CRISIS RESPONSE

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Protection Prevention Preparedness Response Resilience Recovery

CLIMATE FIXES?

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comment

On top of the millions of deaths and protracted health consequences brought about by this pandemic, Covid-19 is a particularly cruel crisis in that it isolates and deprives people of the comfort they would normally derive from the affirming company of other human beings. As Lyndon Bird says on p8: "We are social animals. We need to get together to share thoughts, feelings, ideas, hopes, and sometimes complaints."

Of course, technology has helped with multiple ways of communicating that were unimaginable just a few years ago. But although many of today's virtual methods of communication are widely viewed as being here to stay, in some circumstances human contact is, quite simply, irreplaceable. Virtual interaction can never fully replicate the complex subtexts and nuanced cues when meeting another person face-to-face.

Words and body language are vital, as described in Jeannie Barr's exploration of communication and vocabulary used during emergencies. The choice of language and tone can be either helpful or detrimental in a crisis (p73).

On p64 Lina Kolesnikova examines how Covid-19 has disrupted working and shopping habits, as well as the ways we access healthcare and information. She says that the very essence of what we define as 'critical' infrastructure is being transformed. This brings new risks in terms of resilience and security, including in the areas of technology we have come to rely upon during Covid-19.

Design is another undervalued but essential piece in the jigsaw of humanitarian and emergency response disciplines. David Wales notes on p76: "As the meeting point between states and communities, public service agencies would greatly benefit from making design a standard approach."

The key lies in understanding people – their culture, fears, concerns, past experiences and predispositions. Michele Wucker calls this an individual's unique risk fingerprint (p44).

All of the above should be combined with a simple shift of focus onto the people dealing with – and affected by – a crisis, says Thomas Lahnthaler (p50). Because, above all, we must not forget that crisis management is about people.

Healthcare workers and Covid-19

Erik de Soir relates the experiences of nurses in emergency and intensive care medicine in Belgium, saying their stories of courage and strength, but also of fear, uncertainty and guilt, will provide additional insights into the psychosocial effects of a pandemic outbreak

The pandemic has posed a major mental health challenge in residential care centres, rest homes and hospitals. Perhaps now more than ever, the mental resilience of professionals is vital.

From the outset of the coronavirus pandemic, healthcare workers (HCWs) were worried about the risks of infection and protective measures in their place of work. This led to psychological distress and indicated that action should be taken to enhance the psychosocial support of all those involved on a professional level.

The right care for HCWs spans various aspects: The identification of work-related problematic issues; appropriate leadership policies, such as timely referral to peer support or professional counselling; psychoeducation for self care; and creating a supportive work environment in which both physical and mental health are permanently monitored. It is also the responsibility of each healthcare professional to monitor and maintain their own balance.

The objectives should include offering HCWs psychosocial support to cope with individual stress and to maintain sufficient levels of resilience. It should also provide information on how to deal with stress and resilience through adequate psychoeducation and training and gain insight into the prevention of stress-related complaints during and after the Covid-19 crisis. Support must provide information about aftercare options for stress-related complaints and prepare HCWs for future epidemic outbreaks.

Policymakers and management teams should invest in better working environments and support for their staff during future epidemic waves. A post-Covid decompression period, based on third location decompression programmes for soldiers after an operational deployment, could be considered for first responders and healthcare professionals.

From the beginning of the pandemic, mental healthcare staff – psychologists and social workers – along with medical personnel from intensive care units and emergency departments, supervised by the author of this article, developed adequate collective support and counselling, before and after working shifts in Covid departments, as well as individual defusing or debriefing upon demand.

Groups of HCWs have been offered post-Covid peak debriefing sessions to provide their lived experiences and to develop *ad hoc* questionnaires for ongoing empirical research.

Group debriefings with mental healthcare staff from hospitals and medical staff who worked during the Covid crisis, have indicated that most hospitals developed some form of support during the successive peaks of the pandemic. Some hospitals worked with internal coaches, essentially psychologists, who were on hand in the Covid departments.

