UNDERSTANDING THE CURRENT HEALTHCARE WORKERS' MENTAL HEALTH CRISIS AND THE IMPORTANCE OF REDEFINING WORKPLACE CULTURE

Healthcare workers (HCWs), internationally and in South Africa, are facing an increasing burden of mental health care needs. In addition to the usual demands of medical practice the recent worldwide COVID-19 pandemic placed an additional burden on health care workers. Not only burnout, but an array of mental health conditions such as mood disorders, anxiety disorders and substance use disorders are of concern. The workplace culture is of importance in either protecting HCWs from or posing a risk to the development of burnout and other mental health concerns.

The impact of the COVID-19 pandemic

It would be fair to say that healthcare workers have been under severe strain and bore the brunt of the COVID-19 pandemic to a significant extent. Except for the risk factors for poor mental health that the general population were exposed to such as social isolation and loss of community support, risk to the health of family members and loved ones and financial strain, health care workers experienced additional mental strain. This additional strain came from caring for severely unwell and dying patients (who may include even colleagues) during the COVID-19 pandemic, constantly making life-and-death decisions, concerns about infecting family members on returning home, becoming infected themselves and having to work for longer hours, more shifts and under unusually difficult conditions. It also included the lack of PPE, availability of life saving treatments and other budgetary constraints. Even after the worst of the COVID-19 pandemic, healthcare workers remain under strain to the point of a mental health crisis under healthcare workers.

The rates of (emotional) burnout, as well as psychiatric disorders such major depression, anxiety disorders, substance use disorders and posttraumatic stress disorder are rising under HCWs. A study by Farooq and colleagues, for example found an increase in the rates of suicide ideation, compared to the rates prior to the COVID-19 pandemic, in different countries and populations. They further found that low social support, high physical and mental exhaustion, poorer physical care by self-report from frontline healthcare workers, sleep disturbance, quarantine and loneliness were the main risk factors for the development of suicide ideation.

The COVID-19 pandemic exposed the vulnerabilities of the workplace environment. It brought the preparedness or otherwise of the workplace to light. It also uncovered the workplace culture. The moral injury suffered by healthcare workers can often be attributed to the workplace culture.

Workplace preparedness

Workplace preparedness refers to the proactive readiness of the workplace environment to deal with both foreseeable and unforeseen demands. Workplace preparedness for foreseeable demands are usually

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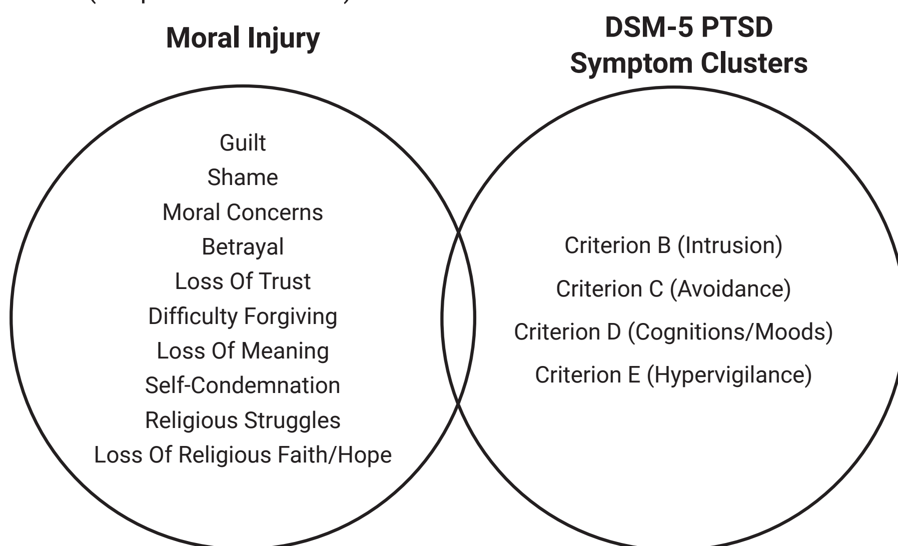
reflected by the workplace standard operating procedures, policies and workflow diagrams. Under standard conditions such measures are suitable to manage the demands of the workplace. During times of unforeseen demands such as disaster events or, in the case of the COVID-19 pandemic, a rapidly evolving and overwhelming threat to the healthcare system, standard operating procedures and policies are no longer sufficient to ensure optimal work functioning. During such demanding times operating procedures and policies should evolve concomitantly. These changes should be evidence based and conscious of resource availability.

Criticism has been leveled at policy and decision makers of decisions made regarding public health policies and operating procedures

which in retrospect was not optimal. Such decision and policy changes defined the workplace culture in which healthcare workers delivered and continue to deliver service.

Workplace culture and moral injury

In a paper by Griffin and colleagues, they recognised that there is not yet a consensus definition and gold-standard measures for moral injury. Despite this limitation, He and colleagues found that moral injury may contribute to the prevalence of suicide ideation and that mental health conditions, especially depressive symptoms, play a significant role as mediators of moral injury. Moral injury, as initially defined by Litz et al in 2009 as “an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness..” is often a result of the workplace environment and prevailing culture. The original definition of moral injury by Shay in 1995 (quoted by Wiinika-Lydon) emphasised three key elements of behavior that constitutes moral injury, 1. a betrayal of what is morally right, 2. by someone who holds the legitimate authority, 3. in a high-stakes situation. Shay further observed that it is the feeling of powerlessness in these situations that leads to helplessness and hopelessness (key elements of depression) as well as feelings of guilt and shame. Shay goes on to link these feelings to erosion of trust, social withdrawal and isolation and emotional numbing. Koening et al link such experiences to the features of DSM-5 defined posttraumatic stress disorder (PTSD) as indicated in the figure below (adapted from source).



A workplace culture where healthcare workers are disempowered to make critical decisions and are unable to care for themselves and their colleagues leads to feelings of helplessness and hopelessness, subsequent moral injury and the resultant mental health concerns. The workplace culture should be one of empowering and enabling healthcare workers.

Looking after our healthcare workers is looking after the nation.

References available on request. MHM