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Editorial

Feel Better, Work Better: The COVID-19 Perspective

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The world appears to many to be a scary place at the moment. News outlets and social media are full of the latest horror stories of exponential increases in COVID-19 patients, dwindling medical supplies, heartbreaking decisions due to rationing of care, and infected health care workers. And, of course, there are tales of individuals who are not taking this pandemic seriously, who are defying physical distancing recommendations and even quarantine and putting others at risk as a result.

In the meantime, myocardial infarction, heart failure, and arrhythmias still happen in uninfected patients. Furthermore, COVID-19 illness is more serious in patients with underlying cardiovascular disease; similarly, dramatic cardiac manifestations have been seen in people with normal hearts. Either way, cardiovascular professionals are now on the front line looking after these critically ill patients.

This comes at a significant personal toll. Some practitioners are making the decision to self-isolate when not at work in the hospital, to avoid risk to their families. Others, on the basis of age or underlying medical conditions, are already at high risk themselves. Even worse, there's no end in sight, only the ongoing anxiety about "what, or who, is next." Work-life balance has always been a challenge, but it has never been more important than now. We may feel confronted by the conflict between our patients and our profession vs caring for ourselves and our families. As an example, many of us are required to be front-line health professionals and simultaneously home school our children.

Strategies to Keep the Workforce Up and Running

As has often been said regarding this pandemic, it is a marathon, not a sprint, and it is affecting all aspects of society, not just the health system. Currently, many practitioners have transferred follow-up care and even consultations to a virtual realm, either by telephone or telehealth, with in-person visits reserved for those judged to require personal clinical assessment. The Canadian Cardiovascular Society (CCS) Rapid Response Team has already provided guidance on the use of procedures and clinic space during this time (Table 1).[1-12] This is predicated, however, on cardiac sciences programs maintaining their workforce.

Most programs have schedules that have been set months in advance, often dependent on travel and vacation schedules, as well as the need for academic deliverables for some individuals. Most of these schedules have been abandoned in favour of "crisis response" mode. With meetings and travel cancelled, the focus should be on both maintaining clinical expertise in all areas of cardiovascular medicine and reducing personal risk. Every effort should be made to avoid exposure for health professionals over the age of 60 years and those with certain underlying conditions, particularly in circumstances where risk may be higher (such as a COVID-19 patient requiring intubation). In a group practice situation, where each member maintains personal patients, now may be the time to "share" patients, such that follow-up can be done for these higher-risk individuals, keeping them safe while at the same time offloading the workload of other clinicians who are providing front-line care. We can learn from our colleagues across the globe, many of whom have specifically designated separate locations to care for noninfected patients with acute cardiac illnesses.

Given the potential physical, emotional, and mental stress of this pandemic, some consideration should be given to the feasibility of reducing the length of clinical rotations to allow all practitioners the opportunity to rest, recharge, and be with their loved ones. Key to this is skilled leadership and the close communication and coordination among group members, with flexibility for clinical assignments to cover those who may fall ill, even with the common cold.

CCS is working on a new initiative where our members can share practical tips and advice, ranging from safety to how groups are handling call schedules. Equally important, please

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Table 1. COVID-19 topics covered by the CCS Rapid Response Team.

Date	Topic
March 15, 2020	CCS's response to the COVID-19 pandemic[12]
March 15, 2020	COVID-19 and use of ACEi/ARB/ARNi medications for heart failure or hypertension[11]
March 16, 2020	COVID-19 and cardiac device patients: a message from the Canadian Heart Rhythm Society[10]
March 17, 2020	Guidance on ambulatory management and diagnostic testing during the COVID-19 crisis[9]
March 17, 2020	Joint letter to the Deputy Ministers of Health and Public Safety offering expert guidance on a coordinated strategy regarding the use of ECMO during the COVID-19 pandemic[8]
March 19, 2020	Guidance on hospital-based care and cardiac procedures during the COVID-19 crisis[7]
March 20, 2020	Updated. COVID-19 and concerns regarding use of cardiovascular medications, including ACEi/ARB/ARNi, low-dose ASA and nonsteroidal anti-inflammatory drugs (NSAIDS)[6]
March 22, 2020	COVID-19 and cardiovascular disease: what the cardiac healthcare provider should know[5]
March 25, 2020	Guidance on community-based care of the cardiovascular patient during the COVID-19 pandemic[4]
March 30, 2020	Reducing in-hospital spread and the optimal use of resources for the care of hospitalized cardiovascular patients during the COVID-19 pandemic[3]
April 1, 2020	Is it COVID-19 or is it heart failure: management of ambulatory heart failure patients[2]
April 7, 2020	Management of referral, triage, waitlist and reassessment of cardiac patients during the COVID-19 pandemic[1]

ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor - neprilysin inhibitor; ASA, acetylsalicylic acid; CCS, Canadian Cardiovascular Society; ECMO, extracorporeal membrane oxygenation.

share the strategies that are not working, and why—we can all learn from each other, saving time and precious resources.

