenishment may not be sufficient many times, compelling the HCWs to work in a compromised set up. HCWs need to be familiar with this fact and prepare themselves accordingly (through proper human resources management, assessing the level of risk quickly, and checking it with available resources). For example, a patient with severe respiratory distress, most possibly need intensive care unit support. Early referral is required in such cases if the appropriate facility is not available in a particular setting.
5. Many developing countries, including India, have a semidigitalized health system. In many hospitals, the procurement of essential medications, equipment, and other accessories is done through digital portals. Nonfunctioning of the digital system (due to network issues, interrupted power supply, etc.) may interfere with smooth health care delivery. The HCWs should be prepared to work through the off-line system.
6. The HCWs (particularly doctors) have to involve in administrative responsibilities like human resources management, coordinating with multiple sectors, organizing and developing the infrastructures in coordination with concerned key authorities, in addition to patient management. So, they should be prepared enough to deal with all these issues effectively.
7. Many patients with COVID-19 have medical comorbidities that may be one of the deciding factors for poor outcome. The HCWs need to focus more on the effective management of comorbidities, in liaison with the appropriate discipline.
8. Posting medical professionals not trained in handling medical emergencies also causes apprehension. They should be posted in isolation wards after appropriate training, along with medical professionals equipped and trained to handle such emergencies.
9. Many are getting infected with COVID-19 as a result of lack of knowledge and/or negative attitude about personal hygiene and social distancing due to which they may continue to disregard these precautionary measures even in the hospital settings. HCWs need to take appropriate precautions to deal with these challenges.
10. The work pressure of the isolation wards may sometimes cause emotional exhaustion of the frontline HCWs. It is important to understand their belief systems (cognitive styles). Acceptance of the challenge may be more beneficial to combat the emotional exhaustion than denying or resisting it.[5]

This study has certain limitations such as small sample size, the inclusion of doctors only, and the use of a nonvalidated tool. Future research may be conducted in a larger sample, including all categories of HCWs and using a structured and validated tool that may be able to give better insight into this important issue.

As the demand for frontline HCWs is increasing to keep pace with the rapid increase in COVID-19 cases, the frontline HCWs (who are the backbone of COVID-19 management) need to be prepared enough to meet the challenges. Sharing the experiences with fellow workers and other HCWs who are expected to do their duty in isolation wards in the coming days may help in meeting the challenges more effectively.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Sujita Kumar Kar[1], Suyash Dwivedi[1], Anand Kumar Maurya[2], Malvika Singh[3], Rajnish Kumar[4], Prabhat Kumar[4], Anupriya Chaubey[3], Nitika Singh[1], Garima Singh[1], Naveen M[5], Rahul Kumar[1], Nikhil Gupta[6], Ankita Mallick[7]

[1]Dept. of Psychiatry, King George's Medical University, Lucknow, Uttar Pradesh, India. [2]Dept. of Pharmacology, King George's Medical University, Lucknow, Uttar Pradesh, India. [3]Dept. of Ophthalmology, King George's Medical University, Lucknow, Uttar Pradesh, India. [4]Dept. of Orthopedics, King George's Medical University, Lucknow, Uttar Pradesh, India. [5]Dept. of Orthodontics, King George's Medical University, Lucknow, Uttar Pradesh, India. [6]Dept. of Oral Pathology and Microbiology, King George's Medical University, Lucknow, Uttar Pradesh, India. [7]Dept. of Radiotherapy, King George's Medical University, Lucknow, Uttar Pradesh, India.

Address for correspondence:

Sujita Kumar Kar, Dept. of Psychiatry, King George's Medical University, Lucknow, Uttar Pradesh 226003, India. E-mail: drsujita@gmail.com

Submitted: **27 Jul. 2020**
Accepted: **3 Aug. 2020**
Published Online: **31 Aug. 2020**

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HOW TO CITE THIS ARTICLE: Kar SK, Dwivedi S, Maurya AK, Singh M, Kumar R, Kumar P, Chaubey A, Singh N, Singh G, Naveen M, Kumar R, Gupta N, Mallick A. Enhancing preparedness among frontline doctors during COVID-19 pandemic: Learning from experience. *Indian J Psychol Med*. 2020;42(5):489–491.

ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/0253717620952052

How to Effectively Break Bad News: The COVID-19 Etiquettes

Bad news is defined as "any information that results in a cognitive, behavioural or emotional deficit in the person receiving the news that persists for some time after the news is received."[1] Effective breaking bad news (BBN) is a complex communication task. This complexity is compounded when less than one-third of clinicians are adequately trained in BBN.[2] In the clinical milieu, BBN not only includes death telling (as per popular perception) but also revealing test results, failure of treatment effects, disease recurrence, major side effects of drugs, and issues pertaining to hospice and resuscitation care.[2] Empathetic, honest, balanced, and unhurried communication (Cunningham's model) and actively involving the significant others while delivering bad news have been associated with healthier clinical outcomes.[2,3]

"How to effectively break bad news?" needs a redressal during the terra incognita COVID-19 pandemic, especially when more than 10.3 lakh victims (with > 26,000 deaths) have suffered in India.[4] Citing the highly infectious nature of the virus, numerous prophylactic measures have been deemed mandatory for health care professionals (HCPs). These measures, the new COVID-19 health care etiquettes, include personal protective equipment (PPE) such as cap, goggle, face mask, gown, and gloves that shield affective display, restrained time of contact, and those mini invisible barricades created by floor marks to maintain adequate safety distance. Surely, these are *barriers* for the ideal setting and skilled communication (e.g., pat on the shoulder) deemed essential by every recommended BBN protocol, be it the ABCDE model,[5] the SPIKES,[2] or the BREAKS.[6] As per the protocols proposed for breaking news of a death in a hospital or emergency set-up,[7–8] meticulous preparation, building a therapeutic relationship, skilled communication, dealing with family reactions (shock, denial, anger, and guilt), and validating emotions are the core strategies to execute BBN effectively.[9] However, the COVID-19 etiquettes pose a tough challenge to these steps. Furthermore, considering the anxiety and stigma around COVID-19, the emotional reactions can be extreme and need sensitive handling by HCPs.

Certainly, there is a need for customized BBN protocols for HCPs, especially of death due to COVID-19. We suggest five "COVID" practical recommendations that can be incorporated into such protocols:

1. ***C***ubicles and minimal PPE: Custom-made double (opposite) entry cubicles with a transparent partition, set up with a two-way audio/microphone-speaker system, may be used specifically for the BBN sessions. Adequate and periodic sanitization of the cubicle will be essential. Proper sanitization will