In most hospitals, the start of the crisis was particularly difficult: there were too little protective materials available, there was too little information on proper protection procedures and no targeted reception of Covid-patients.

Standard operating procedures changed constantly and it was difficult to deal with the numerous deaths properly. The coronavirus could remain active in a corpse for two or more days; people who died in the Covid department had to be put in a plastic body bag as soon as possible; body openings were covered up, inhalation tubes or IV equipment had to remain on the body and there was no time for families to say goodbye.

Fear of contamination

Similarly, it was very tough working in departments where colleagues themselves became ill and in an environment where it seemed that patients did not recover after intubation. It appeared that those colleagues would also die, and this increased the fear of contamination among caregivers. Medical staff in the intensive care units also experienced emotional difficulties since no one was allowed to visit Covid-19 patients. The fact that many patients had to die alone was considered very stressful for most HCWs because during the peak moments of the crisis, there were simply not enough personnel to ensure basic support for the dying. One said: "They died like animals: dying, death, plastic bag and away in a cooling container." Medical staff found it difficult that they could not rely on the humanity they used to show in normal daily routines before the Covid crisis struck.

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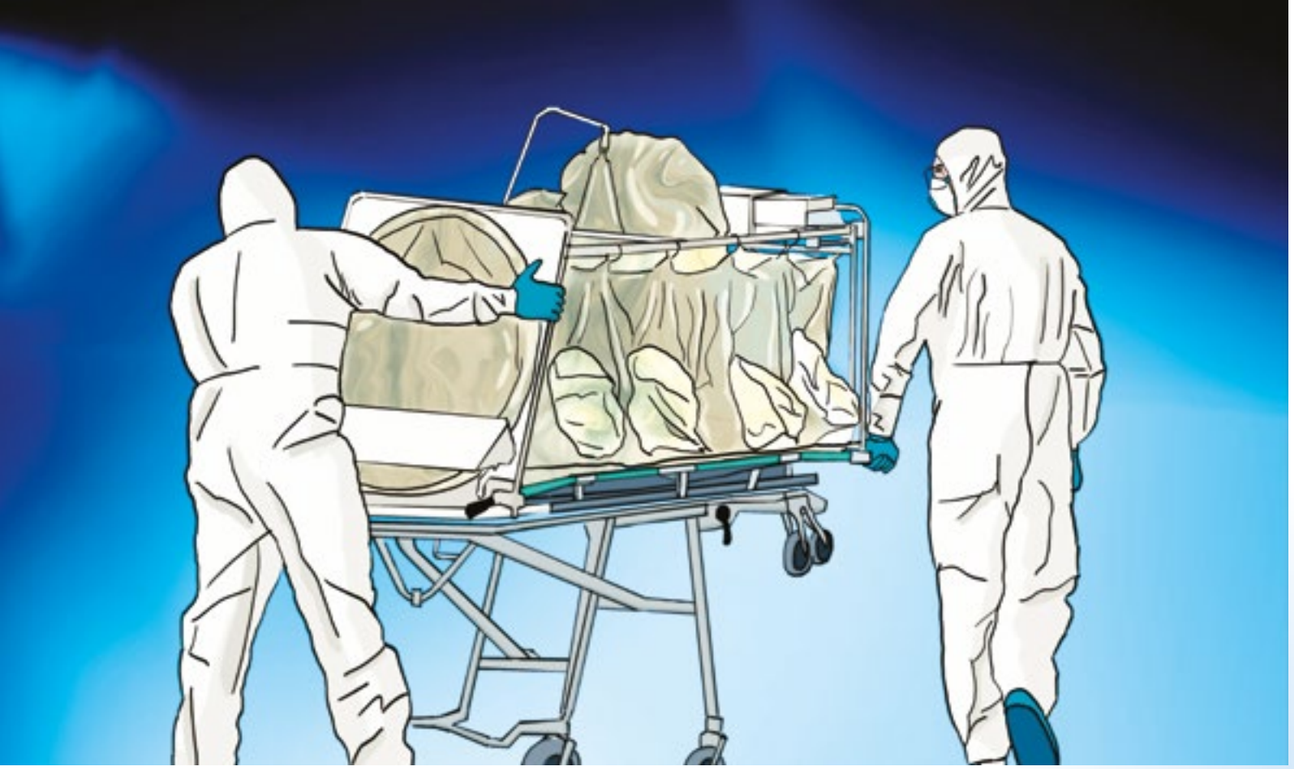
Policymakers and management teams should invest in better working environments and support for their staff during future epidemic waves



