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The future of Iran's health workforce

Iran has been hit by six waves of COVID-19 infection since the outbreak of COVID-19 was announced by authorities in March, 2020.¹ The unprecedented and unknown nature of the disease gradually led to burnout of the health workforce, particularly among those health-care workers who were directly involved in treating patients with COVID-19. On one hand, burnout was caused by the fast spread, absence of treatment, and severe health outcomes; on the other hand, it was driven by persisting deficiencies in the health-care system: inexperienced staff working in an epidemic situation; untrained new medical staff; scarcity of equipment, drugs, and other vital resources; low ratio of nurses and doctors to hospital bed; inefficient rest time; anxiety; inability of families to accompany patients to hospital; rigid and busy work shifts of the health workforce; infected staff continuing to deliver care; and absence of alternative personnel for medical staff.²

The Iranian workforce experienced a remarkable increase in the emigration of nurses and physicians to work in high-income countries such as Germany, Italy, and Canada.³ During the first year of the COVID-19 pandemic, more than 3000 Iranian physicians applied for immigration to foreign countries. The rate of immigration requests from nurses has increased by 300% during the pandemic.⁴ Those who remained in the country have worked day and night through multiple waves of COVID-19, hoping for permanent elimination of the virus and a better, healthier future.

Authorities had to deploy supportive, incentivising, and educational measures during the pandemic to increase productivity of the health workforce and reduce burnout,^{1,5} but no major change was observed. Due to severe resource constraints and budget deficits, increasing the number

of medical personnel with short-term contracts and volunteers has been used by policy makers to maintain the required number of workers and control spiralling costs. Except for the permanent staff and those with long-term employment contracts, the rest of the health workforce was recruited in hospitals using various forms of employment that did not ensure any future job security, including 89-day contracts and a volunteer workforce with small payments.⁴ Moreover, national laws needed to support medical staff were only partially implemented or not implemented at all. The ratio of nurses and nurse aid staff per hospital bed is approximately 0·8–1·0 per bed⁶ (compared with the standard of 3·0 nurses per bed and 4·0 nurse aid staff per bed).⁷ Considering how seriously a nurse's heavy workload affects patients' health outcomes, the government must take measures immediately to compensate for the shortage of hospital staff.⁸

Although Iran seems stable and has passed over the peak of the sixth wave of COVID-19 infection, urgent action is needed to maintain the health of the workforce and ensure their resilience, particularly in anticipation of future outbreaks. Strengthening the district health network in Iran, a symbol of Iranian policy intervention in the past four decades,⁹ promoting home care services, and investing in the development of telemedicine have the potential to reduce the health workforce's workload. For this purpose, different health system levels within the Iran Ministry of Health of Medical Education should be coordinated closely at service delivery and policy making levels.

We have no competing interests.

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The addition of pelvic lymph node treatment to prostate bed salvage radiotherapy

Alan Pollack and colleagues¹ suggest improved freedom from progression and reduced distant metastasis for patients with prostate cancer who are treated with salvage prostate bed radiotherapy (PBRT) and pelvic lymph node radiotherapy (PLNRT) combined with short-term androgen deprivation therapy (ADT; trial group 3) when compared with treatment with PBRT alone (group 1) or PBRT combined with short-term ADT (group 2). We commend the investigators for completing this important clinical multicentre trial.

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