The Emotional and Mental Toll of COVID-19

The widespread measures taken to limit the spread of this virus will have considerable emotional and mental health fallout for patients and individuals who have spent lengthy periods in isolation. We must also not underestimate the psychologic trauma that is being experienced by health professionals worldwide. The moral and ethical dilemma of rationing care, personal protective equipment, and even ventilators will likely have a toll.[13]

Lai et al. recently reported the mental health outcomes of 1257 healthcare workers caring for COVID-19 patients in China, using a series of validated instruments. Depression, anxiety, insomnia, and distress were reported by the majority of participants. Multivariate logistic regression identified nurses, women, front-line workers, and those in the epicenter of the pandemic (Wuhan) to be at higher risk for symptoms.[14]

Acute psychologic distress is not the only risk for our profession. Burnout is defined as a constellation of mental fatigue, physical fatigue, frustration, and disengagement.[15,16] Some are now referring to this as "moral injury," a term borrowed from those observing the "guilt, shame, and anger" present in military and veteran communities.[17] A 2019 survey conducted by the America College of Cardiology suggests that 35% of cardiovascular practitioners were experiencing burnout and 44% acknowledged symptoms of stress.[18] Social support helps to alleviate burnout; in this pandemic, some of these supports are harder to find, or they look and feel different. We are not having coffee with our friends or going to the gym. We are potentially isolating ourselves from our families for their own safety; we are hearing of colleagues who are writing their wills, providing advance care directives, and deciding who will take their children. We are intubating our colleagues. Some are dying from this.

Mitigation Strategies

One thing that has become abundantly clear is that teamwork is sexy again. There's no room for minor drama and frustrations in the midst of this big picture. And that feeling of teamwork is incredibly reassuring and humbling. It's a reminder of why we all chose to do this work in the first place.

We need to be kind to ourselves and kind to each other. We need to model the right behaviour for our fellows, residents, and colleagues, including nurses, pharmacists, respiratory therapists, environmental services, etc. That means "do as I say *and* as I do." Everyone is being told they need to eat well, sleep well, and make time for exercise. This applies to us, too.

We need to take our emotional temperatures as well as assessing physical symptoms. The management of this pandemic can be thought of as a mission. Health care workers can take advantage of the extensive work done by the Canadian Armed Forces Road to Mental Readiness (R2MR) program, which is designed to improve work performance and long-term mental health outcomes through a foundation in resilience. The app for it is free to download and contains a rapid assessment tool to assess a spectrum of healthy adaptive coping to distress and severe functional impairment (mood, attitude and performance, sleep, physical symptoms, social behaviour, alcohol, and gambling). Regular monitoring promotes self-awareness and the identification of areas requiring more attention and resources.[19]

It is important to note that there are many important self-care tools, and individuals need to identify and practice the ones that work for themselves. One person may find yoga and mindfulness calming, whereas others prefer a walk, a run, or lifting weights. Some will make more time to explore their spirituality. Choose the tools that work for you.

Everyone has their own (different) personal and professional contexts; this will influence how we are feeling, and how we make decisions. Individuals react differently to some of the challenges we are facing. Some are taking this whole situation in stride, some are not. Remember, it's okay to be okay, and it's also okay to not be okay. But you are more likely to be okay in the long term if you take steps now. Don't forget those basic building blocks of nutrition, sleep, and exercise. Our junior colleagues and trainees are vulnerable in that they are truly front-line, often with little experience. However, they are also our future and will lead the next time we face a challenge. Our senior colleagues, although more seasoned, were more likely to have symptoms of burnout before the pandemic. While we are looking after ourselves, we need to look out for each other—if everyone reaches out to just a few others every few days, we will be stronger and healthier for it. On the other hand, the failure to reach out might come at an immense cost.

Finally, please remember what we learned as kids: Treat others the way you want to be treated. There is no place for comments like "being stressed is not a good reason to not come to work." The CCS is a tight-knit community. The number 1 reason that members attend the Canadian Cardiovascular Congress is networking. Any time an affiliate group gets together, the respect and camaraderie are evident on the smiles on everyone's faces. We are more than a professional organization; we are a team, a community and a family. This pandemic will end; and it has the potential to strengthen our personal and professional relationships.

Let's play to our strengths.

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