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Running parallel with these potentially traumatising images and experiences was the moral aspect at the beginning of the crisis – having to work without proper protective equipment and adequate procedures. Previously, it was only military medical personnel who had experience of mass deaths in difficult conditions and of working in a heavily biotoxic or contaminated area. The lessons learned by military medical personnel are therefore of utmost importance in times of a pandemic.

ICU nurses and emergency services personnel reported that the sudden and massive influx of infected patients was particularly hectic in the early days of the crisis. At peak times, some hospitals had to send many patients to facilities in other provinces of Belgium because services were saturated and there were not enough supplies.

The search for a way to work safely pushed psychosocial needs into the background. Staff accumulated experiences and impressions, but time was never really taken afterwards to think about them thoroughly.

The impact, the realisation of the amplitude of the crisis and of everything that had occurred came later, as is witnessed in soldiers returning from a military operation. Often, in such cases, soldiers' psychosocial problems become most visible between three to six months after returning home. Many will only be ready to face up to it when they are on leave and rest, but now this has to be seen in a different context.

Medical personnel mention the deep impression left by frequent calls with distressed relatives receiving the bad news of a deceased loved one, often being informed sometime after their loved one had died. In those moments, many social workers felt alone and the only support during their shift came directly from colleagues or even through WhatsApp messages from co-workers on the same medical unit.

After several weeks of acute Covid distress, managers realised that there had to be more rotation of staff, alternating between working in Covid wards and deployment in other departments – one day working in the 'dirty zone' and one day working in the 'clean zone', as some put it. This was a worthy adaptation because it was good for medical personnel to see patients who had been cured and recovered. After all, the general impression had been that once a patient was intubated on intensive care, there would be no improvement and it was sometimes erroneously assumed that certain patients would die.

Continually working in a department of the dying instilled feelings of resignation and the depressive nature of this weighed on staff; this situation became even more acute when personnel were also overcome by fatigue.

A number of nurses and doctors also indicated that they had a lot of difficulty with the spontaneous do not resuscitate (DNR) policy in Covid departments. This was mutually agreed upon between doctors and nurses on the basis of age and pre-Covid medical condition in those patients who could not indicate their views on possible resuscitation. This is a choice based on the 'survival of the fittest' principle, reminiscent of triage in war or disaster conditions. In combat or in disaster situations, medical triage elects only to save the lives of those who can be reasonably expected to live. It is evident that this may pose an ethical problem for civilian personnel who are not used to working in such conditions and this policy can confront caregivers with moral dilemmas.

The initial chaos of searching for the most workable routine in difficult conditions, sourcing protective masks and screens, gloves, warm washable suits and adapting to a fixed process in handling infected patients also took some time to abate.

Eventually, with experience, it became clear which patients should immediately be sent to the intensive care unit – the 'crash box' – upon arrival at the hospital.

Since doctors sometimes had to be everywhere at the same time, more pressure was put on nurses' shoulders who, in some cases, were placed in medical moral dilemmas, having to make life and death choices.

During the peak of the coronavirus crisis, the most difficult thing for both nurses and doctors was the permanent adaptation to changing guidelines and procedures. Owing to the relative unfamiliarity of working in these circumstances, it was essential that procedures had to be frequently adapted owing to 'advancing insight'. A strong and unambiguous information flow throughout the hospital was of great importance.

