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No patient safety without health worker safety

The COVID-19 pandemic provides a stark reminder of the importance of health worker safety. Inadequate personal protection equipment (PPE) has been a problem in many settings and there have been too many examples of health workers becoming infected and dying from COVID-19.[1–3] The harsh consequences of inequalities have also been laid bare by the pandemic. In countries such as the UK and USA, a disproportionate number of infections and COVID-19 deaths have occurred among Black and ethnic minority communities and people in the lowest socioeconomic groups.[4] Women comprise about 70% of the health and social care workforce[5] and have been on the front lines of the response to COVID-19, where they are at increased risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection; women are also likely to be hard hit by the caregiving burdens and economic losses resulting from the pandemic.[5,6]

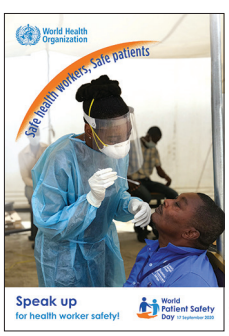
But what the COVID-19 pandemic has also made clear is how dependent patient safety is on health worker safety. On Sept 17, as we mark World Patient Safety Day 2020, it is crucial to highlight that there can be no patient safety without health worker safety. As in previous outbreaks of Ebola virus disease, Middle East respiratory syndrome, and severe acute respiratory syndrome, only when health workers are safe can they keep patients safe and provide health systems with stability and resilience.[7]

Patient safety is an essential component of universal health coverage and patients should not have to choose between no care or unsafe care.[8,9] Equally, when health systems are put under extreme pressure, and health workers are asked to go above and beyond their usual duties, the health workforce too must be kept safe.

In high-income and low-income countries alike, there have been many deaths from COVID-19 among health workers. Although attempts are being made to quantify them, this remains challenging.[10] Failure to provide health workers with adequate protection against threats to their health cannot simply be attributed to inadequate resources. Many countries have revealed insufficient preparedness to protect their health workers in the event of a disaster.[2,11,12] Yet the ability of health workers to protect citizens depends on health worker safety. If health professionals are to provide safer care for patients, all stakeholders need to swiftly and decisively address the global need for health worker safety.

Although some variation exists between the risks health workers face in different settings, they fall broadly into similar categories and so a united, systematic global approach can be applied. The general categories relate to environment and infrastructure, physical safety, mental health and wellbeing, and security.

Environment and infrastructure can limit the ability of staff to complete necessary safety functions; physical incidents are often trivialised as "slips, trips, and falls" but are occupational hazards that cause injuries to health workers and detract from the delivery of safe, high-quality care.[13] Furthermore, environmental challenges around infection prevention control (IPC) have been one of the biggest threats to health worker safety, especially in low-income and middle-income countries.[11,13] Exposure to respiratory and blood borne pathogens is increased in the hospital setting.



WHO

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For more on **World Patient Safety Day 2020** see https://www.who.int/campaigns/world-patient-safety-day/2020

However, these examples are only the tip of the iceberg. Health workers encounter other physical and psychological challenges each day related to mental health, wellbeing, and security. With prolonged hours and high workload, fatigue and stress are threats to the mental health and wellbeing of health workers, increasing the prevalence of burnout and posing a risk to their physical health from non-communicable diseases, which are exacerbated by protracted stress.[14] Preliminary evidence suggests there is a high burden of burnout and problematic safety culture for health workers responding to COVID-19.[15] Additionally, health workers are subject to frequent attacks, both in conflict zones and elsewhere, an issue that has worsened during the pandemic.[16–18] Despite the 1949 Geneva Convention providing protection from violence, the safety and security of health workers remain at risk in many settings.[16] Ongoing violence against health workers and inadequate workplace safety further threaten health workers' mental and physical health.

There now needs to be universal recognition that health worker safety is patient safety. One cannot exist without the other. A focus on ensuring safe working environments will lead to improved patient care. Clear, comprehensive IPC measures and guidance, together with provision of PPE supplies and positive organisational cultures, will reduce the risks of infection and physical and mental harm for health workers, and of nosocomial disease among patients. The ability of health-care systems to absorb learnings from the front line and convey compassionate leadership for their workers can help reduce burnout and foster better mental health outcomes among health workers.[19,20]

If the environment is not safe for health workers, it cannot be safe for patients. Health workers cannot provide high-quality and safe care to patients in environments where there is a physical threat to their safety and they are fatigued and stressed.

During the COVID-19 pandemic, health workers have been among those who have borne the brunt of the disease, with some being more vulnerable than others including women and Black and ethnic minority health workers.[1] Many health workers fear their working conditions are putting them and their families at risk. Governments and health-care organisations must act now to support and protect the health workforce so that we can provide safe care for our patients.

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Announcing the *Lancet* Commission on stigma and discrimination in mental health

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Stigma and discrimination against people with mental ill health are global problems and have severe consequences in terms of social exclusion.[1] Such social exclusion is associated with barriers to health care,[2,3] increased unemployment,[4] and premature mortality.[5] Evidence is clear from high-income countries, and is emerging from low-income and middle-income countries (LMICs), that interventions can be effective in reducing such stigma and discrimination.[6–8] We now need a reappraisal of this field and a set of radical and practical recommendations to guide action locally, nationally, and globally to address mental health-related stigma and discrimination.

This reappraisal has been initiated through a global collaboration, the *Lancet* Commission on Stigma and Discrimination in Mental Health. The Commission has six main aims. First, we will define stigma and discrimination, summarising the various models that have been developed, and provide an integrative framework to guide the work of the Commission. Second, we will summarise the global evidence of how people with mental illness experience stigma and discrimination. Third, we will describe the wide-ranging impacts of stigma, including barriers to clinical services, biases in the behaviour of health-care providers, violation of basic human rights, and adverse social implications, such as in marriage and the workplace. Fourth, we will conduct a literature review on the effectiveness and cost-effectiveness of interventions to reduce stigma and discrimination related to mental illness. Fifth, we will identify what policies, resources, initiatives, culturally relevant narratives, and interventions are required to eradicate mental health-related stigma and discrimination, and what needs to be done to drive the systemic legal, financial, social, and health changes that are required. Finally, the Commission will provide a set of actionable recommendations to put these changes into practice, including measures developed with key stakeholder and target groups, including service users and carers, policy makers, clinicians, educators, carers, celebrities, philanthropists, and researchers.

Since stigma and discrimination occur globally, although their manifestations vary by context and culture, a serious and coordinated international effort is required to produce strong Commission recommendations. The 21 Commissioners (appendix) are drawn from 15 countries and have experience in governmental and non-governmental organisations, service user groups, universities, and other research centres. Most of the Commissioners are from LMICs and most are women. Service user involvement is central to evidence-based interventions to reduce stigma and

See **Online** for appendix

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