Moral injury syndrome

It became clear that only people who worked together as colleagues in the Covid crisis could truly understand the situation and how things were going, which created a potential problem in terms of social support at home and among caregivers' families.

It is also essential to consider the other patients who continued to come to hospitals, often for urgent complaints, with a problem unrelated to Covid-19. They might have been people who felt fortunate that they did not have Covid-19, but who feared contracting it in hospital and even dying from it. Or they might have been people who came to the hospital with a seriously ill child, but panicked and left when faced with the hectic and frenzied Covid-19 reality.

It is this mix of professional and private stressors that makes this situation unique and so difficult for the staff. One can assume that this context involves ongoing burden trauma, owing to the accumulation of all these experiences, images and impressions, as well as a kind of moral injury.

This indicates that mental healthcare providers should take the clinical image of post traumatic stress disorder (PTSD) and moral injury into account when working with Covid-19 medical caregivers.

Moral injury in HCWs occurs when their core moral beliefs are shattered. In evaluating their behaviour negatively, it feels as if they no longer live in a reliable, meaningful world and that they cannot be regarded as decent human beings. Anyone exposed to such events and the aftermath of war or disaster – such as medics and body baggers – can experience moral injury. Seeing someone else violate core moral values or feeling betrayed by persons in authority can also lead to a loss of meaning and faith.

In experiencing a moral conflict, people might judge themselves as being worthless, or decide that no one can be trusted, thus isolating themselves from others; they might abandon the values and beliefs that gave their lives meaning and guided their moral choices.

Some of these issues are already present in the accounts of HCWs who were engaged in the first wave of Covid-19. Next to the moral constraints of their world in the Covid department, they were confronted with terrible, sometimes shocking and potentially traumatising images, which may give rise to post-traumatic symptoms and, at a later stage, to full blown PTSD.

PTSD is a fear-based reaction to extreme life-threatening conditions, involving symptoms of post traumatic stress such as re-experience, avoidance, denial, emotional numbing, hyperarousal and depressive symptoms.

Moral injury, however, is a negative evaluation of the use of personal agency in such conditions – although not PTSD, it can provoke or intensify it. It comes from having a sense of empathy for others and understanding moral reasoning and values. Owing to the overlap between both syndromes, many clinicians would not recognise the difference between PTSD or a moral injury syndrome incurred as a consequence of a disastrous event.

According to field experiences in two successive Covid peaks in Belgium in 2020, most hospitals and rest homes provided at least some support for the deployed HCWs before or during their shift, but very few had an employee assistance programme in place prior to the Covid crisis.

One aspect of support that did not work was that of psychologists waiting for the end of working shifts in order to ask exhausted nurses or doctors how they were doing. At such times, the staff only wanted one thing: to go home and rest.

Some hospitals fell back on a broad team of psychologists and social workers from social or pastoral services who offered some form of discussion, debriefing or ventilation at structured moments. Others set up a cafeteria or chapel as a 'zen lounge' in which staff could relax before and after shifts, providing some decompression before returning home. The casual environment allowed easy access to psychologists, social workers and chaplains and was seen as a very positive addition.

Zen zones were sometimes also set near boards showing children's drawings, letters and thank you cards hung to boost morale. Knowing that support and encouragement were offered outside the hospital – the daily applause at 20:00 hrs and even the music sessions provided in some neighbourhoods – meant a lot to caregivers.

However, the best way to support the Covid teams seems to be the systematic and permanent provision of short debriefing sessions – check-ins and check-outs – after each rotation. This is also the case with first responders from uniformed services.

Given the lived experiences of HCWs and medical staff deployed in the Covid crisis over the last year, it is clear that adequate support should be offered to these heroes before engaging them in the next Covid wave; this is similar to the duty of care that the military has to its troops after a long-term deployment before sending them to another war zone or engaging them in a new military operation.

If the lessons learned from healthcare in crisis situations, disasters and military operations can lead to better psychosocial support, each nation would be more able to show gratitude and recognition for the work carried out in this global pandemic. CRJ

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